Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Documentation and Standardized Care Plans

Nancy Martin-Molina, DC, QME, MBA, CCSP

New to the chiropractic profession, although not new to emergency room personnel, is the development of standardized care plans. In the past, chiropractors may have avoided standardized care plans because of the number of variable conditions or complaints treated in a chiropractic practice. This way of thinking is changing, and many more chiropractors now realize the advantages in instituting standardized care plans, including uniformity in orienting new associate chiropractors, and some uniformity in delivering chiropractic care and instilling patient retention. These plans allow for quality assurance review and provide an accepted standard of care for risk management.

Chiropractic System Management

The components of chiropractic system management include the development of an individualized patient database, whereby the patient initially completes clinically required intake forms: a patient registration form (which lists the reason for the patient's visit, medications, past medical history, surgical history); family history intake; review of systems intake; and baseline outcome assessment intake (pain drawing, visual analogue scale, Roland Morris, etc.). The treating chiropractor next initiates the following: obtaining a history; performing a physical examination; identifying the problem; and formulating an initial plan of action (a chiropractic care plan).

The follow-up office visit is generally a "Report of Findings," or a counseling session, during which the plan of action is discussed and patient consent is obtained. Our office provides written instructions to the patient regarding his or her care plan. This improves patient retention, outlines our mutual care goals, and sets reasonable time frames to achieve these goals. Once the patient enters into the care plan (subsequent visits), documentation occurs that may be handwritten, in the form of progress notes/chart notes. An explanation of these components, as it relates to problem-oriented documentation (in the SOAP format) is included:

Subjective data: This includes all of the information obtained from the patient or from those who accompany the patient.

Objective data: This includes all the chiropractor sees, feels, smells, hears or interprets as a result of tests obtained.

Assessment: After obtaining the subjective and objective data, the chiropractor evaluates this information and makes a decision as to the patient's initial problem, its progression or resolution; or determines if a new complaint has occurred that requires a separate work-up.

Plan: Formulation and follow-through on a plan of action are the ultimate goals. This step also includes establishing the patient's priority of complaints/symptoms (our office also incorporates a problem list), assigning a provider, and initiating any first-aid measures (pain relief/brace/splinting).

The following are examples of this type of subsequent visit documentation, accomplished via chart note or progress note documentation:

S: 33 Y/O LFA C/O SEVERE PAIN LT BUTTOCK; 1 YR S/P FALL ONTO BUTTOCK - DEVELOPED PROGRESSIVE GAIT ABNORMALITY. NO LOSS STOOL/URINE. PERCEIVED WEAKNESS L LOWER LIMB. PMH: NONE. SPANISH-SPEAKING 12 Y/O DAUGHTER TRANSLATES.

O: EXTENSOR LURCH GAIT, A/A OX4, NL VS. TOE WALK, HEEL WALK INTACT, ISD PLI-SI, L3 R, + MYOSPASM L QL'S.

A: POSS HNP L5/S1

POSS INFERIOR GLUTEAL NEUROPATHY

P: LUMBOSACRAL SUBLUXATION

LUMBAR X-RAYS, PT, BRACE, MRI L/SPINE W/O CONTRAST, EMERGENCY PRECAUTIONS HANDOUT, SIGNED CONSENT, OUTPATIENT REFERRAL NEUROSURGEON - TO HAND CARRY SPECIAL DIAGNOSTICS, SNA (SCHEDULE NEXT APPT) 48 HRS, DECLINES REFERRAL FOR PAIN MEDS. CHIRO CARE PLAN: 12-18 SESSIONS OVER 3-6 WEEKS, SEE TREATMENT SUMMARY PLAN ATTACHED TO CHART, OBTAIN OUTCOME ASSESSMENTS EACH SUBSEQUENT SESSION.

S: 23 Y/O PETITE WFA C/O RLBP X 2 DAYS ONSET OF R LIMB PAIN S/P SOCCER GAME. PREVIOUS EPISODE OF LOCALIZED LBP 2 WEEKS AGO SECONDARY TO CUMULATIVE LIFTING ACTIVITY. PMH: NONE. SOCIAL HISTORY: DANCER X 8 YEARS; STOPPED ALL ACTIVITY LAST YEAR DUE TO SCHOLL ENROLLMENT & P-T EMPLOYMENT AS A WAITRESS.

O: GAIT ABN, INTOLERANT R LEG WEIGHT BEARING, PALPABLE PAIN REPRODUCTION SI P->A + ELY'S TEST, + PIRIFORMIS TRP-ACTIVE, SLR (-), DTR INTACT LE, SCIATIC NOTCH NON TENDER, ANTALGIC LIST

A: SACROILIAC SPRAIN
CIATIC "SCOLIOSIS
LUMBOSACRAL SUBLUXATION

P: LUMBAR X-RAYS, THEN SI X-RAYS, GENTLE ADJUSTMENTS, MYOFASCIAL RELEASE OF SOFT TISSUE- PNF, LUMBOSACRAL ORTHOSES, TOPICAL ICE ANALGESIC, SNA 24 HOURS, PRICES, EMERGENCY PATIENT INSTRUCTIONS SIGNED AND RELEASE. CHIRO CARE PLAN: 14-16 SESSIONS OVER 3-4 WEEKS, SEE TREATMENT PLAN SUMMARY ATTACHED TO CHART, OBTAIN OUTCOME ASSESSMENTS AT WEEKLY INTERVALS.

Developing and implementing standardized care plans are major tasks, requiring advanced planning, time and the support and participation of your staff. Realistic and attainable goals should be set for both the chiropractor and the patient. Realistic time frames for completion of the task must be adopted if a chiropractic practice is to be successful. It is best to implement the care plans as they are developed and to avoid presenting multiple plans at one time.

Standardized care plans are developed for category conditions (some mechanism-based), e.g., joint and muscle 12-18 sessions, discogenic 28-32 sessions, lifting injury 12-16 sessions, repetitive trauma 6-8 sessions. Each care plan outlines the area affected, a sample schedule of care, a treatment window of care, and various approaches to achieve the goal.

The quality of chiropractic care is in the performance standard of the average chiropractor. The law expects the chiropractor to perform at the level of an average qualified chiropractor, or if the chiropractor claims a specialty, at the level of the average chiropractor in that specialty. Care that falls below this level is malpractice.

Nancy Molina, DC

San Juan Capistrano, California

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