oscar

CLINICAL DOCUMENTATION

DSP and Documentation Best Practices

The purpose of clinical documentation is to provide evidence of excellent patient care within the medical record while easily identifying appropriate treatment or intervention.

SOAP NOTES

The SOAP format is a way to summarize a patient's encounter in an organized manner and ensures that chronic conditions are not overlooked, assumed or tacitly understood.

Subjective: Includes the chief complaint, HPI, PMH, Problem lists and ROS, as well as any relevant history, symptoms or changes in the health status of the patient.

Objective: Includes a physical exam, laboratory data, vital signs, and any diagnostics completed during or prior to the visit, as well as the practitioner's clinical observational findings.

Assessment: This section represents a synthesis of "subjective" and "objective" information in a singular diagnosis made by the provider. It should include all coexisting conditions and represent all of the considerations in care, treatment, or management; even if these are conditions managed by other providers.

Plan: This section contains the provider's plan, which is to be documented in direct relation to the assessment. This can be extensive for a complex disease or simple details of continued current management, depending on the condition and care requirements of that patient.

DOCUMENTATION ELEMENTS

The Best Way to Support the A&P is to Supply DSP:

DSP is a concise way to clearly document a condition.

- **Diagnosis**: Provider documentation of a condition that was determined through analysis of the health of the patient.
- **Status**: Further definition of the diagnosis using descriptive words (e.g. acute, chronic, ongoing, controlled, asymptomatic, in remission, recurrent, exacerbated, resolved, compensated, etc.) to further support medical decision making and clarify the state of the disease.
- **Plan**: Provider prescribed course of therapy corresponding with the status of the diagnosis; this may include tests, procedures, laboratory studies, consultations, referrals, patient education, pharmacotherapy, or any other therapeutic measures.

Best Practice for Assessment and Plan Documentation:

The A&P should include:

- Final health diagnoses determined during that visit.
- Additional conditions that are present, active, or affect the personal health of the patient - even if managed by another provider.
- This should include personal history of conditions that affect current or future management of health.

The A&P should not include:

- Problem list, PMH list, or a list under any other heading
- Additional headings listed under the final Assessment of the visit
- Orders for screenings, future diagnostics, or testings should be separate from the Assessment and Plan

oscar

CLINICAL DOCUMENTATION

BEST PRACTICES & TIPS

- The provider documentation of a condition within an encounter will ALWAYS override a list of conditions. Any and all active conditions that affect patient care, or are taken into consideration, must be addressed with DSP within the assessment.
- ANY list of conditions, regardless of the location in the document, is not considered to be current. Conditions must be addressed with active DSP to be considered as current.
- Patient reported conditions must be addressed further by the provider to give clinical validity.
- Avoid using terms such as “probable”, “suspected”, “likely”, “questionable”, or “possible” with a confirmed diagnosis of a disease or condition.
- Diagnostic tools, screenings, labs, or imaging, that are used to form a final diagnosis are not a replacement for documentation of a final diagnosis or status.
- A historical diagnosis does not negate the care requirements nor lessen the importance of the care being given; these should be documented and assessed as "personal history of " when appropriate.
- If there are two related diseases, individual discussions should be provided to validate the status of each disease. Ensure that only one disease is being described and not two separate diseases.
- Avoid conflicting documentation. (Example: PE - bilateral pedal pulses present, HPI - hx of left BKA) Continuity must be used throughout the entire document.
- Highly acute conditions requiring an immediate level of care should not be documented in the outpatient setting unless a diagnosis is established there and life saving treatment is being administered or referred.
- Avoid using symbols, such as + -↑ ↓, and instead define the status, relationship or diagnosis in the documentation.
- The use of slashes are not a clear means of documenting a diagnosis because this oftentimes results in disparity (either/or) in the documentation.
- If a treatment can be used as therapeutic or prophylactic, the plan should clearly define the course of therapy along with expected outcome. If treatment is to avoid recurrence of a condition, the status of that condition should be documented as a personal history.

For more resources go to:

HIOSCAR.COM/PROVIDERS/RESOURCES