Record Keeping

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The System

- Policies and Procedures Manual need to be created
- Two records categories:
  - Clinical Files
    - Follow standards of content and confidentiality
  - Business-related documents
    - Establish and maintain in a professional manner
    - Consult
      - An Accountant for
        - Billing
        - Bookkeeping
        - Accounting
        - Taxes
      - An Attorney for
        - Licenses
        - Contracts
        - Other legal documents

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Clinical Records

- Why?
  - To communicate results of evaluation or treatment
    - E.g., to third party payer
      - NO DOCUMENTATION → NO REIMBURSEMENT
  - To educate reader about speech, language, and swallowing disorders
  - To enhance relationship-building with other pros & PR
- Report characteristics
  - Concise, complete, organized, and honest
  - Present essential facts and omit insignificant details
  - Document contacts with clients or their families and referral sources
  - Document progress carefully and accurately
    - Initial or baseline
    - Interim progress
    - Discharge status
    - Subsequent follow-ups
  - Must be legible, dated, and signed
  - CONFIDENTIALITY!!!
  - Use functional goals and outcome measures

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Establishing a Clinical Record Keeping System

- Before opening:
  - Type of filing system
  - Retrieval method
  - Storage space

- Types of filing systems
  - Alphabetically (last name, first name)
  - Numerically (SSN/NN, sequential numbering, others)
  - Alphanumerically (codes involving both numbers and letters)
  - THE THREE E's
    - Ease and speed of filing and retrieving
      - Manila retrieval is time consuming
        - Use exterior labeling system
    - Efficiency of storage space required
      - Manila folders need less storage space
        - But loose papers → internal dividers and fasteners
    - Expenses
      - Manila folders less expensive

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Computerized Record Keeping

- Staff Training required
- Benefits
  - Faster processing time
  - Increased accuracy
  - Improved appearance of records
- Uses
  - To process accounts payable and receivable
  - Keep track of client and employee schedules
  - Organize client demographics
  - Performing statistical analyses
  - File insurance claims electronically
  - Generate clinical evaluation and treatment reports
- Need a duplication system (back up) (e.g., daily)
- Security system to prevent unauthorized access & minimize virus risk

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Organizing and Maintaining Client Charts

- Contents of a client chart
  - Intake form
    - Contact and Demographic information
      - Client's name
      - Client's address
      - Phone number
      - Emergency contact and phone number
      - Date of birth
      - Primary physician
      - Insurance information
      - Referral source
  - Consent Forms
    - Consent for treatment
    - Release of information/reports
    - Financial agreements
    - Credit card authorization

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Contents of a Client Chart

- Record of Contacts (in chronological order)
  - Appointments
  - Telephone calls
  - Appointment cancellations
  - Missed appointments, etc.
- Referral Information
  - Communications from and to referral source
- History
  - Case history information
  - Screening tests
  - Inventories
  - Baseline self assessment
- Reports
  - Evaluation and treatment results
  - Any other written reports
- Payment Information
  - Records of billing and payment information
    - Could be kept separate

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Clinical Record Guidelines

- Clinical Record-keeping list
  - Who, What, Where, When, Why, and How (ASHA)
    - Who: Documenter
    - What: Components
    - Where: Storage
    - When: Time frame for
      - Recording
      - Sending
      - Retaining information
    - Why: Rationale for Documentation
    - How: Methods
  - Check list pp. 127-132

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Problem-Oriented Medical Records

- **Includes**
  - Database
  - Problem list
  - Initial plan of care
  - Progress notes
  - Flow charts
- **Advantages**
  - Produces organized, coherent records
  - Easy to identify problem areas and services provided
  - Easy to locate specific information for chart review and other purposes
  - Easy to distinguish between fact and opinion

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Database

- Uniform, standardized system in content and format
- Consists of
  - History
    - Medical
    - Psychological
    - Developmental
    - Rehabilitation
  - Socioeconomic and demographic data
  - Present complaint/reason for referral
  - Results of previous evaluations and treatments
  - Etc.

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Problem List

- A numbered list of all the client's known problems
  - Medical
  - Physical
  - Psychosocial
  - Communication
  - Etc.
- Usually on first page of client's record

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Initial Plan of Care

- Plan of
  - Further assessments
  - Referral to other specialists (including rationale)
  - Remediation
    - Frequency and duration
    - Long- and short-term goals
    - Etc.
  - Discharge

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Progress Notes

- SOAP
- **S – Subjective:**
  - Comments made by subject (e.g., client, caregiver) – document person's name
    - Only related remarks (concerns, perceptions, attitudes)
    - Reported history
    - Reported complaints (from their perspective)
    - Reported symptoms
  - Significant remarks by others about the client's health
    - E.g., "he has a sore throat"
  - Response to treatment
    - E.g., "she can answer the phone now"
  - Compliance with home assignments
    - E.g., "he practiced three times"
  - Concerns about communication or swallowing skills
    - E.g., "she choked on her cereal today"
  - DIRECT QUOTES
  - NOT for stating your "subjective" opinion
    - E.g., alert and responsive, uncooperative, seemed depressed

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O - Objective

- Objective, observable, verifiable, factual, and quantifiable data
  - Tallies of correct responses
    - Test scores
    - Accuracy percentage on treatment tasks
  - Objective behavioral observations
  - Documentation of family/client education and counseling
    - Information presented
    - Behaviors indicating that information was understood

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A- Assessment

- Practitioner's subjective analysis and professional opinions
- Clinical impressions and interpretation
  - Diagnosis
  - Severity
  - Prognosis

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P- Plan

- Follow-up plans
  - Data and time of next appointment
  - Materials needed for next session
  - Continuation or revision of treatment plans
  - Discharge plans
  - Referrals

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Outcome-Oriented Records

- Measures to compare results of services accurately
- Why?
  - Efficacy of treatment
  - Cost-effectiveness
- How?
  - Compare baselines of
    - Severity of impairment
    - Severity of disability
    - Extent of functional skills or independence
- WHO Definitions
  - Impairment: actual damage or dysfunction of an organ or system
  - Disability: impact of impairment on individual functions
  - Handicap: effects of impairment and handicap on the person's social and environmental integration and overall QOL
- ASHA FORMS from ASHA's Task Force on Treatment Outcome and Cost Effectiveness

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Functional Assessment

- Person's ability to function in his/her environment despite disease, disability, or social deprivation
- Emphasis on abilities rather than disabilities
- Supplement NOT replace traditional assessment methods
- Clinical indicators for SLP services
  - Client satisfaction
  - Effectiveness of treatment
  - Family participation
  - Other factors of care
- ASHA FACS (Functional Assessment of Communication Skills for Adults)
  - Assesses functional skills in four areas
    - Social communication (e.g., participation in telephone conversations)
    - Communication of basic needs (e.g., requesting help)
    - Daily planning (e.g., scheduling and keeping appointments)
    - Reading/writing/Number Concepts (e.g., understanding environmental signs, writing shopping lists and phone messages, making change)
  - 2 rating scales
    - Communication independence
    - Qualitative dimensions of communication

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Functional Treatment

- Focuses on practical skills relevant to the daily life needs of the client
- Less emphasis on impairment, more on disability and handicap
- Skills meaningful and useful to the client from his/her perspective
- Suggestions from client and family member/caregiver should be sought and seriously considered for treatment goals

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Critical or Clinical Pathways (CPM)

- Creates a written, organized, sequential care path for clients to follow from admission to discharge
- For each diagnosis: specific services and sequence
- Indicates preferred pattern of care
- Allows for variations that can be categorized, coded, and tracked to help explain why target outcomes were not attained
  - PDCA (Plan, Do, Check, Act)

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Documentation in Medical & Rehabilitation Settings

- Must be appropriate to setting
- Should use your own form
- Comply with state regulations regarding documentation
- Documentation can be
  - Discipline-specific
    - Each discipline has a section in the client's chart
    - Easy to find information and show continuity of care
    - Disconnection of information among disciplines
  - Interdisciplinary
    - All disciplines record notes chronologically in a continuous sequence
    - Reduced duplication
    - Increased cost-effectiveness
    - Improved communication among disciplines
    - Better understanding of collective work among disciplines
    - More time for one-to-one contact with clients

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Documentation DOs and DON'Ts

- Documentation relates ONLY to skilled, reasonable, and medically necessary services ordered by a physician
- Use appropriate terminology reflecting skilled, professional care
- Match treatment goals and tasks to evaluation findings
- Revise treatment plans as appropriate to meet client's needs
- Document so that each treatment session stands alone and validates the need for services rendered
- Use specific, objective, measurable indications of performance and progress
- Document that progress is occurring as reasonably expected in a predicted time
- Document treatment outcomes showing functional and meaningful gains
- Show that frequency and duration of sessions decrease as client improves
- Document setbacks or factors interfering with compliance or progress
- Document carefully establishing and providing functional maintenance programs
- DON'T continue treatment
  - More than necessary
  - Once significant improvement can no longer be reasonably expected

- Specific DOs and DON'Ts of documentation for homecare pp. 139-140

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Documentation in School Settings

- Must know how to create Individual Educational Plans (IEPs)
  - Statement of annual goals
  - Short-term instructional objectives
  - Objective criteria and evaluation procedures
  - Service provider(s) for each goal
  - Duration of services planned (starting and ending dates)

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Documentation for Insurance Purposes

- Follow claim forms and instructions of insurance company
- Send a brief report and a letter from referring physician with claim form
- Reports should include
  - appropriate diagnostic and procedure codes
  - Dates services were rendered
- SLP services need to be “medically necessary” related to illness or injury NOT “developmental problem” to be reimbursed
- Send educational information to support the claim

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Billing Records

- Accurate
- Complete
- Neat and professional in appearance
- Easy to understand
- Should include
  - ID information
    - Name of client/responsible party
    - Address of client/responsible party
  - Financial information
    - Dates and types of services provided
    - Fees charged
    - Payments received
    - Balance due
  - Appropriate diagnostic and procedure codes
- Send invoices to clients on a timely basis
  - Include preprinted, self-addressed reply envelopes
- Could hire a company to do billing for a fee
- Computerized billing programs
- MUST BE KEPT CONFIDENTIAL

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Legal and Ethical Consideration in Record Keeping

- Majority of lawsuits:
  - Failure to obtain informed consent
  - Failure to file a report
  - Filing a false report
  - Violation of confidentiality
- Clients have legal access to their records
- Records could be subpoenaed and used in legal proceedings

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Personnel Files and Employee Records

- **Employee Personal Records**
  - **Professional status documentation**
    - Job description
    - CV
    - Letters of recommendation
    - Professional credentials
      - Degrees
      - State licenses
      - ASHA certification
  - **Required government forms**
    - Tax forms
  - **Employee records**
    - Employment applications
    - Performance appraisals
    - Required health records
      - Annual physical examination
      - -ve TB, hepatitis B forms
      - Written agreements

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Policies

- Must have written and distributed policies about:
  - CPR
  - Bloodborne pathogens
  - Workers compensation and liability (malpractice) insurance
  - Employee benefits
    - Health insurance
    - Vacations
    - Staff Competency Standards
      - Performance evaluations
      - Promotions
      - Termination
  - Discrimination and sexual harassment
  - “At Will” Policy??

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Contracts

- Consult a knowledgeable attorney
  - Design a contract
  - Accepting a contract
- Mandated contract clauses
- Establish relationship between you and employee/subcontractor
  - Careful!! Employee or independent contractor
- Clearly specify responsibilities of both parties
- “Hold Harmless” clause
- “Noncompetition” clause
- Published compilation of independent contractor agreements available

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