

# Patient Case Management and Progress Notes

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## Case Management

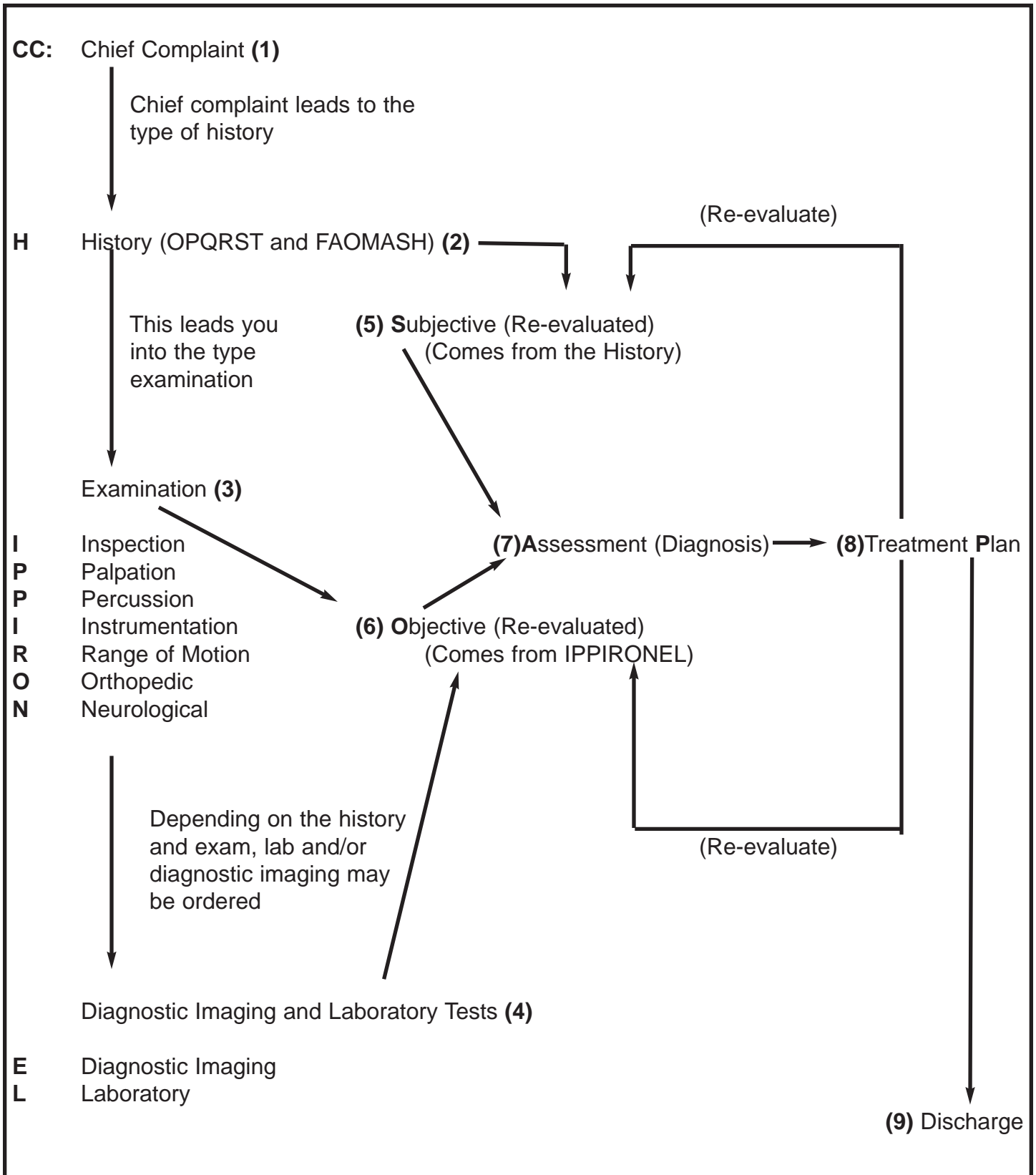
The sequence of events with the patient encounter is outlined in Chart 1: Clinical Case Management below. **(1)** The chief complaint leads to the history. **(2)** The history leads to the type of **(3)** examination. The history and examination may indicate any **(4)** diagnostic imaging and/or laboratory tests.

In the progress notes, the **(5)** subjective section comes from the history. The **(6)** objective section is derived from the **(3)** examination and **(4)** diagnostic imaging and laboratory tests.

The **(5)** subjective and **(6)** objective combine to give the **(7)** assessment (diagnosis). The assessment leads to the **(8)** treatment plan.

Each visit, the **(5)** subjectives and **(6)** objectives are re-evaluated. As each resolves or changes, the **(7)** assessment (diagnosis) may change. As the **(8)** treatment plan progresses, when the **(5)** subjectives and **(6)** objectives resolve or when they reach maximum medical improvement, the patient is **(9)** discharged from care.

# CHART 1: Clinical Case Management



The importance of a thorough history and examination cannot be emphasized enough. The history, examination and any laboratory / diagnostic imaging provide a base-line for the patient's condition. From this information, the patient's response or progress to care is evaluated, and clinical decisions are made based on this data.

There are three case management choices to be made with any condition: 1) Treat and manage the condition exclusively under your care; 2) Co-treat with other health providers, with you providing the type of care you are comfortable with; or 3) Refer out to another provider.

When the patient is under your care, monitoring the changes in the subjectives, objectives, and laboratory / diagnostic imaging is critical in case management. The patient's condition will do one of three things: 1) Improve to a preinjury status or a level of maximum medical improvement; 2) Exhibit no change in the subjectives, objectives and/or laboratory / diagnostic imaging regardless of what changes you make in the treatment methods; or 3) Become worse.

When the condition

- 1) **reaches a pre-injury status or maximum medical improvement**  
This is the situation when nothing you or anyone else can offer the patient to improve the condition past the current point. This is the time for termination of care with or without home instructions.
- 2) **shows no change**, regardless of the treatment methods, your choice is
  - A. send the patient to some other provider who can assist the patient,
  - B. look further diagnostically, given there may be another cause for this condition or
  - C. if there are no other treatment options with you or others and there are no other indications of another pathological or life threatening condition, the patient is discharged from care with home instructions.
- 3) **becomes worse, you**
  - A. re-evaluate to determine why it has become worse and change the treatment approach or
  - B. consult with a specialist to give guidance to the care you are providing or
  - C. refer the patient to another healthcare provider who can better treat and manage the condition.

These are the choices you will be making based on the changes to the history, physical examination and laboratory / diagnostic images. This is why excellent history and physical exam skills are essential – to monitor the outcome measures of the care you are providing to the patient.

## Patient Progress Notes and Documentation

Monitoring the patient progress from visit to visit is usually documented using a SOAP note format. There are other ways to monitor and document the progress from visit to visit, but the SOAP note format is most commonly used in healthcare. The S stands for Subjective, O for Objective, A for Assessment and P for the treatment Plan. This was originally developed to organize the medical records in a problem-oriented medical record (POMR).

**The purpose of documentation has several purposes. These include:**

1. Serving as a record of what the healthcare provider does to manage the individual patient's case. The rights of the health provider and patient are protected should there be any question regarding the care provided to the patient. SOAP notes are considered legal documents, as are all parts of the medical record.
2. Providing a method for healthcare providers to communicate with one another.
3. Influencing third party payers in their decisions about reimbursement, which is often made based on therapy notes. The quality and completeness of the notes can affect the notes' influence on the decisions.
4. Allowing the healthcare provider to organize the thought process involved in patient care.
5. Serving as documents for quality assurance and improvement purposes.
6. SOAP notes can be used in research.

**When keeping progress notes:**

1. List each problem separately; (ie. neck pain, congestive heart failure, endometriosis).
2. Give each problem a number.
3. Keep the numbering sequence through the course of care to completion.
4. When the problem has resolved, indicate it is resolved in the notes and delete it from the daily progress notes.
5. Evaluate and monitor each problem using the SOAP note format.

## Abbreviations

Using abbreviations saves time and space while writing the SOAP notes. When working in a healthcare facility, obtain a list of approved abbreviations so all are communicating the same concepts. See Appendix A (Abbreviations and Symbols for SOAP Notes) for a list of commonly-used abbreviations

### Subjective:

Note how the patient feels, listing any complaints. This section is what the patient tells you about the chief complaint. Include the highlights of the patient's history (OPQRST and FAOMASH). Note how the condition began, including the onset, frequency, intensity and duration of the symptoms. What makes the chief complaint better or worse? Describe the quality or description of the pain. Does the pain move, travel or radiate? If so, describe where the pain begins and ends and how often it occurs and its duration when present. Is there a difference in the condition with change in location? For example: work vs. home vs. athletic field, outside vs. inside, in the car, etc. Does the condition change with the time of day? Compare the most current subjective in each area to the previous visit or first.

### Objective:

This is what is observed by you, the healthcare provider. Document the highlights of the inspection, palpation, percussion, instrumentation, range of motion, orthopedic tests, neurological tests, laboratory, diagnostic imaging, etc. These are the only documents in the progress notes that are positive.

### Assessment:

Based on the above, develop your assessment for each complaint. This is your diagnosis or assessment of the condition you are treating. This includes the working diagnosis and the differential diagnosis, also known as other possible diagnosis. The differential diagnosis is the possible causes and contributing factors for the problem or symptom. The assessment may change as the results of the laboratory testing and diagnostic imaging arrive. Based on the data at hand, a diagnosis is your best assessment of the condition.

### Plan:

The plan is divided into three sections: diagnostics, therapeutics, and patient education. Based on the assessment, a treatment plan for one or all of these areas is designed and documented. List the diagnostic tests to be performed or ordered. Describe the therapeutic treatment plan and therapies used; provide a list of referrals and to whom. List any health education provided or planned. Give a picture of what the future treatment plan may be.

Examples Using Abbreviations	Translation
In the doctor's note, you find the following: Pt. has hx of Htn, ASHD, CHF, MI in 1993, TIA in 1994.	The patient has a history of hypertension, arteriosclerotic heart disease, congestive heart failure, myocardial infarction in 1993, transient ischemic attack in 1994.
In chart of doctor's initial note: Imp: COPD; R/O lung CA	Impression: Chronic obstructive pulmonary disease; rule out lung cancer.
In the PT note: Rx: AROM ® ankle bid	Treatment: Active range of motion right ankle twice per day.

# Appendix A: Abbreviations and Symbols for SOAP

A:	assessment	DC	doctor of chiropractic
AAROM	active assistive range of motion	D/C	discontinue or discharged
abd	abduction	DM	diabetes mellitus
ac	before meals	DO	doctor of osteopathy
AC joints	acromioclavicular joints	DTR	deep tendon reflex
ACTH	adrenocorticotrophic hormone	Dx	diagnosis
add	adduction		
ADL	activities of daily living	ECG, EKG	electrocardiogram
adm	admission	EEG	electroencephalogram
AE	above elbow	EENT	ears, eyes, nose, throat
AFO	ankle foot orthosis	E.G.	electromyogram, electromyography
AIDS	autoimmune deficiency syndrome	E.R.	emergency room
AIIS	anterior inferior iliac spine	eval.	evaluation
AK	above knee	ext.	extension
a.m.	morning		
AMA	against medical advice	F	fair (muscle strength, balance)
amb	ambulation, ambulating, ambulated, ambulate, ambulates	FBS	fasting blood sugar
		FH	family history
ant	anterior	flex	flexion
AP	anterior-posterior	ft.	Foot, feet (the measurement, not the body part)
AROM	active range of motion		
ASA	aspirin	FUO	fever of unknown origin
ASAP	as soon as possible	FWB	full weight bearing
ASHD	arteriosclerotic heart disease	fx	fracture
ASIS	anterior superior iliac spine		
assist.	assistance, assistive	G	good (muscle strength, balance)
		GB	gallbladder
BE	below elbow	GI	gastrointestinal
bid	twice a day	gm	gram
bilat.	bilateral	GYN	gynecology
BK	below knee		
BM	bowel movement	h, hr.	hour
BP	blood pressure	H&P	history and physical
bpm	beats per minute	HA, H/A	headache
BUN	blood urea nitrogen (blood test)	Hb, Hgb	hemoglobin
		HCVD	hypertensive cardiovascular disease
C	Centigrade	HEENT	head, ear, eyes, nose, throat
Ⓒ	cancer, carcinoma	HI	head injury
cal	calories	HIV	human immunodeficiency virus
CBC	complete blood count	HNP	herniated nucleus pulposus
CC, C/C	chief complaint	HR	heart rate
cc	cubic centimeter	hr.	hour
CHF	congestive heart failure	hs	at bed time
cm	centimeter	ht.	height
CNS	central nervous system	Ht	hematocrit
c/o	complains of	Htn	hypertension
CO2	carbon dioxide	Hx	history
COLD	chronic obstructive lung disease		
cont.	Continue	I&O	intake and output
COPD	chronic obstructive pulmonary disease	ICU	intensive care unit
CP	cerebral palsy	IM	intramuscular
CPR	cardiopulmonary resuscitation	imp.	impression
CSF	cerebral spinal fluid	in.	inches
CV	cardiovascular	indep	independent
CVA	cerebrovascular accident	inf	inferior
		IV	intravenous
dept.	department		
DIP	distal interphalangeal joint		

kcal	kilocalories	pos.	positive
kg	kilogram	poss	possible
KJ	knee jerk	post	posterior
KUP	kidney, ureter, bladder	post-op	after surgery (operation)
L, l.	liter	PRE	progressive resistive exercise
(L)	left	pre-op	after surgery (operation)
lb.	pound	prn	whenever necessary
LBP	low back pain	PROM	passive range of motion
LE	lower extremity	PSIS	posterior superior iliac spine
LOC	loss of consciousness	PT	physical therapy, physical therapist (when used after therapist's signature)
m	meter	PT/PTT	protime/prothrombine time
max	maximal	Pt., pt.	Patient
MD	medical doctor	PTA	physical therapist assistant
Meds.	medications	PVD	peripheral vascular disease
MFT	muscle function test	q	every
mg	milligram	qd	every day
MI	myocardial infarction	qh	every hour
min	minimal	qid	four times a day
min.	minutes	qn	every night
ml	milliliter	qt.	quart
mm	millimeter		
MMT	manual muscle test	®	right
mo.	month	RA	rheumatoid arthritis
mod	moderate	RBC	red blood cell count
MP, MCP	metacarpalphalangeal	R.D.	registered dietician
MS	multiple sclerosis	re:	regarding
N	normal (muscle strength)	rehab	rehabilitation
neg.	negative	reps	repetitions
noc	night, at night	resp	respiratory, respiration
npo	nothing by mouth	RN	registered nurse
NSR	normal sinus rhythm	R/O	rule out (in order to make a good diagnosis, the physician will try to rule the disease condition named out; if he or she cannot this will become the diagnosis)
NWB	non-weight bearing		
O:	objective	ROM	range of motion
OB	obstetrics	ROS	review of systems
od	once daily	RRROM	resisted range of motion
O.P.	out patient	T.T.	Respirator therapist, respiratory therapy
O.R.	operating room	Rx	treatment, prescription, therapy
TO	occupational therapist		
oz.	ounce	SCI	spinal cord injury
P	Poor (muscle strength, balance)	SC joint	sernoclavicular joint
P:	plan (treatment plan)	sec.	seconds
P.A.	physician's assistant	SI(J)	sacroiliac (joint)
PA	posterior/anterior	SLE	systemic lupus erthematosus
pc	after meals	SLR	straight leg raise
per	by/through	SOAP	subjective, objective, assessment, plan
per os, p.o.	by mouth	SOB	shortness of breath
PERRLA	pupils, equal, round, reactive to light and accommodation	S/P	status post
P.H.	Past history	spec	specimen
Pre Hx	Previous history	stat.	immediately, at once
p.m.	afternoon	Sx	symptoms
PNF	proprioceptive neuromuscular facilitation	T	trace (muscle strength)
PNI	peripheral nerve injury	tab	tablet
POMR	problem-oriented medical record	TB	tuberculosis
		tblsp.	tablespoon

TENS, TNS	transcutaneous electrical nerve stimulator	+	plus, positive (positive is also abbreviated pos.)
TIA	transient ischemic attack	-	minus, negative (negative also abbreviated neg.)
tid	three times daily		
TKR	total knee replacement		
TM(J)	temporomandibular (joint)	#	number (#1 = number 1), pounds (5# wt. = 5 pound weight; also abbreviated lbs.)
TNR	tonic neck reflex		
t.o.	telephone order	/	per
TPR	temperature, pulse & respiration	%	percent
tsp.	teaspoon	+, &	and
TUR	transurethral resection	↔	to and from
		→	to, progressing toward, approaching
UA	urine analysis	1'	primary
UE	upper extremity	2'	secondary
UMN	upper motor neuron		
URI	upper respiratory infection		
US	ultrasound		
UTI	urinary tract infection		
UV	ultraviolet		
VD	venereal disease		
v.o.	verbal orders (example: v.o. Dr. Smoth/your signature)		
vol.	volume		
v.s.	vital signs		
w/c	wheelchair		
W/cm2	watts per square centimeter		
WBC	white blood cell count		
wk.	Week		
WNL	within normal limits		
wt.	weight		
x	number of times performed (x2 = twice; x3=3 times)		
y/o or y.o.	years old		
yd.	yard		
Yr.	year		
+1 +2	assistance (assistance of 1 person given)		
♂	male		
♀	female		
↓	down, downward, decrease, diminished		
↑	up, upward, increase, augmented		
//	parallel or parallel bars		
̄	with		
̄	without		
̄	after		
̄	before		
~	approximately		
@	at		
	change		
>	greater than		
<	less than		
=	equals		