Dynamic Chiropractic

SOFTWARE / HARDWARE

S.O.A.P. Solution

Editorial Staff

Why do I use S.O.A.P. notes? Because it makes sense clinically, legally, ethically and financially. I have been in practice five years and realized some time ago that my record keeping is awful and that it needs to be cleaned up if I am to be more effective as a practitioner and as a business person. Am I alone out there? The answer is no. Acceptable record keeping is a fact of life for you, for the patient, for the insurance companies, and for the courts. Are we alone in this problem? Not by a long shot. Medical doctors are constantly in trouble with their respective hospitals and particularly with their peer review groups for poor record keeping and note-taking and the resulting non-payment by carriers that has resulted from this.

Medical Economics has had numerous articles regarding the poor note-taking habits on behalf of medical doctors and the subsequent rejection for reimbursement. Medical malpractice is another entire avenue of aggravation that I certainly don't have to elucidate on. Your own state education and professional associations can, will, and do come down with reprimands for inadequate record keeping. Do you need any more incentive? It makes sense again clinically, legally, ethically, and financially to maintain adequate records and S.O.A.P.s have been accepted as a standard in most of the health professions.

Clinically, you simply need documentation of what you are doing on a day-by-day basis. This is one of the most effective methods around. Please see Bedside Diagnostic Examination by Degowin and Degowin, 4th edition, page 29 for further explanation.

Legally, a week doesn't go by that I don't get a lawyer's request for all of my notes -- let alone insurance requests, other doctors' requests, and patient requests for the same information.

Ethically, it represents an effort on your part to do the best for your patient as their doctor (even the best as a representative of your profession).

Financially, you will get paid (probably) by the insurance company when they request all of this information. You won't get paid if you don't send it in, and it's got to be accurate. Also, you can charge for these notes -- occasionally to insurance companies and usually to lawyers in my experience. I have tried to find out what that charge should be, and in talking to insurance companies and lawyers they state that the fee for copying your notes should be approximately what an office charge for an adjustment is. In this office it is $30. And yes, you can charge for the procedure of copying notes, just as you charge for the procedure of copying x-rays. So again you can get paid to do this, and there is nothing wrong with that.

The key to the S.O.A.P. is coding what you do. This requires some work on your part to sit down and figure out what you do for the most part for your patients, ranging from what they are complaining about, through what you are actually doing. It sounds like an immense job, but it is not. I would like to remind you that the vast majority of medical doctors utilize approximately ten drugs of their arsenal

and there are thousands of them out there. The majority of them use just ten. How much do you need to remember? The task is not a voluminous one. It literally took me just a few hours to sit down and work it out. There is always room for modification and I have changed it two or three times to make it more accurate and more simple. For example on the S line for subjective, NP stands for neck pain, LBP stands for low back pain. I use up and down arrows extensively to determine if there is an increase or decrease; ADL, brought on by activities of daily living; or DOE, demands of employment; NKC, no known cause, straight forward information. It doesn't take up an awful lot of room. There is always room at the end of the line for comments if you wish to write it in longhand.

Objective, MS for example for muscle spasm, TP for trigger points, increase or decrease in ROM or range of motion. Again, all of this is coded very simply. I put REX in here for re-examination and circle it at the appropriate time and then go back to my re-exam sheet which can also be coded.

A for assessment. I usually have the diagnosis, DX, and I, U, R standing for improved, unimproved or regressed, and NI for new injury.

P for prognosis and plan, includes TX for treatment, and C, T, L for adjustments of the cervical, thoracic and lumbar spine. TM for therapeutic massage, HE for home exercise program, HI for home ice program, TPW for tolerates procedure well. For the actual progress itself I use numbers. Item #1 can state that the patient is improving and responding favorably to treatment. Item #2 means patient's situation has regressed as a result of, etc. G for guarded, RA for restricted activity, refer means refer to another health professional, and NC for non-complying patient. It is much more extensive that this, but I hope you get the idea.

I code the therapies in a similar fashion. Now I am sure this sounds like a tremendous amount, but the fact of the matter it isn't. This took a few hours for me to put together. I only regret that I didn't do it years ago because it would have saved me an awful lot of time, aggravation, and money. It certainly isn't difficult. If you can pass the national boards, you can remember your own codes. Implementation of this procedure is very simple. I am aware of the other techniques. I have tried them. This one just happens to work best for me and it fulfills what I need to get done. All of the actual note-taking is done after the patient shift in the morning and again, after the patient shift in the evening. It is done very simply by circling the codes and adding any needed comments. Yes, it is possible to remember what someone said just a few hours ago.

The next question is, how long does this take? Well, it certainly doesn't take 30 minutes. On the average, (and I have timed it) it takes me 30 seconds. When that request for my notes does come in, quite simply my dictaphonist takes my notes. I do dictate the history, examination, and the re-exams, although that can also be resolved, if you wish, by coding that. I just happen to do it that way. But my S.O.A.P. notes, which have been in the past very time consuming, are taken by the dictaphonist and she simply looks at the code; she doesn't have to listen to my croaking voice, and types up the required information on the computer and that spills out several copies for whomever wants it and for my records. She has found that coding the progress numbers and punching it out of the databank of the computer to be much speedier and effective, otherwise she knows the codes (she helped me develop this) and finds it easier to type it outright.

So you say you don't have a computer or dictaphonist. Then fine, just type it up. The fact of the matter is, it is still much faster and much more efficient than any other technique that I have ever used and it fulfills all the requirements. Granted, material may never be requested and most of it won't be. But it's

there. Therefore, when it is requested you can deliver it in a timely manner. The purists out there, I am sure, are saying you can't code it, it's too cookbook. The fact of the matter is, I have been using this for a while now and I have sent samples to lawyers and have sent required samples to insurance companies. I have been paid much faster and more effectively by insurance companies. My lawyer friends have read it and said that it is very accurate and very complete, and that they would be more than happy to take this kind of information into court. The fact that insurance companies are specifically requesting the S.O.A.P. format dictates the need for starting to utilize this procedure, let alone the clinical effectiveness of it.

There are some out there I am sure who state, "Well all I have to do is send in a code and a glossary of what the codes mean." Well that's okay, but that doesn't exactly represent a good impression of the profession. Just do your job. Remember you get a lot more with sugar than you do with spice. Also, for those of you who think that it is cookbook, have you ever heard of the ICD9 codes? Or the new Medicare code requirements? Do you get my drift? There is plenty of room for customizing it.

And now for you entrepreneurs out there with the wands and the wall-size charts, I have checked out your procedures an this one is much faster, much more accurate, and a lot cheaper. (Gee maybe I should be selling this?) The end result is I worry less about my notes and my reports, and I get everything out much quicker and in a much more efficient manner. So now, instead of complaining about this very effective method, why not "blow them away" and produce the best notes in the health profession? Just think about it, it works.

Author's name held by request.

JANUARY 1990