

Dynamic Chiropractic

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State Licensing Boards vs. Generic Documentation

When Will EHR's Make It to Your Practice?

Contrary to some rumors, state chiropractic boards aren't against digital documentation. In fact, they're all for it. Recent developments at the FCLB/NBCE conference in St. Louis directly relate to the coming future of electronic health records (EHRs) in your practice. This column is dedicated to telling you how the state boards are preparing for EHRs and exposing some origins of the myths behind those digital documentation rumors. Stick with me long enough and you're going to be left wondering, "When will EHR make it to my practice?"

Too Cliché?

Whipping a dead horse, falling on deaf ears, or preaching to the choir? I often wonder if my concern for improving our profession's documentation standards could be characterized by any one of the above clichés. With all of the ink I've spilled about this topic, I know someone out there is thinking, "How could anyone spend so much time thinking about electronic health records?" The answer is simple. First off, I'm passionate about the convictions I hold for a brighter chiropractic future with proper clinic technology. Second, the future is unfolding at such a pace that it's hard *not* to think about. There are new developments in EHRs every month – developments that are going to affect the way you practice in a few short years. And I think someone needs to tell you about them as they happen. Case in point: digital documentation and the state chiropractic boards.

EHR Will Be Regulated by State Boards

Even before this year, many state chiropractic boards entered the legal stages of drafting digital documentation requirements. All other states are following close behind. They are the kind of requirements that will make sure that any future EHR system in your practice is strong enough to meet government regulations regarding record retention, security and privacy. There was a special breakout session at a recent FCLB event that focused

exclusively on issues related to the development of documentation within an EHR and the preparation for this coming shift in practice management.

This may come as a surprise to some of you because of a persistent myth that state boards, along with some provider networks, don't look favorably on EHR. Like many persistent rumors, this story contains a kernel of truth, which is based on the historical development of documentation within our profession. I would like to put this myth to rest by addressing the truth it obscures, and then exploring the lessons it has for those who want to maximally benefit from digital documentation.

Myth-Busting, Continued

In May, I challenged you to reconsider what you thought you knew about chiropractic practice. I told you that HIPAA is not about privacy – it's about digital portability. I said that the coverage of 24 patient visits by some third-party pay programs is not based on evidence – it's about money. I also said that we're not decades away from EHRs, as electronic billing is already mandated by Medicare for all practitioners with 10 or more employees. I'd like to continue this theme of setting the record straight.

Our Generic Patients

The origin of the notion that your state board doesn't like digital documentation can be blamed on the improper use of digital-note software by some in the profession. Too many identical digital notes were being created, whose only difference appeared to be the date service was rendered. Claims reviewers had a serious complaint: "The record wasn't encounter-specific." In other words, claims reviewers wanted to see a difference in the patient's care over the course of several visits, and these details weren't being included.

This lack of specificity in the patient encounter can be partly blamed on our response to the documentation culture in the late 1980s and 1990s. In those decades, the buzzword was *objectivity* and orthopedic exams ruled the day. In fact, the emphasis on orthopedics created a culture in which assessment was only included as an afterthought. Assessment became a repetitious one-liner: "Continue with the treatment plan." We gathered plenty of objective data on the patient's condition, but didn't document their progress with a frequency that documentation standards required. Aside from the patient's name, intake information and ranges of motion, claims reviewers saw the record of one generic patient after the next. There was no story of progress to follow. The records were not encounter-specific.

Our Randomized, Generic Patients

Unfortunately, the response of some documentation entrepreneurs was to take advantage of the burgeoning digital-note technology and create a feature called *randomization*. If all your notes are looking the same, so the argument goes, then randomization can change your note for you, so that claims reviewers aren't tipped off to the generic content of your note. Generic identical notes were now replaced with "less generic" randomized notes.

The problem was that it didn't work. Claims reviewers saw right through it. I've spoken to a few who will get quite offended if they come across a randomized patient note, which are still produced by some chiropractors.

Randomization cannot change your objective findings, nor can it create an assessment of the patient's status – so what can it do? Essentially, the most randomization can do is change the sentence structure around your objective data. That's it. The note may look different, but the data are exactly identical, which is why it didn't take long for document reviewers to understand someone was trying to avoid scrutiny by pulling a fast one.

This is where we find the origin of the myth that digital documentation is frowned upon by our oversight bodies and claims reviewers. State boards frown upon generic, whether it comes from a digital note or is written by hand. Ultimately, digitization, *per se*, has nothing to do with it.

The New Temptation of Patient Progress

Now that the objectivity of the 1980s and 1990s is behind us, we're faced with a new pressure and new temptation that also could give us trouble if we're not careful. It can be summed up with the following tongue-in-cheek question: "Doctor, have you ever had a patient not get better?"

Today's new buzzwords are *assessment*, *progress* and *outcomes*. Some of us are getting the hint that we're supposed to be demonstrating patient progress, so much so that we're forgetting that not every patient does, in fact, get well. Examine some clinical documentation and you'll be pressed to find notes that include "exacerbation" or "flare-up" or "no sign of patient progress." It's a temptation to create a new kind of generic patient on paper – the kind who doesn't have a bad day from the moment they walk into our practice. Unfortunately, for those who document this way, red flags are going to start appearing on their documentation. We're going to re-create the same scenario from the past decades – the note will not be encounter-specific.

The Specific Solution

Whether you're completely lacking an assessment or your assessments are becoming generic, the solution is to be able to create the encounter-specific note on a consistent basis, including objective findings and a realistic record of the patient's progress. Unfortunately, that's a task beyond most of us on a day-to-day basis, unless we're willing to sacrifice more time from direct patient care. That's why we need the solutions offered by EHRs.

Electronic health records can help us achieve the demand for a greater attention to the patient's progress by prompting us to actually grade our objective data. Digital-based documentation systems can embed the kind of assessment prompts that will force us to efficiently qualify our objective data, which will help us to accurately capture the patient's progress from visit to visit or, more likely, over a series of visits. Instead of

generic objective findings or a generic progress note, the data we capture will demonstratively document the course of the patient's progress. This encounter-specific note will be a standard document in our office, even if the patient doesn't progress as well as we think they should.

Best of all, we can create a quality digital note in only a few minutes (and sometimes in less than 60 seconds), with pages of the kinds of information claims reviewers want to see. Ethical claims reviewers know they're not evaluating how long it took you to create your documentation. They're just looking for those encounter-specific data. If a claims reviewer decides to "ding" you on your reimbursable care because they know it only took you 30 seconds to create a two-page note with digital speed, they have, unfortunately, let their personal jealousies cloud their ethical judgment.

EHR and State Boards

Our state boards understand these potential benefits of digital documentation and are working to ensure that the EHRs embraced by the profession are compatible with the government's expectations of security and privacy. For example, according to most state regulations, all digital notes will need to be backed up, either on-site or on a different server, to mitigate the chance that a computer crash or employee error could wipe out all of your records. Other regulations will require the doctor to have instantaneous access to all digital records. Yet other rules will address the security requirements already demanded by HIPAA, so that the licensing boards can guarantee our EHRs will not come under governmental scrutiny. On first pass, it appears as if this coming regulation will be minimal, based on already established federal law and a desire to protect the patient and the doctor from data failure. Certainly, federal HIPAA and state regulations do not intend to slow down the profession's adoption of EHRs through burdensome regulation. Government wants us to move to the EHRs.

The Future Is Now

With each passing month, there appears to be a greater interest in EHRs and the successful implementation of digital record-keeping by our profession. In May, interest swarmed around developments by the state licensing boards. Perhaps in the next few months it will be something else. However EHRs ultimately become integrated into our practices, either through self-initiation or through acts of Congress, we're all going to eventually realize that the best way to document a patient's progress is through a digital process that will be standard in the clinic of the future. Adapting now just makes sense.