Dynamic Chiropractic

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Docs, Documents and Integrated Care: The Cooperative Formula

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None of us works in a vacuum. At some point, we find ourselves having to interact with other medical professionals, whether it is in a hospital setting, with the referring medical doctor or another health care provider such as a physical therapist or an acupuncturist.

Integrative care, the treatment of conditions that require a team of health care practitioners, requires a cooperative approach that is heavily dependent on high-quality, in-depth documentation. Without it, patient care suffers, perhaps disastrously. Accuracy and clear records benefit the patient, you and the entire chiropractic profession.

Recently, I consulted with a neurologist on a mutual patient. I like to consider her one of my miracle cases. Not only had her post-CVA symptoms responded well to care, but she was now also able to be up and about without the use of a wheelchair. The problem was, without my notes, the neurologist would have never known that.

In fact, the patient had returned to his office, in the wheelchair, stating her need for more narcotics. After reviewing my notes, he was able to be more accurate in his care of the patient. He called and thanked me for keeping him informed of the patients' condition.

Dangerous Habits

I have known chiropractors who prefer to save up data and offer a summary after eight, 12 or 20 visits of care. This approach is reckless and unprofessional. I have also seen chiropractors use computerized note systems that generate a pre-formatted note for every visit; leading to weeks and months of redundant treatment notes that show no progress in patient care. This type of record-keeping is sloppy and only serves to show how ineffective chiropractic is.

There is a standard of patient care in this country that is clearly defined. It is dangerous to think that because we are chiropractors, we do not need to keep records to the same degree as medical doctors. We must learn to think outside the chiropractic bubble in terms of health care in general. Ultimately it is the patient that we take care of, not the insurance companies, attorneys or other doctors. Whether or not you feel obligated to document your case, responsible patient care mandates it. Chiropractic deserves every bit of respect that any other health profession does, but that respect comes with a level of responsibility. Yes, it is a pain, yes, it takes more time, but like it or not, documentation paperwork is part of professional health care.

It Begins At First Contact

Whenever you encounter a patient, there should be some level of documentation. The classic way of keeping daily notes is in the "SOAP" (Subjective, Objective, Assessment, Plan) format. This is the outline for the information you need to keep on every patient encounter on every visit. Using this format makes it simple for any other practitioner to follow along and understand the care you have given the patient, thus allowing for a seamless treatment regimen.

Subjective - This is commonly where you note how the patient is feeling at this encounter. Information in this section of your notes should also include any changes in how the patient feels or functions since the last treatment. Did the patient see any other practitioners (medical, acupuncture, massage)? What diagnoses or treatment plans were given? Was any other care given? How did these treatments affect the patient's level of complaint?

Objective - What were your findings today? This does not have to be a full, complete, formal exam report on every visit, but you should be able to note some degree of quantitative findings on every visit. The comment "unchanged" is not acceptable because this only serves to show your care is ineffective. Is there any change in muscle spasm? Is there any change in motion or function? These should be noted even if they are only minor changes. Other non-tangible changes should be noted such as a decrease in medication or increase in work function. These types of findings give a daily record of how your patient feels with progressive care. This section should also include any discussion of other diagnostic studies or evaluation reports you have received since the last patient encounter such as radiographic reports, functional capacity exams, EMG summaries, etc. These should all be referenced in your daily notes.

Assessment - Your interpretation of the patient's subjective complaints, the objective findings, the current diagnoses and your perception of their overall condition today. This is also where you should note your thought process. Why did you take x-rays? For what purpose? Or: Why did you choose to not refer for an MRI? Why are you doing a particular therapy? You must give a thought process and rationale for your care plan and treatments.

Plan - This is not only the treatment you provide today, but also your plan for future visits. The standard of care dictates that you clearly define what you did. There are a number of clinical forms that provide you the ability to "check off" what you did, but this gives no detail. To what areas did you do muscle stimulation? For how long? What regions of the spine did you adjust? What rehab exercises were done? How many repetitions? At what level of resistance? These questions are all tedious, but this is clinically relevant data that you are responsible for in the care of your patient. You must provide clear, accurate, information contemporaneous to the visit.

[pb]Many Benefits

Good record-keeping is an integral part of good patient care. But more than just being part of good care, maintaining patient records will benefit your practice in many other ways:

It allows you to communicate your findings and treatments, and the patient's response to other professionals in a way that they recognize and understand. It also allows them to have a copy of your treatment notes in their file so that their records on the patient are up-to-date.

Thorough examinations and good records raise your level of professional credibility. In his article in *Dynamic Chiropractic*, Dr. Steven Kraus discussed the "credibility gap" we face as chiropractors in the mainstream health care system.[4] Although we know how effective conservative care is, there is a bias against chiropractic. One of the points he raised is that we cannot integrate into and change the system when "our own insufficient documentation practices fail to show the effectiveness of our approach."

It reflects on your image as a professional. In my work with legal nurses, I once heard the comment that "Two professions are known for under-documenting care - chiropractors and dentists; and two professions are known for over-treating - chiropractors and physical therapists." That is not a professional image any of us wants to be associated with. Failure to meet the documentation standards of the profession reflects badly on the profession as a whole, and helps reinforce a

negative image that is already out there.

Because it's the standard of care.[5] Documentation is part of practice. It doesn't matter whether you are a straight or a mixer; if you use Gonstead, Diversified, Nimmo or acupuncture. It is your professional responsibility to document what you find, what you plan to do, and how you treated the patient. Whether you like it or not, your treatment notes will be looked at by a medical physician, insurance company or attorney at some point in time.

The rule of thumb is: "If it isn't written down, it didn't happen." That is not just the medical rule; that is the general rule for all of health care. It doesn't matter if you are an MD, a DC, an acupuncturist, a massage therapist or a physical therapist. The same medical-legal obligations apply. Most people, including other physicians, don't understand what we do. If you don't explain your care plan and rationale, it is easy to dismiss you as a quack. Furthermore, we will never become truly integrated without this level of communication about our patient care.

In short, if we want to work toward integrated medicine, it starts with us communicating properly.

Five Record-Keeping Must-Haves For an Integrated Practice

Your records must:

1. Be clear and concise. It is of utmost importance that other medical professions fully understand the care you have provided. Explain your care as clearly and succinctly as possible.

2. Be legible. All joking about doctors' handwriting aside, if the medical doctor can't decipher your chicken scratchings, they have no idea what you have done. Take the time to write neatly so that nobody has to guess at what you wrote down.

3. Explain the patient's current condition/response to care thus far. This lets other clinicians understand what treatments have worked, as well as those that haven't. There shouldn't be any question as to the patient's current medical condition if they see another doctor.

4. Discuss any changes in status and rationale for continuing or changing care plan. This will keep other health care professionals in the loop with regard to why you chose a specific treatment plan. This will prevent any second-guessing as to the reasoning behind the care you chose to provide the patient.

5. Be easily understood by a third party. All of these points should support the ultimate goal of making your notes and records easily understood by other professionals, be they doctors, therapists or lawyers. A major component of integrated care is good communication between all parties involved in patient care.

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