2.7.10 MEDICAL RECORDS

POLICY:

Subrecipients must establish a medical record for every client who obtains services.

Medical records must be accurate, complete, and systematically organized to facilitate prompt retrieval of information, align with Title X requirements, major medical association recommendations, QFP guidelines, and correlate with CMS billing and coding requirements.

PROCEDURE:

Each subrecipient must develop electronic medical record (EMR) policies specific to the agency and type of EMR in service.
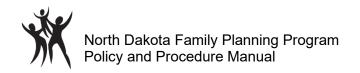
EMR policies should include:

- How to access the client chart and select the visit type
- How several staff members may document entries in a client chart
- How client communication (phone calls, emails, texts, mail correspondence) is documented
- A process for scanning consents, income sheets, lab results, medical records, etc. into charts
- A process to ensure adequate privacy, security, and appropriate access by authorized personnel to a client's personal health information
- All medical records must be secured by computer lock when not in use
- How to add addendums to chart notations after chart has been locked
- Staff members are not allowed to share specific identification (ID) and password
- Medication entry and reconciliation in accordance with the ND Board of Nursing
- Description of how charts should be co-signed by a provider or medical director, as applicable
- How a client can obtain copies of medical records
- Procedures for archiving and storage of inactive charts or EMR's. It is recommended that all client records be retained for a minimum of 7 years plus current year after discharge; or, in the case of a minor, 7 years after their 18th birthday
- How to document correspondence with clients, including phone calls, emails, texts and mail

The content of the medical records should include, but is not limited to:

- Personal data (Income Worksheet)
- Request to Receive Family Planning Screening Services
- Procedural consent forms, if applicable
- Client medication
- Allergies and reactions to drug(s) in a prominent and specific location

- QFP recommended components of client care (e.g., health history, physical exam, laboratory test orders and results, clinical findings, therapeutic orders, plans for care including treatments and client education provided)
- Documentation of refusal of services offered
- Referral, follow-up, and continuing care
- Scheduled revisits, the specific time of return is noted (e.g., weeks, months, or as needed)
- A Face Sheet or Snapshot that provides a summary of past visits and information is encouraged but not required
- Easily adaptable to coding and billing requirements from CMS

All subrecipients are encouraged to assess and modify the EMR templates to be consistent with Title X regulations, QFP and major medical association recommendations, CMS billing and coding requirements, and ND FPP policies and protocols for client care as updates occur.

Documentation in the medical record should be made on the same day services are rendered.
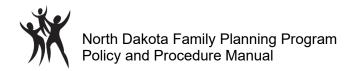
Guidelines for documentation:

- Remember the first rule of charting: If it's not documented – it wasn't done. EMR's should have a process to add prompts to assist staff with meeting required documentation on all aspects of client care, education and counseling.
- Chart objectively. State facts, not conclusions or opinions.
- Unresolved problems from previous visits may be addressed in subsequent visits as appropriate.
- Counseling and education charting should be specific and documented.
- Document a client's understanding of instructions given, his/her ability to repeat instructions given, and his/her ability to teach back as recommended by QFP.
- Each clinical staff member must individually document all services they provide in the client chart. LPNs and RNs must document the nursing care they render; each is held accountable for doing it accurately and completely. Practice FAQ - ND Board of Nursing (ndbon.org) (5/2022)

Avoid ambiguous abbreviations. Avoid using abbreviations on the Joint Commission's Official "Do Not Use" list. List of Error-Prone Abbreviations | Institute For Safe Medication Practices (ismp.org)

Client records must be de-identified if a portion of a chart is copied for education use, chart audits, or other purposes.

RESOURCES:

ND FPP Protocol manual https://www.hhs.nd.gov/cfs/family-planning/grantees

ND FPP Policy and Procedures https://www.hhs.nd.gov/cfs/family-planning/grantees

Coding Search | Reproductive Health National Training Center (rhntc.org)

Electronic Health Records: Why You Need Them and How to Start Webinar | Reproductive Health National Training Center (rhntc.org)

FPAR 2.0 EHR Vendor Discussion Starter Job Aid | Reproductive Health National Training Center (rhntc.org)

QFP rr6304.pdf (cdc.gov)