Information Gathering and Documentation

1

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Topic

The medical record is the central source for information in the inpatient and acute medical setting. While the organization of the medical record may differ slightly depending on setting, medical documentation is universal in medical care and provides the essential vehicle for communicating and documenting information across multiple disciplines. In the acute and subacute medical setting, the medical record is a dynamic and "living" document with contributions from those providing direct clinical care and treatment, documentation of results, as well as information to determine future intervention and discharge. The following chapter provides basic information on record organization, data-gathering strategies, and typical types of clinical documentation used in medical rehabilitation.

Importance

It is important for psychologists to be familiar with the medical record and interview components as well as effective documentation to ensure efficient data gathering and to provide salient information to aid in patient care.

Practical Applications

A. ***Medical record organization***

Reviewing all sections of the record is seldom necessary; however, being familiar with the contents of each section is helpful. Different settings will use different formats; however, the list below provides a basic framework of typical sections with descriptions of the information each includes.

Sections

Admission

Contains general demographic and family contact information, general consent forms, insurance data, social work, and psychosocial intake assessments.

History and physical (H&P)/referral

Contains reason for admission, injury history, pertinent medical history, results of the physical examination and the original problem list. In the rehabilitation setting, H&P will typically include the timeline and course of treatment prior to admission to

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the rehabilitation setting. This section often serves as the most complete narrative of the patient's condition.

Test results/diagnostic/imaging studies

Contains results from diagnostic studies. The organization can be variable but typically includes cardiac rhythm testing, echocardiogram, electrocardiogram (EKG), electromyography (EMG), swallow studies, sleep studies, X-ray, electroencephalogram (EEG), and imaging such as computed tomography (CT) and magnetic resonance imaging (MRI).

Orders/treatment/Tx

Treatment orders and physician order sets

Pharmacy

Contains pharmacy orders and medication history

Laboratory/labs

Results of chemistry, microbiology, hematology, urinalysis/stool testing, and blood alcohol (ETOH) and illicit drug testing

Consultation/consults

Contains consultation notes from specialties outside of the primary medical service line. Psychology and psychiatry consultation reports are often found in this section.

Assessment/evaluation

Contains evaluations from audiology, physical therapy (PT), occupational therapy (OT), speech and language pathology (SLP), social work, and pressure sore flow sheets. OT/PT/SLP may have independent sections in the rehabilitation setting.

Progress/progress notes/H&P progress

Daily documentation of patient progress with multiple providers documenting their encounter with the patient

Discharge/plan/care plan/treatment plan

Contains individual treatment plans, critical care plans, and/or behavioral management plans

Legal

Contains powers of attorney, advance directives, and legal guardianship

B. ***Clinical interview***

After review of the medical record, interviewing the patient and available family is typically the next step in information gathering. Primary team members can also serve as key informants about patient progress (e.g., primary nurse, OT/PT, treating therapist). The interview is a key portion of psychological assessment in the acute medical and rehabilitation setting. An interview is a component of several types of procedures including the *Psychiatric Diagnostic Interview* (Current Procedural Terminology (CPT 90791)) [1], the *Health and Behavior Initial Assessment* (CPT 96150) [1], and the *Neurobehavioral Status Examination* (CPT 96119) [1]. The type of assessment procedure used is dependent on the goals of assessment and the nature of the diagnosis being treated (i.e., medical vs. mental health) (see Chap. 54, CPT and Billing Codes in this book). Irrespective of the procedure used, there is considerable overlap of information gathered.

The Health Insurance Portability and Accountability Act (HIPAA) seeks to protect patient information and provide standards for the transmission and storage of medical information [2]. Clinicians should be aware that HIPAA provides patients greater access to their health records, but some records still demand a greater level of protection (e.g., psychotherapy notes). This can create a challenge for providers with ensuring privacy and confidentiality while at the same time allowing for greater access to patient information. Be aware of privacy laws in your state that might require an even greater degree of protection than HIPAA. Clinicians should be mindful of what information they include in the medical record given the accessibility of the data.

C. ***Documentation***

General guidelines

Accurate and timely documentation are critical to safe and effective patient care. The clinician must be aware of hospital or facility policies on documentation requirements and timelines. Although there is institutional and practice variation, inpatient encounters are typically documented in the medical record on the day the encounter takes place. If a delay in providing a complete report is necessary,

interim documentation needs to be done to communicate contact with the patient and any urgent information (i.e., "hold" note). Outpatient encounters are generally required to be completed within one week, although as EMR become more commonplace, quicker turnaround is becoming the new standard.

Interview reports

The interview report is used to provide a clear and concise initial impression and framework for developing an actionable treatment plan. The documentation should focus on pertinent information that guides patient care. Clinicians should work to avoid redundancy with other easily accessible parts of the medical record (e.g., medical history). Emphasis should focus on the factors assessed by psychology such as cognition, mood, behavior, social/environmental variables, impairments, and retained abilities or the patient's assets. Recommendations should make up the most significant portion of the interview report and should provide guidance to the team, patient, and family.

Progress notes

Progress notes provide encounter-specific information and documentation of treatment and intervention progress. The purpose is to document the clinician's intervention and that you are following acceptable standards of care and clear rationale and results of interventions. In multidisciplinary settings, progress notes allow the team to stay abreast of each provider's observations and interventions. Progress notes are significantly different than psychotherapy process notes, which might include hypotheses, treatment, or diagnostic considerations that are later discarded. Thus, information provided in the progress note should be brief and provide salient information to document and communicate important information to other clinicians for the explicit purpose of improving recovery. They are not intended to provide a detailed narrative. If the progress note is serving as the supporting documentation for billing purposes, which is often the case, the note must include required elements (e.g., date/time of encounter, procedure used, time devoted (if a time-based CPT), and diagnosis).

Tips

A. ***Steps for efficient record review***

1. **Determine the referral question**
   - May not be explicit.
   - Review physician requests in the "Orders" section or H&P.
2. **Review admission and H&P**
   - Review for emergency contact information of family members who can provide collateral information.
   - EMS data sheets that can provide information regarding injury specifics/dates of onset of illness and behavioral observations. For example, this can be particularly helpful when trying to determine head injury characteristics such as the length of loss of consciousness (LOC) and posttraumatic amnesia (PTA).
   - Review H&P for timeline of admission, results of the physical examination, pertinent medical history, family medical history, and results of initial diagnostic testing.
   - Look for evidence of psychiatric history—note mention of terms such as "depression" and "anxiety."
3. **Review consultation reports/ evaluations/progress notes**
   - Typically presented in reverse chronological order with the most recent information on "top."
   - May be helpful to compare original evaluations/notes with the most recent documentation to determine progress and trajectory.
   - Look for mention of the patient's emotional and psychological status, pain ratings, and behavioral observations.

- SLP evaluations can provide information about cognitive status prior to formal neuropsychological testing.

4. **Review pertinent imaging study reports**
   - Neuroimaging studies provide information about the nature of central nervous system (CNS) damage (acute vs. remote) (e.g., hemorrhagic vs. ischemic stroke, diffuse cerebral axonal injury, focal contusion, traumatic hemorrhage, complete vs. incomplete spinal cord injury or impingement).
5. **Review medication list(s)/pharmacy orders**
   - Note common agents used for pain (e.g., opioids) and psychiatric management (e.g., SSRI, SNRI, benzodiazepine, antipsychotics, and MAOI).
6. **Note important laboratory findings**
   - Not typically in the purview of all clinicians.
   - Be aware of elevations and/or deficiencies that might contribute to cognitive or psychological symptoms.
   - Note evidence of substance use or intoxication.
   - Sections usually provide the acceptable/optimal value ranges for each test. Abnormal findings may be "flagged" as to bring to the attention of the reader. Electronic records often highlight abnormal findings in colored font.
7. **Keep abreast of discharge planning**
   - Review for any changes to length of stay or discharge disposition.
   - Note contact information for social work or case management professionals.

B. ***Key components of a diagnostic interview, questions to address, and domains to be documented***

This list is not exhaustive and should be tailored based on the referral question and the patient's capacities.

Identification — Basic demographic information such as age, date of birth, date of assessment, gender, and referral source

Reason for referral — A brief statement about *why* such an evaluation is being conducted

Informed consent — Document that the patient was made aware of the nature and reason for such an evaluation and the limits of confidentiality and that they agreed to the evaluation. Example: *Potential risks and benefits, limits of confidentiality, and test procedures were discussed. Following this discussion, the patient agreed to complete the evaluation.*

Chief complaint — What is the main reason for this evaluation? What symptoms initiated concern? Does the patient have a history of mental illness or treatment? Are there specific psychological or behavioral symptoms impeding rehabilitation progress?

History of present illness— Include a description of the onset of the patient's symptoms including level of severity and/or episodes. One goal here is to establish a timeline of the patient's symptoms, evolution of such symptoms, and any responses to intervention. It is useful to directly quote the patient's own words to describe symptoms.

Past medical history — Note any significant medical history including surgeries and hospitalizations.

Medications — List the patient's current medications. Be sure to note any discrepancies between medical records and the patient's report.

Psychiatric history — Include previous psychiatric diagnoses and any history of treatment (e.g., psychotropic medication management, individual/group psychotherapy, psychiatric hospitalizations). What was the response to treatment? Adherence to treatment? Is the patient currently in treatment?

Substance use — Ask about current and past substance use, both legal (e.g., ETOH, tobacco, prescriptions, marijuana in some states) and illicit. When did use begin? At what age? When asking about alcohol use, it helps to *assume* drinking by asking *How much alcohol do you drink?* This eliminates a simple yes/no answer while still allowing the patient to deny. Ask about frequency and nature of substance use (e.g., *how many*

drinks do you have in a typical day—typical week? how many days a week do you drink? what types of alcohol do you prefer?). Inquire about past difficulties arising from substance use: family/marital discord, employment problems, and financial/legal problems (*have you ever been or has anyone else ever been concerned about your substance use*?). Does the patient have any history of formal treatment (i.e., detoxification, inpatient rehabilitation, response to these)? Results of formal substance abuse screening tools can be included here.

Family medical/psychiatric history—Document family members with history of chronic illness or treated or untreated mental disorders and/or substance abuse.

Social history—Report evidence of developmental delays (*Do you know of any problems with your mom's pregnancy with you? Did she ever say that there were complications? Did you walk and talk on time?* Is there history of abuse (e.g., emotional, physical, or sexual)? Document educational achievement, history of grade retention, or academic remediation (i.e., *special classes*). What is the patient's work history? Is the patient married/divorced/widowed/in a committed relationship? Number of children?

Current status:

Living environment—Type of dwelling (single-family house/mobile home/apartment), how many other residents?

Activities of daily living—Can the patient attend to basic tasks (e.g., feeding, bathing, dressing) independently? Instrumental tasks (e.g., cooking, cleaning, basic financial transactions)? In the acute medical setting, assistance is likely. Note the functional needs indicated by PT/OT documentation (i.e., contact guard, level of supervision, modified independence).

Mood status:

What is the patient's described mood? *Over the past couple of weeks including today, in a word or a phrase, how would you describe your mood? How have you been feeling?*

Sadness/anxiety: *Have you been feeling sad lately….anxious, tense, or nervous? How would you describe it (mild/moderate/severe)?*

Suicidal ideation: *Are you having any thoughts of hurting yourself? Do you want to hurt yourself? Do you have a plan?* Be sure to distinguish between passive thoughts of death (i.e., "I just want this pain to end") and active suicidal thoughts. *In the past, have you had thoughts of hurting yourself? When, what, why? Any attempts? What kept you from doing it?* If suicide is a concern, formal screening tools are available. It is imperative to document evidence of suicidality, assess intent, and take appropriate steps to ensure safety.

Energy, Interest, and Participation—What do you enjoy doing? (Assessing for loss of interest and/or anhedonia) *Are you doing more or less than you did before? What's keeping you from doing things?* Are limitations due to physical/environmental barriers or emotional factors?

Sleep quality—Are there changes in sleep quality such as insomnia, hypersomnia, or fragmented sleep? Does the patient have difficulty going to sleep, staying asleep, or both? Is the patient having nightmares? Is there evidence of a REM behavior disorder such as acting out dreams or waking in a different place than where they went to sleep? Does the patient use medication sleep aids? Does the patient use a breathing device (e.g., C-PAP)?

Appetite—Are there any changes in the patient's hunger? (Increased appetite, cravings, decreased appetite, or binge eating) Has there been unusual weight gain or weight loss? (How much and over what period of time?)

Strengths/assets—*What keeps you going? What things are important to you?* Inform providers about the person's values facilitating resilience as well as indications of patient's goals of care.

Behavioral observations and mental status:

This section provides the reader with the *context* in which clinical information was

gathered and includes information about the patient's general presentation and emotional and cognitive status. This section should include only findings present and observable at the time of the interview. Behavioral observations and the mental status examination, in combination with historical data, form the basis for formulating a diagnosis and treatment plan. The format matters less than completeness and organization.

Who?—Note who was present during the evaluation. Include family members and staff. Include a statement about whether or not collateral information was provided by others (i.e., participation).

Appearance—Gender, race, does the patient look their stated age? Grooming and personal hygiene (e.g., disheveled, unkempt, adequate, well groomed), dress (e.g., casual vs. hospital attire), any distinguishing features of note (e.g., tattoos, piercings, wounds/scars, bandages, etc.), and build and stature (e.g., average, tall, short, large, thin).

Motor—Evidence of gross or fine motor impairment? Is there evidence of lateralized deficit (e.g., unilateral/bilateral, worse on one side)? Does the patient utilize any assistive devices (e.g., cane, wheelchair, walker, hands-free device)? Note the patient's gait (unsteady, normal, shuffled, altered, short, long). If gait is not observed, state this.

Sensorium—Describe the patient's basic vision and hearing. Is there evidence that these are decreased or altered? Does the patient report problems? Do they squint or frequently ask for information to be repeated or for the speaker to increase volume? Does the patient wear eyeglasses (if so, always, only for reading)? Does the patient have hearing aids (do they wear them)?

Speech—Describe speech rate, volume, and prosody. Is there evidence of slowness? Is articulation intact or poor (i.e., do you have difficulty understanding them)? Slurring? Does the patient speak with an accent? Is volume normal, loud, or soft? Prosody—does the speech follow a normal cadence (e.g., rhythm, tone, pitch, stress, intonation)?

Thinking and perception:

Orientation—Is the patient aware of person, time, and place? Often this is noted as "Ox3" which stands for "oriented in three spheres." You can also include whether or not the patient is aware of the situation (e.g., treatment, injury, timeline of events) or "oriented in four spheres (Ox4)."

Thought process—Are the patient's thoughts linear, logical, and goal directed? Is there evidence of tangential thought, circumstantial speech, or circumlocution? If impaired, can you redirect the patient to the task at hand?

Thought content and language—Expressive—Is the patient's speech fluent? Is there evidence of word-finding difficulty, halting, or hesitations? Does the patient exhibit paraphasia (i.e., *phonemic*, "shammer" vs. "hammer"; *semantic*, "hammer" vs. "wrench")? Receptive—Is the patient's basic comprehension intact? Is there evidence of incoherence, neologisms, automatisms, "word salad"? Positive psychiatric symptoms (e.g., paranoia, hallucinations, delusions)?

Judgment and insight—Does the patient demonstrate understanding and appreciation of his or her condition/situation? Can they express a logical/appropriate course of action if given a scenario with attention to important details: (i.e., *what would you do if you saw smoke coming from the window of your neighbor's house*)?

Memory—Basic recall of recent and remote events. Is there evidence of rapid forgetting within the interview? Is the patient a reliable historian? Does patient report match medical records?

Formal cognitive screening tools are helpful in assessing key cognitive domains.

Affect—Include a statement about the observed affect, notably whether or not behavior is congruent with the described

mood. Common descriptors include *blunted, flat, indifferent, normal, expansive, agitated, reserved, pleasant, nervous, anxious, exasperated, happy, and tearful*.

Pain behaviors—Note any observation of pain behavior such as wincing, shifting, or vocalizations. If pain appears to be a significant contributing factor, consider utilizing pain-reporting scales.

Summary and impressions

This section provides the rationale for diagnosis and treatment by combining information from the patient's history as well as observations of behavior and mental status. The goal is not to reiterate the information already provided but instead to highlight the salient points that lead the clinician to arrive at a diagnostic conceptualization and strategies to address symptoms. This section can be brief but should include a clear rationale for diagnosis and future intervention.

Diagnosis

Documentation should include a clear diagnosis. Depending on the institution, this may be done using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) [3], *International Classification of Diseases, Tenth Revision* (ICD-10) [4], or the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) [5]. The multiaxial system used in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) [6] has been replaced with a non-axial system in the DSM-5. The former Axis I, II, and III diagnoses have been combined with separate notations for "important psychosocial and contextual factors" (formerly Axis IV) and qualifiers for severity, duration, and type to clearly identify the most appropriate diagnosis. DSM-5 also dropped the Global Assessment of Functioning (GAF) scale; however, the World Health Organization Disability Assessment Schedule (WHODAS) is referenced as a measure to help note level of disability important to treatment. The WHODAS is based on the International Classification of Functioning, Disability and Health for use across health-care domains. While the psychiatric diagnostic interview is used to identify mental health disorders, formal notation of disability status is a key area of focus in rehabilitation populations. Note—the diagnosis in an H&B assessment would be the primary medical diagnosis.

Treatment plan/recommendations

This portion of the interview note is of greatest interest to the team and potentially has the greatest impact on patient care. It is not an afterthought, rather the treatment plan/recommendations section is the culmination of the information-gathering process. An effective section provides detailed recommendations in response to the referral question, guidance to treatment team members in their care of the patient, and a description of actions the psychologist is going to take following the report.

C. ***Components of a progress note***

Documentation can take many formats (e.g., S.O.A.P, D.A.P). Irrespective of the format, documentation should include these key elements:

Date and time of documentation: When the patient encounter occurred.

Data: Subjective—How does the patient describe their problem or progress? Quote the patient directly and use their own words. Quotes should accurately capture the essence or theme of the session. Example: *I think I'm struggling…not sure what to do.* Objective: What are *your* observations of the patient's behavior/mood/status? Document what services were provided to the patient, and provide time documentation for billing. These are written as statements of fact. Example: *Provided 60 min of H&B intervention. Patient appeared initially indifferent but was later tearful and more engaged. Discussed alternative coping strategies and practiced relaxation techniques.*

Assessment: What is your impression of the patient's status? What progress has been made toward treatment goals? This section should include any serial objective assessment results

(e.g., pain scales, mood screeners). Example: *Patient's subjective pain appraisal is increased as measured by objective screener. It will require continued monitoring and reinforcement of alternative strategies to opioid use.*

Plan: How will you support the patient in pursuing their established goals? Do goals need to be changed/altered? What recommendations do you have for other clinicians? Include any intent to contact or communicate with family or staff. Provide any updated information regarding timeline of treatment. Example: *(1) Continued work toward treatment plan goal of decrease in subjective pain levels by two points. (2) Patient will attempt to use thought stopping when negative thinking takes hold. (3) Patients will contact PT regarding potential co-treatment. (4) Next session scheduled for tomorrow.*

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