CAROLINA FAMILY HEALTH CENTERS, INC.
PROCEDURE

TITLE: HIM-114P Medical Records Operating Procedures

EFFECTIVE DATE: September 2017

SECTION: Medical Records
REFERENCE POLICY: N/A

RESPONSIBLE CHIEF: Chief Medical Officer
RESPONSIBLE COMMITTEE: Medical CIT

REVIEWED: 9/18, 07/15/2020

I. PURPOSE:

The purpose of the procedure is to provide an outline to establish and safeguard the patient's medical records.

II. PROCEDURE:

A patient record is created and initiated upon the patient's first encounter at CFHC, Inc. The encounter may be with a case manager, medical or dental provider, nurse, care coordinator, etc. The patient record is recorded in the electronic health record (EHR) system. Any information received from an outside agency regarding an established patient will be scanned into the patient's record.

Non-established patient information

Records received for individuals that do not have a record in the elecronic health system are destroyed.

Documentation Completeness

CFHC, Inc. records and maintains key patient demographics, clinical data and a comprehensive health assessment for patients. Information is recorded in the patient's electronic medical record.

Demographic data recorded by the Front Office Associate includes:

- Date of birth
- Gender
- Race
- Ethnicity
- Communication needs (preferred language, hearing impaired, visual impairment, etc.)
- Telephone numbers
- E-mail address
- Dates of previous clinical visits
- Legal guardian/health care proxy (including mother's maiden name for children)
- Primary caregiver
- Health insurance information

- SSN
- Preferred communication method

The front office staff provides new patients with the *Adult or Pediatric Health History* form (see attachments) upon registration. The clinical staff uses these forms to record clinic data in the medical record. For more information on patient registration see *OPR-101P Front Office Registration Process.*

Clinical data recorded in the medical record includes:

- Updated problem list with current and active diagnoses
- Allergies, including medication and adverse reactions
- Blood pressure for patients three years and older
- Height for all patients
- Weight for all patients
- BMI for adults
- Growth charts (length/height, weight and head circumference (less than two years of age) and BMI percentile (2-20 years))
- Status of tobacco use for patients 13 years and older
- List of medications and supplements

The comprehensive health assessment, performed by the clinical team at their discretion, includes:

- Age and gender appropriate immunizations and screenings
- Family/social/cultural characteristics
- Communication needs from a clinical perspective (preferred language, hearing impaired, visual impairment, etc.)
- Medical, mental health and substance abuse history of patient and family
- Advance care directives (as appropriate)
- Behaviors affecting health (assessment of risky and unhealthy behaviors beyond physical activity and smoking; for example, nutrition, dental care, risky sexual behavior, and second-hand smoke exposure)
- Developmental screening for pediatrics
- Depression screening for adults and adolescents. Refer to *CLN-104P Screening for Anxiety, Depression, Drug and Alcohol Use*
- Health literacy assessment

For more information on preparing patients for examination, see *CLN-119P Preparing Patients for Examination.*

- The provider and his/her designee are responsible for completing the chief complaint, history of present illness, past social family history, review of symptoms, vitals, physical exam,

assessment and plan sections of the note. Providers review and sign their electronic notes within twenty-four hours of the patient encounter.

- All labs, reports or other patient information aresigned by the provider in the EHR within forty-eight hours of receipt.
- Patient medical records should be faxed within five working days prior to the patient's appointment for specialty care by the Referral Associates or other referring staff.

Paper Documents

At times, staff may utilize paper documents or forms. These documents are scanned into the patient's electronic health record when completed. When making handwritten entries, the following apply:

- Handwritten documentation should be legible
- Entries should include the date and signature of the individual making the entries.
- Only black ink is acceptable for use in handwritten entries.
- Correction fluid/tape is prohibited in paper record documentation.
- If a prior record entry must be corrected and/or changed, a single, thin line must be drawn through the error while making sure the original entry is still legible. The corrected entry should be recorded above or near the original entry. The corrected entry includes the date of alteration along with the employee's initials.
- Only the individual who recorded the original note entry should make alterations.
- In the event the staff member is no longer available to correct an inaccurate entry, his/her immediate supervisor can enter a correction.
- When writing an addendum to a prior note entry, the staff member should include the date of the initial recording for which the addendum applies. The staff member must also document the current date the addendum is written with his/her signature.

Patient Name Changes

A patient with a name change must show proof of his/her name change through government issued photo identification. A copy of this documentation must be kept in his/her record. A patient must also submit a copy of his/her health insurance, Medicaid and/or Medicare card with his/her new name for billing purposes.The front office staff is responsible for updating the patient information at the time of registration.