Practitioner Medical/Treatment Record Evaluation

Practice ID:
Site Number:
Appt Date:
Reason:

Aggregate Score:

Opportunities for improvement are indicated on individual measures with less than 80% compliance. Please indicate improvement implementation plans for the medical/treatment records by completing the Office/Facility Site Corrective Action Plan - Feedback Form.

	Met	Not Met	N/A	Comments
1. An individual clinical record is established, organized, easily located and data is easily retrievable for each patient.				
2. Each page in the medical record contains the patient's name. Another form of patient identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record.				
3. Significant illnesses and medical and behavioral health conditions are indicated on the current problem list and are updated after each office visit and hospitalization.				
4. Each record indicates which medications have been prescribed, the dosages of each, the date of the initial prescription and/or refill, and the date the medication was discontinued, as applicable.				
5. Medication & other allergies, adverse reactions, & relevant medical conditions are clearly documented and dated prominently in the record. It is noted if the pt has no known allergies, no history of adverse reactions or relevant medical conditions.				

6. All entries in the record contain a valid, legible author's signature, which may be a handwritten signature with credentials, printed name & credentials accompanied by handwritten provider initials, or unique electronic identifier with credentials.				
7. All entries in the record are dated and are legible to someone other than the writer.				
8. The medical/treatment records have a notation regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months, or as needed.				
9. For patients 12 years and older, documentation includes past and present use of cigarettes (or other tobacco), alcohol, as well as illicit, prescribed and over-the-counter drugs or other substance abuse. (Assessed at least annually)				
10. If a consultation is requested from a medical specialist, behavioral health practitioner, and/or organizational provider, the medical record contains documentation of follow-up correspondence from the consultant. The consultant reports are filed in the chart and are signed/initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal results.				

11. Consultations, laboratory, imaging, and other studies (including mammograms and pap smears) are ordered, as appropriate. The reports are filed in the chart and are initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal laboratory and imaging results.				
12. There is documentation in the medical record that patients are notified of abnormal test results				
13. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. Possible risk factors for the member, relevant to the particular treatment, were documented, as applicable.				
14. There is a current flow sheet for preventive services, in accordance with the health plan's guidelines, as applicable to practice specialty.				
15. Past med hx (pts seen 3 or more times) is updated every 3 years & includes serious accidents, surgeries & illnesses. For pts 18 yrs & younger, past med hx relates to prenatal care, birth history, surgeries & childhood illnesses.				
16. The history and physical exam identifies appropriate subjective and objective data for each visit relevant to the patient's presenting complaints.				

17. The assessments or diagnostic impressions (working diagnoses) are consistent with the findings.				
18. The treatment or therapy plans are consistent with the diagnoses.				
19. There is evidence of 6 well care visits in the first 15 months of life to include the following: a) A health and developmental history (physical and mental) b) A physical exam c) Health education / anticipatory guidance.				
20. A lead screening test is performed prior to the child's second birthday.				
21. Children ages 3-17 have a yearly well exam which includes documentation of: a) Developmental Assessment b) Anticipatory Guidance c) BMI & BMI percentile d) Counseling for Diet/Nutrition e) Counseling for Physical Activity				
22. Children ages 3-17 have a complete childhood immunization record with dates of service. Parental refusal of immunization is documented, if applicable.				
23. A complete adolescent immunization record with dates of service include: a) Meningococcal vaccine (prior to age 13) b) Tdap/Td (between 10-13 years of age)				

24. Adults have routine health screenings that include: a) Up to date recommended immunizations / vaccinations b) BMI documented at least every 2 yrs c) A physical exam every 1-2 yrs for pts 19-49 yrs d) A yearly physical exam for pts 50 yrs & older				
25. Patients with chronic conditions (eg., diabetes, hypertension, CHF, depression, etc) were seen and the chronic illness is evaluated at least annually.				
26. Adults 65 years of age and older are assessed annually for Comprehensive Pain Screening (i.e. Multidimensional Pain Inventory, Faces Pain Scale, etc.).				
27. Adults 65 years of age and older are assessed annually for a functional status assessment including ADL's, fall risk, and level of physical activity.				
28. Adults 65 years of age and older are assessed for Medication Reconciliation -- medications should be reviewed at least annually and within 30 days after each hospital discharge.				
29. Adults 65 years of age and older are assessed annually for discussion of bladder control issues.				
30. The medical record notes colorectal cancer screening for pts 50-75 yrs of age by any of the following a) Fecal occult blood test-yrly b) Flexible sigmoidoscopy every 5 yrs c) Dble contrast barium enema every 5 yrs d) Colonoscopy every 10 yrs				

31. Adults with a diagnosis of hypertension have their blood pressure measured at each office visit. Any blood pressure 140/90 or higher is addressed by the provider as evidenced by documentation on the medical record.				
32. Adults diagnosed with a cardiovascular condition receive an LDL-C screening annually. (Target LDL-C is less than 100).				
33. Pts. diagnosed with Diabetes Mellitus have yearly: a) BP monitoring (<140/90) b) HBA1C & Lipid Profile c) Nephropathy screening or ACE/ARB prescription d) Dilated Retinal Eye exam e) If also diagnosed with hypertension, treated with ACE/ARB				
34. Any adult 40 years of age or older that has a new diagnosis or newly active COPD had appropriate spirometry testing to confirm the diagnosis.				
35. Patients diagnosed with rheumatoid arthritis were prescribed a disease modifying anti-rheumatic drug.				
36. Female pts. 65 yrs of age & older who suffered a fracture received either a bone mineral density test or a RX to treat or prevent osteoporosis within 6 months of the fracture, if testing had not been done within the previous 2 yrs.				
37. The medical record has evidence of Chlamydia screening for sexually active women ages 16-24 years of age.				

38. The medical record has evidence of a pap test every three years for women 21-64 years of age.				
39. The medical record has evidence of mammogram screening every two years for women 40-69 years of age.				
40. There is documentation in the medical record that the patient 65 years of age and older was counseled regarding an Advance Directive. (Assess annually)				
41. There is documentation in the medical record as to whether or not the patient has executed an Advance Directive and, if so, the Advance Directive or documentation is placed in a prominent part of the patient's record. (Assess annually)				
42. If an Advance Directive is filed or documented in the medical record, a surrogate has been identified. (This question will be answered N/A in the event there is no Advance Directive in the medical record and if there is no surrogate identified.)				
43. There is evidence of communication & collaboration (letters, reports, etc.) from the OB/GYN to the primary care physician, including documentation that a copy of the pt.'s exam with pertinent information has been sent to the primary care physician.				

44. A medical and psychiatric history is documented including: previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and peri-natal events along with a complete developmental history (physical, psychological, social, intellectual and academic).				
45. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, and the results of a mental status exam are documented in the clinical record.				
46. The Mental Status exam documents: a) affect/mood b) speech c) appearance d) thought content e) judgment f) insight g) attention h) memory i) - impulse control.				
47. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.				
48. The DSM-IV diagnoses are identified and are consistent with the presenting problems, history, mental status examination and/or other assessment data.				

49. Treatment plans are consistent with diagnoses, have both objective and measureable goals, have an estimated timeframe for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.				
50. It is noted that the office receives communication from the specialist/organizational provider which assures continuity & coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions.				

General Comments:

The results of this evaluation and suggested recommendations were discussed with . He/she verbalized understanding regarding this evaluation.