

Neighborhood Health Providers - Ambulatory Medical Record Review Tool

Member Name								
NHP ID #						D.O.B		
Clinic Site:						Network Code:		
Provider Name:						Provider ID # :		
Reviewer Name:						Date Reviewed:		
	Chart #		of			Yes	No	N/A
I. DOCUMENTATION STANDARDS								
1. Legibility		(if not legible stop the review process)!!!!						
2. Progress notes elements								
	a. All notes are dated							
	b. Patient's name recorded on each page							
	c. Author identification-signature/legible identification							
3. Patient contact information(address, phone number and emergency contact name and phone number.)								
4. Chart elements:								
	a. Allergies							
	b. Medical problem list							
	c. Current medication record							
	d. Consultation report/correspondence in the chart							
	e. Does the patient have Advanced Directives?							
	f. Are there copies of the Advanced Directives in the chart?							
II. BASELINE CLINICAL ASSESSMENT								
1. Comprehensive history-collected or reviewed by medical provider:								
	a. Comprehensive Medical history (Illnesses and operations etc.)							
	b. Family history							
	c. Immunizations							
	d. Behavioral Health Assessment (BHA) >12 years old							
	e. Was a Behavioral Health Assessment tool used?							
	f. If the BHA was positive, was there follow-up and coordination between the PCP and the BH specialist?							
2. Comprehensive Physical exam (Review of systems)								
3. Anticipatory Guidance								
4. Did the provider refer the patient to the Early Intervention Program for development delay in children?								
5. HIV								
	a. HIV test?							
	b. Documentation of HIV pre-, post-test counseling/consent							
6. Preventive services-members seen at least two times have evidence of appropriate preventive screening activities:								
	a. Age 0-12 months	Height, weight, head circ. on growth chart						
	b. Birth to 25 months	Lead screening (lead level by age 2)						
	c. 26 months-72 months	Exposure risk history						
	d. 7-12 years	Blood pressure recorded once						
	e. 13-21 years	STD & sex education documented						
	f. All patients 12 and over	Tobacco Screening						
	g. All patients 12 and over	ETOH/ Substance abuse screening						
	h. All patients 12 and over	Did the Provider advise the patient to stop smoking, drinking alcohol and drug abuse?						
	i. All patients 12 and over	BMI screening & education						
	j. All patients 12 and over	nutrition assessment & education						
	k. All patients 12 and over	exercise screening						
	l. Sex. active female	Pap q3 years						
	m. Females >18	Domestic Violence Screening						
	n. Male 35-65, Female 45-65	Cholesterol q5 years						
	o. Female >65 or high risk	Osteoporosis Screening						
	p. All patients >50 years	Stool guais q1 year or flexible sigmoidoscopy 5 years/colonoscopy in last ten years						

**Neighborhood Health Providers/Suffolk Health Plan
Medical Record Standards**

CORE INFORMATION / READABILITY	
1. Legibility/Orderliness	Documentation should be clear and legible; the record should be well organized and consistent across patients in the same practice.
2. a. All notes are dated	Each entry or office note must be dated.
b. Patient's name recorded on each page	Every page should contain the patient's name and other identifying information, such as DOB and/or ID number.
c. Author identification-signature/legible identification	All entries in the medical record contain author identification. Writer may sign or initial each entry; or, an electronic signature is acceptable.
3. Patient contact information	Personal/biographical data includes: address, employer, home and work telephone numbers, marital status, name of contact in case of emergency (spouse's name will satisfy criteria as does name of a parent or guardian for a child), date of birth, and sex. Data may be found on a registration sheet, with billing/insurance information, or in the initial H & P.
4. a. Allergies	Medication allergies and adverse reactions should be prominently documented. If the patient has no known allergies or no history of adverse reactions, this also should be noted.
b. Medication list	All past and current medications should be listed, with dose and route of administration. This list should be kept up to date and the progress notes should reflect the same information.
c. Medical problem/surgical history list	Significant illnesses, medical conditions and prior surgeries are indicated on the problem list; the list should be kept up to date.
d. Health Maintenance/Preventive services flow sheet	Health Maintenance/Prevention/Screening activities should be recorded on a flow sheet or other systematic method.
e. Consultation report/correspondence in the chart	If consultation was requested and/or tests ordered, the consult/reports should be documented along with an indication that they were reviewed. If these reports are missing, then efforts to obtain the consult/reports should be documented.
f. Does the patient have Advanced Directives? Are the Advance Directive documents in the chart?	Optional but recommended for adults, especially those with chronic or life-threatening medical conditions.
BASELINE CLINICAL ASSESSMENT	
1. a. Comprehensive history and physical examination	Each chart should contain a complete evaluation for patients seen three or more times, including history of the present illness, past medical, behavioral and surgical history (including prenatal care and delivery information for children), allergies, medications, social history (including use of tobacco, alcohol and drugs) and a complete physical examination.
b. Immunizations	An immunization record, including immunizations administered elsewhere, has been initiated for children or history has been entered in the medical record for adults.

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BASELINE CLINICAL ASSESSMENT (continued)	
c. Behavioral Health Assessment (BHA) > 12 years old	Can include screening tools for depression and follow up assessment of abnormal findings noted on the baseline history and examination; if referral to behavioral health specialist is needed then it should be documented.
d. Weight/Height and BMI	All charts should include at least yearly weight and height and BMI calculation, as well as BMI percentile in children and adolescents.
2. Pediatrics - Anticipatory Guidance	Interval history, measurement of height, weight and blood pressure, developmental appraisal, physical examination, dental care assessment, nutritional assessment, immunization assessment, age appropriate discussion and counseling (which may occur between visits).
3. Pediatrics - Referral to the Early Intervention Program for developmental delay	If the provider suspects developmental delay in a child, should document referral to the Early Intervention Program.
4. HIV test	If HIV testing was done, HIV prevention education with pre-test counseling and post test counseling should be documented in accordance with NYS AIDS Institute guidelines.
ONGOING CARE AND DIAGNOSTIC TESTING	
1. Progress notes	Progress notes clearly document the specific problems that are the subject of the visit: symptoms; medication/treatment compliance; response to treatment and side effects; pertinent physical exam and test results; the provider's diagnostic assessment; plans for diagnostic testing, consultation and treatment, and patient education. Follow-up visits document resolution of previously identified problems or ongoing efforts to diagnose/treat those that have not resolved.
2. Labs, ancillary study results in chart	Test results documented with evidence that they were reviewed by the provider, with follow-up as clinically indicated.
3. Return visit timeframe documented	Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits.
4. Appropriate reporting of communicable diseases	There should be documentation that diseases and conditions required to be reported by the NYSDOH and/or NYC DOHMH have been reported.
5. Documentation that the member has had ER visits or inpatient admission	Record reflects provider awareness of ER visits and admissions.