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Adult Medical Record Review Tool — Primary Care Provider

Member Name:	**DOB:**	**Member ID#:**
Provider Name:		**Provider I.D. #:**
Product:	**Date of Review:**	**Initials of Reviewer:**

The Medical Record contains the following patient information:

1. Patient Identification.

☐ **Each** page within the Medical Record contains the patient's name or ID number on **both sides** of the page.

2. Personal Biographical Data.

Mark off each data element found in the medical record:

- ☐ DOB
- ☐ Gender
- ☐ Address
- ☐ Home telephone number(s)
- ☐ Employer
- ☐ Occupation
- ☐ Work telephone number(s)
- ☐ Marital status
- ☐ Name of next of kin/significant other/proxy
- ☐ Telephone number(s) of next of kin/significant other/proxy

3. All entries in the medical record contain the author's identification.

☐ Author identification may be a handwritten signature, initials, an initials-stamped signature or a unique electronic identifier.

4. All entries in the medical record are dated.

5. The medical record is legible to someone other than the writer.

☐ Is the record an Electronic Medical Record (EMR)?

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6. Allergies and Adverse Reactions are <u>prominently noted</u> in the record, or "NKA" is noted.

☐ <u>Prominently noted</u> refers to: on the front of the chart **or** inside the front cover of the chart **or** on a designated problem list <u>or</u> medication page **or** at the time of each office visit.

☐ <u>Updated</u> at a <u>minimum</u> of annually (preferably during a physical).

7. Medication Record

☐ A medication record/list includes dosages and dates for initial and refill prescriptions.

☐ Discussion of medication side effects and symptoms are reviewed with the member and documented.

☐ Medication Adherence Review for compliance for maintenance medications for members with chronic conditions.

☐ Documentation of drug samples. (NO SCORE)

8. Significant illnesses and medical conditions are indicated on the problem list.

☐ The Medical Record contains a problem list that can <u>either</u> be a separate form **or** listed in the progress notes, is updated as appropriate and contains significant illnesses and medical conditions

Or

☐ For those patients <u>without</u> chronic, serious or disabling conditions and/or active (acute) medical or psychosocial problems, the list should either indicate "well visit" or "no problems/complaints."

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9. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

The baseline history and physical is comprehensive and includes a review of:

☐ ***Baseline History:***

Family history, psychosocial and medical-surgical history must contain at least one qualifier.

- ☐ Family history - including pertinent medical history of parents and/or sibling(s)
- ☐ Psychosocial history - including occupation, education, ethnicity, primary language, living situation, mental health issues/problems, socioeconomic issues/problems, risk behaviors
- ☐ Medical-surgical history - including serious accidents, injuries, operations, illnesses/diseases (acute or chronic), and mental health/substance abuse issues

☐ ***Baseline Physical:***

- ☐ A comprehensive review of systems **with** an assessment of presenting complaints (as applicable).
- ☐ A comprehensive assessment of health and development (physical and psychosocial).

The periodic history and physicals are comprehensive and include a review of:

☐ ***Periodic History and Physicals:***

- ☐ Should be repeated in accordance with age-appropriate preventive care guidelines

☐ ***Periodic History:***

Family history, psychosocial and medical-surgical history must contain at least one qualifier.

- ☐ An updated family history
- ☐ An updated psychosocial history
- ☐ An updated medical-surgical history

☐ ***Periodic Physical must contain:***

- ☐ A comprehensive review of systems **with** an assessment of presenting complaints, as applicable.
- ☐ An updated assessment of health and development (physical and psychosocial).

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10. High-Risk Behaviors and Anticipatory Guidance.

☐ There is appropriate notation regarding the inquiry and/or teaching of specific topics **and** appropriate notation concerning high-risk behavior inquiry.

- ☐ Tobacco/cigarette query
  At every encounter ☐ yes ☐ no
- ☐ Alcohol misuse
- ☐ Substance abuse query
- ☐ HIV/STD/Hepatitis risk query
- ☐ Safe sex practices
- ☐ Nutrition guidance/obesity/exercise query if BMI >30
- ☐ Violence/Injury/safety prevention query/discussion
- ☐ Abuse query/discussion (i.e., Domestic abuse for women of child-bearing age, elder abuse, etc.)
- ☐ Social/emotional health query/depression
- ☐ Illness prevention

And

- ☐ Is the patient counseled regarding high-risk behavior(s) or referred to appropriate treatment?

11. Laboratory and other studies are ordered, as appropriate.

☐ Laboratory and other diagnostic studies are appropriate for the clinical findings and/or diagnoses stated consistent with preventive care guidelines.

12. Communicable Disease(s) are reported to appropriate regulatory agency and documented in the MR. (Reference list of NYS/NYC reportable communicable diseases).

Document Communicable Disease and Regulatory Agency:

_____

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13. Routine or follow-up visits must include:

☐ A focused review of systems based upon presenting complaints, active (acute) medical or psychosocial problems, or management of a chronic, serious or disabling condition.

☐ Unresolved problems from previous office visits are addressed in subsequent visits.

14. Working diagnoses/impressions are consistent with subjective and objective findings.

15. Treatment plans are consistent with diagnoses.

☐ Addresses each chief complaint (subjective/objective) and clinical finding with a plan of care consistent with standards of care and clinical practice (including further diagnostic testing, procedures, medication, referrals, etc.).

☐ The PCP documents discussion(s) and agreed upon decision(s) with the member/guardian of potential treatment options that are available to them regarding their health care needs.

16. Follow-Up Notation

⇒ Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in days, weeks, months, or as needed.

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17. Follow-up after an ED visit or hospitalization. Date(s) listed for ED and/or hospitalizations:

_____

⇒ An office visit, written correspondence or telephone follow-up intervention is clearly documented in the PCP record regarding the ED or IP LOS.

18. Continuity of care.

☐ **Indicate whether a specialist consultation: Name/Specialty: _____**

Or

☐ **If whether a diagnostic study: Name of Diagnostic Study: _____**

☐ If a consultation or diagnostic study is requested, there is a note or report from the consultant in the record.

☐ The ordering health care provider initials consultation and diagnostic study reports filed in the chart.

☐ Abnormal consultation and diagnostic study results have an explicit notation of follow-up plans in the record.

19. Immunization.

☐ An appropriate immunization history has been made with notation that immunizations are up to date *(See Adult Immunization Schedule)***.**

☐ Immunizations **administered after May 1992** contain lot number **and** manufacturer's name. (*Must have 100% compliance)*

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20. The Medical Record reflects an appropriate utilization of Consultants.

⇒ Review of Medical Record for Under- or Over-Utilization of Referrals to Consultants

- **Evidence of Under-Utilization:** Yes ☐ or No ☐
  Definition: Unresolved acute or chronic illness(es) and/or symptoms are being actively treated or monitored by the PCP without referral(s) to an appropriate specialist/consultant.
- **Evidence of Over-Utilization:** Yes ☐ or No ☐
  Definition: A consistent pattern of referrals to a consultant without PCP formulating a treatment plan based on assessment of presenting symptoms.

21. Care rendered is medically appropriate/Follows Clinical Practice Guidelines, Standard of Care. * NO SCORE*
Y N
☐ ☐ *(If this standard is not met, the case is **immediately** referred to the Medical Director for a quality of care review).*

Definition: There is evidence that the patient may be placed at inappropriate risk by an inadequate(ly), incorrect(ly) or inappropriate(ly):

- Performed physical examination or assessment
- Performed procedure
- Performed diagnostic studies, including but not limited to lost specimens, poor film quality, misread results, or delayed turnaround time
- Diagnosed the member
- Prescribed, dispensed, or administered medication
- Developed and/or implemented treatment plan
- Other errors, delays or omissions in the delivery of care

22. Advance Directives

- Documentation in the Medical Record of all patients at least 45 years and older (if younger as appropriate) that advance directives have been discussed. If the patient chooses to make an advance directive, there should be a copy of it in the MR and the records should be flagged.

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23. Preventive Health Guidelines. Indicate:

Male_____ Female_____ and Age: _____

There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines. (Reference: Adult Preventive Services)
(Refer to high-risk behaviors for additional screening not included in this section.)

- Measurements
  - ☐ Blood Pressure – Every 1-2 years (Repeat if elevated?)
  - ☐ Pulse/Respirations and Temperature (as appropriate)
  - ☐ Weight
  - ☐ Height
  - ☐ BMI – Annual – Date of Service_____
- Procedures/Screening
  - ☐ Cholesterol – Starting at 20 years of age, obtained once every 5 years
    Referral ☐ Date of Service:_____
  - ☐ EKG – Test to be done for patients at high risk.
  - ☐ Diabetes Screening – Starting at age 45 every 3 years
  - ☐ Abdominal Aortic Screening – One-time screening by U/S for men 65-75 years who smoked
  - ☐ TB – Skin testing for asymptomatic high-risk patients
  - ☐ Osteoporosis Screening/Testing – women age 65 and older, and men 70 and older testing recommended every two years. Date of Service:_____
  - ☐ Preconception Screening for all women of childbearing age (NO SCORE)
  - ☐ Rubella Testing – Routine screening for all women of childbearing age and health workers
  - ☐ Menopause Screening
  - ☐ Vision Screening – Annual
  - ☐ Glaucoma Screening - Annual
  - ☐ Hearing Screening – Annual
  - ☐ Dental Health Screening – Regular checkups twice a year or as advised
  - ☐ Chlamydia – All sexually active females < 26 years annually, as well as others at risk
    Referral ☐ Date of Service:_____
- Cancer Screening Examinations
  - ☐ Breast Exam/Mammography – Annually for ages 40 and older
    Referral ☐ Date of Service:_____
  - ☐ Pap Smear – Women ages 21-29 every three years; women ages 30-65 every three years or a Pap test plus HPV testing every five years.
    Referral ☐ Date of Service:_____
  - ☐ Colonoscopy every 10 years/Sigmoidoscopy every 5 years/Fecal Occult Blood testing annually starting at age 50
    Referral ☐ Date of Service:_____
  - ☐ Prostate Examination/PSA – Discussion of benefits and risks of screening
    Referral ☐ Date of Service:_____
  - ☐ Skin Cancer – Routine checkup
    Referral ☐ Date of Service:_____
  - ☐ Aspirin for Prevention of CHD – As PCP advises

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- **Prevention**

☐ Aspirin for Prevention of CHD – As PCP advises
☐ Hormone replacement therapy – As PCP advises
☐ Discussion of exercise or physical therapy and Vitamin D supplementation for community-dwelling adults ages 65 or older

24. No shows or missed appointments.

☐ Missed appointments should be documented
☐ Follow-up efforts to reschedule appointment

25. Medical Record reflects documentation of care for older adults (66 years and greater).

☐ Evidence of Pain Assessment (should be performed at every visit): Yes ☐ or No ☐
Can include documentation of either of the following:

- Notation of the presence or absence of pain
- Notation of the results of a screening using a standardized tool

☐ Evidence of a Functional Assessment: Yes ☐ or No ☐
Can include documentation of any of the following:

- Functional independence
- Loss of independent performance
- Activities of daily living (ADLs)
- Social activities
- Instrumental ADLs (IADLs)
- Level of assistance needed to accomplish various tasks
- Result of assessment using a standardized functional status assessment tool

☐ Evidence of Medication Review: Yes ☐ or No ☐
Definition: The percentage of older adults who had the presence of a medication list in the medical record **AND** a medication review during the measurement year.

☐ Evidence of Advance Care Planning: Yes ☐ or No ☐
Definition: Notation of a discussion about preferences for resuscitation, life-sustaining treatment, and end-of-life care or a patients refusal to discuss advance care planning.

End of PCP Adult Medical Record Review Tool