VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Last Approved:	*N/A*
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Next Review:	*3 years after approval*
Owner:	*Lucy Marrero: Ambulatory Care Performance Improvement*
Policy Area:	*Ambulatory Care - Administrative*
References:	

AC.30 Timeliness of Documentation

I. **SCOPE:**
To define the expectation for completion of ambulatory care clinic medical records and establish a procedure for corrective action when a member of the Medical Staff, including Licensed Independent Practitioners (LIP) and healthcare workers who provide direct services to patients, has become delinquent in completion of medical records.

II. **PURPOSE:**
Timely completion of visit documentation is necessary to provide safe and effective care to our patients. Incomplete or untimely documentation creates delays in care and negatively impacts patients.

III. **DEFINITIONS:**

EHR- Electronic Health Record.

LIP- Any Licensed Independent Provider who can provide a visit, including but not limited to; doctor, nurse practitioner, physician assistant, psychologist, licensed clinical social worker and registered dietician.

Healthcare Workers- any professional who provides documentable direct service to patients including LIPs.

Medical Staff Member-any LIP who is a member of the Medical Staff.

Clinic Administration- program or clinic managers responsible for the oversight of clinic operations.

Medical Director- Clinic Medical Director.

Day- Calendar Day

IV. **POLICY:**

A. The patient's clinic medical record should be completed and signed electronically in the Electronic Health Record (EHR) or signed legibly in ink during EHR down-time by those providers involved in the patient's care within 72 hours of each encounter. Clinic Administration will monitor compliance

and enforce consequences if encounters are not closed at 14 days.

B. The ambulatory clinic record should include elements applicable to the practitioner's scope of practice:

1. Updated demographic data.
2. Clinical documentation, including the dates and time of the visit, with the patient's history, physical examination, and all information necessary to support a well-informed assessment and treatment plan.
3. Treatment recommendation should include any notation of prescriptions and/or diet instructions given, if applicable and self-care instructions.
4. Updated summary list, as appropriate, including chronic medical problems, medications, and allergy documentation.
5. Consultation reports.
6. Reports of all ancillary services, including laboratory tests, medical imaging examinations and pathology reports.
7. If a procedure was performed, a well-documented note summarizing the essential details of the procedure, including the techniques used, the findings and tissue removed or altered, as appropriate, and medications given.
8. Referral information from other providers.
9. Consent forms.
10. Resident physician documentation associated with the encounter.
11. Telemedicine encounters and electronic consults.
12. Billing and charges applicable to the visit.

C. Clinic Administration will utilize report for determining incomplete medical records, for determining when an incomplete medical record has reached delinquent status, and for documentation requirements.

V. **PROCEDURE:**

A. Medical records are expected to be completed within 72 hours of the encounter to facilitate care coordination.

B. All healthcare workers shall be responsible for completion of the medical record documentation for the clinic visit, entering all documentation, including progress notes and ambulatory clinic procedure notes, into the EHR. During down time, handwritten notes shall be completed using an approved clinic form and scanned into the EHR. All billing and charges must be supported by the appropriate documentation of services.

C. For each patient encounter, clinic documentation must be in the record, signed and submitted, within 72 hours of the encounter. Clinic notes forwarded for an attending physician's co-signature also require submission within 72 hours of the encounter.

D. If at any time the practitioner contests the incomplete or delinquent medical record, it is the responsibility of the practitioner to contact Clinic Administrator promptly. Clinic Administrator, with the Medical Director's support, will investigate the practitioners claim, taking into consideration any mitigating circumstances to make a final determination. The timeline for pending disciplinary action of

the provider will be stopped until such determination is made.

E. When clinic documentation is not completed within 72 hours, the enforcement process will proceed as follows:

   1. Time = 72 hours Delinquent: Clinic Administrator will inform provider and Medical Director of delinquent documentation. If the documentation is not completed, the process continues as below.
   2. Time = Day 7: The Clinic Administrator will evaluate the medical record to confirm responsibility and, if appropriate, will establish contact with the provider via email, text messaging or phone call and inform the Medical Director of the delinquent medical record and potential for suspension if the medical record is not completed within the next 7 days.
   3. Time = Day 12: Clinic Administrator notifies Medical Director, Regional Administrative Director (RAD) and Ambulatory Care Chief Medical Officer (CMO) of provider's non-compliance status. Medical director informs provider of potential suspension.
   4. Time = Day 14: Clinic Administrator will notify the provider, Medical Director, RAD, Ambulatory Care CMO, and/or their designee of the imminent administrative suspension. If the record is not immediately completed, the Clinic Administrator will notify the Medical Staff Office of administrative suspension of privileges.

F. Once the suspension of privileges for delinquent medical records has been initiated, the Ambulatory Care CMO or designee will:

   1. Contact the provider via phone call.
   2. Forward a suspension letter to the provider via email (See Suspension Letter Template).
   3. Send a certified copy of the suspension letter to the provider via USPS.
   4. Notify the providers Department Chair.
   5. Notify the clinic Medical Director.
   6. Notify the Ambulatory Care CEO

G. While under suspension of privileges for delinquent medical records, no new non-emergent procedures or clinic days will be allowed; however, the provider may finish the current clinic day if no other provider is available to see scheduled patients. Scheduled clinic time that is disrupted due to suspension will still count towards work hours but with zero productivity for patient care encounters.

H. The Ambulatory Care CMO may, on an individual basis, decide to withhold suspension for delinquent records in emergent situations as necessary. No suspension shall compromise patient safety.

I. The practitioner will remain on suspension until the practitioner has completed all delinquent medical records.

J. Upon completion of all delinquent records, the Ambulatory Care CMO and/or their designee will notify the provider and personnel listed in section V.F.1-6 via email, text messaging, or phone call, of reinstatement.

K. Exceptions may be made by the Ambulatory Care CMO for providers with delinquent medical records who are ill, on vacation, sabbatical, or another excused absence. In the provider's absence, the delinquent medical records shall be reassigned to the clinic Medical Director or another provider within the provider's department for administrative closure.

L. Monitoring- The Clinic Administrator shall conduct a monthly review encompassing all clinical

services to determine chart completion compliance. Results shall be reported to the Medical Executive Committee and AC PICC for action.

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lucy Marrero: Ambulatory Care Performance Improvement	pending