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TREATMENT Resource Manual

for

Speech-Language Pathology

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❐ CHAPTER 2 ❐

Information Reporting Systems and Techniques

PHILOSOPHY

The main purpose of clinical reports is to summarize and interpret information regarding a client's performance or status. In this chapter, the term "report" is used to refer to written records which may vary in length from multiple page documents to brief notations in client charts. A well-written document does more than report test scores and performance data. It provides an explanation of each data point and specifies its relation to a client's overall communication profile and needs. Numbers alone do not yield this interpretive information. Inferential statements always must be substantiated by supporting data. Adherence to this philosophy of clinical writing promotes clinician accountability by providing justification for the judgments and decisions that occur throughout the treatment process.

Accountability also requires that reports be written with ethical considerations in mind. Prognosis and recommendation statements, in particular, must be written carefully to ensure that they are not misleading or unrealistic. For example, consider the following prognostic statement for a 60-year-old male with moderate aphasia who suffered his stroke 10 years ago:

> Based on Mr. Hanks' high level of enthusiasm, the prognosis for improvement in therapy is good.

This statement is inappropriate for two important reasons. First, a client's degree of enthusiasm is not a reliable indicator of future success. Moreover, the amount of time that has elapsed since Mr. Hanks' stroke (a more meaningful indicator) would warrant a more guarded statement of prognosis. Ethical considerations also significantly influence the development of treatment recommendations. These statements must be based solely on client needs rather than on the type and frequency of service that a particular therapist or facility can provide.

TECHNICAL WRITING STYLE

Clinical reports are formal documents that must be written in an appropriate technical style (Hegde & Davis, 1992; Knepflar & May, 1989). In many cases, written reports may be the first or the only avenue of contact between a speech-language pathologist and other professionals. Poorly written reports can severely compromise a clinician's professional credibility. Imagine the reaction of a physician when reading the following section of a speech-language pathologist's progress report:

> Shirley was intially nervous in the therapy room, particularly when her mother, she thought was going to leeve her, she cried. Difficult to illicit spontaneous utterances from her, though she was willing to immitate.

For this reason, the ability to communicate effectively in writing is as important as a clinician's knowledge of communication disorders and their

treatment. The guidelines presented below can assist in the development of professional reports that are clear, concise and well-organized.

- ❒ Avoid writing clinical reports in a conversational style (e.g., "He just didn't get the point" versus "He did not appear to understand the task").
- ❒ Use correct spelling, grammar, and punctuation and write in complete sentences.
- ❒ Write in the third person (e.g., "The *Token Test* was administered" rather than "I administered the Token Test").
- ❒ Avoid use of contracted verb forms (e.g., isn't, can't, I've).
- ❒ Give the full names of tests when first mentioned before using acronyms and other abbreviations in the remainder of the report.
- ❒ Express information in behavioral terms (e.g., "followed two-step commands" versus "is able to follow two-step commands").
- ❒ Present information (particularly case history) in chronological sequence.
- ❒ Differentiate clearly between information reported by others versus information obtained directly through clinician observation.
- ❒ List all data such as test scores or baseline measures before providing any interpretative statements. This approach facilitates interpretation of a client's overall profile rather than presenting unrelated descriptions of isolated communication skills.
- ❒ Include information about a client's strengths as well as weaknesses in the body of the report.
- ❒ Avoid presenting information in the summary section of any report that was not introduced previously in the body of the report.
- ❒ Write reports to communicate with colleagues using professional terminology, but include simple explanations and clear examples to make reports meaningful to family members and other nonprofessionals.
- ❒ Use language that is specific and unambiguous (e.g., "He demonstrated language skills characteristic of 4-year-old children" versus "He demonstrated poor language skills").
- ❒ Avoid exaggeration and overstatement (e.g., "*completely* uncooperative," "*absolutely* intelligible," "*never* produces /s/," "*extremely* motivated").

REPORT FORMATS

In the context of intervention, clinical reports are used to serve three main purposes: (a) to outline the intended intervention plan at the beginning of

therapy, (b) to monitor client performance on a session-to-session basis throughout the course of treatment, and (c) to summarize client status periodically and at the end of the treatment program. Report formats for each of these functions can vary greatly among clinicians and service delivery settings. Regardless of the particular format, however, a basic core of information must be included in each of the three types of reports. A framework for each report type is presented below.

I. Initial Therapy Plan

An initial therapy plan (ITP) is developed at the beginning of treatment for each client. It specifies long-term goals and short-term objectives which are based on diagnostic findings and pretreatment baseline results. The basic content and organization of an ITP are presented below:

Identifying Information

List identifying information at the top of the report. This section may include a client's name, age, address, type of disorder, date of report, and so on.

Example

Name: Fred Miller
Parents: Joe & Fay Miller
Address: 1800 Knox Street
College Park, MD 20740

Date of Birth: July 15, 1988
Age: 7 years, 3 months
Date of Report: 10/25/95
Disorder: Articulation & Language
Clinician: Gary Frost

Background Information

In paragraph form, state the full name and age of the client, the location and date of the initial evaluation, and summarize diagnostic information in one or two sentences. For clients who have received previous therapy, this section should specify the provider, identify the dates of service, and briefly summarize goals and progress.

Example

Fred Miller, a 7 year, 3 month old male, was evaluated at Children's Hospital on May 23, 1994. Results indicated a severe articulation deficit which consisted of multiple sound substitutions, final consonant deletion and cluster reduction. Delayed expressive language skills also were noted and were characterized primarily by the absence of grammatical

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morphemes. Fred was enrolled at the Edgewater Speech and Language Clinic for twice weekly therapy sessions from June 10 through August 20, 1995. At the conclusion of this therapy program, Fred demonstrated the ability to:

spontaneously produce final /k/ in single words
imitatively produce initial /bl/ in single words
spontaneously use "is + verb + ing" in sentences
spontaneously use plural marker /s/ in phrases

Present Status

In paragraph form, state the date of client's enrollment in the current therapy program and specify the type, frequency, and duration of therapy sessions to be provided. Describe the client's major speech-language deficits as observed and measured during the first three (approximate) therapy sessions. Report specific baseline data and/or test results in chart form. Make note of any unusual or clinically significant behavior patterns.

Example

Fred began speech-language therapy at this clinic on October 13, 1995 for 1-hour sessions on a twice weekly basis. Baseline results for articulation targets were obtained at the single word level using the *Clinical Probes of Articulation Consistency* (C-PAC):

Initial	*Final*
/k/ = 100%	/k/ = 60%
/g/ = 0%	/g/ = 45%
/r/ = 0%	/d/ = 20%

The *Structured Photographic Expressive Language Test* (SPELT) was administered on October 15, 1995 to assess Fred's expressive language skills:

Raw Score	*% Correct*	*Age Equivalent*
28	56	4–6 to 4–11

This scores falls below the second standard deviation for Fred's chronological age, indicating a moderate delay. Errors included omission of plural markers, regular past tense markers, and incorrect use of prepositions.

Baseline measures were obtained for these grammatical morphemes at the phrase level on October 15, 1995:

plural marker /s/	= 55%
regular past tense	= 0%
present progressive	= 90%
prepositions	= 60%

(continued)

The data indicate that Fred maintained his previous mastery of final /k/ at the word level and present progressive tense at the sentence level. However, production of the plural /s/ marker at the phrase level dropped significantly to the 55% level of accuracy. Fred cooperated with the tasks presented during the initial therapy sessions. However, it was noted that he frequently initiated a response before the clinician finished presenting task instructions or test items.

Goals and Objectives

In outline form, record pertinent speech-language goals and objectives in a hierarchy of complexity ranging from least to most difficult. (Recall that goals are general statements of what is to be accomplished over the course of the treatment program, whereas objectives specify measurable behaviors that lead to mastery of the long-term goals.) Materials and procedures generally are not included as part of this section.

Example

Articulation

Goal I. To produce final /k/ spontaneously at the sentence level.

A. Fred will produce final /k/ spontaneously in single words with 90% accuracy over two consecutive sessions while naming picture cards.

B. Fred will produce final /k/ spontaneously at the carrier phrase level with 90% accuracy over two consecutive sessions in response to clinician questions.

C. Fred will produce final /k/ spontaneously at the sentence level with 90% accuracy over three consecutive sessions while describing pictures.

D. Fred will produce final /k/ spontaneously at the carrier phrase level with 90% accuracy over two consecutive sessions in response to clinician questions.

E. Fred will produce final /k/ spontaneously at the sentence level with 90% accuracy over three consecutive sessions while reading written sentences.

Language

Goal I. To spontaneously use the plural marker /s/ at the sentence level.

A. Fred will use the plural marker /s/ spontaneously in single words with 90% accuracy over two consecutive sessions given groups of objects.

B. Fred will use the plural marker /s/ spontaneously at the phrase level with 90% accuracy over two consecutive sessions while completing oral sentences initiated by the clinician.

C. Fred will use the plural marker /s/ spontaneously at the sentence level with 90% accuracy over three consecutive sessions during a picture description task.

Reinforcement

In paragraph form, indicate the type and schedule of reinforcers to be used for target productions and behavior management.

Example

A continuous schedule of verbal reinforcement coupled with token reinforcers will be used to shape target behaviors. This will be faded to an intermittent schedule as Fred demonstrates progress. A separate response cost system will be used to reduce Fred's tendency to initiate responses prematurely.

Family Involvement

In paragraph form, discuss how family members will be involved in observation of therapy sessions, conferences/counseling, and homework.

Example

Parent(s) will observe Fred's therapy sessions at least once every 2 weeks. Formal conferences will be held every 3 months; brief informal discussions of Fred's progress will take place following every session. Periodic training will be provided to help parents participate in homework assignments.

Generalization Plan

In paragraph form, specify strategies for generalization of target objectives within home, school or work settings.

Example

Fred will be given weekly homework assignments to facilitate generalization of target behaviors. Parent will be provided with written instructions for these assignments. The clinician will also contact Fred's teacher bimonthly to discuss his status and give suggestions for how therapy objectives can be incorporated into the classroom.

The initial therapy plan can be viewed as the clinician's best prediction of what a client can accomplish in a given amount of time. The client's progress in therapy should be monitored on a periodic basis through the administration of probes to determine whether the plan's original objectives remain appropriate or require modification. (A complete sample ITP is included in Appendix 2–A.)

II. Progress Notes

Once therapy has begun, client performance must be documented on an ongoing basis. Progress notes are short and are written during or after each session. They may be filed in a patient's medical chart, a client's folder, or written on the therapy plan itself. Daily notes serve at least three important functions: (a) they enable the clinician to monitor the treatment program on a continual basis and implement any necessary changes immediately; (b) they provide information on a daily basis to other professionals who also may be working with the client (e.g., occupational therapist, social worker); and (c) they facilitate the continuity of treatment by allowing another clinician to provide services in the event of unexpected clinician absence.

One common format of daily progress notes, particularly in medical settings, is known as SOAP notes. SOAP is an acronym that refers to the terms *S*ubjective, *O*bjective, *A*ssessment, and *P*lan.

SUBJECTIVE: Write your opinion regarding relevant client behavior or status in a brief statement.

OBJECTIVE: Record data collected for each task during the therapy session.

ASSESSMENT: Interpret data for current session and compare to client's previous levels of performance.

PLAN: Identify proposed therapy targets for the next session.

Example

S: Fred appeared tired and reluctant to cooperate with the tasks presented.

O: final /k/ in single words = 85% (17/20); plural /s/ in spontaneous phrases = 50% (20/40).

A: Fading of clinician model to a 5:1 ratio on plural task may have been premature. Today's score of 50% constitutes a decrease in accuracy compared to Fred's performance of the same task over the two previous sessions (70% and 75%).

P: Continue work on both tasks at the same levels, but decrease clinician modeling for the plural task to a 2:1 ratio.

III. Progress and Final Reports

A report is written for each client at specific intervals throughout treatment and when intervention services are terminated. These reports also may be referred to as interim summaries, annual reviews, discharge reports, or final summaries, depending on the clinical setting. Progress and final reports document a client's mastery of the goals and objectives outlined in the ITP and implemented over the course of treatment. The basic content and organization of these reports are presented below.

Identifying Information

List identifying information at the top of the report. This section may include a client's name, age, address, type of disorder, dates of service, date of report, and so on.

> **Example**
>
> Name: Fred Miller
> Parents: Joe & Fay Miller
> Address: 1800 Knox Street
> College Park, MD 20742
> Service Dates: 10/13/95–11/21/96
>
> Date of Birth: July 15, 1988
> Age: 8 years, 4 months
> Date of Report: Nov. 25, 1996
> Disorder: Articulation & Language
> Clinician: Gary Frost

Background Information

In paragraph form, state the full name and age of the client and include the following information: (a) date of first therapy session, (b) client's speech and language status at that time, and (c) session frequency and duration.

> **Example**
>
> Fred Miller, an 8 year, 4 month old male, began speech and language therapy at this clinic on October 13, 1995. At that time, he presented with a severe articulation deficit characterized by multiple sound substitutions, final consonant deletion, and cluster reduction. He also demonstrated an expressive language delay which consisted primarily of grammatical morpheme deletions. Fred received therapy twice weekly for 1-hour sessions.

Therapy Objectives and Progress

In outline form, restate the highest level objective listed for each goal in the ITP and indicate whether or not the client has met criterion. If mastery has been achieved, cite the supporting data (e.g., % accuracy). If criterion has not been met for the terminal objective, specify the most difficult objective in the hierarchy that has been mastered and cite the supporting data. In both cases, compare the client's current performance levels to the pretreatment baseline data for that target. Comment on the degree of improvement represented by this comparison (e.g., significant, moderate, minimal). Note any special procedures, strategies, tasks, or cues that facilitated the client's performance.

Example

Articulation

1. Fred will produce final /k/ spontaneously at the sentence level with 90% accuracy over three consecutive sessions while reading written sentences.

   Criterion met with 90% accuracy on 9/12/96 and 100% accuracy on 9/14/96 and 9/18/96. This represents significant improvement over the pretreatment baseline measure of 60% accuracy at the carrier phrase level. In the initial stages of therapy, it was noted that Fred's performance was greatly enhanced by the use of a mirror to monitor and maintain correct tongue placement.

Language

1. Fred will use the plural marker /s/ spontaneously at the sentence level with 90% accuracy over three consecutive sessions during a picture description task.

   Criterion not met. His performance on this objective during the last three therapy sessions was uneven at 90%, 75%, and 80% accuracy, respectively. However, Fred did demonstrate mastery of the plural marker /s/ at the spontaneous phrase level with 95% accuracy on 10/30/96 and 100% on 11/2/96. This represents minimal progress over pretreatment baseline measures of 55% accuracy at the phrase level. Fred benefited from visual cues in the form of written numbers that signaled the need for him to use the plural marker in his response.

Additional Information

Include information about the following:

- ❒ reinforcement (for both targets and attending behaviors)
- ❒ completion of homework assignments
- ❒ family participation/observation
- ❒ parent/client conferences
- ❒ other pertinent issues such as results of additional testing; significant medical information (e.g., changes in medication), change in educational placement, etc.

Example

A continuous verbal reinforcement schedule was used to establish target behaviors. As accuracy improved, an intermittent schedule was introduced. A behavior management system was implemented in which Fred was given 10 tokens at the beginning of each session. He was told that

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these could be traded in at the end of the session for a small prize that "costs" 10 tokens. However, one token would be subtracted from his pile for each instance of noncompliant behavior (e.g., off-task talking) during therapy activities.

Homework practice was assigned weekly. Mrs. Miller reported working with Fred on homework assignments on a daily basis. Mrs. Miller observed therapy at least once every 2 weeks. Fred's progress was discussed with her informally after each session and formally during parent conferences held every 6 months.

It was noted that Fred's educational placement changed in September 1996 to a private school with a higher teacher-student ratio.

Recommendations

State whether continued speech-language intervention is warranted. If so, give suggestions for specific goals and objectives. Make any other pertinent recommendations (e.g., psychological testing).

Example

Fred's parents are withdrawing him from therapy at this facility because his new educational placement will include on-site intervention. Therapy goals should continue to focus on stabilization of final /k/ and plural marker /s/ at the conversational level. New goals for past tense markers and prepositions should be initiated.

(A complete sample Progress Report is included in Appendix 2–B.)

TIPS FOR PROOFREADING CLINICAL REPORTS

Students, beginning clinicians, and supervisors can use the following set of proofreading questions to edit and monitor the quality of clinical reports.

- ❒ Are spelling, grammar, and punctuation correct?
- ❒ Are professional terms used accurately?
- ❒ Is there redundancy of word usage or sentence type?
- ❒ Are any sentences too lengthy, rambling, or unfocused?
- ❒ Is all the important client information included in the report?
- ❒ Is information presented only in the germane sections of the report (e.g., recommendation statements should not be included in the background information section)?

- ❒ Does the report follow a logical sequence from one section to the next (i.e., from background, to data and interpretation, to summary and recommendations)?
- ❒ Are raw data interpreted and not merely reported?
- ❒ Are all conclusions and assumptions supported by sufficient data?
- ❒ Are speculative statements explicitly identified as such?
- ❒ Does the report contain seemingly contradictory statements without adequate explanation?
- ❒ Is the wording clear or are some statements vague and ambiguous?
- ❒ Is content presented with appropriate emphasis (e.g., Has any critical information been overlooked? Has any minor point been overemphasized?)?
- ❒ Is the report written with ethical/legal considerations in mind?

INDIVIDUALIZED EDUCATIONAL PLAN

The Education of All Handicapped Children Act (PL 94-142) was passed in 1975 to ensure that all children, ages 3–21 years with special needs receive a free, appropriate public education. Speech-language pathology is a designated special education service under this law.

Each eligible child must have an annual written Individualized Education Plan (IEP) that documents the need for the provision of special education services. The purpose of this plan is to identify specific areas for remediation. Unlike other clinical reports, the IEP generally does not include a description of the actual intervention procedures that will be used to accomplish the specified objectives.

The IEP is generated as part of a process that begins with a referral. A comprehensive assessment is then conducted by an appointed team and the findings are reviewed at a meeting of all involved parties (including therapists, teachers, parents). The participants develop and approve a written IEP which is implemented over the subsequent school year and reviewed annually. When speech-language therapy is the sole or primary special education service to be provided, the speech-language pathologist may assume principal responsibility for writing the IEP. (For a detailed description of the entire IEP process, see Cornett and Chabon, 1988.)

IEP Content

To ensure a measure of uniformity and accountability nationwide, federal law requires that all IEPs contain the following basic information:

- ❒ **Present Levels of Performance.** This section of the document includes information regarding a child's current status in all per-

tinent developmental and educational domains. For speech-language pathology, test scores and clinical analysis of observed performance are presented. This information should be discussed in sufficient detail to provide a basis for development of intervention goals and objectives.

- **Annual Goals and Short-Term Objectives.** The goals are long-term projections of what a child is expected to accomplish over the entire school year. The short-term objectives are the intermediate steps that are programmed to help the child achieve the long-term goal. These objectives are measurable behaviors and should include specific performance criteria and timelines. The number of objectives will vary depending on the nature of each goal. There is no mandate concerning the number of goals and objectives that must be included in an IEP.
- **Special Education and Related Services.** This section identifies the special services needed by a child to achieve the stated goals and objectives. The type and frequency of services must be specified. A typical example for speech-language pathology might be: "Articulation therapy will be delivered two times per week in 30-minute group sessions."
- **Placement Recommendation and Justification.** This section indicates the specific educational setting into which a child will be placed. By law, this setting must be the *least restrictive environment* that provides an appropriate education to meet a child's individualized needs. Recommendations for placements other than a regular classroom in the child's home school must be accompanied by a written rationale. (Eligibility requirements vary among local educational agencies.) The percentage of time that a child will spend in regular versus special education is documented in this section.
- **Initiation and Duration of Services.** The IEP must state the dates that services will begin and the projected duration of the services. The duration of services typically is 1 year because IEPs are reviewed on an annual basis.

These five categories comprise the basic structure of an IEP. Individual states or local educational agencies may impose additional requirements pertaining to format or content information.

Due Process

PL 94-142 provides legal and procedural safeguards throughout the educational placement process, including timelines for completion of each step, parental notification and consent, and an appeal system to ensure due process for all parties involved. The parent or guardian must be notified prior

to any changes in a child's educational program. The due process system provides a formal mechanism for parents to protest decisions they consider inappropriate or unfair to their child. (See Dublinske and Healey [1978] and Turnbull, Strickland, and Brantley [1982] for additional information about due process issues and procedures.)

INDIVIDUALIZED FAMILY SERVICE PLAN

In 1986, the federal mandate for a free and appropriate education was extended by enactment of PL 99-457 (Part H) to include infants and toddlers with special needs between birth and 3 years of age. This legislation is notable not only for its emphasis on the importance of early intervention, but also the stipulation that all services be provided by qualified personnel (i.e., professionals who meet the highest requirement in the state for a given discipline).

This legislation requires the development of an Individualized Family Service Plan (IFSP) which is similar to an IEP. Both documents require specification of: (a) a child's present level of performance, (b) long-term goals and short-term objectives, (c) recommended special services, and (d) dates of initiation and duration of services.

The IFSP differs from the IEP in that its main focus is on the family as a unit rather than solely on the child. The written document must include the following types of information that are not part of an IEP:

- ❒ **Family Strengths and Needs.** This section provides a description of the family's strengths and weaknesses as they relate to enhancing the development of the child. It also includes a statement of the impact that the child's disability has on family functioning. In addition, individual families can specify their desired levels of involvement in the intervention plan.
- ❒ **Case Manager.** The IFSP specifically identifies the individual from the profession most relevant to the needs of the infant and family. The case manager is responsible for the development of the IFSP and for implementation, coordination, and monitoring of all services. The speech-language pathologist is frequently named as case manager for infants and toddlers whose primary handicapping condition consists of communication or oral-motor disabilities.
- ❒ **Transition.** This section outlines the procedures that will be employed to facilitate the transition to services provided under PL 94-142, if the child continues to need special services beyond age 2 years, 11 months.

In addition to the differences outlined above, this legislation extends eligibility to "at-risk" youngsters, rather than restricting services to children with recognized disabilities. Moreover, these services can be provided through agencies outside the public school system (e.g., social welfare,

respite care, etc.). PL 99-457 also contains provisions for home-based instruction as well as family education and counseling. The IFSP is reviewed every 6 months rather than annually.

PROFESSIONAL CORRESPONDENCE

In addition to clinical treatment reports, speech-language pathologists often interact with other professionals and agencies through written correspondence. These documents may vary with respect to length, content, and format, but all professional correspondence should be written in a clear, concise manner with correct spelling, grammar, and punctuation. Typically, written correspondence involves authorizing the release of information, making referrals to other professionals, and acknowledging referrals from colleagues.

It is essential that clients authorize the release of confidential evaluation or treatment information, whether it is to be written or verbally communicated. It is the sole prerogative of the client to determine the type and amount of information to be shared with teachers, physicians, or other therapists. Correspondence related to referral issues provides documentation for record-keeping purposes and is an important aspect of professional courtesy.

The following pages contain reproducible release of information authorization forms and sample referral letter and acknowledgement formats.