

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