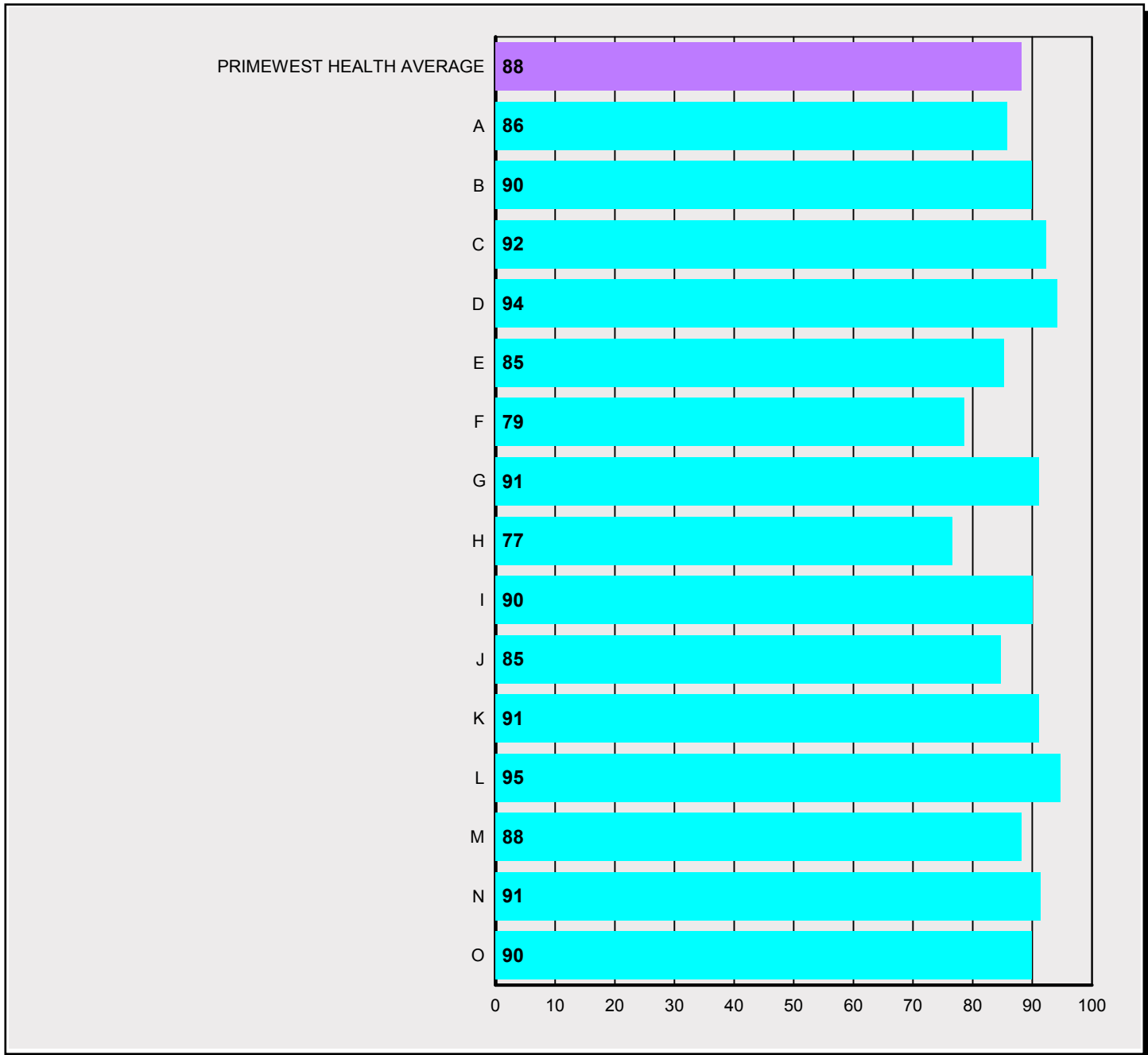


# 2007 Medical/Treatment Record Audit Report





## Attachment A

### PRIMEWEST HEALTH AVERAGE

#### Strengths Above 90%

|  |     |
|--|-----|
| * History and physical exam identifies appropriate subjective and objective information pertinent to member's presenting complaints. | 100 |
| * There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.                          | 100 |
| * Discharge summaries are filed in the member's record.  | 100 |
| * Working diagnoses are consistent with findings.  | 100 |
| * Treatment plans are consistent with diagnoses.   | 100 |
| * Laboratory and other studies are ordered, as appropriate.  | 100 |
| * All entries dated.   | 100 |
| * All entries legible to someone other than author.  | 99  |
| * Unresolved problems from previous visits are addressed in subsequent visits.   | 99  |
| * Member name present on every page.   | 98  |
| * Clinically significant consultation and abnormal lab and imaging reports have an explicit notation of follow-up plans.             | 97  |
| * Personal biographical data includes member address, employer, home and work phone numbers, and marital status.                     | 96  |
| * Prescribed medications are clearly visible in the medical record.  | 94  |
| * Elements in the medical record are organized in a consistent manner.   | 90  |

#### Areas Identified Below 90%

|   |    |
|---|----|
| * Significant illnesses and medical conditions are indicated on problem list.   | 88 |
| * Note from consultant is present for each consultation requested.  | 86 |
| * Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, and illnesses.   | 84 |
| * Absence or presence of medication allergies and adverse reactions are prominently noted in medical record.  | 82 |
| * Encounter forms or notes include information about follow-up care, calls, or visits when indicated. Specific time of return is noted in weeks, months, or as needed.  | 78 |
| * Consultation, lab, and imaging reports filed in the medical record are initialed by the practitioner who ordered them to signify review.  | 75 |
| * There is evidence that preventive screening and services are offered in accordance with PrimeWest guidelines.   | 75 |
| * Past medical history for members under the age of 18 (seen three or more times) includes information such as prenatal care, birth, operations, and childhood illnesses.                                     | 72 |
| * Immunization status information for all ages is recorded on a a single page location.   | 72 |
| * For members 11 years and older, there is appropriate notation concerning the use of tobacco, alcohol, and substances (for members seen three or more times or if indicated, query substance abuse history). | 65 |
| * Author identification present for every entry.  | 64 |
| * Health Care Directives are documented in the medical record for those 18 years and older.   | 37 |
| * Body Mass Index (BMI) for all ages is documented annually.  | 22 |

## Attachment A

### PRIMEWEST HEALTH AVERAGE

#### Strengths Above 90%

|  |     |
|--|-----|
| * All entries are legible to someone other than author.  | 100 |
| * Personal biographical data includes member address, employer or school, home and work phone numbers, including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information. | 100 |
| * A social history must be documented.   | 100 |
| * A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, source of clinical data and relevant family information.                   | 100 |
| * Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.   | 100 |
| * Results of a mental status exam are documented.  | 100 |
| * Laboratory and other studies are ordered, as appropriate.  | 100 |
| * A DSM-IV diagnosis is documented.  | 100 |
| * Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.   | 100 |
| * Unresolved problems from previous visits are addressed in subsequent visits.   | 100 |
| * Clinically significant consultation, abnormal lab and imaging reports have an explicit notation of follow-up plans.  | 100 |
| * Discharge summaries are filed in the member's record.  | 100 |
| * Note from consultant is present for each consultation requested.   | 100 |
| * A medical history is easily identified and includes relevant illnesses and medical conditions.   | 98  |
| * Author identification present for every entry.   | 98  |
| * All entries are dated.   | 98  |
| * Progress notes reflect current treatment interventions.  | 97  |
| * Past medical history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.   | 96  |
| * Member name present on every page.   | 95  |
| * Treatment plans are consistent with diagnoses.   | 95  |
| * Special status situations, when present, are prominently noted.  | 92  |
| * A summary of preventive services is documented in a consistent place in the treatment record.  | 91  |

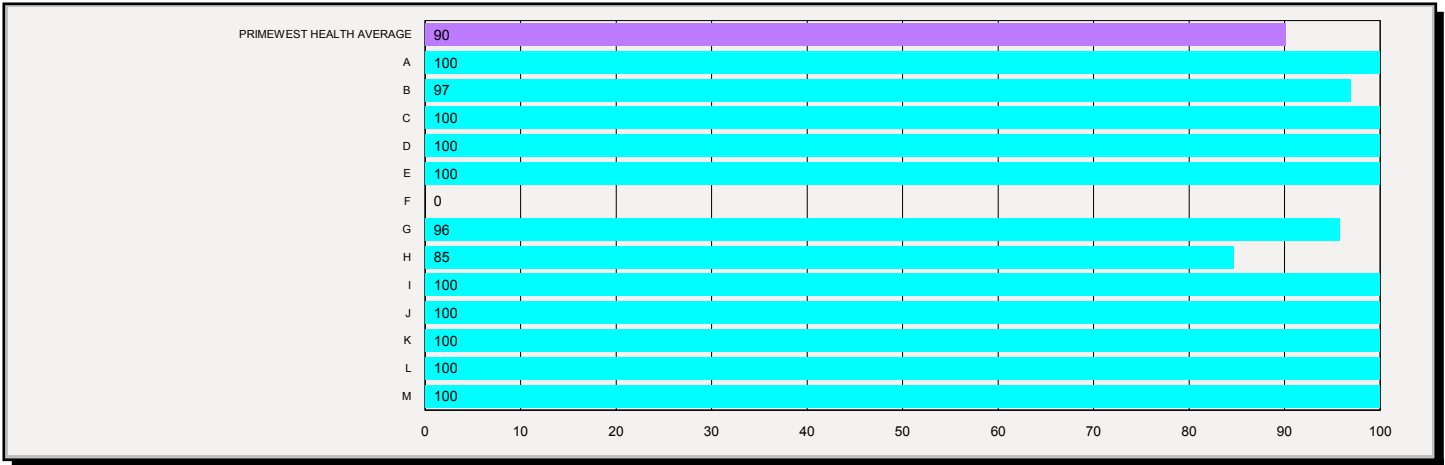
#### Areas Identified Below 90%

|   |    |
|---|----|
| * Elements in the treatment record are organized in a consistent manner.  | 88 |
| * Consultation, lab, and imaging reports filed in the treatment record are initialed by the practitioner who ordered them to signify review.  | 86 |
| * Current medications prescribed by all prescribing practitioners, as well as over-the-counter and herbal preparations, are documented.   | 84 |
| * Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months, or as needed. | 82 |
| * Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.   | 80 |
| * Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.  | 70 |
| * For members 11 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs.  | 64 |
| * Member authorization to release private information and member information obtained from outside sources must be documented.  | 64 |
| * Informed consent for medication and treatment plans are documented.   | 21 |
| * Health Care Directives are documented in the treatment record for members 18 years and older.   | 6  |
| * At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.  | 0  |

**PrimeWest Health  
2007 Medical Record Audit Report**

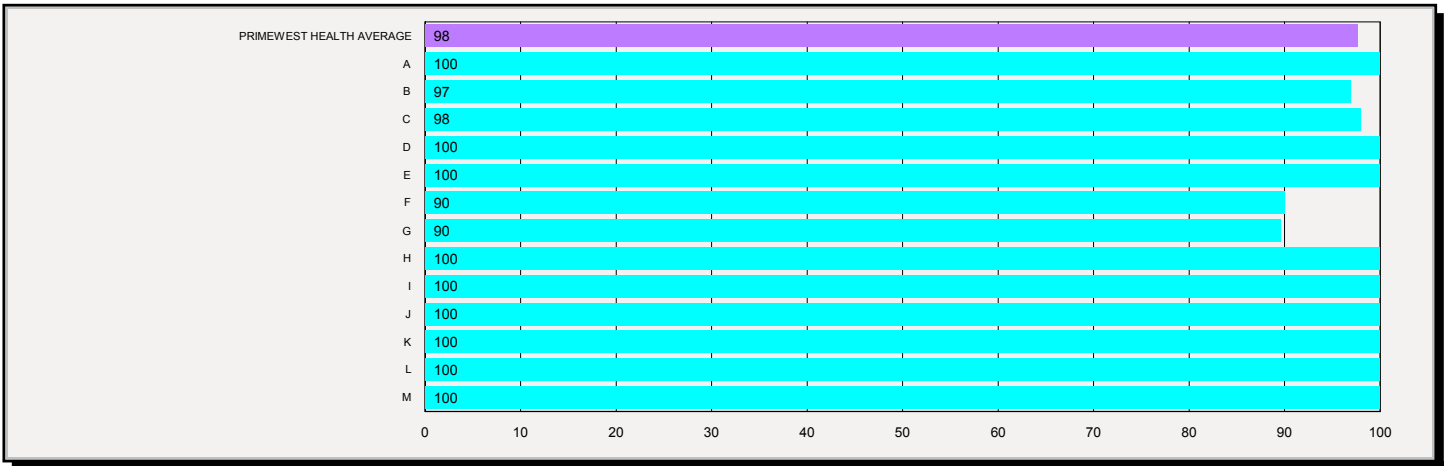
# RECORD FORMAT

## 1. Elements in the medical record are organized in a consistent manner.



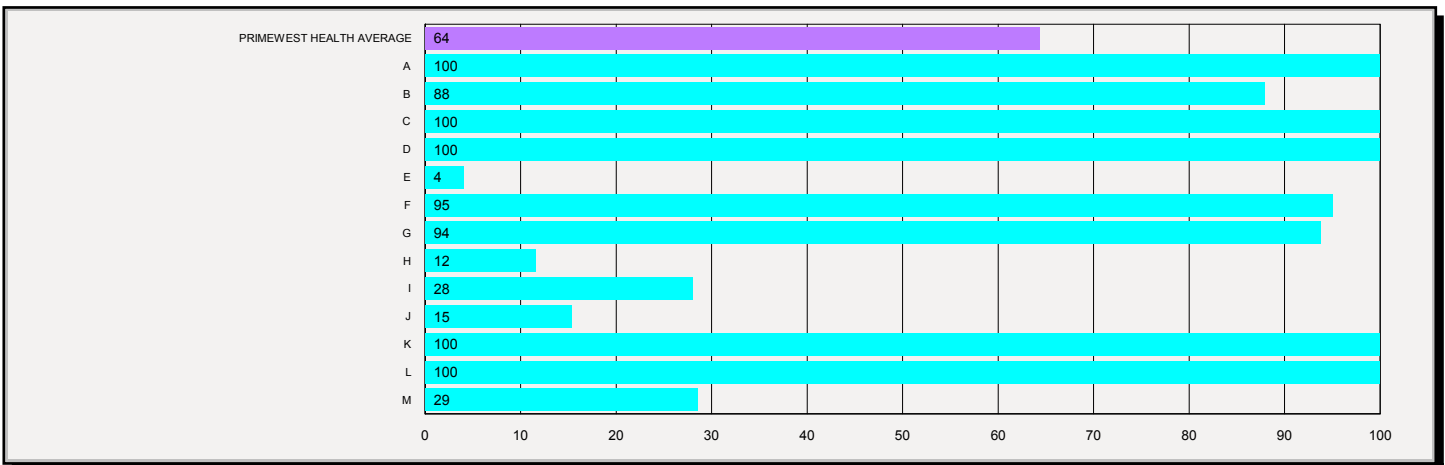
Contents are secured in place and organized in a logical, consistent manner and in chronological order.

## 2. Member name present on every page.



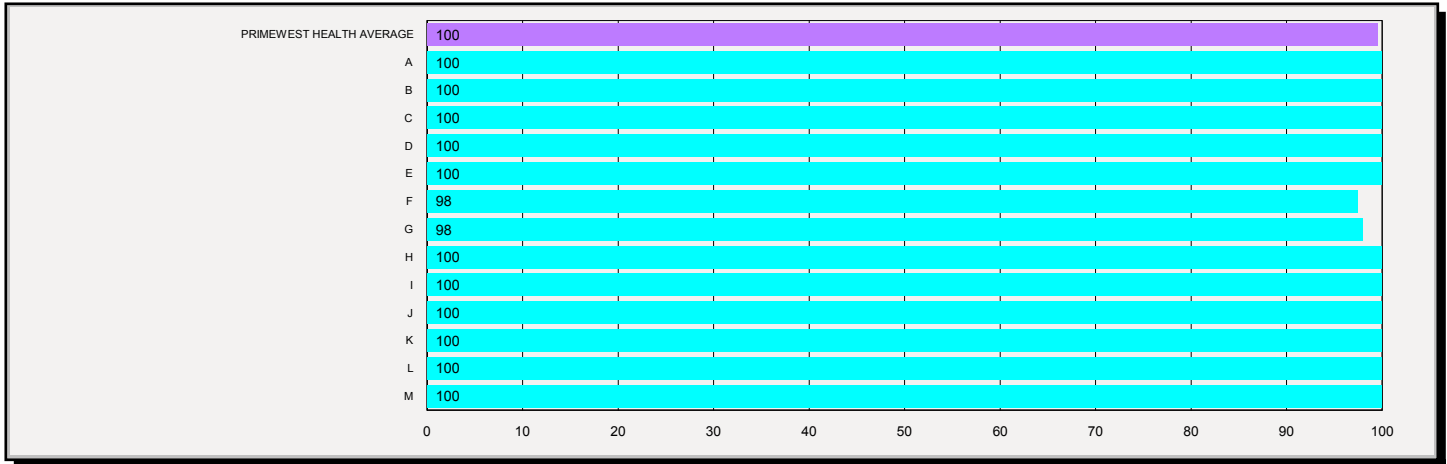
Member name present on every page and there are no pages/entries in record that belong to another person (separate record maintained for each unique member).

## 3. Author identification present for every entry.



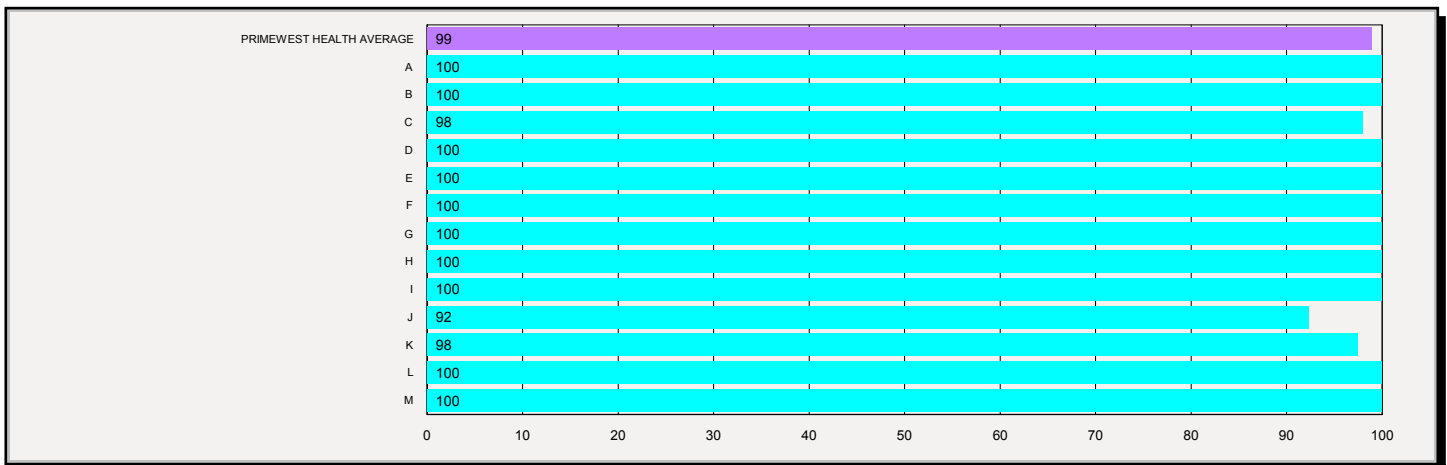
All entries contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials, and title. Transcribed visit notes, nurse/paraprofessional entries, and EMR author authentication must meet criteria.

#### 4. All entries dated.



Each entry must contain the date on which the entry was made and includes the year. Telephone calls and triage notes must also be dated.

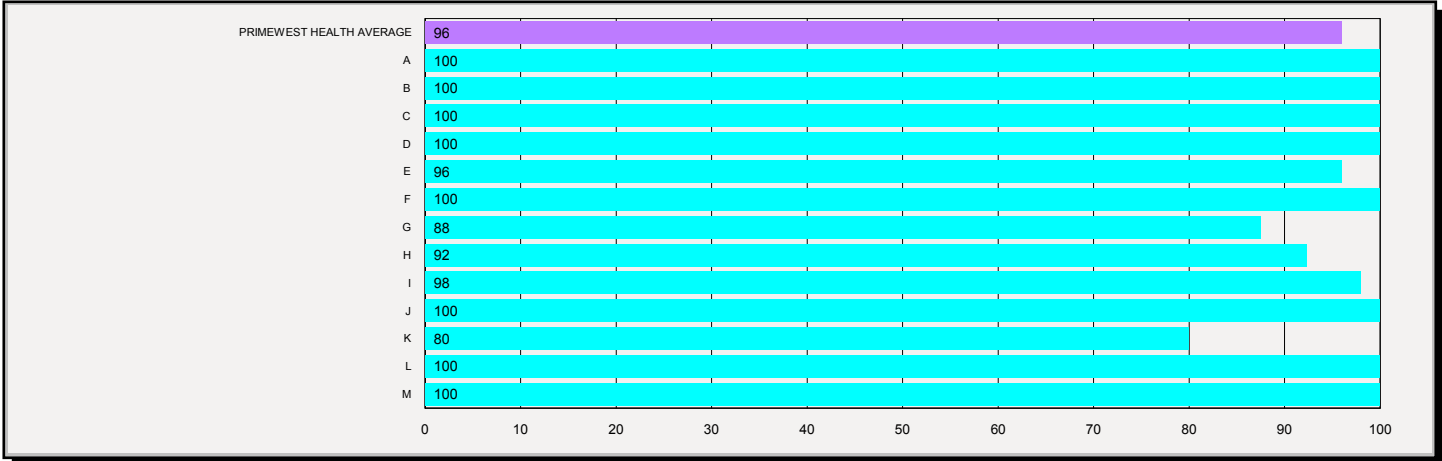
#### 5. All entries legible to someone other than author.



All entries are legible and presented in a standard format that allows a reader to review without the use of a standard legend/key. Visit notes typed by practitioner in EMRs must also be intelligible. Scanned documents in EMRs must be legible.

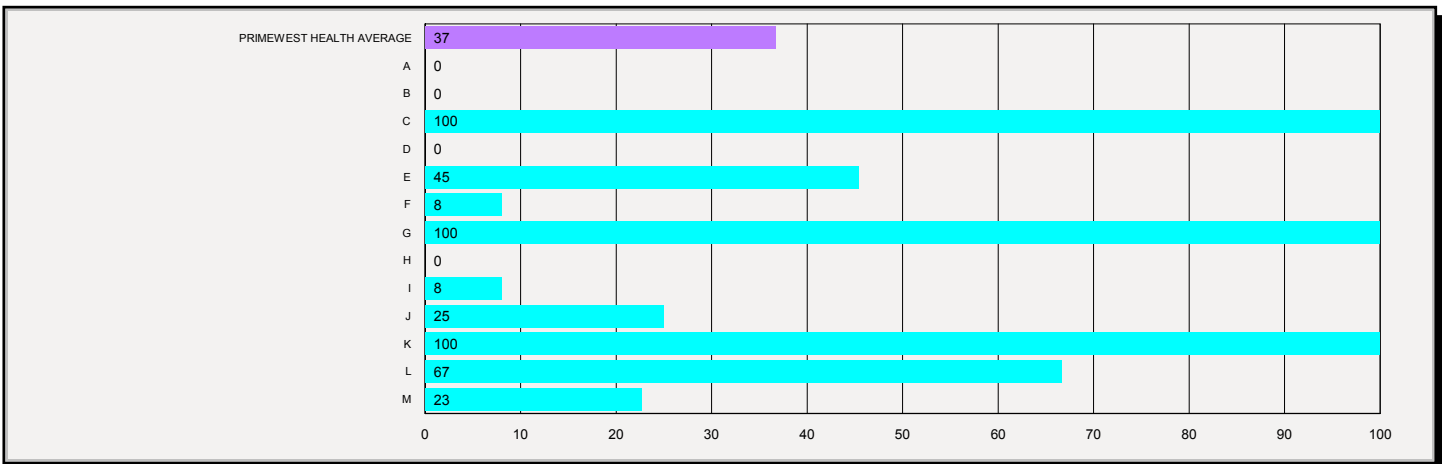
# BASIC RECORD CONTENT

## 1. Personal biographical data includes member address, employer, home and work phone numbers, and marital status.



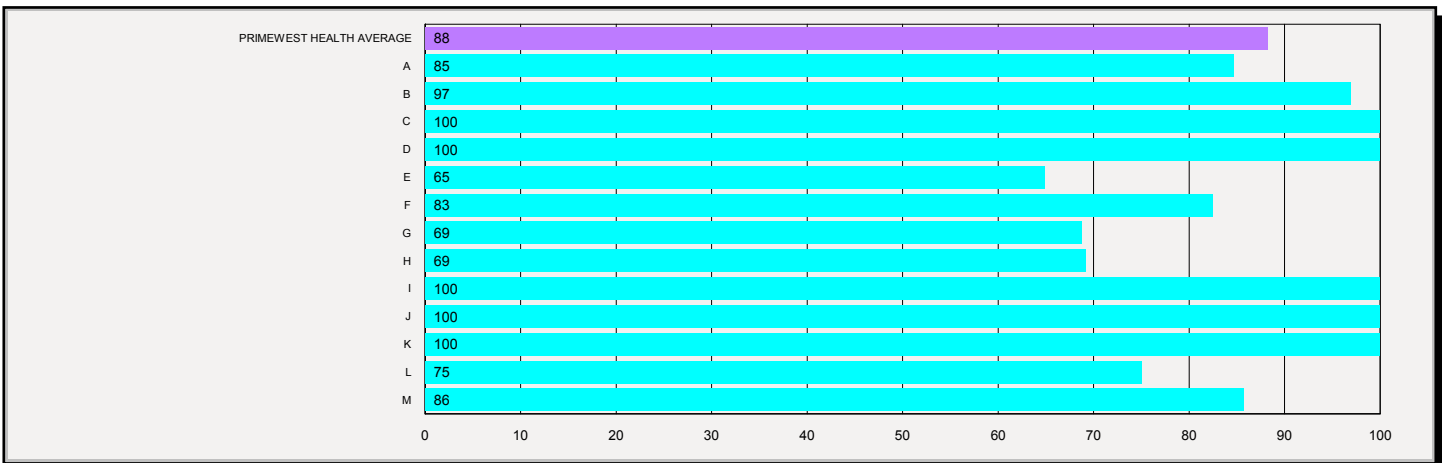
Personal biographical data is documented in a prominent location in each record and includes all information cited in the element. This year, records were scored as “yes” if information, excluding one item, was available anywhere in the record. Employer and marital status were most commonly omitted.

## 2. Health Care Directives are documented in the medical record for those 18 years and older.



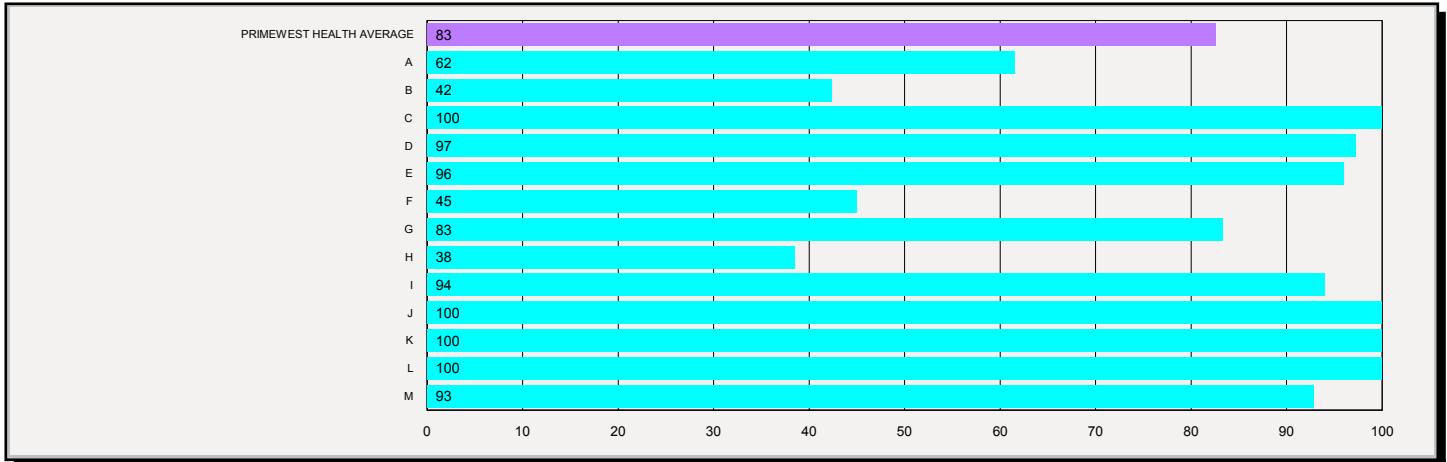
Document whether or not a member has executed a health care directive for those 18 years and older. If member has not executed a health care directive, document that information was offered (this portion was not audited this year).

## 3. Significant illnesses and medical conditions are indicated on problem list.



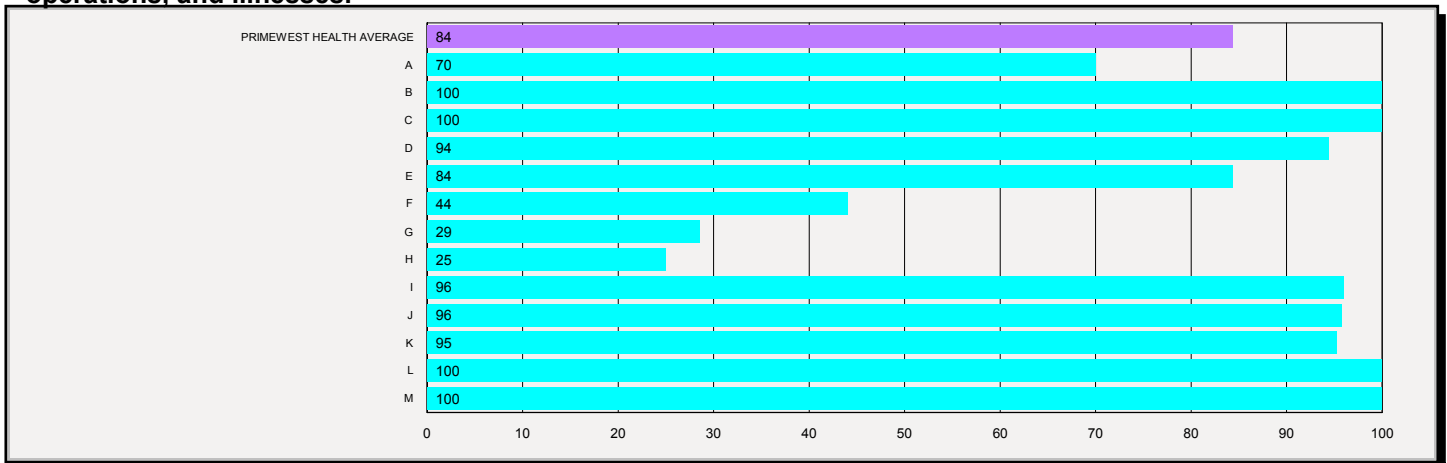
There should be a current problem list either kept separately or within each practitioner progress note including major diagnoses, past medical and/or surgical history, and recurrent complaints. Standard clinic forms for problem lists must be filled out.

**4. Absence or presence of medication allergies and adverse reactions are prominently noted in medical record.**



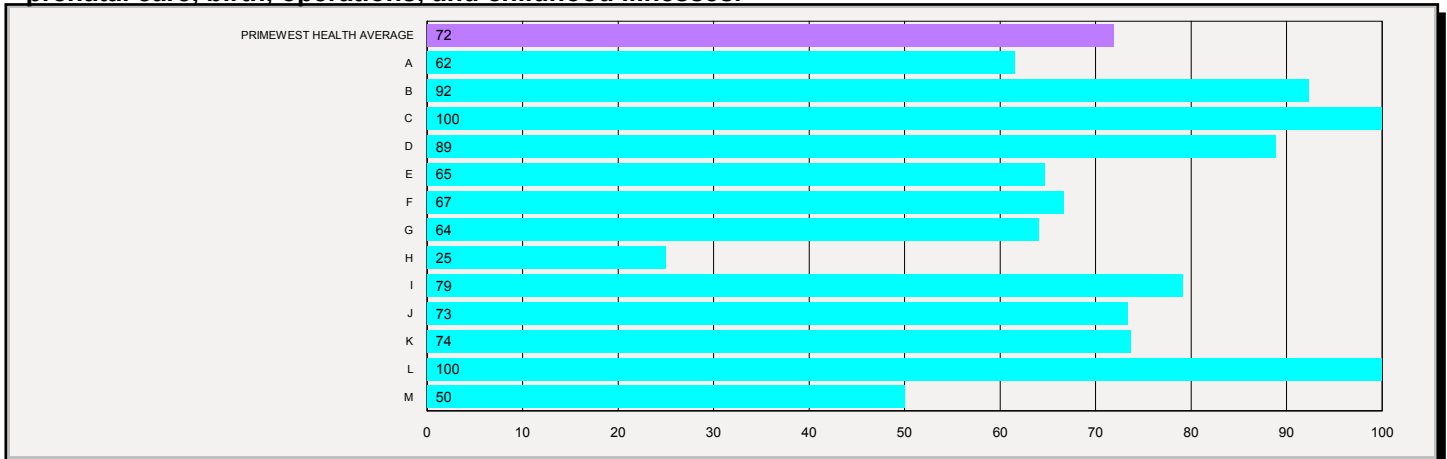
Absence or presence of allergies must be consistently and clearly documented in a prominent location in all medical records. Allergy stamps or forms used for documentation must be filled out. Allergy documentation must be kept current.

**5. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, and illnesses.**



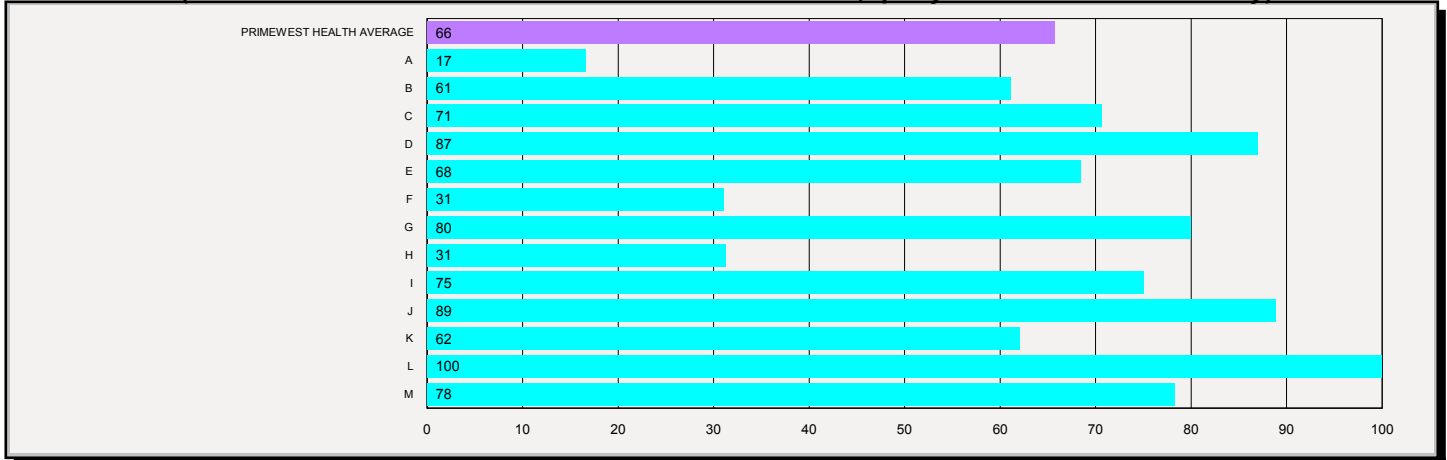
Standard clinic forms for past medical history must be filled out, updated, and complete. This element was scored for members 18 years and older.

**6. Past medical history for members under the age of 18 (seen three or more times) includes information such as prenatal care, birth, operations, and childhood illnesses.**



Standard clinic forms for past medical history must be filled out, updated, and complete. PrimeWest looked for evidence of any past medical history documented for those under the age of 18.

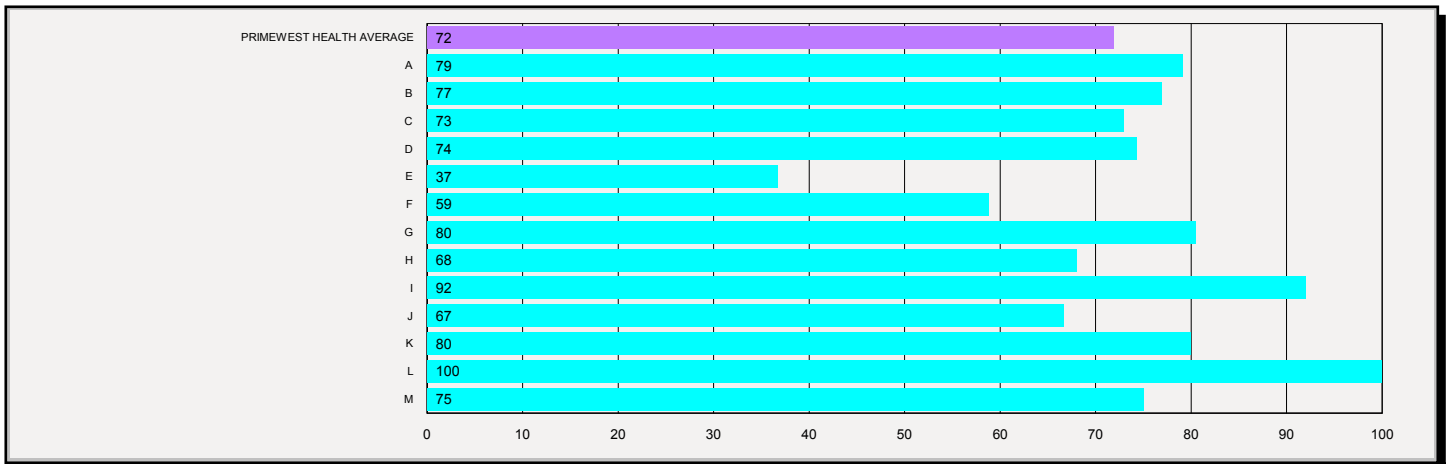
**7. For members 11 years and older, there is appropriate notation concerning the use of tobacco, alcohol, and substances (for members seen three or more times or if indicated, query substance abuse history).**



This year's scores reflect documentation found for any 2 of the 3 areas. Tobacco use was more commonly addressed, followed by infrequent documentation of alcohol use. Substance use was rarely addressed. Standard is there is documentation of all three for those 11 years and older.

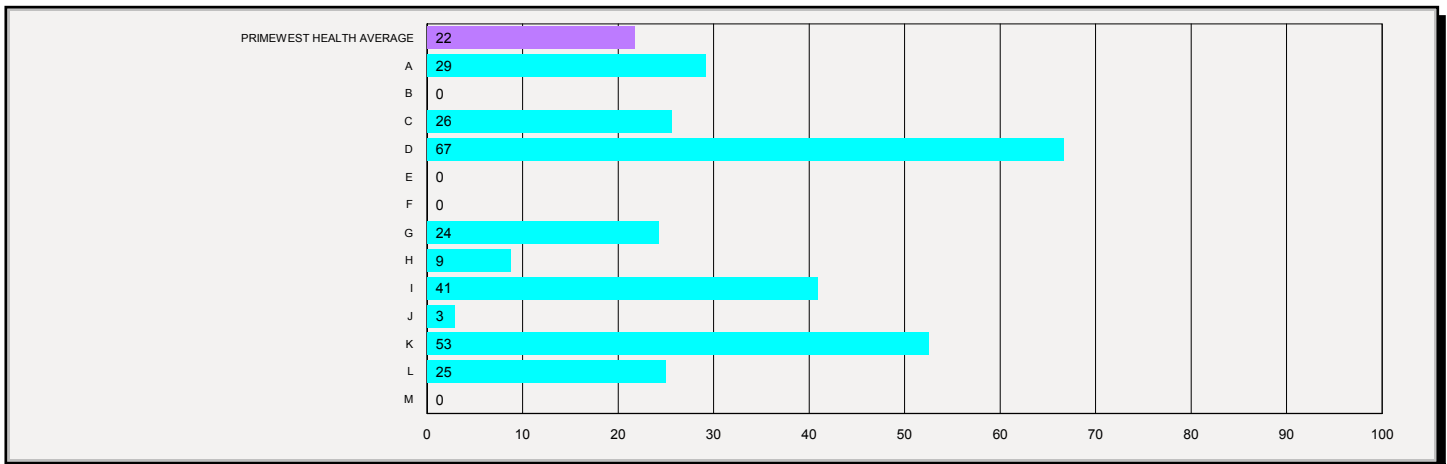
# PREVENTIVE SCREENING AND SERVICES

## 1. Immunization status information for all ages is recorded on a single page location.



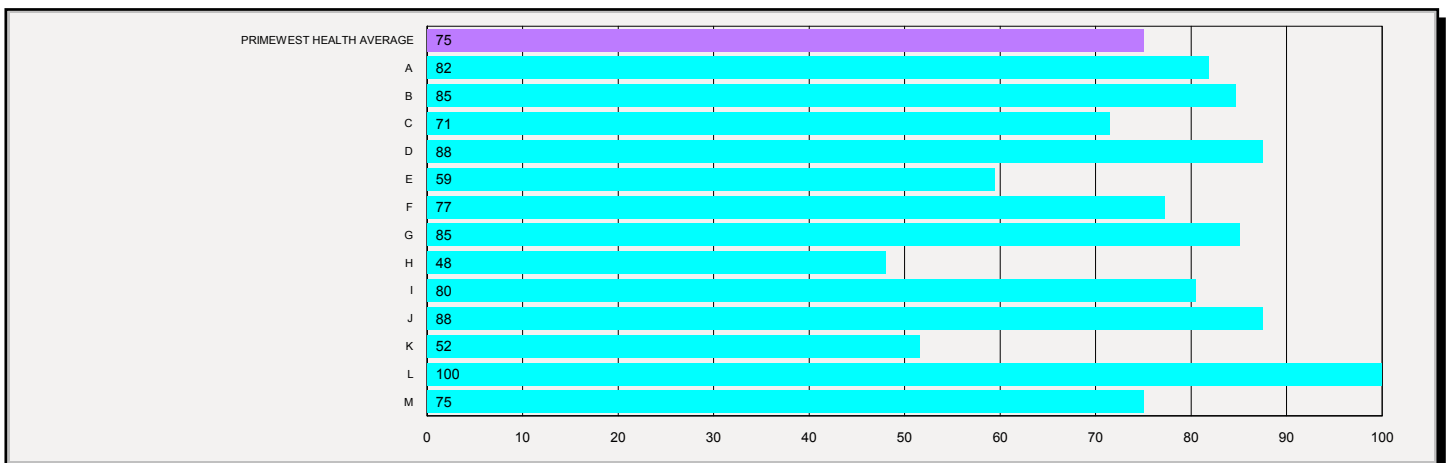
Documentation should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of person administering the vaccine. All immunizations must be documented on a single page location, not throughout the medical record.

## 2. Body Mass Index (BMI) for all ages is documented annually.



This is a new PrimeWest standard and was not included in the overall scoring. Baseline data was gathered. Calculate and document BMI for those 2 years and older using appropriate age and gender specific tables. EMRs have the capability pre-programmed to document BMI if a height is recorded with the weight.

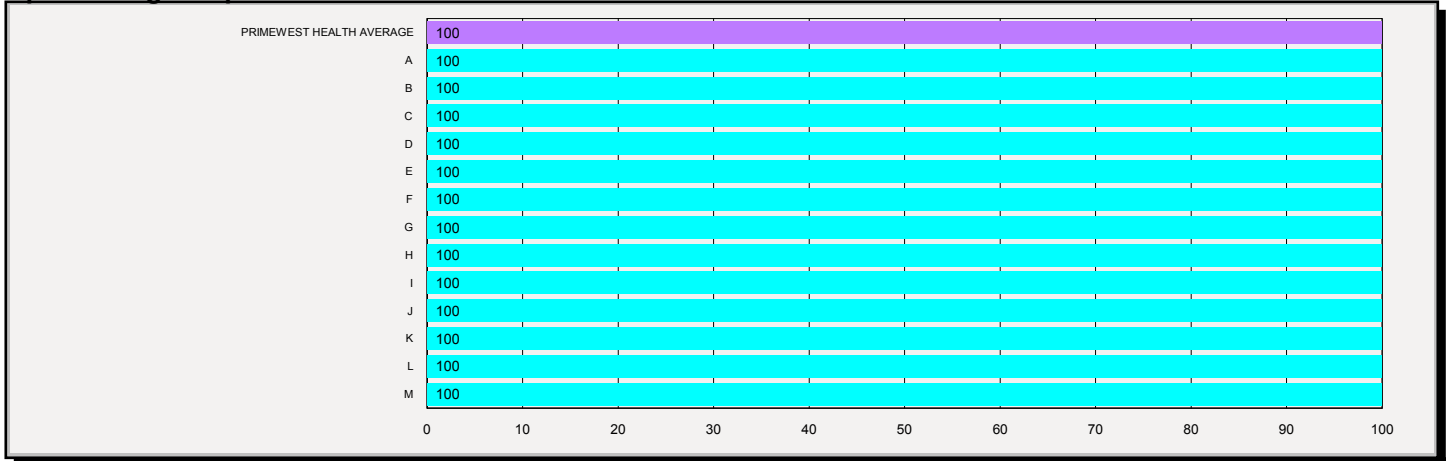
## 3. There is evidence that preventive screening and services are offered in accordance with PrimeWest guidelines.



A summary of preventive screenings is documented in a consistent place in the record. This year PrimeWest looked for any evidence of screenings offered or completed. Child & Teen Checkups per periodicity schedule and adult age and gender specific screenings are strongly recommended.

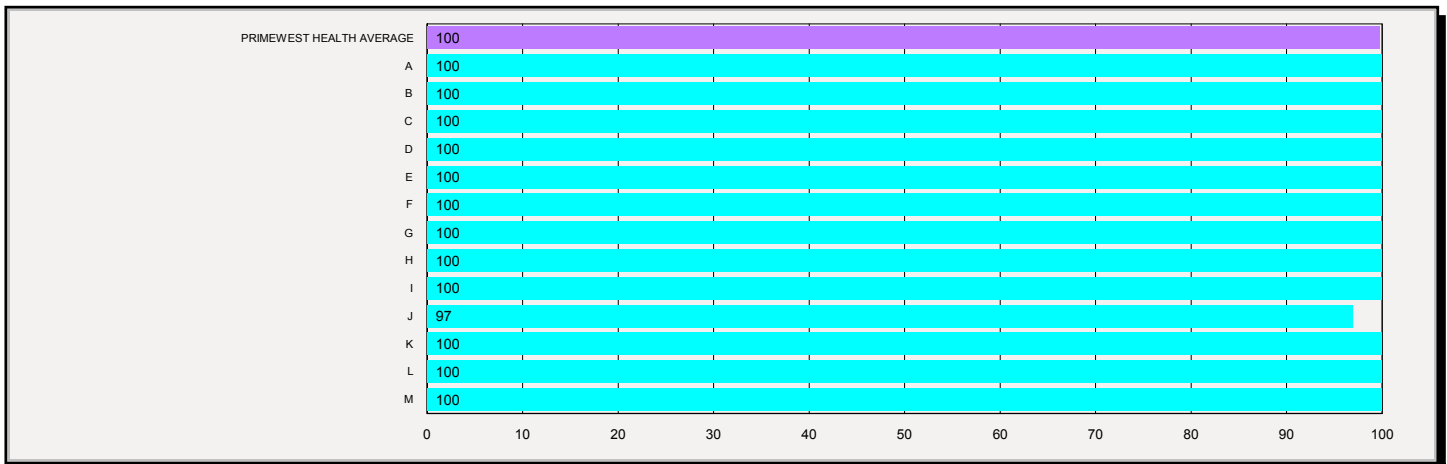
# ASSESSMENT, PLAN, AND FOLLOW-UP

## 1. History and physical exam identifies appropriate subjective and objective information pertinent to member's presenting complaints.



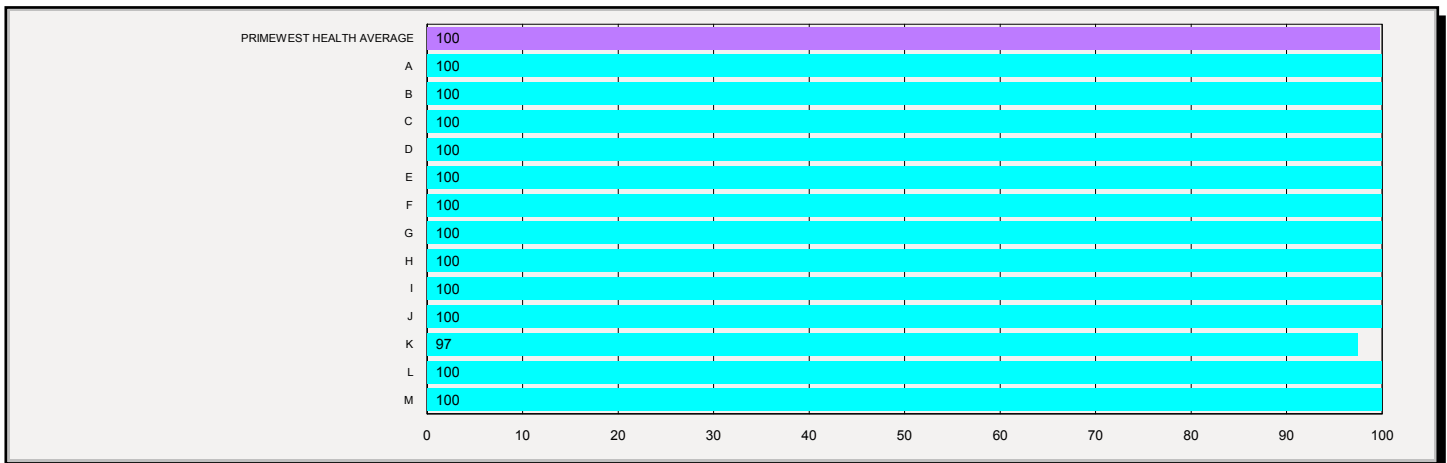
Subjective and objective information identifying why the member is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information. A pertinent physical exam, relevant to the problem, should be documented.

## 2. Laboratory and other studies are ordered, as appropriate.



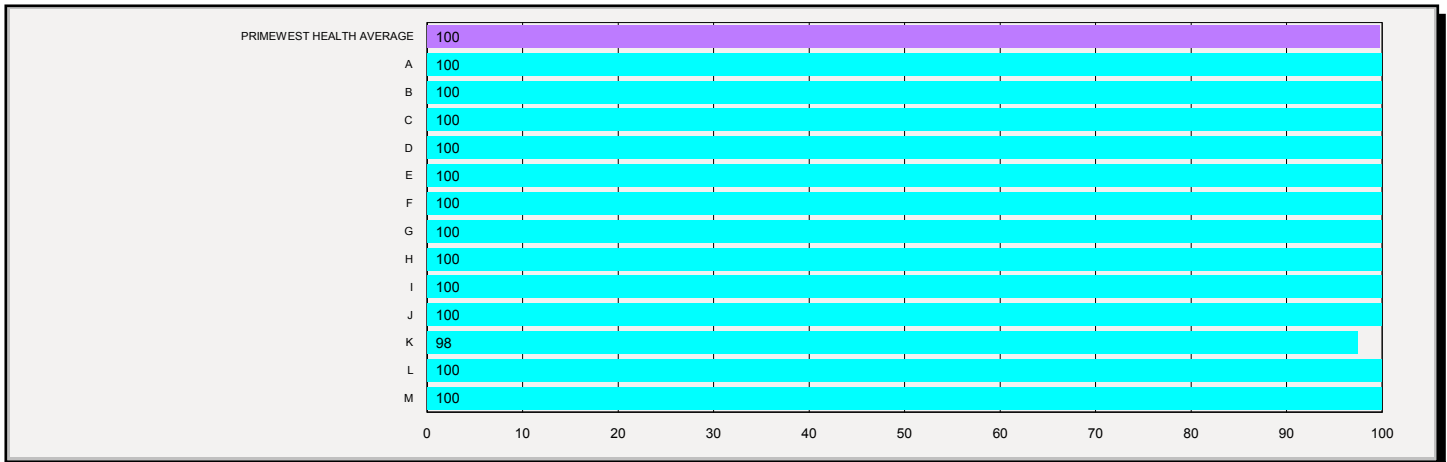
The results of all diagnostic tests and examinations, consistent with the exam and assessment, must be documented in the medical record. Documentation of the order for service must also be in the record.

## 3. Working diagnoses are consistent with findings.



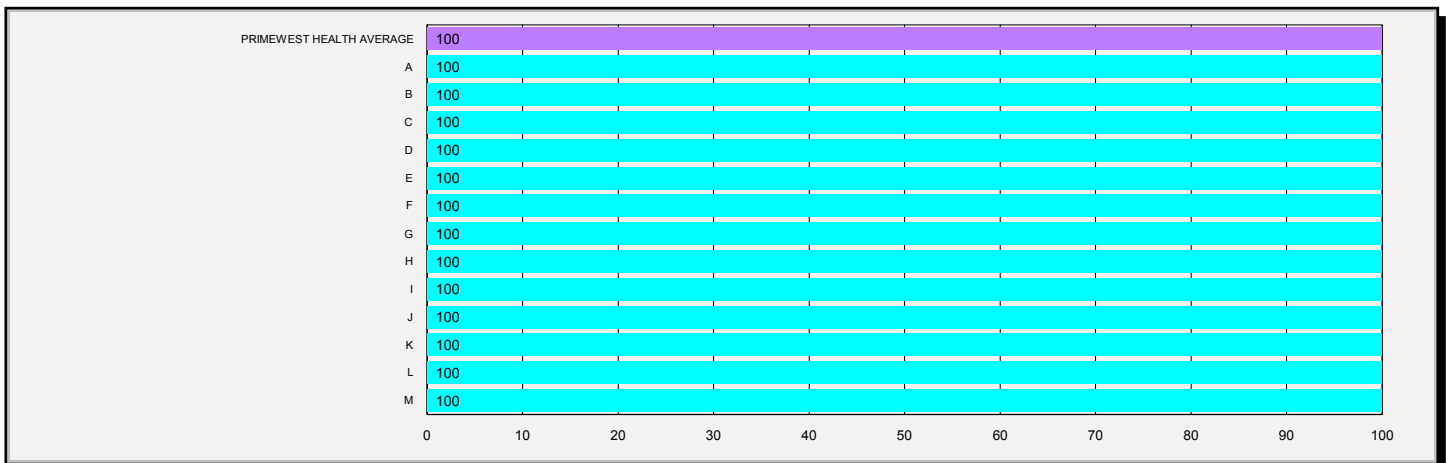
Working diagnosis or medical impressions that logically follow from the clinical assessment and physical exam are recorded.

#### 4. Treatment plans are consistent with diagnoses.



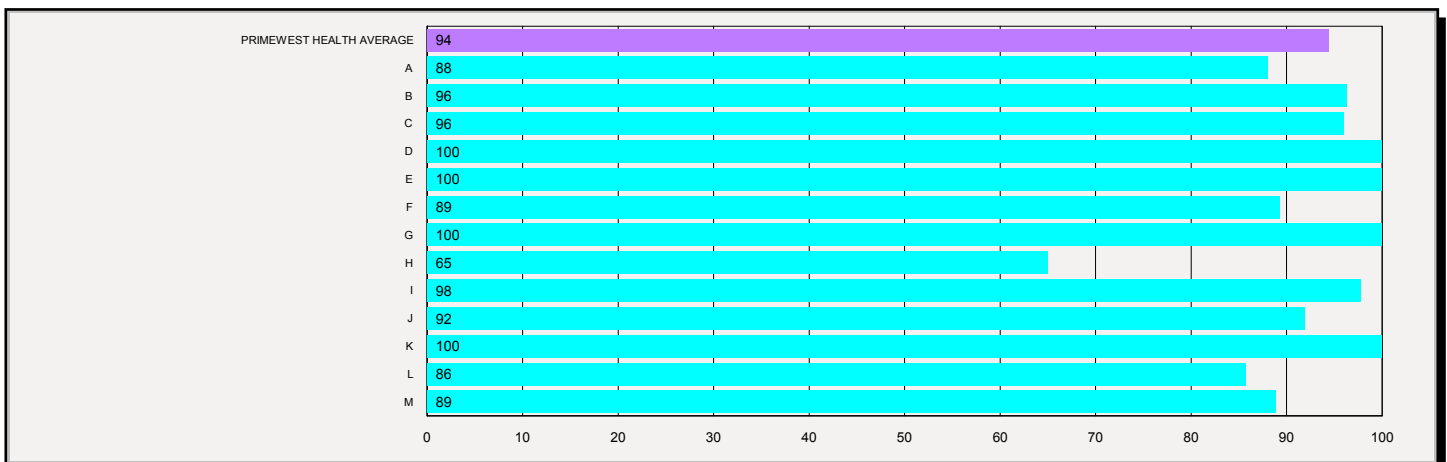
Proposed treatment plans are documented and logically follow previously documented diagnoses and medical impressions. There is evidence of provider consideration of member input in the proposed treatment plan and consultation with any specialists caring for the member.

#### 5. There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.



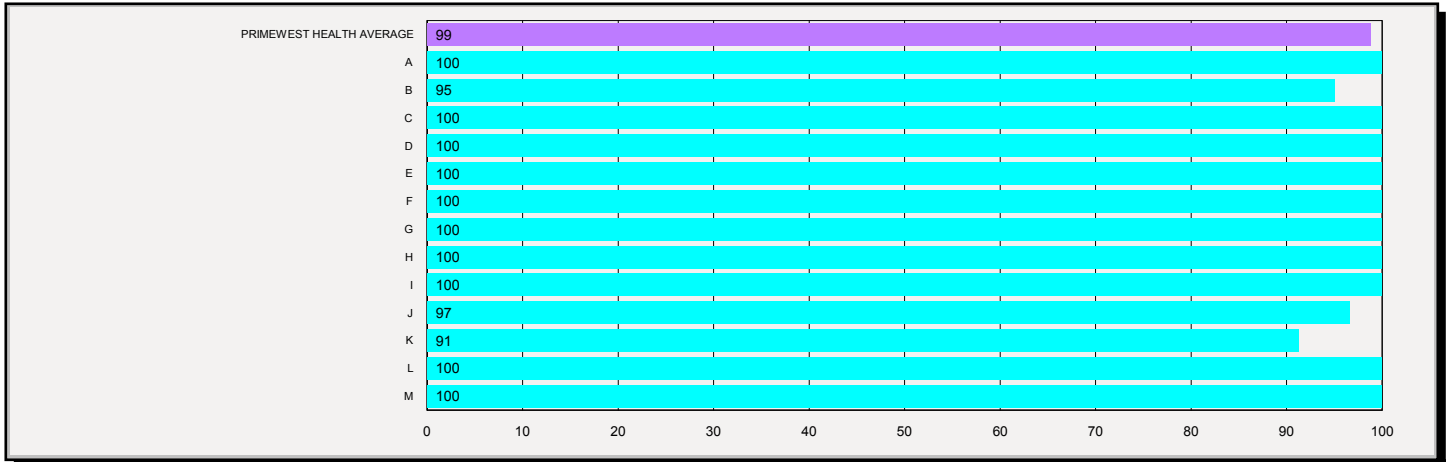
The medical record shows clear justification for diagnostic and therapeutic procedures.

#### 6. Prescribed medications are clearly visible in the medical record.



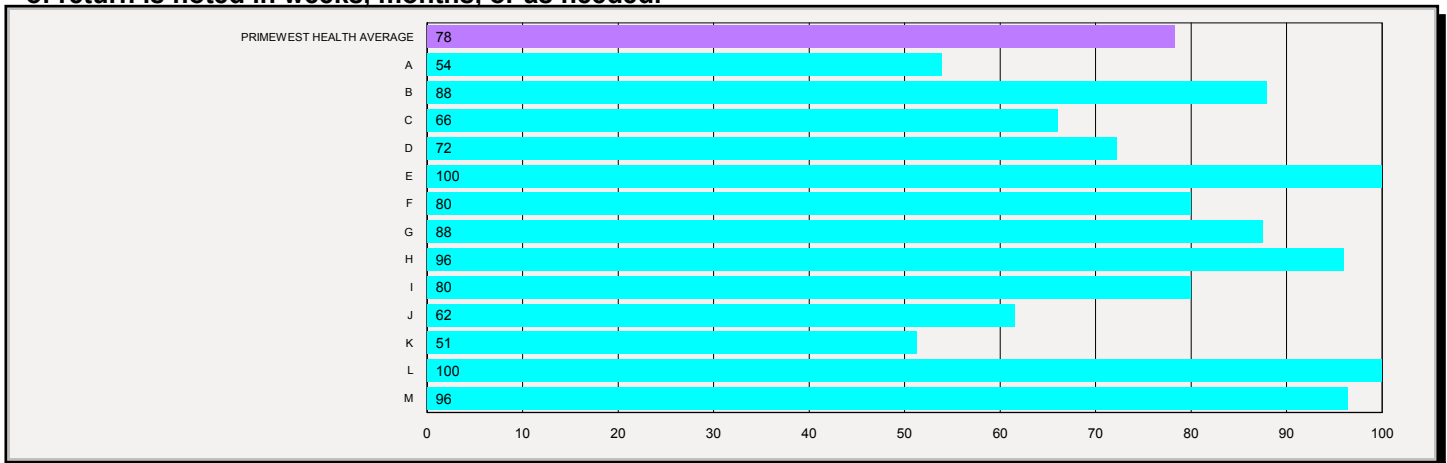
Documentation of prescribed medications (including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions) is clearly visible in the medical record.

**7. Unresolved problems from previous visits are addressed in subsequent visits.**



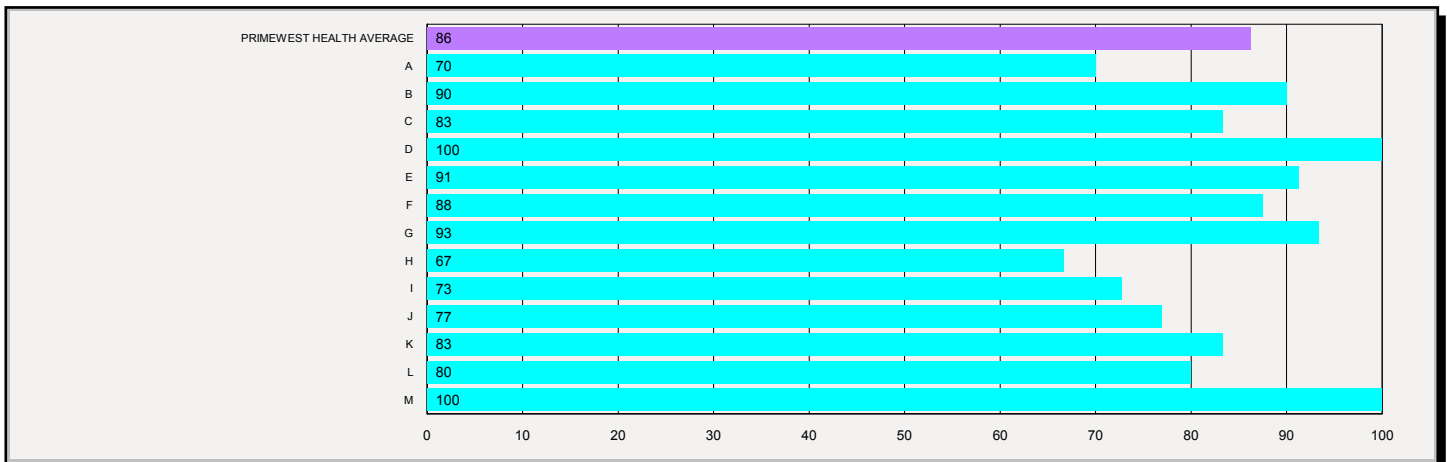
Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes. The record must report the member's progress or response to treatment and changes in the treatment or diagnosis.

**8. Encounter forms or notes include information about follow-up care, calls, or visits when indicated. Specific time of return is noted in weeks, months, or as needed.**



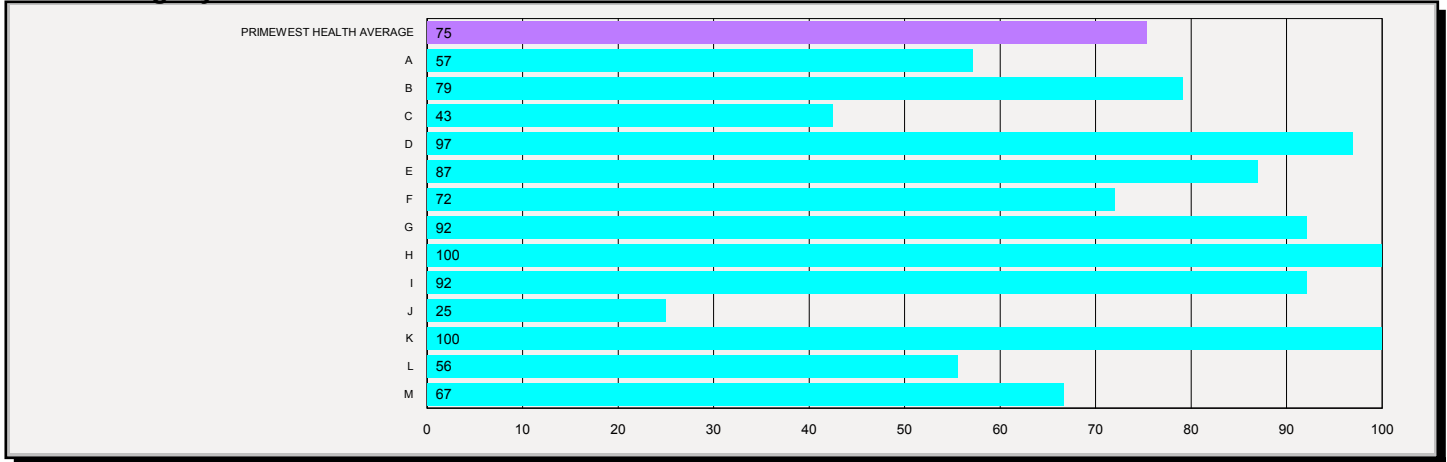
Return to office in a specified amount of time is recorded at time of visit, or as follow-up to consultation, laboratory or other diagnostic reports.

**9. Note from consultant is present for each consultation requested.**



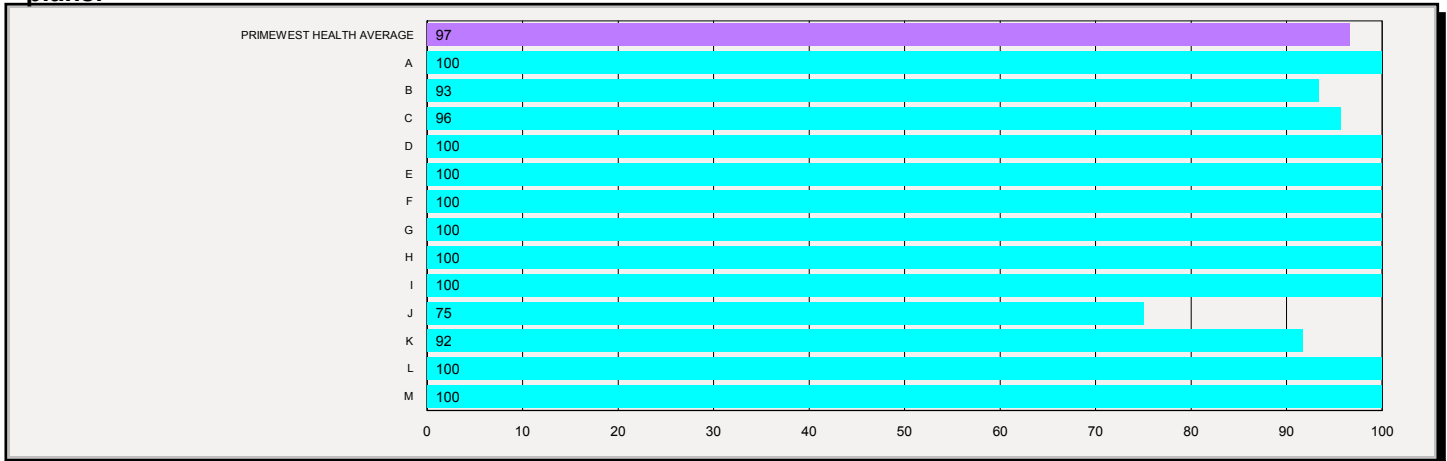
Medical records include consultation reports/summaries that correspond to specialist referrals or documentation that practitioner attempted to obtain reports that were not received.

**10. Consultation, lab, and imaging reports filed in the medical record are initialed by the practitioner who ordered them to signify review.**



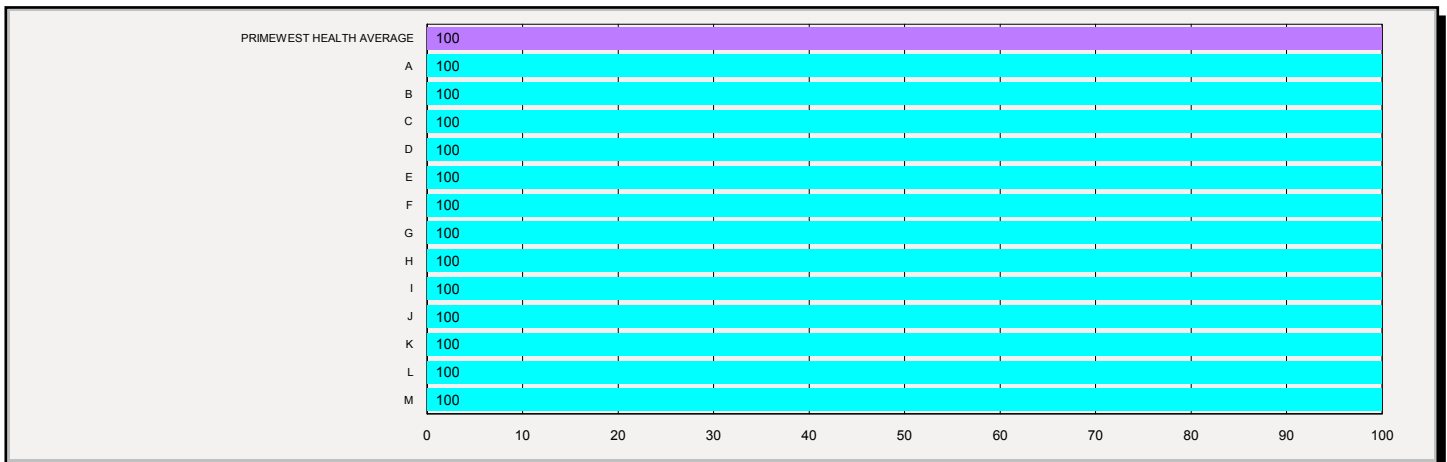
All reports of consultation, lab, and imaging studies ordered are documented in the medical record/EMR and are initialed by the practitioner who ordered them to signify review or another system of ensuring practitioner review is in place.

**11. Clinically significant consultation and abnormal lab and imaging reports have an explicit notation of follow-up plans.**



Follow-up care, communication of test results, and calls/visits should be documented to indicate continuity of care. Subsequent visit notes/treatment plans reflect results of the reports as may be pertinent to ongoing care.

**12. Discharge summaries are filed in the member's record.**

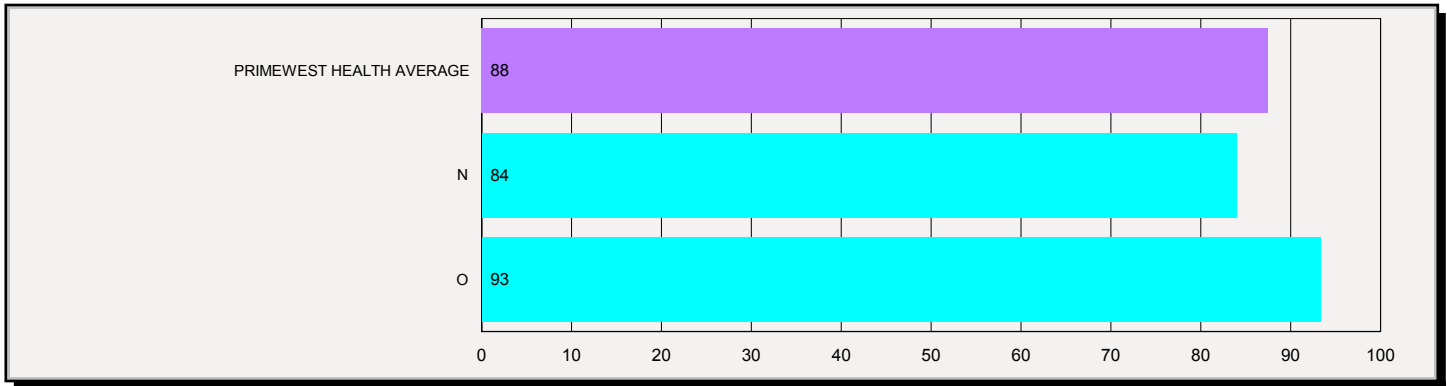


Discharge summaries for diagnostic and therapeutic services for which a member was referred, such as hospital discharge reports, specialty physician reports, home health nursing reports, and physical therapy reports, are found in member's record when applicable.

**PrimeWest Health  
2007 Behavioral Health Treatment  
Record Audit Report**

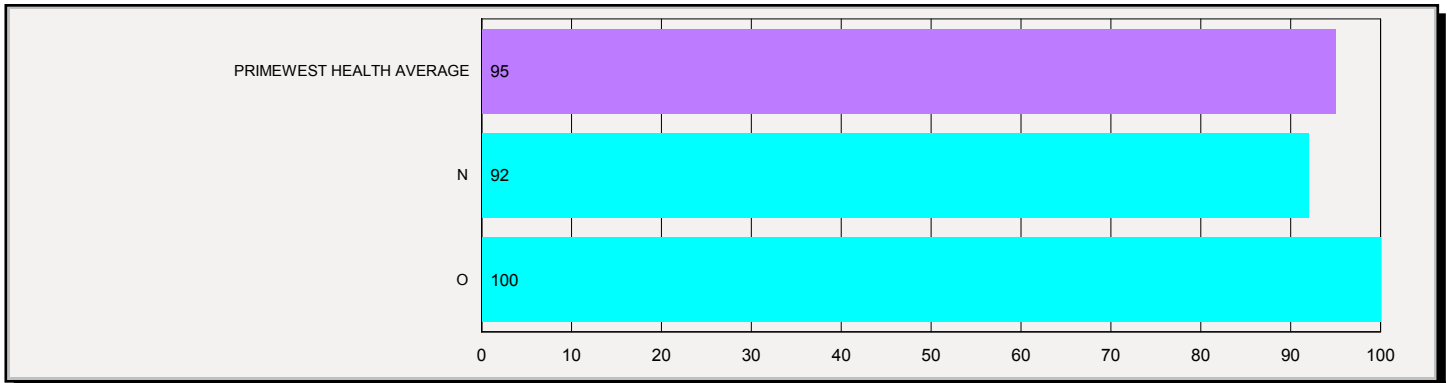
# RECORD FORMAT

## 1. Elements in the treatment record are organized in a consistent manner.



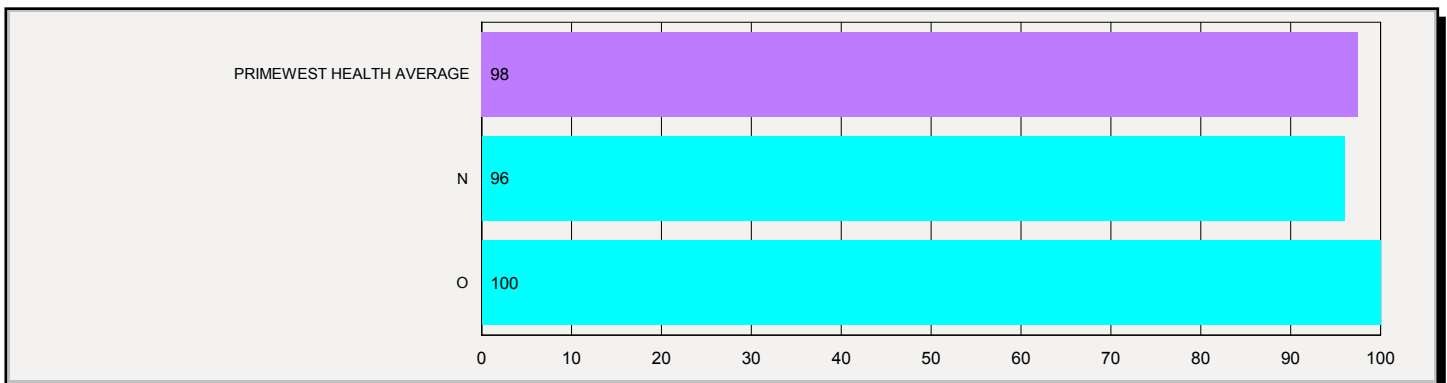
Contents are secured in place and organized in a logical, consistent manner and in chronological order.

## 2. Member name present on every page.



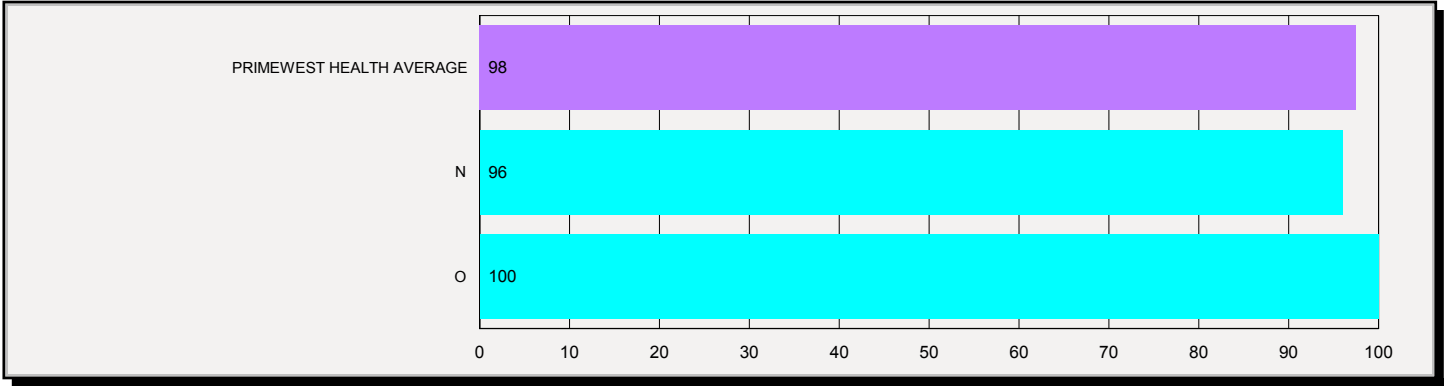
Member name present on every page and there are no pages/entries in record that belong to another person (separate record maintained for each unique member).

## 3. Author identification present for every entry.



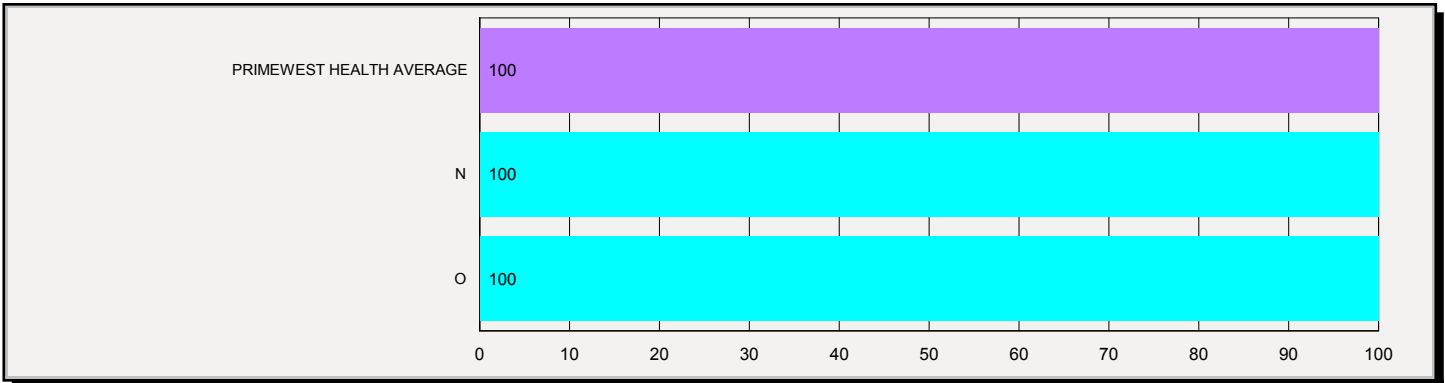
All entries contain the author's identification (which may be a handwritten signature, unique electronic identifier or initials) and title/professional degree. Transcribed visit notes and nurse/paraprofessional entries must meet criteria.

**4. All entries are dated.**



Each entry must contain the date on which the entry was made and includes the year. Telephone calls and triage notes must also be dated.

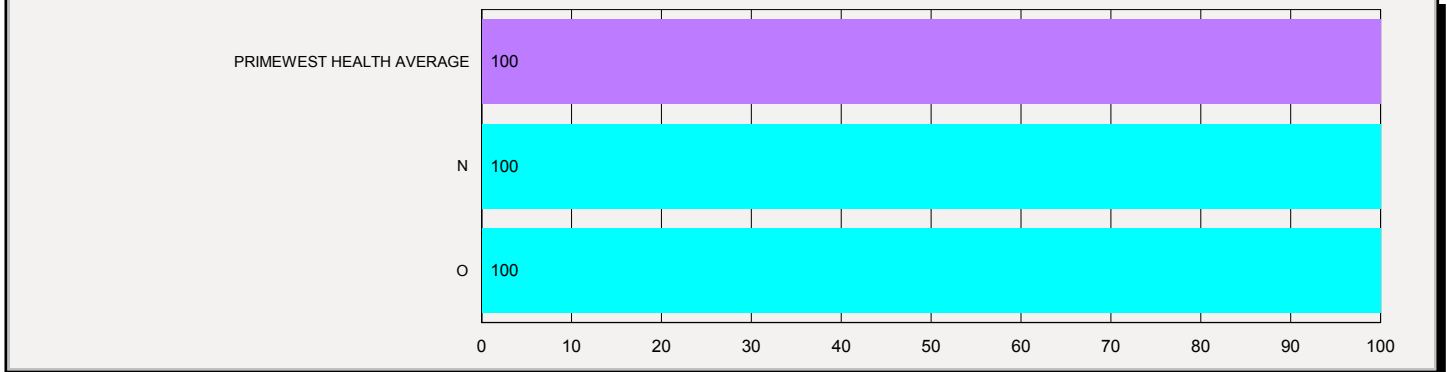
**5. All entries are legible to someone other than author.**



All entries are legible and presented in a standard format that allows a reader to review without the use of a standard legend/key.

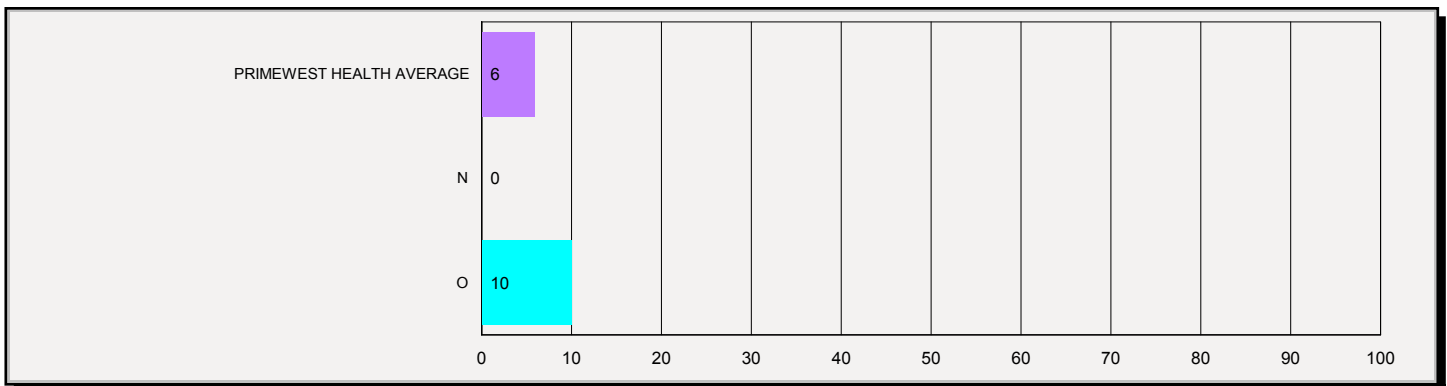
## RECORD CONTENT

- 1. Personal biographical data includes member address, employer or school, home and work phone numbers, including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information.**



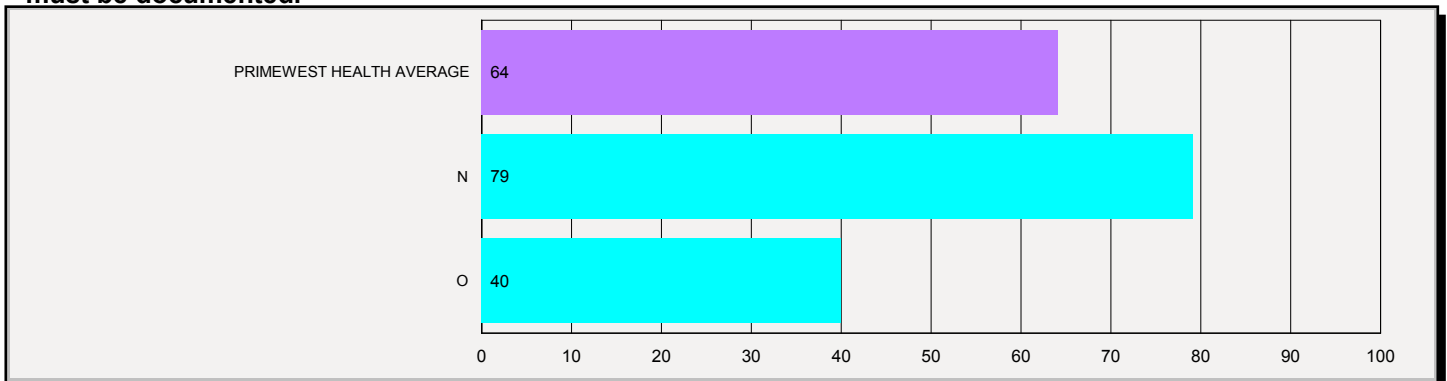
Personal biographical data is documented in a prominent location in each record and includes all information cited in element. This year, records were scored as “yes” if all information was available except one area. Employer and marital status were most commonly omitted.

- 2. Health Care Directives are documented in the treatment record for members 18 years and older.**



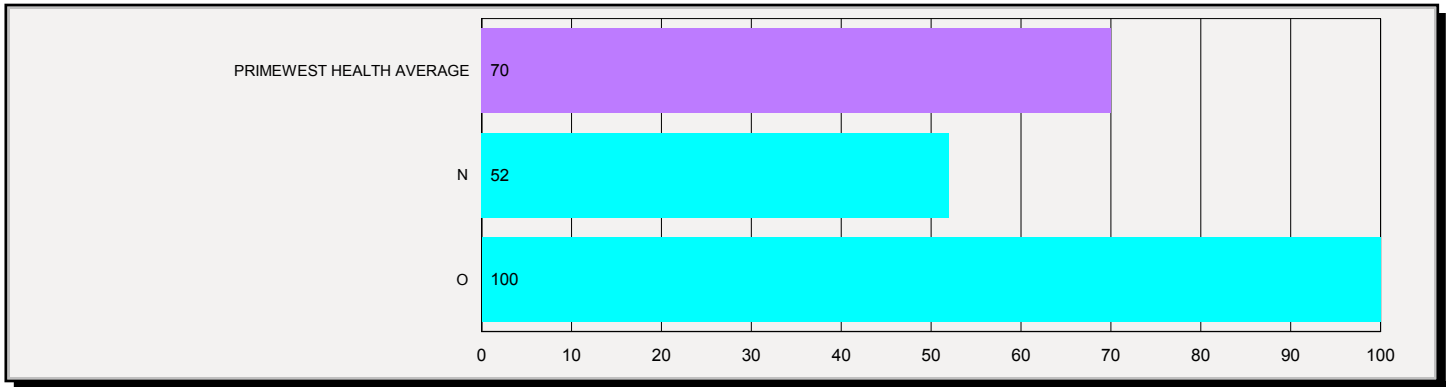
Documentation is in a prominent part of the record whether or not a member has executed a health care directive for those 18 years and older. If member has not executed a health care directive, document that information was offered (this portion was not audited this year).

- 3. Member authorization to release private information and member information obtained from outside sources must be documented.**



When necessary, there must be a signed authorization for all external persons with whom treatment information is exchanged. This authorization to release information must be current for the period covered and not outdated.

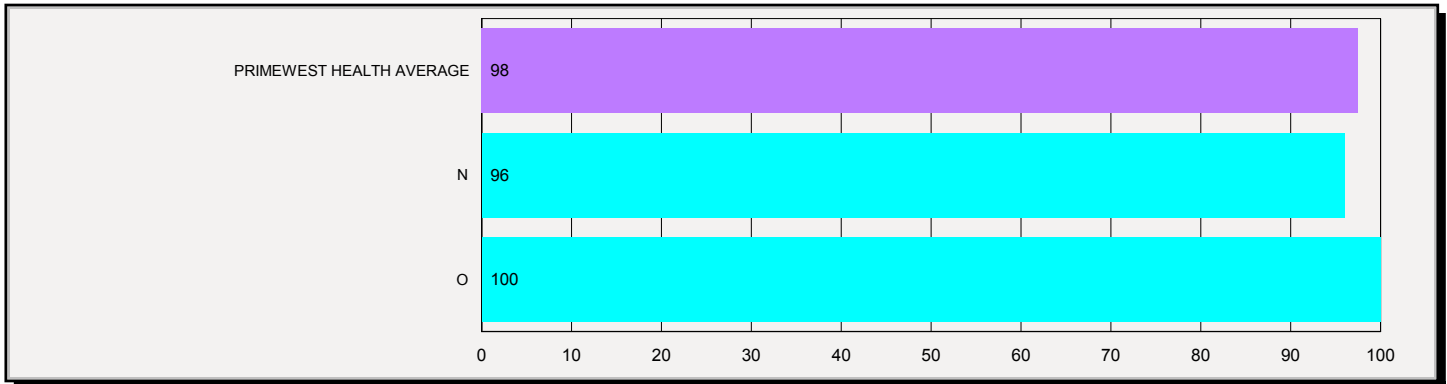
**4. Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.**



Absence or presence of allergies must be consistently and clearly documented in a prominent location in all treatment records per clinic procedure. Allergy stamps or forms used for documentation must be filled out. Allergy documentation must be kept current.

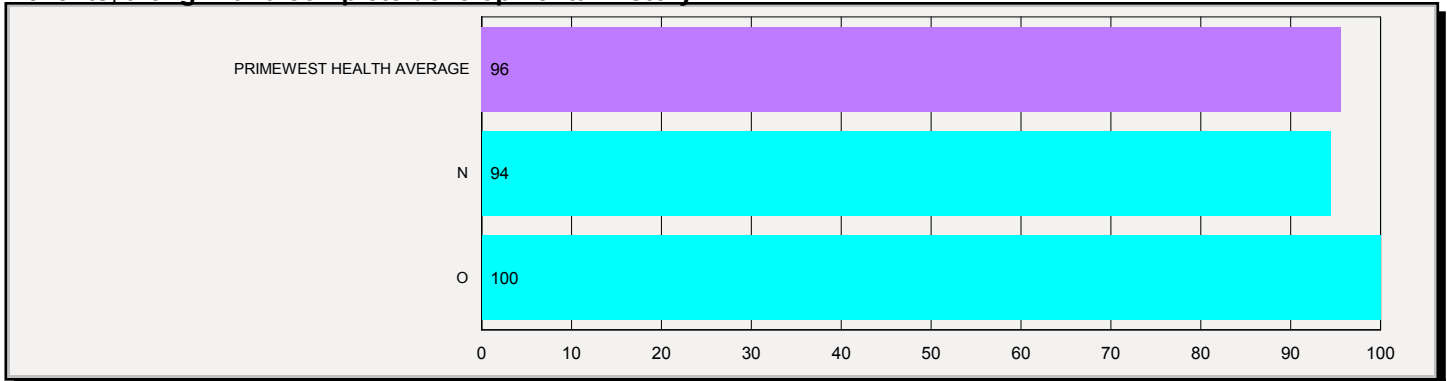
# ASSESSMENT AND TREATMENT PLAN

## 1. A medical history is easily identified and includes relevant illnesses and medical conditions.



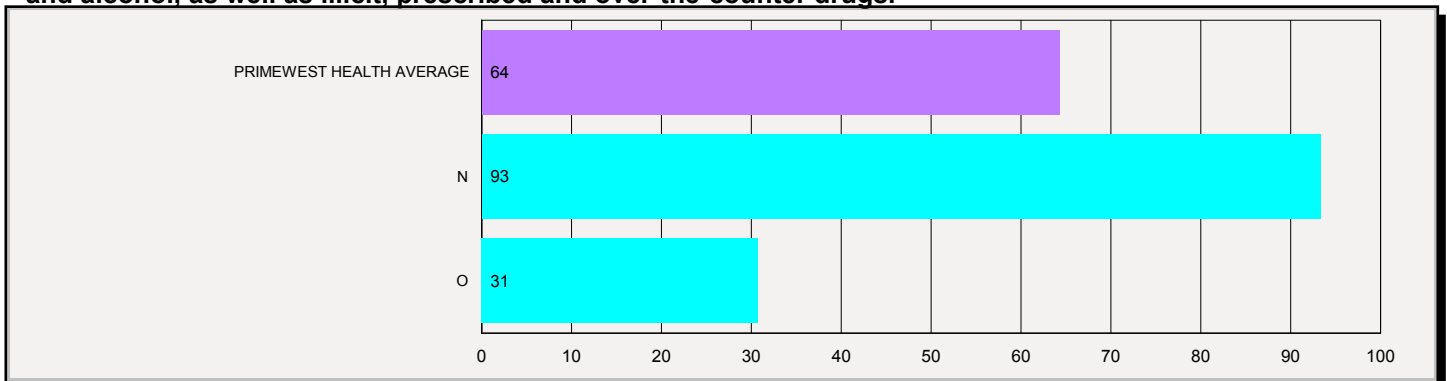
Standard clinic forms for past medical history must be filled out, updated, and complete. This element was scored for members 18 years and older.

## 2. Past medical history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.



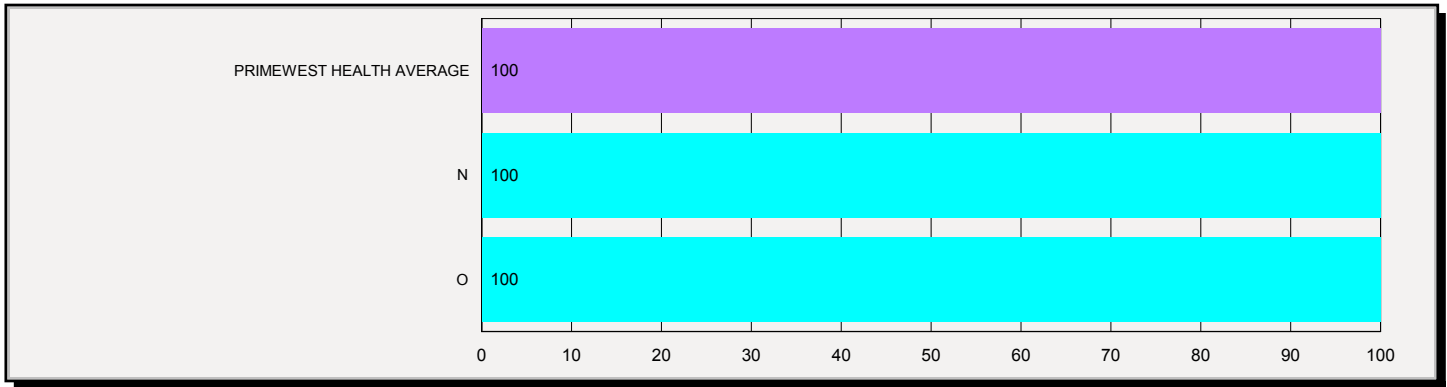
Standard clinic forms for past medical history must be filled out, updated, and complete.

## 3. For members 11 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs.



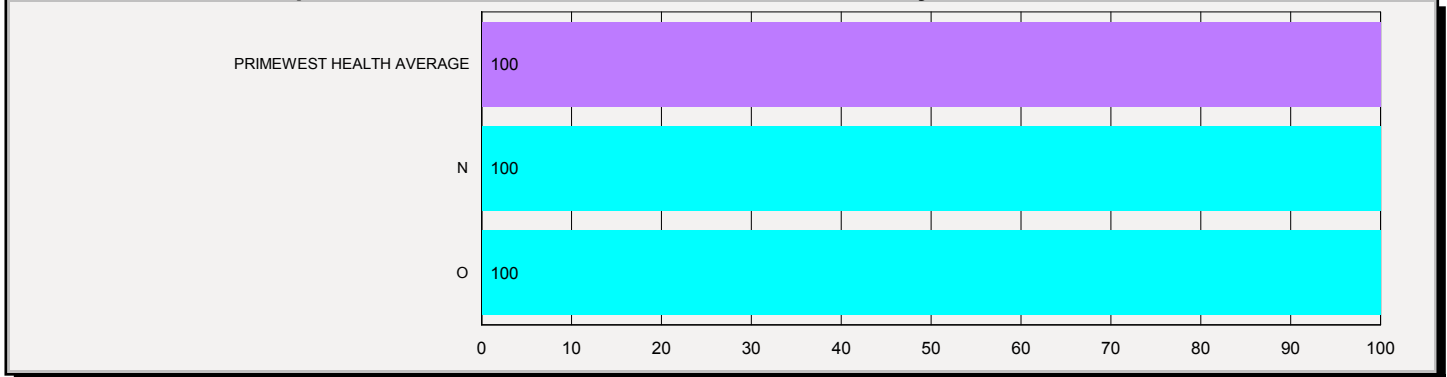
A substance use history must be documented for those 11 years and older. The history must include past and present use of tobacco, alcohol, or illicit drugs and any misuse of prescriptions or over-the-counter drugs. Present caffeine use should also be noted.

**4. A social history must be documented.**



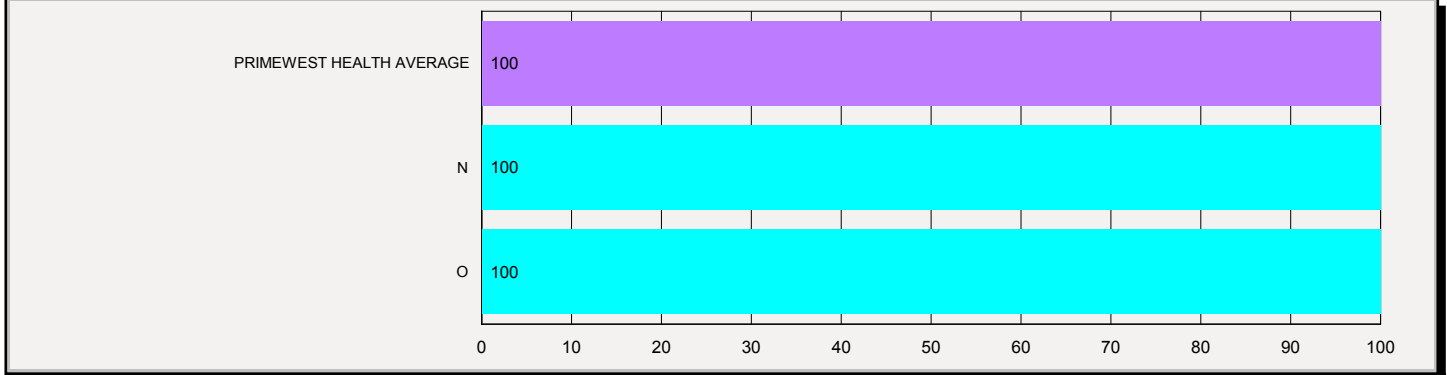
Documentation includes family history; current family status; history of physical, sexual, or mental abuse or trauma; current social network and academic or vocational status.

**5. A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, source of clinical data and relevant family information.**



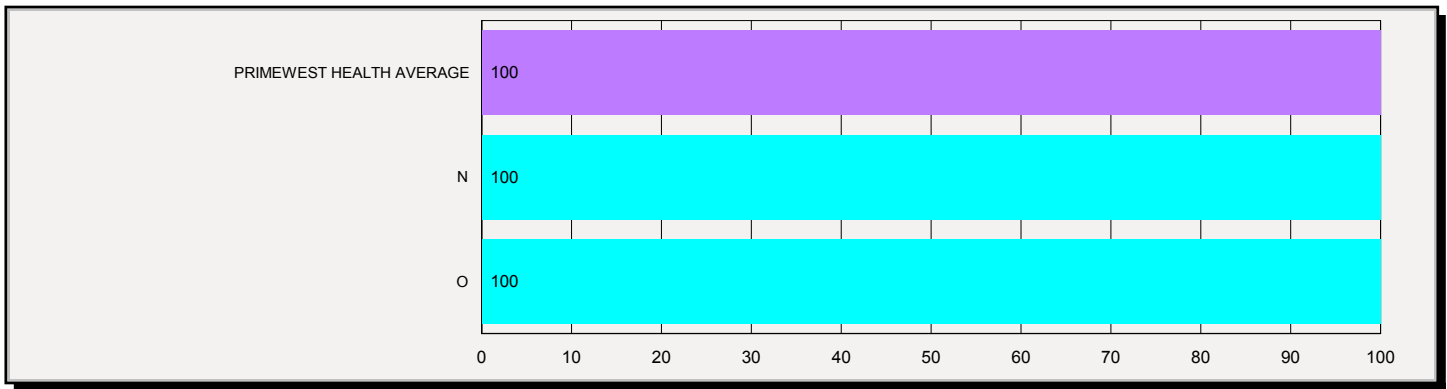
A psychiatric history must be documented and should include, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, relevant family information, lab test results, and consultation reports.

**6. Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.**



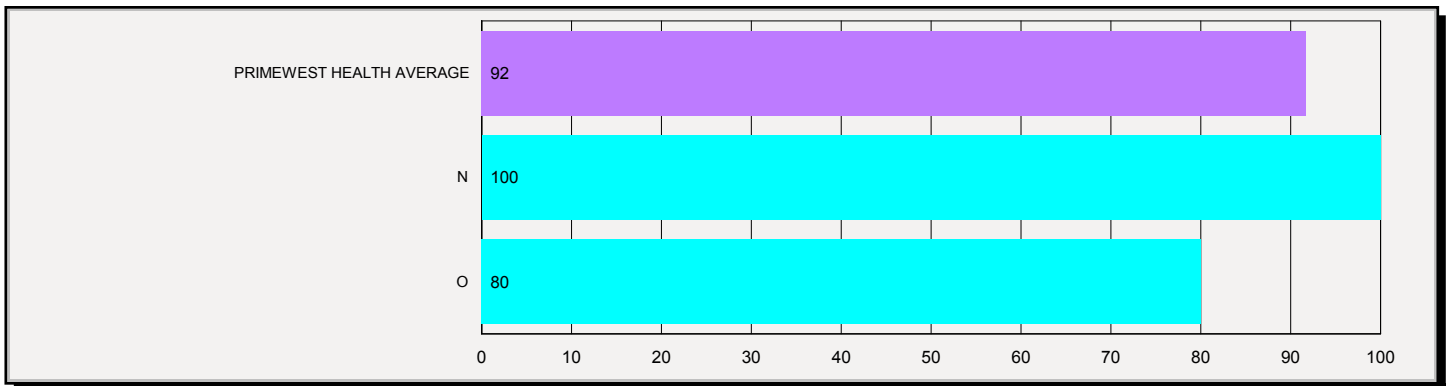
Presenting symptoms must be clearly identified and documented, including the onset, duration, and intensity of symptoms

**7. Results of a mental status exam are documented.**



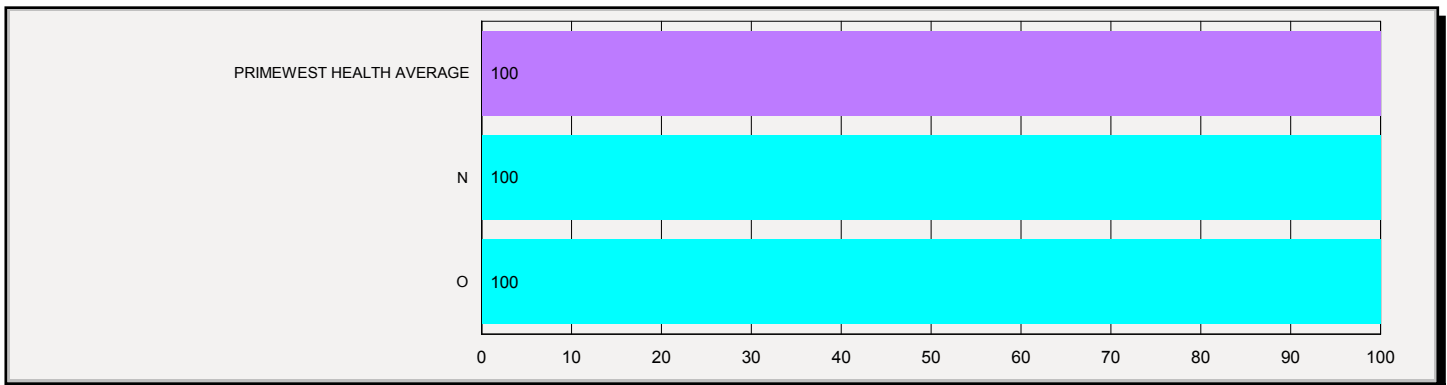
A mental status examination must be documented which includes, at a minimum, information about appearance, speech, affect, mood, thought content, judgment, insight, attention, concentration, memory, and impulse control.

**8. Special status situations, when present, are prominently noted.**



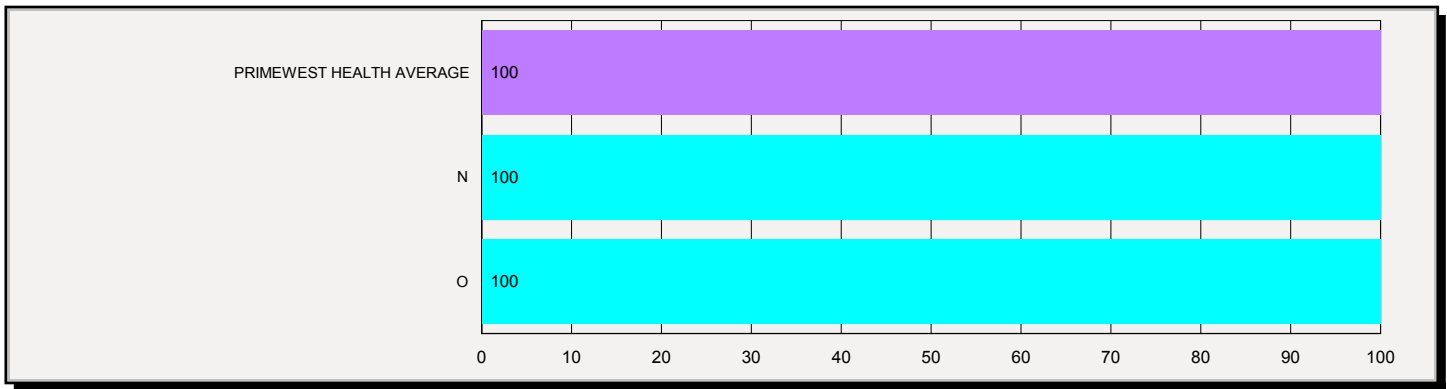
Special status situations, when present, such as imminent risk of harm to self or others, suicidal ideation, or elopement potential, are prominently noted. Continued assessment should be documented in subsequent progress notes or follow-up visits.

**9. Laboratory and other studies are ordered, as appropriate.**



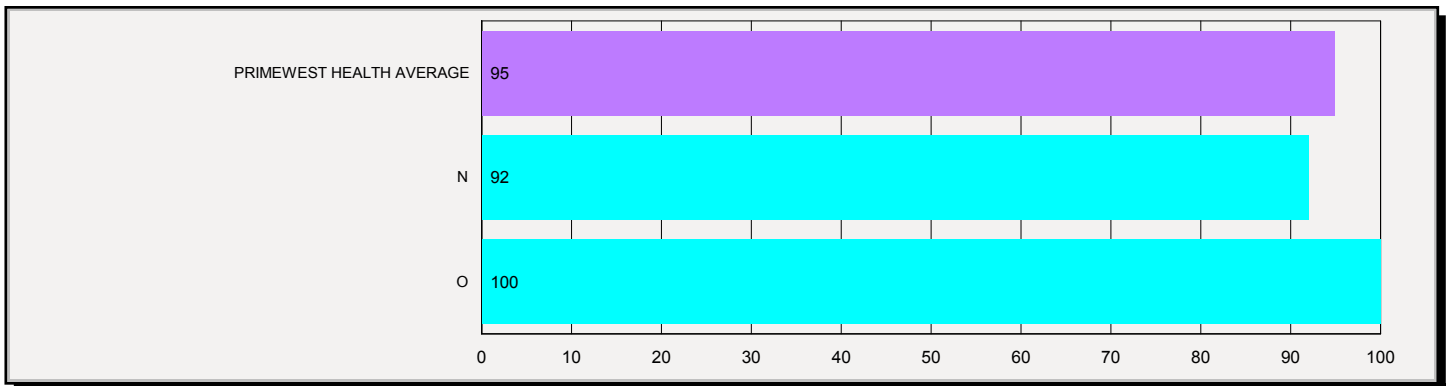
The results of all diagnostic tests and examinations, consistent with the exam and assessment, must be documented in the treatment record.

**10. A DSM-IV diagnosis is documented.**



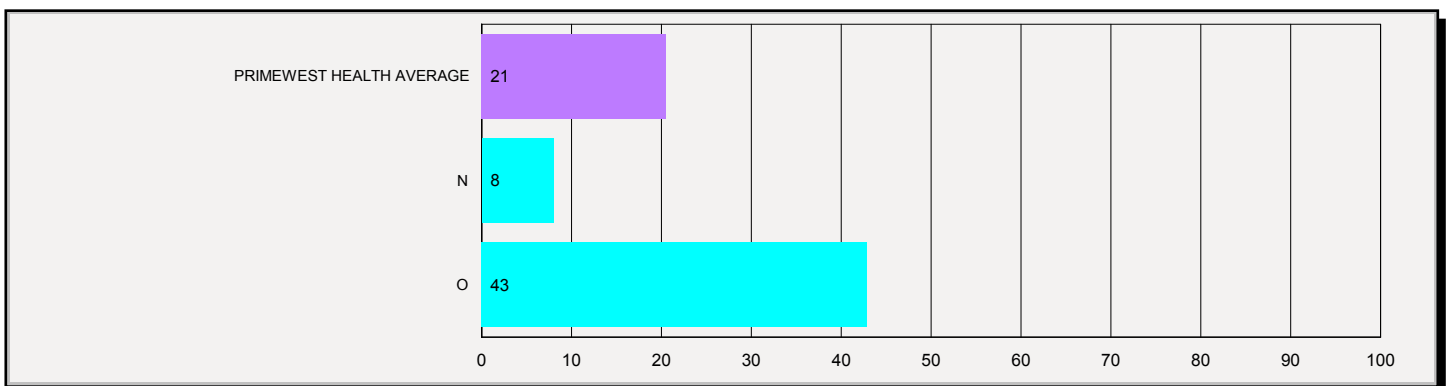
A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data. All five axes must be documented according to the DSM-IV-TR multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses must be listed, when applicable.

**11. Treatment plans are consistent with diagnoses.**



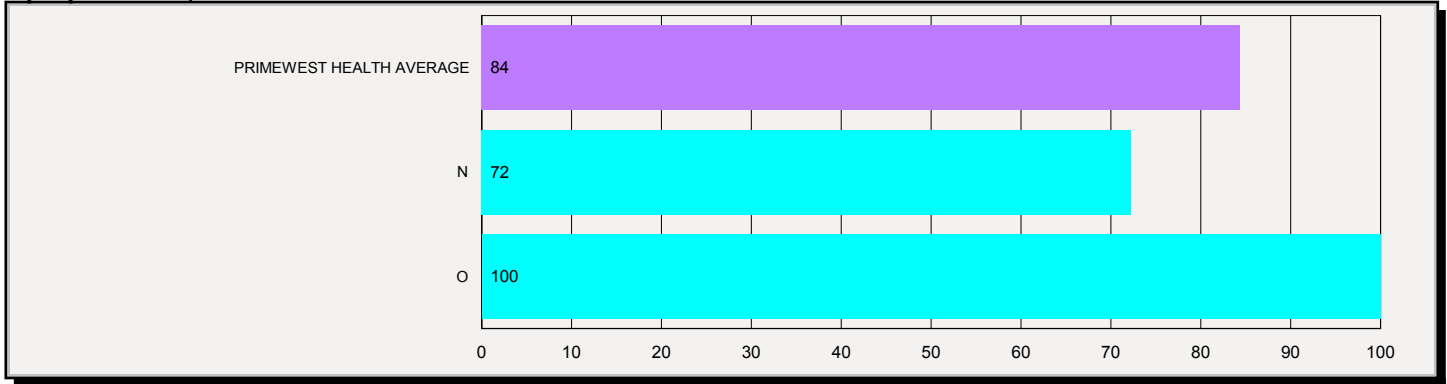
Treatment plans are consistent with diagnoses and have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution. There is evidence of provider consideration of member input into the proposed treatment plan and in consultation with any specialists caring for member.

**12. Informed consent for medication and treatment plans are documented.**



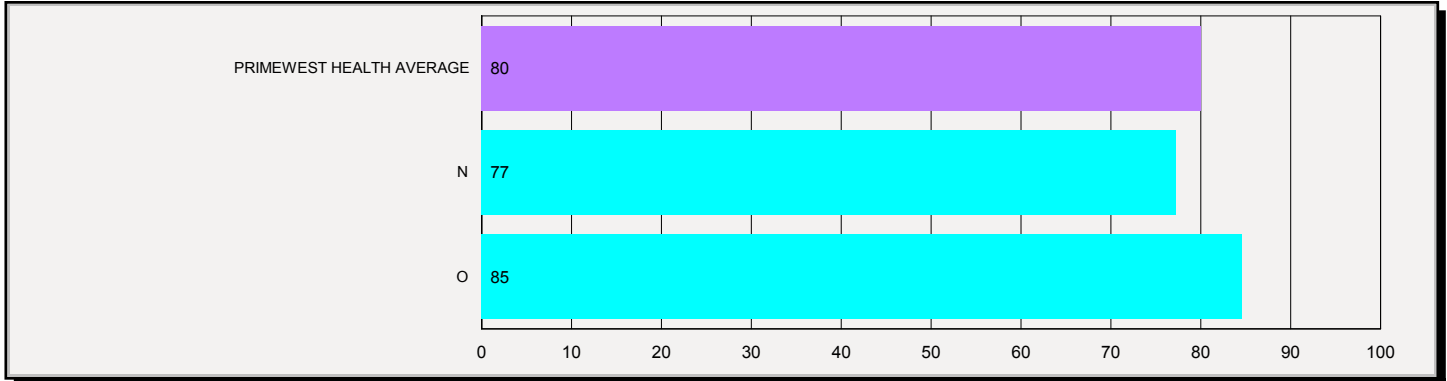
The member must participate in the development of the treatment plan and should sign the initial plan and sign or initial all updates or revisions. For a minor or adult unable to give consent, the parent or guardian has signed.

**13. Current medications prescribed by all prescribing practitioners, as well as over-the-counter and herbal preparations, are documented.**



Ongoing documentation and medication reconciliation of prescribed medication, including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the treatment record. Over-the-counter and herbal preparations should also be clearly noted.

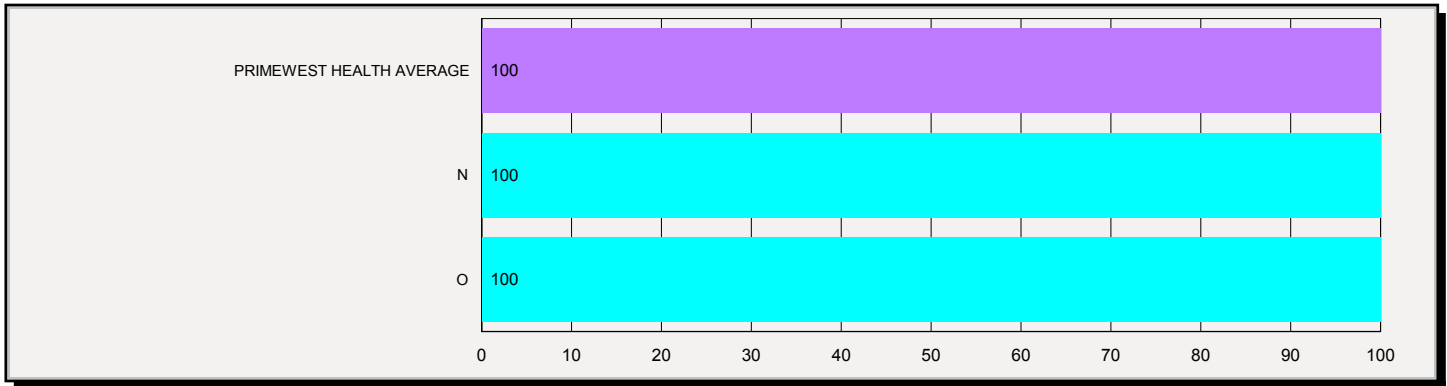
**14. Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.**



As required for continuity and coordination of care, all behavioral health providers shall, when appropriate, convey pertinent information to member's primary care provider, consulting practitioner, ancillary provider, or health care institution. This standard excludes psychotherapy notes.

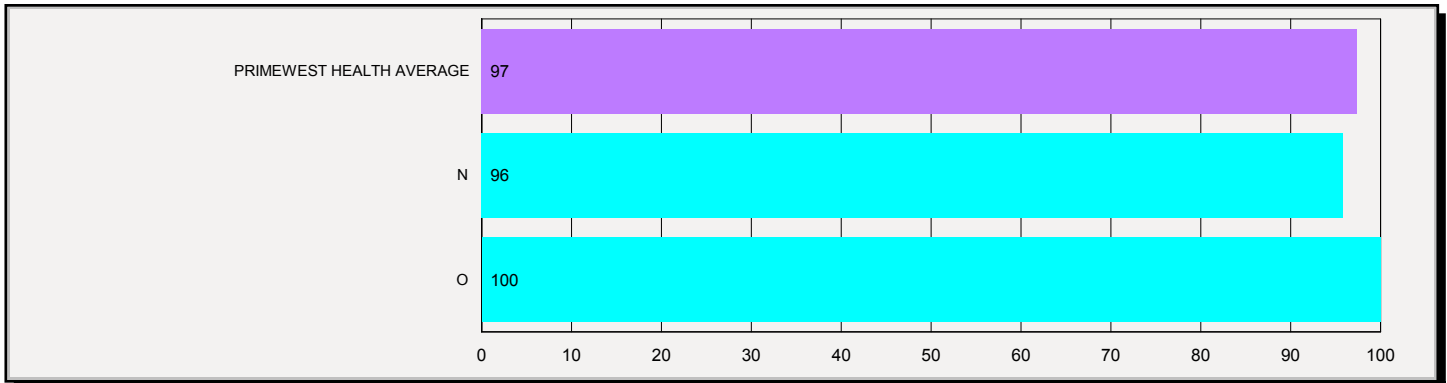
## PROGRESS NOTES AND FOLLOW-UP

### 1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.



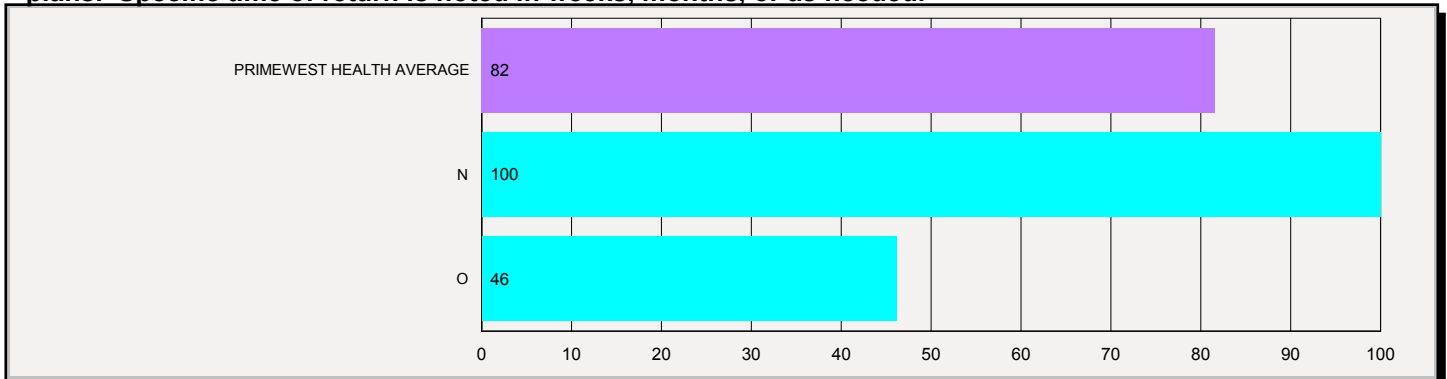
Relevant updates to the member strengths, weaknesses, and barriers that enable or inhibit the member's ability to achieve treatment goals and objectives should be noted and reflect treatment interventions that are consistent with those goals and objectives. Any education interventions should also be noted.

### 2. Progress notes reflect current treatment interventions.



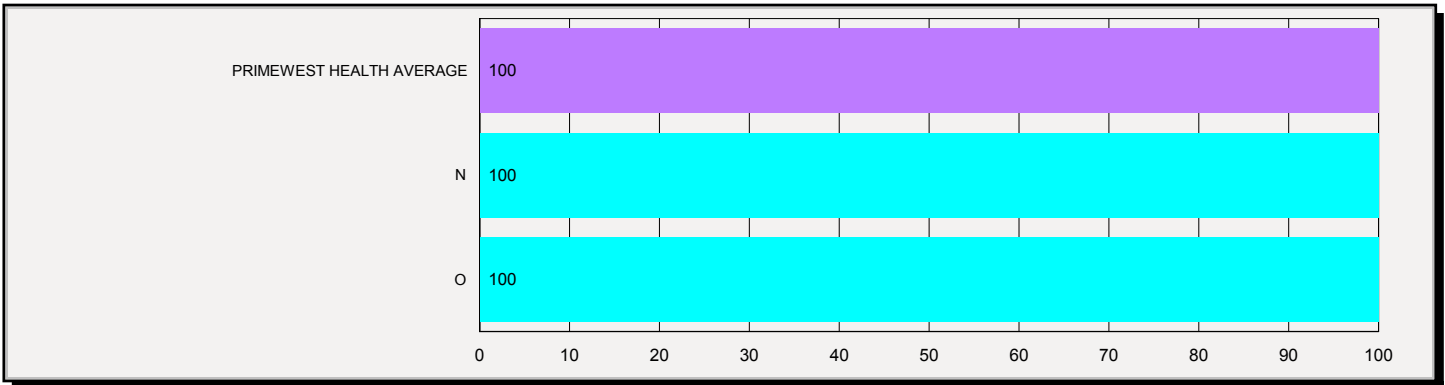
Progress notes are consistent with current treatment plans and objectives. Documentation includes continuity and coordination of care activities, as appropriate. Assessment of special status situations, when present, such as imminent risk of harm to self or others, suicidal ideation, or elopement potential, are documented.

### 3. Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months, or as needed.



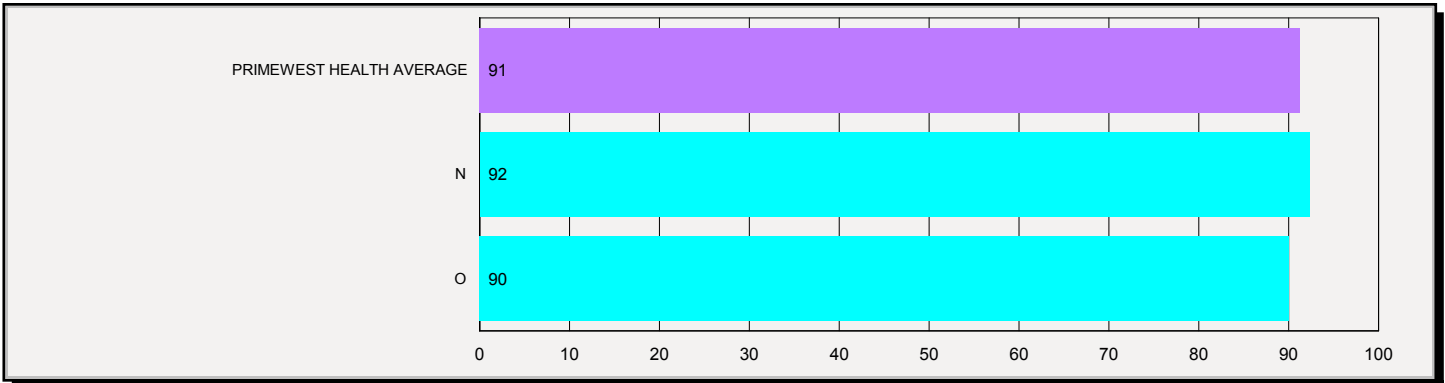
There must be notation in each entry about need for follow-up care, plans for a return visit or termination of treatment. Telephone encounters with individuals relevant to treatment must be documented in the treatment record and reflect practitioner review. The specific date or time frame of a return visit, must be noted.

**4. Unresolved problems from previous visits are addressed in subsequent visits.**



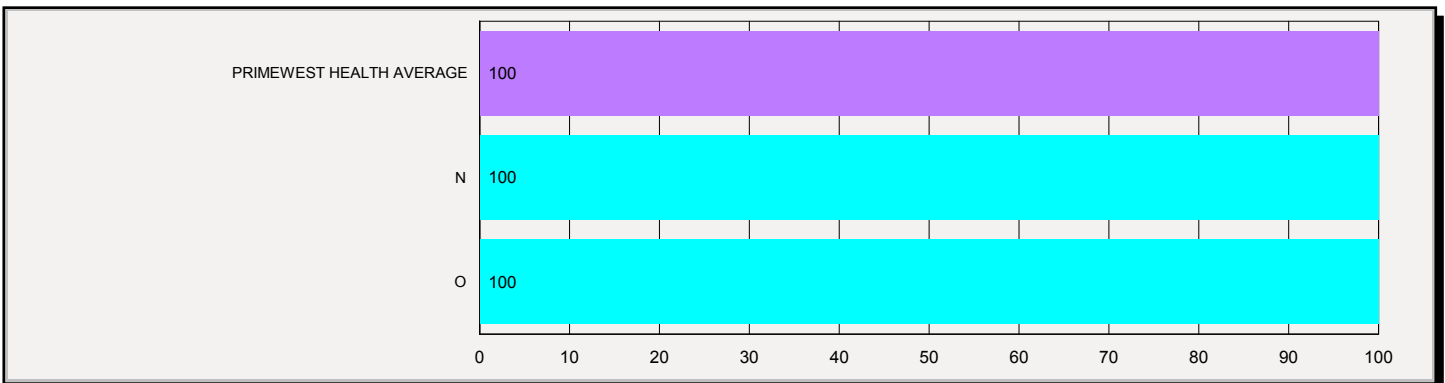
Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes. The record must report the member's progress or response to treatment and changes in the treatment or diagnosis.

**5. A summary of preventive services is documented in a consistent place in the treatment record.**



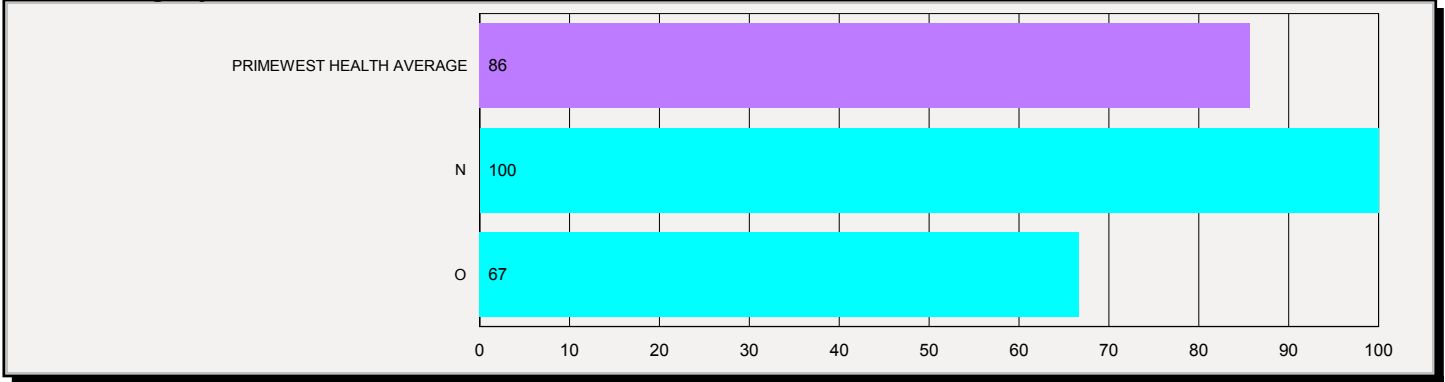
Recommendations or referrals for preventive or other external services (e.g. stress management, relapse prevention, wellness programs, lifestyle changes, or community services) must be documented.

**6. Note from consultant is present for each consultation requested.**



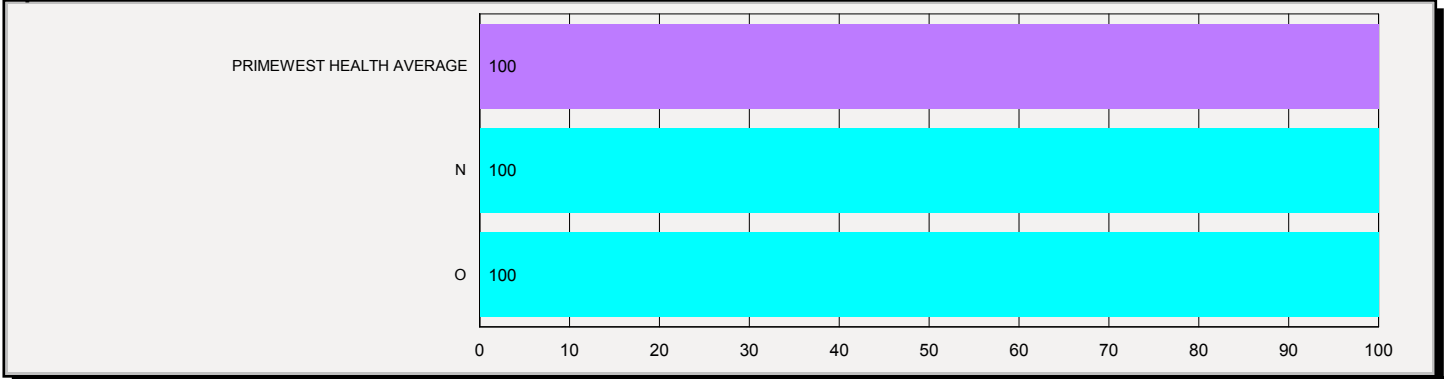
Treatment records include consultation reports/summaries that correspond to specialist referrals or documentation that practitioner attempted to obtain reports that were not received.

**7. Consultation, lab, and imaging reports filed in the treatment record are initialed by the practitioner who ordered them to signify review.**



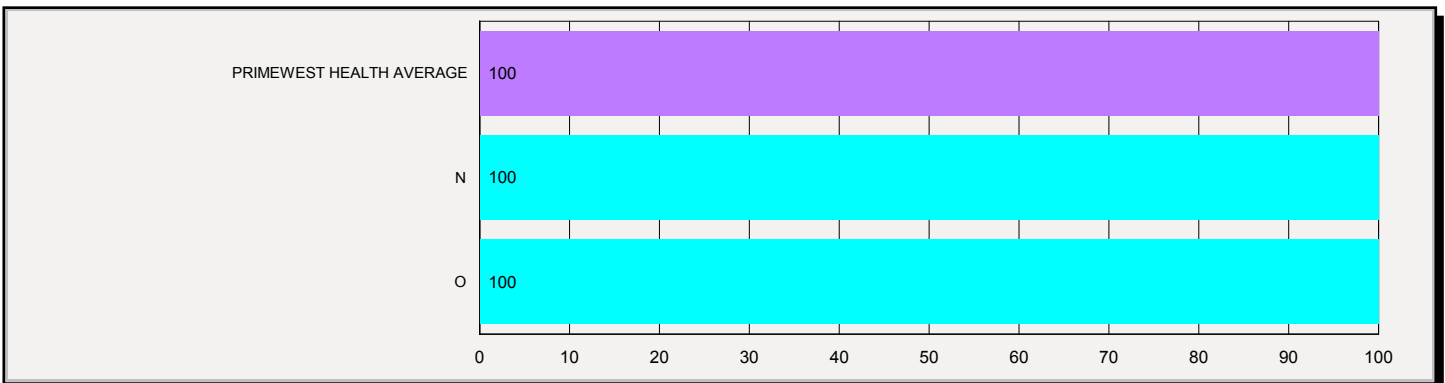
All reports of consultation, lab, and imaging studies ordered are filed in the treatment record and initialed by the practitioner who ordered them to signify review or another system of ensuring practitioner review is in place.

**8. Clinically significant consultation, abnormal lab and imaging reports have an explicit notation of follow-up plans.**



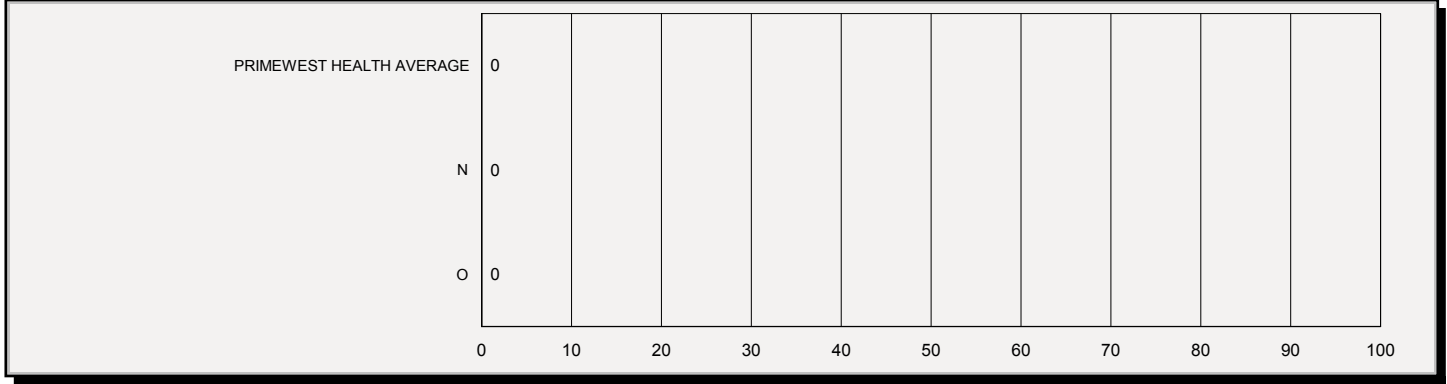
Follow-up care, communication of test results, and calls/visits should be documented to indicate continuity of care. Subsequent visit notes and treatment plans reflect results of the reports as may be pertinent to ongoing care.

**9. Discharge summaries are filed in the member's record.**



Discharge summaries for diagnostic and therapeutic services for which a member was referred (such as hospital discharge reports, specialty physician reports, home health nursing reports, and physical therapy reports) are found in member's record when applicable.

**10. At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.**



A statement of the reason for termination, current client conditions, and the treatment outcome must be documented at the closing of the case. This element did not apply to any of the records reviewed in this audit.