



ORTHO2

Electronic Treatment Charting— Where Will it Take Your Practice?

by **Tina Byrne**

Over the past few years, I have had the opportunity to work

with numerous Ortho2 ViewPoint practices in the design and implementation of their paperless offices. The decision to incorporate an electronic treatment chart is typically initiated to eliminate the need for pulling and filing paper charts, or to solve issues from having multiple locations. What orthodontic teams soon discover is that with digital data entry and computerized inter-office communication, an extremely efficient operational work flow evolves—for both the clinical and business team.

If you have yet to decide whether electronic treatment charting is right for your office, allow me to share my recommendations and ViewPoint tips for creating a “less-paper,” or better yet, a paperless day for your team.

Regardless of the number of patients your office sees per day, clinical efficiency depends not only on moving through a procedure within an allotted amount of time, it also requires the orthodontist to identify the progression or lack of progression of the patient through treatment and sometimes making on the spot decisions accordingly. In busy practices, a doctor may be allotted an entire two minutes to do this. Many an office has experienced a rise in patients over treatment time simply due to the fact

Could ViewPoint Treatment Chart be the answer to your problem? You bet!

that the doctor does not have an effective method for staying on top of a patient’s treatment status during each visit.

The sky is the limit when customizing your treatment chart

Tx. Chart for (Carla) Carla Joiner (AF - J018)

Age: 14 yrs, 5 mos - 5/14/1993
 Start Date: 08/05/2005
 Expected Removal: 08/05/2006
 Month 26 of 12
 Next Appt:

Res. Party: Mr. & Mrs. Jack Joiner (Father) Jack Joiner (Mother) Debra Gilbert
 Dentist: Dr. Wess Becker
 Referral: Dr. Timothy Kaler
 Orthodontist: Dr. Jim Smith
 Family: Willa Meg
 11 yrs, 10 mos
 13 yrs, 3 mos

Allergic to penicillin

Mom is Debra - Stepmom is Ann

Treatment Plan
 Tx Plan
 04/12/2005 RECOMMENDED TREATMENT
 Comprehensive orthodontics
 EXTRACTIONS
 Extract premolars: #4, 13, 20, 29
 FIXED APPLIANCES
 Full upper
 Full lower

Date: 05/09/06

Pre-Txmt	ID	Treatment Provided (Pre-Tx)	XRY	Next Apt	WKS					
08/05/2005	Dr. K	New Patient exam - mom attended - findings in plan - Transfer from Dr. Scholz San Leandro, CA - Transfer records are here - ready for new records		Records	ASAP					
09/09/2005	KAR	Full records		Pan Ceph	Consult					
10/10/2005	Dr. K	Consult - Mom attended - Good Progress - Should finish in 8 months		Adjust	ASAP					
Phase I	ID	OH	HG	ELAS	UPA	LOA	Treatment Provided (Ph1)	XRY	Next Apt	WKS
11/25/2005	JEM	A			16X22NT	17X25NT	Chain both arches		Adjust	5w
12/31/2005	DAS	B			16X22SS	17X25SS	Chain both arches		Adjust	6w
02/14/2006	JEM	B					Chain both arches - 3mm OJ		Class II Elas	5w
03/25/2006	TEM	B					Start Bears 7-30, 10-19		Adjust	6w

and treatment plan. With the ability to use numerous styles of charts, customized columns, and color coding, an electronic chart may be the only way to achieve your individual charting needs. Uniform, well organized documentation within a patient’s treatment chart is an advantage to every member of the orthodontic team.

The doctor benefits from a full view of the patient’s diagnosis, treatment plan, and treatment chart—at every visit. The summary of data in the header at the top of the treatment chart includes current month of treatment vs. total treatment time, number of months remaining in treatment, referral source, medical alerts, and other information useful to have at a glance.

The clinical team establishes consistency in chart entries with the ability to use drop down lists, as well as text,

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for any column within the electronic chart. Columns often not defined on a paper chart, yet easily incorporated into an electronic chart, prompt assistants to assess compliance and proceed as policy dictates. Oral hygiene, communication, breakage, and elastic or headgear wear are just a few examples. Take your assistant's role one step further in that "team approach" and enable your assistants to merge on-going treatment communications while working with the electronic chart. Traditionally the role for the business staff in most practices, merging compliance letters clinically assures that the written communication has been done. The business staff need only to edit or print the documents from the Print Later Queue on the ViewPoint main menu.

The scheduling team will discover appointment information literally "at their finger tips" once a chart entry has been made. The Needs Appointment bar on the schedule will hold a patient's next appointment information—along with the time frame in which the next procedure is requested. By double clicking the patient, the Explore function of ViewPoint goes into action and takes the user directly to the procedure and the number of weeks the patient is requested to return for their next appointment. All of this can be accomplished PRIOR to the patient's dismissal from the treatment chair. A view of the treatment chart is available to the scheduling coordinator when employing the Explore feature.

The tooth chart allows a graphical depiction of the state of your patients' teeth, including dentition, current tooth condition, extraction requests, appliances, and more. All entries are retained with the dates they are charted or changed. The tooth chart can be set with the Universal Numbering, FDI Two-Digit Notation World Dental Federation, or the Palmer Notation systems. A comprehensive list of tooth conditions allows iconic charting or custom notes for any imaginable dental situation.

Banding, bonding, and elastics wear can be charted on the diagram with a click or drag of the mouse. The tooth chart information then integrates into text on the treatment chart.

Need an extraction request? No problem, written requests can be effortlessly produced with an entry into the tooth chart, and the simple merge of a customized extraction document from the ViewPoint Letter Library.

Most doctors and team members can picture the use of electronic charting. What is harder to visualize is the flow of information or pre-treatment progression *without* the physical routing of a "chart."

Are you envisioning efficiency yet?

Let's view the entire process starting the journey as a new patient into your office.

The New Patient Call

Many offices incorporate a new patient call sheet for the gathering of comprehensive information. Regardless, the new patient's information is entered into ViewPoint. At this point, you may opt for one of the following:

1. Maintain a folder strictly for new patient call sheets. The day of the initial visit, the call sheet is removed from the folder and placed with the information you gather from the new patient when they arrive.
2. Scan the sheet of information into the patient's correspondence history labeled as NP CALL. Treatment coordinators need only to open the patient's file and correspondence history to have all information at hand for a welcome call prior to the initial visit.

Benefit Verification

If accepting assign of insurance benefits, verification is necessary in order to be fully prepared to present financials during the patient's initial visit. If this is the case in your office, I suggest either of the following:

1. Including a section on the new patient call sheet to obtain benefit information. Place the patient on an "Insurance Verification" stack in ViewPoint for the Financial/Insurance Coordinator. Enter verified information into the patient's Notepad on a tab labeled "Insurance."
2. Create a separate insurance verification form for the Financial/Insurance Coordinator. Attach the completed form to the new patient call sheet kept in a folder.

Initial Consultation

At this point in the process, the patient paperwork typically expands to include a comprehensive information form and a medical history form. Proceed with the initial examination, placing findings directly into ViewPoint whenever possible. If your office has had difficulty in placing findings as the doctor performs the screening, create a findings checklist that mirrors your ViewPoint findings, and complete the data entry at the conclusion of the visit.

At this point, all new patient information can be scanned into the patient's correspondence history to maintain a paperless process. Fee options and all other information is just a click away for the next team member to prepare treatment and financial agreements for the patient's start into treatment.

But the doctor requires a patient chart to review diagnostic records and produce a final treatment plan...

No problem. Use the STACKS feature in Ortho2 and label one "Treatment Plan." When diagnostic records are complete and

ready for final treatment planning, place the patient into the "Treatment Plan" Stack, and the doctor can take it from there.

If you are ready to take the plunge into an entirely new level of efficiency for your practice, I strongly recommend the implementation of Treatment Chart & Treatment Plan.

I am happy to make myself available to all Ortho2 users as they look for solutions for their "paperless" practice! ☺

About the Author



With over 30 years of experience in the field of orthodontics, Tina Byrne has extensive knowledge and understanding of systems innovation and efficiency, data analysis, strategic business planning, and marketing implementation. She offers a fresh perspective on the many challenges faced daily by the entire orthodontic team, and a unique combination of industry knowledge, humor, wisdom, motivation, and most importantly, practical solutions to maximize practice productivity and profitability. Visit her website at www.byrne-consulting.com or contact her at (800) 580-6580.

Tina will be presenting classes on Marketing and Insurance at the 2008 Ortho2 Users Group Meeting.