I.   SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II.   PURPOSE:

The purpose of this policy is to promote the creation of an accurate and concise medical record that facilitates patient safety, quality care, and appropriate billing for healthcare services in all patient care documentation, including all forms of electronic documentation (*e.g.,* PowerNotes, Clinical Documentation, and Dynamic Document), as well as transcription and hand-written documentation.

III.   DEFINITIONS:

A.   "**Carry Forward**" means the process of using previously documented text from notes, reports, or other electronic sources to document a current patient encounter. This encompasses a variety of processes including, but not limited to, copying and pasting and "copy to new note," but excludes Auto-Populated Elements.

B.   "**Auto-Populated Elements**" means the most recently recorded patient values and/or core data such as vital signs, allergies, medications, and lab values which are inserted into the record without the user's intervention.

C.   "**Macro**" means a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text which is not edited by the user.

IV.   POLICY:

The provider of a patient service must accurately and concisely document the services provided and information gathered during each patient encounter, whether the documentation is in a form of electronic documentation (*e.g.,* PowerNotes, Clinical Documentation, or Dynamic Documentation), is transcribed, or hand-written. Electronic health record users must review and edit previously documented information that is carried forward, imported, or supplied by use of a template to remove all information that does not accurately reflect the services provided during the encounter being documented and to add any missing information pertinent to the current encounter.

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V.   PROCEDURE:

A.   General Requirements

Each user must meet the following general requirements with regard to any entry in a patient's electronic health record:

1.   The signer of each entry is responsible for all of the content of his or her documentation, whether the content of the documentation is original, created using Carry Forward, or includes Auto-Populated Elements or Macros.

2.   Each provider is responsible for confirming the accuracy of documentation and making any necessary corrections, whether the documentation is created personally or by an authorized scribe or surrogate dictator.

3.   Each user must review information created using Carry Forward or Auto-Populated Elements for accuracy and completeness and must edit the information, as appropriate, with specific attention to removal of elements that are no longer pertinent, inaccurate or are not relevant to the current patient encounter.

4.   When using Carry Forward and especially Copy and Paste functionality, limit such information to only currently pertinent and clinically relevant information.

5.   All documentation, including any documentation created using Carry Forward, Auto-Populated Elements, and Macros, must adequately document the reason for the encounter; assessment, clinical intervention or diagnosis; medical plan of care; patient progress; and date and identity of the user in sufficient manner to comply with good medical practice; billing rules; state, federal, and regulatory requirements and all applicable Tenet Entity policies.

6.   The following requirements specifically apply to the use of Macros by a physician relying upon documentation of a medical resident or licensed independent practitioner as a part of the documentation of the physician's services in any encounter:

a.   When billing patient evaluation and management services, the physician may use a Macro as a portion of the required personal

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documentation in a patient's electronic medical record if the physician personally adds it in a secured or password protected system.

b.   In addition to the physician's Macro, either the resident/allied health professional or the physician must add sufficient customized information to the patient's medical record to support a medical necessity determination. The note in the patient's electronic medical record must sufficiently describe the specific services furnished to the specific patient on a specific date.

c.   Use of Macro-generated documentation alone by both the resident/allied health professional and the physician is not sufficient documentation.

7.   Users found to be abusing documentation tools (*e.g.,* inappropriate use of Carry Forward and Copy/Paste functionalities, inadequate editing of Auto-Populated Elements or insufficient customization of Macros) will be subject to performance management including:

a.   Monitoring;

b.   Remedial Education;

c.   Revocation of the ability to use certain documentation tools;

d.   Corrective Action pursuant to Medical Staff Bylaws.

B.   Responsible Person

The Clinical Informaticists are responsible for training and educating users of the requirements of this policy. Unless otherwise set forth in this policy, the Tenet Entity Chief Operating Officer is responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Entity, and that instances of noncompliance with this policy are reported to the Compliance Officer.

C.   Auditing and Monitoring

Audit Services will audit adherence to this policy during its routine audits. Additionally, the Tenet Entity will monitor adherence to this policy as part of its record review activities assessing the quality and content of the medical record.

D.   Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

All other users whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures including the Medical Staff Bylaws, Rules and Regulations.

VI.   REFERENCES:

-Code of Conduct

-Quality, Compliance and Ethics Program Charter

-COMP-RCC 4.03 Health Information Management Operations, Hospital Chart Completion, Documentation and Security

-COMP-RCC 4.17 Legal Medical Record

-The Joint Commission Comprehensive Accreditation and Certification Manual for Hospitals, Record of Care, Treatment, and Services Chapter