The Clinical Practice Evaluation (CPE) tool contains two parts. **Part I** is designed to review a random selection of the diplomate's patient medical records regarding his/her practice of clinical preventive medicine. It is available in two formats (adult and pediatric): please choose the version that is most appropriate for your patient population. Part II is designed to review the diplomate's integration of prevention practice into the system within which he/she provides care. It is the same tool regardless of your patient population. **The diplomate must complete both parts of the clinical practice assessment** (i.e., CPE I (adult) OR CPE I (child) AND CPE II).

If your practice is predominantly or exclusively children, please follow the instruction below to complete CPE I –Medical Record Review (Pediatric Patient Population). If your practice is predominantly or exclusively adults, please see the instructions for CPE I (Adult Patient Population). There is a separate set of instructions for CPE II – Clinical Systems Review.

Please pull a random sample of **ten charts of pediatric patients** for whom you provide preventive care and complete the **Medical Record Review** form for each chart, according to the instructions below. Please make 10 copies of the blank form, as you will be completing one form for each chart you review. Please remember to write your complete name on each page where indicated prior to initiating your record review.

Part A. Record Identifier Information

1. Enter the date the medical record is reviewed, using the format: mm/dd/year.

2. Create a patient identifier and fill in the blank. *Do not enter the patient's name*. Maintain a record of the patient identifier used for each chart, as you will review the **same patients'** medical records following implementation of your Quality Improvement plan.

3. Enter the date of the patient's most recent visit, using the format: mm/dd/year.

4. Circle the patient's gender.

5. Enter the patient's age in the blank.

Part B. History

1. Indicate whether the patient's medical record documents an **initial** history during his/her first visit to your practice by circling the appropriate response.

2. Indicate whether the patient's medical record documents an **interval** history by checking the appropriate box for each age specified in the chart, according to the following definitions:

Yes = chart contains documentation of interval history at specified age
No = chart does not contain documentation of interval history at specified age
N/A = patient entered practice after a specified age OR patient has not yet reached that age

Part C. Objective Findings

Please review the selected chart to assess documentation of physical findings from the patient's most recent examination and fill in the following on the Medical Record Review form. If no

measurement is documented for any of these physical findings, enter "0" in that blank.

Head circumference – number; circle appropriate units or circle N/A
Height/length – number; circle appropriate units
Weight – number; circle appropriate units (only note if in chart; do NOT calculate for form)
Body Mass Index - number
Blood pressure – ratio in mm Hg

Part D. Screening

1. Review the selected chart to assess documentation of **newborn** screening for the health conditions listed on the Medical Record Review form. The current United States Preventive Services Task Force (USPSTF) recommendations are noted below the list of conditions. For each condition, circle the appropriate response regarding screening according to the following definitions:

Yes = chart contains documentation of recommended screening for the disease
No = chart documents that patient did not receive screening as recommended
Unsure = chart does not clearly specify screening for the disease
N/A = screening for this disease is not appropriate, based on patient's age, gender, or risk status

2. Review the selected chart to assess documentation of **childhood** screening for the health conditions listed on the Medical Record Review form. The current United States Preventive Services Task Force (USPSTF) recommendations are noted below the list of conditions. For each condition, circle the appropriate response regarding screening according to the following definitions:

Yes = chart contains documentation of recommended screening for the disease
No = chart documents that patient did not receive screening as recommended
Unsure = chart does not clearly specify screening for the disease
N/A = screening for this disease is not appropriate, based on patient's age, gender, or risk status

3. Review the selected chart to assess documentation of **adolescent** screening for the health conditions listed on the Medical Record Review form. The current United States Preventive Services Task Force (USPSTF) recommendation is listed below each condition. For each condition, circle the appropriate response regarding screening according to the following definitions:

Yes = chart contains documentation of recommended screening for the disease
No = chart documents that patient did not receive screening as recommended
Unsure = chart does not clearly specify screening for the disease
N/A = screening for this disease is not appropriate, based on patient's age, gender, or risk status

Part E. Intervention

1. Review the selected chart to assess documentation of the patient receiving counseling for the clinical situations listed on the Medical Record Review form. The current USPSTF recommendation is listed below each topic. Place an "X" in the blank in front of each topic for which the patience received counseling. If the patient has received counseling on additional health

topics, please check "Other" and list the topic(s) in the blank. If there is no documentation of *any* counseling recommendations, check "None of the above."

2. Review the selected chart to assess documentation of the patient having received the chemoprevention interventions listed on the Medical Record Review form. The current USPSTF or ACIP (CDC's Advisory Committee on Immunization Practices) recommendation is listed below each topic; please see published guidelines for greater detail. Place an "X" in the blank in front of each type of chemoprevention the patient is currently using (medications) or has received (vaccinations). If the patient has received additional chemoprevention, please check "Other" and list the medication(s)/intervention(s) in the blank. If there is no documentation of *any* chemoprevention, check "none of the above."

3. Review the selected chart to assess documentation of any of the conditions listed on the Medical Record Review form limiting the patient's ability to engage in age-appropriate activities. For each condition, circle the appropriate response, according to the following definitions:

Yes = chart contains documentation of specific condition limiting patient's ability to perform age-appropriate activities
No = chart contains documentation that specific condition does not limit patient's ability to perform age-appropriate activities
Unsure = chart does not clearly specify whether specific condition limits patient's ability to perform age-appropriate activities

You have reached the end of the Medical record review for this patient. Please repeat this process (review the chart and compete a Medical Record Review form) on a total of ten pediatric patients. Please retain all forms, as you will need to send your completed evaluation and supporting documentation to the American College of Preventive Medicine after completing the **Diplomate Practice Assessment Plan (DPAP) cycle.**

Return to the DPAP to complete the remainder of the Diplomate Practice Assessment Plan.