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Patient Flow Manual

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Forms and File Construction

Before you meet with the new patient, the patient file should be assembled with all pertinent forms completed. Clerical forms include the New Patient Conversation, the Insurance Verification, signed HCFA, and signed Financial Policy. If this visit is due to a MVA, then an Accident Report should be included. If this is an on-the-job injury, then the patient's portion of the appropriate WC Form should be complete.

The completed clinical forms should include the Patient History, the FRI, and an X-ray Imprint Card. Your Consultation Notes, and blank Exam Forms should be on a clipboard, ready for your use.

Before you meet the new patient, take a few moments to review the forms. This allows you to select your line of approach in consultation. It also allows you to slow down enough to gain rapport with your new patient, a critical item for good compliance.

From reviewing the pain drawing, the VAS, the FRI, and the Chief Complaints, you should be able to get a good working idea of where to start. If this is not clear to you, you will have to sort it out in consultation with the patient. This is time-wasting, and may appear to the patient that you are uncertain. It is preferable to be prepared, and to use the consultation to gain rapport and to fill in details about the case.

When you have a good general understanding of the case, open the door to the waiting room with the file in your left hand, and say,

=> Mr. Goodpatient? I'm Dr. Goodoc. Please come with me.

Extend your hand for a firm handshake while you are saying this. While shaking the patient's hand, look into his right eye, and smile sincerely. These simple things, when accomplished smoothly will communicate to the patient that you are prepared, happy to assist him, and ready to proceed. It is the first step in developing rapport with the patient.

2 - Consultation: History, Differential, Building Rapport

Communication at consultation happens at two levels.

Basic Level: History and Differential Diagnosis

On the basic level, you are performing the elementary and necessary tasks involved in making a diagnosis and treatment plan. Our training tells us that an accurate history is your most powerful tool in determining your range of diagnoses. At the conclusion of the consultation, you should have a good idea of the diagnostic possibilities. If not, you are not likely to discover them in examination.

In addition, a thorough history it is your most powerful tool in determining if the patient's complaints are acute, sub-acute, recurrent or chronic. This information is critical to your prognosis and treatment plan. A chronic or recurrent problem is less likely to completely stabilize or resolve than a truly acute one, regardless of severity. This is something you will need to know to accurately report the patient's condition and prognosis back to him.

If this is truly a chronic or recurrent problem, the patient will not expect "miracles," i.e. an immediate, painless permanent end to the issues at hand.

Ask,

=> How long have you had this problem?

Usually the patient will describe the most recent onset. Then ask,

=> When was the first time you ever felt this problem?

Then ask,

=> Are you sure that was the earliest?

This sort of questioning can unearth a chronic problem that the patient felt he had to live with.

If there is more than one complaint, be sure to prioritize them in the order most significant to the patient. Ask,

=> Which area is the worst?

Or,

=> Which area bothers you most?

Your patient's concepts here must be excavated. If you gloss over this issue, the patient will lose confidence in your understanding of his condition.

In addition to understanding the clinical symptoms, you must gain understanding as to the impact on the patient's life. Use your FRI to determine the areas of greatest impact. Ask open-ended questions about functional issues:

Tell me more about your problems with lifting (sleeping, standing, etc.)…

Dig for details regarding what the patient cannot or will not do because of the condition at hand.

Proceed through your normal line of questioning regarding symptoms:

- Provocation/Palliation
- Quality of symptoms
- Radiating symptoms?
- Strength or intensity of symptoms
- Time or duration of typical symptoms

Dictation of your consultation results speeds information flow. If not, write the information down as the patient reports it.

Rapport/subtext

Your main subtextual message is to underpromise and overdeliver.

Building rapport at this level means communicating several messages to the patient. Your line of questioning and your body language must communicate several important ideas:

- I am a competent and qualified professional
- I am interested in you and your situation: I like you.
- I can help you.
- I won't take advantage of you.
- I won't hurt you.
- I will do my best for you.

If you can successfully communicate these ideas, you will have a happy and compliant patient. If not, they will balk, and "vote with their feet" (i.e. look elsewhere for help).

I am a competent and qualified professional.

This is communicated by **an organized clinical approach, proper attire for the doctor and staff, and the impressive clinical library in the consultation room.** Disorder on the shelves (or the desk!) communicates sloppy thinking to the patient, and should therefore be avoided. Thumbing through papers and files in the patient's presence gives the impression of lack of preparation, and is therefore to be avoided

I am interested in you and your situation: I like you.

Many patients are reluctant to seek medical help, even when the need for help is overwhelmingly obvious. As odd as it may seem, you must convey the message, especially to older patients that you are glad that they came to you. Patients may paradoxically believe that they are somehow annoying you by coming to you for help! This can be communicated by **regular use of the patient's name, by affirmative nodding of the head while they tell you their story, and by maintaining eye contact.** Be certain not to interrupt, as this conveys the opposite message: I don't have time for you, you're boring me, etc.

I can help you.

This message is best conveyed in a non-verbal way. In fact if you tell the patient this message in words, they will feel that you are "Overselling." How can you know if you can help before the examination? This message is best conveyed through simply **repeating the chronology and functional limitations back to the patient.** This conveys the message that you have listened and understood, both rarities in any health care facility.

I won't take advantage of you.

The need for this message arises in part from the public's distrust of doctors in general and chiropractors in particular. The patient may have heard about an isolated incident regarding fraud or abuse, and generalize it to you. The positive corollary to this is I have your best interests at heart. This is conveyed by the previous techniques. It is important to be sensitive to the patient's fears on this subject, however. If the patient tells about a previous abusive or negative relationship with any doctor, listen carefully to the story. Then say,

=> I understand your concerns. That won't happen here.

and return to your questions. This acknowledges the legitimacy of the patient's fears, and reassures him that you are different from the other doctors.

I won't hurt you.

Patients who have never been to a chiropractor are usually apprehensive about what is to come. If you see on the history form that they have never been to a DC, convey gentleness and calmness in you speech patterns and body movements. Smile frequently, and nod affirmatively while the patient is speaking to convey understanding.

I will do my best for you.

This idea is conveyed smoothly with the close of consultation. After repeating the chronology and functional limitations back to the patient, say,

=> Is there anything I haven't asked you that I should know about?

When the patient closes the consultation by saying no, you are ready to move on to the examination.

Your segue is:

=> The next step is a thorough examination of your spine. Please come with me.

If the patient has no insurance benefits, you must quote prices at this time. Say,

=> The next step is a thorough examination of your spine. The fee for that is $112. This doesn't include x-rays or laboratory fees. Please come with me.

Stand up and escort the patient to the exam room. Do not wait for approval or feedback from the patient, simply stand up and start walking to the exam room.

3 - Examination: Forefront and Subtext

Examination

The examination has two basic purposes:

1. Perform tests leading to a diagnostic conclusion while ruling out out-of-scope sources of pain
2. Establish in the patient's mind that you understand his problem

After escorting the patient to the exam room, hand a female patient an exam gown and say,

> => Please undress except for your underwear, and put this gown on, open at the back. Also, please remove your earrings and necklace. Please open the door when you are finished changing.

You may wish to give the patient exam shorts as well. These will preserve modesty and allow for a full exam. Close the door and give the patient a few minutes to change and relax.

If the patient is male, say,

> => Please undress except for your underwear, and put these exam shorts on. Please open the door when you are finished changing.

Close the door and give the patient a few minutes to change and relax.

Have your chart and dictation device ready.

Your testing should begin with something that is familiar and non-threatening to the patient.

Therefore, begin with vitals: height, weight, pressure, pulse, respiration rate.

Then proceed to your normal chiro/ortho/neuro exam. Be sure to note any existing or suspected clinical red flags, such as disc or vascular signs. It is also important to perform Waddell's tests in addition to our normal tests to document functional overlay.

Subtext

The subtextual message to communicate to your patient is "I understand your problem." This is communicated in a verbal way during the consultation. During the exam you communicate this in a non-verbal way. Reproducing the typical pain does this. If you can cause the usual symptoms to worsen or remit using exam procedures, your patient will know that you know what is wrong.

If you cannot exactly reproduce the symptoms, firm palpation at the area of complaint will convey a similar message to the patient.

If the patient qualifies for x-rays (X-ray Criteria), say,

=> need some x-ray pictures of your back. Come with me..

If this is an uninsured patient, you must again quote prices. Say,

=> need two x-ray pictures of your back. Those are $51 apiece.

Come with me.

Again, do not wait for discussion with the patient, simply walk to the x-ray room, and the patient will follow.

If you will be sending your patient out for imaging, say,

=> We'll need some x-rays of your back. Mary at the front desk will arrange that for you later.

Outsourcing X-rays

Radiology is an important diagnostic adjunct to your practice. It provides important information that will be part of ruling out some vital contraindications to manipulative treatment, and it also helps to identify biomechanical issues that may guide or modify treatment. In addition, it plays an important role in educating your patients and helping them to understand the need for treatment.

Consider referring to a DACBR for your radiology needs when you are out-sourcing images.

Chiropractic radiologists are highly trained and have the added advantage of understanding and promoting your own interest in biomechanics.

Use your own x-ray equipment to produce films for only those patients on which excellent films can be obtained. You can use outpatient radiology facilities to supplement your own equipment. Refer out to a DACBR for x-rays on patients too large to obtain optimal films in your office. Also refer out for extremities, chest, recumbent views, and any unusual views that you may not be comfortable in producing or interpreting.

DACBRs also provide second-opinion consultation services on studies produced by you or other facilities, and they can make copies of images. Most payers reimburse for second opinion radiology consultations by DACBRs.

Conclusion

Following your x-rays, it is time to conclude your first visit with the patient.

Say,

=> That concludes our examination. Please get dressed, and open the door when you are ready.

This will give you a few minutes to complete other tasks, such as developing films or reading and dictating findings from previous x-rays.

Conclusion of the visit has three purposes

- After studying the films and exam findings, you will be able to determine the cause of the problem, and help the patient.
- You're going to give the patient some homework
- You expect to see the patient the next patient care day.

Even if you are 99% sure you know what is wrong, do not give a differential diagnosis now. This will cheapen your exam and x-ray findings and damage your rapport with the patient. She will think you're jumping to conclusions, rather than that you're a brilliant diagnostician. Say,

=> I'm glad you came in today. I think we're going to be able to help you. After I study the films, I'll explain the problem to you and outline what needs to be done.

Give the patient appropriate home care. It is important that the patient is able to find a method of palliating his pain at home. This can be advice regarding ADL, a support, or a specific stretch. Say,

=> I want you to wear this neck collar at all times except when you are showering or sleeping, for the next four days.

Or, use other appropriate advice, such as

=> I want you to ice your low back using a gel-pack for 20 minutes per hour for the next three hours.

The important issue is to be specific and direct about advice, not general.

Discharge the patient for the day by saying,

=> Please see Mary at the front desk to schedule your next appointment. She will give you an informed consent document to read. Please ask me any questions about this.

Smile and shake hands with the patient while you say this, and then proceed to your next patient or task. Conclude your dictation as soon as possible, while it is still fresh in your mind. The front desk CA collects any fees, gives the patient the next appointment, and gives the patient the informed consent document to read at home.

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Informed Consent

Informed consent is a complex concept, with varying state laws. It is a time-dependent process whereby the patient understands the basis and body of the doctor's recommendations, understands the risks of the proposed and alternative treatments, has time to consider the facts, and agrees to proceed. A signature on a form is the endpoint of this process, not a substitute for it.

While this may sound simple, problems may arise in case of an unexpected or poor outcome. The patient may then believe that, "If I had known this might happen, I wouldn't have sought or continued treatment." This thought process might lead to litigation in the case of a poor response or a complication.

In addition, health care is changing into an information-driven, consumer service. This means that patients have a right to participate in their health care decisions. The information you provide is intended to alert them to possible adverse outcomes. This information should not alarm patients, and should be placed in context of relative safety of other treatments or non-treatment.

Your only duty is to discuss material (both significant and likely enough to bear mention), and foreseeable problems. Vascular accidents, while extremely rare, can be devastating to the patient's health. Soft tissue injuries, while more common, can usually be repaired, and do not cause large scale permanent damage. Disc injuries, while commonly alleged, are rarely the result of chiropractic treatment.

Remember that even though chiropractic is a safe, effective treatment for many conditions, no health care options are risk-free. Your goal is to explain risks and benefits in simple language, and gain the patient's trust and cooperation for successful completion of their treatment program.

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4 - Second Day: Report of Finding and Care Initiation

Examination

Your report of findings quickly conveys several clinical messages to the patient:

1. Re-assurance that there is nothing terminally wrong
2. The diagnosis in simple language
3. The length of time estimated to treat or correct the problem
4. The patient will be expected to follow recommendations
5. Answering questions regarding risk and informed consent

There are several non-clinical issues to convey:

6. You have seen this problem before and have confidence.
7. The estimated cost (if uninsured)
8. Reassurance that the treatment will not be painful
9. Visits will not take long
10. You will handle insurance and information requirements

General Points

1. Under-promise at first, and over-deliver later
2. Your general tone is to be informational, but not to overwhelm the patient with details.
3. Avoid using technical terms, as these are easily misunderstood, and can be frightening to the patient.
4. Answer any question directly, but briefly.
5. Use x-rays briefly, do not get into great detail.
6. Avoid “selling.” Simply explain the problem and the plan.

Four-Box Concept

The easiest way to convey information to the patient is to use the four-box concept. This will place the patient in an acute/chronic, simple/complex box. The time frames for treatment and prognosis for resolution are different for each.

Have the patient’s x-rays on your viewbox, and a laser pointer and a three vertebra plastic model ready.

Acute Simple

Your intention is to convey a good prognosis, while making it clear that the patient's best interests are served by completing a brief treatment program.

Say,

> => Mr. Goodpatient, first, I want you to know that you don't have an infection, cancer or any serious bone disease. You were wise to seek early treatment. Your back pain is coming from damaged tissues at the back part of your spine, causing joint and nerve pressure.

Point with the laser to the area of concern. Then, turn off the viewbox, so the patient's attention is focused on you.

> => When there is damage like this, it causes the bones to move abnormally and get out of position.

Using your model, place the patient's fingertip in the IVF, and squeeze gently but firmly.

> => Fortunately, this is something that usually responds well to treatment over about six weeks. I will treat you during that time, and also give you homework so you can help yourself.

If you are planning to use adjunctive services, inform the patient of this.

> => In addition to adjusting your spine, we will be (providing/referring) you for (massage therapy/physical therapy) to assist in the healing process. You'll need to see me three times a week (or alternate schedule) for one month. We will re-examine you then to check your progress.

If the patient is uninsured, you will need to quote fees at this time.

> => Treatment fees are forty-five each. Come with me.

Chronic Simple

Your intention is to convey to the patient that pain relief is probable, but that rehab/corrective treatment is necessary. Focus on improvement, rather than "cure."

Say,

> => Mr. Goodpatient, first, these x-rays confirm that you don't have an infection, cancer or any serious bone disease. Your back pain is coming from damaged tissues at the back part of your spine, causing joint and nerve pressure.

Point with the laser to the area of concern. Then, turn off the viewbox, so the patient's attention is focussed on you.

> => When there is damage like this, it causes the bones to move abnormally and get out of position.

Now, using your vertebral model, place the patient's fingertip in the IVF, and squeeze gently but firmly.

=> Since you have had this before, your back has deteriorated, and is not normal.

=> In addition, (use applicable)

- **your discs have thinned, making you more vulnerable to re-injury.**
- **your joints have become arthritic, making you more vulnerable to re-injury**
- **you have an abnormal bone formation (spondylolisthesis, tropism) making you more vulnerable to re-injury.**

Do not use technical terms with patients. Call a spondy a separation, not a fracture. If a patient asks about the type of arthritis, call spondylosis the "Wear and Tear" type, so they will not associate this with RA.

=> This is something that usually improves with treatment. Our treatment has two phases. The first is to relieve your pain. The second is to stop or slow the deterioration so the underlying condition does not get worse. This second part happens when your symptoms are mild or gone. Remember that our purpose is to treat the underlying problem.

If you are planning to use adjunctive services, inform the patient of this.

=> In addition to adjusting your spine, we will be (providing/referring) you for (massage therapy/physical therapy/rehab services) to assist in the healing process. You'll need to see me three times a week (or alternate schedule) for one month. We will re-examine you then to check your progress. We expect to see significant, measurable progress by then.

If the patient is uninsured, you will need to quote fees at this time.

=> Treatment fees are forty-five each. Come with me.

Acute Complex

Your intention is convey that although this is a new problem, it may not be that easy to resolve, and treatment and management may go on longer than the patient would like.

Say,

=> Mr. Goodpatient, first, I want you to know that you don't have an infection, cancer or any serious bone disease. You were wise to seek early treatment. Your back pain is coming from damaged tissues at the back part of your spine, causing joint and nerve pressure.

Point with the laser to the area of concern. Then, turn off the viewbox, so the patient's attention is focused on you.

=> When there is damage like this, it causes the bones to move abnormally and get out of position.

Using your model, place the patient's fingertip in the IVF, and squeeze gently but firmly.

=> In addition, (use applicable)

- **your discs have bulged, squeezing the nerve trunk.**
- **you have more than one area of injury, slowing the healing response. your discs have thinned, making you more vulnerable to re-injury.**
- **your joints have become arthritic, making you more vulnerable to re-injury**
- **you have an abnormal bone formation (spondylolisthesis, tropism) making you more vulnerable to re-injury.**
- **Other complicating factor: smoking, deconditioning, etc.**

Do not use technical terms with patients. If specific disc questions arise, say,

=> We can't see discs with plain x-rays. Your exam findings tell me about your disc problems. This is something that usually responds to treatment over 3–4 months. I will treat you during that time, and also give you homework so you can help yourself. You'll need to see me three times a week (or alternate schedule) for one month. We will re-examine you then to check your progress.

If you are planning to use adjunctive services, inform the patient of this.

=> In addition to adjusting your spine, we will be (providing/referring) you for (massage therapy/physical therapy) to assist in the healing process.

If the patient is uninsured, you will need to quote fees at this time.

=> Treatment fees are forty-five each. Come with me.

Chronic Complex

Your intention is to convey that this is a difficult problem, for which there are no magic answers. You can offer control, improvement, and management, rather than "cure." In this type of case, it is critical not to "over-promise" results.

Say,

=> Mr. Goodpatient, first, these x-rays confirm that you don't have an infection, cancer or any serious bone disease.

(If there is visible osteoporosis or significant arthritis, say nothing about the bone disease.

=> Your back pain is coming from damaged tissues at the back part of your spine, causing joint and nerve pressure.

Point with the laser to the area of concern. Then, turn off the viewbox, so the patient's attention is focused on you.

=> When there is damage like this, it causes the bones to move abnormally and get out of position.

Now, using your vertebral model, place the patient's fingertip in the IVF, and squeeze gently but firmly.

=> Since you have had this before, your back has deteriorated, and is not normal.
In addition, (use applicable)

- **your discs have thinned, making you more vulnerable to re-injury.**
- **your joints have become arthritic, making you more vulnerable to re-injury**
- **you have an abnormal bone formation (spondylolisthesis, tropism) making you more vulnerable to re-injury.**

Do not use technical terms with patients. Call a spondy a separation, not a fracture. If a patient asks about the type of arthritis, call spondylosis the "Wear and Tear" type, so they will not associate this with RA.

=> I expect your condition to improve with treatment. Your treatment has two phases. The first is to control your pain. The second is to stop or slow the deterioration so the underlying condition does not get worse. This second part happens when your symptoms are mild or gone. Remember, the purpose is to treat the underlying problem.

=> You'll need to see me three times a week (or alternate schedule) for one month. We will re-examine you then to check your progress." We expect to see measurable progress and pain relief by then.

If you are planning to use adjunctive services, inform the patient of this.

=> In addition to adjusting your spine, we will be (providing/referring you for) (massage therapy/physical therapy/rehab services) to assist in the healing process.

If the patient is uninsured, you will need to quote fees at this time.

=> Treatment fees are forty-five each. Come with me.

When saying, "come with me.," proceed directly to the treatment room to begin your treatment schedule. You can answer any questions about treatment during treatment.

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5 - First Treatment

On the first treatment, your patient is as apprehensive and symptomatic as they are going to be. Your voice, pace and manner must be soothing and healing. This is where your "bedside manner" is crucial.

Be sure the informed consent document is signed.

Next, give the patient instructions about what you expect on routine visits regarding their preparation.

For female patients, say,

> => When you come in for treatment, please remove your earrings and necklace (glasses), and open your skirt so I can get to your low back easily.

Show the patient where to place these items so they don't get lost.

For male patients, say,

> => When you come in for treatment, please take everything out of your pockets, remove your glasses, and open your collar and/or pants, so I can get to your low back/neck easily.

Then address the apprehension by saying,

> => I want you to know a few things about the treatment. Firstly, it doesn't take long. Secondly, it doesn't hurt. Some patients feel minor discomfort, but most feel either relief, or nothing at all!

Next, familiarize the patient with the equipment. Say,

> => I'd like you place your hands here, and then to lie face down, with your face on the paper.

Gesture to where the handrests are.

Your treatment room is clean and uncluttered. While the patient is lying on the table, use hand sanitizer, so he can smell the alcohol smell associated with doctor's offices.

Begin your treatment gently, giving specific instructions, if any, to the patient. Talk him through the first treatment. It is helpful to treat any surrounding trigger points before delivering a manual adjustment. As you are treating symptomatic area say,

> => This is where you have joint and nerve pressure.

If you have to do a procedure that may be uncomfortable, *warn the patient first!*

As you are getting ready to deliver the first adjustment, say to the patient,

> => I'm going to reposition that joint that's been giving you problems. You'll feel a pressure and a click. Try not to help me or resist me.

Then, position the patient and deliver the adjustment. Do not be too forceful, and be aware of patient discomfort. If there is significant apprehension, reassure the patient by saying,

=> This will just take a moment, and will start the healing process.

After you have successfully delivered the adjustment(s), let the patient know that that part is over. If things went smoothly, say,

=> That went very well. That's what you need to get over this problem.

If there was difficulty delivering a satisfactory adjustment, do not force the issue! Hurting patients, especially on the first visit is a big turn-off.

Rather, say,

=> Your tissues are too tight (swollen)to get a full adjustment. I introduced some movement today. I'm going to need you to do some home care to help with the next treatment.

Then instruct the patient regarding ice application, stretching, etc.

It's best to use adjunctive services in subsequent visits, so the patient can see the effects of the adjustment. Schedule LMT and/or PT in conjunction with the next series of visits.

Close your first encounter by giving the patient encouragement and instructions.

Say,

=> Good. That went well today. You can get dressed now.

As the patient is getting dressed, document your file and mark the procedures and treatment plan on your fee slip

Next, say,

=> Please continue to ice your low back for 20 minutes per hour 4 times today (or other appropriate home care). Please give this to Mary on your way out. She will schedule your next several visits.

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6 - Adjunctive Service

Adjunctive services serve one of two functions:

1. Symptom and reaction palliation during acute management.
2. Rehabilitation of chronic or recurrent problems.

Be sure to document the clinical necessity of these services at the initial and re-exam.

Acute Management Adjunctive Therapy, In-house

When using electrotherapy, ultrasound or massage, you must give a brief explanation to the patient as to the action and necessity of the procedure, and introduce the patient to the therapist. Say,

> => This is (name), and she will be providing (PT, Massage) to assist your other treatment. This will help your muscles relax, to decrease pain and speed healing. Just relax during this treatment.

Unless there is a specific clinical reason to provide adjunctive services before the adjustment (i.e. the patient is too fibrotic, spasmed, inflamed, etc) schedule the adjunctive treatment after the adjustment, so patient flow will not be dependent on time-consuming adjunctive procedures.

Acute Management Adjunctive Therapy, Referred Out

When referring out for this service, say,

> => Mr. Goodpatient, you'll need (PT, Massage) along with the adjustments to heal properly. I'm referring you to (name). This will help your muscles relax, to decrease pain and speed healing. Mary at the front desk will coordinate your schedules so it works well for you.

In this case, the same parameters apply regarding order of treatment. Since the patient is now dealing with two offices and two sets of appointments, convenience and scheduling become more critical as a compliance issue, rather than order of treatment.

Use your LMT Referral Letter as the information source for the LMT or PT. This will allow the other office to bill insurance on behalf of the patient. When referring for adjunctive therapy, schedule only as far as your next re-exam for the patient. You must receive updates from the LMT/PT to continue with further referrals.

Chronic or Recurrent Problem Rehabilitation

This phase initiates after your re-exam findings document that the acute phase is over. The patient's symptoms are under control, and she can tolerate increasing loads to the problematic area. This type of treatment is not necessary for truly new and acute patients.

You must review your original recommendations with the patient at this time. Say,

> => Mr. Goodpatient, you are coming along just as I hoped you would. We're ready for the second part of your treatment program. This part treats the underlying problem, not just the most recent flare-up. The purpose is to improve and stabilize the underlying problem.

In-house Rehab

If you are providing this service in-house, you must schedule the patient separately for this service, and introduce them to the therapist who will be treating (if not you). Say,

> => We'll be doing the active care portion before your adjustments.
> Come with me.

Then, proceed to the rehab room and begin this portion of the care. If rehab is to be administered by an employee, direct the patient to the treatment room after rehab is concluded, for adjustments.

Referred Rehab

Referring for rehab services conveys the same message to the patient. After your segue to the second part of the treatment program, say,

> => I'm referring you to (name) for this part of the treatment. I'll write detailed instructions, so they will know what to do for you. Mary at the front desk will coordinate your schedules for the greatest convenience.

Be sure the patient understands that schedule coordination is a matter of convenience for them, and that the chiropractic adjustments continue to be critical for proper stabilization.

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7 - Routine Office Visits

Your conversations with patients during routine office visits should have one of two purposes in mind:

1. The patient's clinical condition and needs, both forefront and subtle
2. To stimulate referrals of other patients

Chatting or visiting with a patient is counter-productive and undermines the proper doctor-patient relationship. If a patient tells you of a stressful or important event, always bring the contest back to the clinical condition, rather than the emotions of the moment. While you must make the patient feel that you are interested in him as a person, not just a case, maintenance of professional boundaries is crucial. Chatting, especially about non-clinical items tends to erase or blur boundaries, making the perception of unprofessional conduct more likely.

Clinical Forefront

1. Improvement of original complaints according to expectations
2. Symptom severity level and location
3. No appearance of new problem areas
4. Patient compliance with home care, workplace, and ADL recommendations/restrictions
5. Patient compliance with treatment schedule

Brief notation of these items in your SOAP notes will document the necessity of care, and make you less vulnerable to insurance denial and malpractice claims.

Subjective

Say,

=> Anything new or different since our last visit?

Listen to the symptom picture and note the complaints on the SOAP notes form. Use the 0-10 pain rating system with the patient. Say,

=> How bad is the pain on a 0–10 scale?

Objective

Your objective findings should be primarily palpatory, with brief notations about tissue dynamics. If there are specific tests that are positive, such as Minor's or Gower's, note these as well. It is not necessary to do an examination at this time, as you are simply executing your original treatment plan.

However, if symptoms or progress are not as expected, note this and schedule a re-exam as soon as possible. Do not wait for the pre-scheduled time, as this will convey a careless attitude to the patient. They may discontinue care, and blame you for any adverse outcome of treatment!

Assessment

Unless you have a reason to alter your working diagnosis, “unchanged” is the usual assessment. Assessments are modified, if at all, as the result of an examination.

Plan

Unless you have a specific reason to alter your written plan after the last examination, “continue with plan” is the usual entry. Reasons to alter the plan include an aggravation of the original complaint, poor response to care, unrelated complications, etc. If this involves increasing or discontinuing care, the reason must be SOAP noted

Clinical Subtext

1. I still have pain. Is this normal?
2. This treatment seems too (rough/gentle)
3. Am I getting better?
4. Will I have to be treated forever?
5. This is getting tedious
6. I don’t have time for this
7. I can’t afford this.
8. My spouse (family) doesn’t support this kind of treatment

These silent scripts (and others) run through the heads of many patients. You job is recognize the barriers to continuing care, and to address them. Simple encouragement, when warranted helps tremendously. Say,

=> You’re getting better!

Or,

=> This is much better than last week.

Or,

=> It’s normal to still feel some pain in your back.

Remind the patient that there is an end in sight, and that you have a plan. Say,

=> We're going to be re-examining you next Friday. I expect that your tests will look a lot better.

Or,

=> We should be able to see you less often soon.

These comments help the patient see the light at the end of the tunnel.

If you are referring out for adjunctive services, check with the patient regarding their satisfaction with the other office. Say,

=> Are you happy with your care at (name)?

If there is anything but glowing reports, call the other office with feedback and recommendations. Do not continue to use another facility if poor patient satisfaction continues for any reason.

Financial barriers either come up early in the treatment (for uninsured patients), or partway through for those with a small benefit.

For the latter case, it is best to address any incomplete insurance coverage at the time of the re-exam. This will prevent the unwitting accumulation of an uninsured bill. You will need to give the patient an idea of the probable endpoint and cost. Say,

=> Your insurance benefits will pay for some of your care. I am estimating that you will need (time) more than they will pay for. The cost will be about (number).

Even if this yields an uncomfortable financial discussion with the patient, it is preferable to a large surprise bill later.

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8 - Referral Seed-Planting

The routine office visit is the time to ask for referrals from patients. The optimal time to ask for a referral is the very first time the patient reports significant relief or functional improvement. This is an important moment, which will not be revisited. Do not wait for a “less busy” moment.

Typically, the patient feels grateful for effective health care, and human nature is to want to repay a kindness. You can give the patient an avenue to do so by asking for a referral, and couching it in terms of a favor! Remember, patients may not automatically think of referring others unless you ask them. A personal direct appeal from the doctor is a powerful message, and not to be overused or trifled with.

At the conclusion of the treatment, and after talking about the patient’s relief/improvement, say,

> => May I ask you for a personal favor?

When the patient says yes, say,

> => I’m interested in helping other people who have the same problem you have. Will you refer other patients to me who have this problem?

The patient will almost always agree to this. Thank the patient in advance. Say,

> => Thank you for thinking of me.

Asking for referrals for the same problem has the built-in value of a personal testimonial from the patient. It is simpler and more direct. If the patient asks about other conditions, discuss it in detail. You can introduce information later to the patient.

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9 - Compliance

Compliance with your recommendations is an area for constant attention. If a patient is having frequently rescheduling appointments, but keeps his recommended frequency, do not make an issue of this. Your front desk CA will attempt to find the best schedule for the patient. Flexibility in a doctor's office is rare, and appreciated by the patient.

A prn schedule is reasonable for a patient who has completed a rehab or acute management schedule, but is not reasonable at the beginning of care. If you allow this against your better judgement, you may be blamed later, if the patient has serious complications. Your care is not "as needed" unless you have exhausted other options.

If the patient is not keeping the recommended schedule, be kind the first time. Say,

> = > You know, I can't really do my job for you if you're not here. Can I rely on you to keep your schedule?

If there is anything but a "yes," investigate the patient's cause for concern. Do not make him wrong, simply listen to the concerns.

Many times it is something easy to rectify, such as

- *Can I bring my son with me?*
- *Can I change my appointment times?*

Handle these quickly and move on.

Sometimes it is something harder to rectify.

- *The treatment is scary.*
- *My husband doesn't want me to go to the doctor.*
- *I don't have the time/money to continue.*

These types of issues are not easily resolvable. Get as much detail as you can about the concern. Then say,

> = > I understand your concerns. My concern for you is that you may develop a permanent problem if this is not treated properly." What can we do to make this work?

Then, make whatever changes you can to appease the problem, and inform the patient of your changes. These should be minor in nature, as you cannot have separate procedures for all patients!

If the patient agrees to comply, but then fails again, you must be firm rather than kind. Say,

=> I'm sorry, but I cannot continue to treat you if you do not follow my recommendations. What is keeping you from your appointments?

Listen to the concerns. Then say,

=> I understand your concerns. My concern for you is that you may develop a permanent problem if this is not treated properly. What can we do to make this work?

Then, make whatever changes you can to appease the problem, and inform the patient of your changes. Then say,

=> I'll be happy to (change). Please understand that I must release you as a patient if you are not serious about this.

Note non-compliance issues in your record to avoid later charges of abandonment. This must be done in an artful way in your PI cases to avoid having the patient blamed for lack of mitigation of their injuries.

If the patient continues to be non-compliant, cease call-backs, and send Unable to Reach You letter. The patient now becomes inactive.

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10 - Re-Examination

Re-examinations are like milestones in your patient management plan. On the clinical level, you are comparing the last exam data for improvement, and you are measuring functional improvement. These are both critical issues in determining your next course of action. On the subtle level, you are "graduating" the patient to the next level of health.

Your re-exam package includes the Exam Form, the FRI, and the Progress Assessment. The FRI and Progress assessment is completed and scored prior to your exam. Use your dictation for easy data transfer. If using handwritten notes or dictation, report transcription must be complete within 24 hours.

If there are new areas of complaint, be sure to examine thoroughly. Elicit a history, just as if this was a new presentation. Do not commence treatment of a new area without a supporting examination.

If there are elements of worsening of the original complaint, such as more persistent pain, pain at rest, radicular features, etc., treat these seriously, without glossing over the details.

In the exam room, say to the patient,

> We're going to re-examine you today to check your progress.

Ask the patient about any of the items noted on the progress assessment and FRI, particularly about anything that does not conform to your expectations. Ask female patients to put on a gown and/or shorts, as originally. If you did not x-ray the patient originally, and progress is not as expected, this is the time to film the patient.

Acute Case, Good Progress

If the patient has progressed as expected communicate this to the patient. Say,

> I'm pleased with your progress. This is just what I expected.

Your now need to explain the remaining recommended treatment program to the patient, and project an end date of the program. Say,

> We're going to reduce your treatment frequency to (plan), followed by another examination. It's very important that you follow my home care advice, because I won't be able to pick up the pieces as often. If you continue to progress like you have, you should be stable by about (date).

Setting a projected end date is important to the patient and to insurers. The patient doesn't see this as a long-term issue needing constant attention, but rather a short-term breakdown that needs fixing.

Acute Case, Inadequate Progress

If the patient has made slower than expected progress (but has improved somewhat), you must communicate this to the patient. Say,

> => You haven't made as much progress as I had expected.

Review simple issues, such as visit compliance, home care compliance, occupational hazards, personal stresses. Clarify and handle any issues within your control.

If progress is present, but slow, this patient can be treated for another segment. Change your approach and/or technique. Say,

> => We're going to continue with a different approach to care. I'll be doing some other methods in the treatment room, and I'll give you some different homework to speed your progress. I'll see you (treatment plan), followed by a re-examination.

If the case has unclear or conflicting elements, refer the patient for a concurrent opinion. Say,

> => I'm going to continue to treat you at (treatment plan). I'm also going to refer you to Dr. Special for a second opinion.

If the progress is slow due to tissue tightness, weakness, or stress, and you are not offering concurrent care, say,

> => I'm going to continue to treat you at (treatment plan). Because you also have (tension stiffness weakness), I'm referring you for additional care at (massage therapy physical therapy).

If there is worsening of the original complaint, development of other areas of complaint, or development of red flags, say,

> => You are not progressing as I expected. I'm going to suspend treatment here, and refer you to Dr. Special for another opinion. If there are no other problems, we can resume treatment using other methods.

Make this appointment for as soon as possible, and communicate directly with the doctor and patient to ensure continuity of care.

Chronic Case, Good Progress

Progress and improvement should be communicated to the patient simply and directly. Say,

> => Your condition is definitely improving.

Give the patient functional measurement information (briefly). Say,

> => Your pain scale was at 7, now it's down to 4 (or other).

If the patient is a good candidate for rehab, say,

> => I'm going to continue treating you, but we're going to change the focus of the treatment. This is called active care. In addition to your adjustments, you'll be spending time with (me/trainer) to learn ways to help yourself. Your new treatment schedule is (plan), followed by a re-exam to check your progress.

This next segment of treatment may happen with little or no pain, and it is a transition time in treatment, so it is important to communicate clearly to the patient.

Be aware of the following misconceptions:

- Since my pain is gone, I'm OK.
- I'm being discharged from care.
- My adjustments are over.
- I can come in whenever I want.
- My care is being unnecessarily lengthened.

These concerns can be generally addressed with the concept,

> => We're treating the underlying cause of your problem. This will make recurrence and deterioration less likely.

This message bears repeating, as there is a strong cultural bias against treatment in the absence of pain!

Chronic Case, Inadequate Progress

By definition, this type of case is the most difficult and prolonged presentation. It is important to focus on functional improvement, pain control, effective self-management, and decreased dependence on medications and health care providers.

If you have not already incorporated rehab measures, now is the time to do so. Even if the patient has high pain levels, some self care measures must be established. Say,

> => I'm going to continue treating you, but we're going to change the focus of the treatment. This is called active care. In addition to your adjustments, you'll be spending time with (me/trainer) to learn ways to help yourself. Your new treatment schedule is (plan), followed by a re-exam to check your progress.

Sometimes the overall measurements will not improve, but some of the functional measurements will improve. If the critical ones (to the patient) are improving, she may be satisfied with the course of care. Conversely, the overall measurements may improve, with the exception of her most disabling issue ("I still can't sleep!").

Therefore, identify the separate components of your outcome measurements for improvement (or lack thereof). Point out any improvement to the patient,

=> Your sleep was totally disturbed, now it's moderately disturbed.

Since the overall improvement is inadequate, you must either modify the retarding agent, or change your treatment approach. Say, (for example),

=> We'll need to get an ergonomic chair for you at work.

Or,

=> You'll need to hire help for your yard care.

Changing your treatment approach means using different passive care methods, and integrating some form of self-care. Begin your active care, as above, if you have not already done so.

It may also mean getting other providers involved. For concurrent care, say,

=> I'm going to continue to treat you at (treatment plan). Because you also have (tension stiffness weakness), I'm referring you for additional care at (massage therapy physical therapy).

Improvement at the next exam is expected with a higher level of care.

If there is substantial worsening, or appearance of unexplained or radicular symptoms say,

=> You are not progressing as I expected. I'm going to suspend treatment here, and refer you to Dr. Special for another opinion. If there are no other problems, we can resume treatment using other methods.

Treat the appearance of new or worsening symptoms seriously. Do not continue to treat without gaining another opinion.

Reports

After re-examination, transcription of the dictated (or hand-written) notes should be accomplished using the SOAP format. Copies go into the patient file, and to the PCP, other providers involved in the case, and to the insurer.

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11 - Patient Out-Referrals

Referrals of patients out of your office can happen under a variety of circumstances:

- Concurrent care with a PT or LMT
- Concurrent care with a MD/DO or Ph.D.
- Transference of care to an MD/DO
- Second opinion with DC or MD/DO
- Transference out of the area

Concurrent Care with a PT or LMT

Control of concurrent care with a Physical Therapist of Massage Therapist is your responsibility, as these providers are not responsible for a diagnosis. You must define the duration, intensity, and type of care rendered. You must co-ordinate care for maximum effectiveness. The therapist must submit progress updates in a timely fashion to insure appropriateness and continuity of care.

This is best accomplished by sending a copy of the most recent SOAP report, along with Referral Cover Letter #1. This summarizes the patient's condition and need for therapy.

Be aware of patient dissatisfaction with any other office, as this may reflect badly upon you.

Be careful not to duplicate rehab services when referring to a PT.

Concurrent Care with a MD/DO or Ph.D.

This referral happens under several different circumstances:

- Suspected or known untreated illness outside scope
- Request for surgical opinion
- Request for imaging services
- Request for services (psychotherapy, medication, etc) outside your scope.

In this arena, the referral doctor is responsible for a diagnosis. Therefore, your referral gives your impression, response to treatment, and reason for referral. Do not dictate a specific course of action for the referral doctor (other than for sophisticated imaging).

This is accomplished with a copy of the most recent SOAP report, and a Referral Cover Letter #2, modified for the specific problem.

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Transference of Care to an MD/DO

This referral occurs under a variety of circumstances:

- Worsening or unresponsiveness of the original condition
- New injury outside scope of unresponsive to care
- Emergence of other or dominant medical condition

This type of referral should be preceded by a phone call (other than to the ER!) Avoid dropping a difficult patient on a doctor without confirming that the referral is welcome!

After confirming that the referral is welcome, send a copy of the most recent SOAP report, along with Referral Cover Letter #3, modified for the specific problem.

After you develop a working relationship with the specialist, a prior phone call may not be necessary. It is always a good idea with a doctor you do not know well.

After arranging the visit, say to the patient,

> => You are not progressing as I expected. I'm going to suspend treatment here, and refer you to Dr. Special for another opinion. If there are no other problems, we can resume treatment using other methods.

Assure the patient that you are not abandoning her, and you will be speaking with Dr. Special about her case.

Second Opinion with DC or MD/DO

This type of referral is accomplished during the management of a PI case that is complex, unresponsive, or has difficult legal issues. The idea here is that the second opinion doctors will not provide care to the patient, but will guide and support treatment.

After verifying the case with the referral doctor, send a copy of the clinical portion of the file, along with Referral Cover Letter #4.

Transference Out of the Area

Patients who are relocating will frequently ask for a referral to a DC in their new area. Unless you know of a clinically responsible DC, do not make this referral. It is better to ask the patient to find a new DC on their own, rather than risk a poor outcome that could be construed as your fault! Say,

> => I'm sorry, but I just don't know anyone in that area. We'll be happy to make your records available when you do locate someone.

If you give the patient more than one name to choose from, it then becomes the patient's choice, so you are insulated from poor performance after the patient leaves your office.

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12 - End Points of Care

End points of care should fall into one of three categories.

- Discharge from care
- PRN care
- Scheduled supportive care

“Maintenance care,” defined as scheduled care for patients with normal FRI, normal exam, and no symptoms is a type of care that cannot be billed to third party payers. Although many chiropractic methods promote this type of care, there is little clinical justification for it. A cash-paying patient may elect this type of care as “preventative.” However, failure to periodically re-examine this type of patient may yield missed diagnoses, as the patient may assume you are “maintaining” their health, and they do not need to inform you of other health issues.

Maintenance care inhibits patient referrals by feeding into the popular perception that “Once you go to a chiropractor, you have to go forever.”

Maintenance care encourages dependence on the doctor, counter to current practice and clinical guidelines.

Patients who have recovered form an acute episode want prevention tips and a feeling of being “done.” If their condition recurs, they will seek help from you if they have been properly discharged. If you are providing “maintenance care,” they may blame you for the recurrence!

For patients who have stable but abnormal conditions, supportive care is best.

Discharge from Care

This type of end point is for patients who had an acute presentation (simple or complex), and have a normal FRI and exam on the last re-examination.

First, congratulate the patient on their recovery. Say,

> => Mr. Goodpatient, you did extremely well here. All of your tests are normal.

Then, caution the patient. Say,

> => The number one risk of back pain in the future is a history of pain in the past. So, it’s important to follow through with the exercises/home care I showed you.

Then release the patient. Say,

> => This is the end of your care here. Please call us in the future with any concerns or problems you may have. It’s been a pleasure to help you.

Give the patient a firm handshake, a smile, and eye contact, the same way you did when you first met him.

PRN Care

This type of endpoint is for chronic patients (simple or complex) who have an abnormal but stable FRI, and a normal or near-normal exam. In other words, this patient still has some symptoms, but they are predictable, manageable, and mild. Their progress has plateaued, but stable with diminishing care or increasing load.

First, give congratulations for improvement. Say,

> => I'm very pleased with the progress you made. This is chronic problem for you, but you've gotten it under control.

Then, caution the patient. Say,

> => Even though this is stable now, it will probably give you trouble in the future. It's important that you follow through with the instructions I have given you.

Then, discharge the patient to PRN care. Say,

> => This is the end of your scheduled treatment. If you have pain that lasts for more than three days, or is very bad, call us, and we will get you in right away. We will call you in (six/twelve) months for a checkup exam. It's been a pleasure to help you.

Give the patient a firm handshake, a smile, and eye contact, the same way you did when you first met him

Scheduled Supportive Care

This endpoint is for a chronic patient (simple or complex) who has the following features:

- Stable (unchanging) but abnormal exam
- Stable (unchanging) but abnormal FRI
- Worsening with withdrawal of care
- Worsening with introduction of reasonable loads

In other words, this patient has stopped improving, has exhausted care options, and is still symptomatic, functionally impaired, and worsens under adverse conditions.

Your challenge with this type of patient is to minimize dependence while effectively managing away from deterioration and decreased functional capacity.

First, congratulate the patient on any improvement. Say,

> => I'm very pleased with the progress you made. This is chronic problem for you, but you've made some important improvements. You're graduating to the next level.

Next, caution the patient. Say,

> => We've gone as far as we can go. Further treatment is not likely to improve the underlying problem. It's important that you follow through with the instructions I have given you.

Next, give the patient a prognosis and an extended treatment plan. Say,

> => I'm placing you on supportive care. You'll need some infrequent checkups so you don't get worse again. I'll see you every (2–6 weeks) over the next (4–6) months, followed by an exam.

Last, discharge the patient to supportive care. Say,

> => If you get a pain onset that lasts more than three days or is very bad, call us, and we'll get you in right away. Otherwise, I'll see you in (plan). It's been a pleasure to help you.

Give the patient a firm handshake, a smile, and eye contact, the same way you did when you first met him.