Depression Clinical Practice Guidelines (CPG) Medical Record Audit (MRA) Report

The CPG Medical Record Audit (MRA) process assesses whether the provider's medical practices conform to clinical standards of practice. The audit tool serves as an instrument to gather information on the use of evidence-based clinical practice guidelines in order to identify the effectiveness, or lack thereof, of the treatment provided in accordance with the guidelines. This audit tool incorporates the standards, established and published by the American Psychological Association (APA), for the management and treatment of Depression.

https://www.apa.org/depression-guideline/guideline.pdf

What is a Clinical Practice Guideline?
Clinical practice guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances. —Consensus report, Institute of Medicine. Clinical practice guidelines we can trust. March 23, 2011

Purpose of Clinical Practice Guidelines
The intent of clinical practice guidelines are to:

1. Improve the quality of patient care and health care outcomes
2. Summarizes research findings and make clinical decisions more transparent
3. Reduce inappropriate variation in practice
4. Promote efficient use of resources
5. Identify gaps in knowledge and prioritize research activities
6. Provide guidance for consumers and inform and empower patients

Source: Davis D, Joanne G, Palda VA, Handbook on Clinical Practice Guidelines, Canadian Medical Association

The medical records to be audited under the MRA will be selected on a quarterly basis using a true random sample. The actual number of providers audited each quarter will reflect no less than 20% of the total allocated providers within the CMO. The clinical reviewer will randomly select 5 medical records of the selected providers for the review of Depression care according to the CPG. The Georgia Families CMOs are required to collaborate to develop a process of equally dividing all providers and assigning each CMO the same group of providers on an annual rotation. Individual CMO should create a review process that: 1) ensures at least 90% of total allocated providers are reviewed by the end of the review year and 2) avoids repeat reviews of any one provider, unless in the event of a reaudit for a previously identified deficit.

The provider's office manager or designee should be notified in advance of the pending MRA. The medical records should be pulled upon the arrival of the reviewer or may be submitted directly to the CMO (paper or electronic version) for review. Reviewers must utilize the DCH-approved forms (see attached) to conduct the audits. All individually identifiable health information must be kept confidential and private by the reviewer, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable Medicaid laws and regulations. The preliminary results of the audit shall be shared with the provider. Within seven (7) business days of the MRA, formal review findings must be given to the provider's office. Each reviewer/reviewing organization must comply with the DCH approved CPG MRA process when conducting the MRA.

CPG MRA Process:

1. Provider Audit

The CPG Provider Audit Form *(Form A)* should be completed for each provider selected through the random sample process. Based on the identified indicators, the reviewer should thoroughly evaluate the medical record to determine whether the provider's medical practices conform to the clinical practice guidelines for the particular medical condition. Weights have been assigned to each indicator based on the degree of its importance to the members' overall health outcomes. The weights are calculated to render a weighted rate. (Note: When an indicator is determined to be "not applicable," indicate NA. The assigned weight of that indicator will be credited in calculating total compliance rate).

2. Cumulative Medical Record Audit Report

The Cumulative Medical Record Audit Report *(Form B)* must be submitted to DCH within 30 days from the end of each quarter. The Cumulative MRA Report is a compilation of the weighted rates calculated for each quarter. The purpose of this document is to inform DCH and the CMOs of the quarterly trends for compliance with this CPG.

3. CPG Quarterly Report

The CPG Quarterly Report *(Form C)* must be submitted to DCH within 30 days from the end of each quarter. The Quarterly Report, which may be submitted as a Microsoft Word or Excel document, should be completed in accordance with the CPG MRA Specifications.

Rev. 06/2021

Form A - Provider Audit CMO Name: _____ Reporting Period: MM/DD/YYYY-MM/DD/YYYY

Physician ID/Name: _____ Office Contact: _____ Date of Audit: _____

Telephone: Auditor:

INDICATORS	MEDICAL RECORDS					Numerator	Denominator	Weights	Weighted Rate
						(A)	(B)	(C)	(A/B X C) X 100
Match Number to Patient in Confidential Manner	**1**	**2**	**3**	**4**	**5**	**Total # of charts compliant with indicators**	**Total # of charts audited**		
History								***20%***	**%**
Complete history taken of presenting symptoms from patient and all sources (i.e. caregivers, etc.). Include LMP, as needed, and weight (for pediatric patients).								*4%*	%
History taken includes family history of physical,mental and social health								*3%*	%
History taken includes history of depression, suidical ideation and attempts								*3%*	%
History taken includes history of prior treatment and response and known allergies								*4%*	%
History taken of comorbid conditions								*3%*	%
Assessment of changes in medical/ family history since last visit								*3%*	%
Behavioral Factors								***5%***	**%**
Documentation of physical activity and sleep behaviors								*2%*	%
Documentation of tobacco, alcohol and substance use								*3%*	%
Diagnostic Assessment								***25%***	**%**
Assessment of risk of harm to self or others								*8%*	%
Mental status examination								*9%*	%
Established diagnosis according to current diagnostic criteria								*8%*	%
Social Life Assessment								***5%***	**%**
Identified existing social supports								*2%*	%
Identified surrogate decision maker								*1%*	%
Identified social determinants of health (e.g. food security, housing stability and homeless, transportation access, financial security, community safety								*2%*	%
Treatment								***30%***	**%**
Presence of an up-to-date treatment plan in the chart (i.e. updated within a 3-6 month period of initial treatment plan)								*10%*	%
Treatment plan contains details about treatment setting, medications and treatment modalities to be used								*10%*	%
Documentation of medication monitoring and management (if member prescribed medication)								*5%*	%
Documentation of psychotherapy sessions or consultation with therapy provider								*5%*	%
Medications and Vaccinations								***10%***	**%**
Documentation of current medication regimen								*3%*	%
Documentation of medication intolerance or side effects								*4%*	%
Documentation of complementary and alternative medicine use								*3%*	%
Pscyhoeducation								***5%***	**%**

Assessment of member and caregiver (for minors and adults requiring caretakers) knowledge and understanding of illness								*2%*	%
Evidence of education about diagnosis and symptoms								*1%*	%
Evidence of education about treatment options								*1%*	%
Documentation of a safety plan in the chart and evidence that it has been reviewed with the member (and caregivers, as indicated)								*1%*	%
						TOTAL COMPLIANCE RATE			**%**

Note: Additional space has been provided in the event more than one medical record is selected for a provider.

When an indicator is determined to be "not applicable," the indicator should be removed from the denominator.

References

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310101/
https://www.apa.org/depression-guideline/guideline.pdf

Form B - Cumulative Medical Record Audit Report (Complete Quarterly) **CMO Name:** **Reporting Period: MM/DD/YYYY - MM/DD/YYYY**

	Indicators	Weights	QUARTER 1 Weighted Rate	QUARTER 2 Weighted Rate	QUARTER 3 Weighted Rate	QUARTER 4 Weighted Rate
	****History****	***20%***				
	Complete history taken of presenting symptoms from patient and all sources (i.e. caregivers, etc.)	*4%*				
	History taken includes family history of physical,mental and social health	*3%*				
	History taken includes history of depression, suidical ideation and attempts	*3%*				
	History taken includes history of prior treatment and response and known allergies	*4%*				
	History taken of comorbid conditions	*3%*				
	Assessment of changes in medical/ family history since last visit	*3*				
	****Behavioral Factors****	***5%***				
	Documentation of physical activity and sleep behaviors	*2%*				
	Documentation of tobacco, alcohol and substance abuse	*3%*				
	**** Diagnostic Assessment****	***25%***				
	Assessment of risk of harm to self or others	*8%*				
	Mental status examination	*9%*				
	Established diagnosis according to current diagnostic criteria	*8%*				
	****Social Life Assessment****	***5%***				
	Identified existing social supports	*2%*				
	Identified surrogate decision maker	*1%*				
	Identified social determinants of health (e.g. food security, housing stability and homeless, transportation access, financial security, community safety	*2%*				
	****Treatment****	***30%***				
	Presence of an up-to-date treatment plan in the chart (i.e. updated within a 3-6 month period of initial treatment plan)	*10%*				
	Treatment plan contains details about treatment setting, medications and treatment modalities to be used	*10%*				
	Documentation of medication monitoring and management (if member prescribed medication)	*5%*				
	Documentation of psychotherapy sessions or consultation with therapy provider	*5%*				
	****Medications and Vaccinations****	***10%***				
	Documentation of current medication regimen	*3%*				
	Documentation of medication intolerance or side effects	*4%*				
	Documentation of complementary and alternative medicine use	*3%*				
	****Psychoeducation****	***5%***				
	Assessment of member and caregiver (for minors and adults requiring caretakers) knowledge and understanding of illness	*2%*				
	Evidence of education about diagnosis and symptoms	*1%*				
	Evidence of education about treatment options	*1%*				
	Documentation of a safety plan in the chart and evidence that it has been reviewed with the member (and caregivers, as indicated)	*1%*				

Upper Respiratory Infection CPG Medical Record Audit Report
Specifications for Quarterly Report

(may submit report as Microsoft Word or Excel document)

DO NOT MODIFY			
Report Name	CPG Medical Record Review (MRR) Quarterly Report		
CMO Name	Enter name of CMO		
Report Date	Enter report date as MM/DD/YYYY		
Frequency	Submit report quarterly		
Reporting Period	**CPG Claims**	**Date of Review**	**Report Due**
	Jan 1 – Mar 31	Apr 1 – Jun 30	July 31
	Apr 1 – Jun 30	Jul 1 – Sept 30	Oct 31
	Jul 1 – Sept 30	Oct 1 – Dec 31	Jan 31
	Oct 1 – Dec 31	Jan 1 – Mar 31	April 30

FIELD	FIELD DESCRIPTION
Total Number of Records Reviewed	**Conduct a true random sample of records per providers who bill for services with diagnosis codes for the evidence-based clinical practice guideline (CPG) for Depression.** Enter total number of records reviewed this quarter.
Compliance Rate (%)	Enter compliance percentage rate for this quarter.
Total Number of Providers Reviewed	Enter total number of providers reviewed this quarter.
Total Number of Providers by Type	Using the "Total Number of Providers Reviewed" for this quarter, enter the total number of providers for each of the following categories: Family Medicine, Internal Medicine, Pediatrician, NP/PA, Behavioral Health, Specialist Acting as PCP or Other."
Quarterly Summary of Top 3 Provider Audit Deficits	Review deficits as indicated on Form A: Provider Audit. Enter the top 3 deficiency areas in the numbered cells.
Number of Providers with this deficit	For each of the Top 3 deficiencies listed, enter the total number of providers for each deficiency. A deficiency occurs if a provider scores a total compliance rate of less than eighty percent (80%).
Deficits Outcome	**Provider Focused Review:** for providers with deficits in the same CPG for two or more audited records, provide feedback and re-audit for initial CPG if deficits are identified from the re-audit, provide coaching by supervising clinician or a designee of equal or higher clinical practice, and re-audit. If no deficits at second re-audit, no further action is needed. For deficits beyond second re-audit, consider continuing education, or provide proctoring. CMOs will complete a Corrective Action Plan (CAP) for providers with persistent deficiencies. **System Focused Review:** if total number of providers with deficit in any of the top three deficits is equal to or more than 20% of total reviewed providers for the quarter, CMOs will audit additional 10 randomly selected records per related CPG. If evidence of deficit, provide system wide provider education. Re-audit the following quarter. If deficit falls below threshold, no further action is required. If deficit persists, identify offending providers and initiate Provider Focused Review. For persistent system wide deficiencies, the CMOs will complete a Corrective Action Plan (CAP) for providers.

Form C- Quarterly Report

CMO Name:_____

Report Date: MM/DD/YYYY _____ **Reporting Period:** MM/DD/YYYY- MM/DD/YYYY _____

Overview

Quarterly Medical Record Review Summary	
Total Number of Records Reviewed	
Total Number of Providers Reviewed	
Total Compliance Rate (%)	

Provider Summary

Total Number of Providers by Type	
Family Medicine	
Internal Medicine	
Pediatrician	
NP/PA	
Behavioral Health	
Specialist Acting as PCP	
Other	

Provider Summary

	Quarterly Summary of Top 3 Office Review Deficits ➪	Number of Providers with this deficit	Focus Review	Review Type
1			Yes/No	
2			Yes/No	
3			Yes/No	

This form must be reviewed, signed, and dated by the CMO's Chief Medical Officer and submitted with each Georgia Families Clinical Practice Guidelines quarterly reports, as specified, to DCH via the CMO report portal. Graphs, charts, and other documentation can be attached to this form.

I, _____, do hereby attest that the above information is true and correct to the best of my knowledge.

Date: _____