Paramount
Paramount *Advantage*
Paramount Elite
Paramount Care of Michigan, Inc.

Medical Record Documentation Standards – Adult

	Standard	Performance Measures
A	**General Requirements**	
1	Oversight of medical records system	• There is a designated staff person who is qualified by training or experience for the oversight of, and access to, the medical records system.
2	**Medical records confidentiality policy**	• **Provider site maintains a policy regarding the confidentiality of medical records which ensures records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of health information** • **Policy should address the training/education of personnel in regards to patient confidentiality** • **Policy should include compliance with and adherence to Federal HIPAA privacy and security regulations** • **In addition, personnel must hold all information obtained about patients related to their examination, care and treatment confidential and not divulge the information without the patient's authorization, unless such information is:** ➢ **Required by law,** ➢ **Necessary to coordinate the patient's care with physicians, hospitals or other health care entities, or to coordinate insurance or other matters pertaining to payment, or** ➢ **Necessary in compelling circumstances to protect the health or safety of an individual** • **Any release of information in response to a court order must be reported to the patient in a timely manner** • **Policy addresses authorized access to the EMR system (where applicable) and how access is controlled (i.e. unique log-ins and passwords for users, log-off procedures, etc.)**
B	**Structural Integrity**	
1	Elements in the medical record are organized in a consistent manner	• Medical record is clearly organized • Records are organized in chronological order • Medical record does not contain information for other patients • If family members are in one record, each family member must be clearly separated • All EMR entries (where applicable) are indexed consistently
2	Pages are secured	• All pages, reports and forms are maintained in such a way to prevent loss and misfiling

3	Demographic sheet included in medical record	• Personal demographic sheet to include the address, employer, insurer, emergency contact, marital status and home/work telephone numbers
4	All pages contain patient identification	• All pages in medical record will contain at least one of the following for patient identification purposes: ➢ Patient's full name ➢ Identification number
5	All entries dated	• All entries, updates, and addendums in the record must be dated.
6	All entries signed by author	• All entries in medical record must be signed by the author • Author identification may be a handwritten signature, unique electronic identifier or initials • A signature & initial log must be maintained by the office • Timely, signed approval of all EMR entries (where applicable) is evident
7	Entries are legible	• Entries are legible to a reader other than the author • Content of records is presented in a standard format that allows a reader, other than the author, to review without the use of separate legend/key • Scanned images of documents (in EMR, where applicable) are clear and legible
C	**Health Maintenance**	
1	**Updated problem list is maintained**	• **A problem list (patient summary) which summarizes significant illnesses and medical/psychological conditions, including those that are chronic, is updated and maintained on the chart** • **All notations on the problem list (patient summary) are dated**
2	Current medication(s) are documented and reviewed annually by practitioner	• Information regarding current medications is readily apparent • Changes to medication regimen are noted as they occur • Documentation of at least annual review of medications by practitioner
3	**Medication allergies and adverse reactions are prominently noted in the record**	• **Medication allergies are noted in a prominent place** • **Adverse reactions (such as rash, vomiting, etc.) are also noted; history of an <u>unknown</u> adverse reaction should be indicated as such** • **If patient has no known allergies or history of adverse reactions, there is appropriate documentation of "none" or "NKDA"**
4	Documentation regarding the use of tobacco, alcohol, and drug/substance abuse	• Must have documentation in the medical record regarding smoking habits, history of alcohol use and drug/substance abuse for patients 12 years of age and older • Should be documented when patient establishes care and updated/reviewed annually • Prevention and/or education should also be documented in the record
D	**History and Physical**	

1	**Past medical history is documented in medical record**	• **History documentation should include serious accidents, operations, illnesses, and procedures** • **Self administered patient questionnaires are acceptable to obtain baseline past medical history** • **There is written documentation to explain lack of information regarding history (e.g. poor historian, unwilling to provide information, etc.)** • **Medical and surgical history should be updated annually**
2	Comprehensive physical exam every 1-2 years	• A comprehensive exam should include a review of all systems (cardiovascular, pulmonary, endocrine, gastrointestinal, HEENT, hepatobiliary, musculoskeletal, neurological) and a psychosocial assessment • All chronic conditions should be assessed and/or addressed • The exam should also document height, weight, BMI, and vital signs • For patient's age 65 and over, or those with special needs, an annual pain assessment and functional assessment should be documented as well
E	**Documentation For Each Visit/Encounter**	
1	Reason for visit/chief complaint is clearly documented	• The reason for each encounter is clearly documented; may include the patients own words
2	**Objective findings/clinical assessment is documented**	• **Objective findings/clinical assessment and physical examination are documented and correspond to the patient's chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses**
3	**Working diagnoses are documented and consistent with findings**	• **Working diagnoses that logically follow from the clinical assessment and physical examination are documented** • **Documentation of chronic conditions are in accordance with established Clinical Practice Guidelines**
4	**Plan of action/treatment is documented and consistent with diagnosis(es)**	• **Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses** • **Rationale for treatment decisions appear medically appropriate and substantiated by documentation in the medical record** • **Laboratory and other studies are ordered as appropriate**
5	**There is no evidence patient is placed at inappropriate risk by a diagnostic or therapeutic procedure**	• **Clear justification for diagnostic and therapeutic procedures is documented in the medical record**
6	Unresolved problems from previous visits are addressed in subsequent visits	• Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes
7	Follow-up instructions and time frame are documented	• Specific follow-up visits/instructions should be documented and time frame should be documented in days, weeks, months, or as needed (prn)
F	**Continuity of Care**	

1	Consultation, lab and imaging/test results reflect provider review	• Consultation, lab and imaging/test results are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement) • If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner • EMR scanned reports should be initialed prior to scanning/indexing or have an electronic signature with date stamp • Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans
2	Hospital discharge summaries are filed in medical record and reviewed by PCP within 30 days of discharge	• Hospital discharge summaries are included as part of the medical record for all hospital admissions • Review of discharge summary by PCP within 30 days of discharge is documented by practitioner's initials and dated (electronic signature with date stamp for EMR)
3	Patient noncompliance addressed by provider	• Patient noncompliance is documented • Continued noncompliance is readdressed periodically
G	**Preventive Care and Counseling**	
1	Complete immunization record or documented history	• Medical record includes documentation of immunizations administered, including flu shots; or, there is documentation that immunization status was addressed
2	Preventive screening and services are offered in accordance with Paramount Health Care, Paramount Elite, Paramount Advantage and Paramount Care of Michigan's practice guidelines	• Medical record should include documentation that preventive services (i.e. colonoscopy, cervical cancer screening, etc) were ordered and performed • If patient chose to defer or refused services documentation of such should be made as well • Practitioners may document that a patient sought preventive services from another practitioner, e.g., OB/GYN
3	Diet & exercise with annual BMI	• Documentation of counseling relative to diet (including fat and cholesterol intake & screenings), exercise and/or activity level, and evaluation of lifestyle • Should also include documentation of height, weight and BMI annually
4	Advance care planning	• For patient's age 65 and over, or those with special needs, there is documentation in the medical record that the issue of the living will or durable power of attorney for healthcare has been discussed with the patient or that the practitioner has counseled/educated the patient on advanced care planning • It is recommended that a copy of any advanced care directives (e.g. POA, DNRCC, etc.) be on file in the medical record

Critical Documentation Standards are bolded