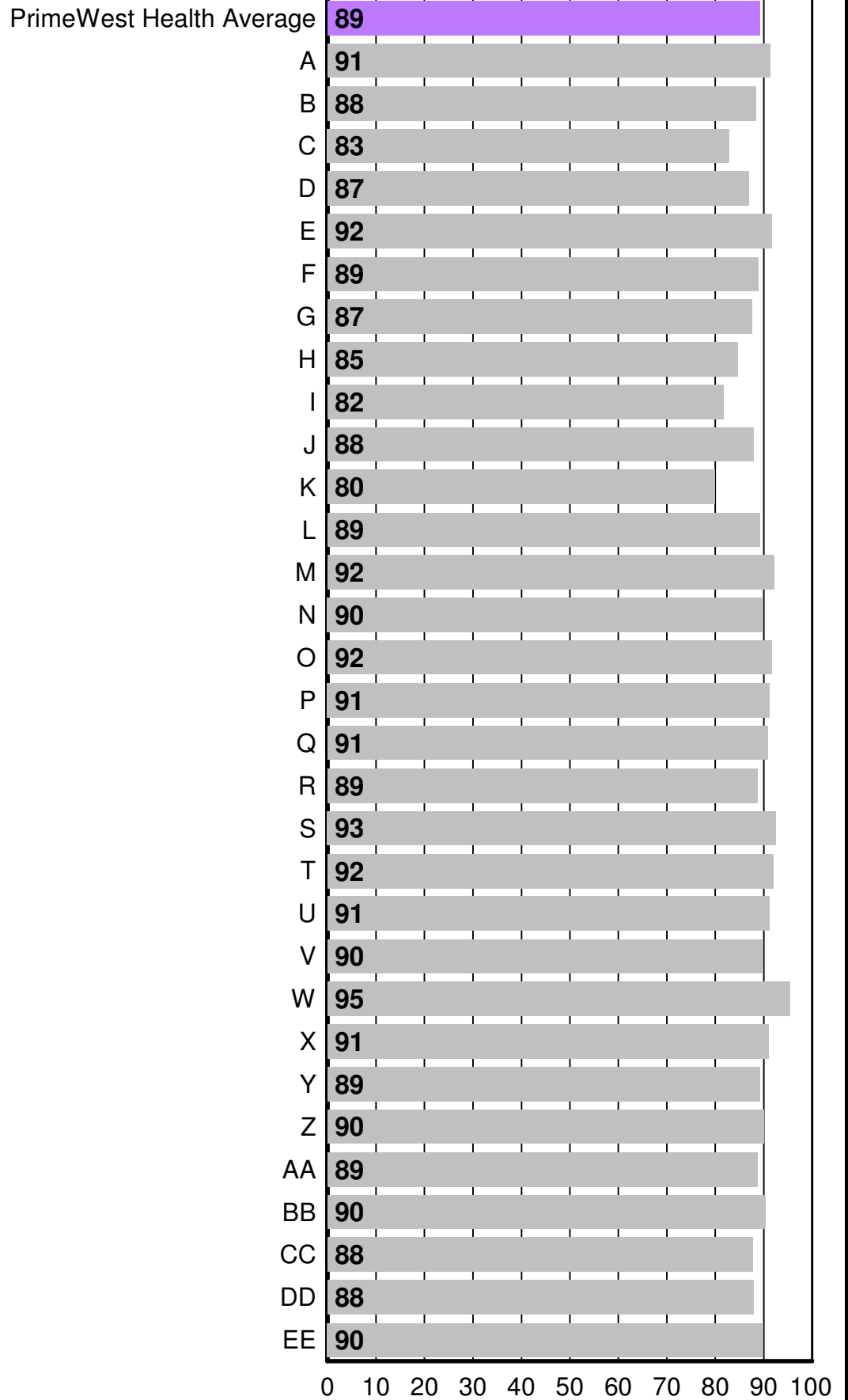


# Medical Record

Review Report

# 2010





# Overall Averages For Individual Elements

## PrimeWest Health Average

### Strengths Above 90%

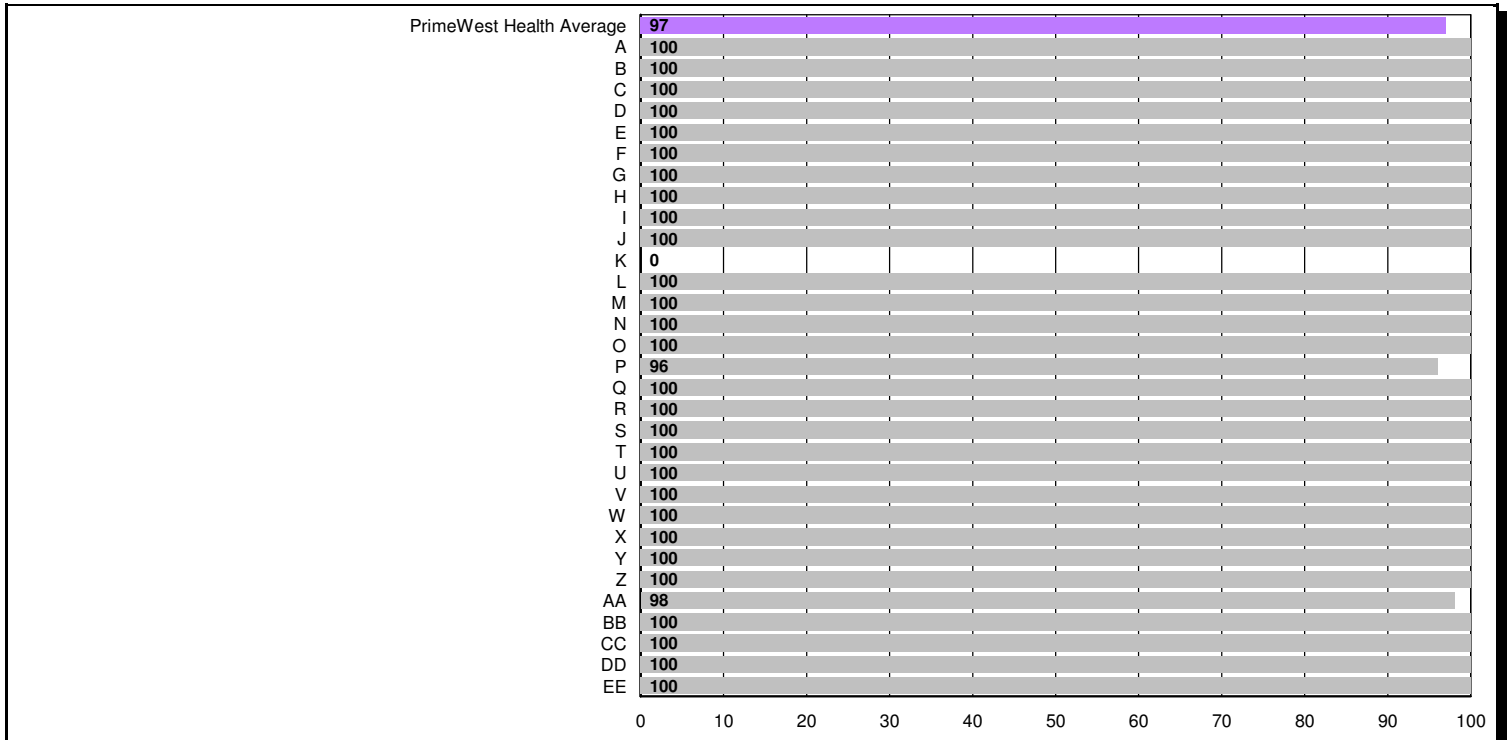
* There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.	100
* Working diagnoses are consistent with findings.	100
* Treatment plans are consistent with diagnoses.	100
* Unresolved problems from previous visits are addressed in subsequent visits.	100
* History and physical exam identifies appropriate subjective and objective information pertinent to member's presenting complaints.	99
* Member name present on every page.	99
* All entries are dated.	99
* Clinically significant consultation, abnormal lab, and imaging reports have an explicit notation of follow-up plans.	99
* Laboratory and other studies are ordered, as appropriate.	99
* All entries are legible to someone other than author.	98
* Elements in the medical record are organized in a consistent manner.	97
* Prescribed medications are clearly visible in medical record.	97
* Discharge summaries are filed in the member's record.	96
* Note from consultant is present for each consultation requested.	95
* Absence or presence of medication allergies and adverse reactions are prominently noted in medical record.	92
* Consultation, lab, and imaging reports filed in the medical record are initialed by the practitioner who ordered them, to signify review.	92
* 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.	91

### Areas Identified Below 90%

* Personal biographical data includes member address, employer, home and work phone numbers, and marital status.	89
* Significant illnesses and medical conditions are indicated on problem list.	86
* Author identification present for every entry.	86
* Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations and illnesses.	85
* Immunization status information for all ages is recorded on a single page location.	84
* 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.	84
* There is evidence that preventive screening and services are offered in accordance with PrimeWest Health's clinical practice guidelines.	77
* Health Care Directives are documented in the medical record for those 18 years and older.	45
* For members 10 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).	45
* Body Mass Index (BMI) is documented annually for members 2 years and older.	43

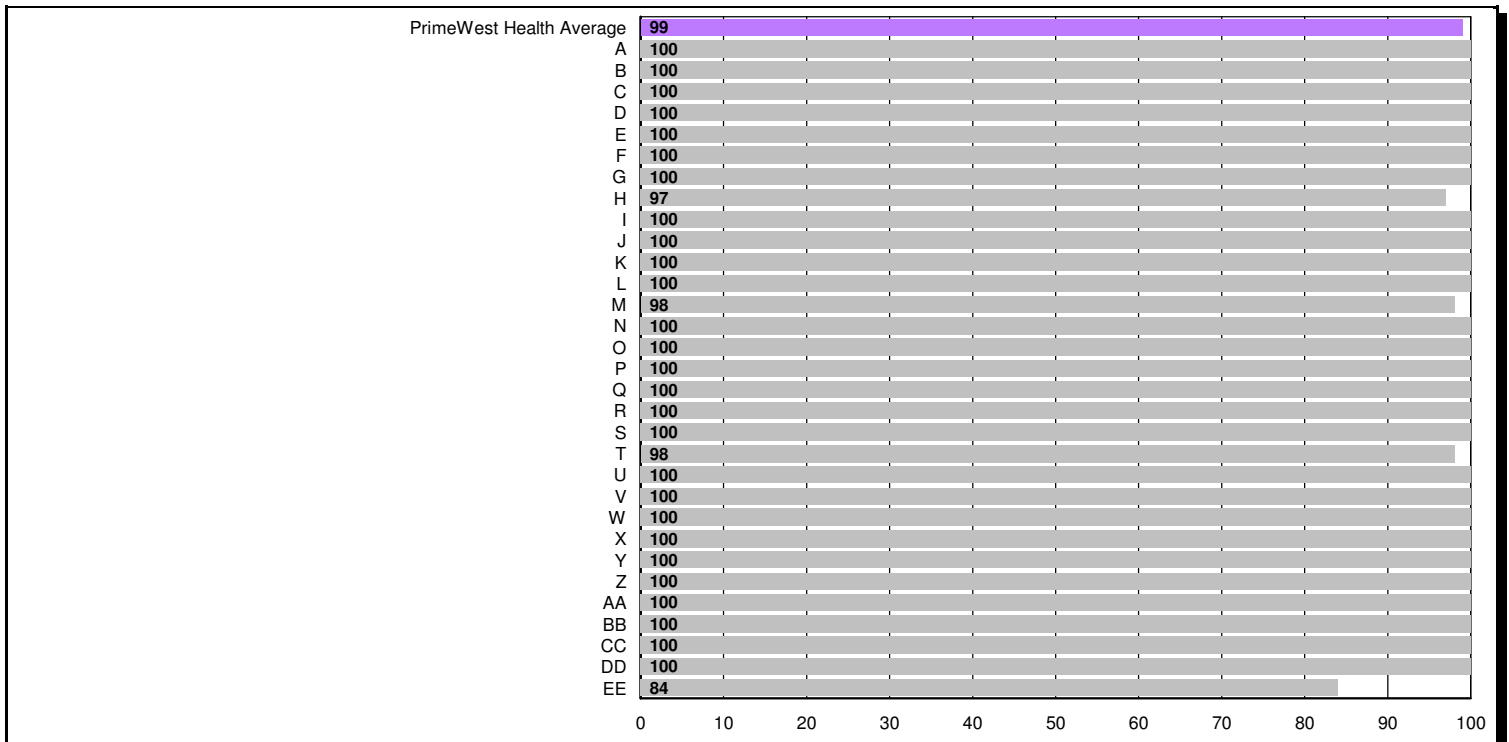
# RECORD FORMAT

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



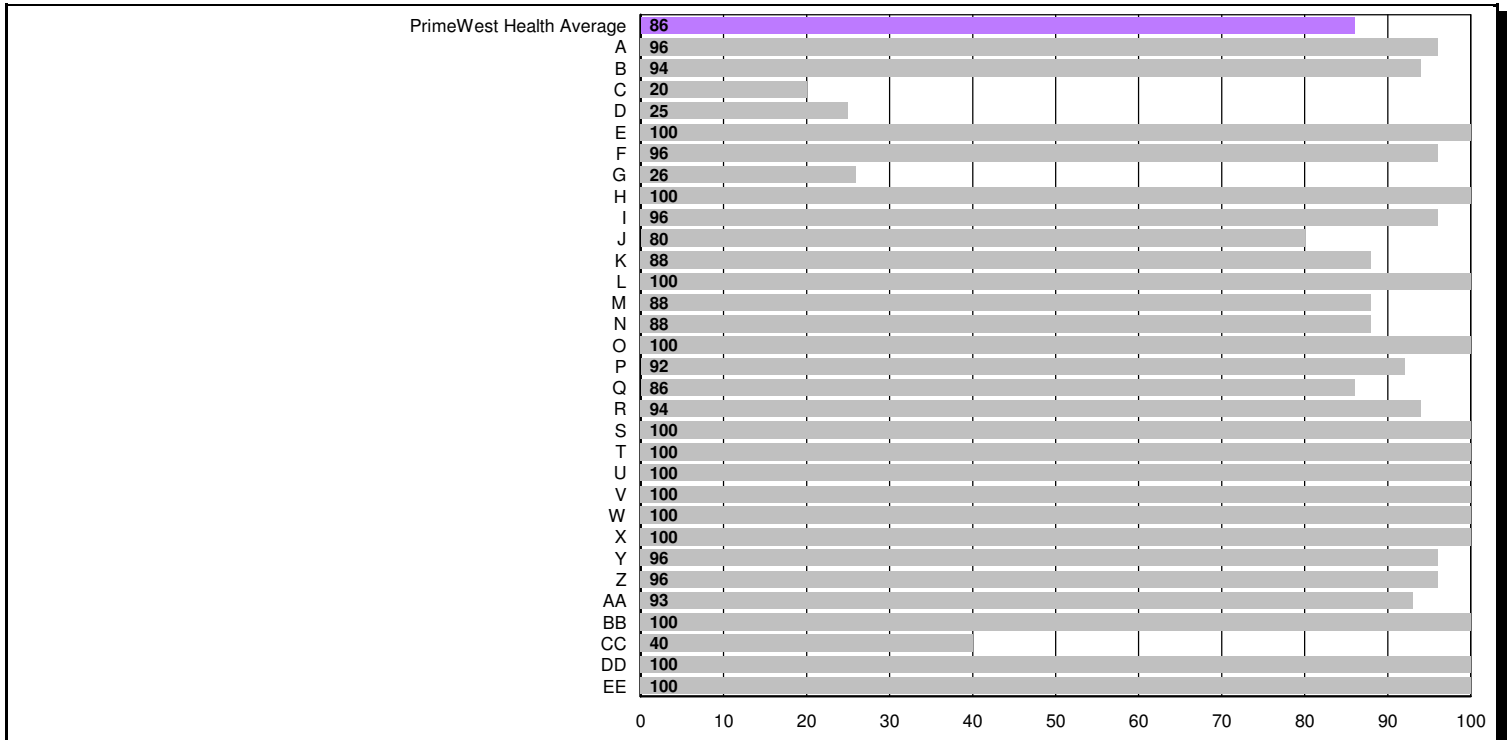
Contents are secured in place and organized in a logical, consistent manner and in chronological order. Electronic medical records (EMRs) are organized in appropriately named folders so documents can be easily located; documents are stored in the correct folders.

## 2. Member name present on every page.



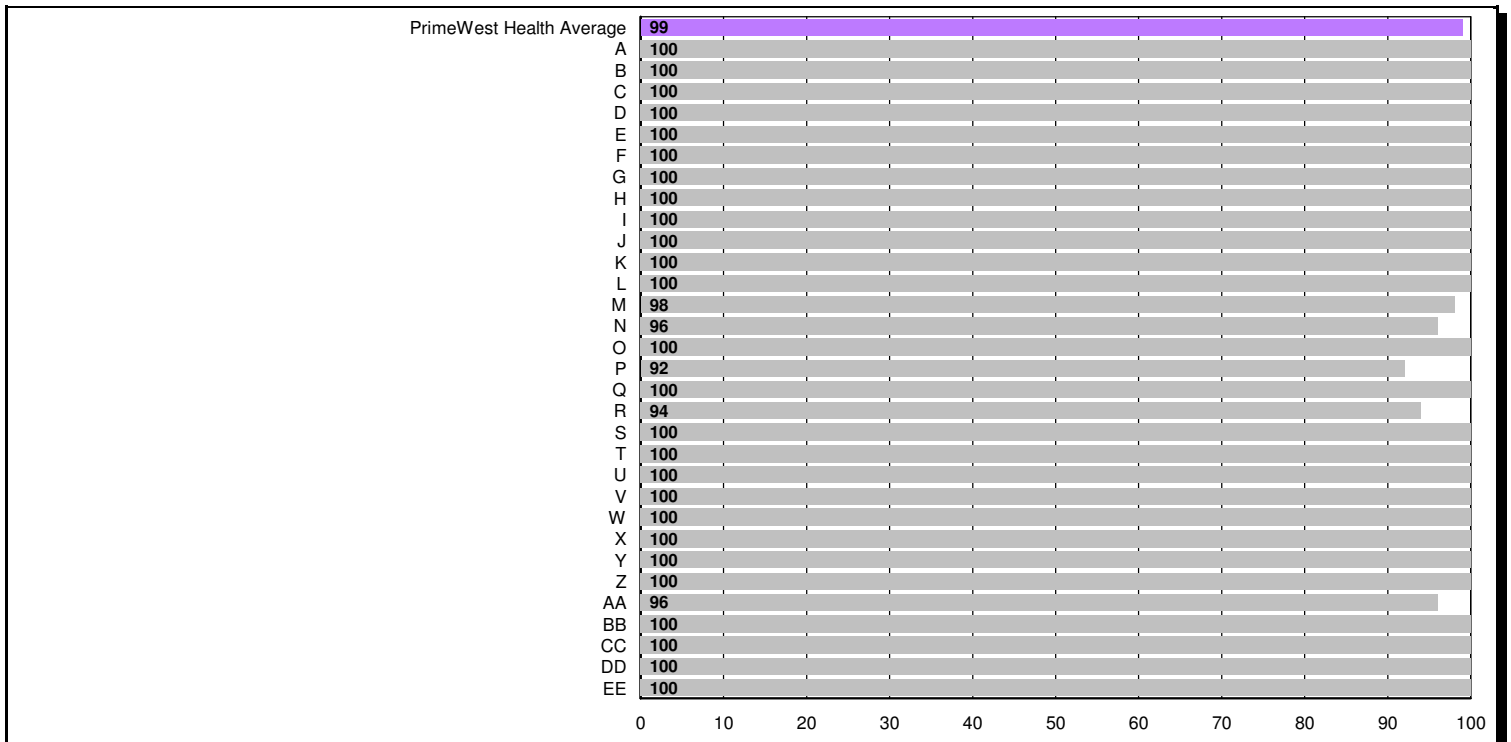
Member name is present on every page and there are no pages/entries in record that belong to another person (separate record maintained for each unique member).

**3. Author identification present for every entry.**



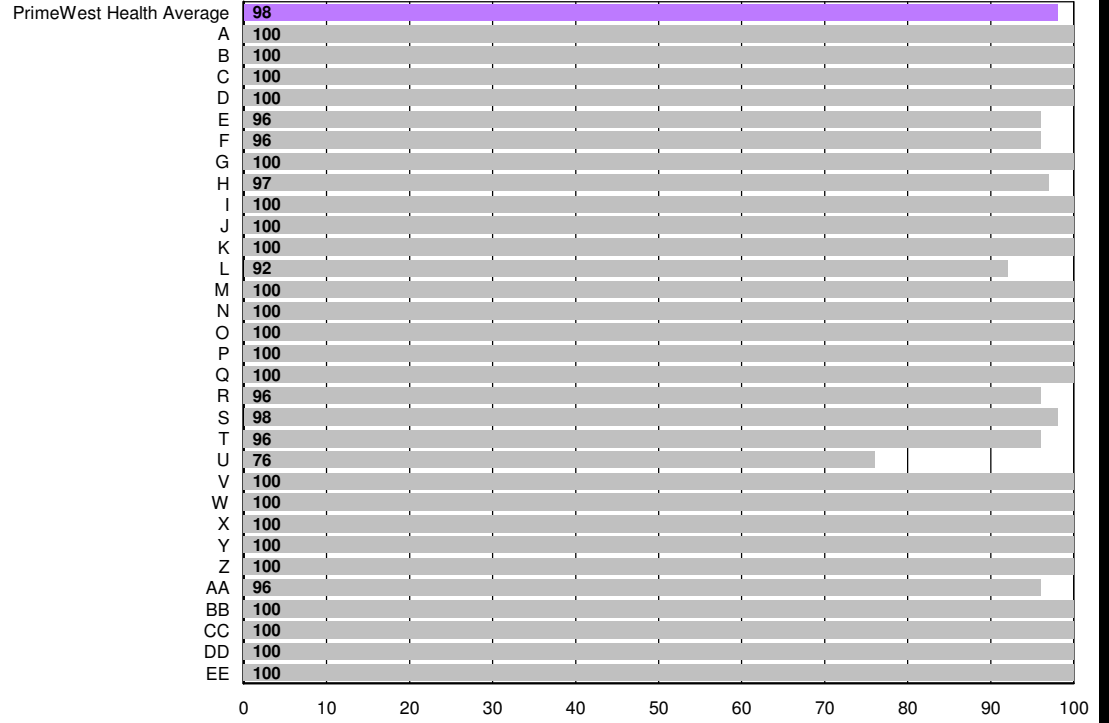
All entries contain the author's name, which may be a handwritten signature, unique electronic identifier or initials, and title. Stamped signatures and signatures from someone other than the author are not acceptable. Transcribed visit notes and nurse/paraprofessional entries must also meet criteria. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note and include the practitioner's name, credentials, and the date signed.

**4. All entries are dated.**



Each entry contains the date on which the entry was made, including the year. Telephone calls and triage notes are also dated.

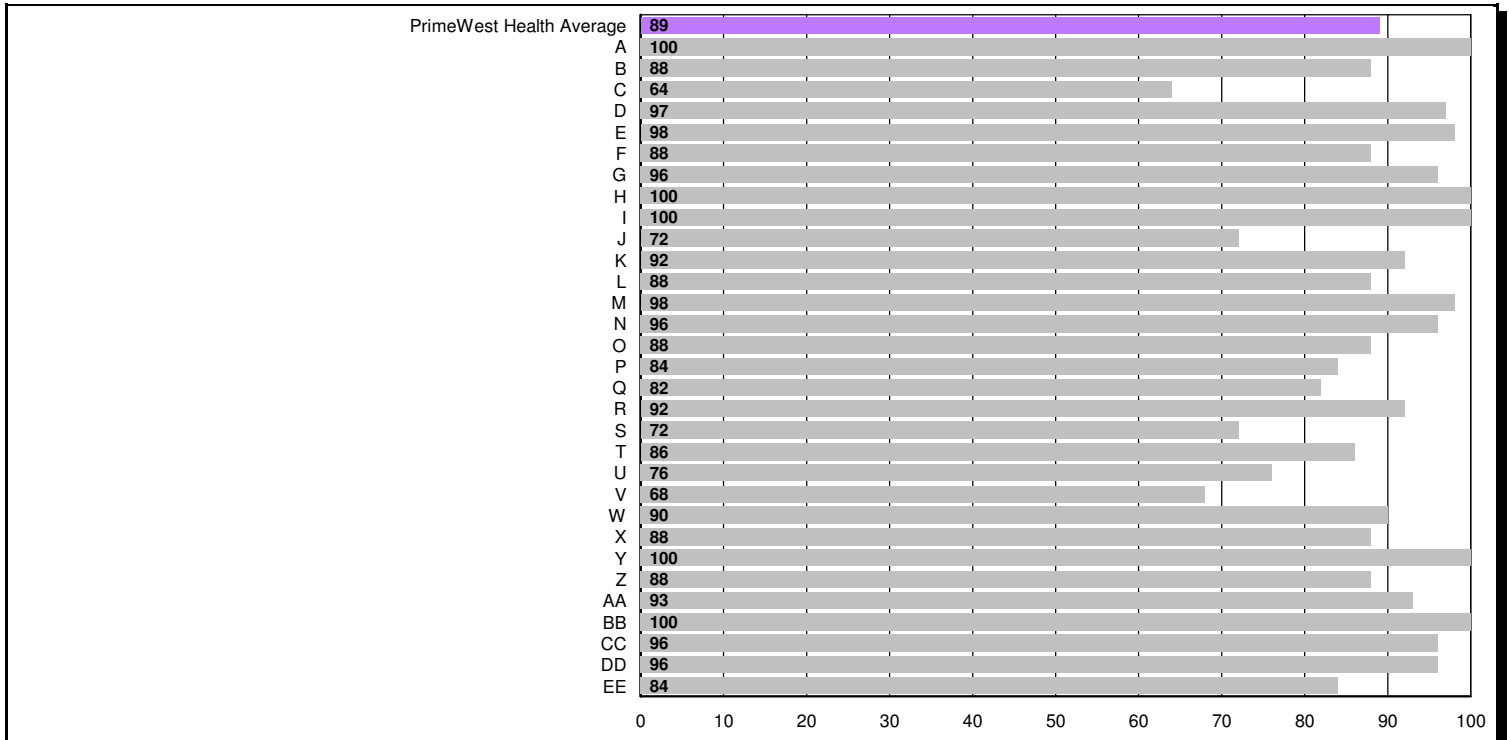
**5. All entries are legible to someone other than author.**



All entries are legible and presented in a standard format that allows a reader to review without the use of a standard legend/key. Unapproved abbreviations are not used. Entries left incomplete by transcriptionist are corrected by provider. Visit notes typed by practitioner in EMRs are also legible. EMRs utilizing voice recognition have entries recorded as intended by provider. Scanned documents in EMRs are legible.

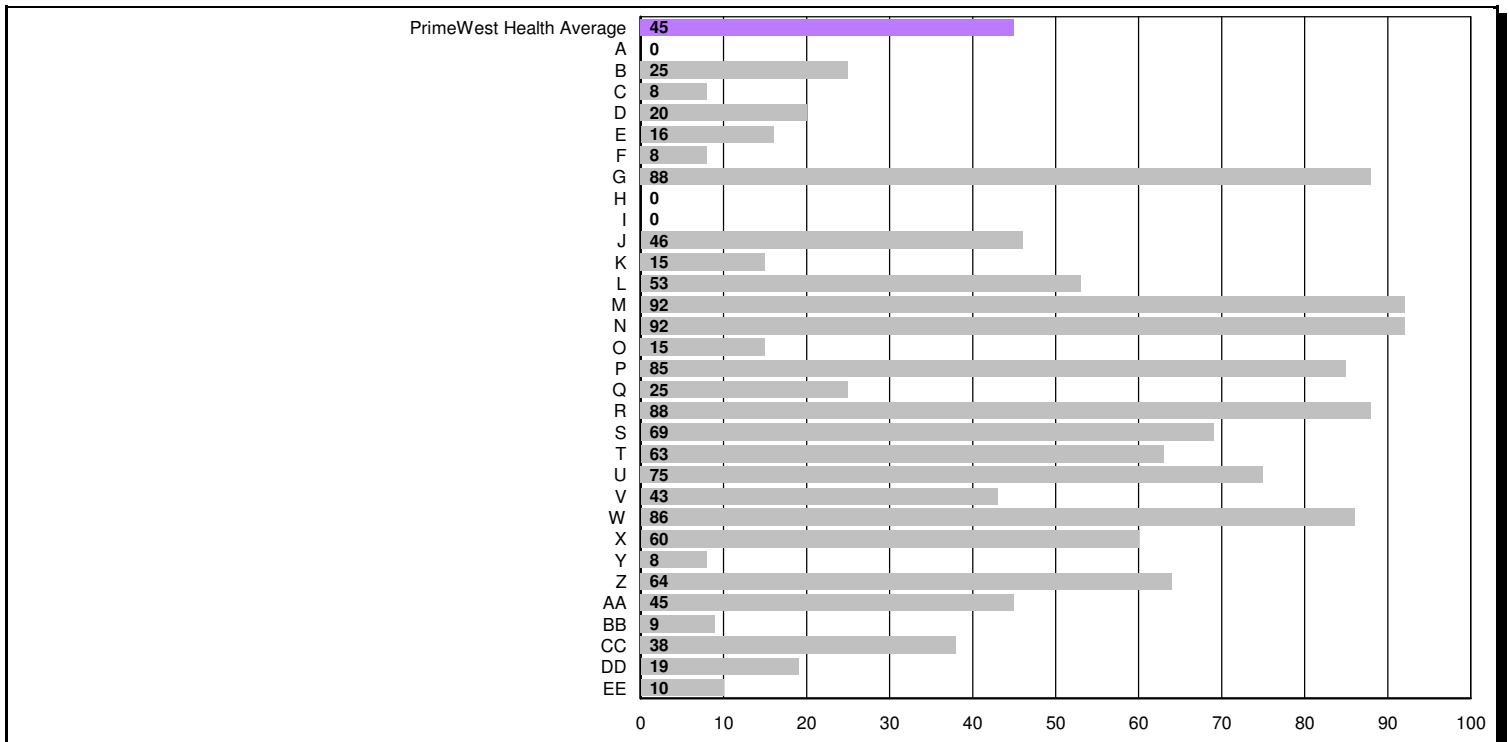
# BASIC RECORD CONTENT

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



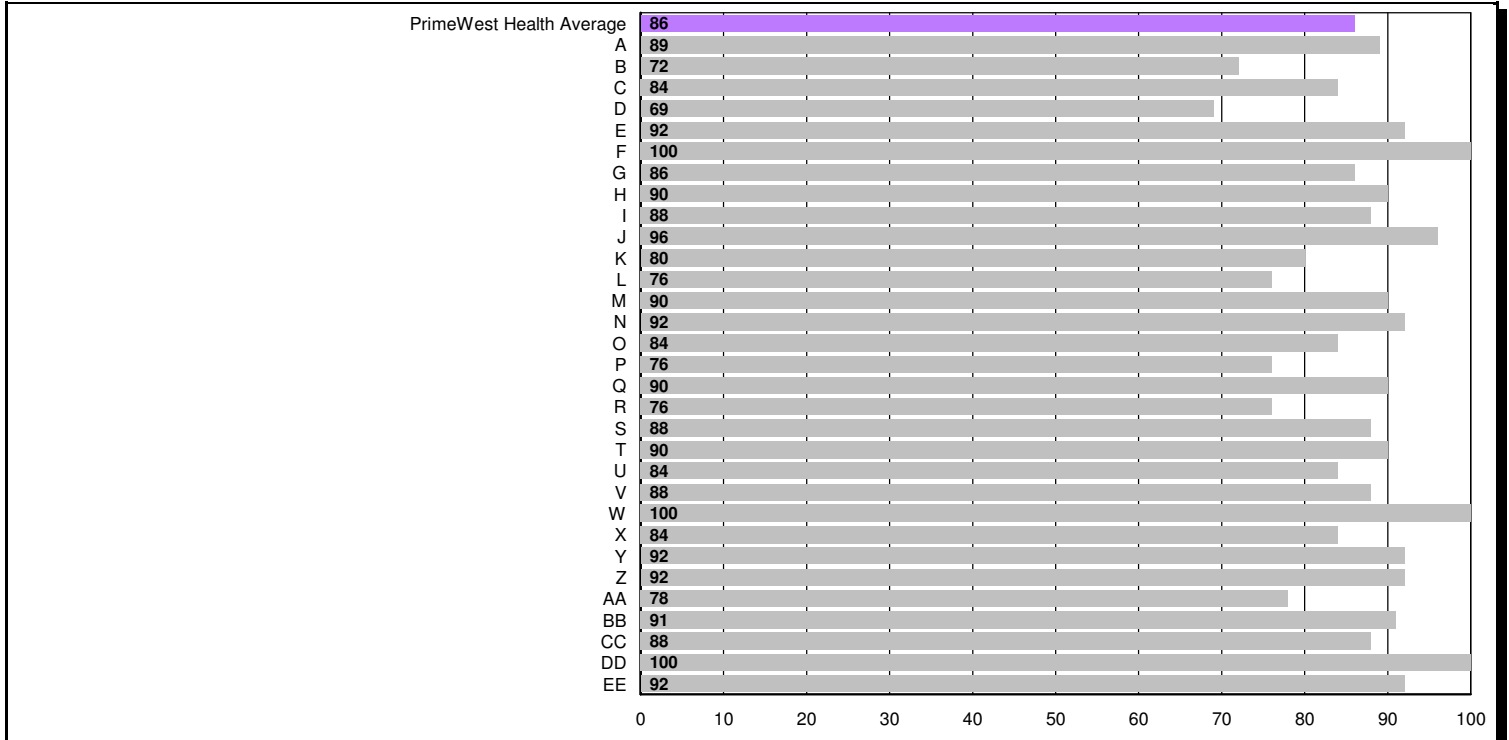
Personal biographical data is documented in a prominent location in each record and includes member's address, employer, home and work phone numbers, and marital status. Scores reflect documentation of all elements. Employer and marital status were the most commonly omitted data elements.

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



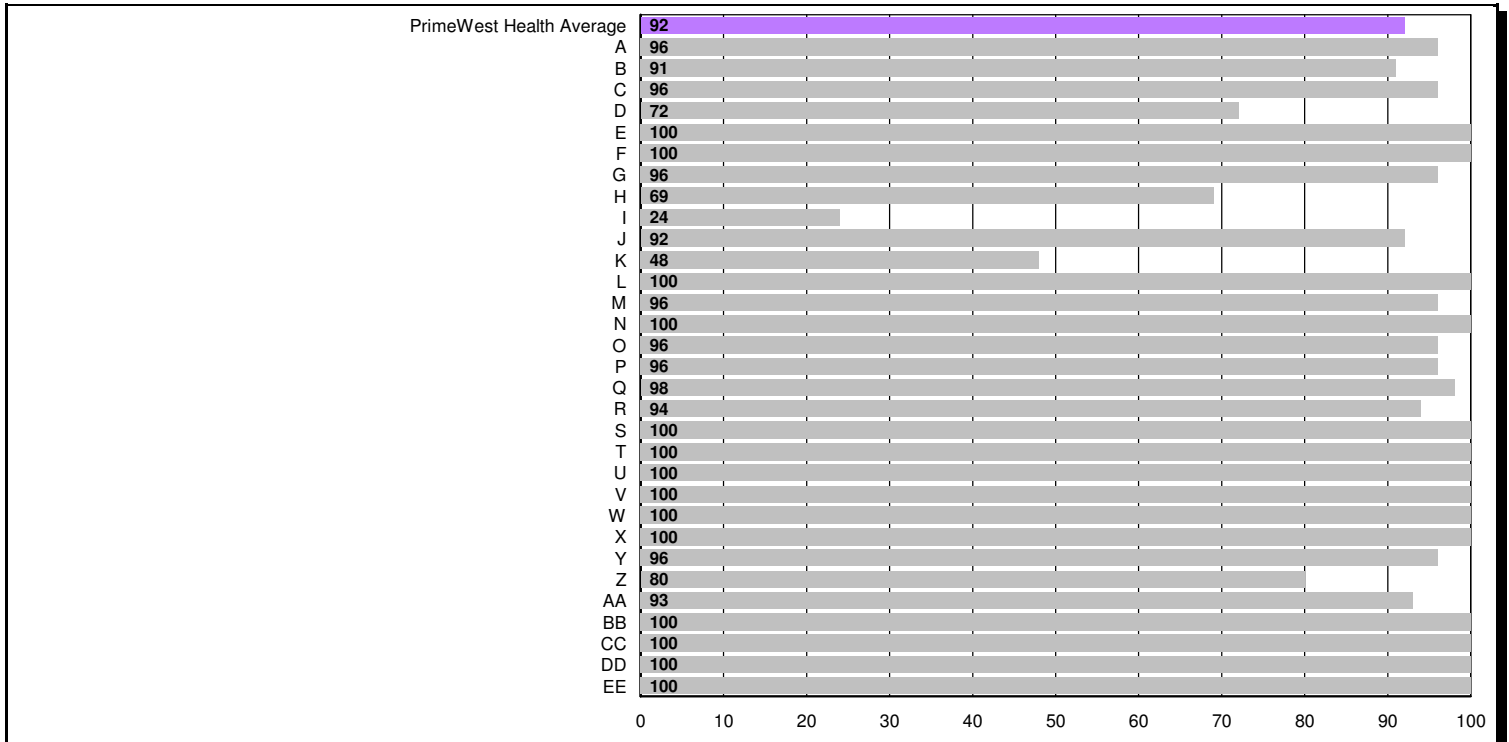
Documentation stating whether or not a member has executed a Health Care Directive (for those ages 18 and over) is in a prominent part of the record. If member has not executed a Health Care Directive, documentation showing that information was offered is included (this part of standard was not reviewed this year).

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



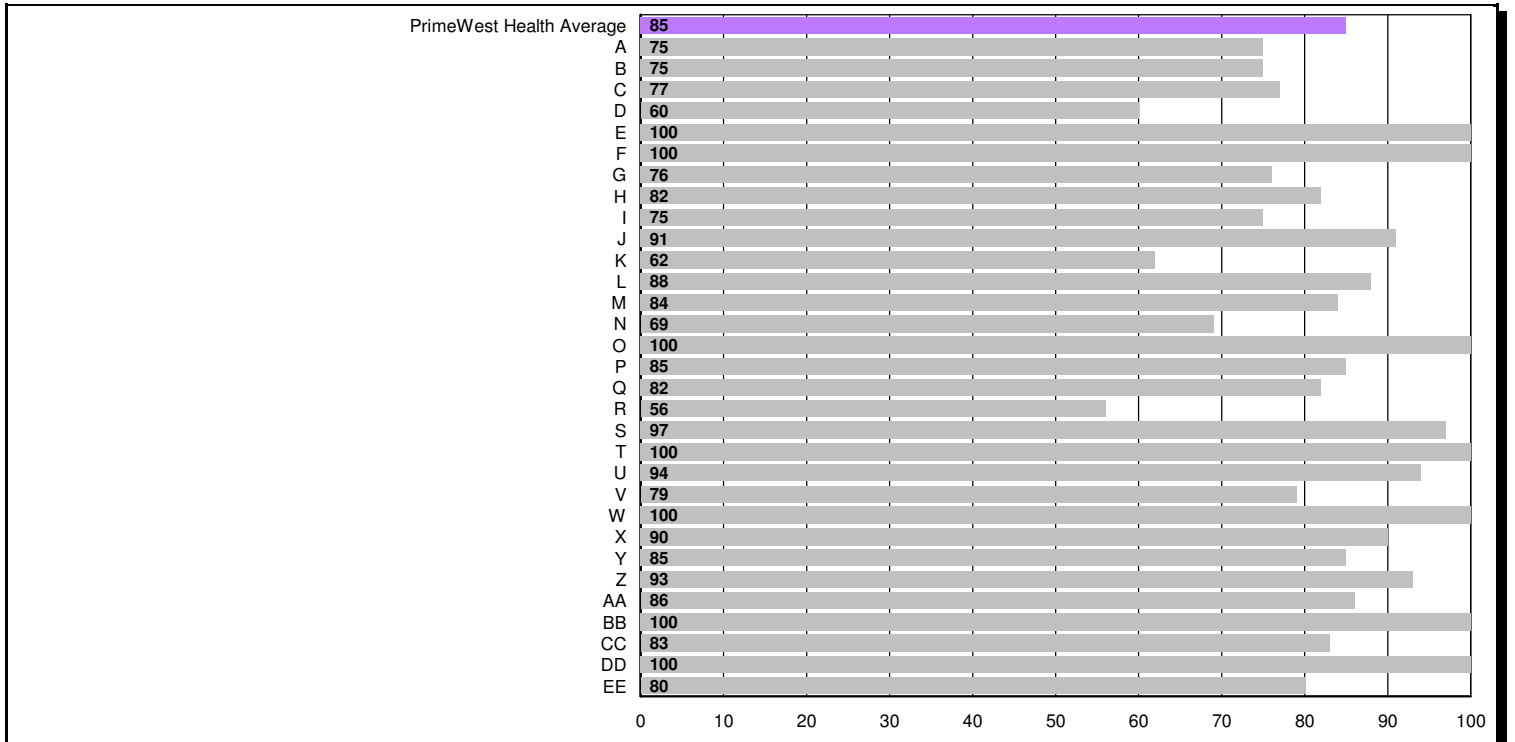
There is a current problem list, kept either separately or within each practitioner progress note, that includes major diagnoses, past medical and/or surgical history, and recurrent complaints. Problems are clearly identified and not buried within the visit note. Members on maintenance medication have a corresponding diagnosis documented on problem list. Standard clinic forms for problem lists are filled out. Problem lists in EMRs are current and up-to-date.

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



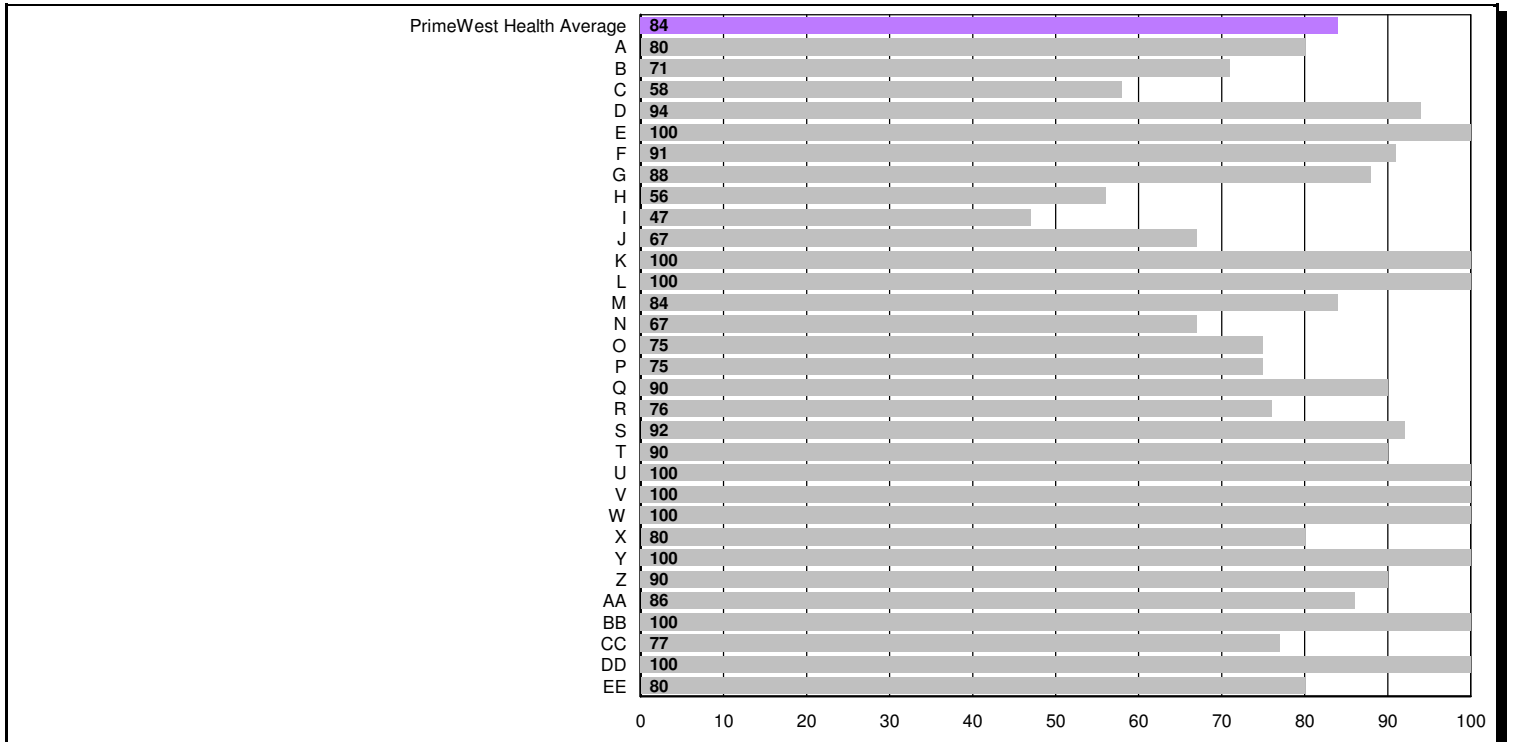
Absence or presence of allergies is consistently and clearly documented in a prominent location in all medical records. Allergy stamps or forms used for documentation are filled out. Allergy documentation is current.

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



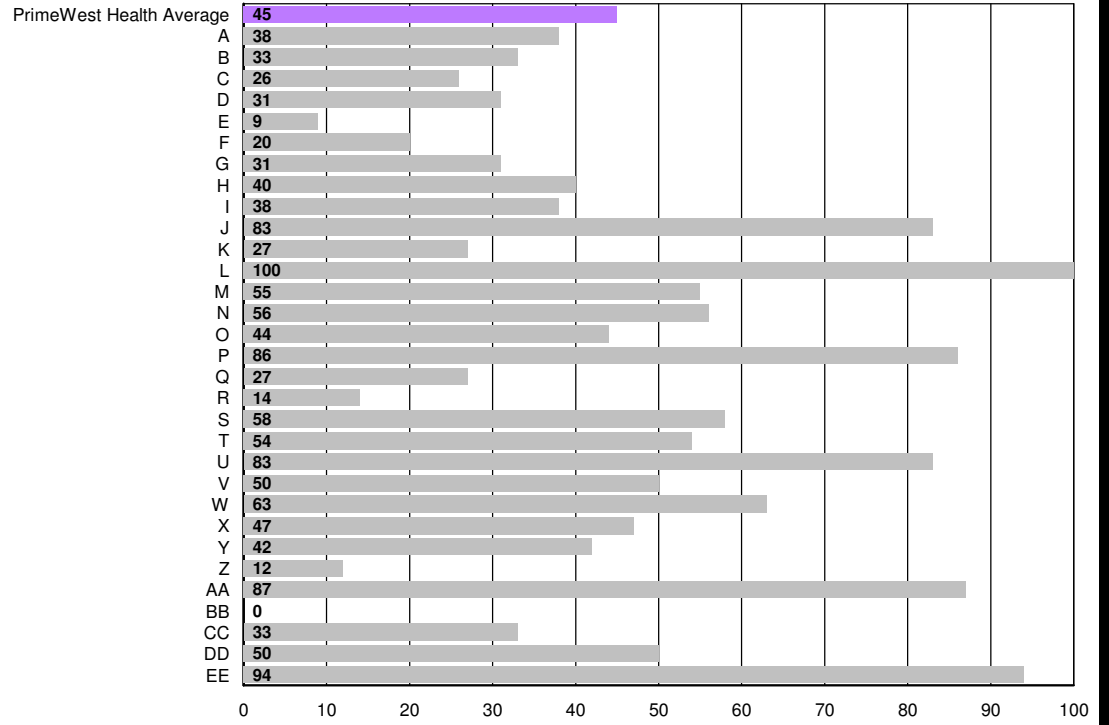
Documentation of past medical history is obtained by the third visit and is kept current. Standard clinic forms for past medical history are filled out, updated, and complete. Past medical history is not buried throughout visit notes in the chart. This element was scored for members ages 18 years and over. Past surgical history and major medical events were most commonly omitted or not updated.

**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.**



Documentation of past medical history is obtained by the third visit and is kept current. Standard clinic forms for past medical history are filled out, updated, and complete. Past medical history is not buried throughout visit notes in the chart. This element was scored for members under the age of 18. Past surgical history was most commonly omitted or not updated.

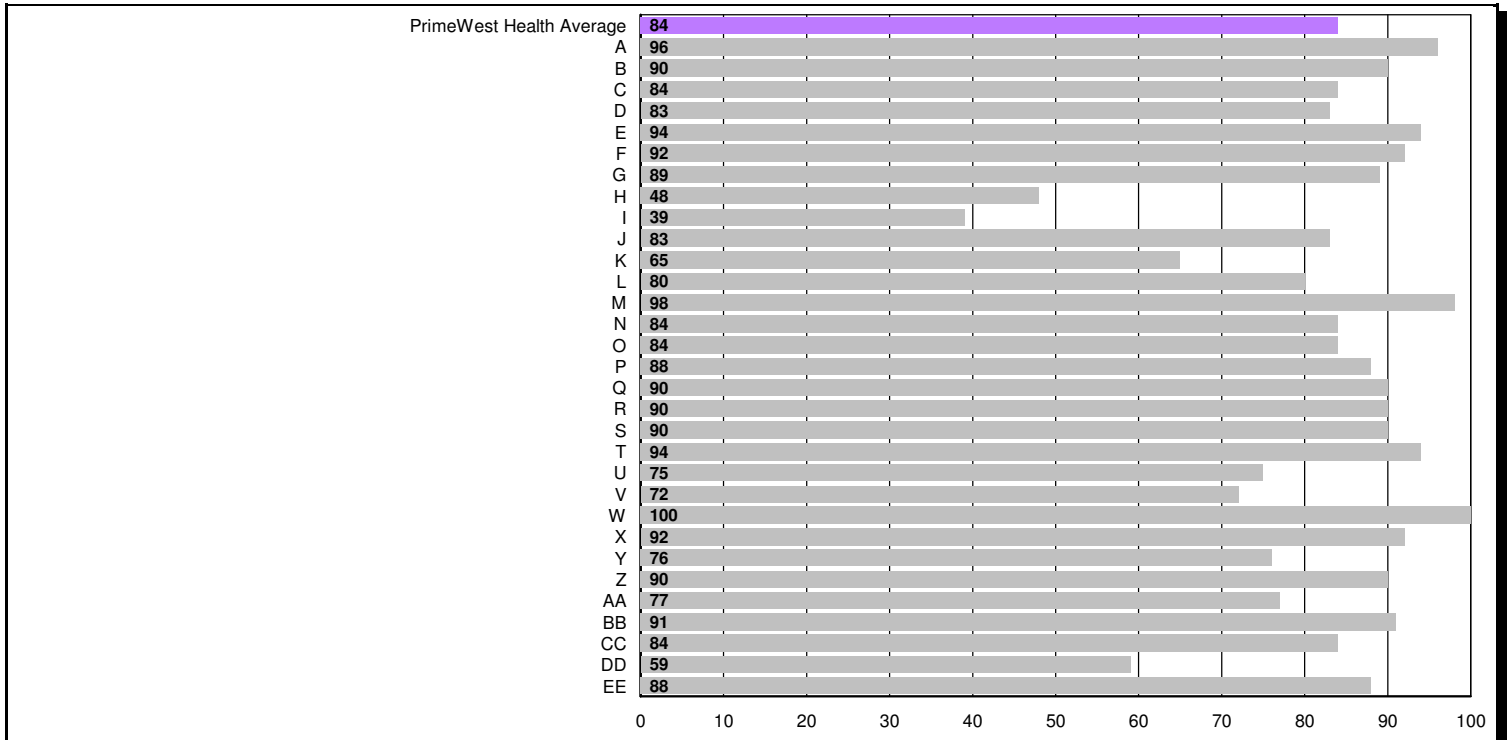
**7. For members 10 years and older, there is appropriate notation concerning the use of tobacco, alcohol and substances (for members seen three or more times or if indicated, query substance abuse history).**



Tobacco, alcohol, and substance use is documented for members ages 10 years and over. Scores reflect documentation of all three data elements. Tobacco use was more commonly addressed, followed by infrequent documentation of alcohol use. Substance use was rarely addressed.

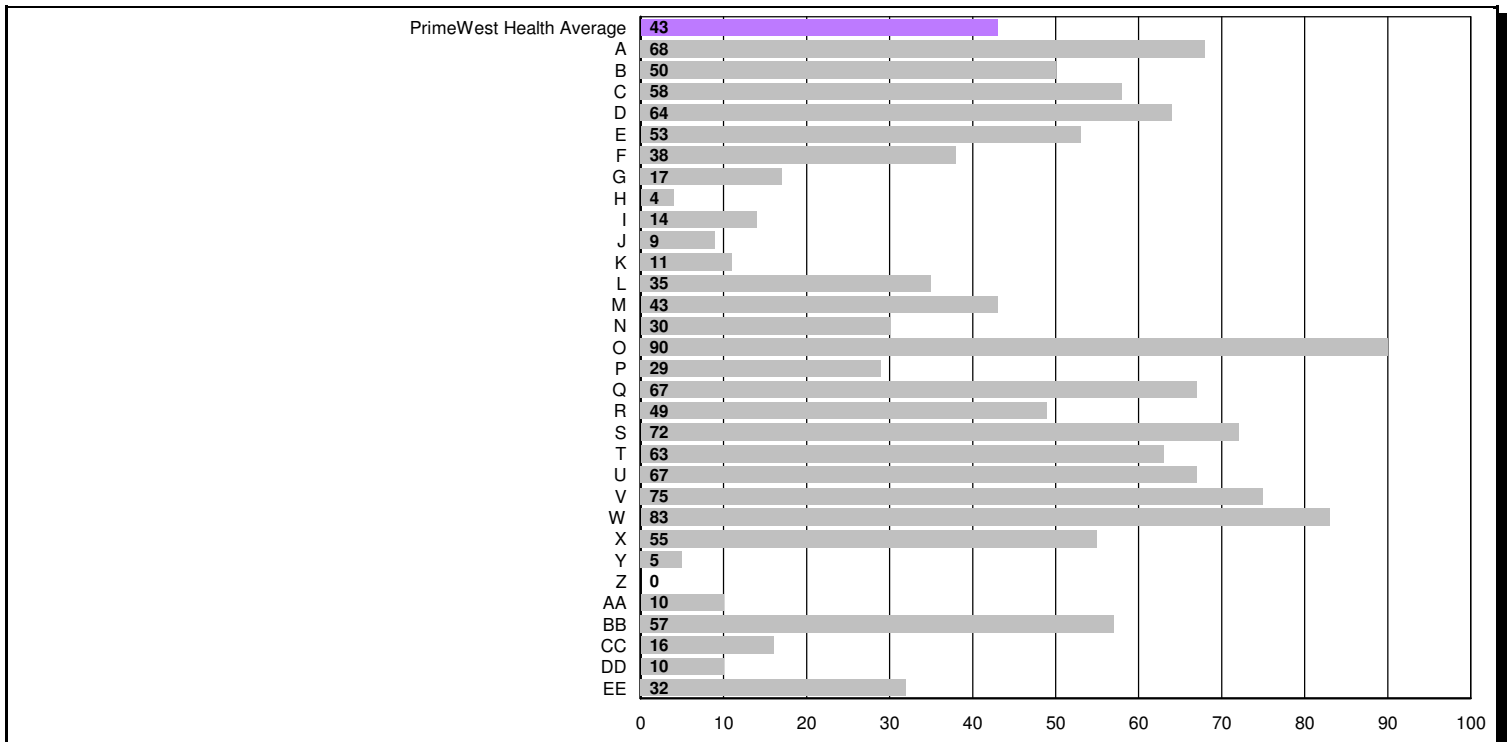
# PREVENTIVE SCREENING AND SERVICES

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



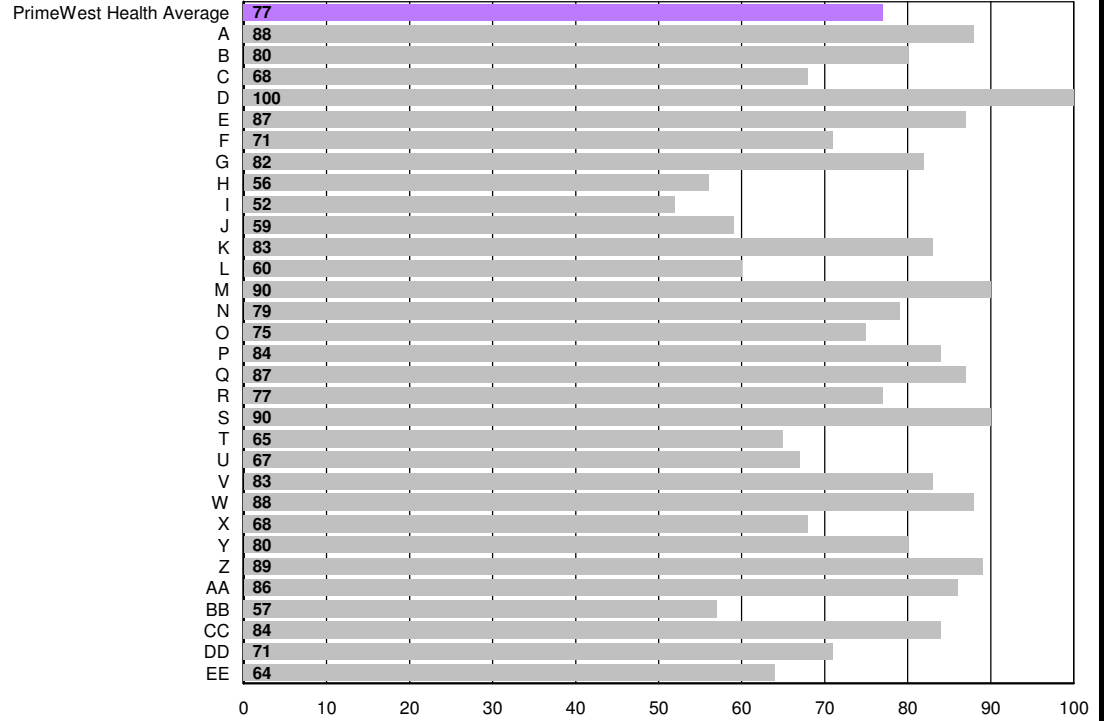
Documentation includes the date the vaccine was administered, the manufacturer and lot number, and the name and title of person administering the vaccine. All immunizations are documented on a single page location, not throughout the medical record.

## 2. Body Mass Index (BMI) is documented annually for members 2 years and older.



BMI is calculated and documented for those ages 2 years and over. For adults ages 20 years and over, BMI is calculated and interpreted using standard height/weight BMI tables. For children and teens ages 2 – 19 years, the calculation and interpretation of BMI is both age- and gender-specific and is made using the child and teen BMI calculator and BMI-for-age growth charts. EMRs have the capability pre-programmed to document BMI if a height is recorded with the weight.

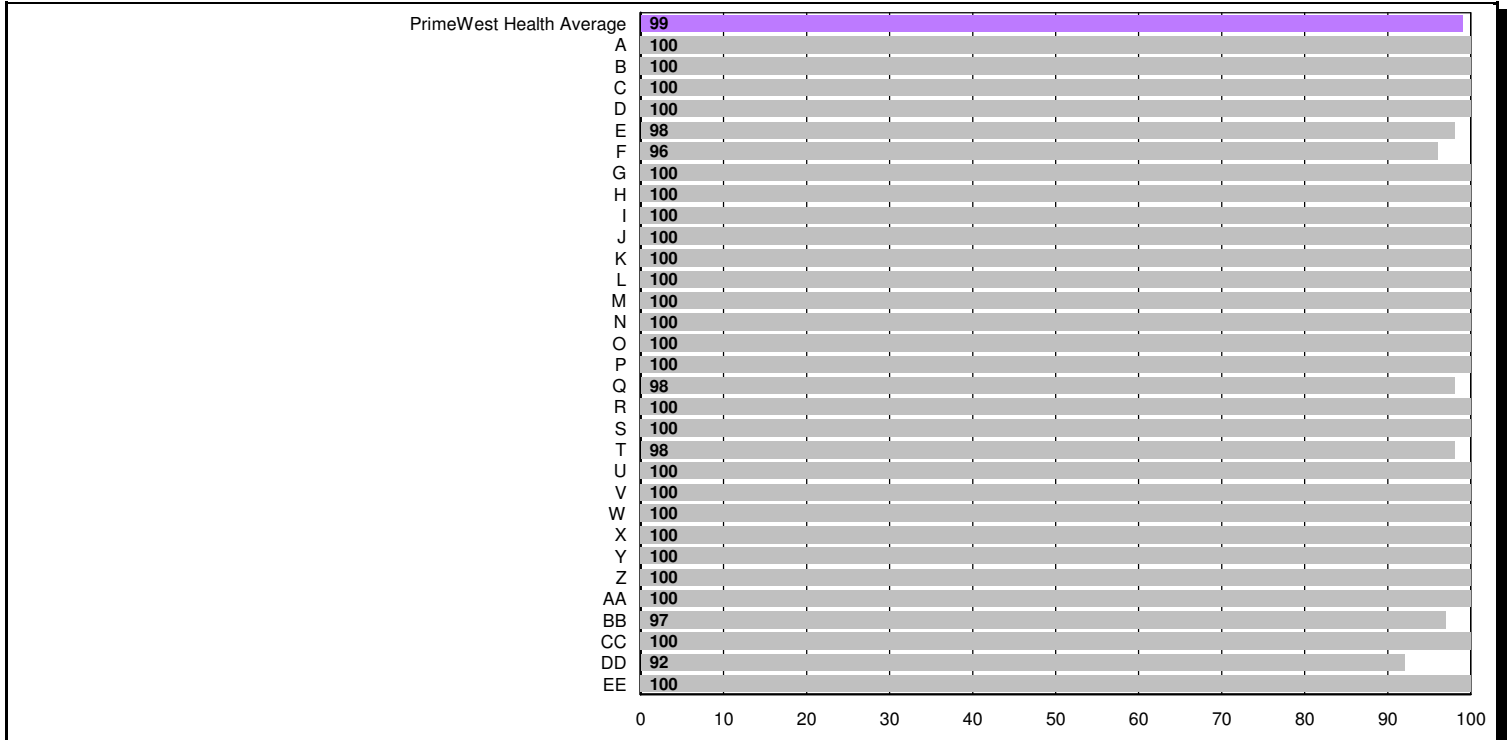
**3. There is evidence that preventive screening and services are offered in accordance with PrimeWest Health's clinical practice guidelines.**



A summary of preventive screenings is documented in a consistent place in the record. PrimeWest Health looked for any evidence of screenings offered or completed. Minnesota Child and Teen Checkups (C&TCs) per periodicity schedule and age/gender specific screenings for adults are strongly recommended. C&TCs were less frequently completed for children over 6 years of age and rarely completed for teens. Practitioners should be proactive in recommending preventive screenings.

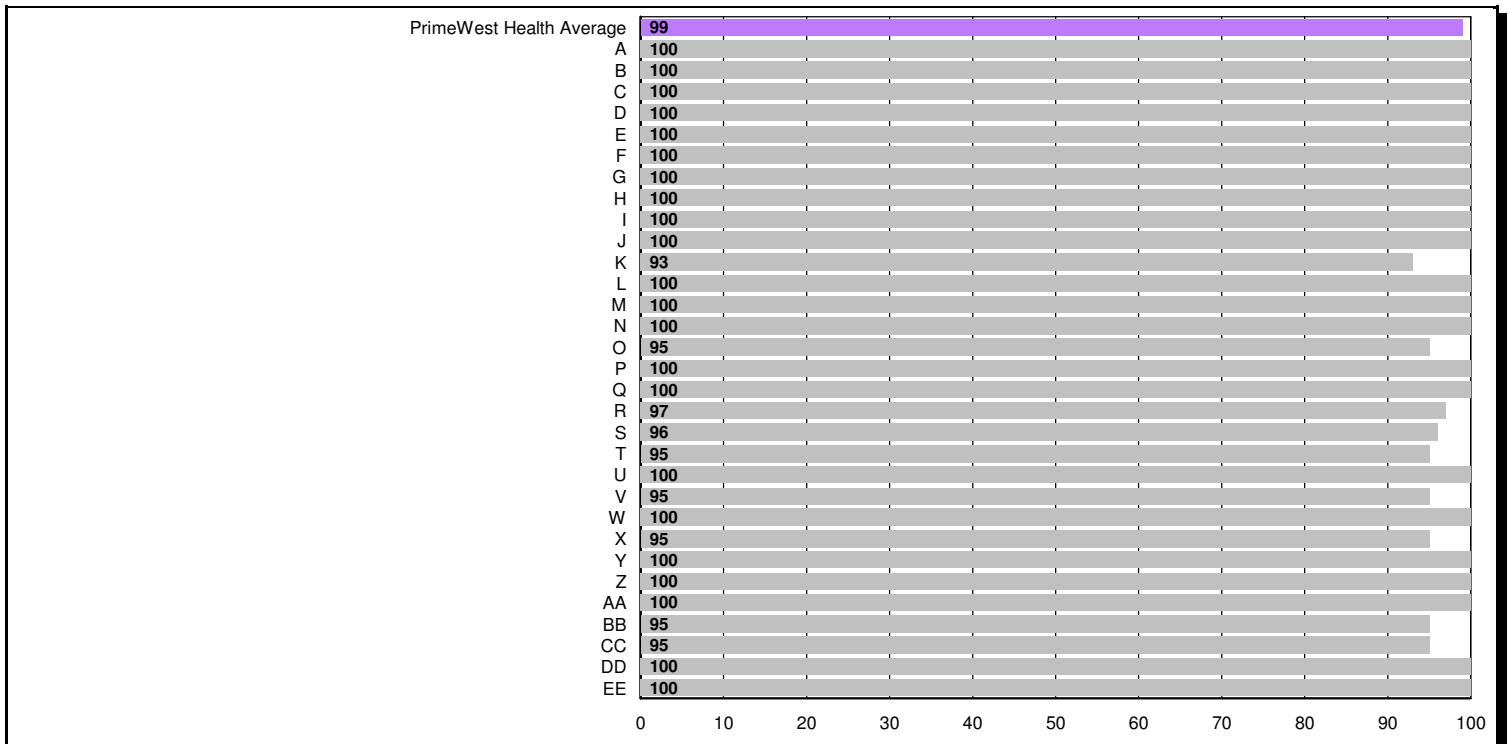
# ASSESSMENT, PLAN AND FOLLOW-UP

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



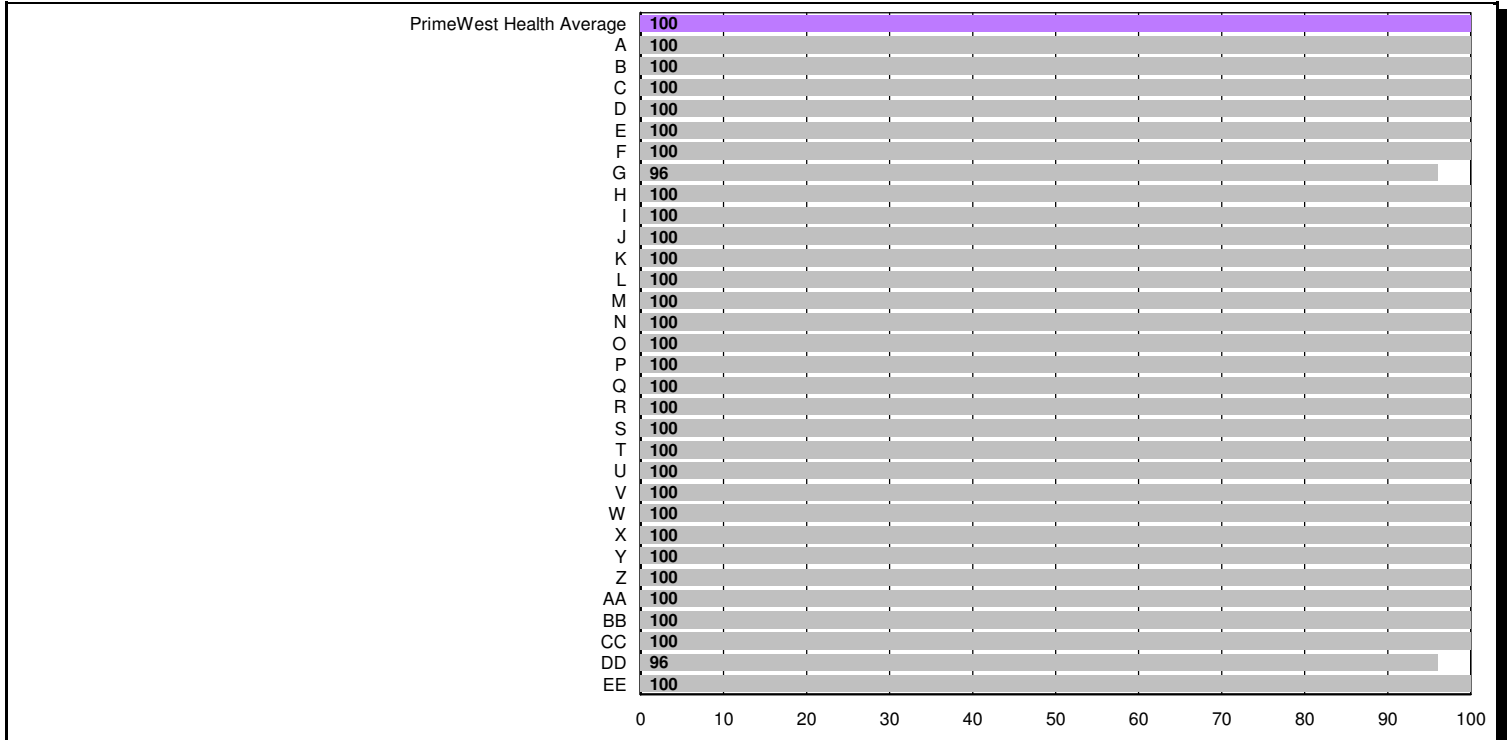
Subjective and objective information identifying why the member is seeking medical attention is documented. The description includes pertinent history, symptoms, and other related information. A pertinent physical exam, relevant to the problem, is documented. EMR pre-built content is appropriate to the member's situation.

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



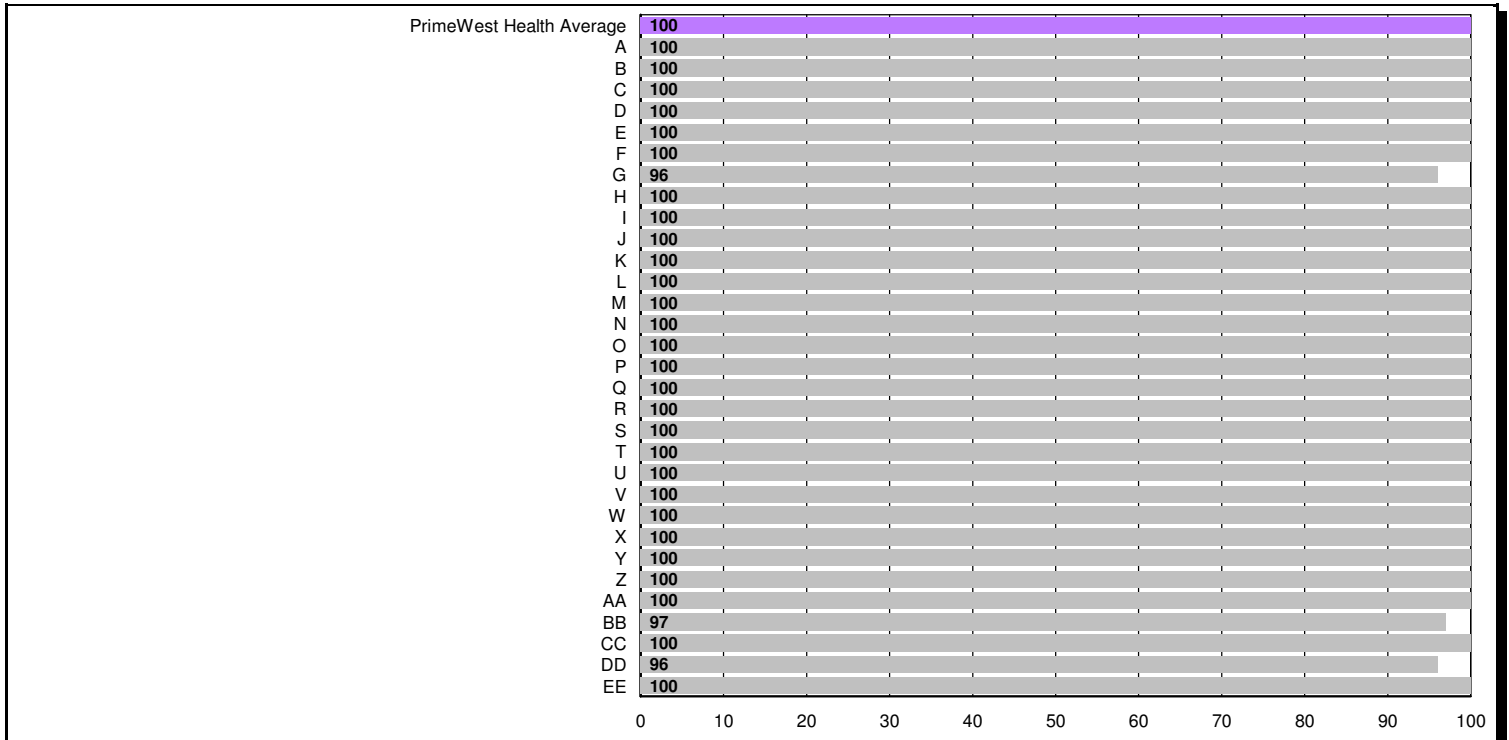
The results of all diagnostic tests and examinations, consistent with the exam and assessment, are documented in the medical record. Documentation of the order for laboratory and/or X-ray service is also in the record. Age-related hemoglobin and lead laboratory tests per guidelines for Minnesota Child and Teen Checkups (C&TCs) were most commonly omitted.

**3. Working diagnoses are consistent with findings.**



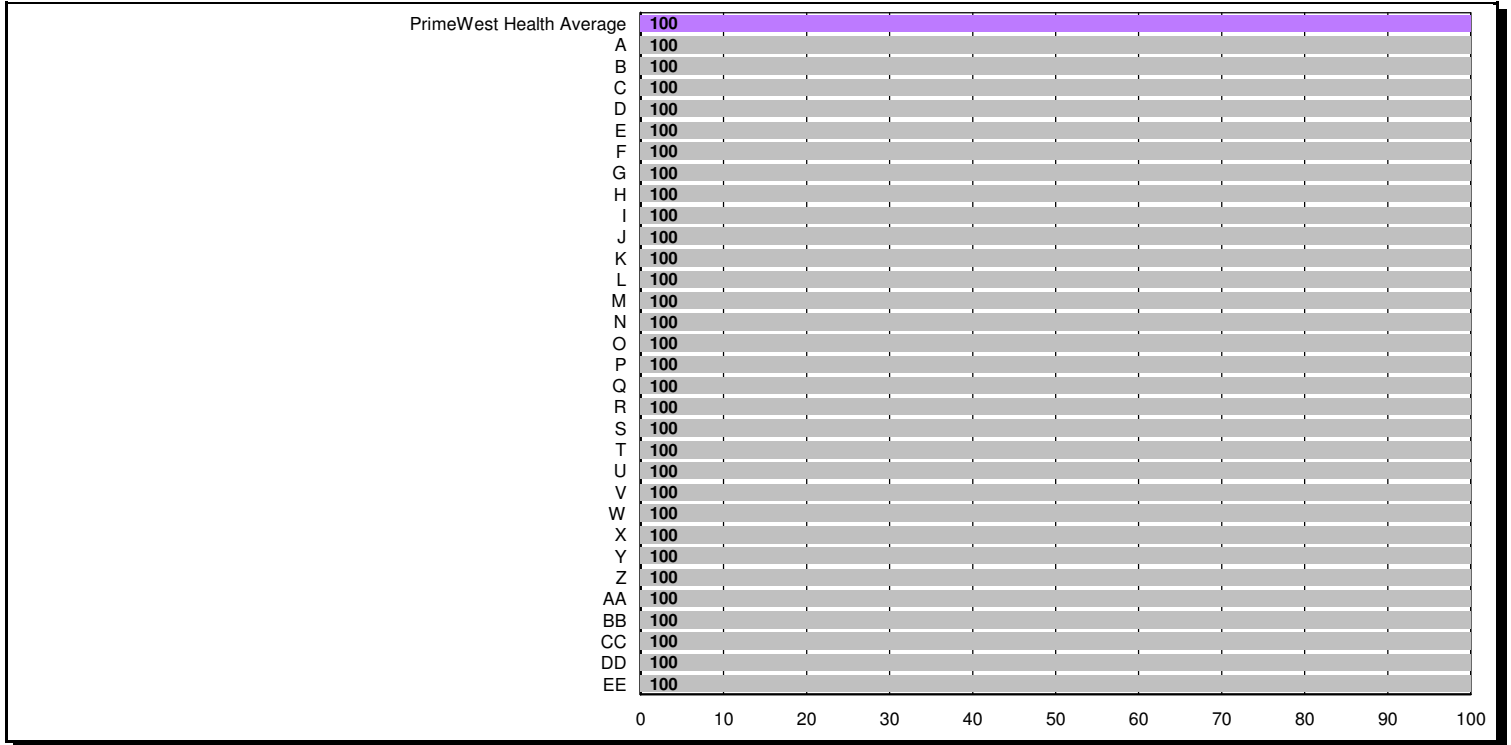
Working diagnosis or medical impressions that logically follow from the clinical assessment and physical exam are recorded.

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



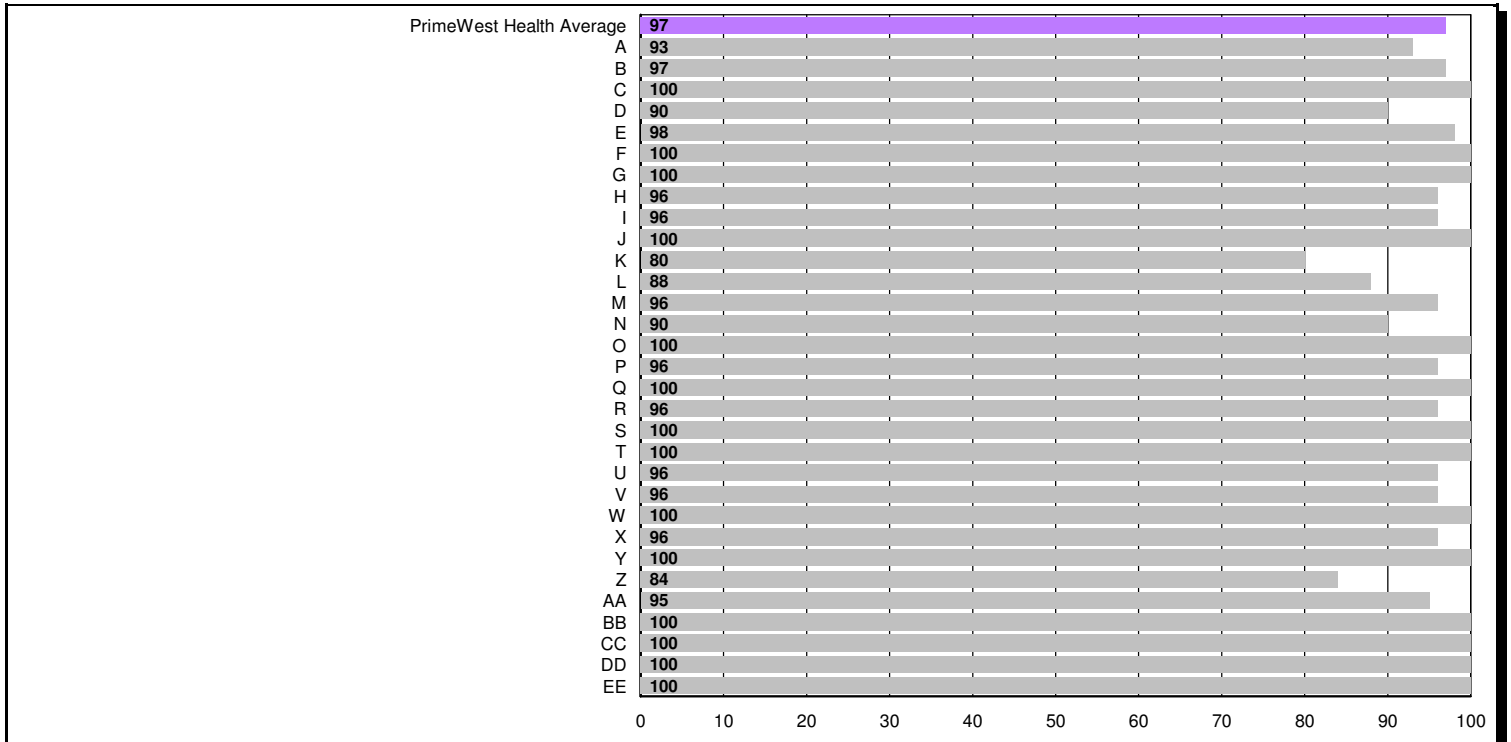
Proposed treatment plans are documented and logically follow previously documented diagnoses and medical impressions. There is evidence of provider consideration of member input into the proposed treatment plan and in consultation with any specialists caring for the member.

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



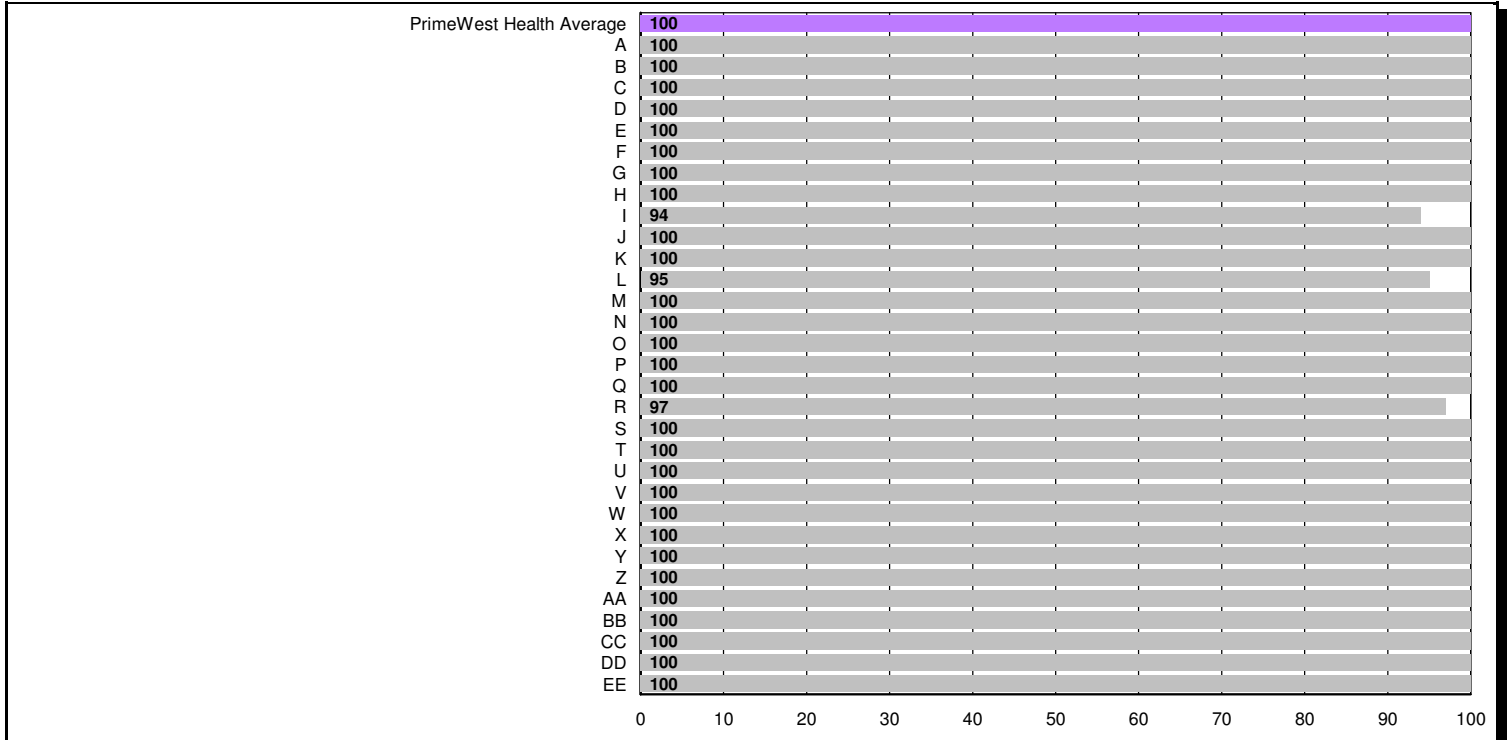
The medical record shows clear justification for diagnostic and therapeutic procedures.

**6. Prescribed medications are clearly visible in medical record.**



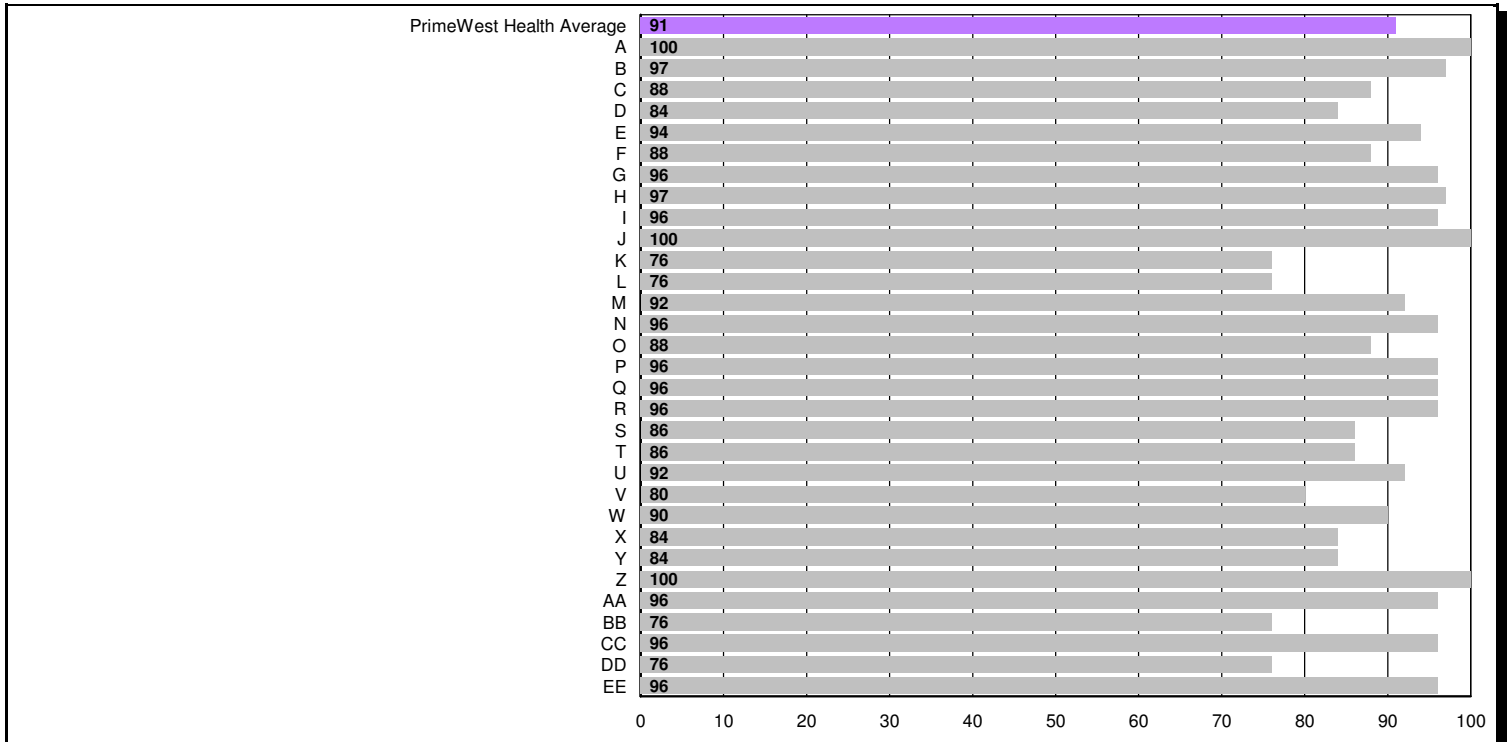
Documentation of prescribed medications (including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions) is clearly visible in the medical record. Medication lists in both EMRs and paper charts are current and consistent with medication orders and/or documentation in visit notes. Orders for medications are not solely documented on laboratory reports.

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



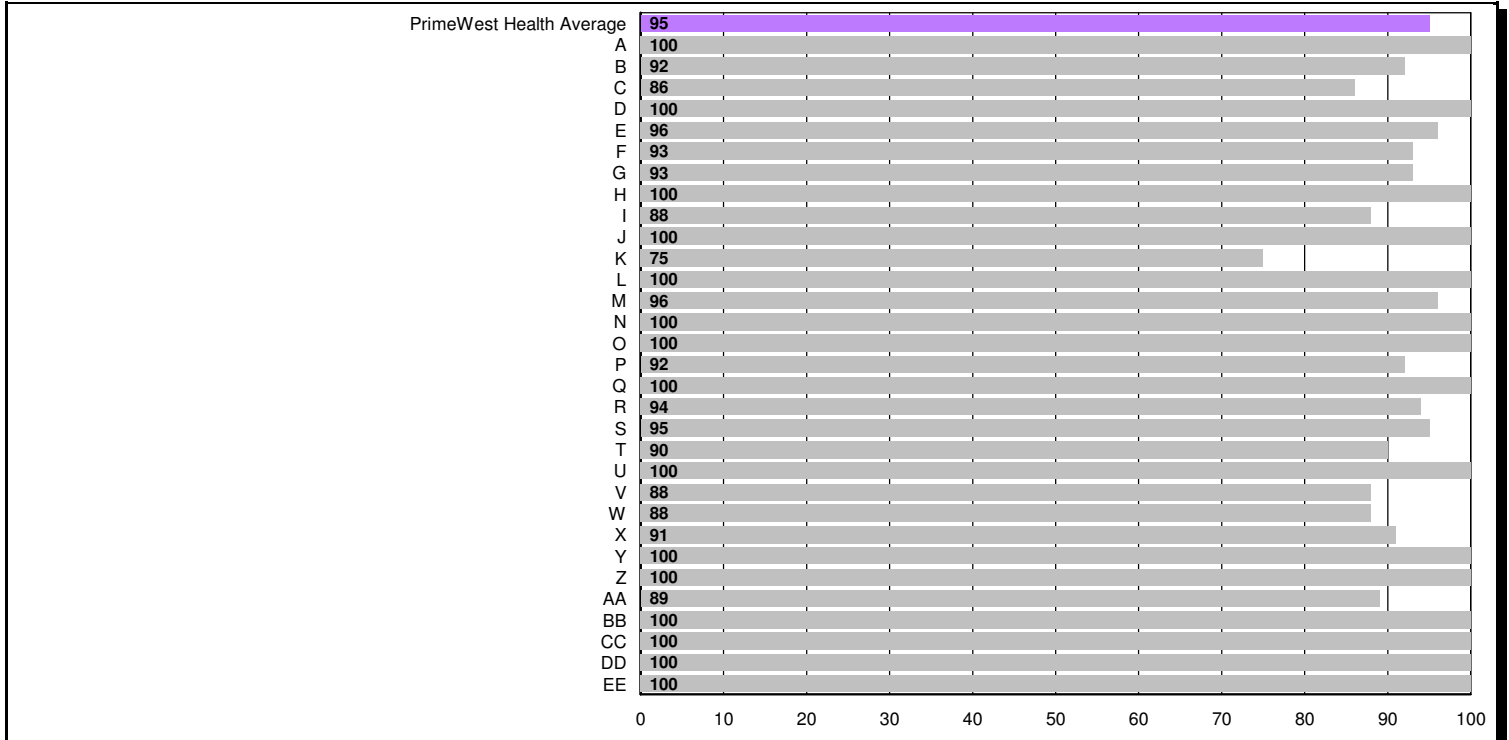
Continuity of care from one visit to the next is addressed with follow-up of unresolved problems from previous visits documented in subsequent visit notes. The record reports the member's progress or response to treatment and changes in the treatment or diagnosis.

**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.**



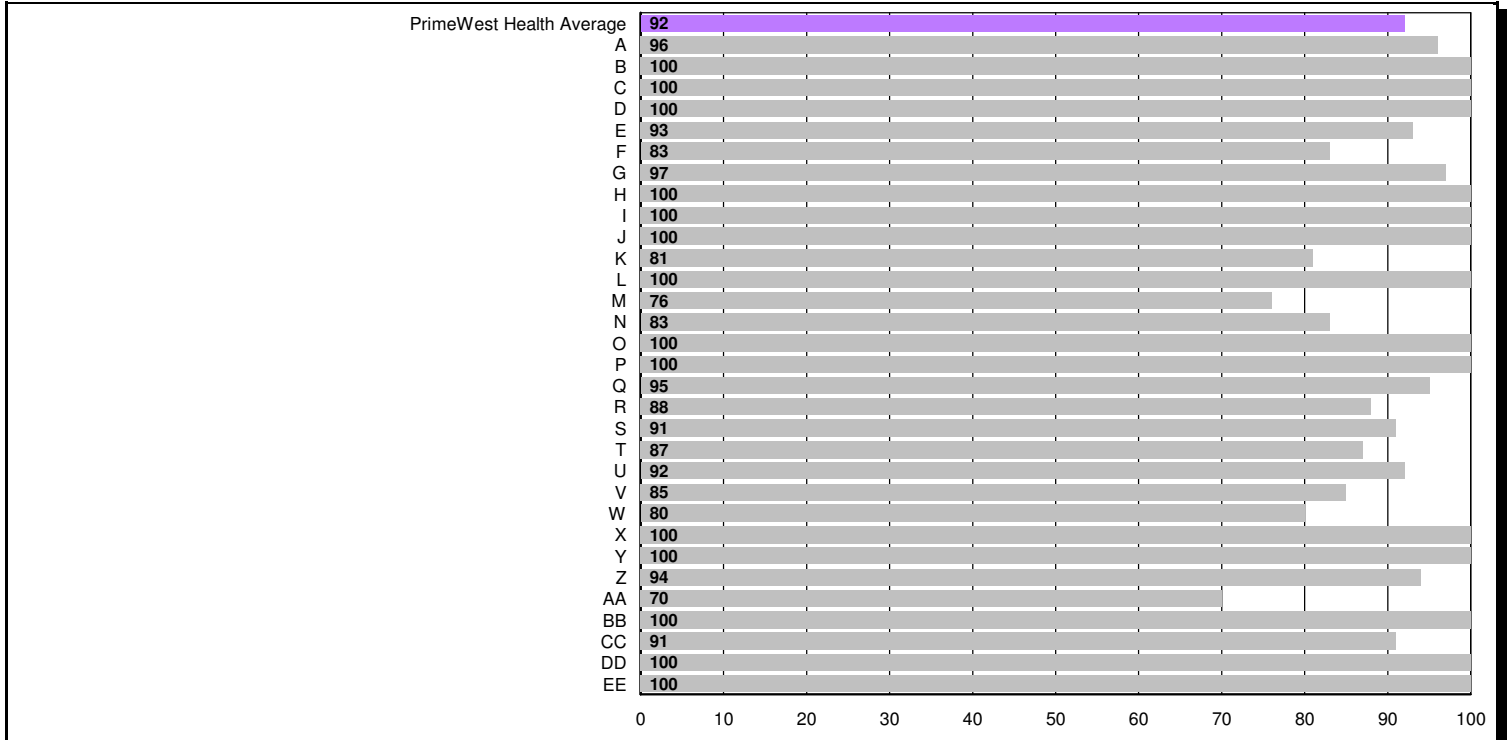
Follow-up is documented for members who require periodic visits for a chronic illness and for members who require reassessment following an episodic illness. Return to office in a specified amount of time is recorded at time of visit or as follow-up to consultation or laboratory or other diagnostic reports. EMR pre-built content is appropriate to the member's situation.

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



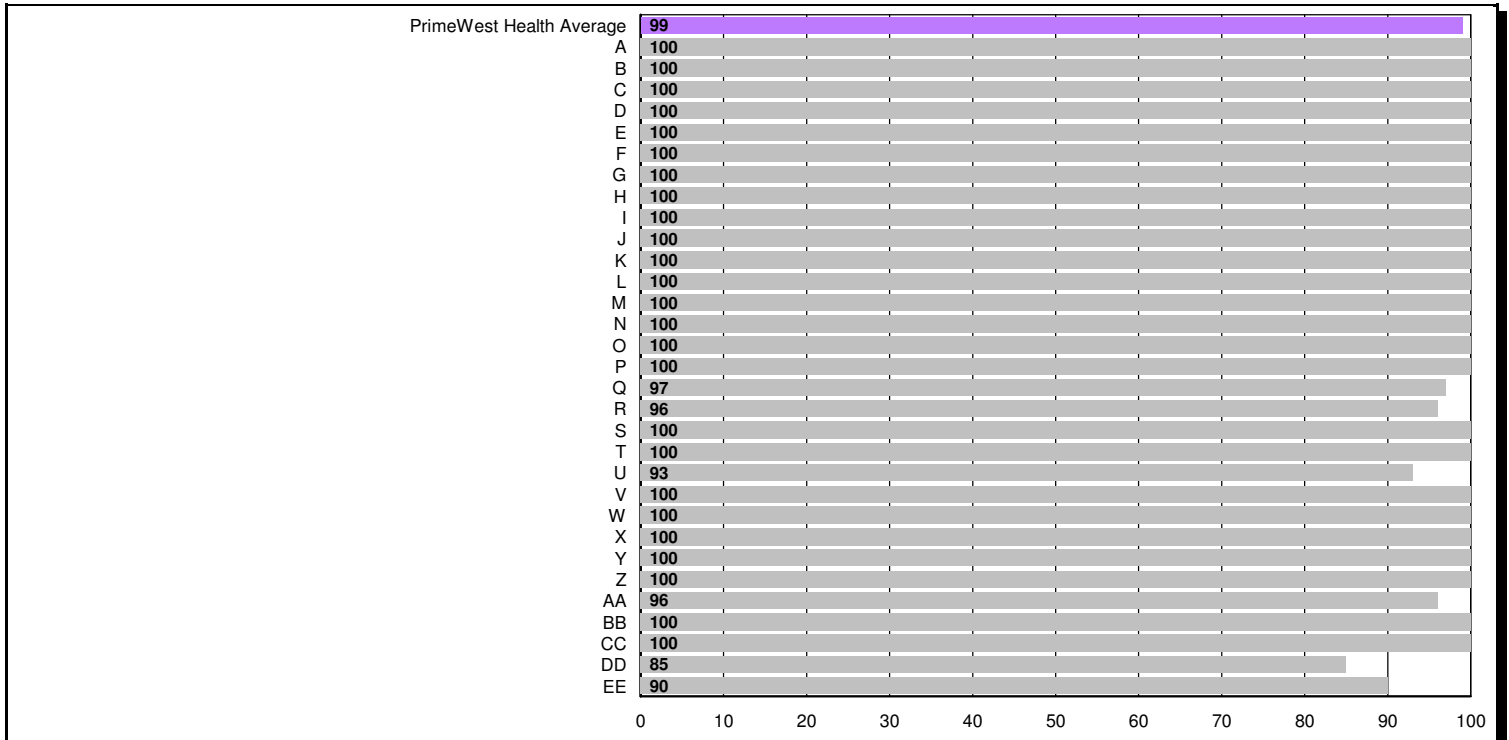
Medical records include consultation reports/summaries that correspond to specialist referrals or documentation that practitioner attempted to obtain reports that were not received.

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



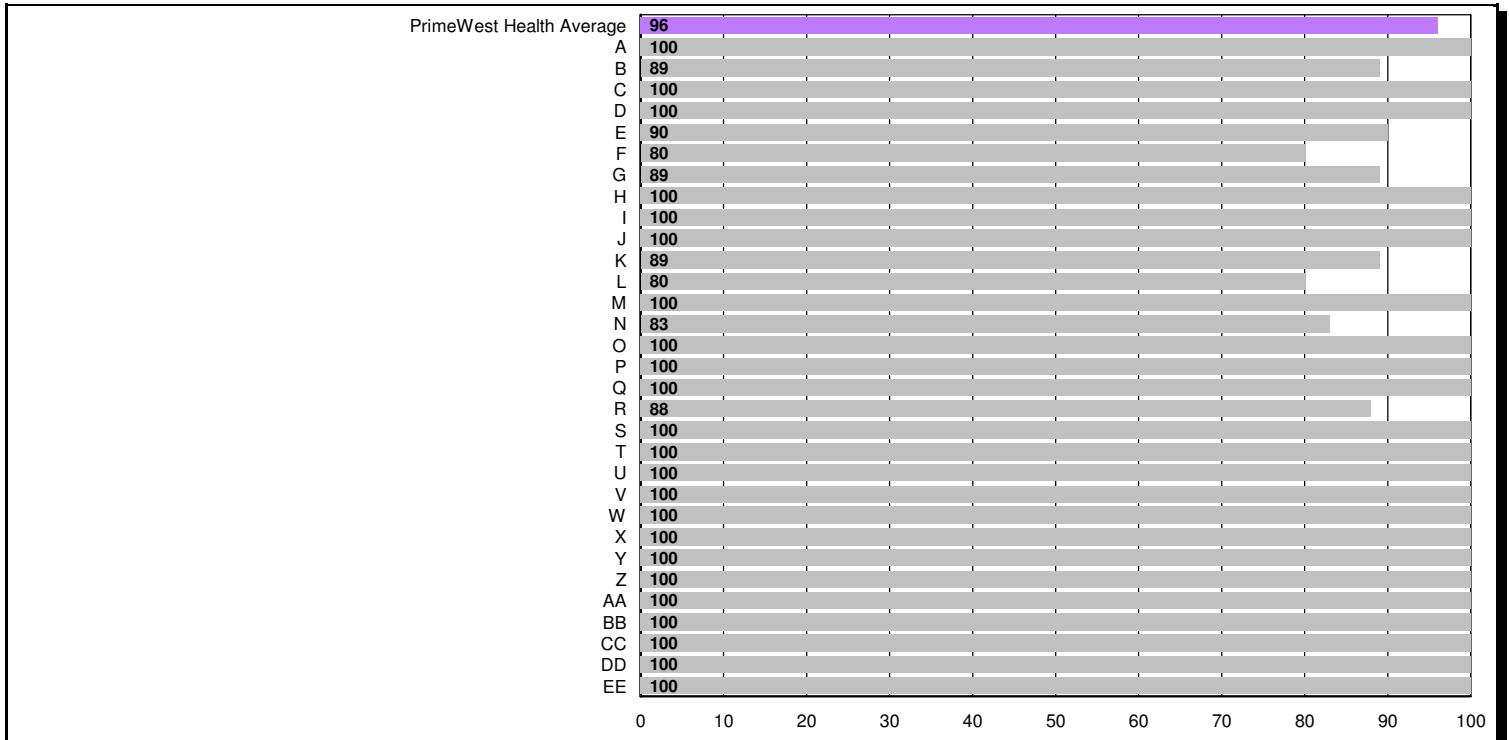
All reports of consultations or laboratory and imaging studies ordered are documented in the medical record/EMR and are initialed by the practitioner who ordered them to signify review; or another system of ensuring practitioner review is in place. This includes reports of consultations requested of providers within the same clinic.

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



Clinically significant consultations, abnormal labs, and imaging reports have an explicit notation of follow-up plans. Follow-up care, communication of test results, and calls/visits are documented to indicate continuity of care. Subsequent visit notes and 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.