Guidelines for Reviewing Medical Records

Introduction

The purpose of this review is to capture from medical records: 1) the experience of children (0 – 5) and parents in their pediatric primary care clinic, and 2) health professional (HP) practice behavior - regarding psychosocial problems (parental depression, intimate partner (or domestic) violence, substance abuse, food insecurity, harsh discipline and major stress).

Someone in the office should identify children 0 – 5 years of age who had at least one checkup by the SEEK health professional (HP), within the past x months; period to be determined. From those eligible children, a random sample of 10 medical records should be selected; for example beginning on day 1, the first such patient, followed by day 2 the 2nd patient, and so on. The selection should be by staff NOT directly associated with patient care.

The record abstractor should thus have a list of 10 children in the practice for a specific HP(s) whose records are to be reviewed.

General Pointers

Checkups – Be sure to focus only on the last checkup visit, not “sick” visits. And, only during the period of interest (eg, the prior x months). Only consider visits with the HP(s) you’re reviewing.

Please be aware of the schedule for using the SEEK Parent Questionnaire (PQ) in the office, and whether the visit being reviewed was SEEK PQ eligible or not. Eg, is the PQ is administered at 2, 9, 15, 24, 36, 48 and 60 months, the 18-month visit should be documented as SEEK PQ eligible: Y___ N X.

Please document whether the PQ was used, in relation to that visit. If there is a corresponding PQ, even if partially completed, this will mean that ALL the risk factors were screened for – for that visit. If the PQ is totally blank = no screen done.

If applicable to the practice, please also review notes by a social worker or mental health provider – associated with that visit, including contacts within a month. Eg, the screen may have been positive for depression, and the assessment may have been done later by a social worker.

A first goal is to capture what transpired regarding possible parental depression, domestic violence, substance abuse, corporal punishment, food insecurity and major parental stress. All regular checkups - during the period of interest (eg, whole life, past year, past two months) – should be reviewed. Please begin with the earliest visit from that period.

Specific Pointers

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1. **Screen:** Any indication that the HP screened for the problem should be considered a screen, including use of the SEEK PQ, and even if only partially completed. If another questionnaire is used, consider each of the targeted problems. Eg, if it includes a screen for depression, that counts.

   If the screen identified a possible or likely problem, “screen” should be coded “2.” If no problem was detected, code “1.” And, if there is no documentation that the problem was screened for, code “0.”

   At times a problem will be noted, perhaps only under the Plan; if so, code that an assessment was done (ie, giving the benefit of the doubt) and that a problem was identified (code = 1). But, code screen = 0, unless there is indication a screen occurred. It may be that without screening, a problem became apparent during the visit. Sometimes there are discrepancies between the PQ (eg, no problem) and the HP’s assessment (eg, a problem). If EITHER indicates a problem, go with that.

   It can be tricky knowing whether screening was done for stress. The HP may document who lives at home; this is too general and should not be counted. Code screen as a “0”. Same for “grandmother caring for baby while mom at work” or “dad helps with night time feedings.” Also, do not consider notations such as “dad not involved, mom has 3 other kids under age 5” as a screen for stress. But “Mom has 3 kids under age 5, but is coping well” should be considered as a screen for stress.

   0 = No screening done
   1 = Screening done, but no problem identified
   2 = Screening done, possible problem identified

2. **Assessment:** Any effort to assess the possible problem counts as an assessment having been done. Note, the assessment may have been done by the project social worker whose notes may be elsewhere in the record. There may be times when a problem is identified and/or an action recorded, without documentation of an assessment. We will assume that the problem was assessed, and a problem identified; code = 2

   0 = No assessment done
   1 = Assessment done, no problem identified
   2 = Assessment done, problem identified
   3 = Assessment deferred to another professional

3. **Action:** If there is no indication of any action pertaining to the problem, code “0.” However, any action should be coded “1.” This includes, for example, “reassurance”, “schedule f/u visit”, or “refer to SW.” If, for example, a few screens are positive or problems noted, a single action (eg, SW referral) may apply to all, even if not explicitly documented. Be generous, and code the action as pertaining to both problems.
0 = No action
1 = Action taken

4. **Type of Action:** Note that **several actions and codes may apply.** For “other,” briefly describe the action.

**Specific Problems:** There may be interest in documenting whether specific conditions or problems occurred before and during implementation of SEEK. If so, a decision needs to be made re. how far back to go (eg, from birth, starting one year prior to implementing SEEK)

Ideally, this assessment should be based on **all** the chart information, including for example a “Problem List.” Also, important to review encounter sheets that include ED and other medical care. If there are 3 visits for a broken arm, note only the date of the first visit. For noncompliance, code each instance if it involves a clearly separate issue, OR, if it occurs at a “distinctly separate” time. For eg, two consecutive visits noting that derm consult has not happened should count as one instance of non-compliance. Again, err on the side of giving the benefit of the doubt. For failure to thrive (FTT; poor growth), code the initial date, although there could be additional documentation later. Consider any documentation in the problem list or encounter sheets of “FTT, poor growth, or inadequate growth” as indication of FTT – AFTER one month of age. Any documentation of “delayed immunization” should be coded as such. Do not separately assess the timing of the shots; we’re relying on HPs’ documentation. Same applies to possible growth problems; no need to assess the growth chart. Please note that documentation of possible abuse or neglect should be recorded. In addition, a report to or involvement of Child Protective Services should be recorded separately.

In general, err on the side of including incidents and practice that **may** reflect the practice of interest. For example, if the chart mentions “worrisome growth or poor weight gain,” consider this as FTT (failure to thrive).