2010 ODS Medical Record Global Scores

	The following questions are about office processes and are included in your overall score.
100.0%	Has your staff received HIPAA training?
99.1%	Are there provisions for non-English speaking patients so that office staff and providers can communicate in the person's preferred language.
98.8%	There are provisions for hearing impaired patients so that the office staff and providers can communicate.
100.0%	Is there a system in place to assure that phone messages and responses (including after hours phone messages) will be documented in the chart when appropriate.
99.8%	Is there a process in place to document failed appointments?
100.0%	Only authorized staff has access to the records.
100.0%	Records are securely stored.
100.0%	Records are easily retrieved.
100.0%	There is one patient per chart.
	The following questions are specific to the patient chart and are included in your overall
95.4%	Record is organized in all of the following ways: securely attached, dated, and patient name is on each page (or on all screens in the case of EMR) permitting effective patient care and quality
91.4%	Medication allergies and adverse effects are prominently displayed in chart.
22.4%	If the patient has a Medicare plan (verify Medicare patient by the type of insurance not by age), there is documentation prominently displayed whether or not patient has executed an advance directive or POLST (Physician Orders for Life-Sustaining Treatment).
93.5%	Chart contains relevant biographical information including all of the following: address, emergency phone numbers and general contact phone numbers.
94.5%	There is a completed problem list with significant illnesses and chronic medical conditions.
92.2%	Is there a current medication sheet in the chart?
87.4%	Is there an immunization record?
70.8%	If there is an immunization record, is it up-to-date?
98.7%	The medical record is legible.
55.5%	In the ADULT (19 years and older) patient record, is there an appropriate past medical history in the chart which includes serious illnesses, surgeries, family history, mental health history.
68.0%	In the CHILD (18 years and younger) patient record is there a past medical history in the chart which includes serious illnesses, surgeries, family history, mental health history and there is documentation of prenatal care, birth, surgeries, childhood illnesses, as appropriate.
84.3%	For patients 10 years and older, is there documented screening for tobacco use at every medical encounter?
99.5%	There is pertinent history with subjective and objective reasons for presenting problem.
99.2%	There is a pertinent physical exam for presenting problem.
99.5%	Diagnosis and treatment plan are consistent with findings.
99.2%	In the CHILD (18 years and younger) patient record, is there:
95.7%	A height and weight chart?
91.6%	If height and weight chart is present, is it current? (Current=appropriate for the age)
75.9%	Documented blood pressure beginning at age 3 during routine exam or at least every 2 years?
64.2%	Documented vision screening to detect Amblyopia and Strabismus once for all children prior to entering school, preferably between ages 3-5?
100.0%	In the ADULT FEMALE patient record, is there:
78.9%	Documented cervical cancer screening every 1 - 3 years beginning when sexually active or at age 18 until age 65? (NA if patient has had a total hysterectomy.)
77.2%	Baseline mammogram by 40 years old and every 1-2 years until 70 years old? NA if patient has had bilateral mastectomies.
71.3%	Colorectal cancer screening beginning at age 50?
99.0%	Blood pressure check at annual exam or at least every 2 years?
83.8%	Cholesterol screening beginning at age 45 years old and every 5 years thereafter?
100.0%	In the ADULT MALE patient record, is there:
67.8%	Documented colorectal cancer screening beginning at age 50?
100.0%	Blood pressure check at annual exam or at least every 2 years?

99.8%	Is there a process in place to document failed appointments?
90.4%	Cholesterol screening baseline beginning at age 35 and every 5 years?
100.0%	If patient was non-compliant, there is documentation by the practitioner of follow-up efforts with the patient that determine the cause was not due to either language or cognitive barriers. (addressing the patient's ability to understand instructions regarding medication usage, diagnostic procedures and follow-up consultations)
25.0%	If there are controlled substances prescribed for intractable pain, there is a "material risk notice" (from ORS 677.485 a form adopted into law for written notice disclosing the material risks associated with prescribed or administered controlled substances for the treatment of intractable pain).
74.7%	If patient is depressed (positive screening or documented diagnosis), educational counseling or literature regarding depression is provided to the patient.
47.1%	If patient is referred to, or is already seeing a behavioral health specialist (psychiatrist, psychologist, social worker, or counselor), is coordination of care with behavioral health specialist documented?
99.4%	There is evidence of continuity and coordination of care between primary and specialty practitioners where necessary. (i.e., there is evidence of recommendations and follow-up for additional treatment or consultations or referrals)
99.9%	Ancillary services and diagnostic tests are ordered as appropriate.
99.8%	There is documentation of follow-up of abnormal tests and/or consultant recommendations, or lab and/or imaging reports where necessary.
	The following questions were not factored in your overall score, but included in our review to 1) monitor compliance with access standards of the Centers for
98.8%	Is there ADA-compliant access to/in the office for patients with disabilities?
100.0%	Is there 24 hours, 7 days a week coverage?
99.1%	How soon are appointments for urgent care scheduled? (Standard is within 24 hours?)
98.9%	How soon are appointments for non-urgent symptomatic care scheduled? (Standard is within 7 days)
99.1%	How soon are appointments for stable or chronic conditions that are asymptomatic scheduled? (Standard is within 30 days of the member's request)
97.6%	How soon are appointments for histories and physicals, preventive exams and new patient exams scheduled? (Standard is within 42 days)
72.5%	Practice site currently uses electronic medical records/electronic health records?
57.7%	Practice site E-prescribes?
96.5%	Practice site emails patients at no charge?
83.3%	Practice uses web/email consultations that are billed?
81.7%	Practice has a website?
98.9%	If yes, to website, what is URL?
7.4%	In the ADULT (19 years and older) patient record, is there documented use of a standardized depression screening instrument (eg, PHQ-9, a 9 question depression screening)?
42.3%	In the ADULT (19 years and older), is there documented use of a standardized alcohol screening instrument (e.g., CAGE, a 4 question alcohol screening)?
7.6%	In the CHILD, (13 years or younger), is there documentation of an ADHD screening (e.g., Conner's Rating Scales or TOVA, a computerized test)?