MEDICAL RECORD STANDARDS

Element	Standards
Confidentiality	• To ensure patient privacy, medical records must be stored in a secure location in all practitioners' offices, protected against unauthorized removal, and with access restricted only to authorized staff. • A release of information policy must be in place to ensure patient confidentiality consistent with federal and state regulations.
Availability	• Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care. • Medical records must be organized in a system allowing for easy retrieval and records should provide the documentation necessary to meet HEDIS and other audit requirements.
Personal data	• The patient's name, address, employer, marital/partnership status and all applicable telephone numbers are included. • The patient's *self-reported* race, ethnicity and preferred language are also documented.
Current and complete contents	• Medical records must be completed and maintained for all Harvard Pilgrim members and contain up-to-date documentation of services rendered by the practitioner.
Patient identification	• Each page of the medical record contains the patient's name or identification number.
Author identification	• All entries are dated and author-identified by handwritten signature, unique electronic identifier or initials.
Legibility	• A person, other than the writer, is able to read the contents of hand-written entries.
Preventive health	• **For patients 12 and older**, there is a notation regarding appropriate education about the use of cigarettes, alcohol and other drugs/substances. Smoking status and substance use history is queried and noted in the record. • **For all patients**, the record contains an up-to-date immunization history. It also contains evidence that age-appropriate preventive screenings and services are offered in accordance with Harvard Pilgrim Preventive Care Recommendations.
Past medical history	• Past medical history is easily identified and includes serious accidents, operations, and illnesses. • **For patients age 18 and younger**, past medical history relates to operations and childhood illnesses. • **For children five and under**, past medical history also includes information related to prenatal care and birth.
Medication allergies/ Adverse reactions	• Medication allergies and adverse reactions are prominently noted in the record. • If the patient has no known drug allergies or history of adverse reactions, this is noted in the record.
Problem list	• A medical problem list is used to indicate all significant illnesses and medical conditions.

MEMBER CARE – PROTECTING HEALTH INFORMATION

Element	Standards
Visit notation	• The chief complaint, assessment and treatment plan, including medications prescribed with dosages, are clearly indicated in the visit notation.
Referrals/ consultation	• There is a note from the consultant in the record when a consultation was requested and has occurred.
Ancillary services, diagnostic tests and other reports	• The record reflects all ancillary services and diagnostic tests ordered by the practitioner and all diagnostic and therapeutic services for which the patient was referred by the practitioner. This includes, as applicable, reports regarding home health care, skilled nursing facility care, specialty care, hospital discharges, physical therapy and ambulatory or inpatient surgery.
Report results	• Consultation, laboratory and imaging reports filed in the medical record are initialed by the practitioner who ordered them to signify review. • If the reports are presented electronically or by some other means, there is also representation of review by the ordering practitioner. • Consultations and abnormal laboratory or imaging study results contain an explicit notation regarding follow-up.
Follow-up care, calls or visits	• Visit notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
Behavioral health	• The record contains up-to-date documentation of pertinent psychosocial history and any behavioral health diagnoses and care received, including medications.
Advance directives	• For all adult patients, the record indicates whether or not the patient has executed an advance directive. Examples of advance directives include health care agents/proxies (Mass. & NH), living wills (NH), do not resuscitate (DNR) policies, and organ donation cards. • Documentation of any advance directive is maintained in a prominent part of the patient's medical record and is kept up-to-date.