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

Please pull a random sample of **ten charts of adult 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. Risk Factors**

Review the selected chart to assess documentation of risk factors for the health conditions listed on the Medical Record Review form. Please note that some categories have more than one condition. For each disease, circle the appropriate response, according to the following definitions:

Yes = chart contains documentation of presence or absence of risk factors for the disease
No = chart does not contain documentation of risk factor assessment
N/A = assessment of risk factors for this disease is not appropriate, given the patient's age or gender

**Part C. Diagnoses**

Review the selected chart to assess documentation of diagnosis of the health conditions listed on the Medical Record Review form. Please note that some categories have more than one

condition. For each disease listed, circle the appropriate response according to the following definitions:

Yes = chart contains documentation of diagnosis of the disease
No = chart documents absence of the disease
Unsure = chart does not clearly specify a diagnosis/absence of the disease

On the line following "Other," write in any diagnoses within that category which are documented in the patient's medical record but are not listed on the form.

**Part D. Objective Findings**

1. Please review the 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.

Weight – number; circle appropriate units
Height – number; circle appropriate units.
BMI – body mass index (only note if in chart; do NOT calculate for form)
Systolic BP – systolic blood pressure in mm Hg
Diastolic BP – diastolic blood pressure in mm Hg

2. Indicate the date (month/year) of the most recent lipid profile and fill in values (in mg/dL) of the patient's total cholesterol and HDL cholesterol on the Medical Record Review form. If there is no documentation indicated the test has ever been performed, circle "Not done." If a test is documented, but no value is documented in the chart for one or both cholesterol measurements, enter "0" in that blank.

**Part E. Screening**

Review the selected chart to assess documentation of 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 definitions below and, on the line underneath, indicate the specific screening test utilized, if screening was performed.

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 recommended screening for the disease
N/A = screening for this disease is not appropriate, give the patient's gender, age, or risk status

**Part F. Intervention**

1. Review the selected chart to assess documentation of the patient having received counseling for the clinical situations listed on the Medical Record Review form. The current USPSTF recommendation is listed below each applicable topic. Place an "X" in the blank in front of each topic for which the patient 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 review. 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 that 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)/vaccination(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 perform activities of daily living (ADLs). For each condition, circle the appropriate response, according to the following definitions:

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

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 adult 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.