

FULL SCOPE
MEDICAL RECORD REVIEW SURVEY
(August 2004)

The following is a summary of the Department of Health Services Medical Record Review Survey tool that is used for all full scope and PCP Incentive Program audits.

1. Format

- a. An individual medical record is established for each member.
- b. Member identification is on each page.
- c. Individual personal biographical information is documented.
- d. Emergency "contact" is identified.
- e. Medical records are consistently organized.
- f. Chart contents are securely fastened.
- g. Patient's assigned PCP is identified.
- h. Primary language and linguistic service needs of limited or non- English proficient (LEP) or hearing impaired persons are prominently noted.

2. Documentation

- a. Allergies are prominently noted.
- b. Chronic problems and/or significant conditions are listed.
- c. Current continuous medications are listed.
- d. Signed Informed Consents are present, when appropriate.
- e. Advance Health Care Directive- document whether or not the member has executed an advance directive for adults 18 years/older; emancipated minors.
- f. Medical record entries are within acceptable legal documentation standards. (signed, dated and written in ink)
- g. Errors are corrected according to legal medical documentation standards.

3. Coordination/Continuity of Care

- a. History of present illness is documented.
- b. Working diagnoses are consistent with findings.
- c. Treatment plans are consistent with diagnoses.
- d. Instruction for follow up care is documented.
- e. Unresolved/continuing problems are addressed in subsequent visit(s).
- f. A physician reviewed consult/referral reports and diagnostic test results.
- g. Missed appointments and follow-up contacts/outreach efforts are noted.

4. Adult/Pediatric Preventive

- a. An Initial Health Assessment (IHA) - a comprehensive history and physical at age-appropriate intervals - must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment.
- b. The Individual Health Education Behavioral Assessment (Staying Healthy Tool) is completed initially on all adults and age appropriate assessments completed for children within 120 days of enrollment into Health Plan, or as part of the Initial Health Assessment.
- c. Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors.
- d. Blood pressure measurement for patients with normal readings is documented at least once every 2 years and more often for those with abnormal readings.

- e. Cholesterol level checked according to the USPSTF guidelines men (aged 35 years and older) and women (aged 45 years and older) which includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C).
- f. Chlamydia screening is offered for women from the time they become sexually active until they are 25 years of age.
- g. A routine screening mammogram for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.
- h. Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix.
- i. Periodic health assessments are provided according to the American Academy of Pediatrics (AAP) recommended schedule for pediatric preventive health care.
- j. Age-appropriate visual and hearing screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate.
- k. Nutritional and dental assessments are performed at every health assessment visit.
- l. Blood lead level (BLL) testing is performed according to Department of Health Services recommended schedule.
- m. All children are screened for risk of exposure to tuberculosis (TB) at each health assessment visit. Adults are screened upon enrollment.
- n. Childhood and adult immunization status is assessed at each health assessment visit. The date the Vaccine Information Sheet (VIS) was given **and** the publication date of the VIS is documented. The name of each vaccine given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs.

5. **Perinatal Preventive Criteria**

- a. Initial Comprehensive Prenatal Assessment (ICA). The ICA, completed within 4 weeks of entry to prenatal care.
- b. Subsequent Comprehensive Prenatal trimester re-assessments are completed during the 2nd trimester and 3rd trimester.
- c. Prenatal care visits according to most recent American College of obstetrics and Gynecologists (ACOG) standards.
- d. An Individualized Care Plan (ICP) is completed.
- e. Referral to **WIC**, the **W**omen, **I**nfants, and **C**hildren program (WIC) is documented. (WIC is a nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.)
- f. The **offering** of prenatal HIV information, counseling and HIV antibody testing is documented.
- g. AFP/Genetic screening tests prior to 20 weeks gestation is documented.
- h. Provision of a Domestic Violence Screening is documented
- i. Family Planning counseling (Birth Control information offered), referral or provision of services is documented.
- j. A comprehensive postpartum reassessment is completed within 4-8 weeks postpartum.