# 2022 Health Record Documentation Standards

Gray text indicates quoted, statutory, or other language not subject to change

<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Record Format</strong></td>
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<tr>
<td>1. Elements in the health record are organized in a consistent manner.</td>
<td>The contents of the health record are affixed and organized in a logical and consistent manner. The record is organized in chronological order.</td>
<td>• National Committee for Quality Assurance (NCQA) guidelines</td>
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</tbody>
</table>
| 2. Member name is present on every page. | A separate health record must be maintained for each unique member with the member's name present on every page. | • MN Rules part 9505.2175, subp. 2 (B)  
• NCQA guidelines |
| 3. Author identification is present for every entry. | All entries in the health record contain the author's identification, which may be a handwritten signature, unique electronic identifier, or initials, and title. Services provided/ordered are authenticated by the author of the entry to signify knowledge, approval, acceptance, or obligation. Stamped signatures are not acceptable. Use of a rubber stamp for signature is permitted in the case of an author with a proven physical disability unable to sign his/her signature. Signatures from someone other than the author are also not acceptable. If there is no legible identifier in the form of a handwritten or electronic signature, a signature log is required. The log must be included in the health record and clearly identify the author associated with the initials, mark, sign, or illegible signature. The identifier may be on the actual page where the initials, mark, sign, or illegible signature appear or may be in a separate log. The log must be part of the member's health record. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Electronic signatures are preceded by "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," or "Validated by," and include the author's name, including credentials, and date signed. | • MN Rules part 9505.2175, subp. 2 (C) (4)  
• MN Stat. sec. 221.173  
• Centers for Medicare & Medicaid Services (CMS) Manual System, Pub 100-08, CR 6698  
• NCQA guidelines |
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| 4. All entries are dated and timed. | Each entry in the health record must contain the date on which the entry was made and the date on which the health service was provided. All entries in the health record must also contain the time on which the entry was made (orders, reports, notes, etc.). **The timed entry standard applies to clinics associated with general and critical access hospitals and clinics using an electronic health record (EHR).** | • MN Rules part 9505.2175, subp. 2 (C) (1) (2)  
• Title 42 Code of Federal Regulations (CFR) 485.638 (a) (4) (iv)  
• NCQA guidelines |
| 5. All entries are legible to someone other than author. | There is a system in place to ensure that all entries in the health record are legible to someone other than the author. The content of the record is presented in a standard format that allows a reader to review without the use of separate legend/key. Late entries must be clearly labeled “late entry.” Corrections to an entry must be made in a way in which the original entry can still be read. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (A)  
• NCQA guidelines |
| 6. Medical and mental health providers can access each other’s notes through a fully integrated electronic health record (EHR). | Providers are able to accommodate the timely, effective, and confidential exchange of patient information between primary care providers, mental health care professionals, specialists, and organizational providers. (Individual health care providers in private practice with no other providers are excluded from the requirements.) | • MN Stat. sec. 62J.495 |

**B. Basic Record Content**

| 1. Personal biographical data includes member address, employer, home and work phone numbers, and marital status. | Personal biographical is documented in a prominent location in each health record and includes the member’s address, employer, home and work phone numbers, and marital status. | • NCQA guidelines |
| 2. Member demographic data includes preferred language, sex, race, ethnicity, and date of birth. | Member demographic data is documented in a prominent location in each health record and includes the member’s preferred language, sex, race, ethnicity, and date of birth. Documentation also includes whether a member declines to specify race, ethnicity, and/or a preferred language. **This standard applies to clinics using an EHR.** | • 45 CFR 170.207 (f) (g)  
• 45 CFR 170.314 (a) (3) |
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| 3. Health Care Directives are documented in the health record for members age 18 and over. | Documentation is in a prominent part of the member’s current health record, for those age 18 and over, whether or not the member has executed a Health Care Directive. If not executed, there is documentation that Health Care Directive information was offered. | • 2022 Minnesota Department of Human Services (DHS) Families and Children contract, article 14  
• 2022 DHS Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract, article 14  
• 2022 DHS SNBC contract, article 14  
• MN Stat. sec. 145C.01  
• MN Stat. sec. 145C.02  
• MN Stat. sec. 145C.03  
• 42 CFR 422.128 (b) (1) (ii) (E) |
| 4. Significant illnesses and medical conditions are indicated on a problem list. | A problem list that summarizes important member medical information, such as major diagnoses, past medical and/or surgical history, and recurrent complaints is documented in a specific location. There should be a current problem list, kept either separately or within each practitioner progress note. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (D) (1)  
• NCQA guidelines  
• PrimeWest Health standard |
| 5. Absence or presence of medication allergies and adverse reactions are prominently noted in the health record. | Documentation of presence of medication allergies, including adverse reactions, must be consistently and clearly documented in a prominent location in all health records. If the member has no known allergies or history of adverse reactions, this is also prominently noted in the health record. Allergies to environmental allergens, food, pets, etc., should also be noted. | • NCQA guidelines  
• PrimeWest Health standard |
| 6. Past medical history for members age 18 and over (seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. | There should be documentation of a past medical history obtained by the third visit that includes serious accidents, operations, and illnesses for members age 18 and over. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (D) (1)  
• NCQA guidelines  
• PrimeWest Health standard |
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| 7. Past medical history for members under age 18 (seen three or more times) includes information such as prenatal care, birth, operations, and childhood illnesses. | There should be documentation of a past medical history obtained by the third visit for members under age 18 that includes information such as prenatal care, birth, operations, and childhood illnesses. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (D) (1)  
• NCQA guidelines  
• PrimeWest Health standard |

C. Preventive Screening and Services

| 1. Immunization status information for all ages is recorded on a single page location. | An immunization record (for children) is up-to-date or an appropriate history (for adults) has been made in the health record. Immunizations should be offered and performed based on the current United States Recommended Childhood and Adolescent Immunization Schedule (the Minnesota Department of Health [MDH] Recommended Childhood Immunization Schedule may be used) or United States Recommended Adult Immunization Schedule and documented on an immunization record (single page location). If immunizations were due but not given, the reason why should be documented. Member refusal of immunizations should also be documented in the health record. Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. For members who have transferred from another practitioner, immunization records should be obtained and reviewed for completeness. | • 2022 DHS Families and Children contract, sections 6.1.57 and 6.6  
• 2022 DHS MSHO/MSC+ contract, section 6.1.57  
• 2022 DHS SNBC contract, section 6.1.61  
• DHS Child and Teen Checkup (C&TC) Program  
• MN Stat. sec. 256B.0625, subd. 39  
• 42 CFR 441.56 (c) (3) (d) (1)  
• NCQA guidelines  
• Centers for Disease Control and Prevention (CDC) guidelines  
• PrimeWest Health standard |

| 2. Body Mass Index (BMI) is documented annually for members age 2 and over. | BMI is a proxy for total body fat, which is related to the risk of disease and death. For adults age 20 and over, BMI is calculated and interpreted using standard weight/height BMI tables and weight status categories that are the same for all ages and for both men and women. For children and teens ages 2 – 19, the calculation and interpretation of BMI is both age- and gender-specific utilizing the child and teen BMI calculator and BMI-for-age growth charts for girls and boys. For children and teens under age 20, only evidence of the BMI percentile meets criteria. | • CDC guidelines  
• PrimeWest Health standard |
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| 3. For members under age 21, there is evidence that preventive screening and services are recommended in accordance with PrimeWest Health’s clinical practice guidelines. | Preventive services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice. A summary of preventive screening and services is documented in a consistent place in the health record. Preventive health guidelines should comply with the Minnesota C&TC Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule for members under age 21. | • 2022 DHS Families and Children contract, section 6.1.5  
• 2022 DHS SNBC contract, section 6.1.6  
• DHS C&TC Program  
• MN Rules part 9505.0175, subp. 25 (C)  
• MN Rules part 9505.0355  
• MN Rules part 9505.1693-1748  
• 42 CFR 441, subp. B  
• NCQA guidelines  
• PrimeWest Health standard |
| 4. For members age 21 and over, there is evidence that preventive screening and services are recommended in accordance with PrimeWest Health's clinical practice guidelines. | Preventive services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice. A summary of preventive screening and services is documented in a consistent place in the health record. For members age 21 and over, utilize standards of care and clinical guidelines adopted by PrimeWest Health (United States Preventive Services Task Force [USPSTF] A and B Recommendations). | • MN Rules part 9505.0175, subp. 25 (C)  
• MN Rules part 9505.0355  
• 42 CFR 438.236  
• 42 CFR 440.130 (c)  
• NCQA guidelines  
• PrimeWest Health standard |
| 5. For members age 10 and over, there is appropriate notation concerning the use of alcohol and substances (for members seen three or more times, or if indicated, query substance abuse history). | There is documentation concerning use of alcohol and substances for members age 10 and over. This could include any provided interventions, including education or brief counseling. For those members seen three or more times, substance abuse should be queried and documented. | • DHS C&TC Program  
• NCQA guidelines |
| 6. For members age 10 and over, there is appropriate notation concerning the use of tobacco (for members seen three or more times, or if indicated, query substance abuse history). | There is documentation concerning use of tobacco for members age 10 and over. This could include any provided interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents. For those members seen three or more times, substance abuse should be queried and documented. | • DHS C&TC Program  
• NCQA guidelines |
| 7. Tobacco cessation information was offered to members who responded “yes” to previous question regarding tobacco use. | There is documentation concerning a referral to tobacco use prevention program or other smoking cessation guidelines provided to the member. | • 2022 DHS Families and Children contract, section 6.1.44  
• 2022 DHS SNBC contract, section 6.1.48 |
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| 8. For members age 12 and over, Screening and Brief Intervention (SBI) to identify unhealthy substance use is conducted annually utilizing a standardized tool. | Substance use disorder (SUD) services will include annual utilization, in primary care clinics, of a valid and reliable tool approved by the STATE, for SBI to identify unhealthy substance use and to provide a brief intervention, when indicated. In addition, when patient screens are positive for substance abuse or dependence, primary care clinics will provide Screening, Brief Intervention, and/or Referral to Treatment (SBIRT). Clinics will utilize valid and reliable tools, approved by the STATE, and resources to provide immediate treatment options, which may include pharmacotherapy options and/or referral to specialized treatment. Suggested tools for members age 18 and over are the ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), AUDIT (Alcohol Use Disorders Identification Test), AUDIT-C (AUDIT-Consumption), CAGE-AID (CAGE [mnemonic acronym for Cut, Annoyed, Guilty, Eye-opener] Adapted to Include Drugs), DAST-10 (Drug Abuse Screen Test), and NIDAMED (National Institute on Drug Abuse Medical Screening). For members ages 13 – 17, suggested tools are the KIDDIE CAGE (mnemonic acronym for Chemical, Avoid, Group, Emotions) and the CRAFFT (mnemonic acronym for Car, Relax, Alone, Forget, Family or Friends, Trouble). | • 2022 DHS Families and Children contract, section 6.1.51  
• 2022 DHS MSHO/MSC+ contract, section 6.1.51  
• 2022 DHS SNBC contract, section 6.1.55  
• 42 CFR 8.12 |

### D. 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 examination, relevant to the problem, should be documented. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (D) (1) (2)  
• NCQA guidelines  
• PrimeWest Health standard |

| 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 health record. Documentation of the order for laboratory or X-ray service must also be in the record. | • MN Rules part 9505.2175, subp. 2 (D) (I) (2)  
• NCQA guidelines |
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| 3. Working diagnoses are consistent with findings. | Working diagnoses or medical impressions that logically follow from the clinical assessment and physical exam are recorded. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (D) (3) (H)  
• NCQA guidelines  
• PrimeWest Health standard |
| 4. Treatment plans are consistent with diagnoses. | Proposed treatment plans, therapies, or other regimens 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. | • MN Rules part 4685.1110, subp. 13 (A)  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• NCQA guidelines  
• PrimeWest Health standard |
| 5. Patient-centered decision-making is utilized and documented. | There is evidence patient-centered decision-making aids/tools are provided to members regarding their health treatment or screening decisions and are utilized and documented by providers in the treatment and care planning for members. Shared decision making occurs when a health care provider and a member (including their family members or caregivers) work together to make a health care decision that is best for the member. The optimal decision takes into account evidenced-based information about available options, the provider’s knowledge and experience, and the member’s values and preferences. There is emerging evidence that supporting people to share in decision-making can improve health outcomes and the extent to which members adhere to their treatment. | • 2022 DHS Families and Children contract, section 7.11  
• 2022 DHS MSHO/MSC+ contract, section 7.11  
• 2022 DHS SNBC contract, section 7.14  
• MN Stat. sec. 256B.69, subd. 9 (c)  
• Agency for Healthcare Research and Quality (AHRQ), Achieving Patient-Centered Care with Shared Decision Making  
• NCQA Patient-Centered Medical Home Recognition Program |
| 6. There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure. | The health record shows clear justification for diagnostic and therapeutic procedures. | • NCQA guidelines  
• PrimeWest Health standard |
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| 7. Prescribed medications are clearly visible in the health record.    | Ongoing documentation and medication reconciliation of prescribed medications, including quantity, dosage (actual rather than prescribed), name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the health record and listed in a composite form. Over-the-counter and herbal preparations should also be clearly noted. | MN Rules part 9505.2175, subp. 2 (E)  
NCQA guidelines  
PrimeWest Health standard |
| 8. 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. | MN Rules part 9505.2175, subp. 2 (H)  
NCQA guidelines |
| 9. 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. Telephone encounters (phone contact) relevant to medical issues are documented in the health record and reflect practitioner review. The member’s return to the office in a specified amount of time is recorded at the time of the visit, or as follow-up to consultation, laboratory, or other diagnostic reports. | MN Rules part 9505.2175, subp. 2 (G)  
NCQA guidelines  
PrimeWest Health standard |
| 10. Note from consultant is present for each consultation requested.   | Health records include consultation reports/summaries that correspond to specialist referrals, or documentation that the practitioner attempted to obtain reports that were not received. | MN Rules part 4685.1110, subp. 13 (A)  
MN Rules part 9505.2175, subp. 2 (F)  
NCQA guidelines |
| 11. Consultation, laboratory, and imaging reports filed in the health record are initialed by the practitioner who ordered them to signify review. | All reports of consultation, laboratory, and imaging studies ordered are documented in the health record and are initialed by the practitioner who ordered them to signify review, or another system of ensuring practitioner review is in place. If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Review and signature by professionals other than the ordering practitioner does not meet this requirement. | MN Rules part 9505.0175, subp. 35 (B)  
NCQA guidelines |
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| 12. Clinically significant consultation and abnormal laboratory and imaging reports have an explicit notation of follow-up plans. | Clinically significant consultation and abnormal laboratory 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. | • MN Rules part 9505.0175, subp. 35 (A) (B)  
• NCQA guidelines  
• PrimeWest Health standard |
| 13. Discharge summaries are filed in the member’s record. | Discharge summaries for all 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 the member's record when applicable. | • MN Rules part 4685.1110, subp. 13 (A)  
• NCQA guidelines  
• PrimeWest Health standard |
# Health Record Review Tool

<table>
<thead>
<tr>
<th>Facility name:</th>
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<th>Date:</th>
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<tr>
<th>Member name:</th>
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<th>Member date of birth:</th>
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## A. Record Format

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<tr>
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1. Elements in the health record are organized in a consistent manner.
2. Member name is present on every page.
3. Author identification is present for every entry.
4. All entries are dated and timed.
5. All entries are legible to someone other than author.
6. Medical and mental health providers can access each other’s notes through a fully integrated electronic health record (EHR).

## B. Basic Record Content

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1. Personal biographical data includes member address, employer, home and work phone numbers, and marital status.
2. Member demographic data includes preferred language, sex, race, ethnicity, and date of birth.
3. Health Care Directives are documented in the health record for members age 18 and over.
4. Significant illnesses and medical conditions are indicated on a problem list.
5. Absence or presence of medication allergies and adverse reactions are prominently noted in the health record.
6. Past medical history for members age 18 and over (seen three or more times) is easily identified and includes serious accidents, operations, and illnesses.
7. Past medical history for members under age 18 (seen three or more times) includes information such as prenatal care, birth, operations, and childhood illnesses.

## C. Preventive Screening and Services

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1. Immunization status information for all ages is recorded on a single page location.
2. Body Mass Index (BMI) is documented annually for members age 2 and over.
3. For members under age 21, there is evidence that preventive screening and services are recommended in accordance with PrimeWest Health’s clinical practice guidelines.
4. For members age 21 and over, there is evidence that preventive screening and services are recommended in accordance with PrimeWest Health’s clinical practice guidelines.
5. For members age 10 and over, there is appropriate notation concerning the use of alcohol and substances (for members seen three or more times, or if indicated, query substance abuse history).

6. For members age 10 and over, there is appropriate notation concerning the use of tobacco (for members seen three or more times, or if indicated, query substance abuse history).

7. Tobacco cessation information was offered to members who responded "yes" to previous question regarding tobacco use.

8. For members age 12 and over, Screening and Brief Intervention (SBI) to identify unhealthy substance use is conducted annually utilizing a standardized tool.

**D. Assessment, Plan, and Follow-Up**

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<td>6. There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.</td>
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Elements met: percent (90 percent Performance Goal)

Review meets PrimeWest Health standards:

Forward to Quality and Care Coordination Committee (QCCC) for review:

Reviewer: Date:

Clinic representative: