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SUBJECT: Office Management	
POLICY AND PROCEDURE: Medical Records	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The medical record shall be maintained to serve the patient/member and healthcare provider in compliance with legal, accrediting and regulatory agency requirements. All member information is regarded as confidential and obtainable only to authorized persons. Medical Records shall be maintained in accordance with medical legal documentation standards including but not limited to health plan operation manual medical record documentation and medical record keeping standards.

PROCEDURE:

I. The provider/designee will ensure that there is a system for the following:
   A. Medical records are available at each encounter and include outpatient, inpatient, referral services, and significant consultations. There must be a separate medical record for each patient

   B. Medical records are accessible within the facility, or an approved health record storage facility on the facility premises.

II. Confidentiality

   A. Staff will ensure that exam rooms and dressing areas safeguard patients' right to privacy.

   B. Staff maintains confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. Computer monitors should utilize privacy screens, as appropriate, to prevent unauthorized viewing of patient information.

   C. Where applicable, electronic record-keeping system procedures are established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to

ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files.

D. The PCP will ensure that medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release will indicate to whom released and for what purpose. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.

E. Fax forms contain the confidentiality statement

~~F.~~ The PCP will ensure that medical records are maintained for a minimum of 10 years following patient discharge

III. Documentation

A. Format Section of the Medical Record Documentation Standards

a. Member identification is on each page
b. The medical record includes biographical personal data that is easily located.

c. Emergency contact phone number is noted in medical record.

d. Each member has an organized individual medical record. Hard copy medical records are securely fastened.

e. Member's assigned and/or rendering primary care physician (PCP) is identified.

f. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted

g. Person or entity providing medical interpretation is identified and documented each visit, regardless if done by provider, staff or external vendor. (Note: all forms given in language other than English, must have the English version in member's medical record also)

h. Signed Copy of the Notice of Privacy is included in medical record

B. Documentation Section of the Medical Record Documentation Standards

1. The medication allergies (or no known allergies) are documented in a prominent location.

2. Chronic medical problems and/or significant conditions are consistently documented and can be easily identified.

3. Current continuous medications are consistently documented and can be easily identified.

4. Appropriate consents are present and signed:

    a. Consent for treatment
    b. Release of medical records
    c. Informed Consents are present when any invasive procedure is performed.

5. Advanced Health Care Directive information is offered, and date documented. (Adults, 18 years/older and emancipated minors only). (Note: reviewed every 5 years or as appropriate)

6. All entries are signed, dated and legible.

7. Errors are corrected according to legal medical documentation standards

C. Coordination of Care Section of the Medical Record Documentation Standards

1. History of present illness or reason for visit is documented.

2. Working diagnoses are consistent with findings.

3. Treatment plans are consistent with diagnoses.

4. Instruction for follow up care is documented.

5. Unresolved/continuing problems are addressed in subsequent visit(s)

6. The practitioner instructions for follow-up care, (e.g. when a return office visit is needed), is documented.

7. There is evidence documented of practitioner review of consult/referral reports and diagnostic tests results.

8. There is evidence documented of follow up specialty referrals made and results/reports of diagnostic tests, as appropriate

9. Missed primary care appointments and outreach efforts/follow-up contacts are documented.

D. Preventive Care Section of the Medical Record Documentation Standards

1. Pediatric Preventive Care

A. Initial Health Assessment (IHA) includes comprehensive History and Physical that includes Individual Health Education Behavioral Assessment using the DHCS required Staying Healthy Assessment (SHA) tool according to the appropriate age. (see SHA P&P.)

B. Subsequent Comprehensive History and Physical exam completed as age appropriate frequency and SHAs to be reviewed annually and reapplied at age appropriate intervals.

C. Pediatric well visits annually according to AAP guidelines.

1. Alcohol/Drug Misuse: Screening and Behavioral Counselling
2. Anemia Screening
3. Anthropometric measurements
4. Anticipatory guidance
5. Autism Spectrum Disorder Screening
6. Blood Lead Testing
7. Blood Pressure Screening
8. Dental Assessment
    a. Dental home
    b. Flouride supplementation
    c. Flouride varnish
9. Depression Screening
    a. Maternal Depression Screening
10. Developmental Disorder Screening
11. Developmental Surveillance
12. Dyslipidemia Screening
13. Folic acid supplementation
14. Hearing Screening
15. Hepatitis B Screening
16. HIV Screening
17. Intimate Partner Violence Screening
18. Nutrition assessment/Breast Feeding support
19. Obesity Screening
20. Psychosocial/Behavioral Assessment
21. Sexual Activity Assessment
    a. Contraceptive Care
    b. STI screening on all sexually active adolescents, including chlamydia, Gonorrhea, and Syphilis
22. Skin Cancer Behavior Counselling

23. Tobacco Products Use: Screening and Prevention and Cessation Services
24. Tuberculosis Screening
25. Vision Screening

D. Childhood Immunizations

1, Pediatric Immunizations are given according to ACIP guidelines.

2.Vaccine administration documentation (Vaccine administration documentation to include lot number, manufacturer dose, site, VIS publication date)

3.Vaccine Information Statement (VIS) documentation (Vaccine Information Sheet (VIS) given and publication date documented)

2. Adult Preventive Care

A. Initial Health Assessment (IHA) and Comprehensive History and Physical that includes Individual Health Education Behavioral Assessment using the DHCS required Staying Healthy Assessment (SHA) tool according to the appropriate age. (see SHA P&P.)

B. Periodic Health Evaluation according to most recent USPSTF Guidelines

C. Subsequent SHAs to be reviewed annually and reapplied at age appropriate intervals.

D. Adult Preventive Care Screenings

1. Abdominal Aneurysm Screening
2. Alcohol Misuse: Screening and Behavioral Counseling
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. Colorectal Cancer Screening
6. Depression Screening
7. Diabetic Screening
    a. Comprehensive Diabetic Care
8. Dyslipidemia Screening
9. Folic Acid Supplementation
10. Hepatitis B Screening
11. Hepatitis C Screening
12. High Blood Pressure Screening
13. HIV Screening
14. Intimate Partner Violence Screening
15. Lung Cancer Screening

16. Obesity Screening
17. Osteoporosis Screening
18. Sexually Transmitted Infection (STI) Screening including Chlamydia, Gonorrhea and Syphilis
    a. Sexually Transmitted Infections Counseling
19. Skin cancer Behavioral Counseling
20. Tobacco Use Counseling and Interventions
21. Tuberculosis Screening

E. Adult immunizations
1. Given according to ACIP guidelines.(Flu, tetanus, and/or pneumovax if over age 65 or high risk)
2. Vaccine administration documentation to include lot number, manufacturer dose, site, VIS publication date.
3. Vaccine Information Sheet (VIS) given and publication date documentation

3 OB/CPSP Preventive Criteria

A. Initial Comprehensive Prenatal Assessment (ICA)
1. Initial prenatal visit is completed within 4 weeks of entry into prenatal care.
2. Obstetrical and Medical History
3. Physical Exam
4. Dental Assessment
5. Lab Tests
    a. Bacteriuria Screening
    b. Rh Incompatibility Screening
    c. Diabetes Screening
    d. Hepatitis B Virus Screening
    e. Chlamydia Infection Screening
    f. Syphilis Infection Screening
    g. Gonorrhea Infection Screening

B. First Trimester Comprehensive Assessment
1. Individualized Care Plan
2. Nutrition Assessment
3. Psychosocial Assessment
    a. Maternal Mental Health Screening
    b. Social Needs Assessment
    c. Substance Use/Abuse Assessment
4. Health Education
5. Preeclampsia Screening
6. Intimate Partner Violence Screening

C. Second Trimester Comprehensive Re-assessment
    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Preeclampsia Screening
    6. Intimate Partner Violence Screening

D. Third Trimester Comprehensive Re-assessment
    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Preeclampsia Screening
    6. Intimate Partner Violence Screening
    7. Screening for Strep B
    8. TDAP Immunization

E. Prenatal care visit periodicity according to most recent ACOG Standards

F. Influenza Vaccine

G. Referral to WIC and assessment of Infant Feeding status

H. HIV-related services *offered*

I. AFP/Genetic screening *offered*

J. Family Planning Evaluation

K. Postpartum Comprehensive Assessment (within 21-56 days after delivery)

    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health/Postpartum Depression Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Comprehensive Physical Exam