**Fieldwork Topics: Resource Guide for Students & Fieldwork Educators**

1. Student Subject Matter-
	1. Occupational Therapy and Fieldwork requires a prerequisite knowledge of medical terminology is essential to health and allied health professions for the understanding of reading health professional’s orders, notes, evaluations, lab reports, etc. Students can take courses that are free, low cost or through community colleges and universities. Bell, et al., (2001) found that there was no significant difference in medical terminology scores in courses that were in-person versus online or distance courses. Understanding how to use prefixes, roots and suffixes of words helps students to break words into parts and translate them into meaning.
	2. Learning medical terminology
		1. Textbook options
			1. Medical Terminology: A Short Course, 9th Edition by Davi-Ellen Chabner
				1. [Buy on Amazon](https://www.amazon.com/Medical-Terminology-Davi-Ellen-Chabner-MAT/dp/032347991X)
				2. [Buy on Elsevier](https://evolve.elsevier.com/cs/product/9780323479912?role=student)
			2. [7 Popular Medical Terminology Textbooks for 2022](https://www.aeseducation.com/blog/review-popular-medical-terminology-textbooks)
			3. Open Textbook Library University of Minnesota
				1. [Medical Terminology for Healthcare Professions](https://open.umn.edu/opentextbooks/textbooks/1147)
		2. Low cost or free depending on chosen option
			1. [7 Best Free Medical Terminology Courses](https://crushtheusmleexam.com/best-free-medical-terminology-online-training-courses/)
			2. [Udemy](https://www.udemy.com/course/medical-terminology-foundations/?utm_source=aff-campaign&utm_medium=udemyads&LSNPUBID=0F1O0otUXQc&ranMID=47901&ranEAID=0F1O0otUXQc&ranSiteID=0F1O0otUXQc-g7m1NVDhK74ZsCgH3jC3AQ)
			3. Des Moines University: [Medical Terminology](https://www.dmu.edu/medterms/)
			4. Coursera:
				1. [University of Pittsburgh Medical Terminology](https://www.coursera.org/learn/clinical-terminology)

Clinical Terminology for International and U.S. Students

How to use the Prefix, Root, Suffix (PRS) List for Beginning Students is embedding in the course for the free version as well as the for pay course.

* + - * 1. [Rice University Medical Terminology Specialization](https://www.coursera.org/specializations/medicalterminology)
			1. [EdX](https://www.edx.org/course/medical-terminology?index=product&queryID=a69a1d17406c20612d8813122e8eef16&position=1)
		1. In Sames’ (2015), chapter 3 reviews buzzwords, jargon and abbreviations, it also includes extensive lists of abbreviations for professional credentials and job titles, abbreviations related to time and frequency, abbreviations of body parts, diagnoses and tests, “x” abbreviations, range of motion abbreviations, abbreviations of clinical procedures, abbreviations of related to administration and reimbursement, and educationally relevant abbreviations on pages 18 to 35.
			1. Sames, K. (2015). *Documenting occupational therapy practice* (3rd ed.). Pearson.
		2. Another resource for medical terminology, definitions and terms is the Quick Reference Dictionary for Occupational Therapy by Karen Jacobs and Simon.
			1. [Book Resource site](https://www.slackbooks.com/quick-reference-dictionary-for-occupational-therapy-seventh-edition/)
			2. The beginning of the book starts with a dictionary of terms and then has multiple appendices the offer a vast resource of information pertinent to occupational therapy. Specific to medical terminology:
				1. Appendices 1-3 include acronyms and abbreviations.
				2. Appendix 16 is the medical terms for diseases, pathologies, and syndromes.
	1. Documentation in Occupational Therapy: This is the process of learning the in and out of the various modes of documentation in occupational therapy can be daunting. From daily treatment notes to evaluations to re-certifications, every facility has its own style and nuances. However, knowing the basics will build a foundation of skills to start the journey.
		1. Documentation textbooks for students learning in occupational therapy
			1. Documentation Manual for Occupational Therapy, fifth edition.
				1. Gateley, Crystal A. (2023). *Documentation manual for occupational therapy* (5th ed.). Slack.
			2. Documenting Occupational Therapy Practice, third edition.
				1. Sames, K. (2015). *Documenting occupational therapy practice* (3rd ed.). Pearson.
		2. Documentation for referrals:
			1. Should include the date of the referral, the source of the referral and the reason for the referral (AOTA, 2018).
		3. Screenings: Documents the referral source and the reason for occupational therapy screening (AOTA, 2018).
			1. Should include:
				1. Referral information such as referral date, source of referral, services requested, and the reason for referral*.*
				2. Client information such as the description of client’s occupational history, their experiences, and their performance; current health status, any applicable medical, educational, and developmental diagnoses, and patient precautions and contraindications.
				3. Brief occupational profile

As a reference the AOTA Occupational Profile Template is a good start.

The occupational profile should include the client’s occupational history, interests and values, daily living patterns as well as contexts.

* + - * 1. Any assessments used and results
				2. Recommendations based on professional judgment
		1. Evaluations
			1. [AOTA Guidelines for Documentation of Occupational Therapy Services](https://research.aota.org/ajot/article/72/Supplement_2/7212410010p1/6508/Guidelines-for-Documentation-of-Occupational):
				1. The Evaluation “documents the referral source and data gathered through the occupational therapy evaluation process” (AOTA, 2018).
				2. Should include the referral information, client information, occupational profile, assessments used and results, analysis of occupational performance, summary and analysis and recommendations (AOTA, 2018).
		2. Intervention and Plan of Care (Plan of Treatments): Documents the goals and the intervention types and approaches to be used in the occupational therapy process (AOTA, 2018) including:
			1. Client information
			2. Start of Care Dates (SOC)- dependent on agency and facilities
			3. Intervention goals
			4. Intervention types and approaches
			5. Service delivery mechanisms
			6. Plan for discharging
			7. Outcome measures
		3. Discharge planning
			1. It is inclusive of client information, summary of the intervention process and recommendations that supports the client’s discharge from occupational therapy (AOTA, 2018).
			2. Sames (2015) relays that the discharge summary should be comprehensive way to report goal progress and outcomes. The starting elements of a summary includes the client information with the summary of the various interventions as well as future recommendations.
			3. Dependent on the facility the format may vary but can also be in a SOAP format or narrative format. It should not be detailed in session to session yet should be the highlights toward the outcomes (Sames, 2015).
			4. May also contain the individual goals with beginning and ending status.
		4. SOAP Notes/ Daily Contact or Treatment Notes
			1. Should include client information and therapy log
			2. Must demonstrate medical necessity and justification for skilled services.
				1. Skilled services are those that cannot be done without the performance and supervision of a therapist.
			3. SOAP notes
				1. Function as communication, accountability, billing, legal documentation

Reduces redundancy

Continuity of care

Justification for level of service (Pearce et al. 2016 & AOTA 2018)

Standard presentation

* + - * 1. EHR documentation using SOAP format

Pearce et al. (2016) relays concerns with distractions of the EHR with practitioners from patient care.

EHR is not consistent format throughout health care

Documentation in the EHR is ‘heavily dependent’ on clinician skill for accuracy of the patient encounter, however, Pearce et al. (2016) warn that yes/no options, check boxes and drop-down lists should not drive the patient encounter documentation.

Subjective includes:

Chief complaint

Past medical, family & social history

Review of systems

Significant patient statements

Objective includes:

Information on treatment directly observed

Assessment includes:

Synthesis of information

Clinical impression

Identifiable relationship to O section

Plan includes:

Future strategies to address the O and A

* + - 1. WHEW notes by Molly Setliff, OTR, OTD, Assistant Professor Texas Tech University Health Sciences Center School of Health Professions
				1. The WHEW documentation techniques allows the clinician to write a quick, yet concise daily narrative note attached to a specific CPT code. The article explains and provides examples of this effective and efficient note writing technique to save the clinician time and decreases the risk of denials from payor sources.
				2. <https://www.aota.org/publications/ot-practice/ot-practice-issues/2021/whew-documentation>
				3. The reference: Setliff, M., & Tiongco, C. (2021). WHEW: An Efficient and Effective Note-Writing Technique. *OT Practice*. [https://doi.org/10.7138/otpracticemagazine](https://urldefense.com/v3/__https%3A/doi.org/10.7138/otpracticemagazine__;!!PZU9J6Y!ZjpSwx1tXAB3b0sa2gbQoUxQV8RlXrIUO0UyIt6SsVgd1osj2rGbr1txlXHJXxv3_OnrXZvzFA2SXt9Q_JJhVIDHALo$)
			2. EHR Notes
				1. Many EHR formats provide a variety of options for documentation of services.
				2. While there are standard items that are included, they may be based on CPT codes explaining what occurred during the session, then have a response to the intervention section that can be more narrative and a section for barriers to the treatment section that is also narrative in nature.
				3. The entry-level practitioner must be able to know the ways to gather the essential data from the EHR in order to progress with background knowledge that is vital to the plan of care.
		1. The Documentation of Skilled Care Tips
			1. In therapy documentation, therapist must show and support an evolving plan of treatment.
				1. The positive outcomes will not solely support the medical necessity for services. Therefore, the skilled therapist must consistently analyze the patient’s response to skilled interventions and adjust/ modify/ adapt treatments, strategies, and techniques the course of treatment progresses. It is the therapist’s responsibility to provide clear documentation that proves that the complexity of the client’s need requires a licensed therapist for services. Additionally, therapists must prove that the skilled intervention they are providing cannot be trained to a family member or other non-skilled staff to achieve the same progress toward the achievement of their discharge goals. Guidelines for the provision of skilled services as guided by CMS can be found [here.](https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33631&ver=51)
			2. The therapy must be reimbursable.
				1. Moninger (2023) provides for skill service providers to be reimbursed and avoid denials of claims including justification of the plan of care, using the correct terms and CPT codes, justification of treatment approaches as well as explanations of plateaus or declines in progress. Additionally, Moninger (2023) points out that through your documentation you can show your skills as a provider from education of caretakers to on the spot adaptations of an activity or treatment based on the client responses.
				2. Read the full article at the [BTE website.](https://www.btetechnologies.com/therapyspark/skilled-service-documentation-tips-for-reimbursement/)
			3. There are many additional resources on the internet that provide guidance for writing documentation.
				1. PT Management Support Systems’ article PT/OT Skilled Therapeutic Exercise Documentation Examples is one such source. It provides OT and PT related documentation noted that clearly outline the skilled nature of the therapy. [Website](https://pt-management.com/documentation/ptot-skilled-therapeutic-exercise-documentation-examples/)
				2. The Note Ninjas provides resources, tips and membership options for OTs and PTs. Some of the resources include cheat sheets, articles on documentation tips and various treatment guides. [Note Ninjas Website](https://thenoteninjas.com/)
				3. My OT Spot has a variety of options new practitioners and students for documentation tips for any setting as well as resources for SOAP notes. [My OT Spot Website](https://www.myotspot.com/occupational-therapy-documentation-tips/)
				4. OT Flourish is a website dedicated to resources for evidence, documentation, goal writing and more specific to skilled nursing and home health. Some of the resources are no cost and others are fee-based. There is a specific article on [SOAP notes and documentation](https://otflourish.com/soap-note-and-documentation-examples/) that provides auditory sections, examples and templates. [OT Flourish Website](https://otflourish.com/)
	1. Intervention plans
		1. Treatment/ Lesson planning template
		2. Treatments planning involves identifying the focus for defining the occupation-based intervention. For a minimum, the intervention plans should include:
			1. The approaches within the treatment
			2. How the therapist will meet the objectives outlined
			3. The materials or equipment needed for the intervention
			4. An assessment of the intervention and a plan for what would or could be changed
			5. Links to the OT theories and frameworks
		3. When developing intervention plans, the Quick Reference to Occupational Therapy by Kathryn Reed is a good resource with condition specific information for students and therapists. Each diagnosis covered provides a description of the condition, the causes, assessment areas, problems, treatment and management, precautions, and prognosis and outcomes.
			1. The 3rd edition is from 2013 and can be purchased online.
		4. An addition resource that can be available as a resource by conditions is written by Ben Atchinson and Diane Powers Dirette that has a new 2023 edition. It is divided into 4 units including pediatric conditions, mental health conditions, physical conditions and general medical conditions. Each chapter reviews the description of the diagnosis, the etiology, incidence and prevalence, signs and symptoms, diagnosis, course and prognosis, medical and surgical management, impacts on occupational performance and practical case studies. These can be helpful in treatment and intervention planning if there are condition specific needs.
			1. The newest edition is available online and from the [publisher](https://shop.lww.com/Conditions-in-Occupational-Therapy/p/9781975209353).
	2. Formal and informal assessments in occupational therapy
		1. Formal assessments are those that would look at specific skills, are standardized or criterion-referenced, and provide concrete numbers, percentages or outcomes related to a population.
			1. Examples of formal assessments for adult populations for occupational therapy could be the SLUMS (St. Louis University Mental Status), ACLS (Allen Cognitive Level Screen) or the COPM (Canadian Occupational Performance Measure).
			2. Examples of formal assessments for pediatric populations for occupational therapy could be the VMI (The Berry-Buktenica Test of Visual Motor Integration, the SPM (Sensory Processing Measure or the DAY-C (Developmental Assessment of Young Children)
			3. Use of these types of tools may be dictated by the facility as a part of the evaluation process.
		2. Informal assessments are those that may still give quantifiable numbers, however they are not standardized to a population.
			1. Examples of informal measures for adults may include manual muscle testing or grip strength measurements, observations of gait and functional range of motion, range of motion measurements using a goniometer, checklists for various skills, sensation assessments or measurements for edema
			2. Examples of informal measures for pediatrics may include handwriting samples, muscle testing or grip strength measurements, observations of gait and functional range of motion, range of motion measurements using a goniometer depending on the condition, daily living skills checklists or observation of various gross and fine motor skills.
	3. Form samples
		1. COAST Goal worksheet
		2. Level I Fieldwork Activity Tracker example
		3. SOAP Note Grading Rubrics
			1. SOAP note guiding questions
		4. Intervention plan grading rubric
1. Therapist/ Educator subject matter
	1. Level I
		1. Level I evaluations
			1. Level I evaluations can be completed using the paper format of the AOTA form or programs can develop their own evaluation to review the student learning and progress during the Level I experience.
			2. Sample form
	2. Level II:
		1. Fieldwork Data Form (AOTA): This form can be found on the [CMU fieldwork page](https://www.coloradomesa.edu/occupational-therapy/fieldwork.html) near the bottom of the page under the Fieldwork Educators Resources tab.
		2. FEAT
			1. This is a tool for the student and fieldwork educator to complete together to gather insight, encourage communication, discussions and promote problem solving. [CMU fieldwork page](https://www.coloradomesa.edu/occupational-therapy/fieldwork.html)
		3. Self-Assessment Tool of Fieldwork Educator Competency: This tool is a guide to help fieldwork educators guide professional development, define strategies and align with measurable outcomes for professional growth planning. [CMU fieldwork page](https://www.coloradomesa.edu/occupational-therapy/fieldwork.html)
		4. Fieldwork Performance Evaluation resources and scoring
			1. AOTA has resources available for fieldwork educators that includes training videos, scoring guidelines, and step by step instructions under the [Fieldwork Educators](https://www.aota.org/education/fieldwork/fieldwork-performance-evaluation) tab at the bottom.
		5. Weekly Review Sheet
			1. Most fieldwork coordinators and educators utilize some form of a review sheet during the Level II experience. This form allows the student to reflect on their strengths, areas of learning, goals for upcoming weeks and express desires of what they would like to learn about in the future.
				1. embed PDF
		6. Student Feedback:
			1. It is important that the student is able to evaluate each site that they are at with an open means of communication providing constructive feedback, options available at the site and an overall picture of what fieldwork is like at the site. This is a valuable resource for future students and the Academic Fieldwork Coordinator. It helps to meet ACOTE standards as to the quality of the fieldwork sites as well.
				1. SWEFE
				2. Student feedback form example

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