PATIENT CARE DOCUMENTATION IN ATHLETIC TRAINING: A QUALITY IMPROVEMENT PERSPECTIVE

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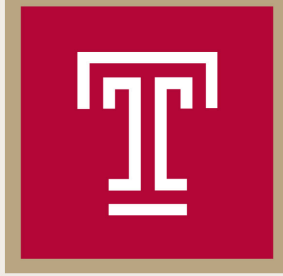

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Disclosures

No conflict of interests and views are my own

Not the views of my colleagues or Temple University

Use your own discretion- this is not legal advice to you.

As a result of this session, you will be able to:

ATHLETIC TRAINING

1. Identify common mistakes within you own medical documentation.
2. Evaluate your own medical documentation through chart auditing
3. Determine and implement a plan for bettering documentation through quality improvement

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Reframing our Thinking

When we stop thinking of medical documentation as something *in addition* to our patient care rather than *part* of our patient care our habits and attitudes will simultaneously change.

Top Priority: Patient Centered Care

The National Academy of Medicine (Former Institute of Medicine) defines **patient-centered care** as:

"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." This approach requires a true partnership between individuals and their healthcare

Risk Management

If it is not written down, it didn't happen!

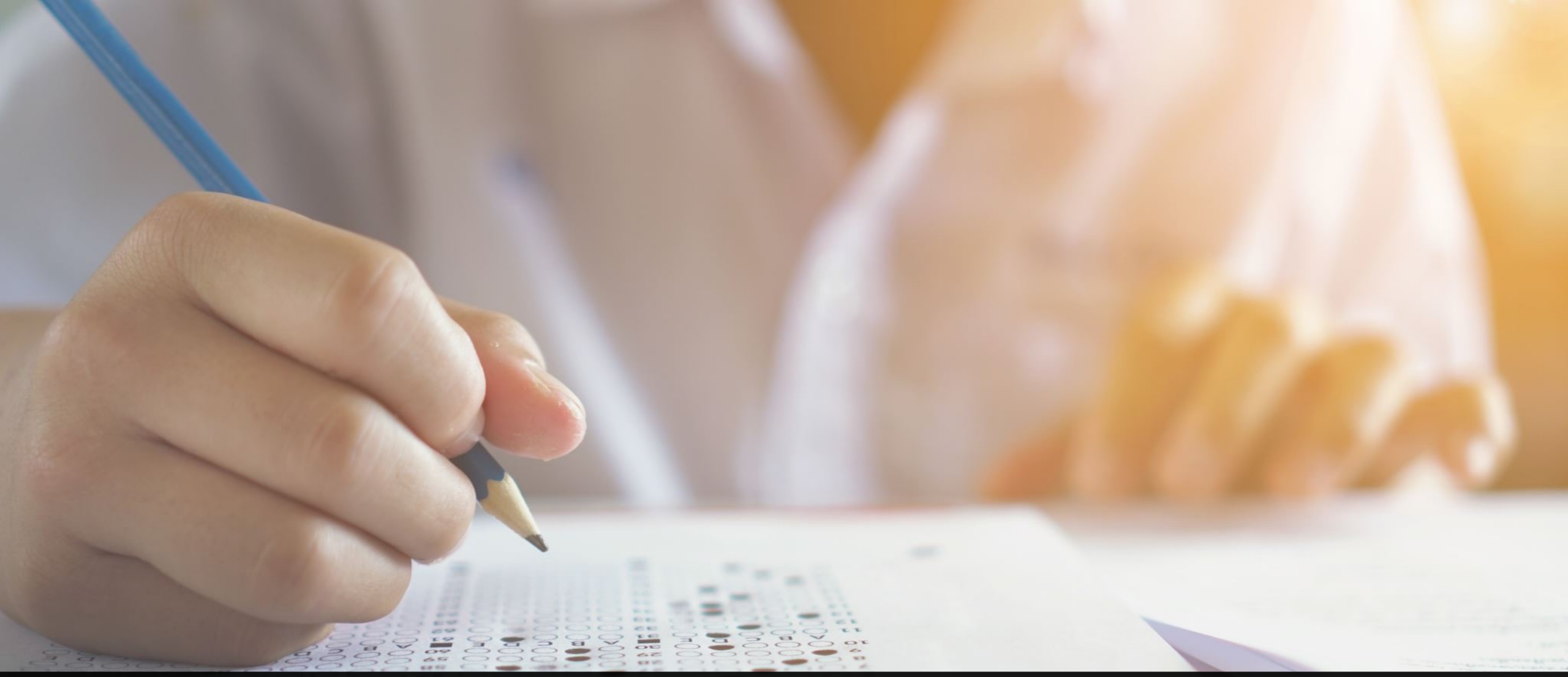
Risk to the patient

Risk to the health care provider

Change in Patient Status

Any unexpected changes or deviations from the expected result should be documented in the interim and include appropriate follow-up documentation. When an AT provides any service, evaluation, consultation, subjective and/or objective measurement of a status change, the specifics of the service provided or action taken, and the short/long-term plan would need to be documented.

- *Best Practice Guidelines for Athletic Training Documentation 2017*

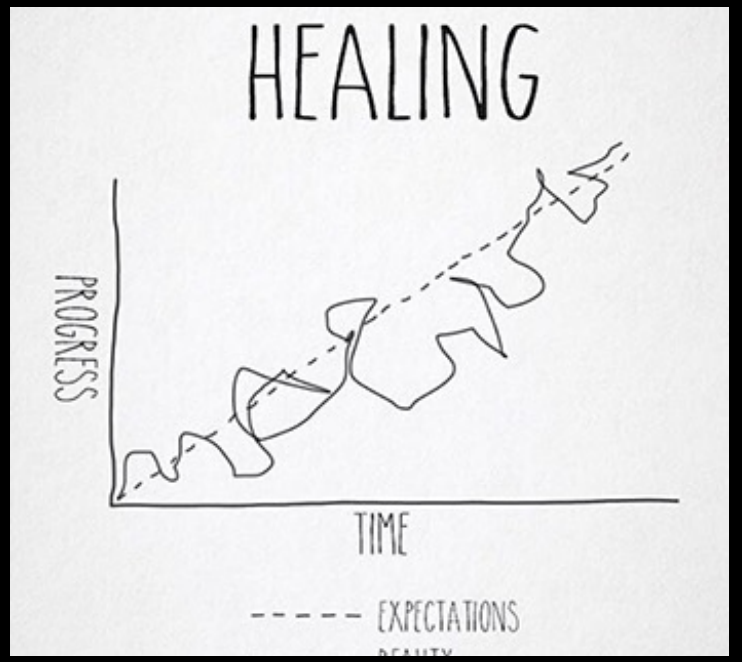


So, How Do I Improve My Medical Documentation?- QUALITY IMPROVEMENT

What is Improvement?

How it started

How it ended



Along the Way

Accreditation Standards

Core Competencies: Quality Improvement

Standard 63 Use systems of quality assurance and quality improvement to enhance client/patient care.

What is Quality Assurance?

So, What is Quality Improvement?

- **Quality improvement** (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance.

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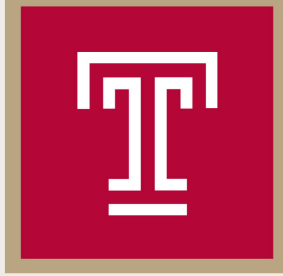

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Documentation- In Any Platform

- Participants indicated that they always (45.7%, n = 478/1046) or very frequently (39.0%, n = 408/1046) documented their patient care.

- However, many ATs stated that they occasionally (10.8%, n = 113/1046), rarely (1.9%, n = 20/1046), very rarely (1.5%, n = 16/1046), or never (1.1%, n = 11/1046) documented their patient care.

Documentation Fast Facts

- Electronic documentation (36.6%, n = 380/1038)
- Documented to demonstrate their value to stakeholders (32.1%, n = 338/1053)
- Bill for care or reimbursement (3.1%, n = 33/1053)

20%

LET'S START OVER....AND MAKE IT POSITIVE

UNLEARNING & GROWTH MINDSET

How Do I Start QI in Medical Documentation?

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Why do we need to know our systems?

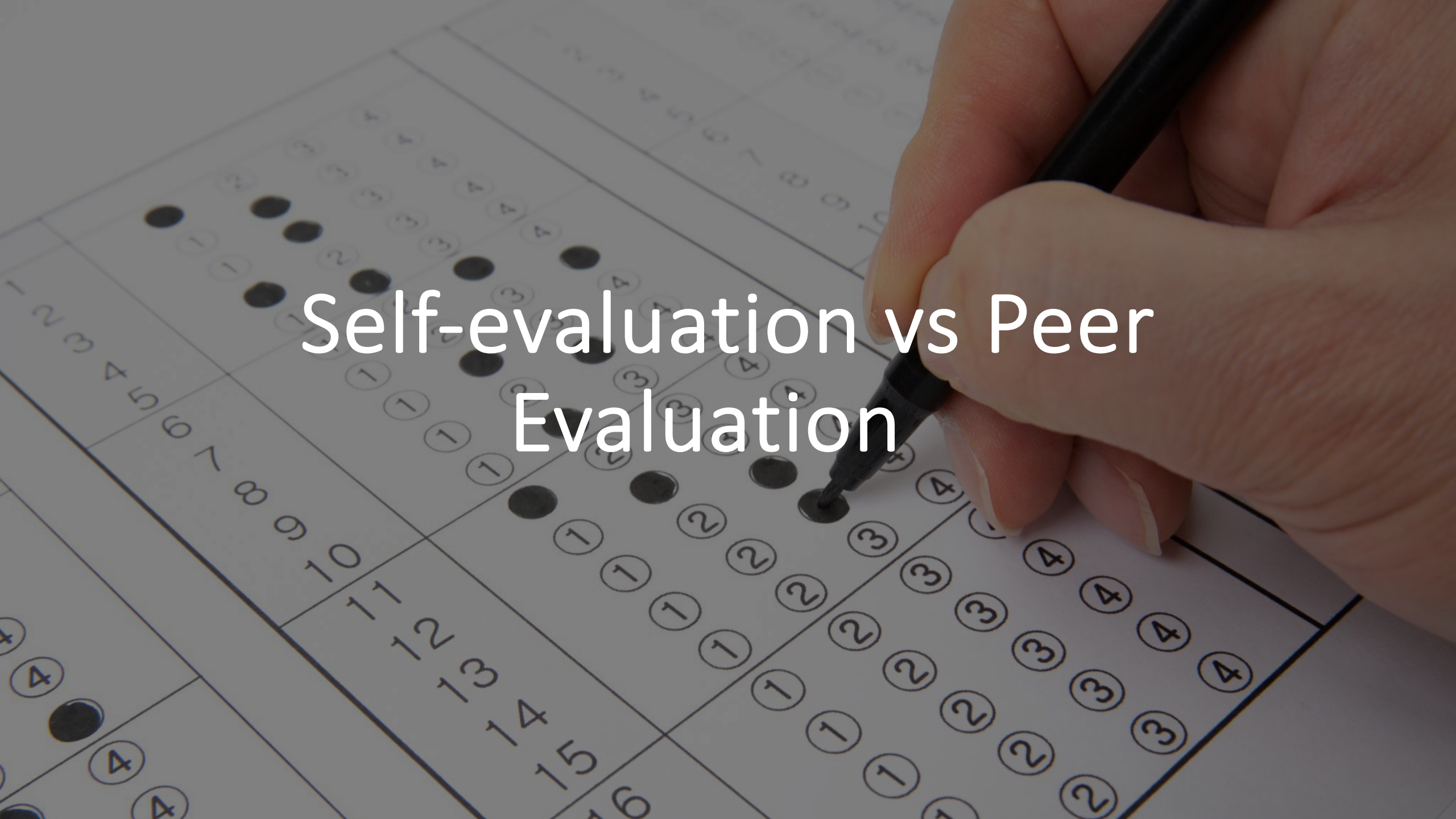
It is important to know what is in existence

- What is currently being done?
- How is it being done?
- Where are the gaps?

Chart Reviews in Athletic Training

Initial Evaluation

TASK	YES or N/A	NO
Intake Paperwork/Subjective Measures		
MD order with specific diagnosis, signed, and dated		
Medical history		
Medications listed		
Date of injury onset listed		
Patient's specific functional limitations noted		
Patient's previous level of function listed		
Patient's societal role listed		
Patient's goal(s) listed		
MD/work restrictions indicated		
MD precautions listed		
Objective		
Functional limitations measured (numbers)		
Work/task requirements described quantitatively		
Assessment		
Athletic training diagnosis		
Impairments related to functional limitations		
Prognoses		
Patient barriers listed, if applicable		
Assessment clearly demonstrates patient's need for rehab		



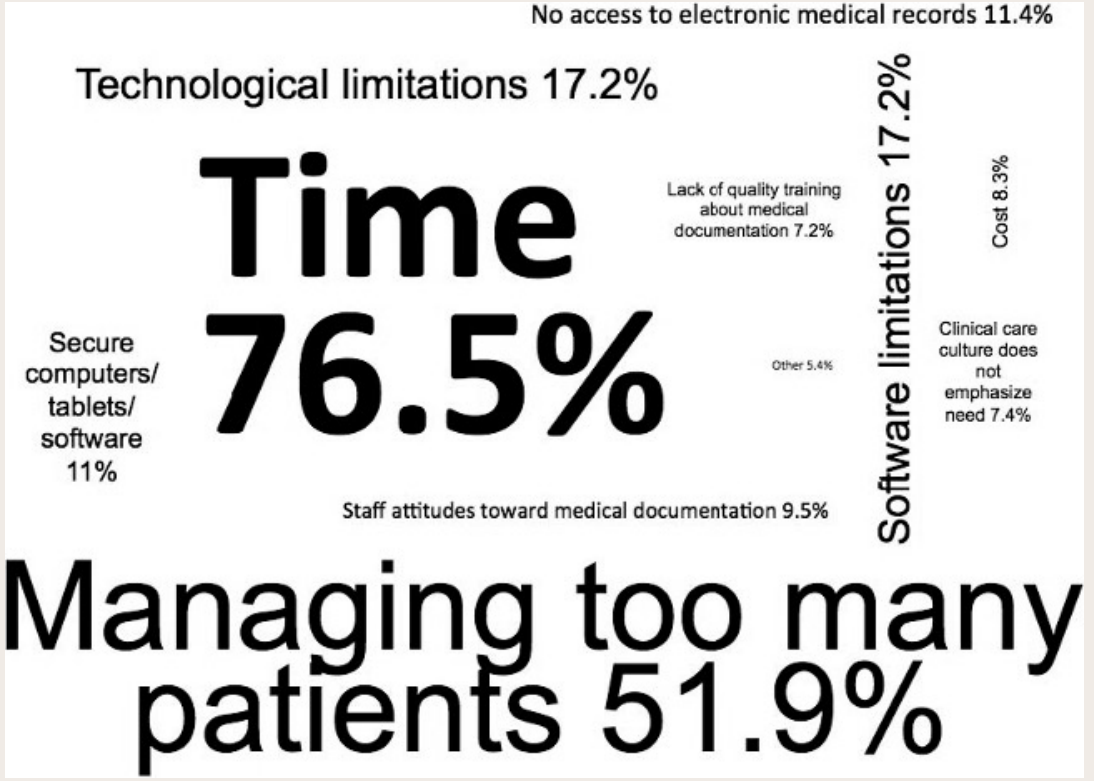
Self-evaluation vs Peer Evaluation

What Do I Do with this Information?

- SWOT Analysis --> TOWS
  - What are the biggest areas of deficit?
- Determine what is most important for you/your patient care.
- What is realistically manageable for you over this time frame?

Barriers to Documentation

- Lack of Time
- Lack of Accountability
- Inadequate Facilty Resources
- Lack of Personnel



Let's Do it!- Create Your Aim Statement

- In the next 2 weeks, 100% of the time I will add *[2 components that are missing from my medical documentation]* in my medical documentation.

2 things, 2 weeks

Sometimes Things Will Go Well


IT'S FINE

What are Some Common Areas of Improvement?

Construct of Chart Review	Percentage in four-week follow-up
Specific modality info listed, if applicable including treatment parameters	50.00%
Modifications to treatment plan are listed	50.00%
All SOAP sections filled in	50.00%
MD/AT order with specific diagnosis, signed, and dated	45.45%
Medications listed	45.45%
Patient's societal role listed. This information can include but is not limited to daily living/ and other information dependent on the patient.	45.45%
Prognoses	45.45%
Work/task requirements described quantitatively	45.45%
Impairment addressed in every goal	45.45%
One item reassessed every visit as necessary	45.45%
Treatment time listed in minutes	40.00%
Frequency of visits	36.36%
Specific, functional task listed in every goal	36.36%
Goals are quantifiable/measurable	36.36%
Objective criteria and assessment on decision for return to activity/activities of daily living	27.27%
All entries signed with legal credential and dated	25.25%
Goals for every 2 to 3 weeks of rehab	18.18%
Time deadline for every goal	18.18%
Cancelled and no show appointments listed with dates	0.00%

Now What?

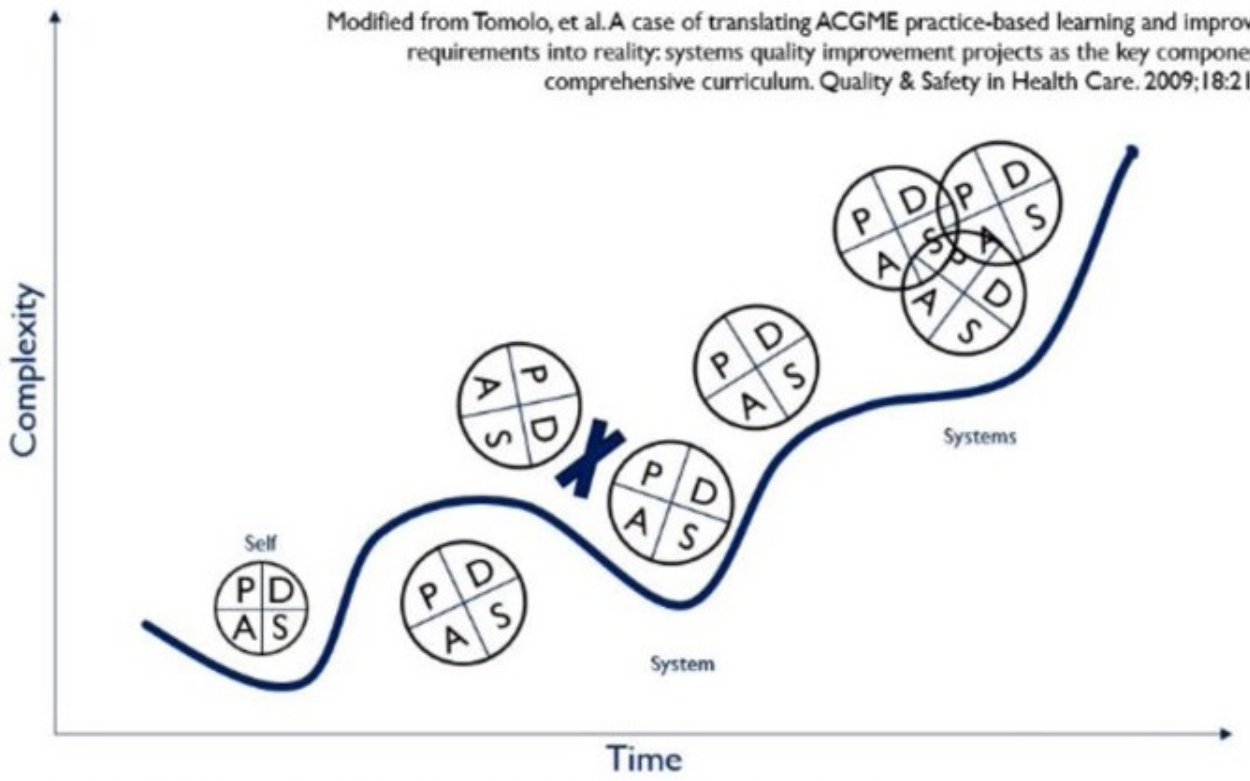


Figure 1. Translation of Individual PDA Cycles to Systems-Level Approach

http://clinat.indstate.edu/index.php/clinat/article/view/101/56

Who is your role model?

Upwards of 60% to 90% of health care students stated that role models shaped their professional attitudes and behaviors and that the learning affected them at a greater impact than lecture only

What are you actually modeling to those around you?

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Click Here for the Chart Review!

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Let's Practice Together

[redacted] reported to campus this fall about 8 months post- surgery. She has participated well with slight modifications in the weight room and fully in softball related activities. She has been restricted from cleans in the weight room and has modified grips for any upper body CKC activities. She wears a wrist widget during practices and a brace she found and likes from CVS during lifts. She does US or Premod/Ice 1/x and joint mobs to maintain her motion and pain management. She still feels a ittle restricted with full wrist extension, but I explained that may be normal now as a slight post-surgical change.

Trust the Process

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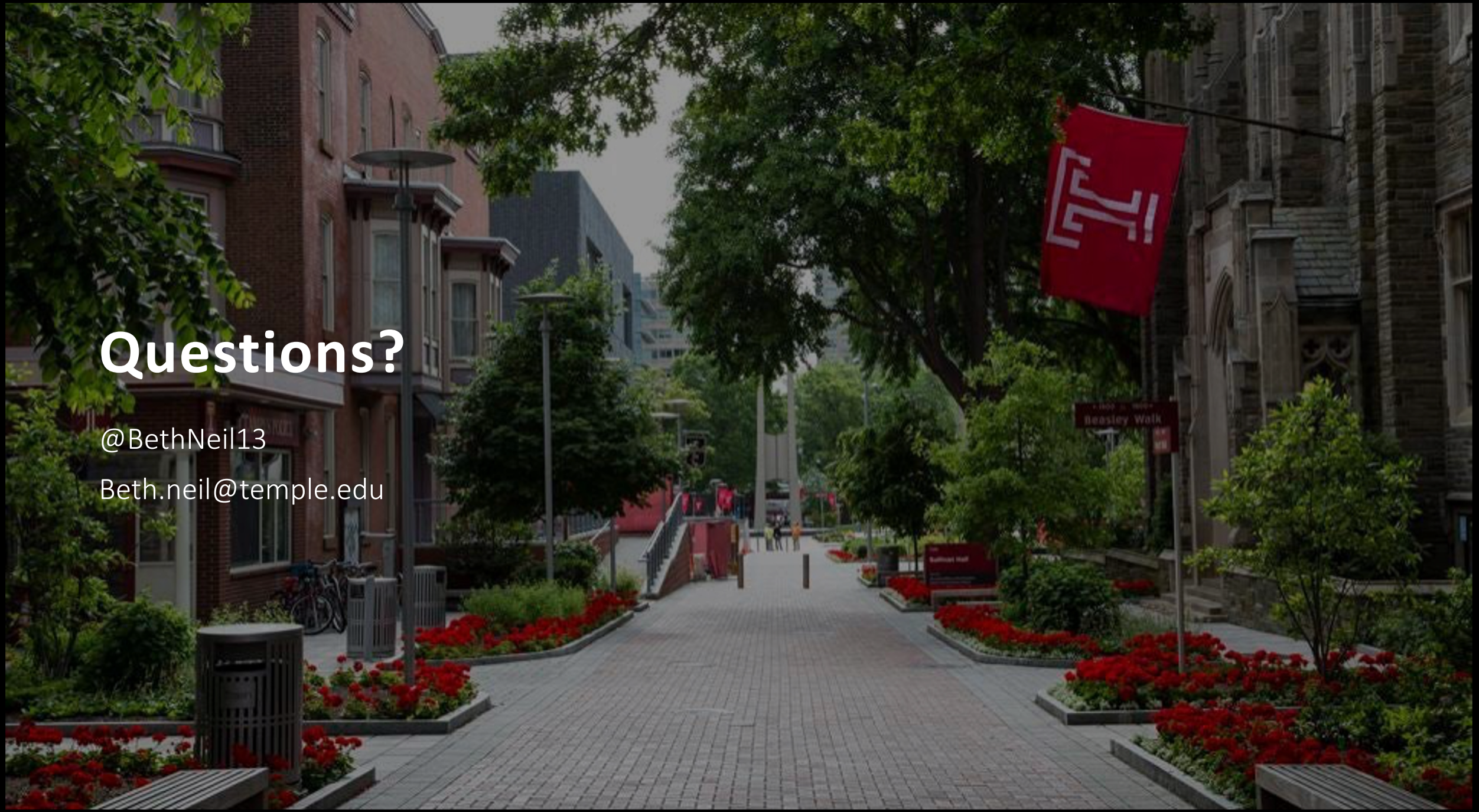

Questions?

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Additional Slides

- In the slides following, there is a lot of information on the foundations of medical documentation in athletic training. This is information that so often I am told that people truly do not know the basics. Please feel free to look through the information and find what is needed for you!

Types of Medical Documentation

- Initial Note
- Progress Note
- Discharge Note

Purpose of Medical Documentation

Provision of an accurate, thorough medical record

Communication with referral source (physician)

Communication with other parties involved with the patient

Communication with coworkers

- Continuity of care

Protection from liability litigation

- If not document “interaction never occurred”

Show our worth as athletic trainers

Common errors

Failure to include the visit number (visits actually attended)

Failure to list the treatment time listed in minutes

Failure to sign and date all entries

Failure to document all treatment modalities and procedures used

Failure to reassess objective data and goals

Lack of skilled assessment every visit

Use of nondiagnostic, nontherapeutic, routine, repetitive, and reinforcing procedures without evidence of skilled feedback

Patient Encounters

"A patient encounter is defined here as any interaction with a patient when an athletic training service is provided or a communication occurs regarding their health status. Communication regarding a patient's status may include, but is not limited to, written, verbal, or electronic communication with any individual or entity."

- *Best Practice Guidelines for Athletic Training Documentation 2017*

Progress notes

Must be completed every patient interaction/visit

Abbreviated SOAP note

Changes in pain, limitations, and patient comments

Treatments provided, reassessment performed

Home program response, progress towards goals

Interventions for next visit, assessment of goals

All communications documented (all modes including fax, email, text, etc) and understanding of communication

Cancelled appointments

Changes in work or participation status

Discharge notes

Must be included for every patient

Must happen for re-injury

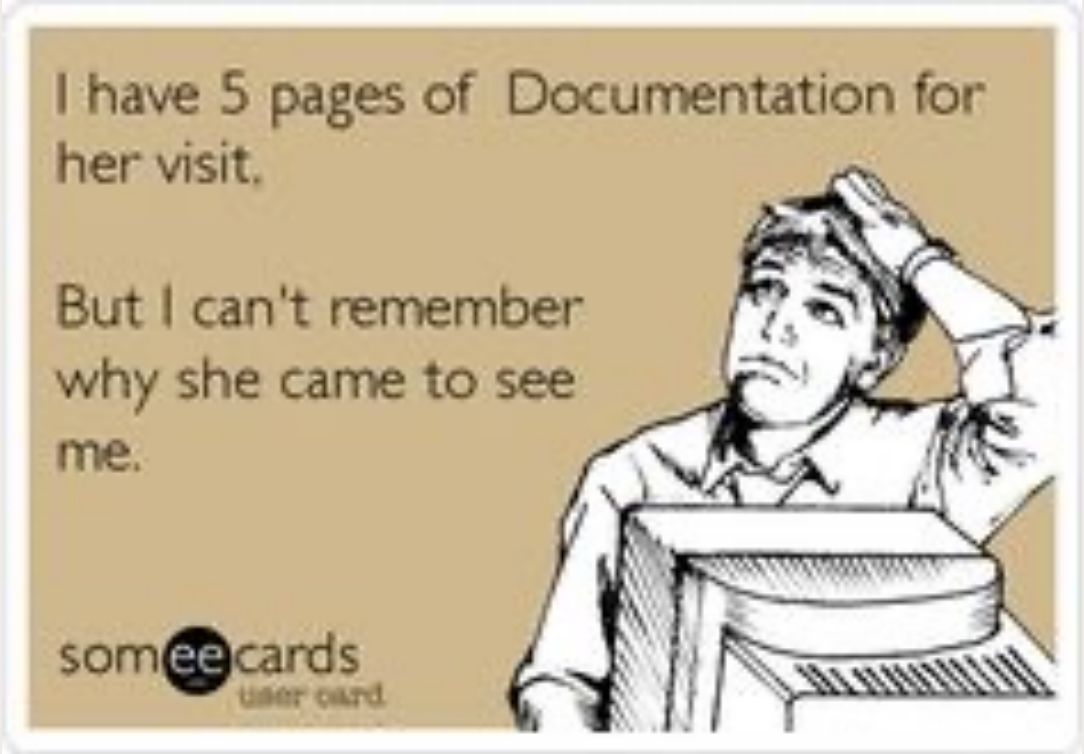
Date of discharge

Reason for discharge

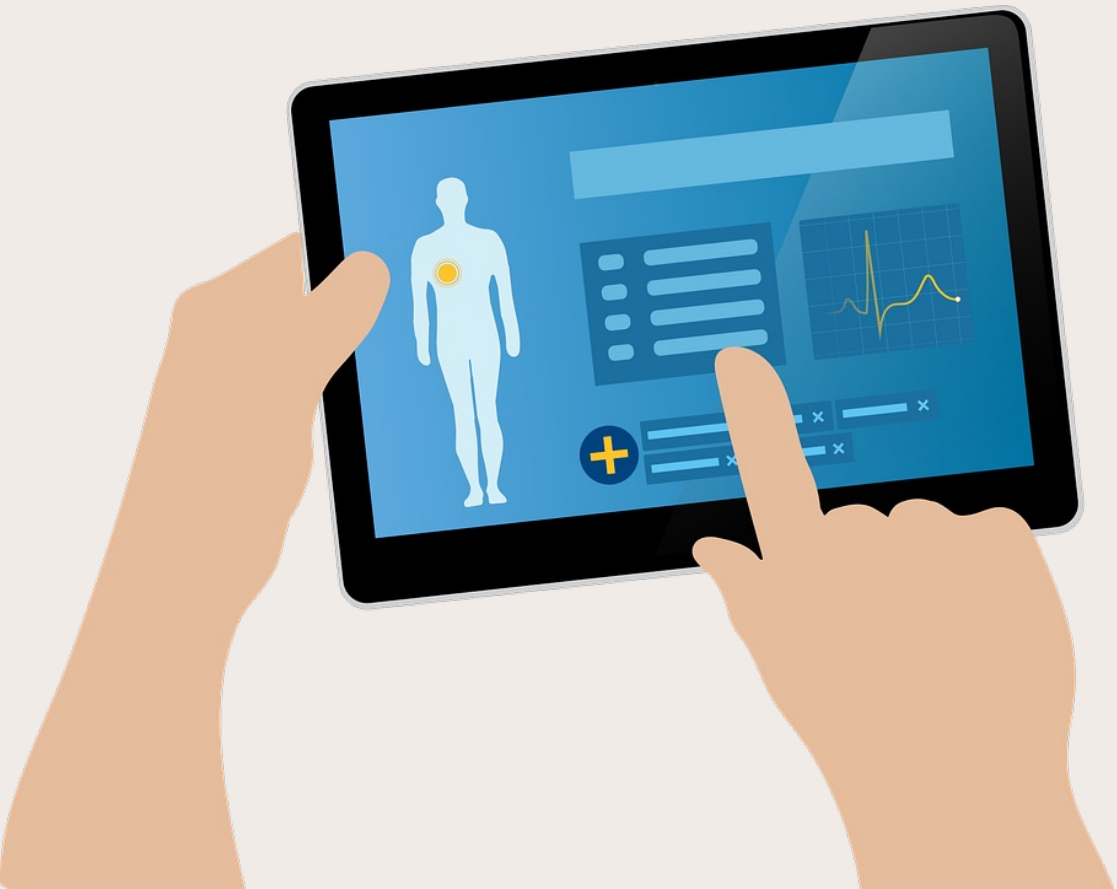
Patient Current Status

Sign

Date



Medical Documentation Mandates



American Recovery and Reinvestment Act-2009

Required that as of January 1, 2014 all public and private healthcare providers must have electronic health records in order to maintain existing Medicaid and Medicare reimbursement levels.