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Adopting EHR with confidence – Ask the right questions and get better results

Chiropractors who are seeking a digital solution for their office management needs often are disappointed with the end product. Their expectations for what can be accomplished with this new system aren't met because the system doesn't accommodate their true needs.

Why does this occur? Because doctors may assume that the lengthy list of features promoted by a software vendor, which can be confusing and filled with complex technical jargon, will undoubtedly serve them well. Or, the doctor doesn't realize the importance of reviewing actual real-life simulations of the documentation system in use.

Doctors considering an [EHR](#) solution should make the same investment of time, energy and research they made when opening their clinic office. An integrated clinic management system is a long-term investment that should serve the doctor's needs now and well into the future. And what should chiropractors do to ensure that they are satisfied, and hopefully delighted with their new system? They should ask themselves the following questions:

What does the [documentation](#) look like? Knowing what the documentation looks like will help the doctor determine if the system is adequate for the clinic. Do the notes look professional? Would you be impressed as a claim reviewer, attorney, state board auditor, or referring MD, when reading the documentation of a patient? High-quality documentation should include detailed patient records, functionality to allow integration with other office technology like digital x-ray or inclinometer software systems, and adaptability to your current practice workflow. The documentation should also be comprehensive and easily understood by anyone reviewing it. A complete documentation program should be robust and accessible, and include comparisons to past history of objective findings, progress graphs, and other key data.

Does the system offer more than just digital notes? When reviewing the documentation, the information included in a given chart should be more detailed than a series of notes. Often, technical jargon leads the doctor to believe that the system will provide true EHR. But if the doctor doesn't research the product carefully, he or she may find that the program simply provides an updated note-taking system. A doctor looking for EHR wants more than just legible

notes. A true EHR is a secure, real-time, integrated information source about a patient. Essentially every document that is housed in a patient chart should be available through the electronic health record and accessible within seconds from multiple departments in your clinic. If the billing department needs to submit notes, therapy personnel need access to document today's treatment and the doctor must chart today's progress, then the EHR must provide access to the chart from points throughout the clinic simultaneously.

An EHR also provides data integration to support billing, scheduling, outcome assessments and practice management imperatives. Digital notes cannot offer such comprehensive information. Unlike simple notes, EHR provides administrative controls, portability, accountability, and data back-up portals as well as the communication mechanisms necessary within the clinic and for interacting with the outside healthcare community.

Will this system improve office efficiency? A true EHR documentation system automates and streamlines workflow, improves intra-office communication, and reduces the time it takes to respond to record-keeping issues. Plus, the cost savings on manual tasks such as filing and avoiding redundant tasks amounts to thousands of dollars each year. The integration that is fundamental to an EHR contributes to increased efficiencies throughout the clinic and provides added support for audit processes and other external reporting requirements. Only a comprehensive system delivers such efficiencies across the entire clinic, and the cost to implement an EHR solution should be evaluated based on how robust the system is. An important note: The American Recovery and Reinvestment Act of 2009 provides most chiropractic physicians an opportunity to recoup the investment of implementing and purchasing a qualified EHR, with reimbursements starting in 2011 for those who implement now. Reimbursements will be managed through the Medicare system and can be as high as \$44,000. Those who choose to wait will be eligible for less reimbursement, and those who choose to ignore the directive will pay penalties down the road. Such incentives and penalties should make adopting an interoperable EHR as soon as possible a no-brainer.

Researching the answers to the aforementioned questions will help to ensure that doctors who are adopting an EHR solution can do so with confidence. Relying only on a list of features without actually reviewing the end product, or comparing pricing without understanding the full capabilities of the system will likely leave the user dissatisfied. But conducting a comprehensive investigation into a comprehensive system before making a final decision will no doubt yield a better result for the doctor and the patient. With the right system, patients will benefit from better quality of care and improved case management. Doctors will realize efficiencies, lower overhead and enjoy improved documentation. As taxpayers, we all benefit from an overall reduction in healthcare costs and lower incidence of errors thanks to a team approach to patient care that is fully supported by EHR.