University of Wisconsin Department of Family Medicine – Residency Clinics
CLINICAL POLICY AND PROCEDURE

TITLE: Timelines for Completion of Documentation of Patient Visits and Telephone Encounters

Effective Date: July 2006 **Approval:** Vice Chair of Clinical Care

Supersedes Policy: none **Contact:** DFM Director of Clinical Care Services

Reviewed				

Scope: Applies to all DFM residency clinics using EpicCare documentation functionality.

Purpose: To provide guidelines for the completion of documentation of patient care visits or phone calls by faculty, nurse practitioners, physician assistants, residents, dieticians, mental health clinicians and any other providers of direct patient care. To provide timing guidelines for the co-signing of documentation by the supervising clinician for patient care notes generated by residents and physician assistants.

Definitions: Based on UWMF Ambulatory Care Guidelines, documentation of all interactions with patients, whether in person or via other electronic means, must be completed within 24 hours of the visit / contact. A **Co-signature for supervised care** on a note indicates agreement with the medical care provided by the physician assistant or resident and the acceptance of responsibility for that care. **24 hour and 48 hour timelines** refer to usual working days and exclude weekends / Holidays.

Type of documentation	Available Methods	Timing Guideline
Documentation of visit or telephone encounter	Dictation, free text typing entry, EpicCare smart tools.	Dictation should be completed within 24 hours of visit / encounter. Providers with full EpicCare functionality should type ".dict" in the progress Note section of the EpicCare Visit Navigator after they have dictated. Documentation using EpicCare tools or free text typing should be closed within 24 hours of the visit / encounter.
Transcription of dictation	Transcription is routed to clinician inbasket	Transcription should be routed to clinician inbasket within 48 hours of dictation.
Authentication of received dictation	Note is read and edited as necessary once received in inbasket	Authentication by clinician should be completed within 48 hours of receipt in clinician's inbasket
Co-signature for supervised care (PA and resident notes).	Note is read and addended as necessary once received in inbasket. Addended notes should be forwarded to original clinician.	Co- signatures for supervised care should be completed within 48 hours of receipt in supervisory clinician's inbasket.

Management of away time: Clinicians who have planned time away are encouraged to use EpicCare smart tools for documentation to close visits before leaving.

Documentation becomes past due as follow:
Closing encounter – Days past due are timed from the date of the visit / encounter
Authentication of dictation by clinician who provided the service – Days past due are timed from the date the transcription was received in the In Basket of the clinician providing the service.
Co-signature for supervised care – Days past due are timed from the date the transcription was received in the In Basket of the supervisory clinician.

PROCEDURE for past due documentation:

Action Needed:	**Timeline:**	**Next steps:**
Close Encounter	24 hours (weekend days excluded) from date of service	• Encounter Provider receives notification in InBasket Past Due Charts folder 3 calendar days after encounter. • Clinic Manager receives notification of past due chart 7 calendar days after encounter. • Clinic Manager explores potential reasons for non-compliance (leave of absence, time off) and speaks with staff or provider regarding plan for completion. • Clinic Manager reports unresolved issues to the clinic's Medical Director and the Director of Clinical Care Services who at their discretion intervenes to help resolve. • Unresolved issues are forwarded to the Vice Chair of Clinical Care.
Electronically Sign Transcribed Dictation and / or Electronically Co-sign Supervised Care	48 hours (weekend days excluded) of completed transcription	• Encounter provider receives notification in InBasket that dictation is transcribed and awaiting authentication / co-signature. • The Director of Health Information/Manager may attach to a provider's InBasket to verify that authentication is happening in a timely manner. Results will be shared as needed with the respective Clinic Manager, Director of Clinical Care Services or Vice Chair of Clinical Care. • Chart audits will be performed by site Manager randomly on a quarterly basis, and initiated at any point there is a concern about documentation being dictated in a timely manner. Past Schedules may be checked against patient records in EpicCare to ensure transcription has been completed. Results will be shared with respective Medical Director, Director of Clinical Care Services and Vice Chair of Clinical Care.

NOTES:

1. Deadlines for signatures on verbal orders, standing orders and protocol development are contained within those documents.

2. This policy only deals only with timing guidelines for co-signing of resident and PA documentation of visit / encounter. Documentation guidelines for resident supervision are contained in a separate policy.

WRITTEN BY: Maggie Dugan, RN, MS, FNP, DFM Director of Quality Services
ADAPTED FROM: UWMF Policy: Past Due Charts, Cosigning Orders (9/05) written by UWMF EpicCare Policies and Procedures Committee
REVIEWED BY: DFM Residency EpicCare Workgroup

AUTHORIZATION: **6/28/06**

Vice Chair of Clinical Care **Date**