Children's Wisconsin Medical Staff Guidelines:
Provider documentation in the Electronic Health Record

Timely, clear, concise, and complete documentation in the medical record is critical for safe and quality care. The documentation should meet the needs of the patient and the care team and be compliant with regulatory and billing standards. Duplication of information is unnecessary, creates a redundant and repetitive note, and increases risk of mistakes.

The electronic health record (EHR) incorporates patient- and encounter-specific documentation. For Children's Wisconsin (CW), the medical record documentation of an encounter is defined as encompassing both the encounter-specific documentation entries as well as the information that resides at the patient level.

These guidelines apply to documentation in the EHR for the Milwaukee hospital, emergency department and ambulatory specialty clinics.

General Documentation

1. Formatting: Font style, color, and size should be consistent within a document, and bolding or the use of italics within the paragraph of a note is discouraged in documentation.
2. Medical necessity: Documentation in the medical record must support:
    a. Necessity of the care being provided:
        i. What specific care does a patient need and why? (E.g., clinical indications which support obtaining authorizations and coding.)
            1. Medications
            2. Monitoring
            3. Therapies
            4. Procedures
            5. Diagnostic testing
            6. Consultations
    b. Severity of illness:
        i. How ill is the patient?
        ii. What are the co-morbidities?
        iii. What are the risks for deterioration?
    c. Level of care: The designated billing class must be indicated by an order from the provider.
        i. Inpatient:
            1. Pediatric ICU
            2. Neonatal ICU

3. Oncology/BMT
4. Acute care

ii. Outpatient (including but not limited to):

1. Clinic encounters
2. Infusions
3. EDTC
4. Procedures and recovery (procedural short stay)
5. Observation service

d. Professional and hospital billing requirements.

3. **Abbreviations**:
   a. Truncation of words or use of symbols is strongly discouraged anywhere in the medical record unless acceptable per the CW Policy and Procedure ***Medical Records.***
   b. Truncation of words or use of symbols is prohibited on any consent forms unless the abbreviation can reasonably be expected to be understood by patients (or parents/guardians) or has been specifically defined in the consent.

4. **Copy functionality:** The use of copying tools within an electronic health record can enhance the efficiency of users, but cloning of information increases the risk of inaccurate and/or fraudulent entries. Therefore, all providers are obligated to review their own documentation to ensure that the information is accurate and relevant. "You sign it; you own it."
   a. **Copy Previous**
      i. Copy Previous is available for all note types and across encounters to facilitate care coordination and efficiency. With Copy Previous, "*Smart Tools*" will be refreshed. This does not occur if Copy and Paste is used. **Use of Copy and Paste functionality is strongly discouraged, except in situations where other copy options are not available or practicable.**
      ii. If Copy Previous is utilized in the creation of a document, it is essential that all elements of the document are reviewed for relevance and accuracy. All entries in the medical record should reflect the current condition of the patient and should capture the original thoughts, exam, impression, and plan of the author and reflect the work and effort of that day and time. Incorporation of non-original impressions or findings or inaccurate or outdated information in a medical record is fraud and is considered unprofessional behavior. Medical records are regularly reviewed by payers and may be periodically audited by CW or other agencies.
      iii. Copy Previous is an acceptable efficiency tool to replicate facts that are static (unchanged) during the admission. Using Copy Previous to pull forward a template to serve as the framework for documentation on a complex patient is also

reasonable. The writer must always remember to refresh in order to update the "smart" information.

iv. Use of Copy Previous is not appropriate in most other situations, including copying documentation of the physical exam or copying another provider's note.

b. **Copy Forward** may be appropriately used to bring forward data elements from flow sheets that are static.

5. **Orders:** An order from a provider is required for all care and services which are not within the scope of independent practice of the health care professional who is carrying out the order. All orders must be entered into the EHR. Verbal orders may only be accepted as per circumstances defined in the CW Policy and Procedure ***Patient Care Orders*****.**

6. **Patient-level documentation:** Documentation domains within the electronic health record enable storage of information at the patient level. This information is available to all disciplines and at all encounters. Examples of these tools are the **Problem List**, the **Past Medical and Surgical History**, the **Social and Family History**, **Home Medications**, and **Allergies**. The information in these domains is shared, and it is the responsibility of all providers to maintain its accuracy.

a. **Problem List**: A list of currently relevant, important clinical issues, diagnoses, and unexplained symptoms or findings that may impact an individual's current or future physical or mental health or may influence the medical care and/or testing that the patient will receive.

i. The Problem List pertains directly to the patient.

ii. Problem List entries should be concise and visible to all providers.

iii. The Problem List and the Past Medical and Surgical History work together to provide a more complete understanding of past and current concerns. Issues that are no longer germane to current care should be documented in the history section.

iv. The Problem List should include significant social determinants of health.

v. The Problem List can supplement provider documentation but is not a substitute for key components of provider documentation (such as history or medical decision making).

vi. Problem List responsibility:

1. All credentialed providers share responsibility for management of the Problem List.
2. Although PHPs, residents, and fellows should update and maintain the Problem List, the attending physician, dentist, or other member of the Medical Staff is ultimately responsible for the accuracy and integrity of the list.

3. The non-provider clinical staff is encouraged to review the Problem List as part of the workflow during an encounter, but nursing staff and medical students are not responsible for maintaining or updating the Problem List.
    a. Ambulatory clinic nursing staff may transcribe changes that are documented elsewhere by a provider after the changes have been reviewed with and approved by a credentialed provider.

vii. Problem List maintenance:

1. The provider should review and update the Problem List and overview section at every outpatient encounter, regularly throughout a hospital stay, and at hospital discharge. Marking the Problem List as reviewed should be done after every review.
2. For hospital encounters, the problems should be categorized as a "Hospital Problem" where appropriate. Clinically important problems that are not currently actively managed or have no significant likelihood of influencing ongoing care should not be included on the Hospital Problem List.
3. The provider who originally obtains the information or the provider who makes a diagnosis should add the problem to the Problem List.
4. Providers should add any currently active problems that are missing from the Problem List, even if they did not originally diagnose the problem, including new problems (diagnoses or unexplained symptoms or findings) that may have current or potential future clinical importance.
5. Minor or self-limiting problems should be excluded from the Problem List.
6. The Problem List entry should include the problem being treated, not the treatment or diagnostic testing being rendered. For example, "seizures" may be listed as a problem, but "long-term video monitoring" should not be.
7. Any provider may and should provide appropriate additional information or description of the problem and its stage or evolution. Supplemental information may be included in the Care Coordination note or the overview section of the problem.
8. Any provider may and should refine the problem to the most specific diagnosis based on his or her best clinical judgment by using the "Change Diagnosis" button.
9. Duplicate entries should be combined by deleting one entry and updating the remaining problem.
10. Inactive problems for which treatment/therapy is complete should be resolved and filed to the history if appropriate.
11. Significant post-surgical states should remain on the Problem List permanently.
12. Incorrect entries should be deleted.

a **Past Medical and Surgical History**: A comprehensive, pertinent, and updated list of known important past and present medical and surgical information. This often may be

more extensive than the Problem List and may contain issues no longer pertinent to the patient's current care needs. The overview sections of the Past Medical and Surgical History can be used to record the details of the resolved issue.

c. **Social and Family History** should include updated information that may influence the care given, such as significant social situations, as well as past family history. Protected Health Information (PHI) for patients less than 18 years of age should be documented in an Adolescent Sensitive note (see section below).
d. **Medication reconciliation** (including dietary supplements) should be reviewed at every encounter.
e. **Allergies** should be reviewed at every encounter.

7. **Mark as Reviewed**: Clicking the "Mark as Reviewed" button indicates that the user has reviewed and updated the available information and is ready to proceed with care within his or her scope of practice.

Care in the Hospital

1. **Hospital documentation** for initial hospital care requirements should include:
    a. An initial order defining patient class as an **Inpatient or Outpatient** (Observation or Procedural Short Stay). This order must be signed or co-signed by a provider with admitting privileges.
    b. An up-to-date **Problem List**.
    c. A **History and Physical** (H&P), completed within 24 hours of arrival or prior to discharge, whichever comes first. A Medical Staff member may choose to delegate all or part of the history and physical examination and/or update assessment and note to an appropriately privileged professional health provider, resident, or student for completion. A Medical Staff member must sign the History and Physical and, as applicable, update the note and assume full responsibility for the history and physical examination.
        i. The **History of the Present Illness (HPI)** should clearly convey the history and severity of the present illness. The **Chief Complaint** may be incorporated as part of the HPI and should describe in terms of location, quality, duration, severity, modifying factors, and context the primary reason that the patient requires hospitalization. The status of chronic medical conditions should be updated in the history section.
        ii. A **Review of Systems (ROS)** pertinent to age, presenting problem, diagnosis, and medical necessity should be performed.
        iii. Reference patient-level documentation of the **Past Medical and Surgical History**, **Family History**, **Social History**, **Medications**, and **Allergies.**
        iv. The **Physical Exam** documentation should include elements for which the provider is responsible, including the details of the current exam that are medically necessary and relevant to the care needed, noting pertinent negative and positive findings.

v. **Preliminary Diagnoses** should be indicated in the medical record as supported by the history, examination, laboratory and/or imaging findings

vi. A thorough **Assessment and Treatment Plan** which supports the decision that care in a hospital setting is required and the level of services ordered. The assessment and plan should include:

1. A narrative assessment that incorporates the primary presenting problems and reflects what the provider thinks is happening based on review of the history, physical exam, and diagnostic evaluations.
2. A specific management plan for each problem that is being managed.
3. A differential diagnosis (if no clear diagnosis has been established).
4. The plan for diagnostic testing and therapeutic interventions.

vii. A signature or co-signature from the attending.

viii. Teaching/supervising physician attestation as appropriate.

2. **Hospital progress notes**:

a. A progress note should be written at least daily by the primary service, or more often if needed based on changes to the patient's condition.

b. If a discharge summary is completed on the day of discharge, a progress note is not required.

c. It should be an accurate, concise narrative interval summary (not recitation) of the patient's current medical conditions and recent changes.

d. The information should only incorporate what is relevant since the last note and, in combination with other information in the chart, should succinctly provide the information needed for another provider to assume care in an urgent or emergent situation.

e. It should include a summary and discussion of important (not all) diagnostic studies, vital signs, assessments, and interventions.

f. It should only include pertinent updates to the ROS and custom history fields (Past Medical and Surgical History, Social History, etc.) if they are necessary to explain the reasoning for a change in therapy or the rationale for additional diagnostic evaluation.

g. It should include germane positive and negative physical exam findings.

h. It should *not* include a restatement of every piece of information (diagnostic studies, vital signs, medications, past history, etc.) since the last progress note or since admission.

i. It should include an updated assessment and plan demonstrating the medical decision for each active problem.

j. It should clearly convey the medical necessity of the hospital care being provided.

k. Progress toward discharge goals and anticipated discharge date should be included when relevant to current decision making.

l. APSO (assessment/plan/subjective/objective) and problem-based charting are both acceptable alternatives to the traditional SOAP note format. For patients with longer hospital stays, an Interim Summary progress note may also be appropriate.

m. Signature or co-signature from the attending.

n. Teaching/supervising physician attestation as appropriate.

3. **Transfer of service**:
    a. A transfer of service occurs only after there is agreement by the accepting physician to assume care. (A verbal conversation between the transferring and accepting attendings is strongly encouraged.)
    b. An order to transfer care to a different service must be entered into the EHR.
    c. Medical record documentation (a transfer note) is required unless the accepting service has been actively co-managing the patient prior to transfer. Documentation should be sufficient for the new service to assume care of the patient and should be available prior to a planned transfer or completed promptly after an emergent/unplanned transfer.

4. **Hospital consultation**: It is the responsibility of the consulting service to enter a complete consultation note in the patient record documenting any recommendations and plans within 24 hours of evaluation of the patient unless other arrangements are made with the requesting service. Consultation documentation requirements can be found in ***Medical Staff Rules and Regulations II.C***.

5. **Discharge documentation**:
    a. The discharge summary is the primary tool for communication with the provider(s) who will assume care after discharge and should be completed within three business days after discharge. It should summarize the principle reasons for the hospitalization and incorporate:
        1. a final/principal diagnosis (the condition established after study to be the primary reason for admission of the patient to the hospital);
        2. other diagnoses (any additional diagnoses that coexisted at admission or developed during hospitalization and affected patient care for the current hospital admission);
        3. a brief summary of the hospital course;
        4. the key therapeutic interventions;
        5. procedures;
        6. the patient's medical state;
        7. pertinent discharge physical exam findings;
        8. recommended follow-up care;
        9. discharge disposition;

10. signature or co-signature from the attending; and
11. teaching / supervising physician attestation as appropriate.

b. Discharge medication reconciliation

c. Patients and families should receive discharge information that conforms to recognized health literacy norms. The After Visit Summary (AVS) should contain:
   i. diet and activity recommendations;
   ii. a list of all active medications with dosing instructions;
   iii. comprehensive discharge instructions which include disposition and care coordination information;
   iv. home health and durable medical equipment (DME) vendor contact numbers and device management information;
   v. when and whom to call in an emergency; and
   vi. all recommended follow-up care appointments.

d. **Death:** In addition to the discharge summary, the provider is also responsible for making sure that the "Report of Death" and "Notice of Removal of Human Corpse, Communicable Disease Alert" forms and a death note are completed. Please refer to CW Policy and Procedure ***Care of a Dying Patient and Disposition of the Body***. A discharge medication review and after visit summary are not required.

Operative and Procedural Documentation

Additional requirements for care of patients undergoing invasive or diagnostic procedures requiring moderate or deep sedation or regional or general anesthesia.

1. The provider performing the procedure is responsible for:
   a. Obtaining and documenting consent for any procedure requiring informed consent beyond the Consent to Admission.
   b. Providing an H&P completed or countersigned by a physician that contains all of the legally or policy required elements and the indications for the procedure, which are clearly stated.
      i. An H&P or clinic note which is performed within 30 days of the procedure may be utilized.
      ii. H&Ps are acceptable from non-staff physicians if they are countersigned by a privileged member of the Medical Staff.
      iii. An electronic or durable, legible copy of the H&P must be filed in the patient's medical record, and the provider performing the procedure must review the H&P and sign or co-sign. By signing or co-signing this document, the attending provider attests to the accuracy of the H&P.

iv. An additional statement confirming the patient's status at the time of the procedure must be entered into the medical record and signed by the attending provider if the H&P is completed prior to the day of the procedure.

v. In an emergency, when there is no time to complete an H&P, a note of the preoperative diagnosis and the reason for the emergency must be recorded by the attending physician or privileged designee prior to the procedure.

c. Operative reports must be completed within 24 hours of the procedure; required elements include:

i. Name(s) of the provider(s) performing the procedure and any assistant(s);

ii. Findings;

iii. Procedure(s) performed and full description;

iv. Estimated blood loss as indicated;

v. Whether or not any specimens were removed and description;

vi. Complications; and

vii. Post-procedure diagnosis.

2. If the operative report is not completed immediately after the procedure(s), a post-procedure note must be completed which includes the elements set forth in Section B.1.(c) of the Bylaws.

3. Operative documentation must be signed by the provider who performed the procedure and the surgeon of record.

4. The anesthesia service or the provider administering the sedation is responsible for all aspects of sedation/anesthesia care, including:

a. Conducting a pre-sedation/anesthesia assessment prior to the start of the sedation/anesthesia;

b. Discussing and documenting relevant sedation/anesthesia options and risks with the patient and/or family;

c. Developing and documenting the sedation/anesthesia plan;

d. Administering sedation/anesthesia and monitoring the physiological status according to hospital standards;

e. Continuing post-procedure assessment and monitoring as appropriate for the patient's sedation and physiological status with appropriate handoff; and

f. Completing all required documentation in the patient record as defined by medical staff and hospital policy.

NOTE: Elements of this sedation/anesthesia must be either personally performed by a privileged physician or delegated to a qualified individual pursuant to hospital policy, but the physician must be either physically present or immediately available to assist the qualified delegate continuously

until the patient has met criteria for discharge from a phase 1 recovery area according to hospital policy.

5. Dental and podiatry providers are responsible for:
    a. Making sure an H&P is completed or countersigned by a physician.
    b. Providing a day-of-surgery, specialty-specific H&P update to include the pre-procedure diagnosis, a summary of clinically pertinent positive and negative findings which justify the need for the procedure, and a detailed description of the examination of the focused area.
    c. Performing the procedure.
    d. Completing the immediate post-procedure note or operative note which completely describes the findings and technique. In the case of extraction of teeth, the dentist should indicate the number and type(s) of teeth and fragments removed.
    e. Arranging for an attending physician to manage the hospitalization of the patient if necessary.
    f. Recording pertinent daily progress notes.
    g. Documenting the discharge diagnosis.

Care in CW Specialty Clinic Setting

1. Documentation should be completed within three business days.
2. Documentation is considered delinquent if not completed by 15 days following the encounter.
3. Home medications, allergies, and the problem list should be reviewed at all visits.
4. The clinical documentation should include pertinent elements of the history and physical exam, results of diagnostic studies, a list of procedures performed, and a complete evaluation and management plan
5. Visit diagnosis must be documented.
6. An After Visit Summary should be generated for all encounters.
7. The provider is expected to communicate with the primary care and referring physicians in a timely manner, as appropriate.

Care of EDTC Patients

1. Documentation should occur at the time of service.
2. Home medications, allergies, and the problem list should be reviewed at all visits.
3. The clinical documentation should include pertinent elements of the history, physical exam, diagnostic studies, and procedures, as well as an evaluation and management plan
4. The clinical impression must be documented.

5. An After Visit Summary should be generated for all encounters.
6. EDTC providers are expected to communicate with the referring physician after assessment if requested.

Telemedicine Services

1. Per the Centers for Medicare & Medicaid Services (CMS), "Telemedicine seeks to improve a patient's health by permitting two-way, real-time interactive communication between the patient and the physician or PHP at a different site. This electronic communication means the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment."
    a. Telemedicine services do not include conversations or electronic communications that occur solely between providers, including the professional interpretation of diagnostic studies in situations where the information is provided to a CHW provider electronically and there is not a direct interaction with the patient.
    b. Documentation should occur at the time of service in the medical record where the patient is located.
2. The provider must be licensed to provide medicine at the institution where the patient is being treated.
3. The clinical documentation should include pertinent elements of the history, physical exam, diagnostic studies, and procedures, as well as an evaluation and management
4. The visit diagnosis must be documented.
5. Please refer to CW Policy and Procedure ***Telehealth Remote Care*** for specific definitions and guidelines.

"Telephone" Documentation

1. All non-face-to-face communications with patients and families, including electronic and phone communications, should be documented in the EHR.
2. Communication that occurs in between face-to-face encounters should be recorded in the "Telephone Encounter" form.

Provider Students

1. Provider students are encouraged to work to improve their documentation skills while at CW.
2. Provider student notes are considered part of the legal health record. With input from their supervising provider, students can document progress notes and other approved note types as listed below. Students are encouraged to use appropriate smart phrases for their documentation.

   Approved note types include:

Progress Note	Consult Note
Adolescent Sensitive Note	Discharge Summary
H&P	ED Note
Transfer Note	Brief Op- Note

3. Using the navigator, a student may enter information regarding:
    a. past medical and surgical history;
    b. family history;
    c. social history;
    d. allergies; and
    e. immunizations.
4. Medication reconciliation may be started and pended.
5. Orders may be pended but need co-signature.
6. Pharmacy students', interns', and residents' documentation standards are governed by pharmacy department policies.

Alternate Plan of Care

1. Code status is presumed to be a full code unless there are alternate code orders entered.
2. Conversations with patients and families about alternate care plans should be documented in an "Altered Code" note. This note type can be accessed in the Altered Code navigator.

Adolescent Sensitive Notes

1. An Adolescent Sensitive note should be used by all providers to document information that is granted special legal privacy protections (Sensitive Information) to patients less than 18 years of age who do not want this information shared with their parents/guardians. This SI includes:
    a. Sexual activity, STI screening, STI results, contraception, pregnancy and substance abuse appropriate for ambulatory treatment services.
2. The provider should review with the patient the confidentiality/privacy protections and limitations.
    a. Providers should identify times when confidentiality/privacy protections cannot be maintained:
        1. If the sensitive information needs to be shared to obtain consent from the parent/guardian for a medically necessary procedure
        2. If the patient is at risk of harm to self, others or maltreatment
        3. If the patient is being harmed by others while engaging in sexual activity or substance use
        4. If the patient is being coerced to engage in sexual activity or substance use
        5. appointment reminders may be sent to the parents

6. If they test positive for a reportable STI, a public health nurse may contact their home

b. Other care providers will have access to these notes
c. CW Medical records will not release Adolescent Sensitive notes to parents/guardians.
d. Pharmacies may have a different process which may result in the release of information on medications that are filled for minor patients.
e. Patients covered by commercial insurance, the explanation of benefits that a parent receives may contain details of testing and services.

3. Sensitive Information should never be listed in the problem list, copied from the Adolescent Sensitive note into any other documentation in the EHR. Details of the Adolescent Sensitive note should not be referred to in any other documentation within the EHR.
    a. Adolescent Sensitive notes are listed in the Notes section of EPIC.
    b. Providers should review these notes when providing care to adolescent patients so they are aware of a patient's sensitive information that may impact the treatment they are providing.
    c. Encounters that include Adolescent Sensitive notes, providers may in their standard progress note refer in their Assessment or Plan to "Adolescent Note" in order to prompt other providers to review PI provided.
4. If a provider inadvertently includes SI in a regular note, you may open the encounter as an addendum, cut the PI from the regular note and create an Adolescent Sensitive note and paste the PI into this note.
    a. If a provider is unable to open an encounter that inadvertently includes PI in a regular progress note, the provider should contact Medical Records to review options available for providing the requested privacy.
5. Providers may want to establish a method to communicate to patients confidentially by phone
    a. Document if the patient has access to a confidential phone number, this number should be documented in EPIC adolescent sensitive note.
        i. Providers should consider having the patient create a Password for phone communication so clinic staff can confirm they are speaking with the patient and not someone posing as the patient.
        ii. If a password is created, it should be documented in EPIC with the confidential phone number
        iii. Determine if voice mail messages can be left and the level of detail the message can include
    b. Patient's confidential phone number and password should be shared with Public Health nurses and others who may need to contact patient regarding their PI.

Attestation

1. An attestation statement should be added as needed to be compliant with billing and trainee supervision requirements. The attestation must be compliant with Medicare's Teaching Physician Guidelines and must accurately reflect the provider's involvement:
    a. The teaching physician evaluates the patient independently without resident involvement.

b. The teaching physician and resident evaluate the patient at the same time. The teaching physician must document his or her presence for the critical aspect of the evaluation and whether he or she agrees with the assessment and plan.
c. The teaching physician and resident see the patient at different times. The teaching physician must document his or her performance of the critical aspects of the patient's care and whether he or she agrees with the assessment and plan.

Revision of the Electronic Health Record

1. A record for a specific date of service may be amended to provide clarification, correct errors, or add additional information, as long as that information was known to the provider at the time that the services were rendered.
2. A prior record should not be amended to include information that was not known on the day of service related to that electronic health record entry.
3. Information, including recognition of errors, should be documented on the day and time that it was recognized.