

# The Health Plan Standards for Patient Records



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## **Disclaimer**

This document is intended as a guideline only. The guideline is not a substitute for the exercise of the physician's independent medical judgment.



**2018**  
**STANDARDS FOR PATIENT RECORDS**

The medical record should be organized with the various types of information placed in a consistent location to enable easy access for reviewing the chart. Practitioners are responsible for medical records that were created in their office only.

1. **Patient Identification:** Each page in the record or electronic file contains the patient's name and date of birth or chart ID.
2. **Advance Directives:** There is evidence that advance directives have been executed or that information regarding advance directives was provided to The Health Plan members age 18 and over.
3. **Completed Problem List:** A problem list noting significant and/or chronic medical/surgical conditions is in the medical record.
4. **Completed Medication List:** Medication list includes name of medication, dosage, frequency, start date and stop date. The Medication List should be reconciled at each visit. Any change to medications requires either dating and initialing the change or entering a stop date for the initial entry and re-entering the medication with the change. For patients that have had admissions to an acute or non-acute facility, the Medication Reconciliation should include documentation indicating current medications and discharge medications were reviewed and reconciled.
5. **Allergies & Adverse Reactions:** Medication/food allergies and adverse reactions are prominently noted in the record. Absence of allergies should be recorded as N.K.A. The documentation for allergies should be in a consistent location in all charts.
6. **Provider Identification:** All entries in the medical record should contain the author's signature and credentials. (If EMR, electronic signatures and credentials is acceptable). Initials may be used only if there is a signature log identifying 1st initial, last name, and credentials. This standard

excludes ancillary documents such as problem list, medication list, flow sheets e.g., Diabetic Flow Sheet.

7. **Dated Entries:** All entries are dated.
8. **Legibility:** The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer. A second reviewer can be office staff. Non-compliance occurs when a second reviewer cannot read the entry.
9. **Vital Signs: Blood Pressure:** Blood pressure measurements should be checked using optimal technique at every visit with a primary care physician and recorded in the medical record. If the blood pressure reading is abnormally high or abnormally low based on the patient's age, gender, medical/surgical conditions, etc., the blood pressure measurement should be repeated. Both blood pressure readings should be recorded.
10. **BMI or BMI PERCENTILE/ NUTRITION & PHYSICAL ACTIVITY:** Patients' height, weight, and Body Mass Index (BMI) should be assessed at the time of all adult, children, and teens well visits and/or at a minimum of annually. Because BMI norms for children and teens vary with age and gender, any patients under 18 years of age require height, weight and a BMI percentile. The percentile ranking must be based on the CDC's BMI-for-age either by graph or a percentile calculator using standard formulas. For children and adolescents under the age of 18, assessment and/or counseling regarding nutrition and physical activity must be assessed at the time of all well visits and/or at a minimum of annually.
11. **History And Physical (H&P):** The History and Physical documents contain subjective and objective information. H&Ps performed by other medical professionals participating in a member's care meets compliance. Patient-completed questionnaires count as evidence of compliance for history component.
12. **Lab/Other Studies:** All lab and other studies are ordered as appropriate for member age, gender and symptoms, as well as chronic conditions per The Health Plan guidelines.
13. **Clinical Findings & Evaluation:** There must be evidence of clinical findings and evaluation including plan of action/treatment for presenting problem(s).

14. **Return Visit/Follow-Up:** Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
15. **Problems From Previous Visits:** Unresolved problems from previous office visits are addressed in subsequent visits. Unresolved is defined as an illness or symptoms not responding to treatment.
16. **Pain Assessment:** Documentation in the medical record must include evidence of a pain assessment and the date it was performed. This may include a result of an assessment using a standardized pain assessment tool such as a numerical rating scale or pictorial pain scales for example or documentation including negative or positive findings for pain. Screening for chest pain alone or documentation of chest pain alone does not meet overall pain assessment.
17. **Cognitive and Physical Development/Functional Assessment:** Cognitive assessment is meant as an assessment of conscious intellectual activity (as thinking, reasoning, remembering, imagining, or learning words). Assessing and documenting cognitive status on an annual basis during the Annual Wellness Visit, allows practitioners an opportunity to identify delays in mental developmental for children and monitor cognitive decline in patients over time.

Physical development and/or functional assessment is meant as an objective review to identify the milestones of normal growth and development and the signs of developmental delay for children as well as, prevent functional decline, and improve health-related quality of life. Optimizing functional status as an outcome of care is not limited to the elderly, but is of major concern for individuals of all ages with chronic illness or disability. Functional status can include such things as ambulation/mobility, sensory ability (hearing/vision/speech), taking medications, ADLs and self-care to name a few.

18. **Continuity and Coordination of Care:** If a consultation is requested, there should be a note from the consultant in the record. The record should indicate communication and feedback between the primary care physician and all specialists. Specialists that necessitate patients having frequent visits (ex: daily, biweekly, weekly) for care and treatment purposes such as chemotherapy, physical therapy, counselor/therapists, wound care etc. do not need to provide feedback with each visit. It is

expected that any positive and/or negative outcomes be relayed to the primary care provider timely.

19. **Emergency Room Visits:** There is evidence in the medical record of visits to emergency rooms, when applicable.
20. **Hospital Admissions:** There is evidence in the medical record of admissions to hospitals, when applicable.
21. **Tobacco Use:** For patients age 11 and over, assessment of the use of tobacco and smokeless tobacco must be documented. Counseling must occur with identification of tobacco use.
22. **Alcohol Use:** For patients age 11 and over, assessment of the use of alcoholic beverages must be documented. Counseling must occur with identification of alcohol use.

For patients age 21 and over, assessment of the use of alcoholic beverages must be documented. Moderate drinking is defined as no more than one drink a day for women and no more than two drinks a day for men. Twelve ounces of beer; 5 ounces of wine; or 1.5 ounces of distilled spirits (80 proof) counts as one drink. Counseling must occur if alcohol abuse is identified.

23. **Substance Abuse:** For patients age 11 and over, assessment of substance abuse must be documented. Counseling must occur with identification of substance abuse.
24. **Preventive Services:** There is evidence that preventive screening and services are offered in accordance with The Health Plan Preventive Health Guidelines.
25. **Immunization Record:** An immunization record for children and adults is up to date according to The Health Plan Preventive Health Guidelines. Practitioners not providing immunizations in their offices are responsible for obtaining updated information from source providing the immunizations.
26. **Audit Trail:** Does the office maintain an audit log to track access to patient information including user name, document(s), and description of use.

## **ELECTRONIC HEALTH RECORD (EHR)**

1. **Copy & Paste or Cut & Paste:** Does the office have a policy/procedure to monitor and audit information "copied & pasted" or "cut and pasted into" the EHR to ensure copied information includes proper validation including name, credentials, date, time, and source of data?
2. **Defaults:** Defaults are defined as data that is entered that does not require a positive action or selection, or data is entered by abbreviated words or keystrokes. Does the office have a policy/procedure to verify the validity of auto-populated information?
3. **Multiple Individuals Adding Text/Addendums to the Same Progress Note, Entry, Flowsheet:** Do documents with multiple authors or contributors retain signatures so that each individual's contribution is clearly identified?
4. **E-Prescribing:** For offices currently utilizing prescribing, do they have a policy/procedure to monitoring to prevent fraud, waste, and abuse?
5. **Technical Specifications:** Does the office have a policy/procedure such as a backup system to prevent loss or destruction of EHR?
6. **EHR Health Information Exchange:** Does the office have a policy/procedure to ensure secure, authorized electronic exchange of patient information?

### **Resources used in standard development:**

- The Health Plan Quality Improvement Committee
- The Health Plan Guidelines
- Qlarant Quality Improvement Standards
- CMS Quality Improvement Standards
- Centers for Disease Control
- US Department of Health and Human Services
- National Institute of Health