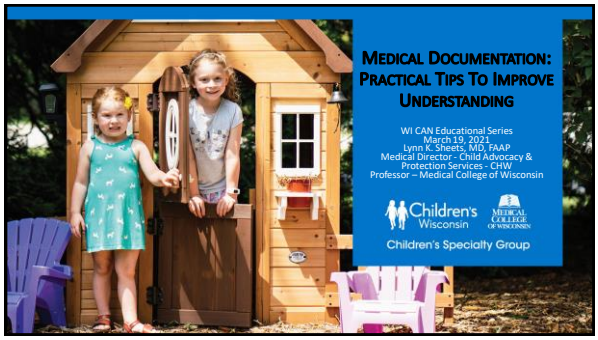

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Disclosure Information for:
Lynn K. Sheets, MD, FAAP
Medical Documentation: Practical Tips To Improve Understanding

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Speaker Biography – Lynn K. Sheets

Lynn K. Sheets, MD, FAAP is a Professor and Section Chief in the Department of Pediatrics at the Medical College of Wisconsin (MCW) and Medical Director of Children's Hospital Wisconsin's (CHW) Child Advocacy and Protection Services (CAPS). Her career began in 1988 as the medical director of the child abuse program at the University of Kansas Medical Center where she co-founded the first Child Advocacy Center in Kansas and led development of a joint nursing and medical student elective in family violence. Dr. Sheets has led the CAPS program at CHW since 2006 and was instrumental in developing the accredited child abuse pediatrics fellowship at MCW which was one of the first in the nation. She is board certified in pediatrics and child abuse pediatrics. In addition to providing clinical services, educating others and leading research, she is the Chair of the Wisconsin Child Death Review Executive Council, and co-founded the Wisconsin Child Abuse Network (WI CAN). On the national level, Dr. Sheets was elected to the American Academy of Pediatrics' Executive Council for child death review. Dr. Sheets served on the Wisconsin American Academy of Pediatrics Board of Directors. In 2013, she received the prestigious Ray E. Helfer MD Award from the National Alliance of Children's Trust and Prevention Funds and the American Academy of Pediatrics. In 2014, the Legal Aid Society of Milwaukee awarded Dr. Sheets the Equal Justice Medal for her work in advocating for poor and vulnerable children and families. She has a strong commitment to the prevention of child maltreatment and the development of trauma-informed approaches to improve child, family, workforce and community resilience.

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Disclaimer

- Cases are de-identified through a variety of techniques
- Not legal advice

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Learning Objectives

- List the major components of each section of a "SOAP – style" medical report
- Explain why clear attribution is important in medical documentation pertaining to a child maltreatment suspicion
- Describe the primary goal of the 21st Century Cures Act

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Who is the Intended Audience?

- In the past, **other medical providers**
- Health literacy and increased collaborative health care between the patient and provider is shifting the audience **to the family**
- In cases reported for suspected child maltreatment, the audience is other medical providers and **investigators**
- Admission note = "H&P" = History (subjective) and Physical exam (objective) and lots more
- 21st Century Cures Act will gradually change the intended audience

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ABCs of Medical Reports

- CC – Chief Complaint – Patient's statement about why they have sought care
- HPI – History of the Present Illness – The 'story' of their Chief Complaint
- ROS – Review of Systems (other symptoms unrelated to the CC)
- SH – Social History – home situation, school performance, etc.
- FH – Family History – health of relatives
- PMH – Past Medical History – birth, immunization status, primary care provider, other diagnosed medical conditions, developmental history, sleep, diet, medications, allergies, etc.
- PE – Physical Exam, Vital Signs, Growth
- Impression/Assessment – Diagnoses usually in order of importance
- Plan/Recommendations – further diagnostic tests, referrals, steps to be taken by the provider, etc.

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SOAP Notes – Organization Structure of Medical Documentation

- CC – Chief Complaint
- HPI -
- ROS
- SH
- FH
- PMH
- Physical exam
- Diagnostic tests
- Impression/Assessment/Diagnosis
- Plan/Recommendations

- Subjective (Patient = Source)
- Objective
- Assessment
- Plan

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The Patient Entered What Door?

- Each separate patient interaction is called an encounter
- Many types – phone, direct admission, ED to admission, ED, clinic visit, documentation only, etc.
- Routine outpatient encounter – Notes from intake, provider, and nurse. Outpatient provider note – this is usually a single note; it can be addended
- Telephone call encounter – usually brief note
- Consultation (usually by a subspecialist at the request of another provider within a current encounter or as a separate encounter in a clinic)
- Surgery encounter – "Op Note" = surgery details note
- Admissions to the hospital – The primary health care team writes the "H&P," daily progress notes, and discharge note
- Best source of summary information – H&P, discharge note, and consult notes

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Attribution – What it is and Why it is Critical in Child Maltreatment

- Often unclear in many medical notes
- Attribution (or citation) = the source of information
  - Specific family member
  - The patient
  - The CPS professional
  - The Law Enforcement professional
  - Another medical provider
  - The medical record
- In child maltreatment related notes, it should be very clear
- The attribution allows the reader to assess how the story got told and weigh the importance of the information

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Language and Jargon

- Challenges regarding medical jargon
  - Specialty specific
  - Not usually understood by the patient (parent)
  - Creates frustration for investigators
  - Often seems to be at conflict with what an investigator was told or was documented in another note
- Strategies to address
  - Keep asking questions
  - Medical dictionaries might help
  - If the patient will be seen or the record reviewed by a CAPS provider, wait, ensure safety and talk with the medical provider with the most expertise as soon as is reasonably achievable

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Jargon - Examples

- History – "no history" means no explanation to medical providers but has a very broad psychosocial meaning for CPS
- Impression – These are diagnoses to medical provider but sound like a hunch because we associate 'impression' with a superficial, preliminary, initial assessment
- Recommendations/plan – This directs medical treatment information for medical providers, but are often interpreted by investigators just as suggestions
- Fracture = broken bone
- Hot water ≠ scalding temperature

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Asking Questions

- Move beyond perceptions of hierarchy! Don't be afraid to contact and ask questions
- Know your "point person" who controls access to the provider – nurse in a clinic or the medical social worker in a child abuse center or administrative assistant in the office
- Leave messages and try to make it easy for providers to return your call
- Asking questions improves mutual understanding
- What about the story of the fall?
  - Ask if the injury is **"expected"** given the history
  - Avoid asking if the injury is "possible" – is it expected or plausible are more likely to get the result that is needed

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Questions to ask

- Is there an injury? Can you date or time when it happened? What symptoms would be **expected** in this child?
- Other than injury, what other diagnoses have you considered?
- Is the finding something other than an injury?
- Is there any condition that could have predisposed the child to the injury?
- **Is the injury expected given the history**?
- Have you screened for additional or occult injuries (for children under 2 y/o)?
- Do you have the contact information for child abuse experts who might be available to consult with you?

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Electronic Health Record (EHR – Epic, etc.) The Good, Bad, and Ugly

- The good
  - Care Everywhere – allows access to records beyond a single health system
  - Templates – create consistency in language and help educate the reader
  - Links – pulls together information from multiple data sources
  - Imbedded dictation tools
- The bad
  - Copy Forward
  - Templates
  - "Telephone" game style of notes that get carried for many days
- The ugly?
  - Billing related (necessary blemishes)
    - MDM – medical decision making
    - Risk
    - Time statements
  - Dictated narratives can be comical and have errors! It is OK to point those out.
- Trainees and experienced providers sometimes make errors

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Medical History in Child Maltreatment

- Often changes or evolves for many reasons
  - Intentionally changed as information about plausibility is obtained by family – common in abuse cases but sometimes to conceal other bad acts
  - Missing because the parent who is present does not know but then adds on as the parent learns more from others
  - Concealed accidents
  - Communication problems – game of 'telephone'
  - Language challenges
  - Lack of attention to details by the various people who speak with the family
  - Avoid telling suspects about biomechanics and timing – this can prompt a changing story
  - Intimidated disclosures – child may say untrue things
  - Example – shaking case

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Differential diagnoses

- These are diagnoses that could reasonably explain the finding(s)
- Usually listed from the most likely first to least likely
- In court and sometimes in reports, these are called "alternative hypotheses"
- In Child Advocacy and Protection Services' medical reports, these are sometimes included to educate investigators even if they are improbable explanations
- Tension sometimes develops between the medical diagnosis and substantiation/safety determinations

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Diagnosis

- From a medical standpoint, how sure is the provider that the situation is due to abuse or neglect?
- Sometimes an iterative approach is used:
  - Preliminary report
  - Supplemental reports as more information comes in
  - CAPS medical provider notes are based upon the information available – additional information could change the medical opinion
- Sometimes there is nothing else other than maltreatment that can explain the injuries in the context of the history

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Level of concern

- Part of child abuse medical specialty
- Range from no concern (most of these are never reported) to diagnostic
- Can change with time as more information such as diagnostic tests becomes available
- Words in medical reports can communicate the level of certainty

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No to Low Concern - Large % of Cases

- Child abuse specialist involved because SOMEONE suspected CAN
- No concern – medical mimics, normal variants, definite accidents
- Low concern – most are likely accidents but can't rule out abuse
- These are generally not reported
- Example accessory suture on skull

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"Gray zone cases"

- Moderate concern – could be either abuse or accident.
- If reported, then further investigation likely warranted
- Very unsettling – examples
  - Skull fracture cases with a history of a short fall
  - Collarbone (clavicle) fracture that is healing in a 15-month-old child but not story about how it happened
- If reported, the investigation is usually critical to formulating a medical opinion

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Concerning for abuse

- Abuse is high on the list of diagnoses
- Further investigation is warranted
- The provider likely needs information from the investigation to further formulate the level of concern
- These cases are always reported per mandatory reporting statutes

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High concern to diagnostic = Diagnosis of abuse

- High concern = making diagnosis of abuse. Unless there is a concealed and unusual accidental explanation, these are abuse
- Diagnostic – there is nothing other than abuse that could have caused the finding(s) in the context of the history
- These tend to be cases where medical may feel intrusive to CPS professionals when safety determinations are made
- ABA bias – "anything but abuse" bias. All professionals have less work if the incident was caused by something other than abuse. Sometimes 'magical' or 'is it possible' thinking takes the professional down the wrong path.

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Handling "Differing Medical Opinions"

- Usually, the most experienced child abuse professional should be relied upon
- Disagreements amongst the treating health care team – ask questions to better understand
- Opinions for the defense are available for hire
- Well-resourced families often purchase these opinions

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Accessing Accurate Information

- Involvement of a child abuse pediatrician improves accuracy (Anderst)
- The source attribution should be clear
- Dictated narratives can contain typos
- Determinations of abuse or not abuse in an ED or clinic setting should be viewed as suspect or preliminary – often influenced by bias.
  - Most providers are treatment/forward looking
  - Child maltreatment medical experts use extensive education, published science, and experience to determine the likelihood of abuse
- Use the Child Protector app for initial guidance – free from your app store

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Collaboration

- Results in best safety for the child/family
- Involvement of a child abuse pediatrician improves decision-making and often can reduce level of concern for CAN (Anderst)
- Work to develop trusting relationship with bidirectional flow of information (if allowable)
- Health care providers can use "teach back" to ensure that CPS understands the concerns
- CPS can use a similar strategy "This is what I am hearing. . . "

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Strategies to improve collaboration

- Training
  - Mandated reporting is more than checking a box – when you learn of a "missed case" by health care, offer to provide education about mandatory reporting and early recognition of maltreatment.
  - Roles defined
  - Inter-professional education
- Increase access to expert medical
- Decrease CPS Caseloads? (see 2019 WCHSA study)
- Require certain types of cases to have expert medical
- Create toolbox to help – include HIPAA resource (2009 AAP)
- MDTs and CACs

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HIPAA and Child Maltreatment

- Medical providers often misunderstand the restrictions
- Providers may share information with CPS and LE when there is a child maltreatment investigation
- See: The AAP Policy Statement-Child Abuse, Confidentiality, and the HIPAA. Pediatrics 2010;125:197-201
- "Although HIPAA generally overrides state laws, HIPAA rules do not apply where the "provision of state law…provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation or intervention" (Section 160.203[c])"

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Medical Record Access

- CW CAPS' program will release all relevant records to investigators upon request if there is an active investigation for child maltreatment
- Release during active investigations does not need to go through medical records
- Most other releases – after the investigation or for additional records not initially included usually must go through HIM (health information management)
- Starting 4/5/21 – families will have immediate access to signed notes if they have opted into a patient portal like MyChart

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21st Century Cures Act

- Primary purpose is to improve the ease for patients in obtaining their medical records to promote a collaborative patient-provider team
- As of 4/5/21, Information Blocking is not allowed except under certain circumstances
- Health care provider notes and diagnostic test results should be easily and immediately available to the patient once they are final.
- Harm exception is the only exception that pertains to child maltreatment records:
  - **Preventing Harm Exception**: It will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided **certain conditions** are met.

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Conditions That Must Be Met

- Key Conditions of the Exception
  - The actor must hold a reasonable belief that the practice will substantially reduce a risk of harm;
  - The actor's practice must be no broader than necessary;
  - The actor's practice must satisfy at least one condition from each of the following categories: type of risk, type of harm, and implementation basis; and
  - The practice must satisfy the condition concerning a patient right to request review of an individualized determination of risk of harm.

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What This Means

- CAPS has a long-standing practice of blocking parent/guardian access to the child's records if there is risk of harm to the child or others.
- Usually blocked if parent/guardian is a suspect or not protective
- It is likely that this practice would be invoked more often
- There may be cases when the CAPS provider waits to sign a note until pending information that could influence the medical decision making is available, such as a forensic interview, scene investigation, diagnostic tests, etc.

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The End

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