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Documentation recommendations and requirements for Licensed School Health Staff Working in a School Setting

Oregon Department of Education Statement on Documentation of Health Services:

Documentation is critical for a number of reasons:

- Complete and descriptive documentation of related service delivery substantiates compliance with each student's Individual Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and provides evidentiary support in response to due process complaints and state dispute resolution processes.
- School district staff must document related services aligned to their individual license as identified within their licensing board's standards.
- Documentation supports quality school-based health services required for the student to access general education curriculum and extracurricular activities.
- Documentation supports high quality health service delivery and may mitigate risk and liability to individual staff or the district.

Oregon Health Authority Medicaid Documentation Oregon Administrative Rule:

Oregon State Medicaid Documentation Requirements. (OAR 410-133-0320)
(1) Record keeping must conform and adhere to federal, state, and local laws and regulations.
(2) Records must record history taken, procedures performed, tests administered, results obtained, and conclusions and recommendations made. Documentation may be in the form of a "SOAP" (subjective objective assessment plan) note, or equivalent.
(3) Providers will retain information necessary to support claims submitted to the Authority including: documentation and supervision of the specific health services provided, the extent of the health service provided, the dates and the name and credentials of medically qualified staff who provided the service to the Medicaid-eligible student for seven years from date of payment. This documentation must meet the requirements of and must be made available pursuant to the requirements in the General Rules, OAR 410-120-1360 Requirements for Financial, Clinical and Other Records. These requirements may be met if the information is included in the IEP or IFSP and the school medical provider maintains adequate supporting documentation at the time the service is rendered, consistent with the requirements of OAR 410-120-1360:
(a) Supporting documentation should:
(A) Be accurate, complete, and legible;
(B) Be typed or recorded using ink;
(C) Be signed by the individual performing the service including their credentials or position;
(D) Be signed and initialed in accordance with licensing board requirements for each clinical entry by the individual performing the service;

(E) Be reviewed and authenticated by the supervising therapist in compliance with their licensing board requirements (Also see covered services 410-133-0080 and not covered services 410-133-0200.);
(F) Be for covered health services provided as specified for the service period indicated on the Medicaid-eligible student's current IEP or IFSP.
(b) Corrections to entries must be recorded by:
(A) Striking out the entry with a single line that does not obliterate the original entry or amend the electronic record preserving the original entry; and
(B) Dating and initialing the correction. School-Based Health Services Rules
(c) Late entries or additions to entries shall be documented when the omission is discovered with the following written at the beginning of the entry: "late entry for (date)" or "addendum for (date)."
(4) Supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's IEP or IFSP must be kept for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals and must include:
(a) A copy of the Medicaid-eligible student's IEP or IFSP as well as any addendum to the plan that correlates with the covered health services provided and reimbursed by Medicaid;
(b) A notation of the diagnosis or condition being treated or evaluated, using specific medical or mental health diagnostic codes;
(c) Results of analysis of any mental health or medical analysis, testing, evaluations, or assessments for which reimbursement is requested;
(d) Documentation of the location, duration, and extent of each health service provided, by the date of service, signed and initialed by medically qualified staff in accordance with their licensing board requirements (electronic records can be printed);
(e) The record of who performed the service and their credentials or position;
(f) The medical recommendation to support the service;
(g) Periodic evaluation of therapeutic value and progress of the Medicaid-eligible student to whom a health service is being provided;
(h) Record of medical need for necessary and appropriate transportation to a covered health service is supported by a transportation vehicle trip log including specific date transported, client name, ID number, and point of origin and destination consistent with transportation services specified in the child's IEP or IFSP as part of record-keeping requirements; and
(i) Attendance records for Medicaid-eligible students to support dates for covered services billed to Medicaid;
(j) In supervisory situations, the record documenting therapy provided must name both the assistant providing services and the supervising therapist including credentials. The licensed health care practitioner who supervises and monitors the assessment, care, or treatment rendered by licensed or certified therapy assistants shall meet the minimum standards required by their licensing board and shall co-sign for those services where appropriate with their name and professional titles (documentation may not be delegated except in emergency situations).

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Oregon Licensing Board Requirements

	Speech-Language Pathology and Audiology	Occupational Therapy	Physical Therapy	Nursing
General	**Philosophy (OAR 335-010-0050)** Speech-language pathology and audiology professionals in all positions and settings are responsible for maintaining ongoing and complete documentation of the clinical services they provide.		**General Standards for Record keeping (848-040-0110)** (1) The licensee who performs the physical therapy service shall prepare a complete and accurate record for every patient, regardless of whether compensation is given or received for the therapy services and regardless of whether the patient receives treatment pursuant to a referral or is self-referred.	**Scope of Practice Standards for All Licensed Nurses (851-045-0040)** (4) Standards related to the licensee's responsibility for documentation of nursing practice. The licensee shall document nursing practice in a timely, accurate, thorough, and clear manner
Requirements for Record Keeping and Documentation	**General Requirements for Record Keeping and Documentation (335-010-0070)** (1) Record keeping must conform and adhere to Federal, state, and local laws and regulations. (2) Records must record history taken; procedures performed and tests administered; results obtained; conclusions and recommendations made. Documentation may be in the form of a "SOAP" (Subjective Objective Assessment Plan) note, or equivalent. (3) Records and documentation must:	**Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs Regulated by Federal Laws (339-010-0050)** (4) Documentation: (a) The occupational therapy practitioner must document evaluation, goals, interventions and outcomes if they are not included in the service plan. (b) Documentation should reflect the child's current status, progress towards goals, response to interventions, and	**General Standards for Record keeping (848-040-0110)** (2) A record shall be prepared on the date a physical therapy service is provided. (3) The permanent record shall contain information for every physical therapy service provided, the date the service was provided and the date the entry was made in the record. The permanent record of a physical therapy service shall be prepared within seven calendar days of the date the service was provided.	*The Nurse Practice Act does not specify documentation requirements other than above, but here is the list of 'conduct derogatory' related items:* **Conduct Derogatory to the Standards of Nursing Defined (851-045-0070)** (4) Conduct related to communication: (a) Failure to accurately document nursing interventions and nursing practice implementation; (b) Failure to document nursing interventions and nursing practice implementation in a timely, accurate, thorough, and clear manner. This includes failing to document a late entry within a reasonable time period;

	(a) Be accurate, complete, and legible; (b) Be printed, typed or written in ink; (c) Include the documentor's name and professional titles; (d) Stamped identification must be accompanied by initial or signature written in ink. (4) Corrections to entries must be recorded by: (a) Crossing out the entry with a single line which does not obliterate the original entry, or amending the electronic record in a way that preserves the original entry; and (b) Dating and initialing the correction. (5) Documentation of clinical activities may be supplemented by the use of flowsheets or checklists, however, these do not substitute for or replace detailed documentation of assessments and interventions.	strategies that were promising or ineffective. (c) The occupational therapist should utilize a method of data collection that allows for concise and accurate recording of intervention and progress. (d) The occupational therapy practitioner is responsible for the analysis of data collected to verify progress and the documentation of their own activities to accomplish the goals.	**Standards For The Documentation of Treatment Provided (848-040-1050)** (1) Except as provided in subsection (5) of OAR 848-040-0125, the record of treatment for each patient visit shall include at a minimum: (a) Subjective status of patient; (b) Specific treatments, information, and education provided; (c) Objective data from tests and measurements conducted; (d) Assessment of the patient's response to treatment, including but not limited to: (A) Patient status, progression or regression; (B) Changes in objective and measurable findings as they relate to existing goals; and (C) Adverse reactions to treatment. (e) Changes in the plan of care.	(c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to: (A) Documenting nursing practice implementation that did not occur; (B) Documenting the provision of services that were not provided; (C) Failing to document information pertinent to a client's care; (D) Documenting someone else's charting omissions or signing someone else's name; (E) Falsifying data; (F) Altering or changing words or characters within an existing document to mislead the reader; or (G) Entering late entry documentation into the record that does not demonstrate the date and time of the initial event documented, the date and time the late entry is being placed into the record, and the signature of the licensee entering the late entry to the record. (d) Destroying a client or agency record to conceal a record of care; (e) Directing another individual to falsify, alter or destroy an agency record, a client's health record, or any document to conceal a record of care; (f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care; or (g) Failing to communicate information regarding the client's status to other individuals who are

				authorized to receive information and have a need to know.
Plan of Care		**Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs Regulated by Federal Laws (339-010-0050)** (1)(b) "Service plans" document the program of services and supports necessary to meet a child's developmental or educational needs under the IDEA. These specify the need for occupational therapy services and include: the individualized family services plan (IFSP) for infants, toddlers and preschoolers; the individualized education plan (IEP) or a Section 504 Plan for school-age youth.	**Standards for the Plan of Care (848-040-0135)** (1) Prior to initiation of treatment, a physical therapy plan of care for the patient shall be determined by a physical therapist. As appropriate, a plan of care may include the IFSP, or, in a school setting, a plan of care may include the IEP for a student, or other designated plan of care. **Standards For The Documentation Of The Plan Of Care (848-040-0140)** (1) The permanent record of the plan of care shall include: (a) Objectively measurable treatment goals that incorporate the patient's goals; (b) Proposed treatment to accomplish the goals; and (c) Proposed frequency and duration of treatment or number of visits. (2) The permanent record of the plan of care shall be authenticated and dated by the physical therapist who developed the plan.	**Definitions (851-045-0035)** (23) "Plan of Care" means the comprehensive outline authored by the RN that communicates the client's identified problems or risks, identifies measurable client outcomes, and identifies nursing interventions chosen to mitigate the identified problems or risks. **Scope of Practice Standards for Registered Nurses (851-045-0060)** (3) Standards related to the RN's responsibility for nursing practice. Through the application of scientific evidence, practice experience, and nursing judgment, the RN shall: (a) Conduct comprehensive assessments by: (b) Develop reasoned conclusions that identify client problems or risks; (c) Develop a client-centered plan of care based on analysis of the client's problems or risks that: (A) Establishes priorities in the plan of care; (B) Identifies measurable outcomes; and (C) Includes nursing interventions to address prioritized diagnostic statements or reasoned conclusions. (d) Implement the plan of care; (e) Evaluate client responses to nursing interventions and progress toward identified outcomes; and (f) Update and modify the plan of care based on ongoing client assessment and evaluation of data.