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Pediatric and Adolescent Medical Record Review Tool

Primary Care Provider:		
Member Name:	**DOB:**	**Member ID#:**
Provider Name:		**Provider ID #:**
Product:	**Date of Review:**	**Initials of Reviewer:**

The Medical Record contains the following patient information:

1. Patient Identification

⇒ Each page within the Medical Record contains the patient's name **or** ID number on **both** sides of the page.

2. Personal Biographical Data
Mark off each data element found in Medical Record:

- ☐ DOB
- ☐ Gender
- ☐ Address
- ☐ Home telephone number(s)
- ☐ Parent(s)/guardian(s) name(s)
- ☐ Parent(s)/guardian(s) occupation(s) (NO SCORE)
- ☐ Parent(s)/guardian(s) employer(s) (NO SCORE)
- ☐ Parent(s)/guardian(s) work telephone number(s)
- ☐ Grade in school/college
- ☐ Name of school/college

3. All entries in the Medical Record contain the author's identification.

☐ Author identification may be a handwritten signature, initials, an initials-stamped signature or a unique electronic identifier.

4. All entries in the Medical Record are dated.

5. The Medical Record is legible to someone other than the writer.

Is the record an Electronic Medical Record (EMR)?

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6. Allergies and Adverse Reactions are <u>prominently noted</u> in the record, or "NKA" is noted.

☐ <u>Prominently noted</u> refers to: on the front of the chart **or** inside the front cover of chart **or** on a designated problem list <u>or</u> medication page **or** at the time of each office visit**.**

☐ <u>Updated</u> at a <u>minimum</u> of annually (preferably during a physical).

7. Medication Record

☐ A medication record/list includes dosages and dates for initial and refill prescriptions.

☐ Discussion of medication side effects and symptoms with the member/parent/guardian and documented.

☐ Medication Adherence Review for compliance for maintenance medications for members with chronic conditions.

☐ Documentation of drug samples. (NO SCORE)

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8. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

The baseline history and physical are comprehensive and include a review of:

⇒ Baseline History:

Family history, psychosocial and medical-surgical history must contain at least one qualifier.

- ☐ Family history - including pertinent medical history of parents and/or sibling(s)
- ☐ Psychosocial history - including occupation, education, ethnicity, primary language, living situation, mental health issues/problems, socioeconomic issues/problems, risk behaviors
- ☐ Medical-surgical history - including serious accidents, injuries, operations, illnesses/diseases (acute or chronic), and mental health/substance abuse issues

- ☐ Prenatal care, delivery and birth history.

⇒ Baseline Physical:

- ☐ A comprehensive review of systems **with** an assessment of presenting complaints (as applicable)
- ☐ A comprehensive assessment of health and development (physical and psychosocial)

The periodic history and physical are comprehensive and include a review of:

⇒ Periodic History and Physicals:

- ☐ Should be repeated in accordance with age-appropriate preventive care guidelines.

⇒ Periodic History:

Family history, psychosocial and medical-surgical history must contain at least one qualifier.

- ☐ An updated family history
- ☐ An updated psychosocial history
- ☐ An updated medical-surgical history

⇒ Periodic Physical:

- ☐ A comprehensive review of systems **with** an assessment of presenting complaints, as applicable.
- ☐ An updated assessment of health and development (physical and psychosocial)

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9. High-Risk Behaviors and Anticipatory Guidance

There is appropriate notation regarding the inquiry and/or teaching of specific topics **and** appropriate notation concerning high-risk behavior inquiry. Based on the child's age, the inquiry and/or teaching and the high-risk may be completed with the parent(s)/guardian(s). (If a topic is not applicable, indicate accordingly and points are given).

- ☐ Tobacco/cigarette query – starting at age 11 years
- ☐ Alcohol query – starting at age 11 years
- ☐ Substance abuse query – starting at age 11 years
- ☐ HIV/STD/Hepatitis risk query – starting at age 11 years (STD screening if sexually active starting at 11 years, HIV screening starting at age 13 including those that are pregnant)
- ☐ Nutrition guidance
- ☐ Dental referral – should be done at 6, 9, 12 months; ages 2-20 dental check-ups twice a year
- ☐ Injury/safety prevention
- ☐ Violence/abuse query/discussion
- ☐ Social/emotional health/depression query – starting at age 11
- ☐ Activity/exercise query
- ☐ Illness prevention
- ☐ Sleep positioning counseling
- ☐ Skin cancer counseling starting at age 10 for those with fair skin

And

⇒ ☐ **Is the patient/parent/guardian counseled regarding high-risk behavior(s) or referred to appropriate treatment.**

10. Laboratory and other studies are ordered, as appropriate.

☐ Laboratory and other diagnostic studies are appropriate for the clinical findings and/or diagnoses stated and consistent with preventive care guidelines.

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11. Communicable Disease(s) are reported to appropriate regulatory agencies and documented in the MR. (Reference list of NYS/NYC reportable communicable diseases)

Document Communicable Disease and Regulatory Agency:

_____

12. Routine or follow-up visits must include:

☐ A focused review of systems based upon presenting complaints, active (acute) medical or psychosocial problems, or management of a chronic, serious or disabling condition.

☐ Unresolved problems from previous office visits are addressed in subsequent visits.

13. Uses the patient teach-back educational method for office teaching. (NO SCORE)

14. Treatment plans are consistent with diagnoses.

☐ Addresses each chief complaint (subjective/objective) and clinical finding with a plan of care consistent with standards of care and clinical practice (including further diagnostic testing, procedures, medication, referrals, etc.).

☐ The PCP documents discussion(s) and agreed upon decision(s) with the member/guardian of potential treatment options that are available to them regarding their health care needs.

15. Follow-Up Notation

☐ Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time to return is noted in days, weeks, months, or as needed.

16. No-shows or missed appointments should be documented including follow-up efforts to reschedule appointment.

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17. Follow-up after an ED visit or hospitalization. Date(s) listed for ED and/or hospitalizations:_____

⇒ An office visit, written correspondence or telephone follow-up intervention is clearly documented in the PCP record.

18. Continuity of care.

☐ **Indicate whether a specialist consultation:**

Name/Specialty: _____

Or

☐ **If whether a diagnostic study:**

Name of Diagnostic Study: _____

☐ If a consultation or diagnostic study is requested, there is a note or report from the consultant in the record.

☐ The ordering health care provider initials consultation and diagnostic study reports filed in the chart.

☐ Abnormal consultation and diagnostic study results have an explicit notation of follow-up plans in the record.

19. The Medical Record reflects an appropriate utilization of Consultants.

☐ Review of Medical Record for Under- or Over-Utilization of Referrals to Consultants.

- Evidence of Under-Utilization: Yes ☐ or No ☐

Definition: Unresolved acute or chronic illness(es) and/or symptoms are being actively treated or monitored by the PCP without referral(s) to an appropriate specialist/consultant.

- Evidence of Over-Utilization: Yes ☐ or No ☐

Definition: A consistent pattern of referrals to a consultant without PCP formulating a treatment plan based on assessment of presenting symptoms.

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20. Care rendered is medically appropriate/Follows Clinical Practice Guidelines, Standard of Care. *NO SCORE*

Y N

☐ ☐ *(If this standard is not met, the case is **immediately** referred to the Medical Director for a quality of care review).*

Definition: There is evidence that the patient may be placed at inappropriate risk by an inadequate(ly), incorrect(ly), or inappropriately:

⇒ Performed physical examination or assessment
⇒ Performed procedure
⇒ Performed diagnostic studies, including but not limited to lost specimens, poor film quality, misread results or delayed turnaround time
⇒ Diagnosed the member
⇒ Prescribed, dispensed or administered medication
⇒ Developed and/or implemented treatment plan
⇒ Other errors, delays or omissions in the delivery of care

21. Immunization

⇒☐ An appropriate immunization history has been made with notation that immunizations are up to date (See Adult Immunization Schedule).

⇒☐ Immunizations administered after May 1992 contain lot number and manufacturer's name. (*Must have 100% compliance)*

22. Advance Directives

⇒ Documentation in the Medical Record of all patients (patients/guardians depending on age) at least 45 years and older **(if younger, as appropriate)** that advance directives have been discussed. If the patient's choice is to make an advance directive, there should be a copy of it in the MR and the records should be flagged.

23. Preventive Health Guidelines. Indicate: Male ☐ Female ☐ Age: _____

There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines. (Reference: Pediatric and Adolescent Preventive Services)
(Refer to high-risk behaviors for additional screening not included in this section.)

⇒ **Measurements:**

☐ Height – annually
☐ Weight – annually
☐ Pulse/respirations and temperature (as appropriate)
☐ BMI percentile – annually starting at age 2 years. Date done_____
☐ BMI value – age 16 and over
☐ Head circumference – at every visit until age 2 years
☐ Blood pressure – annually starting at age 3 years

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⇒ **Sensory Screening**
- ☐ Vision screening – starting at age 3 annually until age 21
- ☐ Hearing screening – starting at age 4 annually until age 21

⇒ ☐ **Developmental/Behavioral Milestones by history and appropriate physical examination. If suspicious, appropriate referral for specific developmental testing.**

⇒ ☐ **Parenting Skills should be fostered at every visit.**

⇒ **Procedures: General**
- ☐ Lead testing (NYS mandated) at 12 months and 24 months of age.
  Date done_____
- ☐ H&H at 12 months of age
- ☐ Urinalysis at least once during teen years
- ☐ Cholesterol screening to be done between ages 9 and 11 and again between ages 17 and 21
- ☐ Hereditary and metabolic screening (e.g., Thyroid, Hemoglobinopathies, PKU, Galactosemia)

⇒ **Procedures: For Those At Risk**
- ☐ TB testing
- ☐ HIVscreening, starting at age 13, including those that are pregnant
- ☐ STD screening (chlamydia, gonorrhea, syphilis) if sexually active starting at 11 years
- ☐ Hepatitis B testing
- ☐ Pelvic exam (offered for sexually active females as applicable)
- ☐ Skin cancer counseling – starting at age 10 for fair skinned children

24. Child Abuse
- ☐ Screening for child abuse is conducted
- ☐ Suspected child abuse is reported to appropriate regulatory agencies and documented

End of Pediatric and Adolescent Medical Record Review Tool