magnolia health

			Facility:																	
			Date:																	
STANDARD #	POINTS POSSIBLE	STANDARD DESCRIPTION	MEMBER #1	MEMBER #2	MEMBER #3	MEMBER #4	MEMBER #5	MEMBER #6	MEMBER #7	MEMBER #8	MEMBER #9	MEMBER #10	MEMBER #11	MEMBER #12	MEMBER #13	MEMBER #14	MEMBER #15	TOTAL POINTS	TOTAL POSSIBLE	% / STANDARD
1	1	Member's name and/or medical record number is/are found on all chart pages.																0	15	0.00%
2	1	Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)																0	15	0.00%
3	1	Prominent notation of any spoken-language translation or communication assistance is included																0	15	0.00%
4	1	All entries must be legible and maintained in detail.																0	15	0.00%
5	1	All entries must be dated and signed or dictated by the provider rendering the care																0	15	0.00%
6	4	Significant illnesses and/or medical conditions are documented on the problem list, along with all past and current diagnoses.																0	60	0.00%
7	4	Medications, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If there are no allergies, "no known allergies" (NKA) or "no known drug allergies" (NKDA) should be documented.																0	60	0.00%
8	1	An up-to-date immunization record is established for pediatric members, or an appropriate history is made in the chart for adults.																0	15	0.00%
9	4	Evidence that preventive screening and services are offered in accordance with Magnolia Practice Guidelines is documented.																0	60	0.00%
10	1	Appropriate subjective and objective information pertinent to the member's presenting complaints are documented in the history and physical.																0	15	0.00%

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			Facility:		0							Surveyor:	0							
			Date:		1/0/1900															
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11	4	For adults, past medical history (for members seen three [3] or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.																0	60	0.00%
12	1	For children and adolescents (eighteen [18] years and younger), past medical history relating to prenatal care, birth, any operations and/or childhood illnesses is included.																0	15	0.00%
13	1	Working diagnosis is consistent with findings																0	15	0.00%
14	1	Treatment is appropriate for diagnosis.																0	15	0.00%
15	2	Treatment prescribed, therapy prescribed, and drug(s) administered or dispensed, including instructions to the member, are documented.																0	30	0.00%
16	4	Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns is included.																0	60	0.00%
17	1	Required consent forms are signed and dated.																0	15	0.00%
18	1	Unresolved problems from previous visits are addressed in subsequent visits and documented.																0	15	0.00%
19	2	Laboratory, and other studies ordered as appropriate, are documented																0	30	0.00%
20	1	Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entires should be initialed by the PCP to signify review.																0	15	0.00%
21	4	Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment(s) rendered elsewhere, including family planning services, preventative services, and services for the treatment of sexually transmitted diseases.																0	60	0.00%
22	1	Health teaching and/or counseling is documented.																0	15	0.00%
23	1	For members ten (10) years and over, appropriate notations are included concerning use of tobacco and alcohol and substance use (for members seen three [3] or more times, substance abuse history should be queried).																0	15	0.00%
24	1	Documentation of failure to keep an appointment is included.																0	15	0.00%
25	1	Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.																0	15	0.00%
26	1	Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem is documented.																0	15	0.00%
27	4	Confidentiality of member information and records is protected																0	60	0.00%
28	4	Evidence that an advance directive has been offered to adults eighteen (18) years of age and older is documented.																0	60	0.00%
		SCORE:																0	810	0.00%

Met= x Not Applicable= n/a Not met= *leave blank*

Needs Improvement

MEETS