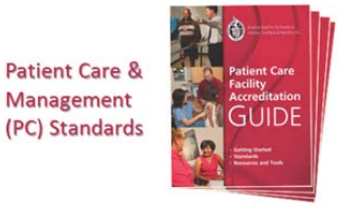
American Board for Certification

On The Record Webinar

June 28, 2018

Today we are going to look our topic from a bit of a different angle; we plan on using our time today to explore the direct link between your practitioner notes and the ABC Accreditation standards. We're going to address and spend time on just the four specific standards applicable to our topic. With the February 2018 passage of legislation that now recognizes orthotists and prosthetists documentation as part of the patient's medical record for medical review purposes, good, strong sufficient notes are more important than ever! Not only is documentation critical, your notes need to be clear, complete, and tell the story of your patient's care. On today's presentation we're going to get right to the point and then give you plenty of time for your questions afterwards and I'll have a few experts from ABC to help answer your questions. So let's get started.



What we're going to do today is specifically on the ABC Patient Care and Management Standards that relate to documentation. All of the standards are located in the ABC Patient Care Facility Accreditation Guide that you can find on the ABC website. The guide not only has all of the ABC standards and tips and hints related to the standards it contains a plethora, did he actually use the word plethora, yes I did, a plethora of resources to help you and your staff be compliant in your patient care facility. If you don't have the latest version please get it. I'll give you our website at the end of the presentation and it's a very easy download.

Orthotist and prosthetist notes in the patient's clinical record have always been critical even though it's been somewhat frustrating because we all feel they haven't received the respect they deserve. They have always been important but with the passing of this legislation they are now even more significant and vital to the process. We need solid documentation that hits the mark and is consistent throughout your patient's records using evidence based practices. The physician's notes are still required but your notes are now part of the complete record.

As I said earlier, let's take a look at the specific ABC standards that address your clinical notes.

We're going to start with an overall look at the Patient Care and Management standards which are referred to as PC.

Patient Care and Management (PC):

The Patient Care and Management Standards address the essential components that support the delivery of appropriate, safe and effective patient care and ensure that patient needs are met. These standards are designed to address the following:

- Physician interaction
- Patient rights,
- Patient and family (or care-taker) education
- Patient follow-up care

These standards are created to also be a guide for you and your team in establishing procedures to help you provide quality care for your patients.

The following four areas are covered by the Patient Care (PC) standards and address the components required by the ABC standards.

- Physician Interaction and Communication: If interaction with the physician is necessary these standards relate to the required documentation that supports the continuity of care between your practice and your referral sources. These standards relate to the communication mechanisms that you establish between your facility's professional staff and the patient's referring physician.

- Patient Rights: These standards are in place to ensure that you are providing an environment that facilitates the delivery of effective care and creating an atmosphere of mutual trust between your patients and the professional staff, which is essential. Which basically mean you have documentation that the patient has been informed of their rights.

- Patient and Family Education: The success of patient care depends not only upon the competency of the practitioner and the quality of the device, but also upon its proper and effective use and care by the patient, family members or caregivers. You can provide your expertise services; provide a tremendous quality device yet if the patient or caregiver does not understand how to properly use the device they cannot fully reach their established goals.

- Patient Follow-up Care: The standards in this section relate to ongoing patient care and reflect the standards of care generally accepted by our profession. They require that you provide follow-up care, appropriate to the patient's condition and complexity of the care, of course in accordance with the current valid order. Let's keep in mind, not every patient needs the same level of follow up.

Let's dive a little deeper and look at what the standards specifically require.

Patient Care, PC.3.4

Now PC.3.4 states that *the patient care provider must perform and document in the patient's record an in-person, diagnosis-specific, clinical examination related to the patient's use and need of the prescribed device.*

Your initial evaluation should include the following:

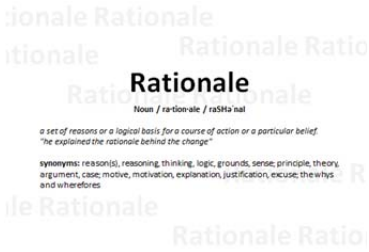
- sensory function,

- range of motion,
- joint stability,
- skin condition (the integrity of the skin, the color and temperature),
- How about the presence of edema and/or wounds,
- vascularity,
- pain,
- manual muscle testing,
- What about functional limitations,
- cognitive ability, and of course the patient's
- medical history

Now let's say this, not all of these are appropriate for every type of patient you may see. But if you are assessing a patient for a custom device then this list represents the baseline for what your clinical documentation should include.

PC.3.4.1

PC.3.4.1 states: *The patient care provider must determine and document the appropriate orthosis, prosthesis or pedorthic device. This determination must be based on the patient's need and must ensure optimum therapeutic benefits and appropriate strength, durability and function as required for the patient.* In other words, why does the patient need the device you're recommending?



So your patient records must document your determination and rationale for the appropriate orthosis or prosthesis and the appropriate materials, components and design based on the patient's need. For example, if you are recommending the patient be provided with a custom AFO your notes should detail why the patient needs a custom device rather than a prefabricated one. What factors are present that require the patient be provided a custom device? Again, what are the specific therapeutic benefits?

Now the next two standards (PC.4, PC.4.1) are where you determine what your patients are trying to achieve. Do they see themselves as a high performance athlete or do they simply want to be able to perform the activities of daily living? Or what about something in between?

PC.4 states: *The patient care provider must document in the patient's record the patient's goals and expected outcomes related to the use of the item or services provided.*

So, it's essential that the patient records include documentation that specific patient goals and expected outcomes have been established. What goals have been discussed? What goals have been agreed on and set? Is the patient aware of what their potential could be? Has this been discussed in detail? Keep in mind there are goals that the patient may set and goals that the practitioner may set. For example, a person with foot problems may have a goal of standing on their feet for longer periods of time without pain. Your goal may be more technical such as correcting a malalignment of their joints. And again, is all of this sufficiently documented in the clinical notes section of the patient's record?

PC.4.1 Tells us that *the patient care provider must document the patient's progress toward meeting their goals and expected outcomes related to the use of the item or services provided.*

Now that the goals and expected outcomes are documented in the patient's record let's look at the next step. How is your patient progressing? When seeing the patient for follow-up you need to document how they are meeting the goals by referring back to those goals that were set at the initial evaluation. Are they making progress more rapidly than anticipated? Are they encountering issues that are slowing down their progression? Sometime goals and outcomes change and that needs to be reflected in your

notes. In all situations you need to continue to update your notes as they proceed in their treatment. We're continuing to tell the patient's ongoing story.

Patient Records (PR) - The Patient Records (PR) section of the standards contains specific requirements on the

- centralization,
- accessibility and
- protection of patient records, as well as keeping Protected Health Information (PHI) secure and confidential.

Federal HIPAA regulations apply to all facilities providing care. Your practice needs to have well established documented policies and procedures that address the creation and maintenance of patient records. An effective patient record program must adhere to those three principles.

Your practice must maintain a secure patient record system that allows for prompt retrieval of all patient records. Again, it's critical that all patient records be treated in a strictly confidential manner.

Regarding the Backup of Patient Records if you are using electronic medical records for patient care, you must make sure that data is secure and backed up on a regular basis. I've heard of practices where their computer system has gone down and they had not been backing up their records, because of that they were forced to close their practice for an extended amount time. Even if you do not use an electronic medical record system you must have a policy in place to protect your patient records from loss or damage. There have been many stories where there were no back up or the records were not protected and all was lost. No one wants that.

Standard PR.6.1 states that your patient records must include:

- Patient evaluation/assessment, the cornerstone we're building our entire patient care on, needs to contain the diagnosis, prescription or valid order, relevant patient history and medical necessity
- Pre-treatment photographic documentation as appropriate for the item, if there are pre-treatment photos. More and more practices are using these every day.
- Confirmation that patient education was provided, we must document that.
- The name of the practitioner, their findings, recommendations, treatment plan and follow-up schedule, complete documentation of your entire patient records need to be consistent.

If you are using photo documentation, do you have a policy that describes how, when and under what circumstances this type of documentation is used? As you are conducting your assessment, are you recording the informative data that you are using to support your treatment plan? Are your patient's goals objective and measurable?

If your patient was able to walk 50 feet in 2 minutes before treatment and now they are able to walk 100 feet in the two minutes after treatment, how does this data support the success of your treatment plan? That's just one example of data documentation that supports your treatment plan.

Standard PR.6.1.1

Your patient records must document the patient's need for and use of the orthosis or prosthesis, including:

- Pertinent medical history – Have you interviewed the patient to get as in-depth a history as possible? Again, that's telling the story, we need that baseline.
- Allergies to materials – This would include all materials which could potentially be used. Don't forget any adhesives.
- Skin condition

- Diagnosis
- Previous use of orthoses or prostheses– Is there a history of device usage? Were they successful users of the device? Were there any issues? There are times when practitioners are not aware of the patient's previous usage of orthosis, ask the questions.
- Results of any diagnostic evaluations or tests
- Patient expectations – Again, are they aware of their potential? Have all possibilities been discussed with the patient? This could be their first experience with O&P and remember, you're the expert.

The standards I've discussed today specifically relate to the legislation passed in February. I understand it sounds like a broken record but ultimately you need to tell the patient's story AND support your work with in-depth and comprehensive documentation. You need to show how you came to your conclusions and what objective measurements you used. If you are able to aim for the best written, most thorough clinical notes, then you not only create the appropriate patient record but you have all the information you need if you are subjected to an audit or denial of your reimbursement claim. And as is always your goal, it will help you to provide the best possible patient care.

If that's all the time we have then I'd like to share my contact information as well as the Accreditation team here at ABC, Tammi and Kyle. Please feel free to contact us with any question you may have. I also want to give a little shout out to all of the ABC surveyors. They are all over the country and sharing best practices with all of the ABC accredited facilities. It's often that I hear from business owners and practitioners that our surveyors helped them through documentation issues and I'd like to publically thank them for their good dedicated work.

I said earlier that we'd show you where you could locate All of ABC's standards are located on the ABC website. Click on Facility Accreditation and go to the Patient Care section. Just download your own copy of the guidebook and the tips for compliance. Each standard has an accompanying tip that will help

guide you with compliance. I'd like to thank you again and I hope this has been helpful. I'd also like to encourage you to reach out to us with any question you may have. And again, please go to ABCOP.org to find all of our resource tools. Have a wonderful day.