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Assessing Quality of Primary Care through Medical Record Review: Lessons and Opportunities

Neil Goldfarb*

* Thomas Jefferson University

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Assessing Quality of Primary Care through Medical Record Review: Lessons and Opportunities

The review of medical records by “outsiders” has become a part of daily existence for primary care practitioners (PCPs) in recent years. To a large part, the increased focus on quality of primary care can be attributed to the growth of managed care, and its reliance on PCPs to serve as the main coordinators of care and the gateway to other services. Many managed care systems also capitate their PCPs, creating a potential incentive to under-provide care.

In recognition of these potential issues, quality watchdog groups such as the National Committee for Quality Assurance (NCQA) have established standards for the evaluation of quality of primary care via medical record review. Health plans are expected to periodically review a sample of records for each participating high volume provider, to assess compliance with basic care standards and identify opportunities for continued quality improvement. The types of standards typically assessed include:

- documentation of basic patient demographic and clinical information at intake, including prior medical history, family/social history, and allergies;
- ongoing maintenance of the record, including establishing and updating problem and medication lists, and organizing progress notes, lab and consulting reports, and other hard copy documentation within the record;
- documentation at each visit of chief complaint, a clinically appropriate treatment plan, follow-up plan, provider signature, and visit date;
- documentation of preventive care, including immunizations and patient education (e.g. alcohol, tobacco and drug assessment and counseling), and documentation of advance directives; and
- documentation of efforts to coordinate care with other providers, such as follow-up on referrals and initialing of lab findings and reports from consultants.

In conducting medical record review, health plans typically rely on clinical personnel such as nurses with appropriate training. A plan Medical Director or physician advisor may become involved in the review process, particularly for a provider with a track record of poor audit performance. For the typical plan, five or ten medical records will be reviewed per provider or site, with results shared as part of an exit interview, and/or via a follow-up feedback communication. Feedback reports typically include findings regarding each standard, an overall score, and recommendations for continued quality improvement.

There are several concerns with these efforts. First, the audits to a large extent measure the quality of documentation, rather than the quality of clinical care. However, documentation is clearly important, not only in helping the solo practitioner deliver continuous and comprehensive care, but also in cases when records are shared by multiple providers in group practice, or when records are transferred, practices are purchased, or providers arrange coverage during vacations.

In addition, the typical medical record review focuses on process measures, and does not address health outcomes. Another concern is the significant burden placed on providers as a result of these audits. Each plan conducts its own audits, and most PCPs participate in numerous plans. This burden is magnified by the need for PCPs to make records available to health plans and other agencies for a variety of other purposes as well (special quality studies, billing audits, "HEDIS" reports which focus on the plan's performance but still require review of the provider's records, etc.).

While many managed care plans and health systems maintain the in-house staff to conduct quality audits, others choose to outsource the review function. For example, MEDISYS QI (MQI), a quality and utilization management consulting firm specializing in field data collection, reviewed medical records at over 5,000 primary care offices throughout the United States in 1999. Several of the medical record review standards stand out as being common problems:

Allergies are not prominently displayed in the medical record: physicians generally are very good at documenting allergies, but less good at documenting the absence of allergies. Recording "NKA" (no known allergies) on the chart's face sheet or in the allergy section of the presenting history page (which is often left blank) should be a simple task.

The problem list or medication list is not kept up to date: Many records contain charting forms that are either blank, or not updated as new chronic conditions are diagnosed and new long-term medications prescribed. For providers who maintain the problem and medication lists within the progress notes, most plans expect that this information will be recorded at each major visit.

Routine preventive care measures are not kept up to date: A variety of preventive care flow sheets and charting tools are available from managed care plans, professional societies, and advocacy groups to help providers quickly identify when preventive measures were administered and when they are next due. Many automated systems print out "ticklers" to remind the physician of which preventive measures are due at each visit. Providers need to consider introducing preventive measures and counseling into acute care visits for patients who only present to the office for acute, episodic care.

Education is not documented: Providers undoubtedly deliver a wealth of patient education and counseling on subjects such as health maintenance, importance of preventive care, and disease-specific instructions. However, for the purposes of quality review, if it isn't documented in the record, it never took place. Preventive care flow sheets that incorporate check boxes for education on substance use, nutrition, bicycle and automobile safety, advance directives, and other topics are increasingly being used to easily document compliance with insurer expectations.

Documentation of continuity is limited: Managed care plans increasingly are examining records for evidence of coordination and continuity of care. For example: if a referral to a specialist is noted in the record, is there also documentation of a report back from the specialist; are follow-up plans for acute and chronic care visits documented; and, are problems identified at previous visits addressed upon next presentation to the office?

Other commonly found problems include the following: providers who do not sign all progress notes in the record (particularly a problem in solo practices); lab reports and consultant reports that do not reflect physician initials or other evidence of review; and, records in which many pages do not contain patient identification.

Eradicating these common findings will not only help providers demonstrate a commitment to quality improvement efforts, but also focus the medical record review of the future on evaluating clinical quality.

About the Author

Neil Goldfarb is Program Director for the Office of Health Policy and Clinical Outcomes at Thomas Jefferson University.