2009 Medical Record Reviews
By Cindy Mazey, RN

SummaCare conducts an annual assessment of primary care physician compliance with medical record standards. While the assessment is no longer performed as part of the recredentialing process, a review of documentation practices of primary care physicians in the office setting is required by the National Committee for Quality Assurance (NCQA) and SummaCare's Quality Management Program. A 10 percent random sample of primary care physicians (21) was selected from the population of primary care physicians with at least 50 SummaCare members. Those physicians/practices included in the review for this reporting year will be excluded from the sample in subsequent years until all physician practices with 50 or more members have been reviewed.

Prior to the review, the SummaCare Medical Record Review Tool and a letter noting a number to call with questions were sent to the physicians/practices selected. The nurse reviewer also offered the opportunity for questions and suggestions for improvement, if needed, upon completion of the review. Final results were communicated to each provider in writing.

SummaCare is proud to share that 95 percent of the physicians/practices reviewed passed the review with an average score of 90 percent. The following table provides a comparison of the years that SummaCare has conducted this activity:

Year	% Passing	Average Score
2009	100%	93%
2008	100%	93%
2007	95%	90%

There are three areas identified where room for improvement exist. The following elements had an aggregate score of less than the compliance threshold of 80 percent:

75%	The immunization record is complete and updated as appropriate (includes adults and children)
69%	Documentation of health education is reflected in the record
22%	Documentation of whether or not an Advance Directive has been executed for all Medicare members and others as appropriate

The Federal Balanced Budget Act of 1997 requires primary care physicians document in a prominent part of the medical record whether or not an Advance Directive has been executed for members who are 65 years or older, have a chronic illness or have a catastrophic event/illness.

SummaCare is implementing a plan-wide goal of improving documentation of Advance Directives on member medical records. We encourage practitioners to discuss Advance Directives with appropriate members, and to document the outcome of the discussion in the medical record. Upon provider request, SummaCare will gladly supply a copy of Ohio's Advance Directive.

SummaCare also offers chart stickers for immunizations, Advance Directives and health education materials upon request.

Patient Education/Materials Provided Topic ________________ Date _________________	Has Advance Directive Been Executed? Date __________________ Copy of Durable Power of Attorney or Living Will on Chart? Yes________ No________	Influenza Vaccine Date: Pneumonia Vaccine Date: Tetanus Booster Vaccine Date:

For your information, the following is a complete listing of the SummaCare Medical Record Standards:

1. Allergies and drug reactions are documented in a prominent and uniform location
2. Past medical history including history of familial and hereditary disease is documented
3. There is a current problem list
4. There is a current medication list
5. Demographic information including the member's name, date of birth, sex, address, telephone number, marital status, and next of kin or responsible party are documented
6. All entries are dated and signed or initialed
7. A return visit or follow-up for each encounter is documented
8. There is documentation of health education when appropriate
9. The practitioner initials consultations, Lab and X-ray reports
10. Telephone advice is documented in the record
11. There is documentation of whether or not an Advance Directive has been executed for all Medicare members and others as appropriate
12. There is documentation of the presenting complaint/reason for visit
13. There is documentation of working diagnoses
14. There is documentation of a plan of action / treatment
15. There is documentation of smoking, alcohol and substance abuse habits for members 12 years or older
16. There is evidence of continuity and coordination of care; documentation of all diagnostic and therapeutic services (received) for which a member was referred, such as: home health nursing reports, specialty physician reports, hospital discharge summaries, and physical therapy reports
17. There is documentation that preventive services are appropriately utilized or offered
18. The immunization record is complete and updated as appropriate
19. There is a standardized and organized medical record keeping system
20. Medical records are kept in a secure area way from public access; HIPPA Privacy Rules are practiced and Notice of Privacy Rights given to patient.