Data Havoc and Tales from the Crypt

By Dawn Christodoulou, President, XLdent

The improper use of a software program not only causes data havoc; it can result in operational dysfunction.

A few stories from my data crypt might help put this all in perspective. Once while converting a doctor’s database from a front-desk-only system to XLdent’s full EDR, we discovered just over $120,000.00 in unrecognized A/R. After further investigation, we found that it had accumulated over a ten-year time period as a result of a CDT code that had been incorrectly set up. The first problem was that the office manager configured the new code incorrectly; she was never properly trained on the core elements of the software program. The second issue for this office was that there was no system, or data review process, in place to catch the error. There were reports the doctor and staff could have used to clearly identify the problem, but none were generated as part of a data review regimen. In the end, the doctor was only able to collect about ten percent of the lost A/R because of the amount of time that had passed.

One of the things we stress when transitioning clients to electronic records is the importance of configuration and set-up. The establishment of clearly defined data structures is extremely important to the accurate calculation and presentation of information. Don’t allow free-form data to be entered in any field you may want to query, and do not allow tabled codes or data sets to be entered into your system without a review process. Predictable consistency in the capture of data is paramount. Well-designed software will help you keep your data contained, but when a feature allows you the freedom and flexibility to customize, your only salvation will be the rules you establish and enforce on the staff capturing and inputting the data into your EDR.

Another story from my data crypt involves a conversion from a partial EDR. The doctor was still processing patient and clinical forms on paper, but had fully implemented his charting process and clinical notes into an electronic record. In the process of transitioning the clinical notes from the old system to the new, we discovered that there was no consistency in where the information was recorded. Clinical team members had no Standard Operating Procedure (SOP) that dictated where or how to record their clinical notes. Everyone just did their own thing—so over the course of time, because of staff turnovers, lack of training, and no SOPs, they became operationally dysfunctional. After much hard work on the part of our Conversion Specialists, we identified all points of possible entry in the old system and pieced the doctor’s notes together chronologically to produce a congruent note history for each of his patients. The sad part of this story is that the doctor never questioned why clinically significant information was not presented consistently and was being stored in this random fashion. He did not establish an SOP for the input of clinical notes, insist on input discipline from each team member, nor did he intervene when data integrity started to slip.

When we discussed the complexity of this data conversion issue with this particular doctor, he shared that he had no idea this could get so out of control. He was previously using a well-known, mature software product and told me that everyone he hired identified users of this program on their résumé. He thought that experience with this software program was all that was necessary to successfully utilize electronic records. What he didn’t know at the time was that this assumption couldn’t be further from the truth. While many people use programs, they may not have formal training. In addition, the way one clinic implements a software system can be different from the way another clinic implements it, due to special needs, data presentation preferences, etc.

This example of electronic data havoc could have been a complete disaster, especially if the doctor was required to produce clinical documentation for legal review. Fortunately, this story has a happy ending. After participating in our paperless transitions planning process and reviewing XLdent’s EDR toolkit, the doctor put together a plan and implementation strategy of his own. This office is now fully operational and running a fully implemented EDR. All of his forms are paperless, all data input functions have associated SOPs, review processes are in place, and staff is held accountable for data accuracy and placement. Proper data management is helping him to be successful in more ways than staff productivity, streamlined workflows, and increased revenues. It is also resulting in better patient experiences, patient loyalty, and treatment outcomes.

I will never forget the day I tried to solicit help in transitioning dental offices to electronic records from a well-known dental consultant in the area. It was about seven years ago. My intent was to get his input on the development of a paperless transitions guide and establishment of some standard operating procedures for a paperless workflow. Do you know what his response was? I still can’t believe it. “What’s so hard about going paperless?” he asked. “All you have to do is the same thing you’ve always done except scan the paper into the computer.” I thought he was joking, but he was serious! I laughed anyway.

Transition is not an event. It is a journey. Prepare for the journey of implementing a fully paperless, electronic records system by reviewing workflows, utilizing the services offered by your EDR software company, and planning for adequate, continual implementation and training time. This is especially true for start-up practices. While some might think the transition from nothing to something is easy, it’s not. What is often neglected or forgotten is the establishment of proper data structure and standard operating procedures that are designed for electronic workflows. This is the key to being successful and maximizing your potential with an EDR.