Heath Partners Medical Record Documentation Standards

Consistent and complete documentation in the medical record is an essential component of quality patient care. The Health Partners standards have been developed utilizing the standards of the National Committee for Quality Assurance (NCQA), DPW and CMS and the Pennsylvania Medical Society Guidelines for documentation.

1. Each page in the record contains the patient's name or I.D. number
2. Each record contains appropriate biographical/personal data
3. Each author is identified on each entry
4. All entries are dated
5. The record is legible to someone other than the writer
6. There is a completed problem list*
7. A listing of medications is easily found and lists all medications currently used
8. Allergies and adverse reactions to medications are prominently noted*
9. There is an appropriate past medical history*
10. There is documentation of tobacco habits for members > 11 years
11. There is documentation of alcohol use for members > 11 years
12. There is documentation of substance abuse for members > 11 years
13. There is a pertinent history and physical exam
14. Lab and other studies are ordered as appropriate
15. Working diagnoses are consistent with findings*
16. Plans of action/treatment are consistent with findings*
17. There is evidence of patient teaching
18. There are dates for return visits or other follow- up plans
19. There is documentation and follow-up of "no-shows"
20. Problems from previous visits are addressed
21. There is evidence of appropriate use of consultants
22. There is continuity and coordination of care between PCPs and specialists
23. Consultant summaries, lab and imaging study results, and surgical procedure summaries reflect PCP review
24. Care appears medically appropriate for the diagnosis/conditions*
25. There is completed immunization record*
26. Preventive services are appropriately used*
27. There is documentation of discussion of a living will or advance directives
28. Phone calls to and from the patient are documented
29. Evidence of hospital discharge summary in medical record
30. Evidence of review of hospital discharge by physician
31. Evidence of communication between home care agency and physician in medical record

* Measure is weighted more highly within the measurement tool.

Approved by QMC 3/03

The Privacy Rule of HIPAA, in the Healthcare Operations definition, includes the performance of credentialing activities. Specifically, the definition is as follows: "Healthcare Operations: Any of the following activities of the covered entity to the extent that the activities are related to covered functions: 1) conducting quality assessment and improvement activities, population-based activities, and related functions that do not include treatment; 2) reviewing the competence or qualifications of health care professionals, evaluating practitioner, provider, and health plan performance, conducting training programs where students learn to practice or improve their skills as health-care providers, training of nonhealth-care professionals, accreditation, certification, licensing, or credentialing activities, ..."
[45 CFR 164.501]