MEDICAL RECORDS STANDARDS

CRITERIA	GUIDELINE
Medical records are stored securely and out of public access	To maintain the confidentiality of patient information, records must be stored away from areas accessible to non-employees. Policies and procedures should be in place to ensure that access to patient information is restricted to authorized individuals only.
Medical records are easily and readily retrievable	The practitioner maintains a system of medical record storage/filing that facilitates quick access and retrieval of clinical information.
Written authorization is obtained for the release and transfer of medical records	Releasing, transferring or copying any patient information without a written consent must be strictly prohibited. Access to patient information should be monitored on a regular basis to avoid inappropriate use of patient information. Providers should have specific policies on how records are transferred to other providers to ensure confidentiality is maintained.
A confidentiality (HIPAA) policy is in place, including P/P for electronic record security	All employees should strictly follow policies and procedures on patient confidentiality. Staff should receive training and sign a confidentiality agreement outlining the organization's confidentiality policy. Facilities using electronic records must have policies and procedures for system back-up and password security.
There is a procedure for retention and safeguarding medical records	State and federal law require that inactive medical records be preserved for at least 7 years after last date of service. It is recommended that pediatric records be kept for a minimum of 7 years beyond the age of adulthood. Records must be maintained in an organized manner that facilitates easy retrieval for a minimun of 7 years. Policies and procedures should be in place delineating the safeguarding of records against loss, theft, destruction or inappropriate use.
The medical record is organized and in chronological order	A standardized medical record format is used to facilitate review of the record and to ensure all pertinent information is present and in order of occurrence. Disorganized records may cause delays or errors in treatment.
Individual charts maintained	The potential for confusing individual entries, consultations and reports of diagnostic testing increases when family members' records are maintained in one chart. Confusing medical information can lead to misdiagnoses or mismanagement, and increases the chance of poor outcomes in patient care.
There is a process to enter name or patient ID on all pages	The patient's name or identification should be recorded on each page of the record. Individual pages can become lost, removed from the chart, misfiled or reproduced by copy machine or facsimile. When the patient's name or ID number is recorded on each page of the medical record, the potential for confusing medical information is reduced.
There is a section and/or form for patient demographic/personal data	Complete personal and demographic data should be recorded on one central and uniform form to include: name, address, home and work phone numbers, occupation, employer, insurance information, marital status, date of birth, emergency contact phone numbers and consent to treatment. This information should be updated at each patient visit to ensure current data.
Medical record documentation standards are applied	Each medical record must include: 1) History and physical, 2) Allergies and/or adverse reactions, 3) Problem list, 4) Medication list, 5) Documentation of clinical findings and evaluations for each visit, and 6) Preventive services/risk screening.
Pages are fastened-not loose	Individual pages can become lost. When the pages of the chart are fastened with clips, the potential for losing medical information is reduced.

All entries dated	All entries should be dated to maintain the chronological order of the chart.
The record is legible	Handwritten records should be legible to a reader other than the author. A legible record ensures continuity of care and accurate interpretation of records by other professionals and clerical staff.
Each entry is signed by the person making the entry	All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials. A signature or initials authenticates the entry and proves that specific individuals have provided services to specific patients.
Problem list maintained	A CURRENT problem list/diagnostic summary sheet should be maintained in each patient record to include significant illness and medical conditions. As changes or updates occur, they may be added and dated. In this way, a patient's major diagnoses, recurrent complaints and preventive care are available in a summarized format for quick review.
Medication list maintained	Establishing and maintaining a CURRENT comprehensive listing of medications provides a quick reference to all prescription and over-the-counter drugs provided to the patient. It should include allergies, dates of initial prescriptions/refills and stop dates.
Allergies/adverse reactions prominent or NKA noted	Medication allergies, histories of adverse reactions or the absence of allergies should be prominently displayed in a consistent location in each patient chart. By choosing a consistent location in each chart (such as the front of the chart or on the medication list), providers and staff can quickly reference allergy status without reading through narrative progress notes.
Appropriate past medical history	Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, illnesses, hospitalizations, family medical history and social history. It should be updated periodically as appropriate. For Behavioral Health, past medical history relates to medical and psychiatric information. For children and adolescents 18 years and younger, past medical history relates to prenatal care, birth, operations, childhood illness and developmental history.
Documentation of smoking habits and ETOH/Substance abuse	Lifestyle risk factors such as smoking habits, alcohol use and substance abuse, should be assessed and documented in the medical record for patients 10 years and older. Substance abuse should be assessed in patients seen 3 or more times. Assessment of risk factors can identify interventions to be incorporated into the patient's individual preventive health plan.
Pt/health education, counseling or medical social services as required documented	Patient education includes information concerning the diagnosis, instructions regarding diet, exercise and medications, pertinent risk factors and providing information about health maintenance. This helps patients to become active participants in their own care and improves compliance with the plan of care. You can ensure that information and services have been offered/reinforced during subsequent encounters.
Pertinent history and physical exam	Documentation of both subjective symptoms and objective exam findings pertinent to the patient's presenting complaints are used to develop a treatment plan for the patient. Behavioral health initial assessments should include problems, needs, strengths, functional, nutritional and mental status, family support system and history of any physical/sexual abuse.
Labs and other studies ordered as appropriate	Progress notes should include documentation of appropriate diagnostic studies and lab work ordered. Requested diagnostic testing should be consistent with the patient's presenting history and physical examination. Notes should also indicate when the patient has been referred for such tests and failed to follow through.
Working diagnoses consistent with findings	The diagnosis or medical impressions documented should be consistent with the physical findings. The medical record should document a diagnostic assessment or, at the very least, medical impressions if a definitive diagnosis is not possible. There must be a DSM-IV diagnosis on all 5 axes for Behavioral Health.

Plans of action/treatment consistent with diagnosis(es)	The treatment plan stated should be consistent with the documented diagnosis. A plan of treatment, including specific documentation of any treatment or procedure actually performed, should be present in the record and based on the patient's health care and social needs.
There is notation of follow-up needed within a specific timeframe	Encounter forms or progress notes should include notation of follow up care, calls orreturn visits needed for follow-up within a specific timeframe (e.g. days, weeks, months or PRN). This ensures either resolution of the health problem or continued care if the problem still exists. If follow-up to care is not needed, a preventive health screening should be advised.
Unresolved problems from previous visits addressed	It should be evident from the record that unresolved problems from previous visits are addressed in subsequent visits. This documentation will reflect on the continuity of care provided by the physician.
Evidence of appropriate use of consultants-no over or underutilization	Requests for specialist consultations should be consistent with physical findings and medical impressions. The record should include the reason for requesting the consultation.
Evidence of continuity/coordination of care with primary and specialty physicians	When consultations or referrals have been ordered, a copy of the consultation should be present in the record. This demonstrates evidence of continuity of care maintained between the primary care provider and the specialist.
Consultant summaries, lab and imaging study results reflect physician review	Consultations, lab results, imaging studies and other diagnostic reports should reflect the ordering practitioner's review, authenticated with initials or signature, and with an explicit notation of follow-up plans. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. With no indication of physician review, it is not clear that proper physician or patient notification has occurred.
Communication of abnormal labs and/or test results to patient documented	When significantly abnormal lab results or diagnostic findings are filed in the record, notation should be made in the record of patient notification and follow-up plans. Providers should be sure to document that patients understand the need for and the nature of continuing treatments, as well as the implications of abnormal studies.
Immunizations up to date for children or there is an appropriate history in the adult record	There should be a appropriate immunization histories documented for adults. Documentation should reflect adult and pediatric immunizations consistent with the recommended immunization schedule of the Centers for Disease Control and Prevention (CDC). Because patients may be new to a provider and had immunizations elsewhere, it is important that the provider document communication with parents and other providers regarding immunizations.
Care appears to be medically appropriate	There should be evidence that the care delivered is consistent with the diagnosis(es).
Preventive services appropriately used in accordance with the organization's practice guidelines.	Records should reflect compliance with EPSDT periodicity schedules for preventive care for appropriate populations. Providers should discuss mammograms, pap smears, breast exams, prostate exams, hemoccult testing and cholesterol screening with adult patients. Whether patients choose to undergo these tests, defer them or refuse them, providers should document the discussion.
No evidence that the patient is put at risk by a diagnostic or therapeutic procedure	It should be evident that specific procedures, either for diagnosis or treatment, do not place the patient at risk (such as an MRI being done on a patient with a pacemaker). This includes procedures that are omitted, such as a flu shot for a senior or asthmatic.

PEDIATRIC MEDICAL RECORDS STANDARDS – The following criteria apply to pediatric providers in addition to the standards above

CRITERIA	GUIDELINE
Childhood or Adolescent Immunization status/history is documented	There should be a current immunization record for children. Documentation should reflect pediatric immunizations consistent with recommended immunization schedule of the Centers for Disease Control and Prevention (CDC). Because patients may be new to a provider and had immunizations elsewhere, it is important that the provider document communication with parents and other providers regarding immunizations.
Well-Child Visits Newborn to 15 months of age	At each well visit a complete physical examination is essential. Records should reflect compliance with EPSDT Periodicity Schedules for newborns to 15 months of age.
Well-Child Visits at 3, 4, 5 and 6 years of age	At each well visit a complete physical examination is essential. Records should reflect compliance with EPSDT Periodicity Schedules for 3, 4, 5 and 6 year olds.
Adolescent Well-Care Visits are documented (12+ years of age)	At each well visit a complete physical examination is essential. Records should reflect compliance with EPSDT Periodicity Schedules for adolescents (12+ years old).

BEHAVIORAL HEALTH MEDICAL RECORDS STANDARDS – The following criteria apply to all Behavioral Health providers in addition to the standards above

CRITERIA	GUIDELINE
There is a signed and dated consent to treatment	There should be a signed and dated consent to treatment on each record. It is the patient's right to informed consent unless legally determined incompetent.
Assessment/progress notes indicate presenting problems and relevant psychosocial condition	This is to ensure the level and intensity of care and to determine referral needs. There should be a psychosocial assessment to include at minimum: threat of harm to self or others, need for intensity of supervision, barriers to processing information, potential/actual neurological deficits, mood and affect, signs/symptoms of psychosis and other thought disorders.
Assessment/progress notes indicate appropriate past medical/psychiatric history	Information obtained during a complete history such as: significant illnesses, surgery, accidents, hospitalizations, family medical history and social history, should be documented and updated periodically as appropriate. Medical and psychiatric information for children and adolescents should include prenatal and perinatal events and complete developmental history. History should include past psychiatric hospitalizations, outpatient therapy and testing for adults and children.
Assessment/progress notes indicate DSM IV diagnoses on Axes I, II and III	Using the American Psychiatric Association's standards, the Multiaxial system provides an overview of the patient. Axis I: the focus for treatment; Axis II: personality disorders and mental retardation; Axis III: general medical conditions.
Assessment/progress notes indicate problems, needs and strengths	This should include coping skills to ensure level and intensity of care. It should be evident that the patient is involved in determining the plan of care.
Assessment/progress notes indicate functional status	Functional status should be according to Axis V, the Global Assessment of Functioning (GAF).

Assessment/progress notes indicate nutritional status	Nutritional status should be specific when related to eating disorders. Weight and appetite should be included.
Assessment/progress notes indicate family and support system	Family and support system should be according to Axis IV, psychosocial and environmental problems (including degree of severity).
Assessment/progress notes indicate history of abuse and compliance with reporting as applicable	State laws should be followed when reporting abuse.
Assessment/progress notes indicate comprehensive documentation of mental status exam results	A mental status exam should include general physical appearance, behavior activity, speech, affective state, thought process, perception, memory and coping skills.
Assessment/progress notes indicate imminent risk of harm, suicidal ideations and plan for safety	Documentation should include specific suicidal plans and contracts made with the patient for safety.
There is documentation of missed appointments and when applicable, documentation of followup efforts	Missed appointments should be documented as part of non-compliance with the treatment plan. When appropriate to the patient's situation, there should be documentation of follow-up or why follow-up should not be done.