RH Access Fund Chart Documentation Standards

Medical services must be completely and accurately documented in the client's record. Each record should contain sufficient information to justify the diagnosis and treatment. ICD-10 codes and purpose of visit provided on the CVR should be supported by documentation in the client's record.

These standards should be used as a guidance; individual circumstances should be considered.

Standard	Performance Measures
Client's purpose of visit or chief complaint	A purpose of visit or chief complaint, as stated by the client, is recorded at or near the top of the form. If RH is not the stated purpose of visit, documentation should support what transpired to make it an RH visit.
New vs established patient.	Client is identified as new or continuing according to CMS definition: New Patient: An individual who has not been seen in the agency within the previous three years. Established Patient: An individual who has been seen in the agency within the previous 3 years.
Initial history: past medical history (includes hospitalizations and surgeries), family history and social history	Documentation of relevant history includes pertinent information, including: • Medical history, preventive health maintenance, risk screening • Immediate family history, or documentation that it is non-contributory • Health behavior, including smoking, alcohol/substance use disorder, sexual risk assessment, STIs. Documentation when history has been reviewed, at least annually.
Allergies and adverse reactions	Allergies or history of adverse reactions to medications are displayed in a prominent and consistent location or noted as none or NKA.
Reproductive life plan	Documentation indicates provider discussed the plan and services provided reflect the plan.
Vital sign screening	Documentation of vital signs (height, weight, BMI, BP) if indicated per purpose of visit or chief complaint.
Diagnostic information	Documentation shows clinical assessment and physical examination is provided corresponding to the patient's purpose of visit or chief complaint. Services are provided according to

	national standards of care cited in protocols. Documentation supports any deviation from the national standards.
Medication information	Information regarding current medications (prescriptions and over-the-counter) is readily apparent. When medications appear to remain unchanged, documentation should show at least annual review by provider. RXs are documented.
Preventive screenings	Age appropriate screenings – CT/GC, Pap, HIV, Hepatitis C, Syphilis, mammography – are documented, when indicated. Documentation indicates when client declines screenings. Documentation shows results have been reviewed by provider. Abnormal findings are followed up with documented discussion with client.
Assessment and plan	History and exam findings are summarized and include a plan when to return to office/follow-up with specific timeframe, as indicated. Documentation indicates client understands the plan and agrees or declines. Documentation of referrals to outside providers.
Age appropriate anticipatory guidance/health education	Documentation shows what information, education, and guidance was provided to client including risk reduction for STIs, illicit drug use, tobacco use, as well as nutrition and exercise education, as indicated. Specific considerations for minors include parental involvement and relationship safety counseling.
Continuity of care	Record of referral information sent. When client receives services at/through another provider, a consultation report/summary has been received. Attempts to obtain report if not received.

Per CMS, a “smart phrase” can be used as a framework for the note; however, the phrase needs to be edited by the provider to demonstrate it was client and visit specific and that actions indicated were taken.