Documentation
Evidence of Patient Care
- Evidence of patient care
- Proves care was given
- Reason for treatment
- Treatment effectiveness
- Communication:
  b/n PT/PTA to document progress & Rx
  b/n PT & other disciplines to coordinate care

Documentation
Accountability for Care
- 3rd party payers review notes to determine if they will pay based on appropriateness of care and effectiveness
- focus on FUNCTION
- Care Provider is held accountable for medical care given
- if we don’t get reimbursement for PT services physical therapy will cease to exist

Legal Document
protects you and patient
- can be used in a court of law
- ***it doesn’t matter how effective your treatment is – if you didn’t document it didn’t happen!
Evolution of PT/PTA Responsibilities

- Physical therapy prescription prior to 1960's
  - PT's were technicians: Dr. gave the patient a prescription that was very specific i.e. US 3x/week for 2 weeks
  - PT's documented treatment given and if patient improved

Role of PT & PTA's 1960's

- Evaluate and treat, 1960's:
  - PT prescriptions often said eval and treat
  - PT's began evaluating neuromuscular system and determined appropriate Rx
  - PTA's began around 1967 became technicians under supervision of PT & shared documentation

Direct Access

- Pt. can come directly to PT
  - PT given clinical decision making opportunity
  - PT education shifted to scientific knowledge, evaluative skills, creative thinking
  - So PT would know when problems were NOT PT problem and to make appropriate referrals to MDs etc.
Changes in Response to Direct Access

- PTA education gave more theories for treatments so PTA can make decisions within parameters of PT POC.
- PTA's role now includes performing assessments and reporting to the PT any changes, lack of progress or signs & symptoms that would indicate a need for a PT re-evaluation.

Role of Documentation in Patient Care

1. Records the QUALITY of patient care:
   - Quality: is defined by the APTA in the Standards of Practice
   - Is it appropriate and relevant for the patient's problem?

Documentation/quality

- Documentation is used to determine quality of care by: audits
  a. Quality assurance/management- does it meet standards and criteria; Performed by facility on-going and by accrediting bodies every 5-10 years
  b. Research: what works best; cost-effective
  c. Third-party payers: decide reimbursement based on doc.; must show problems were identified, treatment solved problems
Role/ quality care
- Must have communication between the team for patient’s problems, solutions, plan and to coordinate care.
- Must have communication between the PT/PTA; it’s vital everyone understands the problems, plan and what was done, the patient’s response, etc
- Patient’s response to treatment and progress toward goals

Role/Communication
- Medical Record for communication b/n medical team:
  1. Identification of pt.’s problems
  2. Solutions
  3. Plans for pt.’s discharge
  4. Coordination of care

Role of Documentation in Patient Care
- Legal report of patient care
  - Testify in court case
  - Basis for reimbursement
<table>
<thead>
<tr>
<th>Standards &amp; Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Federal Government – medicare</td>
</tr>
<tr>
<td>2. State Government – medicaid</td>
</tr>
<tr>
<td>3. Accrediting Agencies –</td>
</tr>
<tr>
<td>- Hospitals - JCAHO</td>
</tr>
<tr>
<td>- Rehab Facilities – CARF</td>
</tr>
<tr>
<td>4. Health-Care Facility</td>
</tr>
<tr>
<td>- Quality Assurance</td>
</tr>
<tr>
<td>- Policies &amp; Procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content Categories:</td>
</tr>
<tr>
<td>- Data relevant to pt.’s condition</td>
</tr>
<tr>
<td>- Problem(s) requiring medical tx</td>
</tr>
<tr>
<td>- Tx plan or action to address problems</td>
</tr>
<tr>
<td>- Goals or outcomes of tx plan</td>
</tr>
<tr>
<td>- Record of administration of tx plan</td>
</tr>
<tr>
<td>- Tx effectiveness/results of tx plan</td>
</tr>
</tbody>
</table>
Relevant Data
- SUBJECTIVE: information told by pt. or family member to PT/PTA or HCP (Health Care Provider)
  - Symptoms
  - Medical history
  - Cause(s) of symptoms
  - Patient’s functional and lifestyle needs
  - Patient’s goals or expectations from treatment
- OBJECTIVE: measurements, tests, observations, reproducible, repeat testing during course of treatment

Problem(s)
- Medical Diagnosis:
  - Determined by physician’s eval and diagnostic tests
- Physical therapy problem
  - not medical diagnosis
  - neuromusculoskeletal dysfunction
  - functional limitation

Problems
- Medical Diagnosis:
  - Systemic disease
  - Pathology
  - Ex: Fractured femur
  - Rheumatoid Arthritis
  - CVA
  - Parkinsons
  - Multiple Sclerosis
Problems

- PT Diagnosis – NOT a medical diagnosis
  - Biomechanical or neuromuscular problem
  - Impairments & Functional Limitations
  - Ex:
    - Ataxia
    - ROM deficits unable to dress independently
    - Unsafe gait

Terminology

- APTA Guide to PT Practice: begin with pathology which leads to impairments which may lead to functional limitations: “restriction of ability to perform a physical action, activity, or task in an efficient, typically expected or competent manner”

- Disability: “inability to engage in age-specific, gender-specific, or sex-specific roles in a particular social context and physical environment”

Treatment Plan or Action

- Determined by problems
- Frequency
- Duration
- Informed consent: obtained by PT; provide pt. with info about Rx
- Established by PT
- Strategies to minimize problem and increase function
Goals & Outcomes

- Established by PT (should include pt.s goals)
- Gives PTA direction for -(planning Rx sessions, progressing Rx)
- Recommending Rx termination
- DIRECTLY related to problems
- Functional Outcome Expected

Record of Administration of the Rx Plan

- Flow charts
- Progress notes
- Recording of Rx provided for each problem
- Patient’s reaction to treatment
- Progress towards goals or outcomes
- PROVIDES PROOF of what was done

Treatment Effectiveness

- Patient’s response to Rx (progress toward goals, goals met)
- MOST IMPORTANT PART; is interpretation of pts response to Rx
- Quality of medical care provided
- Research to determine the effectiveness of treatment procedures
- Third party payers use to determine reimbursement
Exam/Eval by PT
5 Elements of PT Management

- Examination
- Evaluation
- Diagnosis
- Prognosis
- Intervention

Terminology

- Examination: process of gathering subj & obj. data
- Evaluation: "clinical judgment" by PT based on the examination; decide PT dx, prognosis, interventions
- Prognosis: judgment regarding patient's ability to improve, level of improvement and time required
- Interventions: skilled techniques and activities in POC

Physical Therapist Documentation
Responsibilities & Role

- Initial Evaluation:
- Discharge Evaluation
- Progress/treatment Notes
- Interim Re-Evaluation
- Change in Treatment Plan

*See Appendix F for APTA Guidelines for PT Documentation
PT Initial Evaluation

- Hx & risk factor Identification
  - May find in chart
  - Age
  - Medical Dx
  - Name
  - Sex
  - DOB
  - Complications
  - Precautions

PT Initial Evaluation cont'd

- Subjective Data:
  - Pt. or family member “tells” PT
  - Onset of injury/disease/pain
  - Chief Complaint
  - Location of Complaints
  - Functional Limitation
  - Home Situation
  - Lifestyle
  - Goals
  - Work Requirements

PT Initial Evaluation cont’d

- Objective Data
  - Results of assessments
    - MMT, ROM, balance, gait, transfers, endurance, skin condition, functional status, ADL's, ability work, school, home, & mental status, cognition, orientation, communication, judgment, ability to follow directions
PT Initial Eval cont’d

- Evaluation
  - PT’s “interpretation of the results of the testing and observations”
  - Find in Assessment component of SOAP note

PT Initial Evaluation cont’d

- PT Diagnosis
  - Identify impairments and functional limitations

PT Initial Eval cont’d

- Goals
  - Goals & expected outcomes
  - MUST be MEASURABLE and FUNCTIONAL
PT Initial Eval cont’d

- POC: plan of care
  - Interventions and treatment to accomplish goals
  - Frequency
  - Duration
  - Prognosis (Rehab potential)

---

Authentication:

- PT signature
- PT title
- Professional License Number

---

PTA Documentation Role & Responsibilities

- Progress/treatment/interim note
- May assist PT in gathering data for evaluation
- May NOT interpret data, set goals, design treatment plan

- PTA is responsible for following treatment plan to meet goals outlined in PT Eval.
Organization & Presentation of Content
- Format
  - Used to organize pt info in chart
  - Varies from facility to facility
  - Often depends on setting
    - Acute Hospital
    - Out-patient PT Clinic
    - Rehab Facility

Organization of the Medical Record
- Types of Organization
  - SOMR: Source Oriented Medical Record
  - POMR: Problem oriented Medical Record
  - Combination of SOMR & POMR

SOMR
- Organized by medical services
  - Physician
  - Nursing
  - Physical therapy
  - Occupational therapy
  - Respiratory therapy
Each discipline documents in their section their content:

- Data
- Problems
- Treatment plan
- Goals
- Progress notes
- Treatment Effectiveness

Disadvantages of SOMR:

- Other disciplines may be unaware of pt problem
- Time to locate & read other disciplines
- Difficult to audit for reimbursement & quality control

Problem Oriented Med. Record (POMR):

- Organized by identification & Rx of pt.’s problems
- Sequence
  - Data Base
  - Problem List
  - Treatment Plans
  - Progress Notes
  - Discharge Notes
POMR

- Each discipline places the info in the section
- Advantages
  - Improved communication b/n disciplines
  - Problems all in one place
  - Treatments all in one place
  - Easier for auditors

Organization of the Documentation Content

- Ways to Organize Notes
  - SOAP: Subjective, Objective, Assessment, Plan
  - PSP: Problem, Status, Plan
  - PSPG: Problem, Status, Plan, Goals
  - DEP: Data, Evaluation, Performance Goals
  - FOR: Functional Outcome Report

SOAP Note

- Most common method to organize info
- Logical Sequence
- Organized for quick & easy reading & locating info
SOAP Note cont’d

S=Subjective
- Info told by pt., caregiver, family member
- Symptoms
- History
- Previous Medical History
- Response to treatment
- Activity level

SOAP Note cont’d

O=Objective
- Data that can be reproduced or confirmed by another professional with same training
- Gathered by “measurable & reproducible tests and observations”
- “signs” of pt.’s disease or dysfunction

SOAP Note cont’d

A=Assessment
- PT or PTA summarizes S & O info to answer “What does it mean?”
- PT interprets & makes clinical judgment
- PT sets functional outcomes & goals based on info in S & O
- Report progress toward goals
- “SO WHAT”
SOAP Note cont’d
P=Plan
- What will happen next?
- PT treatment plan
- PTA in progress note what you will do in next treatment or before next treatment

SOAP Note Example
- Dx: Fractured L ankle
- Pr: NWB LLE requires A.D. for amb.
- S: Pt reports 1 flight of stairs in home, curbs & ramps at work. Pt reports she has never used an A.D. before
- O: Instructed pt. in NWB LLE 3.0 gait pattern with crutches. Pt. ambulated 50 feet with min asst for balance and verbal cues 50% of times for correct gait pattern on level surfaces.
- A: Pt. needs to continue gt training to reach goal of I on level surfaces, ramps, and stairs.
- P: Cont gt training BID for 3 more treatments

PSP
Problem, Status, Plan
- P = problem/diagnosis
- S = subjective & Objective data
- P = modified treatment plan based on clinical findings
PSPG
Problem, Status, Plan, Goals

- Same as PSP with addition of G
- G = functional goals
FOR Functional Outcome Report

- Structured format for reporting “functional assessment & outcomes
- FOR Sequence
  - Reason for referral
  - Functional limitations
  - Physical therapy assessment
  - Therapy problems
  - Functional outcome goals
  - Treatment plan & rationale

FOR cont’d

- Reason for referral
  - Diagnosis, PMH, subjective data
- Functional Limitations & PT Assessment
  - Objective data
- Physical problems
  - Problems identified by data
- Functional Goals
- Treatment Plan
  - How it relates to goals & how goals will be accomplished
Content Organization/Sequencing

1. Gather Data
2. Interpret Data to identify PT Dx
3. Develop goals & outcomes
4. Treatment plan/interventions to meet goals & functional outcomes

Guidelines for organizing note

- PT diagnosis
- Subjective data
- Objective data
- Meaning of data “so what”; relate to treatment effectiveness and progress toward goals & functional outcomes
- Plan
- *can follow these guidelines for organizing note even if narrative paragraph form rather than SOAP, PSP, PSPG, FOR

Formats

- Computerized
- Flow Charts
- Checklists
- Letter
- IEP
- Cardex
- Standardized Medicare Forms
Formats

- Computerized
  - If pre-programmed phrases, must make sure individualize for specific pt.s
  - Content must show skilled need

Flow Charts & Checklist

- Fill in the blank forms
- Advantage can locate quickly
- Can combine narrative with flow chart
- Disadvantage: often no note is combined with flow chart so no skilled need is demonstrated

Flow Chart
Letter Format
- Often used in private practice
- Sent to referring physician

Cardex
- PT Department
- Pt.’s goals & treatment interventions
- Available for quick access
- Written in pencil for easy updating
- Must be updated
- NOT part of medical record
- Disadvantage: still need to review chart prior to pt. treatment to review other disciplines and pt. info

Standardized Medicare Forms
- HCFA: Health Care Financing Administration
- HCFA: specifies time lines & format
- Not completed by PTA because evaluation or re-evaluation form
- Form also serves as discharge eval
- PTA can provide info to PT but not complete form
- PT completes these forms
IEP
Individual Education Program

- Treatment provided in public schools
- Team records goals
- Team has periodic meetings to review goals
- Team meets with parents every 7 months
- PT completes IEP
- PTA can write progress notes
- Pg. 39

- Pg. 36 & 37 & 38 in doc book
- Examples of checklist & progress note forms