

THE BLUEPRINT TO CHIROPRACTIC SUCCESS: Getting paid in a new era of healthcare

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HOW DCs GET PAID IS ABOUT TO GET A MAJOR ADJUSTMENT

By Steven Kraus, DC

Value-based reimbursement, pay for performance, outcomes-based care, patient-centered medical homes, accountable care organizations: Heard of these terms? Most likely. Understand how they're about to affect your practice—and your income—in the very near future? That's the more important question, because change isn't just coming, it's already here.

Medicare and the major insurance companies have been conducting trials over the past few years and have recently announced that they intend to roll out new payment models across the country in less than two years.

Nothing quite gets your attention as a doctor and small business owner as when you see major changes in how healthcare practitioners will get paid, and this time, it can be to your benefit. Well that's if (and only if) you adapt to the coming changes spreading like wildfire.

PAYMENT MODELS

First let's understand, from a macro perspective, the sweeping changes taking place in how healthcare providers are getting reimbursed.

To put it bluntly, the days of us adjusting patients and being paid separately for each service performed for a fee are numbered. Just as an ENT specialist performing sinus surgeries a dozen a day and being paid for procedural quantities is changing soon.

What's taking its place in 2017 is the move from fee-based reimbursement to value-based reimbursement. It actually has started in the medical and hospital communities already, but is moving into all of healthcare provider models in 2017 as recently announced at the HIMSS conference in Chicago in April.

Value-based reimbursement is all the rage in the circles of healthcare third-party payers, provider networks, and new reimbursement models designed by the government. We'll dive into that in just a moment, but first, back to those terms, just in case you need a refresher:

Patient-Centered Medical Homes (PCMH): This model was proposed by the American Academy of Family Physicians, American

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Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in 2007. It is, in essence, an enhanced primary care delivery model that strives to achieve better access, coordination of care, prevention, quality, and safety within the primary care practice, and to create a strong partnership between the patient and primary care physician. In the model, payers often reward providers with per member per month "bonus" for improving primary care services for each patient in the medical home. Like accountable care organizations as described below, the medical home model is referenced many times in current health reform efforts as one way to improve health outcomes through care coordination.[1] You as a DC can be a member of the "medical home" and still practice in your own clinic and function as an integral member providing chiropractic care as part of that patient's network or neighborhood of providers.

Accountable Care Organizations (ACO): This model is also based around a strong primary care core. But ACOs are comprised of many "medical homes"—in other words, many primary care providers and practices that work together. Some have even dubbed ACOs the "medical neighborhood." The difference is that ACOs would be accountable for the cost and quality of care both within and outside of the primary care relationship.

As such, ACOs must include specialists and hospitals in order to be able to control costs and improve health outcomes across the entire care continuum. ACOs by nature would be larger than a single medical home or physician's office. There are many known benefits of the ACO structure over the medical home model, including the ability to better manage the care for a greater population of people with a larger budget. Being able to use the dollars across a wider range of patients and conditions allows for better overall cost management, less variation within the population, and the ability to track and trend for quality.[1]

ACOs are comprised of many "medical homes"—in other words, many primary care providers and practices that work together. Some have even dubbed ACOs the "medical neighborhood."

Being connected to this neighborhood requires you as a DC to understand protocols and guidelines and to be electronically connected to the other providers.

To put both of these models in perspective, according to the National Committee for Quality Assurance (NCQA), the number of PCMHs is approaching 7,000.[2] And over the past year alone approximately 120 organizations have become ACOs in public and private programs, bringing the total to 744 covering nearly 25 million patients.[3]

Value-based Reimbursements: Instead of providers being paid by the number of patient visits and itemized services performed and tests they order (fee-for-service), their payments are based on the value of care they deliver (value-based care). Think about it for a moment: Providers currently are incentivized to provide more services because they get paid for each service they provide and the more times they perform a surgery or a procedure the more income they generate.

Providers inherently only provide care that they believe is beneficial and necessary for the patient to improve. If only that were universally true 100 percent of the time. Whether appropriately so, subconsciously, rationalized, or even fraudulently, providers

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find ways to justify the care they provide. Payers want to get out of the game of incentivizing providers to do more and more services and be paid for defensive medicine, unnecessary care, fraudulent care, and overutilization.

They want to pay for a case based diagnosis and the value of the care provided. For a few years there will be a blend of service payments combined with bonus payments for outcomes and the value of the patient results and satisfaction of the care.

The move to value-based reimbursement is exactly why chiropractic is, for the first time ever, poised to move from the fringes, (on average, 8 percent of the US population visits a DC), to considerable adoption. But there is a big if: If we can show empirically, through aggregated data, that chiropractic is a savings center versus a cost center. And while we all know it is, that's not going to cut it.

Government and private payers need proof, and if we give it to them they'll not only recommend but require certain patients be seen by a chiropractor prior to undergoing more costly forms of treatment, namely injections and surgery.

As stated by Gerard Clum, DC, in an interview with Cleveland Chiropractic College, "In the insurance world, chiropractic is seen as a cost center. But it's not actually a cost center, it's a savings center. All of the data show this to be true. We need to begin discussing the cost-replacement value. We don't add cost to the system; we take expense out of it. This fact involves a huge shift in thinking for folks in the insurance world because they don't see chiropractors in that light. It's very important that we keep bringing this concept of expense reduction to the attention of people in the insurance and policy worlds."[4]

He went on to make the point that there really is no hotter issue today in all of healthcare than prescription drug abuse. And the impetus is on us, as a profession, to drive the point home that the DC improves patient health sooner and at a lower cost without drugs and the secondary issues of abuse, dependency, and addiction.

WHY DATA MATTERS

We simply won't see more volume of patients and help more patients under the new payment models if we don't have (and aren't able to share) the data that proves the efficacy of chiropractic! It's not enough to have anecdotal evidence. We need proof. We need to be able to say to both the government and private payers: We help

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patients achieve health at a lower cost while drastically reducing unnecessary spending on surgery and drugs

To this effect, your ability to contribute is actually simple, you need to do three sequential steps:

1. Adopt a certified EHR software into your practice to document your daily visit encounters and the health history of the patients.

2. Use your professional protocols and guidelines to document the care outcomes by using easy data capture with outcome assessment tools, such as basic questionnaires that patients fill out to

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quantify their progress and satisfaction of care received from you.

3. Make sure that your software has the ability to formulate those results into an actionable display of metrics and data to let you know that you have successfully achieved recovery or that you should modify the care plan approach or whatever care pathway is needed, you have data to guide you.

And now the biggie, this data must be aggregated with other data in your practice to look at an overall practice value of care delivered. Essentially, it is your report card demonstrating that you get good results with your overall slate of patients for specific conditions and that you are a provider that these medical home. ACO allopathic providers want to refer more patients to you, and utilize you more frequently, so that you truly have a waiting list of referrals because your data demonstrates the quality of your care.

VALUE RESULTS IN MORE REIMBURSEMENT

Data demonstrates the value so long as it's certified and has the ability to aggregate and compare data and compares data in a way that is accepted by the third-party administrators and government regulators.

Today, 89 percent of every medical doctor in America is practicing with a certified EHR software system. Approximately 25 percent of chiropractors are using a certified EHR and another 20 percent are using non-certified EHR; and 55 percent aren't using any EHR.

We've positioned our profession at a serious disadvantage. With data as the new oil in the modern engine driving these massive changes in healthcare, and ultimately where patients will be directed for care, our profession is running a few quarts low. The warning light is blinking, and we need to take it seriously.

LEADING FROM THE FRONT

So, what do we as chiropractors need to do to not only benefit from these changes but indeed thrive? As well stated in an article by Aubrey Westage, Senior Editor of Physician's Practice, in order for doctors to take advantage of value-based reimbursement opportunities, they can:[5]

- Ask payers about value-based models and incentives.
- Identify the metrics payers are using to assess quality.
- Implement patient satisfaction surveys and take steps to improve.
- Implement a certified EHR that functions specifically for that provider specialty.
- Add value-based incentives to doctor compensation.
- Implement a practice-wide strategy to address value.

And for DCs, I'll add one more: lead. We have to launch a cultural shift in our profession from one that seems to be happy operating apart from the "mainstream" to one that engages the healthcare industry with data backing up its claims. Not a study of 300 or even a 1,000 patients, but one where the EHR aggregated data is able to have tens of thousands of patients demonstrating the effectiveness of chiropractic care. ■

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IS YOUR EHR SOFTWARE KEEPING YOUR PRACTICE FROM GROWING?

By Robert Moberg

There are a great many benefits to a solid, supportive practice management system. But is it possible that your EHR software may be stifling your practice's development? A good chiropractic software system should be tailored to suit your individual needs and should help you streamline your business to achieve prosperous and steady client growth. Let's take a look at some of the telltale signs that your chosen technology may be stalling your success.

IT'S NOT SCALABLE

It's vitally important that your chosen EHR be able to grow along with your practice. If you find yourself creating more and more workarounds and running up against the boundaries of your EHR, it may be time to look at alternate systems that can support the amount of growth you envision for the future of your practice.

IT'S NOT A TOTAL PRACTICE MANAGEMENT SOLUTION

Do you find yourself needing multiple software systems to handle your complete business? Having to transition from system to system and missing out on the continuity between billing, patient flow, and scheduling (to say the least) can slow down your practice.

If you're constantly working to reconcile information between your multiple software systems, it may be time to trade up and opt for a more comprehensive

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solution that allows you to get back to the task of managing your practice instead of your software.

IT'S NOT SUPPORTED

Do you find your EHR software company to be exquisitely hands-off? Do your peers and mentors tout alternative EHR software systems and recite better customer support experiences? What about key industry leaders? Is your EHR software company present at events, backed by key figureheads within the chiropractic community, and offers an extensive support system for its clients?

A supportive EHR software system should be ready with updates to keep your office compliant with government mandates, able to provide a comprehensive support package, able to prove a commitment to the chiropractic industry, and most of all, available to support you when you need them.

IT'S NOT CUSTOMIZABLE

If you constantly seem to be trying to fit a square peg into a round hole when conducting business with the aid of your EHR software system, you may be suffering from a lack of customizability. This means a greater number of time-consuming workarounds, sub-par patient service interactions, and challenging internal processes.

If you can't seem to get your EHR software system to fit your unique practice, it might be time to find a competing software system that supports your



REVENUE GROWTH THROUGH EFFICIENCY

By Robert Moberg

Chiropractic can be incredibly profitable, but often profits are dampened by poor management, time-consuming manual processes, missing or inadequate technology, and a lack of inspiration. When it comes to the ultimate success of a practice, efficiency is the name of the game.

With the exact same building blocks, a provider can build a marginally successful practice through inefficient and unrefined processes, or build a wildly profitable practice by maximizing every ounce of efficiency; from patient parking to checkout, and everywhere in between.

SYMPTOMS OF AN INEFFICIENT PRACTICE

The first step in maximizing efficiencies is to know how to target processes within your

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practice that can be quickly and easily improved upon. Inefficiencies often follow common threads when it comes to their notable symptoms. Check your practice for the following symptoms:

- The level of patient care is variable and often determined by staffing and alternate priorities.
- Patients are limited to who they can see and when, must often wait for an open appointment, and spend the majority of their time in the waiting room.
- Technology is limited or nonexistent.
- Overhead is high and places pressure on patient volume to effectively maintain operations.
- Regardless of a healthy patient volume, revenue remains low.
- DCs feel rushed and overbooked with no time to handle day-to-day tasks outside of treatments.
- There is a large number of staff members with limited competency and little cross-training.
- Both staff and providers experience bouts of burnout.
- The amount of time spent with each individual patient is minimal.

BURNOUT AND ITS ROLE IN EFFICIENCY

Burnout may not be a common bullet point when discussing efficiency, but it has a greater impact than one might assume. The price of burnout can eat into revenue growth from multiple angles. You are your practice's most vital resource, and if you are not running efficiently, the rest of your practice will falter as well.

There is nothing worse than spending extra time in the office completing tasks more slowly because you are worn out and uninspired. By making sure that you are running on all cylinders while you are in the office you keep your staff productive, your patients engaged, and your time useful.

Take vacations and breaks, and find new and innovative ways to engage in your craft—whether it be continuing education, new techniques, or staff challenges to sharpen everyone's competitive edge and revitalize the hours spent in the office by all.

You are your practice's most vital resource, and if you are not running efficiently, the rest of your practice will falter as well.

TURNING THE TABLES WITH TECHNOLOGY

Efficiency and automation go hand-in-hand, and a truly efficient practice can only be achieved when manual processes are replaced. This reduces time spent performing menial tasks, lowers staffing requirements, and most importantly—reduces operational costs. Significant revenue growth does not always require higher patient volumes, more time in the office, or additional staff.

When it comes to increasing revenue by maximizing current resources, technology is the chiropractor's best friend.

SCALABILITY

An EHR offers scalability and can easily handle new patients and a growing practice. And without the overhead costs and space required to purchase and house file cabinets, folders, and printers (not to mention staff time spent rummaging through paper files) your dollars are not stretched so thin, and patient volume becomes less critical to the bottom line.

ACCESS AND SPACE

Converting to a paperless practice allows staff to retrieve, store, and share documents electronically in an instant. Paperless files can be accessed anywhere within the practice, making retrieval immediate.

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SCHEDULING

Scheduling can be a very time-consuming task. Checking in patients and collecting copays while simultaneously answering phone calls, searching for open appointments, and juggling an array of highlighters can bog down the day and preoccupy precious staffing resources. With EHR software on board the scheduling becomes seamless, and the front desk is automatically notified of late patients, uncollected copays, treatment type, and any other identifying features.

PATIENT FLOW

The easier it is for patients to understand your practice and their place within it, the more efficiently the system will run. Proper signage, well-placed and available staff, patient self-check-in stations, and speedy payment processing can all help clients get in and out faster, keeping your practice moving at optimal speed.

BILLING AND INVOICING

Billing is often the bane of a practice, requiring a great deal of time and attention. Accurate invoicing, reporting, claim filing, and status reports are a crucial aspect of a smooth-running office and a consistent revenue stream. An EHR system can quickly prepare invoices, check claims for errors, set up payment arrangements, and provide billing reports that allow you to keep a closer eye on your real-time financials.

AUTOMATED PATIENT REMINDERS

Reminder calls can eat up staff time, and leaving messages can be an unsuccessful means by which to remind patients of their upcoming appointments. This is where automation really shines.

Revenue growth means not only building new business but also mining your current patient base for new opportunities. Oftentimes there is gold sitting in that bucket of monthly missed appointments. With the right practice management software, patient reminders can be automatically generated and sent out via email, text, or phone. This leaves your office staff free to focus on the patients currently in the office.

There are plenty of areas of the practice where efficiencies can bring down overhead and help release that tied up revenue.

COMPLIANCE

Compliance is a major player in healthcare these days, and maintaining compliance requirements set by seemingly constant new government mandates can become a frustrating and laborious process. A well-equipped EHR system can automate compliance and walk you through required processes, leaving you free to focus on your clients while reducing additional paperwork and minimizing the risk of a daunting audit.

Revenue growth doesn't always require increasing your number of staff or taking on a higher volume of clients. There are plenty of areas of the practice where efficiencies can bring down overhead and help release that tied up revenue. Many manual practice processes can be automated, and that extra time can be spent investing in the human element of your practice: Yourself, your staff, and your patients.

Efficiency is a major player in every component of practice design including management of overhead, proper workflow, applicable technology, and effective staffing. Improving your practice's efficiency can be challenging, but targeting certain key areas can help you leverage improvements that result in larger revenue gains and better health for your bottom line. ■

THE GROWING IMPORTANCE OF DENIALS MANAGEMENT IN THE NEW ERA OF HEALTHCARE

By AJ Johnson

How much time does it take your organization to manage claim denials? It's probably much more than you would like to spend.

However, of all the efforts you put toward ensuring your organization is financially successful, managing denials may be the most critical step — especially when you consider that providers transmit millions of claims every day and even the best-performing medical practices experience a denial rate of five percent.[1]

Having a strong denials management process can help you recoup significant revenue that would otherwise be lost, as well as identify trends in errors, so you can correct your processes to prevent future denials.

TODAY'S FINANCIALLY CHALLENGING ENVIRONMENT

In today's healthcare environment, it is challenging for providers to succeed financially. Here are some of the top issues impacting your revenue:

1. Healthcare costs for providers continue to rise. One of the top five

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top challenges facing medical practice business leaders is dealing with rising operating costs.[2] There have been exciting advancements in medical technology and equipment that can bring long-term cost efficiencies for providers, but they require large investments upfront. These expenditures, combined with costs associated with electronic health record implementation, have put many providers in a financial crunch.

2. Reimbursement rates are declining. Providers have faced repeated cuts to Medicare and Medicaid reimbursement over the past several years. In addition, the Affordable Care Act has impacted reimbursement for providers in the form of value-based payment models and cuts in the Disproportionate Share Hospital payment program to reimburse hospitals for caring for the uninsured.

3. It's harder to get paid. In today's healthcare insurance market, high deductibles prevail and healthcare savings accounts are common. What does this mean for providers? According to revenue cycle management expert Elizabeth Woodcock, 30 percent of a medical practice's revenue comes directly from patient responsibilities[3] and it is expected to grow. Almost six out of seven (85 percent) employers have implemented an increase in medical plan employee cost sharing or are considering doing so through plan design changes over the next three years.[4]

This increase in patient responsibility is challenging because patient payments are the hardest revenue to collect. More than half (55 percent) of patient payment responsibility after insurance ends up as bad debt.[5]

To offset these financial challenges, you need to ensure you are getting paid correctly from payers. A big part of that is identifying, appealing, and tracking claims that were denied incorrectly. This potential revenue loss isn't easy to see when it's hidden. If left unchecked, denied claims can significantly impact your bottom line.

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THE MANUAL DENIALS MANAGEMENT PROCESS

Only one out of three providers (35 percent) appeal denied claims.[6] And, even today, many of those providers still use a highly manual and heavily paper-oriented approach to managing denials. Here's a summary of what this process typically looks like:

Step 1: A cash flow representative goes through a stack of remittances they received from payers.

Step 2: When they see a denial was made, they put it into a separate pile.

Step 3: This pile is passed along to a second representative who focuses on denials.

Step 4: That denials representative manually logs the remittance information, including date received, type of denial, amount of claim, insurer, remark code, and payer appeal deadline into a spreadsheet, so they have a record of the denials.

Step 5: The denials representative

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researches the insurer's requirements for resubmitting denied claims.

Step 6: The denials representative begins work on the manual appeal process, which could include filling out a specific payer form, preparing a letter to describe your case for reconsideration, or compiling documentation of the service and a record of the original filing of the claim. The tedious process of appealing denials to get them overturned costs nearly $15 per claim, according to the Medical Group Management Association.[7] And, all of this work needs to be completed before the payer's appeal deadline.

While providers may have some level of technology to help automate aspects of this process, many of them are not using the technology to its fullest extent because it's not integrated into their workflow and, therefore, not easy to use. Or, their technology doesn't help with the most important aspect of denials management, which is aggregating data in an organized way, so they can easily uncover trends and analyze the root cause of their denial issues.

A BETTER WAY TO MANAGE DENIALS

A manual denials management process is time intensive. To make sure the time you invest is worthwhile, you should focus on denials that represent the "lowest hanging fruit." Here are three ways to identify denials that will yield the highest return when appealed:

1. Fastest payment opportunity. Review your historical claims and remit data to track when you received denials and when you received the correct payment back from the payer. By measuring this, you can determine what types of denial reason codes have the shortest appeal resolution time to help you get money in the door faster.

Focus on denials that you can most easily fix, such as denials where information was missing from a field or where coding or data was incorrect due to human error. You can easily fix this information and resubmit the claim.

2. Highest value denial. When you receive denials, look at your historical data to determine and track how much you typically get paid for the type of services provided on the claim. Focus on appealing claims that bring in the highest amount of revenue.

3. Highest probability of getting paid. Focus on denials that you can most easily fix, such as denials where information was missing from a field or where coding or data was incorrect due to human error. You can easily fix this information and resubmit the claim. Other denials may be out of your control, such as denials due to a service that was never documented or benefit eligibility issues. You won't be able to convince the payer to pay for undocumented services or change their fee schedule contract, so these denials are not worth your time to appeal. However, to help stop this type of denial from occurring in the future, you should go back and review your eligibility verification process to ensure it is working correctly.

Focus on these three areas to identify where you'll receive a high return on your staff time investment for appealing denials.

Denied claims represent unpaid services and revenue that you deserve. On the

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surface, the work that goes into identifying, tracking, and appealing denials may seem too time intensive. However, the number of denials you receive and the missing revenue they represent can add up quickly.

The denials management process can be made much more efficient if you know where to focus your efforts. Now's the time to take a closer look at your denials management process to identify which denials represent your "low-hanging fruit," so you can spend your time on appeals wisely.

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INCREASING PATIENT ENGAGEMENT WHILE USING AN EHR

By Kaitlin Morrison

Although EHR use provides a variety of benefits for chiropractors, software can become a distraction from quality patient care if it interferes with physician-patient interaction.

You may find yourself avoiding eye contact with patients, ignoring questions, or forgetting to review key information with your patients because you're focused on your software.

However, there are some tips you can implement to help your communication with patients improve. Although you may have to practice them in order to get in the habit, it will become natural over time and your relationships with your patients can improve.

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THE PHYSICIAN-PATIENT RELATIONSHIP

EHR use appears to cause more distractions compared with paper-only records. One study tracked eye gaze patterns to evaluate attention changes and understand how physicians interacted with patients and with technology during clinical encounters. EHR use was linked to less interaction with patients and more distracted doctors.

Doctors using EHR spent more time looking at patient charts and less time making eye contact with patients. Patients also spent more time staring at the doctors' computer screens, regardless of whether or not they could actually see the charts. Doctors spent less time interacting with patients and more time interacting with the charts when EHR was used.

In other words, software appears to reduce interaction between physicians and patients, in other words. Although patient care is ultimately supposed to be the most important part of the clinical encounter, many physicians are focused primarily on the patient's chart and are not providing the patient with the care they really need.

By arranging yourself, your computer and your patient in a triangle shape in the exam room, you can easily shift your focus between the patient and the computer without turning away from your patient.

BRING IT BACK TO PATIENTS

A good starting point is paying attention to your patient and their needs at every visit to your practice.

EHR use is valuable for your clinic, your patient, and for your daily work as a DC. In many cases, avoiding EHR is either

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impossible, impractical, or both. You may need to refocus some of your habits and behaviors and re-train yourself to focus on your patients, rather than stop using software.

American Medical News suggested several ways physicians can address this problem, including:

1. Triangle setup: By arranging yourself, your computer, and your patient in a triangle shape in the exam room, you can easily shift your focus between the patient and the computer without turning away from your patient. From your patient's perspective, you also appear to face them throughout the appointment.

2. Create a patient-centered workflow: Redesign your workflow to show your patients that they are your top priority. Review the patient's chart briefly before the appointment, introduce yourself to the patient or greet the patient before logging into the exam room's computer and explain to the patient what you are doing when you begin using the EHR system.

3. E.V.E.L. System: Let the patient look at your screen by keeping Eye contact with patient, Value the computer (share the beneficial features of your EHR with the patient), Explain what you are doing, and Log off at the end of the encounter to show the patient that their data is secure.

These strategies may help you overcome EHR distraction and demonstrate your commitment to patient care. Since DCs are often not the only people in the office using EHR, your office staff should also cultivate an awareness of patient needs and the potentially-distracting nature of software. Letting others in your office know about the importance of eye contact, nonverbal communication, and direct interaction with patients can help improve patient care quality at your clinic.

PROVIDING QUALITY CARE

Because a significant part of providing quality care is all about listening to your patients, you may also want to involve them in the process of improving care and communication at your clinic. Using surveys, you can readily gauge how your patients feel about communicating with you and other staff members.

Because a significant part of providing quality care is all about listening to your patients, you may also want to involve them in the process of improving care and communication at your clinic.

Improving communication is a learning process, so it may be challenging at the beginning. Making quality communication with your patients a constant priority will help you connect better with your patients and deliver better health care. It is well-worth the effort.

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TIMING IS EVERYTHING: WHEN YOU SHOULD MAKE THE SWITCH TO A NEW EHR

By Robert Moberg

Breaking up is hard to do, but sometimes you have to let go of the past in order to really take hold of the future. Switching EHRs can be a daunting task, and oftentimes the thought alone can stifle any attempts to move forward with the endeavor. But if your current EHR system is outdated, laborious, and inefficient, it may be costing you much more than that apprehension is worth. There are many reasons that providers make a switch in EHRs. They may be looking for added functionality, EHR certification and adherence to government mandates, a more usable system, better support, or a consolidation of systems and services.

IT HAS A LACK OF SOLID CORE FEATURES

If your workarounds are so numerous that they commandeer the majority of your processes, it may be that your current system lacks the core features

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and functionality necessary for you to effectively run your practice. If you can't easily document and navigate through notes, customize your macros, track your patients from walk-in to walk-out, and manage your billing, your system may be slowing down the exact practices that its purchase was meant to speed up. And if it's not keeping pace with the rapid changes happening in the healthcare realm, you may be risking more than simple speed and efficiency.

YOU EXPERIENCE PAINFUL UPGRADES AND SUPPORT

If you rue the day that your system needs its next update, then it may be time to think about upgrading out of your old system and into a new one. With the technological advancements on the market today, there is no reason that you have to live in the dark ages of long phone queues and lengthy upgrade processes. After all, the software isn't the only thing you purchased. You also purchased a long-term relationship with your vendor. And if that vendor isn't in chiropractic for the long haul, your system won't be either. Every software system encounters issues from time to time. But if your vendor is not responsive to the needs of the market and the overwhelming requests of their users, it might be time to find a new dance partner.

YOUR SYSTEM DOESN'T PLAY WELL WITH OTHERS

Is your system a technology silo? Do you see a great many partnerships within your industry between systems that you don't have the luxury of gaining access to? Do you find yourself cobbling together services from multiple vendors to try to complete a comprehensive, fully-featured EHR system that covers patient reminders, patient intake, data backup, patient exercise prescribing, outcome assessments, online bill pay, and more? A comprehensive, fully-featured system can build bridges for you between the latest offerings on the market and your practice.

Every software system encounters issues from time to time. But if your vendor is not responsive to the needs of the market and the overwhelming requests of their users, it might be time to find a new dance partner.

YOU'VE OUTGROWN YOUR SOLUTION

You may have made your initial EHR purchase decision in a very different environment than the one you find yourself in today. Past budgetary restrictions, patient flow, staff size, and other external influences may have established a very different hierarchy of needs than those that you find yourself prioritizing today. If your system is bursting at the seams and its engine is struggling to keep up with a growing practice, it may be time to retire that old beater and pick up a new practice vehicle with a cleaner engine.

One of the greatest fears of changing systems is a loss in productivity. But productivity may be slipping through the cracks every day in the hands of an EHR system that has overstayed its usefulness. It's never easy to make a switch as impactful as change in EHR systems. But in some ways it can be even more difficult to remain stagnant, paired with a system that does not aid your practice in running to the best of its ability. ■

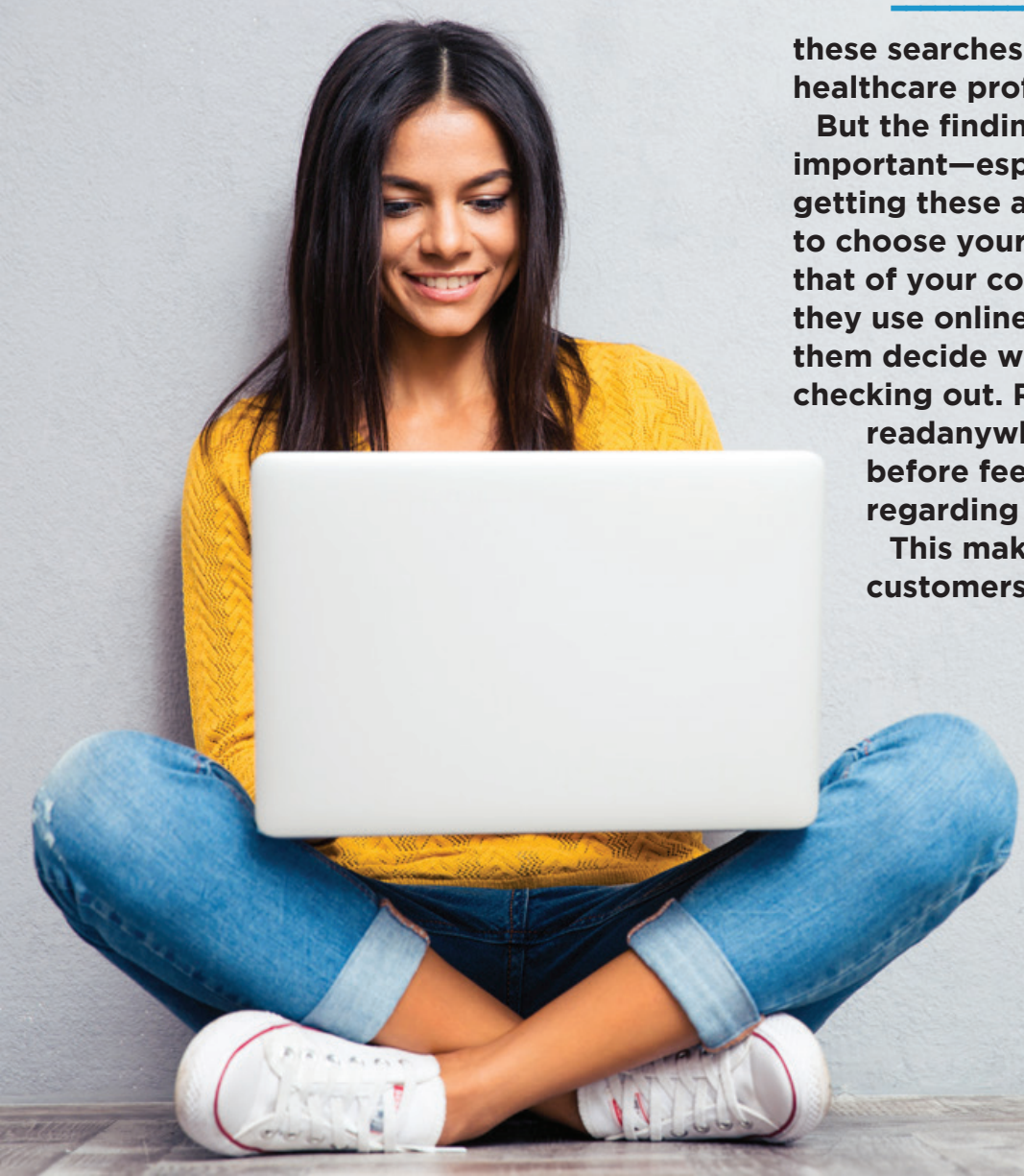
BOOSTING YOUR CHIROPRACTIC PRACTICE WITH ONLINE BUSINESS REVIEWS

By Christina DeBusk

According to a BrightLocal survey, almost one-third of the more than 2,000 people questioned indicated that they use the Internet to find local businesses at least two to five times per month.

Additionally, 30 to 40 percent of these searches are to find some type of healthcare professional.

Boosting your customers' online reviews a critical part of growing your chiropractic business. But how do you get them to post one?



But the finding that is perhaps the most important—especially when it comes to getting these at-home, online researchers to choose your chiropractic practice over that of your competitors—is that half say they use online customer reviews to help them decide whether the business is worth checking out. Roughly one-third of people readanywhere from two to six reviews before feeling some level of trust regarding the business itself.

This makes boosting your customers' online reviews a critical

continued>>

part of growing your chiropractic business. But how do you get them to post one?

HOW TO GET MORE ONLINE REVIEWS

Fortunately, there are several options when it comes to enticing your patients to submit an online review, telling the world about all of the good things you do. One to consider is simply asking them to write one. This thought normally doesn't enter people's minds, so letting them know that you'd appreciate an online review is sometimes enough.

You can do this by placing a sticker on your door with one of the online review sites on it or hanging up a flyer on your wall that thanks all of those who've already submitted a review, asking those who have not to consider doing the same. You can also put a link in your email newsletter so all they have to do is click on it.

For the person who may need a gentler nudge, you can also offer some sort of reward for filling out an online review of your practice. For instance, you could hold a monthly drawing for all of your patients who completed a review. Even something as simple as mentioning their name in your newsletter, thanking them for their kind words, means a lot and may entice others to do the same.

It also helps to make writing a review as simple as possible for your patients. Maybe you could put a laptop computer or tablet in your waiting area so they can write it while waiting for their appointment. This helps them pass the time and it helps you boost your online presence, making it a true win-win.

Finally, if someone takes the time to write a positive review about your practice, show your appreciation by responding to it—ideally, sooner rather than later. This helps your patient leaving the review feel valued while showing others who are merely reading it that you care enough about your business and your patients to thank those who took the time to compliment your services.

If someone takes the time to write a positive review about your practice, show your appreciation by responding to it—ideally, sooner rather than later.

Even if the review is negative, a simple, "Thank you for your opinion as we value the opinion of all of our patients," shows that you're willing to acknowledge people's thoughts of you, even if they are critical.

A WORD ABOUT RESPONDING

Speaking of responding to reviews, you need to be extremely careful that you don't release any patient information that is protected under the Health Insurance Portability & Accountability Act (HIPAA).

According to the U.S. Department of Health & Human Services, this includes any information relating to:

- The individual's condition,
- The "provision of health care to the individual," and
- Personally identifiable information, such as the patient's name, address, date of birth , or social security number.

Releasing this type of information in an online review site is a clear violation of HIPAA, potentially causing you some major legal issues. In fact, one article published by The Washington Post provided many different cases in which healthcare professionals are being investigated for putting patient's private health information online — costing violators both their money and their reputation. ■

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