Santa Clara
Family Health Plan
The Spirit of Care

To: Providers and Delegates

From: Santa Clara Family Health Plan (SCFHP)

Date: December 18, 2014

Subject: **Medical Records Standards**

Dear Providers and Delegates:

Please see the attached SCFHP Medical Record Standards for the Practitioner's Office/Clinic. All participating providers must adhere to these guidelines in accordance with California Department of Health Care Services' (DHCS) regulatory requirements.

The medical record standards were taken from the SCFHP Physician and Medical Services Operating Manual, the SCFHP Quality Improvement Program, SCFHP's most current Adult Preventive Health Guidelines and Pediatric Preventive Health Guidelines, the DHCS Facility Site and Medical Record Review Criteria, and the National Committee for Quality Assurance (NCQA) Managed Care Organizations Standards for Medical Records.

If you have any questions, please feel free to call us at 1-408-874-1788 or email us at providerservices@scfhp.com.

Thank you for your continued support!

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www.scfhp.com

Medical Records Standards for the Practitioner's Office/Clinic

The medical record is an important source of patient data. It documents the health care provided to the patient by the practitioners. Therefore, it is important that the medical record be current, detailed, and organized to promote effective continuity of patient care, promote efficient and effective treatment, and facilitate quality review.

The following guidelines/standards for patient medical records were taken from the Santa Clara Family Health Plan (SCFHP) Physician and Medical Services Operating Manual, the SCFHP Quality Improvement Program, SCFHP's most current Adult Preventive Health Guidelines and Pediatric Preventive Health Guidelines, the Department of Healthcare Services Facility Site and Medical Record Review Criteria and the National Committee for Quality Assurance (NCQA) Managed Care Organizations Standards for Medical Records.

1. All active medical records must be stored in a secured area that is accessible only to office staff who have direct patient care responsibilities;
2. Inactive records are stored for a minimum of 7 years and may be kept in a location off-site. Children's records must be saved until the child reaches 21 plus the statute of limitations or 24 years of age;
3. All records must be protected from loss, tampering, destruction, alteration, and unauthorized or inadvertent disclosure of information;

Requests for clinical information cannot be released without prior written approval of the patient or parent/guardian. Exceptions to written approval and signed release of medical records information may be made if regulatory criteria for disclosure of information without authorization are met.

Medical Records Standards

1. Format Criteria
A. An individual medical record is established for each patient • "Family charts" are not acceptable
B. Member's Identification is on each page • Identification includes first and last name and/or a unique patient number
C. Individual personal biographical information documented • If patient refuses, "Refusal" is noted in the medical record
D. Emergency Contact is identified • If a patient refuses, "Refusal" is noted in the medical record
E. Medical records are consistently organized
F. Chart contents are securely fastened
G. Member's assigned primary care physician (PCP) identified • Assigned PCP is ***always*** identified
H. Primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing-impaired persons are prominently noted • Patient refusal of interpreter services documented
2. Documentation Criteria
A. Allergies are prominently noted • In a consistent location in the medical record • If no known allergies or adverse reactions, "No Known Allergies" (NKA, NKDA), or Ø is documented
B. Chronic problems and/or significant conditions are listed • May be on a separate "problem list" page
C. Current continuous medications listed • May be on a separate "medication list" page and includes medication name, strength, dosage, route, and start/stop dates
D. Signed *Informed Consents* are present when any invasive procedure is performed • For medical treatment, operative, and invasive procedures, human sterilization, and for release of medical information
E. Advanced Health Care Directive information offered (Adults, 18 years/older Emancipated Minors) • Document: Offered information and/or executed
F. Entries are made in accordance with acceptable legal medical documentation standards • All entries are signed, dated, and legible. Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page)

G. Errors are corrected according to legal medical documentation standards • No cross-outs, erased entries, or use of correction fluids • Note: The S.L.I.D. rule is one method used to correct documentation errors: Single Line, Initial, Date (omit the written word "error")
3. Coordination/Continuity of Care Guidelines Criteria
A. History of present illness documented
B. Working diagnoses are consistent with findings
C. There is evidence of Health Plan and/or other agency Individual Care Plan for high risk members
D. Treatment plans are consistent with diagnosis and documented for each diagnosis
E. Instructions for follow-up care documented • Specific follow-up instructions and a definite time for return visit or other follow-up care documented
F. Unresolved and/or continuing problems addressed in subsequent visit(s) • Until problems are resolved or a diagnosis is made
G. There is evidence of practitioner review of consult/referral reports and diagnostic test results • Consultation reports and diagnostic test results documented for ordered requests • Evidence of review may include the physician's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting physician review • Abnormal test results/diagnostic reports have explicit notation in the medical record • Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals, and/or other pertinent information
H. There is evidence of follow up of specialty referrals made and results/reports of diagnostic tests, when appropriate • Consultation reports and diagnostic test results documented for ordered requests • Abnormal test results have explicit notation in the medical records, including attempts to contact the member/guardian for follow-up treatment, etc. • Missed or broken appointments for diagnostic procedures, lab tests specialty appointments and/or other referrals are noted and include attempts to contact the member/guardian and results to follow up actions
I. Missed primary care appointments and outreach efforts/follow-up contacts are documented • Documentation includes incidents of missed/broken appointments (cancellations or "No Shows"). Attempts to contact the member and/or parent/guardian (if minor) and the results of follow-up actions are also documented

4. Pediatric Preventative Guidelines Criteria

A. Initial Health Assessment (IHA) includes H&P and IHEBA
- Completed within specified timeline for the provision of an IHA from the date of enrollment into the health plan according to SCFHP's IHA policy or documented IHA within the past 12 months
- If IHA is not present, the reason must be documented in the medical record e.g. patient refusal, missed appointments and contact attempts to reschedule are documented

B. Individual Health Education Behavioral Assessment (IHEBA)
- Age Appropriate IHEBA at age intervals:
  - 0-3 years
  - 4-8 years
  - 9-11 years
  - 12-17 years
  - 18 years and older
- Health Education and Anticipatory Guidance documented at each health assessment visit
- Problems, interventions, and referrals documented

C. Age-appropriate physical exams according to most recent AAP schedule. AAP scheduled assessment must include all components required by the Child Health and Disability Program (CHDP) for the lower age nearest to the current age of the child including:
- Initial History
- Physical Examination from head to toe
- Height, Weight, are documented at each well child exam
- BMI percentile is plotted on an appropriate CDC growth chart for each well exam ages 2-20 years
- Head circumference of infants up to age 24 months
- Blood Pressure for children over 3 years of age
- Hematocrit/Hemoglobin –9-12months of age & all menstruating adolescents should be screened
- Pelvic Exam/Pap Smear, Chlamydia/STI screening annually if sexually active 11 years and older
- Tobacco and Drug/Alcohol Habit assessment
- Urine Test (Urine Dipstick or urinalysis) at each health assessment visit starting at 4-5 years
- Assessments and identified problems recorded on the PM160 form is documented in the progress notes
- Developmental screening at each visit and screening for
- Developmental disorders at the 9^{th},18^{th} and 30^{th} month visit
- Evidence of referrals to the Early Start programs
- Evidence of communication and acknowledgement of HP and SARC on Early Start referrals/follow up
- STI screening on all sexually active adolescents
- Pap smear within three years of onset of sexual intercourse

D. Vision Screening

- Age appropriate visual screening occurs at each health assessment visit
- Visual acuity screening usually begins at age 3 years

E. Hearing Screening
- Non-audiometric screening for infants/children (2 months - 3 years) includes family and medical history, physical exam, and age-appropriate screening
- Audiometric screening for children and young adults (3-21 years) is done at each health assessment visit

F. Nutrition Assessment
- Screening includes food/nutrient intake and eating habits
- At-risk children under 5 years of age referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program

G. Dental Assessment
- Inspection of the mouth, teeth, and gums are performed at every health assessment visit
- A child is referred to a dentist at any age if a problem is detected or suspected
- Beginning at age 3 years, all children are referred annually to a dentist

H. Blood Lead Screening
- Blood lead level (BLL) testing done at 12 months and 24 months of age
- Children with confirmed BLL's >20µg/dl must be referred to CCS

I. Tuberculosis Screening
- All children screened for risk of exposure to tuberculosis (TB) at each health assessment visit
- The Mantoux skin test administered at ages 4-5 years and ages 11-16 years
- For all positive skin tests, there is documentation of follow-up care

J. Childhood Immunizations
- Immunization status documented including name of each vaccine given, the manufacturer, and lot number
- The Vaccine Information Sheet (VIS) given for each immunization and the publication date of the VIS documented in the medical record
- Note: Immunizations administered according to the most recent recommended pediatric and adolescent immunization schedule established by the CDC Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent

5. Adult Preventative Guidelines Criteria

A. Initial Health Assessment (IHA) includes H&P and IHEBA
- New members: A History and Physical completed within 120 days of the effective date of enrollment into the health plan according to SCFHP's IHA policy or documented IHA within the past 12 months
- If an IHA is not present, patient's refusal, missed appointments or other reason must be documented

B. Individual Health Education Behavioral Assessment (IHEBA)
- For adults 18 years and older, IHEBA is re-administered every 3-5 years

- Clinical interventions, health education and counseling and/or referrals are noted

C. Periodic Health Evaluation
- In accordance with SCFHP current Adult Preventive Health Guidelines

D. Tuberculosis Screening
- All adults screened for tuberculosis (TB) risk factors
- When a positive skin test is noted, there is documentation of follow-up care

E. Blood Pressure
- Height, Weight, BMI, and Blood Pressure (BP) measurement documented at least once every 2 years

F. Obesity Screening
- Includes weight and BMI

G. Lipid Screening
- Total Cholesterol and high –density lipoprotein cholesterol (HDL-C) screening – every 5 years starting for males at age 35 years & women at age 45 years

H. Chlamydia Screening
- Annual Chlamydia infection screening for sexually active females 25 years and under (and older depending on risk factors)

I. Breast Cancer Screening
- Mammogram screening starting at age 40 years and then every 1-2 years of age depending on risk factors

J. Cervical Cancer Screening
- Pelvic Exam/Pap Smear – depending on risk factors every 1-3 years starting at 21 years of age
- For women ages 30 to 65 years a screening every 5 years is acceptable if a combination of cytology and Human Papillomavirus (HPV) takes place at each interval
- Routine Pap testing may not be required for the following:
    i. Women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of invasive cancer
    ii. Women after age 65 who have had regular previous screenings in which the smears have all been consistently normal

K. Colorectal Cancer Screening
- All adults are screened from age 50-75 years to include:
    - Annual screening with high-sensitivity fecal occult testing **OR**
    - Sigmoidoscopy every 5 years with high sensitive fecal occult blood testing every 3 years **OR**
    - Screening colonoscopy every 10 years

L. Adult Immunizations
- Immunization status and/or immunizations administered, including name of each vaccine, date given, the manufacturer, and lot number are documented
- The date Vaccine Information Statement (VIS) given and the publication date of the VIS

documented
- Note: Immunizations administered according to the most recent adult immunization schedule recommended by the CDC Advisory Committee on Immunization Practices, unless medically contraindicated or refused by the patient

6. Perinatal Preventative Guidelines Criteria

A. Initial Comprehensive Assessment (ICA)
- The ICA, completed within 4 weeks of entry to prenatal care, includes the following obstetric/medical assessments:
  - Health and obstetrical history (past/current)
  - LMP
  - EDD
  - Physical Exam
  - Lab Tests
  - Nutrition Counseling
  - Psychosocial
  - Health Education
  - Screening for Hepatitis B Virus
  - Screening for Chlamydial Infection
    - All pregnant women ages 25 and younger and older pregnant women who are at increased risk are screened for Chlamydia during their first prenatal visit

B. Second Trimester Comprehensive Re-assessments
- Include Obstetric/medical, Nutrition, Psychosocial and Health Education assessments are completed during the 2nd trimester

C. Third Trimester Comprehensive Re-assessment
- Re-assessment includes Obstetric/Medical, Nutritional, Psychosocial and Health education are completed during the 3rd trimester
- Screening for Strep B between 35th and 37th week of pregnancy

D. Prenatal care visit periodicity according to most recent ACOG standards
- For a 40-week uncomplicated pregnancy, document missed appointments, attempts to contact patient, and/or outreach activities

E. Individualized Care Plan (ICP)
- ICP documentation includes specific obstetric, nutrition, psychosocial and health education, risk problems/conditions, interventions, and referrals

F. Referral to WIC and assessment of Infant Feeding status
- All plan members referred to WIC
- Referral to WIC documented in the medical record

G. HIV-related services offered
- The offering of prenatal HIV information, counseling, and HIV antibody testing documented

H. AFP/Genetic Screening offered
- The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period documented
- Genetic Screening documentation includes:
  - Family history
  - Triple marker screening tests
  - Member's consent or refusal to participate

I. Domestic Violence Abuse Screening
- Provision of Domestic Violence Screening documented

J. Family Planning Evaluation
- Family Planning counseling, referral, or provision of services documented

K. Postpartum Comprehensive Assessment
- Postpartum reassessment includes:
  - Medical exams
  - Nutrition (mother and infant)
  - Psychosocial
  - Health education within 4-8 weeks postpartum
- Document missed appointments; attempts to contact patient and/or outreach activities
- Infant feeding/breast feeding status documented during the postpartum period