Clinical Operations Policy 604

Reporting of Clinical Information and Progress

Effective Date: August 18, 2022
Supersedes Date: August 19, 2012
Review Date: May 2028

Policy: Clinical services are documented electronically and reported verbally to the client/guardian.

Procedure:

I. Reporting
   a. Evaluation Report
      i. All reports are to be completed in the EMR system or if completed outside of the EMR system, scanned into the EMR.
      ii. The student will complete speech/language reports within 3 to 5 working days (depending on the type of report and supervisor instruction) and audiology reports within 24 hours.
      iii. For audiology students, the first version of the electronic report is reviewed by the supervising faculty member. Acceptability is based on timeliness and extent of revision required. The faculty member will make the necessary revisions and may forward the revised report to the student as feedback. If the report is poorly written and the faculty member's revision is exhaustive, the faculty member can request a full re- write of the report with guidelines for improvement. A poorly written report may be reflected in the student's clinic grade.
      iv. For speech-language pathology (SLP) reports, a template is used for the heading and format for the report. If the report is poorly written and the faculty member's revision is exhaustive, the faculty member can request a full re- write of the report with guidelines for improvement. Grading consequences for a poorly written report will apply on subsequent submissions.
      v. Speech-language test forms should be kept in the master file located in the file room.
      vi. After the responsible faculty member reviews and evaluates reports, they may notify the student that the report requires corrections and edits. The student has one day to make corrections. The faculty member is responsible for reviewing, signing, and sending it to the patient and relevant partners in care.

vii. The office associate may mail the report to the patient and relevant partners in care along with individuals or agencies listed on the release of information form when requested by the supervising clinician. Reports must be mailed within 48 hours of report completion. Reports can also be sent electronically via the patient portal or fax.
viii. The office associate ensures that the master files' contents are in the appropriate order (see Policy 605) and returned to the designated location. The master file is filed in the file room by business office personnel or a graduate assistant.

b. Clinical Summary Report
    i. Reports will be completed at the supervising faculty member's discretion every semester, depending on the requirements of the pay source.
    ii. The report format templates are on the shared clinic drive.
    iii. The final summary report will be added to IMS, and a copy will be sent to the patient and relevant partners in care. The master file will be placed in the file room.
c. Annual Re-Evaluation Report for Clients in Treatment/Instruction
    i. After one year of service, clients may be re-evaluated by the current supervisor and student seeing the client that semester. An annual report will be written to summarize services provided, results of testing, progress made, and subsequent recommendations.
d. Discharge Summary Report
    i. The discharge summary report is a complete summary of service, the progress gained in treatment and instruction, results of final testing, and recommendation at discharge.
e. Progress/SOAP Notes
    i. Progress notes or SOAP notes will be recorded in the electronic medical record.
f. Verbal Reporting
g. Evaluation Reporting
    i. Results of the evaluation will be presented and explained to the client/guardian at the conclusion of the evaluation unless the client was referred by the DDS.
    ii. The student and supervising faculty member may choose to plan the delivery of the results before they meet with the client/parent.
h. Formal Client/Family/Parent Conferences in Treatment
    i. The student and supervising faculty member will discuss treatment objectives, procedures, and discharge criterion with the client/family at the beginning of the service period.
    ii. The student and supervising faculty member will discuss the results of the treatment objectives, post-therapy testing results, and subsequent recommendations with the client/family at the end of the service period/discharge.
    iii. Additional conferences may be scheduled if necessary.
    iv. The supervising faculty member must be present during all client/family/parent conferences.
i. Informal Dissemination of Information

i. Following a session, the student clinician may briefly inform the parent/caregiver of how the client did in therapy that day, in accordance with HIPAA policy.
ii. If a parent/caregiver expresses specific concerns or requests more detail, the student will suggest that the caregiver schedule a conference with the supervising faculty member to address concerns or requests.