Fourth Edition

The OTA's Guide to Documentation

Writing SOAP Notes

Marie J. Morreale
Sherry Borcherding

SLACK Incorporated

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Published by: SLACK Incorporated
6900 Grove Road
Thorofare, NJ 08086 USA
Telephone: 856-848-1000
Fax: 856-848-6091
www.Healio.com/books

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Library of Congress Cataloging-in-Publication Data

Names: Morreale, Marie J., author. | Borcherding, Sherry, author.

Title: The OTA's guide to documentation : writing SOAP notes / Marie J.

Morreale, Sherry Borcherding.

Other titles: Occupational therapy assistant's guide to documentation

Description: Fourth edition. | Thorofare, NJ : SLACK Incorporated, [2017] |

Includes bibliographical references and index.

Identifiers: LCCN 2017021354 (print) | LCCN 2017021691 (ebook) | ISBN

9781630912963 (alk. paper) | ISBN 9781630912970 (Epub) | ISBN

9781630912987 (web)

Subjects: | MESH: Occupational Therapy--methods | Medical Records |

Documentation--methods

Classification: LCC RM735.4 (ebook) | LCC RM735.4 (print) | NLM WB 555 | DDC

615.8/515--dc23

LC record available at https://lccn.loc.gov/2017021354

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Dedication

This book is dedicated to OTA students everywhere. May you find purpose and joy in your work as you embark on your occupational therapy journey.

Marie J. Morreale, OTR/L

This book is dedicated to all the occupational therapy students, faculty, and fieldwork instructors who have taught me so much about documentation, and to my grandson, Jan, who carries on the family tradition in occupational therapy.

Sherry Borcherding, MA, OTR/L

Contents

Acknowledgments

I will always be thankful to Ellen Spergel, past coordinator of the OTA Program at Rockland Community College, for giving me a start in academia. Her wisdom, kindness, and support regarding occupational therapy education will impact me forever. Appreciation goes to Sherry Borcherding for developing the initial materials for an OT documentation manual which has now morphed significantly over several editions to become this current expanded work. I would also like to recognize Carol Kappel for her work in the first edition of this text. Finally, special thanks to my husband Richard. Without his love, patience, and support, this book would not have been possible.

Marie J. Morreale, OTR/L

Many people have contributed to the writing of this manual. I would like to thank Diana Baldwin for her patience in teaching me how to teach. Without her nurturing and support, my life might have taken another path entirely. Thanks to Fred Dittrich for moving me as gracefully and quickly into the information age as I could tolerate, and to both Fred Dittrich and Boden Lyon for teaching me video editing. Thanks to Sandy Matsuda, Crystal Gately, and a host of local occupational therapists for assistance with the content. Thanks to Doris O'Hara for bequeathing me the basic course many years ago, and to Leanna Garrison, the Format Goddess. Thanks to Brien Cummings at SLACK Inc. for his negotiation skills. Most of all, I would like to thank all the occupational therapy classes at University of Missouri who allowed their notes to be used to teach others.

Sherry Borcherding, MA, OTR/L

About the Authors

Marie J. Morreale, OTR/L taught occupational therapy assistant (OTA) students for 17 years at Rockland Community College, State University of New York. As an adjunct faculty member, her various courses included: Professional Issues and Documentation; Geriatric Principles; OT Skills; Advanced OT Skills; Therapeutic Activities; and Advanced Therapeutic Activities. Marie contributed significantly to curriculum development and served briefly as interim coordinator of the OTA Program.

Marie graduated Summa Cum Laude from Quinnipiac College (now Quinnipiac University) in Hamden, Connecticut, and has clinical experience in a variety of OT practice settings including: inpatient and outpatient rehabilitation, long-term care, adult day care, home health, cognitive rehabilitation, and hand therapy. She maintained certification in hand therapy for over 20 years and also served several years on a home health Professional Advisory Committee, consulting on quality assurance issues. Marie enjoys professional writing and, in addition to co-authoring the prior two editions of this documentation manual, has published several other occupational therapy texts: *The Occupational Therapist's Workbook for Ensuring Clinical Competence* and *Developing Clinical Competence: A Workbook for the OTA*. Additional published works include a chapter on documentation for *The Occupational Therapy Manager, Fifth Edition*, several OT articles and web-based continuing education courses. She is also a test item writer for the American Occupational Therapy Association continuing education products. In her spare time, Marie is active in her church community and has a passion for travel.

Sherry Borcherding, MA, OTR/L is retired from the faculty of the University of Missouri–Columbia, where she taught for 15 years. During the time she was on the faculty, she taught disability awareness, complementary therapy, clinical ethics, frames of reference, psychopathology, loss and disability, long term care, wellness, and a three-semester fieldwork sequence designed to develop critical thinking, clinical reasoning, and documentation skills. As a part of the fieldwork and documentation courses, she filmed simulated occupational therapy interventions for student use in class. Three of these "movies" are available on www.efacultylounge.com with this edition of the book.

Sherry graduated with honors from Texas Woman's University, Denton, Texas with a BS in occupational therapy and went on to complete her master's in special education with special faculty commendation at George Peabody College, Nashville, Tennessee. Along with her staff positions in rehabilitation, home health, and pediatrics, she assumed a number of management roles, including Chief Occupational Therapist at East Texas Treatment Center, Kilgore, Texas; Director of Occupational Therapy at Mid-Missouri Mental Health Center, Columbia, Missouri; and Director of Rehabilitation Services at Transitional Housing Services, Columbia, Missouri. She has planned, developed, and directed occupational therapy programs at Capitol Region Medical Center, Jefferson City, Missouri and at Charter Behavioral Health Center, Columbia, Missouri.

Sherry is a lifelong learner. Since her retirement, she has further expanded her private practice devoted to complementary and alternative therapies. She is certified in CranioSacral Therapy through Upledger Institute, Palm Beach Gardens, Florida, and is attuned as a Reiki master. She is currently learning Eden Energy Medicine. For leisure, Sherry enjoys music, English country dance, and all kinds of three-dimensional art. Her pottery has appeared in several local shows over the past several years. For 10 years, she volunteered with the Community Emergency Response team doing logistics.

Chapter 1

Documenting the Occupational Therapy Process

An occupational therapy assistant (OTA) has many roles and responsibilities, including the essential task of documenting occupational therapy services. In addition to writing in the health record, documentation also encompasses accurate recordkeeping for school, community, or nontraditional settings. Your professional documentation provides important information and feedback to the occupational therapist (OT) and other members of the health care or education team regarding your clients. It also communicates the distinct value of occupational therapy to other audiences such as insurance companies and accrediting agencies. Initially, writing in the record might seem very intimidating to an OTA student or new practitioner. When you first see an experienced OT or OTA make an entry in a health, education, or early childhood record, you might be tempted to think you will never be able to do it. The technical language alone can be daunting, and then there is the amazing attention to detail in the client observation, the insightful assessment, and the documentation that just seems to flow from the pen, computer keyboard, or touch screen without apparent effort. You may wonder whether you will be able to organize all of your client observations as effectively, predict what the next steps will be, and record interventions quickly and professionally. Perhaps you are also apprehensive about navigating the unfamiliar maze of templates and drop-down lists present in electronic medical record (EMR) programs or being able to locate and decipher essential information in voluminous client charts. You might feel overwhelmed because the whole process seems a bit foreign to you. Rest assured that many occupational therapy practitioners felt the same way as you when they were students.

Professional documentation is a skill, and like any skill, it can be learned. Learning a skill, whether it is ice skating, playing the violin, or composing a progress note, requires three things of you: instruction, practice, and patience. This manual is designed to get you started with learning and practicing the process. Information is systematically provided on each part of the documentation process and the worksheets are designed to let you practice each step as you learn it. Use the manual as a workbook. Take time to integrate the information in each section, complete each exercise, and check it against the suggested answers in the appendix. As you reflect and learn from your mistakes, you will develop more confidence in your documentation abilities.

Overview

This manual will help you to understand the purpose and standards of occupational therapy documentation for various practice settings and different stages of the occupational therapy process (evaluation, intervention, and targeting of outcomes) (American Occupational Therapy Association [AOTA], 2014b). Current occupational therapy practice is in many ways determined by which services are reimbursable, and documentation of skilled client care is the method by which that service is communicated. Although electronic health record (EHR) systems are becoming

Morreale, M. J. *The OTA's Guide to Documentation: Writing SOAP Notes, Fourth Edition* (pp. 1-14).

more widespread, you might find that some facilities or settings still use a traditional paper-based charting system. Throughout this book you will learn the fundamentals of both electronic documentation and traditional paper-based records.

This manual presents a thorough and systematic approach to one form of documentation, the **SOAP** note. SOAP is an acronym for the four parts of an entry into the record. The letters stand for Subjective, Objective, Assessment, and Plan. You will learn the origins and meanings of those terms in Chapter 2 along with an explanation of an alternate format, called a *narrative note.* The format this manual teaches for writing SOAP notes is one that is reimbursable by third-party payers, including Medicare, which has rigorous requirements. Not all funding sources require a SOAP note format and not all occupational therapy practitioners and facilities use SOAP notes. Practitioners using EHRs must conform professional documentation to specifications of the particular electronic documentation program in place. However, once you learn the basics for composing SOAP notes, you will then be able to adapt and apply those skilled observation and documentation skills to EHR formats and other methods of recording client care (e.g., flow sheets or narrative notes) required by your medical facility, school, or other practice area. Also, if you learn to meet these strict standards, you are not likely to be denied reimbursement by any third-party payer. Fundamentals of documentation, EHRs, billing, and reimbursement are explained in Chapters 2 and 3. These principles are also reflected in the many documentation examples presented throughout the manual. Each section of the SOAP note is also explained thoroughly in separate chapters for the S, O, A, and P. Other topics in this text include professional terminology, a review of grammar, an explanation of the initial evaluation process delineating the roles of the OT and OTA, a method for goal-writing, guidelines for selecting appropriate interventions, and an overview of the documentation requirements for different practice settings. A detachable documentation checklist is also included at the end of this book to help ensure that your notes contain all the necessary elements. In addition, the appendix in this book provides suggested "answers" for the worksheets. However, as there are many "right" ways to answer and compose therapy notes, these must be viewed as suggested best practice examples rather than the only "correct" answers. In actual clinical practice, you will see varied documentation styles among occupational therapy practitioners. Each OT and OTA develops individualized writing skills and a personal repertoire of professional language while complying with accepted legal and facility standards. Notes will also vary based on the type of practice setting and the particular documentation formats and systems used.

This manual reflects the collaboration of the OT and OTA and incorporates standards of The American Occupational Therapy Association (AOTA) and the Accreditation Council for Occupational Therapy Education (ACOTE) for education, documentation, and clinical practice. It reflects the scope of occupational therapy and emphasizes the basis of those services as described in the *Occupational Therapy Practice Framework: Domain and Process, Third Edition* (AOTA, 2014b). This manual also incorporates educational standards delineated in the *2011 Accreditation Council for Occupational Therapy Education (ACOTE) Standards* (ACOTE, 2012) along with concepts and guidelines delineated in AOTA official documents such as:

- *The Philosophical Base of Occupational Therapy* (AOTA, 2011)
- *Guidelines for Documentation of Occupational Therapy* (AOTA, 2013a)
- *Occupational Therapy in the Promotion of Health and Well-Being* (AOTA, 2013b)
- *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014a)
- *Scope of Practice* (AOTA, 2014c)
- *Occupational Therapy Code of Ethics* (AOTA, 2015a)
- *Occupational Therapy's Perspective on the Use of Environments and Contexts to Facilitate Health, Well-Being, and Participation in Occupations* (AOTA, 2015b)
- *Standards of Practice for Occupational Therapy* (AOTA, 2015c)

The material presented in this book originally grew out of documentation courses taught to occupational therapy seniors at the University of Missouri–Columbia. The material was edited to be more appropriate for clinical practice of OTAs for the first edition of this book. Subsequent editions incorporated new material stemming from documentation courses taught to OTA students at Rockland Community College, State University of New York. The material has been field-tested to be sure it is practical, understandable, and effective in helping you learn both documentation and clinical reasoning skills. This fourth edition reflects current guidelines for professional documentation and ethical occupational therapy practice. It includes updated billing and reimbursement information and more material regarding electronic documentation. Several new tables have been added to help the reader learn professional language and create occupation-based goals. New worksheets have been added and others revised to test the reader's attainment of knowledge and to practice documentation skills. For new purchasers of this book, client intervention

videos are available on the publisher's website for convenience and additional practice. An Instructor's Manual has been created for faculty as an online resource to accompany this book and includes client intervention videos, grading rubrics, and additional learning activities for documentation.

Our Professional Language and Focus

International Classification of Functioning, Disability and Health

The *International Classification of Functioning, Disability and Health* (ICF) is a health and disability framework established by the World Health Organization (WHO) and endorsed by WHO members in 2001 (WHO, 2002, 2017). ICF classifies, describes, and measures disability and health from the perspectives of not just physical health (pertaining to body structures and functions), but also a person's functional abilities (capacities) and actual performance levels for life tasks, while also considering the influence of social, personal, and environmental factors (WHO, 2002, 2017). The standard, universal language of ICF pertains to individuals, institutions, and society and influences public policy. ICF posits that most individuals will experience some level of disability through declining health as a result of illness, injury, or the normal aging process (WHO, 2002). Occupational therapy is a natural fit with the WHO viewpoint that health and disability are not based solely on a diagnosis but are impacted and intertwined with environmental factors, personal and social contexts, and actual abilities and limitations, all of which directly affect function, occupational participation, and performance of life tasks (AOTA, 2014b; WHO, 2002, 2017). It is useful to consider and incorporate terminology and concepts delineated in the ICF into your occupational therapy documentation.

Occupational Therapy Practice Framework

The *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014b), also referred to as the *Framework-III*, is an important document that embodies the focus and heart of occupational therapy and is a useful resource for documenting professional terminology and the therapy process (Figure 1-1). The *Framework-III* describes the domain of occupational therapy as "achieving health, well-being, and participation in life through engagement in occupation" (AOTA, 2014b, p. S2) and holistically delineates best practice for evaluation, intervention, and targeting of outcomes. This document presents a client-centered process that centers on enabling individuals to perform necessary and desired life activities for occupational participation; the *Framework-III* groups these broad and varied meaningful life tasks into **occupations** (AOTA, 2014b). The ability to engage in occupation is impacted by many interrelated factors: the client's **performance skills** (in the areas of motor, process, and social interaction), **performance patterns** (habits, routines, rituals, and roles), **client factors** (body structures and functions, spirituality, values, and beliefs), the influence of **contexts and environments**, as well as **activity and occupational demands** (AOTA, 2014b). Occupational therapy practitioners use clinical reasoning, therapeutic use of self, activity analysis, and other specialized skills to plan and implement effective, evidence-based skilled interventions (AOTA, 2014b). Your therapy notes should reflect the skilled care, professional language, and underlying concepts set forth by the *Framework-III.* The distinct value of occupational therapy should be evident to others reading your notes, such as payers and other disciplines.

OCCUPATIONS	CLIENT FACTORS	PERFORMANCE SKILLS	PERFORMANCE PATTERNS	CONTEXTS AND ENVIRONMENTS
Activities of daily living (ADLs)* Instrumental activities of daily living (IADLs) Rest and sleep Education Work Play Leisure Social participation	Values, beliefs, and spirituality Body functions Body structures	Motor skills Process skills Social interaction skills	Habits Routines Rituals Roles	Cultural Personal Physical Social Temporal Virtual

*Also referred to as basic activities of daily living (BADLs) or personal activities of daily living (PADLs).

Figure 1-1. Aspects of the domain of occupational therapy. (Reprinted with permission from American Occupational Therapy Association. (2014b). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy, 68*(1 Suppl.), S1-S48. doi: 10.5014/ajot.2014.682006)

By starting with an **occupational profile**, occupational therapy practitioners are able to determine whether any contextual or environmental features, activity demands, individual client factors or skills need to be addressed, depending on the occupational needs of the client (AOTA, 2014b). This allows appropriate goals and interventions to be determined for desired outcomes. The occupational profile is a client-centered approach to gathering information (occupational history, interests, experiences, habits, and patterns of daily living) as well as what the client values, needs, or hopes to gain from the present situation, allowing the client to set priorities for therapy (AOTA, 2014b). All of this initial data, plus any subsequent changes in the client's status, priorities, interventions, goals, and targeted outcomes will be recorded in the different types of notes that occupational therapy practitioners write throughout the intervention process.

Engaging in Meaningful Occupation

Before we talk about documenting the occupational therapy process, we must differentiate occupational therapy from other health care disciplines. OTs and OTAs provide interventions for people who have problems engaging in ***occupation.*** This distinction is very important to convey in an OT or OTA's notes. When documenting occupational therapy services, the focus on ability to engage in occupation is critical for demonstrating the necessity for occupational therapy and for preventing any question of duplication of services (Youngstrom, 2002). Occupational therapy practitioners in *all* service delivery settings have this common goal of facilitating occupational engagement (AOTA, 2014b; Youngstrom, 2002). Targeted outcomes can include occupational participation, health and well-being, occupational justice, quality of life, and role competence (AOTA, 2014b). It is also important to understand that each funding source has an interest in different outcomes or areas of occupation, meaning that payers have specific guidelines for what services they allow or consider necessary and will reimburse. This includes the specific type of occupational therapy interventions, frequency and duration of therapy services, or any special equipment clients may need (e.g., hospital beds, orthotic devices, adaptive equipment, assistive technology, customized wheelchairs). Your documentation should reflect those payer interests and requirements as they pertain to the client's condition and needs, living environment/contexts, and realistic expected outcomes. For example, Worker's Compensation will be interested in a client's ability to return to work, Medicare may be concerned about a home care client's ability to perform activities of daily living safely at home, whereas, a school district will be focused on a child's ability to perform educationally related tasks as per the Individualized Education Program (IEP). The *Framework-III* describes the following eight occupations (AOTA, 2014b):

Activities of Daily Living

BADLs or PADLs are necessary tasks for self-care and personal independence. These are tasks such as bathing, grooming, hygiene, dressing, eating, toileting, sexual activity, and functional mobility (AOTA, 2014b). It is important to consider not just the physical ability to care for self, but also other components, such as cognitive deficits or mental health conditions that might cause limitations in performance. For example, rather than being unable to perform grooming skills due to a physical factor, a client might fail to notice that his or her poor hygiene is problematic or, perhaps, might be depressed and unmotivated to perform self-care. If your services are being reimbursed by Medicare, you will often find yourself writing goals for ADLs. For children, you will address ADLs as developmentally appropriate.

Instrumental Activities of Daily Living

IADLs require more complex problem-solving and social skills. IADLs include such tasks as money management, cleaning, laundry, child care, driving, shopping, and meal preparation (AOTA, 2014b). While these are necessary skills in adulthood, IADLs are also important developmental milestones for children and teenagers and can include tasks such as caring for a pet, managing an allowance, babysitting, and using a microwave or stove. Occupational therapy practitioners who work with persons with brain injuries also consider executive functions that are an issue in frontal lobe damage. Executive functions involve planning, goal setting, and organizational tasks, which impact the ability to perform effectively IADLs. If your client population has cognitive impairment, intellectual disability, or mental health problems, you may find that your goals include multiple IADLs.

Work

Work includes successfully seeking and carrying out paid employment, as well as participating in volunteer experiences and planning for retirement (AOTA, 2014b). Work is a primary area of occupation for adults, forms a part of adult identity, and helps to structure one's day. If your services are being reimbursed by Workers' Compensation, you will generally find that the client's goals and interventions center around the return to work. Other work goals might

include injury prevention, using interventions such as ergonomic education, occupational adaptations, safety training, and the elimination of hazards. If vocational rehabilitation is your funding source, you might find instead that your work goals involve helping prepare a client for work that is both meaningful and within the client's capabilities.

Leisure

Leisure activities are those intrinsically rewarding things one does when not obligated to do anything else. Leisure is a very important area of occupation, particularly for older people. Leisure is generally considered as activities that enhance one's quality of life, and is not usually regarded as being reimbursable goal. However, the performance skills and patterns required to perform leisure activities are transferable to a variety of occupations that are reimbursable. Therefore, leisure is usually approached indirectly in documentation, with a focus on functional performance skills and patterns. However, in some practice settings, such as mental health, it might be appropriate to have leisure-related goals addressing areas such as coping strategies, appropriate use of leisure time, and intrapersonal, interpersonal, or social components.

Play

In a young child, play can be solitary or social and may consist of organized tasks, such as games with rules or spontaneous activities such as exploratory play. One of the primary occupations for a child is acquiring those skills necessary to progress through age-appropriate developmental milestones, and these skills are acquired through play. When providing occupational therapy to young children, you will often find yourself talking about play in your documentation.

Education

Education is another of the primary occupations of a child. Those activities and skills needed to perform well in formal or informal educational settings are unique. Occupational therapy services to children in the educational system are for the purpose of the child performing school-related activities successfully. If you are working in school-based practice, your goals and interventions must relate to behaviors and skills needed in the classroom or school environment to be reimbursable. You should also consider the child's ability to engage in extracurricular activities such as music, clubs, and sports. Education for adults encompasses college classes and formal, informal, or personal educational situations such as attending a continuing education seminar for professional needs or personal enrichment (AOTA, 2014b).

Social Participation

People, as social beings, need to be able to interact successfully with others and to keep one's behavior within the contextual norms of the community, the family, and peer groups. If you are working with clients who have brain injury, intellectual disability, or mental health conditions, you might find yourself documenting goals and interventions for social participation.

Rest and Sleep

Proper rest, relaxation, and sleep are essential for physical and emotional health, stamina, and safety. Clients who have pain, illness, incontinence, or who are caregivers of young children or a parent with Alzheimer's disease may have interrupted sleep patterns or limited opportunities to rest or relax. Mental health conditions such as depression or anxiety can result in excessive or inadequate sleep. Other factors such as a noisy environment, working multiple jobs, or the night shift may also significantly impact attainment of proper rest and sleep. Your documentation should include any concerns related to sleep preparedness or inadequate rest and sleep patterns.

Influencing Contexts and Environments

The *Framework-III* also describes how clients engage in meaningful occupation in a variety of arenas called **contexts and environments** (AOTA, 2014b). In addition to internal and external contextual factors (e.g., age, gender, culture, socioeconomic status, developmental stages, temporal aspects), environments may be physical (e.g., home, school, climate, terrain), social (e.g., family, colleagues, church community), or virtual (e.g., internet access, video chat, texting) (AOTA, 2014b). If your client is being seen in an environment such as a hospital or clinic that is not usual for him or her, it is important to determine whether or not the skills you are teaching are transferable to that client's own environment. It is especially important to document how particular contexts and environments relate to the client's condition and may be barriers to occupational participation. For example, a client who has good

functional mobility in the hospital may be completely stopped by 3 steps into a mobile home, an old-fashioned bathtub on legs, or lack of an elevator at the jobsite. A client who lives in a rural area and can no longer drive may not have availability of public transportation for grocery shopping or getting to work. Due to peer pressure, a teenager may refuse to wear leg braces or a hand orthosis, or might avoid use of adaptive equipment in public. A recently retired executive might have difficulty adjusting to an abundance of leisure time or, perhaps, a nursing home resident may have difficulty getting adequate sleep due to a roommate crying out frequently during the night. Your documentation should always include relevant contextual and environmental factors or problems along with any interventions or occupational adaptations to address these situations.

Underlying Factors

Occupational therapy practitioners document the pertinent underlying factors that influence a client's abilities, limitations, and occupational participation. **Client factors** consist of **body structures and functions**, which refer to the client's anatomy and physiology, along with **spirituality, values, and beliefs**, which influence a client's meaning of life and motivation (AOTA, 2014b). For example, an amputation of a limb, a hysterectomy, or a dental extraction would be considered loss of a body structure. An adult with a degenerated hip joint, scoliosis, or aneurysm or a child born with cleft palate, spina bifida, or club foot have impairment in a particular body structure. Body structures provide a physical framework to enable all of the body's systems to function, just like a water heater requires a metal container, pipes, nuts, and bolts before it can begin to work.

Some deficits in body structures can be "fixed" permanently or semi-permanently (total joint replacement, organ transplant, corrective surgery) or temporarily (dentures, prosthesis, wig). These underlying deficits and surgical/medical "corrections" might affect body functions and may sometimes necessitate a referral to occupational therapy to help manage the condition and improve occupational participation. For example, intervention may include teaching compensatory dressing and bathing techniques following a total hip replacement, improving activity tolerance for a prosthesis, teaching energy conservation and occupational adaptations following a heart transplant, or improving body image and limb function after a mastectomy.

The term *body functions* refers to making the body systems perform their duties, just like a water heater getting turned on and heating the water. Body functions include vital processes of basic life and movement functions, such as breathing, righting reactions, reflexes, wound healing, digestion, and immunology (AOTA, 2014b). More overt body functions include areas such as strength, the senses, and joint motion. Mental functions encompass cognitive and perceptual aspects, and also include intrapersonal characteristics such as personality, self-image, and emotions (AOTA, 2014b). If any of these client factors do not limit the client's ability to engage in desired activities and occupations, they do not necessarily need to be assessed or addressed in treatment. However, if a client has problems that do impact occupational participation such as poor memory, open wounds, dyspraxia, orthostatic hypotension, low vision, impaired sensory processing, decreased strength, spasticity, low self-esteem, hallucinations, or anxiety, then these might be relevant client factors or conditions to document and target in your interventions.

Performance Skills

Occupational therapy practitioners use professional knowledge to assess the demands or requirements of activities/occupations and also to observe and analyze **performance skills**; these are client behaviors and actions grouped into three primary areas: **motor, process,** and **social interaction skills** (AOTA, 2014b). As your client is performing activities and occupations, you will examine and document how these task skills are performed and consider what factors may impede or support occupational participation (AOTA, 2014b). For example, you can note the client's motor skills used to carry dishes to the table; reach to get clothes out of the dryer; draw a picture with crayons; push a shopping cart; manipulate knitting needles and yarn; bend to pick boxes up from the floor; grip pliers; or stand at a workstation for ten minutes. Process skills are evident when you see a client sort laundry; put away clean utensils; play checkers; choose proper coins for the vending machine; attend to the math teacher; organize a locker; or pay bills. You can note level of social interaction skills by observing how a client initiates casual conversation; requests a pain pill; handles a frustrating situation; asks for help with homework; shares toys; shakes hands; or maintains eye contact. You will be recording your professional observations and skilled analysis of client behaviors, actions, skills, and underlying client factors in your SOAP notes.

Activity Demands

Activity demands are interactive. They are most easily thought of in terms of task analysis. The demands of an activity include both what is needed to perform the activity and how that influences or relates to the client's stated goals. Occupational therapy documentation should specify the activity demands that are problematic for a particular client along with any interventions, grading methods, and adaptations needed for occupational performance.

Interventions

Occupational therapy practitioners record the varied interventions that are planned and implemented to work toward attaining desired client outcomes such as managing chronic conditions, enabling occupational participation, and improving quality of life. According to the *Framework-III*, types of occupational therapy interventions include occupations; activities; preparatory methods (done *to* the client) and preparatory tasks (done *by* the client); group interventions; advocacy and self-advocacy; and education and training (AOTA, 2014b). Documentation should delineate the specific methods used, the client's response to intervention, progress made toward goals, and any changes to the intervention plan.

Roles of the Occupational Therapist and Occupational Therapy Assistant

When communicating about occupational therapy, it is important to understand that the terms *therapist* and *clinician* are used to refer only to the OT, *not* an OTA (AOTA, 2014a; Centers for Medicare & Medicaid Services [CMS], 2014). An OTA, of course, uses the term *occupational therapy assistant* and should never be referred to as a therapist. OTs and OTAs are also identified as *occupational therapy practitioners*. In documenting the occupational therapy process, OTs and OTAs have different roles and responsibilities. AOTA's *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014a) and *Standards of Practice for Occupational Therapy* (AOTA, 2015c) specifically delineate the roles and responsibilities of both OTs and OTAs regarding documentation and clinical practice. In partnership with the supervising OT, the OTA performs delegated aspects of client care and can assist in designing, implementing, and assessing occupational therapy services (AOTA, 2014a, 2015c). The OTA may also contribute to documentation at all stages of treatment under the supervision of the OT and concurring with relevant laws and regulations (AOTA, 2013a, 2014a, 2015c).

Although these guidelines are considered "best practice," state statutes and licensure laws may differ from the guidelines. The guidelines may also differ from federal laws that delineate mandatory documentation requirements. In addition, funding sources may specify who would be an approved documenter or service provider for reimbursement purposes. You, as an occupational therapy professional, are accountable for adhering to the mandatory policies and procedures adopted by state and federal regulatory agencies. However, you will find the standards established by AOTA very useful in interpreting and following regulations.

Types of Notes

Different kinds of notes are written at different stages of the occupational therapy process. Notes also vary according to the type of practice setting. From the first notation in the chart that a referral has been received to the closing lines of the discharge report, occupational therapy practitioners document the many varied activities of the intervention process. The specific content of the note, format and organization of the note, and the timelines required all vary greatly according to type of setting, accrediting and regulatory agencies involved, and requirements of the funding source. The contents required for the following types of notes are described in *Guidelines for Documentation of Occupational Therapy* (AOTA, 2013a) and will be addressed in this manual.

Initial Evaluation Reports

Before beginning intervention, the client is evaluated to determine whether occupational therapy is appropriate, and if so, what kind of therapeutic intervention will be most useful. The OT directs the evaluation process, documents the results, and establishes the intervention plan; although, the OTA can contribute to this process (AOTA, 2013a, 2014a, 2015c). Each practice setting or facility has its own way of evaluating a client. A behavioral or mental

health center, for example, may not do the same kind of an evaluation as a public school or a skilled nursing facility. Evaluations are usually documented by completing a specific form provided by the setting or using a particular software program linked to the facility's EHR system. Sometimes, even if an EHR system is in place, the therapist might utilize a paper-based form or take handwritten notes during the actual evaluation session (i.e., for convenience or portability), then formally enter that information into an electronic format afterward. In some instances, an evaluation may also be done in a SOAP format for entry into the record.

Contact Notes

Each time an intervention is provided by the occupational therapy practitioner, a notation is made of what occurred. Contacts may also include pertinent telephone conversations and meetings with the client, family/caregiver, other professionals, or service providers (AOTA, 2013a). Depending on the setting, each intervention session is documented in the health or school record using a formal contact note or, perhaps, the occupational therapy practitioner might simply fill out a flow sheet or checklist of services provided instead. In other settings where no formal contact notes are required, the occupational therapy practitioner might only keep an attendance sheet, informal log, or perhaps just jot down some observations to refer to later when writing progress notes. Contact notes can be written in many different formats, but in this manual the SOAP format will primarily be taught.

Progress Report

At the end of a certain period of time, a progress note is written. The occupational therapy practitioner records the client's progress toward goals and details any changes made in the intervention plan. Different practice settings vary regarding time periods for reporting, but progress notes are usually written in specified time frames such as weekly, every two weeks, monthly, or after a particular number of intervention sessions have been implemented. Progress notes may also be written in different formats, but will be taught in a SOAP format in this manual. Regulatory and payer mandates often delineate the required frequency of progress notes (or benchmark reporting in school settings) and specify whether or not an OTA is allowed to write a progress note for clients in that setting.

Reevaluation Report

The OT directs and documents the reevaluation that is part of the occupational therapy intervention process and modifies the intervention plan according to the client's needs and changes in status. The OTA may contribute to this reevaluation process (AOTA, 2013a, 2014a, 2015c). Some settings and payers require a formal reevaluation report. For example, in a practice setting where managed care is involved, a client may need to be reevaluated in order to be recertified for treatment after the number of initially allocated visits are completed. EMR programs may use a format similar to the evaluation, making it easy to compare results.

Transition Plan

Transition notes are written when a client is transferring from one service setting to another (such as from early intervention to preschool or from special education to vocational services) within the same system of service delivery (AOTA, 2013a). Transition notes ensure that the client's intervention plan remains intact through the move and that services that have already been provided are not duplicated. The transition plan is the responsibility of the OT, but the OTA may contribute to this process (AOTA, 2013a, 2014a, 2015c).

Discharge or Discontinuation Report

At the end of the intervention process, a discharge or discontinuation report is written to describe changes in the client's ability to engage in meaningful occupation as a result of occupational therapy intervention (AOTA, 2013a). The discontinuation plan is directed and documented by the OT, but the OTA may contribute to this process (AOTA, 2014a, 2015c). Discharge notes summarize the course of intervention; progress toward goals; status at the time of discharge; provision or recommendation of any durable medical equipment, orthotic devices, assistive technology, adaptive equipment, home programs, and any other referrals or follow-up required. Some settings will provide a specific form for the discharge note, whereas other facilities might use the same form that was used for the client's evaluation. EMR programs might use a format that automatically pulls up the initial evaluation data, making it easy to compare and record discharge results side by side.

Conclusion

Professional documentation pulls together all of your observation skills, clinical reasoning, and knowledge of occupational therapy. It communicates important information to the health, education, or early childhood team and substantiates the need for occupational therapy services to third-party payers. Due to space limitations in this book, some required contents of various notes have been purposely left out. Understand that if you were writing an actual note in a client's health or education record, you would always use the client's whole name and identification information along with any other required demographic data and insurance information. A "real" note might also include additional pertinent background facts and assessment findings. In addition, all notes must be signed with the occupational therapy practitioner's full name and credentials. An OTA's notes should also be cosigned by the OT when required by law, facility policy, or payer requirements (AOTA, 2013a).

It is important to understand that each client has unique circumstances and needs. Although this manual provides sound guidelines and examples of best practice, occupational therapy practitioners must always use clinical judgment when working with clients and documenting in the record. In regard to the many notes and examples presented throughout this manual, realize that fictitious names have been used and any specific resemblance to a real person is purely coincidental. The following three worksheets will help you to understand and practice using the *Framework-III* terminology to record your observations and interventions. Then, in the next chapters, you will be introduced to important aspects of the health record, billing and reimbursement fundamentals, and the specifics of your documentation in the record. There will be ample explanation and opportunity for practice so that you will systematically acquire the appropriate documentation skills. Eventually, **you** will be the OTA we talked about in the beginning paragraph whose documentation was so amazing to the beginning student.

Worksheet 1-1
The *Occupational Therapy Practice Framework*

The following multiple choice questions are based on the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014b). Questions may have more than one correct answer. For each question, indicate all of the answer choices that are correct.

1. Which of the following are examples of a performance pattern?
   a. Tracing a client's hand during orthotic device fabrication
   b. One's family or work role
   c. Bilateral coordination
   d. A religious ritual
   e. Bedtime routine
   f. Two-point gait
2. Which of the following are examples of a performance skill?
   a. Bending far enough to retrieve clothing from dryer
   b. Muscle strength of Good (4/5) for shoulder flexion
   c. Standing for 10 minutes
   d. Reciting a prayer from memory
   e. Normal muscle tone
   f. Gag reflex
3. Which of the following are considered occupations?
   a. Spirituality
   b. Social participation
   c. Range of motion
   d. Sleep
   e. Rest
   f. Play
4. Which of the following are client factors?
   a. Values
   b. Sleep
   c. Mental functions
   d. Roles
   e. Blood pressure
   f. Age
5. Which of the following are examples of contextual or environmental factors?
   a. Gender
   b. Completing high school or college
   c. Internet access
   d. Lack of public transportation for a client who is unable to drive
   e. Presence of lead or pesticides in client's home
   f. Income below poverty level

6. Which of the following are examples of preparatory methods?
   a. Using pulleys to increase range of motion
   b. Squeezing therapy putty to improve grip strength
   c. Practicing buttoning a shirt
   d. Measuring ingredients to make a cake
   e. Passive range of motion to increase elbow flexion
   f. Fabricating and issuing an orthotic device
7. Which of the following are activities?
   a. Practicing writing one's name in cursive
   b. Preparing a meal after shopping for ingredients
   c. Peeling potatoes
   d. A 50-year-old client stacking cones to improve upper limb function
   e. Maintaining balance while sitting on a therapy ball
   f. Completing morning grooming routine
8. Which of the following are examples of preparatory tasks?
   a. Rolling out pie dough
   b. Performing wound care on a client
   c. Fluidotherapy
   d. Using hand weights to increase upper extremity strength
   e. Using an upper extremity pedal exerciser
   f. Washing lettuce for a salad
9. Which of the following are delineated as the primary performance skills categories in the *Framework-III*?
   a. Motor skills
   b. Emotional regulation skills
   c. Social interaction skills
   d. Sensory integration skills
   e. Preparatory skills
   f. Process skills
10. Which of the following are rituals?
   a. Biting one's fingernails when feeling anxious
   b. Lighting candles on the Sabbath
   c. Wearing a seatbelt when driving
   d. Showering, dressing, and buying coffee at Starbucks before going to work every day
   e. Always making Irish soda bread for St. Patrick's Day
   f. Making the sign of the cross when entering a church

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

Worksheet 1-2
Using the *Occupational Therapy Practice Framework*

Observe someone make an object out of clay or another craft project. Use terminology from the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014b) and list 10 specific performance skills or client factors that you observe or assess during this activity. Try to describe, qualify, or quantify levels of performance.

Activity observed: _____

Examples:

Process skill: Attends well to task

Client factor: Has good range of motion in both hands

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

Worksheet 1-3
Occupational Therapy Practice Framework—More Practice

Observe someone perform a cooking task such as making tea, a sandwich, or can of soup. Use terminology from the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014b) and list 10 specific performance skills or client factors that you observe or assess during this activity. Try to describe, qualify, or quantify levels of performance.

Activity observed: _____

Example:

Motor skill: Coordinates use of both hands well when using can opener

Client factor: Able to hear whistling tea kettle

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

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Chapter 2

The Health Record

Definition, Types, and Purpose

The medical record is also referred to as the health record. It is a *legal document* that provides an electronic or written history of a client's past and present health, substantiates care, and creates proof of advance directives, vital statistics, course of treatment, and related correspondence (Fremgen, 2016; Scott, 2013). The primary purpose of the health record is the exchange of information among health care providers in order to determine a client's problems and strengths, establish an appropriate plan of care, record treatment, facilitate continuity of care upon discharge (or in the future), and fulfill legal documentation requirements (Fremgen, 2016; Scott, 2013). In addition to an individual's health care information, records typically contain standard content such as the person's identifying information, demographic data, insurance and physician information, assignment of benefits, privacy notices, and consent forms. Any advance directives should also be contained in the record and kept updated as appropriate. Occupational therapy practitioners in inpatient, outpatient, and community settings typically use the health record to obtain and record client data, document planned and implemented interventions, and substantiate services for reimbursement.

As medicine advanced, so did the complexity and detail of the health record. A profession called *health information management* was created to oversee the health record. Useful resources regarding various aspects of the record are offered by The American Health Information Management Association (AHIMA) at www.ahima.org. Many health providers have already shifted from the use of traditional paper-based records to a computerized format, called an ***electronic health record* (EHR)** or ***electronic medical record* (EMR)**, which is becoming more the norm to manage and store client information. You will find that both terms tend to be used interchangeably by providers and vendors (Centers for Medicare and Medicaid Services [CMS], 2016b). To promote EHR infrastructure and use across the United States (U.S.), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 was enacted (U.S. Department of Health & Human Services [USDHHS], 2015a). HITECH set technology standards and also authorized the CMS to initiate incentive programs beginning in 2011. These incentives provided eligible health professionals and institutions with up to six years of monetary incentives to adopt and implement approved EHR technology and use it meaningfully, such as reporting clinical quality measures (CMS, 2010, 2016c, 2016d). While various types of software programs and systems are available, Medicare and Medicaid mandate that providers use **certified EHR** technology in order to meet specific CMS requirements for security and functionality (CMS, 2016b).

Another type of computerized record, called a ***personal health record* (PHR)** is an EHR used and controlled by the individual rather than a provider or facility, thereby allowing individuals to track and maintain their own health information for personal/family use or to selectively share with health care providers and caregivers (CMS, 2012). PHRs may include data that the individual enters, such as allergies and medication history, along with information

Morreale, M. J. *The OTA's Guide to Documentation: Writing SOAP Notes, Fourth Edition* (pp. 15-39).

obtained from a number of sources (CMS, 2012). Some health providers provide a ***patient portal,*** which is a website through which individuals can access their personal health information anytime, such as lab test results, medications, discharge summaries, etc. The portal might also allow patients to exchange e-mail securely with their health providers, request refills for prescriptions, schedule appointments, pay bills, fill out forms, and perform other related tasks (USDHHS, 2015c). Besides enhancing communication between the patient and health care team, portals help to empower clients and improve patient outcomes (USDHHS, 2015c).

OTs and OTAs working in school-based settings provide interventions and documentation that focus primarily on the educational needs of children requiring special services. It is important to understand that a student's **education records** (including any occupational therapy documentation) also require accurate recordkeeping, confidentiality, and adherence to established protocols. Education records provide a means of communication among professionals in the child's school and district concerning the child's academic abilities and pertinent medical or social concerns. If you are an OTA working in a school-related setting, understand that it is also very likely that a parent or guardian will eventually read what you and the OT have written about a child receiving services (Sames, 2015). In addition, education records are used to obtain aggregate data for local, state, and federal reports. While this manual often refers to the *health record*, many of the documentation "rules" also apply to education records. Specific information regarding occupational therapy documentation in school-based settings is presented in Chapter 17.

Legislation Impacting Health Care and Documentation

Education and health care in the United States are regulated by numerous federal and state laws that impact access to care, costs, professional roles, and types of services available in various communities. Government mandates influence how occupational therapy and other health services are delivered, paid for, communicated, and valued. Some legislation specifically applicable to the documentation, management, and meaningful use of health information include the following:

Health Insurance Portability and Accountability Act

In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which established national standards to manage and protect the privacy and security of an individual's health information (USDHHS, 2003a). HIPAA delineates an individual's right to understand and control the use of one's own health information and also be informed about a provider's privacy practices, including how one's information will be used and shared (USDHHS, 2003a, 2003b).

The Privacy Rule required compliance by April 14, 2003 (with a 1-year extension for small health plans) (USDHHS, 2003a). It specified regulations for the use and disclosure of **protected health information** (PHI), which is defined as "individually identifiable health information" (USDHHS, 2003a, p. 3). Facilities and individuals providing health or medical services and transmitting health information electronically (i.e., claims, referral authorization requests, payment) are considered a **covered entity** (USDHHS, 2003a). Occupational therapy practitioners come under this category and must adhere to the HIPAA regulations.

A written **Notice of Privacy Practices** (NPP), which must be given to each patient, delineates the provider's privacy practices regarding PHI. The patient signs this document which grants permission for their PHI to be disclosed for treatment, reimbursement, and certain other health care reasons (Fremgen, 2016). The signed document is maintained in the patient's medical record. A major part of the Privacy Rule is the **minimum necessary** standard, which states that only the minimum amount of PHI must be requested or disclosed to accomplish the intended purpose (USDHHS, 2002, 2003a, 2003b). In addition, the covered entity must establish reasonable safeguards, workplace policies, and procedures protecting PHI, such as allowing access only to the personnel requiring that information for their job duties and locking up records when not in use (USDHHS, 2002, 2003b). Some instances in which PHI disclosure is permitted without express written authorization include public health activities (e.g., tracking certain communicable diseases or adverse effects of products), various law enforcement situations, organ and tissue donation, reports of child abuse or neglect, and national security (USDHHS, 2003a).

In practical terms, as an OTA, you typically cannot provide information about the client's condition with the client's family, friends, or employer without the client's permission. However, you can usually communicate with the referring physician and other team members involved in the client's care. Also, although you might be very curious and concerned, these are not acceptable reasons to look up information on a friend, colleague, family member or public figure admitted to the facility if you are not authorized to be involved in that individual's care. Most importantly, you must always try to protect client privacy and safeguard information. If you happen to have a client in your

facility or on your caseload that is famous, such as a movie star, musician, high-profile athlete, or politician, you are still *not allowed* to divulge this to your friends or family, or provide information to any news outlet, even though you might be very tempted to do so. Understand that these public figures also have the right to privacy. They should not have to worry that their PHI will be plastered across the front page of a newspaper or supermarket tabloid! Any information released to the public must be expressly authorized through the proper channels and personnel, such as the facility's legal department or public relations staff, and only with the client's permission. As this is only a brief overview of HIPAA, **it is essential that you do not disclose or give out any health records or client information without fully understanding the law and knowing your facility's policies and procedures.**

Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) outlines a student's rights and privacy regarding his or her education records. FERPA applies to all schools receiving U.S. Department of Education funding for pertinent programs (U.S. Department of Education, 2015). This federal law allows the parent or eligible student (e.g., students 18 or older or who attend schools beyond high school) to fully review the student's education record and to formally request correction of any inaccuracies, including what is written in occupational therapy (U.S. Department of Education, 2015). FERPA also mandates that, in order for a school to release a student's protected information, written permission from a parent or eligible student is needed. There are some exceptions for the consent requirement, such as for emergencies, a student's financial aid or school transfer, judicial orders, legitimate functions of school officials, accreditation, and certain types of studies (U.S. Department of Education, 2015). Schools are also allowed to release basic directory information (e.g., names, awards, honors) as long as parents are notified of this general practice and can opt out (U.S. Department of Education, 2015). At schools, a student's health information (including Individualized Education Program [IEP] designated special services) is typically contained in *education records* and, as such, would be subject to FERPA privacy requirements rather than the HIPAA Privacy Rule (USDHHS, 2008). It is essential that you do not disclose student information or give out any records without fully understanding the law and adhering to your school district or facility policies and procedures.

Health Information Technology for Economic and Clinical Health Act

As previously noted, the HITECH Act of 2009 is legislation that authorized the USDHHS to establish programs that improve the quality, efficiency, and safety of health care through the promotion of health information technology. This included setting standards for EHR use and the secure exchange of electronic health information (USDHHS, 2015a, 2016). The following aims of HITECH have significantly influenced how health information is now being communicated and managed (USDHHS, 2015a):

- A Health IT Policy Committee to make recommendations regarding a nationwide health information technology infrastructure
- A Health IT Standards Committee to make recommendations regarding standards, specifications, and certification criteria for the use and electronic exchange of health information
- Delineation of processes for health IT standards, testing, interoperability, and certification criteria
- Health IT and quality reports
- Ensuring privacy and security related to health information exchange and use
- Establishment of grant, loan, and demonstration programs to aid health providers and communities in acquiring and using EHR technology effectively
- Establishment of Medicare/Medicaid EHR incentive programs

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) was passed in 2010 to establish reforms for health care insurance. Aims of the ACA include increasing health care access, lowering costs, providing new protections for consumers, and improving health care quality and efficiency (USDHHS, 2010, 2015b, 2016). The ACA has led to various changes regarding the purchase and cost of health insurance. It also influences the coverage of various services and impacts how health care is delivered and paid for. Some of the numerous provisions in this legislation that may directly or indirectly impact occupational therapy are listed in Box 2-1 (USDHHS, 2010).

Box 2-1

MANDATES INCLUDED IN THE AFFORDABLE CARE ACT

- Affordable quality health care and health insurance coverage for all Americans
- Requirement for individuals to maintain minimum essential coverage
- Ensuring that consumers get value for their dollars
- Essential health benefits requirements
- Health information technology enrollment standards and protocols
- Development of quality outcome measures
- Data collection and public reporting
- Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs
- Hospital readmissions reduction program
- Improving Medicare and Medicaid for patients and providers
- Ensuring beneficiary access to physician care and other services
- Linking Medicare payment to quality outcomes
- Medicare shared savings program
- National pilot program on payment bundling
- Hospital readmissions reduction program
- Payment adjustment for health care-acquired conditions
- Clinical and community preventive services
- Increasing access to clinical and community preventative services
- School-based health centers
- Removing barriers and improving access to wellness for individuals with disabilities

Adapted from United States Department of Health and Human Services. (2010). Compilation of Patient Protection and Affordable Care Act. Retrieved from: https://www.hhs.gov/sites/default/files/ppacacon.pdf

Food and Drug Administration Safety and Innovation Act

The Food and Drug Administration Safety and Innovation Act (FDASIA) of 2012 requires collaboration among the FDA and several other governmental agencies to propose strategies and recommendations for a health IT regulatory framework that is appropriate, risk-based, and includes medical mobile applications. Aims of FDASIA include protecting patient safety, avoiding regulatory duplication, and promoting innovation (USDHHS, 2016).

Improving Medicare Post-Acute Care Transformation Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) is legislation that requires long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and skilled nursing facilities to submit standardized client assessment data and also report on quality measures and resource use (CMS, 2015a). It requires these facilities to report on certain measures, such as total Medicare spending per beneficiary; major falls incidence; whether the client was discharged to community; and risk-adjusted hospital readmission rates that were potentially preventable (CMS, 2015a). This legislation aims to enhance care coordination, improve client outcomes, provide overall comparisons of quality, and reduce costs through more efficient care (CMS, 2015a). The IMPACT Act and the ACA are requiring providers to be more accountable for the care they provide. As a result, health care is trending toward *value-based care*, which includes different payment models such as episode-based management and bundled (consolidated) payments over the traditional fee-for-service model (DeJong, 2016). DeJong (2016) posits that occupational therapists will need to be "smart" clinicians who use the available data to improve client care, outcomes and provide more value for consumers and payers.

Individuals with Disabilities Education Act

The Education for All Handicapped Children Act (PL 94-142) was enacted in 1975 to address the individual needs (i.e., development, education) of infants and children with disabilities and their families. The law was amended in

1997 and renamed the Individuals with Disabilities Education Act (IDEA) (U.S. Department of Education, 2007). In 2004, President George W. Bush reauthorized IDEA, with the majority of the new law effective July 2005 (U.S. Department of Education, 2006). Part C of IDEA mandates the provision of **early intervention** services to children less than 3 years of age who are experiencing a developmental delay (or are at risk for developmental delay due to a diagnosed condition) in one or more areas (Küpper, 2012). The five areas of development addressed in IDEA include physical, cognitive, communication, adaptive (i.e., daily living skills), and social/emotional (Küpper, 2012). States have discretion to expand the definition of "at risk" factors to include environmental or biological factors and, if appropriate, may also extend a child's services until kindergarten (Küpper, 2012). The law mandates that early intervention services must be provided in the child's "natural environment," which can include the home or a community setting with typical children, such as a daycare center or preschool (Küpper, 2012). Particular documentation for each child is required, including an Individualized Family Service Plan (IFSP) that describes the child's development, family situation, and identifies specific services needed.

IDEA Part B applies to children ages 3 to 21 with a disability or qualifying health condition, mandating that schools provide an appropriate free public education in the "least restrictive environment" (LRE). The LRE regulation requires that children be educated (and perform other typical school activities) in settings alongside nondisabled peers to the maximum extent possible (Center for Parent Information and Resources, 2016). As appropriate, special education, related services (e.g., skilled services, which can include occupational therapy), and supplementary aids and services may be provided to help the child succeed in school. Supplementary aids and services can include student accommodations and modifications, such as an aide, extra time to take tests, physical adaptations, slower-paced instruction, communication aids, etc. (Center for Parent Information and Resources, 2016). The law requires that an IEP be established for each child requiring special services. The specific documentation requirements for early childhood and school settings will be described further in Chapter 17 of this manual.

Electronic Documentation Systems

Health information can now be entered and obtained from different locations and means, such as handheld wireless devices, computers, and smart phones. Many facilities have already switched to using EMR systems for documentation and billing, thereby changing in recent years how occupational therapy practitioners approach the documentation process, use specific formats, communicate with others, and obtain reimbursement for services. Some facilities also use electronic client wristbands with memory chips or barcodes that link to a client's identifying data, medications, or other health information (Scott, 2013). Barcode scanning helps to reduce errors by ensuring that the correct patient is getting the intended medication, diagnostic tests, or treatment. Your facility will provide training for whatever electronic systems are in place there.

Electronic Health Record Systems

Electronic documentation requires computer *hardware,* which is the actual physical equipment, such as a computer hard drive, server, printer, monitor, hand-held devices, etc. *Software* are specific programs that run on a computer. They include the basic operating system, anti-virus software and other installed programs that perform various functions. EMR systems are generally classified into two types: on-site (e.g., local) and web-based systems, which must meet legal requirements (i.e., HIPAA, HITECH) for privacy, security, and functionality (Cohen, 2013). Systems must have proper firewalls and be able to effectively back up data.

Local/on-site systems have their own server to run an EMR program on *local* networks and store the data privately in-house. On the other hand, web-based systems use a program that runs on an *Internet-based* system (Cohen, 2013). Web-based systems use computers located outside of the health provider's facility to store information in a data center, such as a cloud based-system. An advantage of web-based EMRs is that authorized personnel can access records from any location via the Internet, such as from a client's home or one's own residence (Cohen, 2013). Web-based systems typically entail a subscription model with recurring monthly costs (Cohen, 2013). Costs vary according to the number of users, amount of data and claims processed, but the subscription price usually includes training, upgrades, and technical support (Cohen, 2013). Depending on the setting, the OTA might share a computer in the occupational therapy office, enter data in a more central area (such as a mobile computer station on a hospital unit), or have a personal laptop or hand-held device to access and record information. Some clinics also have designated iPads or kiosks for clients to enter information, such as to complete a questionnaire or check in for a scheduled appointment.

Advantages of EMRs

Electronic records are legible and organized, which is beneficial to the different audiences that might be reading them, such as the client, other health providers, attorneys, etc. EMR systems may include various organizational functions, such as managing scheduling, tracking productivity, entering proper code sets for billing claims, and compiling and analyzing data regarding that facility or provider's practices and outcomes (USDHHS, 2014b). In addition, when using EMRs, integrated program prompts are provided to help ensure that necessary paperwork or data are in place, such as privacy and consent forms, medication history, code sets, plan of care, etc. (USDHHS, 2014b). EMRs can also improve efficiency by centralizing chart management, eliminating duplicate paperwork, requiring less storage space, and reducing staff time needed to fill out forms, process billing requests, pull and file charts, etc. (USDHHS, 2014b). Authorized users also have easy, immediate access to comprehensive patient information from multiple sources and locations. Several people can review client data at the same time, such as medical orders, lab results, X-rays, or clinical assessments from other health professionals. This helps to coordinate care and reduce duplication of tests or procedures. Secure patient portals allow easy electronic communication between the client and provider, such as for prescription requests, questions, or access to test results. Various shortcuts are often integrated into EMR programs such as automated patient appointment reminders (e.g., e-mails, phone calls); the tallying of number of visits or missed appointments; treatment notes linked to appointments; comparing prior test results to the present assessment; applying correct code sets to conditions and procedures, etc. (USDHHS, 2014b). Other time-saving EMR functions could include routine paperwork being sent to clients ahead of time (by e-mail) and surveys generated and sent automatically upon discharge.

Documentation completed using paper and pen often necessitates that health care providers fill out duplicate information (particularly client identifiers and demographic data) on facility and regulatory forms; this redundancy is minimized with EMRs (Herbold, 2016; Sames, 2015). Another benefit of electronic documentation is that it typically includes the use of prompts or templates for the information necessary to meet requirements for the setting or funding sources (Herbold, 2016). For example, templates can allow for entered data to be routed into regulatory systems to facilitate reporting of mandated CMS outcome measures used in various settings, such as the Minimum Data Set (MDS) in nursing homes, Outcomes Assessment Information Set (OASIS) in home care, and the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) (Herbold, 2016). These standard quality measures will be explained further in Chapter 17. Practitioners can also save time by selecting from standard menus of problems, goals, and possible intervention strategies specific to a particular practice setting, such as hand therapy, mental health, or pediatrics. Programs might also include established clinical pathways for particular diagnoses commonly treated at that setting. Medical errors can be reduced by system prompts such as alerting the provider to drug interactions or, perhaps, the presence of an allergy documented by another care provider (USDHHS, 2014a). Other EMR features can include electronic reminders or alerts telling health providers when code modifiers are needed, therapy is reaching a therapy cap (requiring an Advanced Beneficiary Notice), or that a certification or report is due.

EMR systems designed for use by rehabilitation professionals may include various standard assessments such as pain scales and functional questionnaires and might also have optional accessories that are integrated in the system such as grip and pinch meters or a goniometer. These allow assessment results to be scored and incorporated automatically into the treatment note as tests are administered. Also, to save time, there could be an option for particular data or standard phrases to be copied and pasted into subsequent notes and reports, as appropriate, without having to retype the same information over and over. Of course, you must ensure that any information that is copied and pasted must be completely accurate for the clients it is being used for. The following are some examples of standard phrases that might be used as shortcuts; although additional clarification would still need to be added in the note, (i.e., particular exercises shown, specific resistance level of therapy putty, type of orthotic device, right or left hand, purpose).

"Client was instructed in home program of therapy putty exercises and precautions. Client provided with written instructions and demonstrated good understanding by performing all exercises accurately."

or, perhaps,

"Client was instructed in use and care of orthotic device. Written copy of instructions provided. Client demonstrated ability to don/doff orthosis independently and verbalized understanding of wearing schedule and precautions."

Disadvantages of EMRs

There can be significant costs related to setting up an electronic documentation system. These include the costs of purchasing, troubleshooting, and replacing equipment/software and also subscription costs if using an EMR web service (Cohen, 2013). Although staff training might be included in the purchase or subscription price of an

EMR system, costs are still incurred for the *time* needed to train staff in the use of a particular software program or system. Training could be time consuming or meet resistance from staff inexperienced with computers, used to documenting "the old way," or switching over from a different system. Practitioners used to paper-based records may also experience an adjustment period with additional documentation time needed to merge their own organizational style with a more structured format that "flows" very differently. Practitioners may have to shift through various menus or pages to enter information in the appropriate places. Concerns regarding EMRs include security, privacy, computer downtime, and crashing. Also, information might be accidentally destroyed or entered inaccurately due to errors in typing or using a touch screen, misdirected pointing and clicking, or mistakes in cutting, copying, and pasting. Another concern is that devices containing sensitive information on hard drives or discs could be stolen, lost, or hacked into.

When accessing or entering computer data at point of service, there is often a tendency to focus on the computer screen, keyboard, and mouse. However, practitioners must ensure that their attention is also directed toward the client. The OTA should display a caring approach, make eye contact with the client, and not cut off the person's conversation just because it doesn't fit with the present data entry page. Be cognizant of your nonverbal communication, casual sitting posture, and especially your frustration level if the computer happens to be temperamental or very slow at inopportune times.

OTs and OTAs must always use clinical reasoning and a client-centered approach throughout the occupational therapy process, such as when gathering information, establishing goals, selecting and implementing interventions, creating home programs, and documenting in the record. The terminology or methods used in a facility's EMR program may not be fully compatible with occupational therapy language or departmental needs. Therefore, occupational therapy practitioners must be careful to avoid a rote or cookbook approach when selecting problems, goals, interventions, and other clinical options from a program menu. Some software programs are very structured and rigid while others offer flexibility in terms of customizing formats to the specifications of a facility or department (such as for evaluations, contact notes, and intervention plans). Some software programs allow for greater individualized detail by providing places for comments or allowing users to mix-and-match programs or menus. Practitioners must not lose sight of a client's individual needs or compromise quality care by making the client conform to the specifications of a particular software package. There are a variety of EMR vendors and products to choose from. One example of an EMR system is AOTA PERFORM (a trademarked and copyrighted product) developed by Cedaron, a private company at www.cedaron.com, which partnered with AOTA to help ensure that essential occupational therapy terminology and features were integrated in that product.

Storing, Managing, and Disposing of Health Records

There are federal and state guidelines for storing, managing, and retaining health records, such as the types of safeguards that must be put in place to protect client privacy and the length of time records must be kept. Each facility establishes policies and procedures to comply with the laws, and the OTA must follow these protocols.

To safeguard protected health information, workers must be educated regarding privacy practices and proper disposal of client files (USDHHS, 2002). In addition, health care workers typically have *password-protected* computer access to the patient information necessary to perform their job functions. This helps to ensure that unauthorized users cannot view that information (USDHHS, 2002, 2009). Systems can track who accessed patient data and when. Items containing PHI such as traditional paper-based charts, computers, tablets, and computer discs should be kept in a secure location such as a locked cabinet or office. Never leave records where others can see them, such as open on a desk or treatment table. Ensure that the computer screen is not in view of others when entering or accessing information and always remember to log out and close the computer screen when you are done. Volunteers, visitors, other clients or staff (i.e., housekeeping, maintenance, secretaries, rehab disciplines) may have valid reasons to enter the treatment area or your office, so you should manage records properly at all times to protect client confidentiality. In addition, be very careful if conversing about clients in public areas such as an elevator or cafeteria. You must always ensure that other people cannot inappropriately see or hear the confidential information.

Paperwork should normally remain and be completed on-site and not taken home to review or complete documentation. However, it might be necessary for an occupational therapy practitioner working in home care or traveling among several sites to have secure access to electronic record systems off-site or be allowed to keep a temporary working copy of paper records while the original stays within the agency. Do not leave briefcases, laptop computers, or other equipment on the seat of a parked car where it might be tempting for someone to try to steal it. Again, it is essential to always follow HIPAA guidelines and facility policies.

Records may be stored in their original paper format or on microfilm, hard drives, or computer discs, depending on federal and state regulations and the type of practice setting (Scott, 2013). Individual states mandate the specific minimum time periods (ranging from 5 to 10 years) for retaining medical records for minors and adults, including occupational therapy documentation. Most states also require that the health records of minors be kept until a certain number of years after the child reaches the age of majority in that state (Scott, 2013). Records may be kept longer than the state minimums for various reasons, such as possible future care of the client or tort concerns (Fremgen, 2016; Scott, 2013). If records containing PHI are no longer needed, they must be disposed of properly according to legal guidelines (USDHHS, 2009). Your facility will have policies and procedures in place to comply with this. Paper records with PHI must *never* just be put in a dumpster or ripped up in a few pieces and thrown in a garbage pail because someone might find them and be able to reconstruct and read the confidential information. Instead, paper records must be completely destroyed by incinerating, pulverizing, or shredding (USDHHS, 2009). Disposal of electronic records must be done by specified methods of clearing or purging data or destroying the computer media through shredding, disintegrating, incinerating, etc. (USDHHS, 2009). Realize that any other paperwork or electronic files containing confidential client information not yet entered in the chart (such as any attendance logs or working copies used for day-to-day occupational therapy intervention), must be properly secured and also later destroyed. Your department or facility should have a shredding machine or designated locked bin (to contain items for later shredding) readily available for proper disposal of confidential records.

The health record is the physical property of the health care facility that furnishes the client's care, but clients do have a legal right to obtain and review copies of their health information, including what you have written in occupational therapy (Fremgen, 2016; Scott, 2013; USDHHS, n.d.). However, a physician can use professional discretion to determine whether a particular patient (such as an individual with mental illness) would be harmed by reading the record (Fremgen, 2016). In order to obtain their records, clients usually have to submit a formal signed request and may also be charged for the copying costs (USDHHS, n.d.). Individual states usually determine the maximum reasonable fees that may be charged for copies of reports, X-rays, etc.; and your facility will have specific policies regarding this process. In addition, third-party payers may require health record documentation to substantiate claims for reimbursement. In these cases, only the *minimum necessary* is sent. Some occupational therapy documentation, such as outpatient Medicare Part B services, might require physician certification (requiring a handwritten or electronic signature) to certify the patient requires skilled services and the physician approves the plan of care, even if an initial order is in place (CMS, 2015c). As previously mentioned, **privacy laws regulate the disclosure of medical information, so never, ever give out or send any health records or client information without knowing the exact policies and procedures in your facility**. To comply with legislative and payer requirements regarding the exchange of health information, facilities establish policies and procedures delineating which departments or personnel (e.g., Health Information Services Department or the outpatient department secretary) are responsible for sending out specific records or reports to clients, physicians, other professionals, or funding sources, depending on the situation. All staff must be very careful when using electronic communication, fax machines, and copiers to avoid breaches of confidentiality to unintended recipients. Paperwork must always be removed after using the copier, printer, or fax machine and it is prudent for the sender to always double check fax numbers and e-mail addresses for accuracy. A copy of pertinent correspondence, including letters, home exercise programs, or instructions given to the client, should be maintained in the record.

Organization of the Health Record

How information is entered and organized in the record largely depends on the particular format used by the facility or the specifications of the particular electronic documentation program. Software programs display various templates, menus, and comment areas in a particular order for various functions. This structures how data is entered and organized into notes and presented as reports, with the amount of flexibility dependent on the particular program.

Paper-based records have traditionally utilized formats such as a **source-oriented medical record** or **integrated medical record** to organize all of the client's health information in the chart. A source-oriented record is divided into sections for each discipline (i.e., nursing, lab results, occupational therapy). Within each section, the discipline's information is presented in chronological order using SOAP notes (or another format) to record that discipline's care and the client's status. This type of organization makes it easy to locate information or track progress for a particular discipline such as occupational therapy. This is especially beneficial when contributing to an occupational therapy progress report or discharge report. A disadvantage is that one has to search through many sections to determine the client's overall status at a given time. With an **integrated medical record** format, all disciplines record information in chronological order, one right after the other. For example, an occupational therapy note might come directly after a nursing note,

followed by a physical therapy or respiratory therapy note. If using paper-based records, this format makes it easy to find client information pertaining to a particular time period but it is harder to find or track information for a particular discipline. For example, the OTA might have to search through all of the shift changes of nursing notes to find out what was done in the client's occupational therapy session yesterday. It is also more difficult to locate and gather information for the occupational therapy discharge report, such as the number of sessions provided. However, the use of EMRs can help eliminate such unnecessary steps by being able to click on a menu to pull up a particular discipline's notes or automatically tracking how many occupational therapy sessions have been provided.

SOAP Note History

In the 1960s, Dr. Lawrence Weed advocated the problem-oriented medical record (POMR) in order to provide more meaning and organization to the client's record through a structured, objective, and client-centered approach to documentation (Weed, 1971). The problem-oriented medical record consists of the following four components (Fairchild, 2013):

1. A data base (e.g., client's history, physical evaluations by all disciplines, lab results)
2. A list of the client's current problems
3. An interdisciplinary treatment plan
4. Progress notes assessing plan effectiveness

Weed organized the progress note into four distinct sections and called it a SOAP note (Fairchild, 2013; Quinn & Gordon, 2016). The acronym SOAP stands for subjective, objective, assessment, and plan and consists of the following:

- **S (Subjective):** The *client's perception* of the treatment being received, progress, limitations, needs, and problems. Normally the subjective section of a treatment note is brief. However, in an occupational therapy initial evaluation note, the "S" might be longer because it contains the information obtained by occupational therapy practitioners in the initial interview (i.e., occupational profile).
- **O (Objective):** The *health professional's observations* of the treatment being provided, such as the specific interventions implemented, the client's performance, and levels of assistance needed. In an occupational therapy initial evaluation note, this section also contains all of the measurable, quantifiable, and observable data that the OT determines should be collected. In an evaluation, the first two sections form the data base from which the OT, with contributions from the OTA, develops a problem list and treatment plan.
- **A (Assessment):** The *health professional's clinical judgment and interpretation* of the statements and events reported in the subjective and objective sections. This section includes the client's progress, functional limitations, problems, and expectations of the client's ability to benefit from therapy (sometimes called *rehabilitation potential*). In an initial evaluation, the OT, with feedback from the OTA, will determine and include the problem list, which is one of the key elements of the POMR method of charting.
- **P (Plan):** *What the health professional plans to do next* to help meet the goals and objectives in the intervention plan. In an occupational therapy initial evaluation, this section contains the OT's intervention plan, including the anticipated frequency and duration of treatment.

SOAP is simply a format—an outline for organizing information. Any note can be written in this format, although some notes lend themselves to it better than others, such as contact (treatment) notes and progress notes. Of course, electronic documentation programs may delineate how specific information needs to be entered and organized in the record. However, OTs and OTAs can still incorporate important aspects of SOAP criteria when recording data and documenting progress toward goals in a standard, organized way. Also, some practitioners still include all or part of a SOAP note in the comments section of an EMR note to ensure that no important client details have been missed and to further substantiate the care provided in case claims are later audited. A more detailed discussion of each section of the SOAP note will follow in Chapters 6 through 10.

Narrative Notes

An alternative to the structured SOAP format is the **narrative note**. Narrative notes are typically written in a less restricted paragraph format; although the information may still be organized into various pertinent categories

such as client factors or occupations. As narrative notes are not divided into standard sections like the SOAP note, the occupational therapy practitioner must be very careful to ensure that all of the necessary information is still included. A good narrative note will contain all of the components of the SOAP note but just not have the information divided into separate categories for the S, O, A, and P. The general documentation rules in this manual still apply to narrative notes. However, you might find that the information typically entered in the S and O sections of the SOAP note is sometimes ordered a little differently in a narrative note. For example, a SOAP note might begin with something like the following:

S: *Client reported having a "constant dull ache" in his right shoulder for the past two days which he described as 3/10.*

O: *Client participated in 30-minute session in rehab gym to work on decreasing pain and increasing strength/function of right upper extremity to enable return to work…*

Whereas, a narrative note might begin like this:

Client participated in 30-minute session in rehab gym to work on decreasing pain and increasing strength/function of right upper extremity to enable return to work. When client arrived at therapy today, he reported having a "constant dull ache" in his right shoulder for the past two days which he described as 3/10…

If you first learn the SOAP note format presented in this manual, you can easily convert your client information into a proper narrative note if that is the format your facility uses. An example of a narrative discharge report is provided in Chapter 16 and several examples of narrative contact notes are provided in Chapter 18.

Users and Uses of Health Records

The health record is a communication tool and, thus, has many different uses and users. As an OTA, it is important to consider all of your different audiences when you make an entry in the client's record.

Client Care Management

The record is one method the health care team uses to communicate with each other about the day-to-day aspects of a client's condition and treatment. Other occupational therapy practitioners in your department or other members of the health care team will read your notes in order to coordinate appropriate care. The OT, with contributions from the OTA, will document the results of the occupational therapy evaluation in the health record and establish the intervention plan. The OT and OTA will then collaborate to implement interventions, record the client's progress toward established goals, and advise other team members of the occupational therapy plan for continuing care. This communication is extremely important to the health care team. One occupational therapy practitioner may not be providing all of the client's care and may depend upon the treatment notes to find out what interventions were provided in his or her absence. A particular advantage of electronic documentation is that it organizes information and makes it easy to generate multiple written patient reports for various audiences as needed (Herbold, 2016).

The Client

Of course, another significant user is the client. When you are writing in the record, always remember that clients (or parents/guardians as appropriate) have access to information in the health or education record and may choose to exercise their right to read what you have written.

Reimbursement

The record is the source document for what services were provided, and thus, for what occupational therapy services may be billed. It is used in billing to substantiate reimbursement claims. For example, if a question arises about the duration and frequency of interventions provided, the record would be the source document used to answer that question. Often in managed care, initial evaluation data and periodic progress reports must be submitted in order to obtain authorization for additional therapy sessions.

Clinical Quality Measures

As previously indicated, legislation such as the ACA and IMPACT Act require that health providers report on various patient quality measures to improve efficiency and quality of care, reduce costs, and provide better client outcomes. Individual client data (such as level of function) is recorded according to specific required measures for

particular settings, such as a skilled nursing facility or home health agency. Aggregate data, such as hospital readmission rates and overall incidence of falls or decubiti, is used to determine and compare a provider's quality of service and whether care there is value-based. Various measures are used by CMS as monetary incentives and can affect reimbursement rates for that provider.

The Legal System

The health record is a legal document that substantiates what occurred during a client's illness or condition and course of treatment. If you as an OTA have to appear in court to testify, you will be very glad that your documentation is clear and thorough. Sometimes court cases will occur years after the event or intervention that is being contested and you may not even remember the client or the event. What you have written in the record should provide you with the information you need to testify. Therapy records may be subpoenaed for many reasons, including cases involving Workers' Compensation, malpractice, personal injury lawsuits, child abuse, spousal abuse, or elder abuse.

Research and Evidence-Based Practice

The record is also used to provide data for medical research and evidence-based practice. Researchers might use individual data specific to that client or aggregate data where no client name is attached to the data. In either case, the source document is often the health record, under the security regulations of HIPAA.

Accreditation

Accrediting organizations, such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF), review medical records (including your occupational therapy notes) to help ascertain whether the extent and quality of services provided by your facility and/or your department meet the standards of care set by the accrediting agency. If the facility is found not in compliance, accreditation may be withdrawn. Accreditation from particular national accrediting organizations, including the Joint Commission, Accreditation Commission for Health Care, Inc. (ACHC), Community Health Accreditation Program (CHAP), and several others, can be used to meet Medicare certification requirements for facilities and providers that bill Medicare (CMS, 2016a). If the facility or equipment provider does not meet CMS standards, claims made by that facility for Medicare services (including occupational therapy) will be denied. The health record is one of the primary sources used during a visit from an accrediting organization or a CMS State Survey Agency.

Education

The record may be used as a teaching tool. A fieldwork student uses the health record to gain information about clients and learn about quality and appropriate occupational therapy intervention, in accordance with HIPAA guidelines.

Public Health

The health record is used to identify and to document the incidence of certain diseases, such as tuberculosis or HIV and outbreaks of contagious illness within a facility. In addition, the health record is used to report vital statistics (births, deaths); substantiate and report child, spousal, or elder abuse; and provide statistics for epidemiology.

Business Development

Management teams use the information contained in the record to review what kinds of clients are being seen and how services in the facility are being utilized. This information is used to help plan and market the services provided and to determine appropriate levels of personnel. For example, are enough cases of clients with cardiac conditions being admitted to open a specialized cardiac rehabilitation program? Would this necessitate hiring more staff in the occupational or physical therapy departments?

Documentation for Quality Improvement

The health record is one of the primary sources of information used in the quality assurance (QA) process, which assesses the quality of care provided and compares it to established standards (Fremgen, 2016). Clinical data is gathered (such as mandatory clinical quality measures, incidents, outcomes, etc.) and analyzed. Various mandatory

and/or voluntary quality measures reported to Medicare and Medicaid can impact the payment amounts that facilities and providers receive.

Quality Improvement Committees

Most facilities have a QA or Quality Improvement (QI) committee whose duty it is to oversee the appropriateness and adequacy of the care that is being provided. These committees are in charge of finding and solving problems in client care. Employees are usually encouraged to help make positive changes in their facility to reduce medical errors, improve safety, increase efficiency, and ensure high standards of care. For example, the occupational therapy staff might determine that one problem they are seeing is that a certain percentage of outpatients are not complying with their orthosis-wearing schedule, which impedes the clients' recovery. The QI team might collaborate with the occupational therapy department to brainstorm possible solutions, determine appropriate outcome measures, and implement new procedures (e.g., develop a checklist for proper fitting, provide clients with additional training and written instructions, implement reminder e-mails/phone calls and timely follow-up appointments) to address this problem. The occupational therapy practitioners will then document and track whether these new methods increase compliance and meet desired outcomes.

Learning Activity 2-1: Quality Improvement

Imagine you are working in a skilled nursing facility as an OTA. One problem the occupational therapy staff is seeing is that residents' adaptive equipment and orthotic devices often go missing. Sometimes these items get mixed up in the sheets and inadvertently get sent to the laundry department when linens are changed. In other instances, devices may be left on a meal tray and arrive in the dietary department when the used tray is sent back. The dietary and laundry departments often do not know who these items belong too or might throw items out because they do not even know what they are. Describe the negative effects of this situation. Brainstorm a list of ideas to help minimize this problem of lost devices and determine the pros and cons of each. Determine which ideas you think will work best and explain how you will implement your plan. Include specific procedures, costs that will be incurred, and personnel needed. Discuss if your plan is really feasible to achieve the outcome you want.

Facilities also use other types of quality measures to determine if policies and procedures are being followed and to help ensure proper standards. One method is through the use of periodic **peer reviews**. Health professionals may be assigned various client records to review peer documentation and look for any deficiencies in notes or care implemented. For example, you might review another OTA's notes or another occupational therapy practitioner might review your notes for a client who has been discharged from therapy. Typically, the reviewer fills out a facility checklist or form as the chart is examined for predetermined criteria, such as if verbal orders have been followed up with a written order, all goals in the intervention plan have been addressed, or all the OTA's notes have been cosigned by the OT (if required).

Following discharge from therapy or from the facility, clients may be asked to fill out a **client satisfaction survey,** which asks for the client's perspective about the care that was received from the facility, rehabilitation department as a whole, or a single discipline, such as occupational therapy. These surveys are a useful tool for improving client care. In addition, positive reviews might also be a consideration used in incentive programs honoring deserving staff members.

Learning Activity 2-2: Client Satisfaction Survey

Imagine you are responsible for developing a client satisfaction survey for the occupational therapy department. List 10 aspects of care that you would include on this survey. Would these aspects of care be the same for inpatient and outpatient clients?

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) is a voluntary CMS quality initiative applicable to eligible providers of Medicare Part B services, including group practices and individual providers such as OTs and physical therapists (PTs) in private practice (CMS, 2016e). PQRS involves the use of quality metrics to assess and report on 9 measures that pertain to at least 3 quality domains. For providers that do not report satisfactorily, there are negative payment adjustments (CMS, 2016e). Information regarding reporting pertinent to occupational therapy practice can be found on the AOTA website (www.aota.org) in the Advocacy and Policy section (AOTA, 2012). Individual quality measures assess specific areas, such as fall risk, pain, body mass index, tobacco use, list of current medications, etc.

Writing in the Record

As health and education records are not only a communication tool during the client's course of treatment, but also the source document for financial, legal, and clinical accountability, the record should indicate the following:

- What services were provided, where and when they occurred.
- What happened and what was said.
- How the client responded to the services provided.
- Why skilled occupational therapy services were needed rather than what an aide, teacher, or family member could do.
- How skilled occupational therapy is different from the services being provided from another discipline.

AOTA's *Guidelines for Documentation of Occupational Therapy* (2013) includes a list of fundamental elements that should be incorporated into all occupational therapy documentation (Box 2-2).

Box 2-2

Fundamentals of Documentation

- Client's full name and case number (if applicable) on each page of documentation
- Date
- Identification of type of documentation (e.g., evaluation report, progress report/note)
- Occupational therapy practitioner's signature with a minimum of first name or initial, last name, and professional designation
- When applicable, signature of the recorder directly after the documentation entry. If additional information is needed, a signed addendum must be added to the record.
- Co-signature by an occupational therapist or occupational therapy assistant on student documentation, as required by payer policy, governing laws and regulations, and/or employer
- Compliance with all laws, regulations, payer, and employer requirements
- Acceptable terminology defined within the boundaries of setting
- Abbreviations usage as acceptable within the boundaries of setting
- All errors noted and signed
- Adherence to professional standards of technology, when used to document occupational therapy services with electronic claims or records
- Disposal of records (electronically and traditionally written) within law or agency requirements
- Compliance with confidentiality standards
- Compliance with agency or legal requirements of storage of records
- Documentation should reflect professional clinical reasoning and expertise of an occupational therapy practitioner and the nature of occupational therapy services delivered in a safe and effective manner. The client's diagnosis or prognosis should not be the sole rationale for occupational therapy services.

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Before you write anything in the record, make the following assumptions:

- Someone else will have to read and understand what I write because I may be sick or have the day off the next time this client needs to be treated.
- This entry I am about to make will be the one scrutinized by a CMS review team, Child Study Team, or managed care representative. If I were a funding source, would I want to pay for the occupational therapy services I am about to record?
- This entry I am about to make will be subpoenaed and scrutinized by attorneys. If I am called upon to testify, will I be able to recall pertinent client information based on this record?
- My client (or the client's parent/guardian) will exercise his or her right to read this record.
- Once I have entered information in the record it needs to remain there. Proper protocols must be followed to correct any mistakes.

It is critical to know your payment sources when documenting. Payers have different requirements and time frames, and some look for quite different outcomes than others. With a client who has Medicare, you will normally discuss and write goals for specific occupations such as self-care, functional mobility, and home management, as CMS generally looks for **functional** improvement. It is not enough to simply indicate that the client is working toward a goal of increasing elbow range of motion or attaining a better grip score with a dynamometer. You must indicate what this increased motion or improved strength will enable the client to do, such as get food out of the refrigerator, open a jar, or put on a shirt. There are certain exceptions for skilled maintenance care, which will be explained in Chapter 3. With a Workers' Compensation case, your documentation will likely be oriented toward the client's return to work or prevention of a costly injury. For example, a software engineer who has carpal tunnel syndrome might benefit from skilled interventions such as ergonomic education, occupational adaptations, and use of an orthotic device to help alleviate symptoms for work tasks and avoid surgery. When working in home care, your documentation might focus on your client being homebound and the reasons why the client is unable to leave home to receive services at this time. Additionally, you will document the skilled occupational therapy services implemented in the home such as ADL retraining, adaptations for safety, functional mobility for IADLs, and client/family education. If your documentation states that your client is shopping at the mall or routinely driving to the grocery store, then payment for home care services will likely be denied as this indicates the client is not really homebound (CMS, n.d.; 2015b). For a child receiving early intervention services, occupational therapy notes will be oriented toward the developmental needs and concerns identified in the IFSP and describe the skilled interventions and family/caregiver education provided. In school settings, documentation addresses particular skills the student needs to acquire for that educational setting and discusses the specific services provided as per the IEP. Documentation for children in pediatric medical settings or outpatient clinics describes occupational therapy interventions that focus on managing/improving the child's health condition or circumstances to support occupational performance and quality of life.

Additionally, you must **always follow established facility, payer, and legal time frames for entering client information into the record.** Some settings or payers may require that contact notes be entered right at the time the client is being seen (point of service). Other settings may allow you to complete your daily notes by the end of that workday or other established time frame. Electronic records typically track the date and time each note is entered into the record or altered. If you are not able to compose and enter a formal note into the record as you are working with a client but are planning (and allowed) to do it later in the day, it is helpful to at least jot down some observations/information for yourself during the therapy session to refer to later so that you do not forget any pertinent facts. Realize that you must properly secure and dispose of any informal notes or drafts containing PHI as per HIPAA guidelines. Consider the following facts when planning to write in the health record:

- Accuracy is your best protection against problems. You cannot be accurate if you wait too long to record what happened.
- A note in the health or education record will be a reflection of your professional identity and abilities as well as a reflection of your department and occupational therapy as a profession.
- No activity or contact is ever considered a service that has been provided until a clinical entry is in the record. In terms of legal and fiscal accountability, as the saying goes, "If it is not written, it did not happen."

The following are some helpful hints on writing notes:

- Avoid generalities.
- Be as concise as possible without leaving out pertinent data.
- Report behavior objectively and avoid judgments except in assessing your data.

- Be sparse with technical jargon, which may be unfamiliar to the reader.
- To help avoid errors, *be extremely careful* when entering or transposing data; typing; tapping touch screens; pointing and clicking on drop-down menus or check-off boxes; and copying, cutting, and pasting information.
- Proofread your work before hitting the submit button

Use Respectful Language

Use appropriate terminology for the recipients of services. When referring to the persons who use occupational therapy services, terms such as *client, patient, consumer, resident, veteran, participant, individual, student, infant, child, caregiver,* and *family* may be used. Please use these or other terms that are considered most respectful and appropriate for your practice setting.

Use people-first language. Emphasize the person rather than the disability. Do not refer to an individual *as* a diagnosis. Avoid referring to clients as *victims* or stating that an individual is "afflicted with" or "suffers from" a condition (American Psychological Association [APA], 2010, 2016; Quinn & Gordon, 2016).

For example:

Rather than saying *"the para…"*
It is better to say *"the person with paraplegia."*

Rather than saying *"total hip patient…"*
It is better to say *"patient who had total hip replacement surgery."*

Rather than saying *"suffers from Alzheimer's…"*
It is better to say *"diagnosed with Alzheimer's."*

Rather than saying *"wheelchair bound…"*
It is better to say *"wheelchair user."*

Use culturally-sensitive language when referring to individuals, groups, and populations. Avoid words with negative connotations such as crazy person, fat, lazy, difficult, or old people. Do not use slang terms for a person's culture, ethnicity, or sexual orientation. Using an appropriate term, you might say something like, "The person identifies as _____." Do not refer to an individual as *"the Italian guy in room 246."* It is better to say, *"Mr. Rigatoni in room 246"* or *"the patient in room 246."* Complete Worksheet 2-2 to help you to practice using people-first language and more culturally-sensitive terminology.

The Mechanics of Documentation

There are "rules" that must be followed when writing in the health record:

1. **Use black ink that is waterproof and nonerasable.** For any paper-based documentation, do not use a pencil or marker for notes entered into the record. Indelible ink will help ensure that notations are not altered or accidentally smeared (Gateley & Borcherding, 2017; Scott, 2013).
2. **Never use correction fluid/correction tape.** For handwritten or printed health records, using correction fluid or correction tape to alter entries or copies is not allowed. Health records are legal documents that must always stand as originally written.
3. **Correct errors properly.** Corrections/alterations for an EHR must follow the established standards in place for that particular facility and software program, such as *"correction," "late entry," "entered in error," "addition"* and/or *"deletion"* (Fairchild, 2013, p. 8). The EHR will indicate when and who altered the record and only certain personnel may be authorized to make corrections, such as the original author of the note (Fairchild, 2013). If you make an error in a handwritten record, draw a single line through it, then date and initial your correction (Fairchild, 2013; Fremgen, 2016; Quinn & Gordon, 2016; Scott, 2013;). Do not attempt to change a word or phrase by writing over it or squeezing in additional words.

   mm 2/15/17
   Pt. able to dress lower body with ~~verbal cues~~ min Ⓐ using a reacher.
   Pt. able to dress lower body with ~~verbal cues~~ (mm 2/15/17) min Ⓐ using a reacher.
4. If you are using traditional paper-based records and inadvertently write your note in the wrong client's chart, draw a single line through the entire entry and write "wrong chart" beside it with your signature and date.

5. For handwritten records, if you need to add something after you have written and signed your note, write an addendum with the current date and time. For an EHR, follow the established standards in place for that particular software program and your facility.
6. **Do not erase.** This is also considered illegally altering the record and is another reason that indelible ink should be used. Electronic records normally indicate the date and time that previously entered information is modified or new information added.
7. **Do not leave blank spaces or lines when using traditional paper-based forms/records.** Draw a horizontal line through the center of blank spaces in handwritten notes. If completing a form, do not leave any questions blank. Write an appropriate answer such as, "N/A," "not applicable," "to further assess," etc. This prevents the record from being altered at a later date.
8. **Be sure all required data are present.** The *Guidelines for Documentation of Occupational Therapy* (AOTA, 2013) specify requirements for each type of occupational therapy note such as an evaluation report, contact note, or discharge report. This information will be addressed in other chapters of this manual. Make certain that your documentation contains all of the required basic information such as the facility name, department name, and specific type of note (AOTA, 2013). If paper-based forms are being used, this information is usually preprinted as a heading at the top of each page (Figures 2-1 and 2-2). Your facility or agency might have different forms for each type of note. The following are some examples of headings:

   Best Rehabilitation Center
   Occupational Therapy Department
   Progress Note

   ABC Therapy for Children
   Occupational Therapy Department
   ____Contact Note ____Progress Note ____Discharge Note

   WeCare Home Health Care Agency
   ❑OT ❑PT ❑ST Department
   Progress Note
9. The full name of your client must be included on each piece of documentation along with any applicable health record number or identification number (AOTA, 2013). This will ensure that you are looking at the correct EHR or that documentation is placed in the correct chart if paper-based forms/reports/notes accidentally get misplaced, mixed-up, or if loose papers fall out of charts. Identifying and other demographic information will generally come up in an EHR system automatically if you click on a particular individual who is already entered in the system. Always check with your facility and the particular software program template, but the client's name is generally written as last name, comma, then first name (Doe, Jane). Be especially careful to avoid clerical errors with record numbers, different spellings of similar sounding names (Jean, Gene, Jeanne), or unfamiliar or complex ethnic names (Coffman-Kadish, 2003).
10. **Sign and date every note.** Remember, it is absolutely critical that you date and sign all of your notes with your legal signature and credentials. **Do not** sign or enter information in the health record for someone else and do not ask someone to enter data for you (Fremgen, 2016). CMS (2015c) requires that health providers sign their documentation with a handwritten or electronic signature but does *not* allow for stamped signatures as a substitute (except in very limited special circumstances). Notes written by an OTA and students may need a co-signature by a supervising OT when the agency, state, or federal regulations require this (AOTA, 2013). In addition, some facilities require that you also document the exact time of day that occupational therapy services were provided or phone calls were made.
11. **Be sure to save information in an electronic record** (Scott, 2013). When you have completed an entry be sure to save it. EMR programs may provide prompts or save information automatically if you accidentally log out.
12. **Be concise.** In today's health care system, busy professionals are often pressed for time. They will appreciate being able to read what you have written in the shortest time possible, and your own time for documentation will also be limited under today's productivity standards.

13. **Be prudent in using abbreviations.** While you might use slang abbreviations in social e-mails and texts to friends and family, many of these casual abbreviations such as *SLAP* (sounds like a plan) and *IDK* (I don't know) are not appropriate for use in professional documentation. Use **only** the abbreviations that are approved by your facility and do not make up abbreviations. This will be further addressed in Chapter 4.
14. **The use of emoticons and emojis do not give a professional appearance.** These should not be used in professional documentation.
15. **Refer to yourself, the OTA, in the third person** (Sames, 2015). Avoid referring to yourself with the words "I" or "me." For example, instead of recording, "*Child attempted to kick me,*" write, "*Child attempted to kick OTA*." As another example, instead of writing, "*I instructed the client in dressing skills,*" you could write, "*OTA instructed the client in dressing skills*." However, in this instance, it is even better to use a more formal style and focus on the client rather than the health care practitioner in your note such as, "*Client was instructed in dressing skills*" (Sames, 2015).
16. **Use proper spelling and grammar.** To demonstrate professionalism, use proper spelling and grammar when communicating with faculty, fieldwork educators, and other professionals. Facilities have different styles of organizing and writing information. Some facilities will allow you to use sentence fragments or incomplete sentences, and you will notice this in some of the examples in this book. Other facilities may have a more formal style and may insist on complete sentences (Sames, 2015). Follow the style used in your particular facility and always use proper spelling and grammar. This will be addressed further in Chapter 5.
17. **Notes continued.** When using a paper-based record, if your note for a particular entry does not fit on one page, at the end write "*(cont.)*." Then, on the next page that you resume writing the same note, write the date and "*(OT note cont.)*" on the first line.
18. **Always adhere to ethical and legal guidelines.** Keep abreast of laws, regulatory guidelines, facility policies, and AOTA's guidance and documents concerning both the delivery of occupational therapy services and documentation. This includes anti-discrimination and privacy laws; current billing and reimbursement requirements; avoiding fraud and abuse; maintaining certification and continuing competency requirements; appropriate supervision; scope of practice; and other pertinent issues. OTs and OTAs should *never compromise ethics* even if nursing home or school administrators are pressuring you to keep clients on program longer than medically necessary to maintain clients in a higher payment category. It is unethical to falsify documentation or submit claims for extra sessions of therapy that are not reasonable/necessary (AOTA, 2014a, 2015a).
19. **Always be truthful and objective.** The information you record should never be misleading, fabricated, or falsified (AOTA, 2015a). Don't guess at or embellish information; be careful to avoid personal complaints; and do not judge, criticize, or blame other employees in your note. Defamatory statements could potentially be considered libel (Fremgen, 2016; Sames, 2015; Scott, 2013).
20. **Enter all information accurately. Write legibly, type carefully, point and click accurately.** Remember that other professionals and insurance companies will be reading and reviewing your occupational therapy notes. You will also be providing written home programs for clients and caregivers. Sloppy handwriting or data entry errors using a keyboard, touch screen, or misdirected pointing and clicking of a mouse may result in serious inaccuracies, substandard work, or could lead to possible client harm. In addition, ensure that you are always identifying right and left accurately (e.g., parts of the body) as documentation of your interventions must match the identified condition (Fairchild, 2013). It is essential that your notes be understandable and accurate in order to communicate effectively, minimize denial of claims, and help avoid medical errors.
21. **The OTA should not be referred to as *therapist*.** There is a clear distinction between an OT and an OTA regarding roles and responsibilities (AOTA, 2014b, 2015b). The OTA should be referred to as an *occupational therapy assistant* or an *occupational therapy practitioner* rather than a *therapist*. Medicare regulations regarding occupational therapy also state that the words *therapist* and *clinician* apply only to the OT and are not appropriate terms for the OTA (CMS, 2014).
22. **Do not include other clients' names in your note.** There are times when it is important to note that your client is interacting with other clients but, for confidentiality reasons, their names should not be listed in another client's notes. You can state something like:
    - *Client reports that his roommate's yelling kept him from getting a good night's sleep.*
    - *During activity group, client initiated conversation with 3 other group members.*
    - *Student reports that a classmate helps her with opening containers for lunch.*
    - *Resident played checkers with another resident.*

23. **Always review the client's chart and communicate with the client and team members as appropriate before beginning intervention.** It is important to determine if there have been any changes in the client's status or discharge plan or if new medical orders are in place. For example, the client may have developed complications or may be undergoing testing that necessitates fasting, bed rest, or measuring fluid intake and output.
24. **Don't assume you will find all of the information you need in the chart.** You must always use clinical reasoning and good communication skills to decipher and clarify information present in the chart and determine what information or medical orders might be missing or incomplete. If you are unsure of something regarding a client, discuss it with your supervising OT or other team members as appropriate. When in doubt, always err on the side of caution.

Conclusion

Federal regulations have greatly influenced how health information is managed and communicated. Additionally, government mandates impact how health care is delivered, paid for, and assessed for quality. The use of EMRs is becoming more widespread and, although EMRs have many advantages, there are also various disadvantages. Occupational therapy documentation serves many purposes. Notes can be organized into different formats and must meet third-party payer requirements for reimbursement. When writing in the health or education record, all occupational therapy practitioners and students are obliged to follow professional, legal, and ethical standards (AOTA, 2015a, 2015b). Complete Worksheets 2-1, 2-2, and 2-3 to test your knowledge of respectful, professional language.

XYZ Home Health Care Agency

☐ OT ☐ PT ☐ ST Department

Progress Note

Name: _____ **Record #:** _____

Dx: _____ **SOC:** _____

Date	

Figure 2-1. Example of a facility paper-based form.

Healthy Hospital
Occupational Therapy Department
Contact Note

Name: _____ **Record #:** _____

Date/Time	

Figure 2-2. Example of a facility paper-based form.

Worksheet 2-1
Internet and Chat Slang

Consider the following messages intended for a fieldwork educator, supervisor, or other members of the health care and education team. Rewrite each of the sentences to make them more professional and determine what abbreviations could be appropriate to leave in place. A list of commonly used acceptable abbreviations is included in Chapter 4. Slang abbreviations are identified in the worksheet answers in the Appendix. *Remember that HIPAA guidelines and facility policy must be followed regarding electronic communication pertaining to a client's protected health information, such as using a secure portal.*

1. TX, SLAP. Pt's DH and DD will be instructed in use of the equipment you suggested.

2. Client AWOL today. Could not reach her by phone 2X.

3. K, I will call parents. FWIW the student did not hurt herself when she fell. TTYL.

4. OMG, that client's wound stinks and has bad yellow drainage. Please TMB ASAP.

5. IDK why the adaptive equipment was not ordered. Sorry, G2G

6. Resident negative for TB and AFAIK will be discharged in am.

7. Got ur message. IMHO client is unsafe transferring by herself and needs SBA.

8. The MS pt. tires easily when AMB short distances and needs a w/c eval before discharge. TIA.

9. Transporting the CA victim to his room now. BRB.

10. Doc, WDUT about US and TENS to pt's wrist?

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

Worksheet 2-2
People-First and Culturally Sensitive Language

Rewrite the following sentences using more appropriate people-first and culturally sensitive language.

1. The TBI was alert and oriented to person but not place or time.

2. The cerebral palsy child demonstrated difficulty fastening ½" buttons on her shirt because she is spastic.

3. The first grader is fat and mentally retarded. She seems lazy.

4. The resident diagnosed with polio is crippled and wheelchair bound.

5. The 3 Mexicans were teaching their classmates some Spanish phrases.

6. The client had a sex change.

7. The OTA led an activity group consisting of 2 schizophrenics and 2 borderlines.

8. The Haitian stroke victim speaks only Creole.

9. The client suffers from amyotrophic lateral sclerosis and lives in an old folks home.

10. The quad has an upper respiratory infection. He is being very difficult and won't come to therapy.

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

Worksheet 2-3
Written Communication

Critique the following e-mail message that an OTA student sent to a professor. List 10 suggestions to improve this note.

Prof,
OMG, my activity analysis grade is HORIBLE!!!!!  *I DON'T WANT TO FAIL UR CLASS. Lets meet ASAP. Tell me when. TTYL.*
Stewart

Suggestions to improve this note:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Adapted from Morreale, M. J. (2015). *Developing clinical competence: A workbook for the OTA.* Thorofare, NJ: SLACK, Incorporated.

Morreale, M. J. (2017). *The OTA's guide to documentation: Writing SOAP notes* (4th ed.). Thorofare, NJ: SLACK Incorporated.

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Chapter 3

Billing and Reimbursement

Health care spending in the United States (U.S.) reached $3 trillion, or $9523 per person, in 2014 (Centers for Medicare & Medicaid Services [CMS], 2015e). This chapter describes various funding sources and provides an overview of the billing and reimbursement process. Also addressed is the necessity of documenting services as skilled occupational therapy in accordance with established legal and ethical standards. It is important to realize this manual contains information based on current practice guidelines and legislation at time of publication. Reimbursement criteria and documentation requirements change as new laws are enacted and health care systems evolve.

Health Care Funding Sources

Individuals can pay providers directly for health care services received but the majority of health care is funded through a wide range of public and private health insurance programs and managed care plans. Local, state, and federal governments combined funded nearly half of total U.S. health care spending in 2014. Federal spending alone increased 11% over the prior year, primarily due to Affordable Care Act (ACA) provisions, such as Medicaid enrollment expansion (CMS, 2015e). As a result, payers have been moving toward reimbursement aligned to outcomes that justify treatment over the fee-for-service model (DeJong, 2016). Various attempts at more cost-effective ways of improving client outcomes and providing value-based care have been implemented, such as quality measures, bundled payments, and episode-based management, influencing how occupational therapy and other health services are managed, delivered, and paid for (DeJong, 2016).

Third-party payers (e.g., insurance companies, managed care plans, governmental programs) vary greatly regarding program eligibility, premiums, out-of-pocket expenses, provider networks, and plan benefits such as types of coverage for prescriptions, mental health services, catastrophic care, rehabilitation services, medical equipment/supplies, etc. Health providers and suppliers (e.g., institutions, agencies, medical equipment vendors, pharmacies, and individuals, such as physicians and therapists in private practice) contract with various third-party payers to be an approved health care provider for patients with that insurance. For reimbursement, these contracted providers agree to accept **assignment** which are the predetermined amounts the insurer will pay for each covered service or supply if certain criteria are met. This *allowable* amount is considered payment in full and the provider "may not bill or collect from the patient any amount other than unmet copayments, deductibles, and/or coinsurance" (CMS, 2015d, p. 15). Thus, if a patient receives health services or supplies from a provider that accepts his or her insurance plan, all sides agree to those terms in regard to what is or is not covered as a benefit and the maximum amount the patient and insurer will each have to pay to the provider. The billing and reimbursement process will be explained in more detail a little later in this chapter.

Morreale, M. J. *The OTA's Guide to Documentation: Writing SOAP Notes, Fourth Edition* (pp. 41-60).

The ACA mandates that individuals in the U.S. must obtain health insurance (or pay a fine) and that insurers must offer certain standard benefits, such as specific health screenings, immunizations, and other services (U.S. Department of Health and Human Services [USDHHS], 2015). An individual may purchase a private policy directly from an insurance company or might obtain insurance through a group plan from one's own employer or an employer of a parent or spouse (Gateley & Borcherding, 2017). **Premiums** are the yearly costs to purchase the plan, often paid in monthly intervals. A person who is covered by an insurance plan is called the **plan beneficiary**. In certain circumstances, private organizations and foundations may provide some charitable assistance or special grants to needy individuals to help pay for certain out-of-pocket health care expenses such as rehabilitation therapy, medical equipment, or other services.

A government-funded program called **TRICARE** provides health care benefits for active and retired military personnel and their families. Another funding source is **Worker's Compensation**, which is a mandatory insurance paid by businesses to cover employees who are injured on the job. Workers' Compensation pays for an injured employee's wages, medical care, and rehabilitation; although programs and benefits do vary from state to state. **Medicare** and **Medicaid** are major public programs that provide health care benefits to eligible populations, as described briefly in the following sections. Chapter 17 provides further explanation of the Medicare and Medicaid documentation requirements for rehabilitation therapy in specific practice settings, such as home care, hospitals, rehabilitation facilities, outpatient clinics, and skilled nursing facilities.

Medicare (www.Medicare.gov)

Medicare is a federal insurance program for people ages 65 and older, individuals with end-stage renal disease, and eligible people younger than 65 who have permanent disabilities. In 2014, Medicare spent $618.7 billion, which accounted for 20% of total health care spending in the U.S. (CMS, 2015e). Individuals may choose either Original Medicare (Parts A and B) managed by the federal government or a Medicare Advantage Plan (Medicare C), which is a plan managed by a private insurance company. The Medicare program obtains revenue through a designated Medicare payroll tax and consists of the following four parts:

1. **Medicare Part A (Hospital Insurance)**: This covers inpatient hospital care (including inpatient rehabilitation facilities and psychiatric care), limited skilled nursing facility stays, hospice, and medically necessary home health services. Premiums are generally free for individuals (and spouses) if they paid enough Medicare taxes while working, but the individual does pay deductibles and some other expenses for care received.
2. **Medicare Part B (Medical Insurance)**: For persons with Part A, this is a supplemental insurance that covers medically necessary outpatient care (such as occupational therapy), medical supplies, doctor's visits, and preventative services (such as health screenings and immunizations). Part B also provides benefits for some therapy services in skilled nursing facilities and home health. Part B has a monthly premium cost and there are also some additional out-of-pocket expenses for care received.
3. **Medicare Part C (Medicare Advantage Plans)**: This is a type of Medicare plan contracted with private insurance companies such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) to provide Medicare Parts A and B benefits. There are a variety of plans the beneficiary can compare and choose from so the cost of premiums will vary depending on the particular plan. Medicare Advantage Plans also usually include some coverage for prescription drugs.
4. **Medicare Part D (Prescription Drug Coverage)**: This provides prescription drug coverage through Medicare-approved companies. The costs of premiums and out-of-pocket expenses vary depending on the particular plan. Individuals who have Medicare Parts A and B can purchase a Medicare Part D prescription plan.

Further information about Medicare eligibility, benefits, out-of-pocket costs, and plan limits can be found at www.medicare.gov.

Medigap Insurance

This is a supplemental plan offered by private insurance companies to "bridge the gap" and help pay for out-of-pocket medical expenses (i.e., deductibles, copayments, and coinsurance) incurred by individuals with Original Medicare. There is a monthly cost for premiums that individuals pay to the private insurer. Spouses covered by Medicare must purchase a separate Medigap policy if they want Medigap benefits (CMS, n.d.). Medicare does not cover health services when an individual is traveling outside of the U.S. so an individual might select a particular Medigap plan that provides international travel benefits. Also, as Medigap plans sold after 2006 can no longer provide prescription benefits, Medicare beneficiaries can choose to additionally purchase a Medicare D prescription plan if desired (CMS, n.d.).