PeakHealth

Clinical Practice Guidelines Audit Process 2026

Clinical Practice Guidelines (CPGs) are designed to establish standards of care, reduce variations in provider practices, support decision-making in patient care, and improve overall healthcare outcomes. This brochure aims to provide a detailed overview of the medical record audit process for select CPGs.

The Peak Health Quality Improvement Department (PHQID) uses CPGs to guide quality of care reviews and improvement initiatives. As part of this effort, annual provider audits are conducted to assess adherence to clinical best practices and identify areas for improvement.

PHQID will begin monitoring adherence to CPGs Q1 2026, reviewing records from calendar year 2025 for the following conditions:

- Depression
- Diabetes
- Hypertension

This brochure provides a comprehensive overview of PHQID's medical record audit process. These audits are part of our ongoing quality assurance efforts to ensure members receive care aligned with the most current, evidence-based clinical standards.

Provider Selection and Audit Frequency

PHQID conducts annual audits using a random sample of medical records. Any provider submitting Peak Medicare Advantage member claims with a primary diagnosis of depression, diabetes, or hypertension is eligible for audit. For each selected CPG, the PHQID will review 30 charts to assess how well providers are adhering to guideline standards.

Audit Process

Audit tools are based on standards set by nationally recognized organizations such as the American Psychological Association (APA), American Diabetes Association (ADA), the American College of Cardiology (ACC), and The National Committee for Quality Assurance (NCQA) and will outline key indicators for documentation and clinical compliance used in the medical record reviews.
Providers must achieve an audit score of 80% or higher for each record reviewed.

What Providers Can Expect

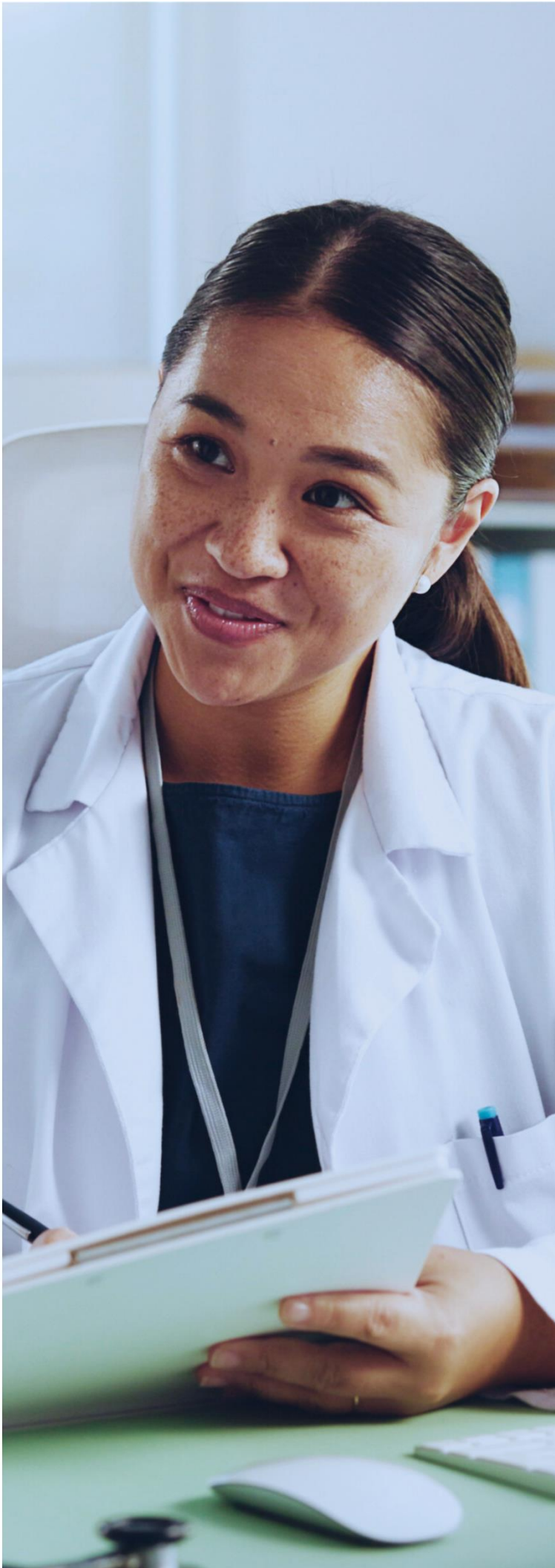
- Annual chart reviews.
- Feedback and guidance when compliance gaps are identified.
- Opportunities for re-audits and support to improve performance.
- Integration of audit results into provider credentialing files.
- Annual review and updates to audit tools and scoring requirements as applicable.

Access and Communication

All CPG audit tools, scoring criteria, and updates are:

- Available online on the Peak Health Provider Resources webpage.
- Communicated through the Provider Network team.

The Peak Health CPG Audit Program ensures that care delivered across our provider network aligns with the highest standards of quality. By monitoring adherence to clinical guidelines, offering support and feedback, and incorporating audit results into provider credentialing, we aim to continually improve care for our members while supporting excellence in provider performance.



Depression Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with depression:

Depression Medical Record Indicators	Weight
Critical Element **This critical element must be met to pass the audit regardless of compliance with other indicators	Pass / Fail
Screened for depression using a standardized instrument with documentation of total score during the audit year.	
Vital Signs	**10%**
Documentation of the following elements: Height and weight with BMI (individual weight 2%) Temperature (individual weight 1%) Pulse (individual weight 1%) Respiratory rate (individual weight 1%) Blood pressure (with documented repeat blood pressure if initial systolic reading is ≥ 140 or diastolic reading is ≥ 90) (individual weight 5%)	10%
Medications	**10%**
Documentation of medication reconciliation, if applicable (e.g., if medication prescribed, validate patient taking correctly, drug interactions, contraindications)	8%
Documentation of medication allergies or NKDA	2%
Medical and Behavioral History	**30%**
Complete history of presenting behavioral symptoms (e.g., depression, suicidal ideation, suicide attempts) from patient and all sources (e.g., caregivers)	5%
Family history of mental and social health (e.g., depression, suicidal ideation, suicide attempts)	3%
History of prior treatment and response	3%
Comorbid conditions (e.g., comorbid psychiatric disorders such as anxiety, schizophrenia, bipolar disorder)	5%
Assessment of risk of harm to self or others	10%
Documentation of physical activity and sleep behaviors	1%
Documentation of tobacco, alcohol and substance use	3%
Education and Referrals	**13%**
Education on self-management, lifestyle changes (e.g., tobacco cessation, alcohol use, eating disorders)	3%

Depression Medical Record Indicators	Weight
Education and Referrals Continued	
Education about diagnosis, symptoms, treatment options and treatment plan	5%
Referrals to specialists (e.g., LSW, CBT, Psychotherapy)	5%
Social Life Assessment	**4%**
Documentation of existing social support, identification of surrogate decision maker, advance care plan	2%
Identification of social determinants of health (e.g., food security, housing stability and homelessness, transportation access, financial security, community safety) (within the last 12 months)	2%
Treatment/Therapy	**33%**
Presence of an up-to-date treatment plan in the chart corresponding to depression screening score	11%
Treatment plan contains details about treatment setting, medications and treatment modalities to be used	11%
Documentation of medication monitoring and management (if patient is prescribed medication)	6%
Documentation of psychotherapy sessions or consultation with therapy provider if applicable	5%

Resources:

American Psychological Association (2021). Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (apa.org)

American Family Physician (2018). Depression: Screening and Diagnosis | AAFP

National Committee for Quality Assurance. (2025). Technical Specifications For Health Plans Volume 2

Diabetes Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with diabetes:

Diabetes Medical Record Indicators	Weight
Critical Element **This critical element must be met to pass the audit regardless of compliance with other indicators	Pass / Fail
HBA1c or eAG Completed during the audit year	
Vital Signs	**10%**
Documentation of the following elements: Height and weight with BMI (individual weight 2%) Temperature (individual weight 1%) Pulse (individual weight 1%) Respiratory rate (individual weight 1%) Blood pressure (with documented repeat blood pressure if initial systolic reading is ≥ 140 or diastolic reading is ≥ 90) (individual weight 5%)	10%
Medications	**8%**
Documentation of medication reconciliation, if applicable (e.g., if medication prescribed, validate patient taking correctly, drug interactions, contraindications)	7%
Documentation of medication allergies or NKDA	1%
Medical and Behavioral History	**25%**
Assessment of signs/symptoms of diabetes complications (e.g., hypoglycemia, hyperglycemia, macrovascular and microvascular complications)	5%
Review of previous treatment regimens and responses	4%
Frequency/cause/severity of past hospitalizations (if applicable)	2%
Changes in medical and family history since last visit	2%
Comorbid conditions (e.g., obesity, hypertension, dyslipidemia, heart disease, kidney disease	4%
ASCVD Risk	2%
Tobacco, alcohol, and substance use	2%
Nutrition and weight history	2%
Physical Activity / Exercise	2%

Diabetes Medical Record Indicators	Weights
Education and Referrals	**10%**
Education on self-management, lifestyle changes (e.g., tobacco cessation, alcohol use, diet and exercise) and other education as needed	3%
Education about diagnosis, symptoms, treatment options and treatment plan	5%
Referrals to specialists (e.g., podiatrist, endocrinologist, nutritionist, ophthalmologist, nephrologist, neurologist, dentist), if applicable	2%
Social Life Assessment	**4%**
Documentation of existing social support, identification of surrogate decision maker, advance care plan.	2%
Identification of social determinants of health (e.g., food security, housing stability and homelessness, transportation access, financial security, community safety) during the audit period	2%
Diabetes Treatment/Management	**43%**
Presence of an up-to-date treatment plan that contains details about treatment, setting, and modalities to be used	5%
Fasting lipid profile	3%
Testing for glucose control: • Estimated average glucose (eAG) ≤ 9% • Hemoglobin A1c results ≤ 9%	10%
Kidney Health Evaluation • Estimated glomerular filtration rate (eGFR) • Urine albumin-creatinine ratio (uACR)	10%
Retinal Eye Exam • Completed retinal or dilated eye exam during the audit year or • A negative retinal or dilated exam completed the year prior to the audit year or • Referral order for eye exam or • Documentation that patient declined screening, reasons for declining, and education was provided	10%
Additional Exams • Foot exam (individual weight 2%) • Neuropathy exam (individual weight 3%)	5%

Resources:

American Diabetes Association | Clinical Diabetes (2024). Improving Care and Promoting Health in Populations: Standards of Care in Diabetes—2024 | Diabetes Care | American Diabetes Association

American Association of Clinical Endocrinology | Clinical Guidance 2023 AACE Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm | American Association of Clinical Endocrinology

Hypertension Medical Record Indicators

The following documentation is required (as clinically appropriate) for patients with hypertension:

Hypertension Medical Record Indicators	Weights
Critical Element **This critical element must be met to pass the audit regardless of compliance with other indicators	Pass/Fail
Blood pressure (with documented repeated blood pressure if initial systolic reading is ≥ 140 or diastolic reading is ≥ 90)	
Vital Signs	**10%**
Documentation of the following elements: Height and weight with BMI (individual weight 2%) Temperature (individual weight 1%) Pulse (individual weight 1%) Respiratory rate (individual weight 1%) Blood pressure (individual weight 5%)	
Medications	**10%**
Documentation of medication reconciliation, if applicable (e.g., if medication prescribed, validate patient taking correctly, drug interactions, contraindications)	9%
Documentation of medication allergies or NKDA	1%
Medical and Behavioral History	**25%**
Assessment of signs/symptoms of hypertension/coexistent illnesses (e.g., chest pain, shortness of breath, palpitations, headaches, blurred vision, nocturia, dizziness)	5%
Review of previous treatment regimens and responses	4%
Frequency/cause/severity of past hospitalizations (if applicable)	2%
Changes in medical and family history since last visit	2%
Comorbid conditions (e.g., obesity, diabetes, dyslipidemia, heart disease, kidney disease	4%
ASCVD Risk	2%
Tobacco, alcohol, and substance use	2%
Nutrition and weight history	2%
Documentation of physical activity	2%

Hypertension Medical Record Indicators	Weights
Education and Referrals	**13%**
Education on blood pressure monitoring, self-management, lifestyle changes (e.g., nutrition/diet/weight management such as DASH eating plan, dietary sodium reduction, etc.) and/or other education,	5%
Education about diagnosis, symptoms, treatment options and treatment plan	3%
Referrals to specialists (e.g., cardiologist, nephrologist, nutritionist, etc.), if applicable	5%
Social Life Assessment	**4%**
Documentation of existing social support, identification of surrogate decision maker, advanced care plan,	2%
Identification of social determinants of health (e.g., food security, housing stability and homelessness, transportation access, financial security, community safety) during the audit period.	2%
Hypertension Treatment / Management	**38%**
Presence of an up-to-date treatment plan that contains details about treatment, setting, and modalities to be used	5%
Home monitoring or reported blood pressures – including how readings were obtained i.ie., manual reading, digital cuff, or remote monitoring	10%
Annual EKG	5%
Fasting glucose or HBA1c	5%
Fasting Lipid Panel	5%
Serum creatinine/eGFR	8%

Resources:

Annals of Family Medicine (2023) AAFP Issues New Clinical Practice Guideline on Hypertension | Annals of Family Medicine

AHA| ASA Journals Circulation (2022) Harmonization of the American College of Cardiology/American Heart Association and European Society of Cardiology/European Society of Hypertension Blood Pressure/Hypertension Guidelines: Comparisons, Reflections, and Recommendations | Circulation

AHA| ASA Journals Hypertension (2020) 2020 International Society of Hypertension Global Hypertension Practice Guidelines | Hypertension

Journals of the American College of Cardiology (2017) 2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults | Journal of the American College of Cardiology