

## Medical Record Standards

McLaren Health Plan strives to provide high quality care for our members. Complete and accurate medical record documentation is essential to ensure optimum communication between all providers of care and to support patient safety.

Medical Record Review Standards are distributed at orientation. The following documentation should be in each patient medical record:

### **A. PATIENT IDENTIFICATION**

Identification sheet or demographic data documented and current.

- 1) AN IDENTIFICATION SHEET, WHICH INCLUDES ALL OF THE FOLLOWING INFORMATION PERTAINING TO THE PATIENT/ENROLLEE:
  - a. Name
  - b. Address
  - c. Date of Birth or Age
  - d. Gender (*Except Obstetrics and Gynecology*)
  - e. Emergency contact person
  - f. Home and work telephone numbers
  - g. Employer
  - h. Marital status

### **B. RECORD CONTENT**

The following documentation should be in each patient's medical record:

- 1) ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS PROMINENTLY DISPLAYED  
May be on front cover, inside cover, medication sheet, patient information sheet.
- 2) ALL ENTRIES IN MEDICAL RECORD CONTAIN THE WRITER'S ID (INCLUDING FLOW SHEETS)  
All writers in the patient record (including flow sheet) must be identified. If initials or signature stamp is used, a signature list is available. A written policy and procedure is needed for use of the signature stamp and the stamp must be locked or kept with the practitioner at all times.
- 3) ALL PAGES CONTAIN PATIENT ID  
If pages are not secured in the record, each page must have an ID# (e.g. DOB, MR#, etc.) in addition to the name.
- 4) RECORD LEGIBLE  
Can be read by at least two people other than the writer.
- 5) ALL ENTRIES DATED
- 6) UPDATED PROBLEM LIST  
Pediatric records should include any acute or recurrent problems.
- 7) UPDATED MEDICATION LIST  
Must be separate from progress notes
- 8) IMMUNIZATION RECORD PRESENT  
Is there a centralized form in record for recording all immunizations?

9) **ADVANCE DIRECTIVES**

The Michigan Legislature authorized the use of Durable Power of Attorney for Health Care in our state. The member can appoint another individual to make decisions concerning his/her care, custody and medical treatment when member is unable to participate in medical treatment decisions. Need to have evidence of inquiry of Advance Directives prominently located. (Adults age 18 and older).

10) **APPROPRIATE MEASURES TAKEN TO ENSURE CONFIDENTIALITY OF PATIENT MEDICAL RECORDS**

Includes storage, accessibility of records, (must not be accessible to patients), release of information, a written policy and procedure, and a signed confidentiality statement.

11) **MEDICAL/TREATMENT RECORD ORGANIZED IN A CONSISTENT MANNER**

All labs, x-ray reports, consults, etc., organized in the record in a consistent manner.

**C. HEALTH HISTORY**

Comprehensive health assessment completed or offered. If patient refuses to complete the form documentation should be present. Checklists are acceptable as long as they include the following:

1) **MEDICAL HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)**

Patient can complete, but practitioner must review, date and sign. Include delivery data for children.

2) **FAMILY HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)**

As above. For children, if in foster care or adopted, it must be documented.

3) **SOCIAL HISTORY DOCUMENTED**

Marital status. # of children, sexual activity & contraceptive usage.

4) **SUBSTANCE USE DOCUMENTED**

Includes documentation of smoking habits and history of patient alcohol use, according to Plan's Preventive Guidelines.

5) **SAFETY EDUCATION**

Evidence of inquiry regarding use of seat belts, helmets, smoke detectors, etc.

6) **COMPLETE PHYSICAL EXAMINATION**

A completed physical exam should be documented or offered, in timeframes according to Plan's Preventive Guidelines.

7) **ABUSE INQUIRY**

Evidence of inquiry regarding present or previous mental, physical, sexual abuse.

**D. PROGRESS NOTES**

1) **REASON FOR VISIT**

The reason patient came to see the practitioner.

2) **OBJECTIVE PHYSICAL FINDINGS**

What physical findings are found according to patient presenting complaints.

3) **DIAGNOSIS/PHYSICAL FINDINGS**

4) **TREATMENT RENDERED**

What was done for the patient relative to the patient's presenting complaints.

5) **FOLLOW UP PLANS**

Next visit, return as needed, etc.

6) **PREVIOUS UNRESOLVED PROBLEMS ADDRESSED**

#### **E. REFERRALS/CONSULTANTS**

- 1) REPORT DATED UPON REVIEW BY PHYSICIAN
- 2) SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN
- 3) CONSULTANT/REFERRAL REPORTS IN RECORD
- 4) REFERRALS ISSUED APPROPRIATELY

#### **F. LAB/X-RAY REPORTS**

- 1) DATED UPON REVIEW BY PHYSICIAN (CAP Required if not passed)
- 2) SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN (CAP required if not passed)
- 3) FOLLOW-UP TO ABNORMAL FINDINGS  
Need documentation of patient notification of abnormal findings and plan to address findings (CAP required if not passed)

#### **G. PREVENTIVE SERVICES**

Preventive healthcare services should be offered and documented accordingly.

- 1) IMMUNIZATIONS APPROPRIATE FOR AGE  
Evidence of immunizations, according to the Plan's Preventive Guidelines
- 2) MAMMOGRAM
- 3) PAP SMEAR
- 4) PSA  
Performed in accordance with the Plan's Preventive Guidelines
- 5) PATIENT EDUCATION  
Based on diagnosis and Plan's Preventive Guidelines
- 6) SMOKING INQUIRY ON EACH VISIT  
Recommended to be done on each visit; may be noted on vital signs sheet
- 7) SMOKING COUNSELING ON EACH VISIT

#### **H. CONTINUITY AND COORDINATION OF CARE**

- 1) IS THERE EVIDENCE OF CONTINUITY AND COORDINATION OF CARE BETWEEN PRIMARY AND SPECIALTY PHYSICIANS?  
Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners, behavioral health practitioners, and other specialist providers.
- 2) EVIDENCE OF DISCHARGE SUMMARIES FROM HOSPITALS
- 3) EVIDENCE OF DISCHARGE SUMMARIES OR PROGRESS NOTES FROM SKILLED NURSING FACILITIES/HOME HEALTH PROVIDERS

MHP on an annual basis chooses two medical record standards (e.g., patient identification, record content, and continuity and coordination of care) to be assessed through an on-site visit at 50% of PCP's with >50 members.

If this review or an entire standard review is completed, passing is at a minimum of 80% of charts must be in compliance. If any review section is below 80%, a corrective action plan (CAP) is required to be submitted within 30 days, as well as a re-visit in 60 days.