Asthma Chart Review Rubric

Element 3/C/1 – Conducts pre-visit preparations
What they're looking for: do we anticipate what we'll need at the visit before the child arrives? Look in messages, task lists, HSR section, appointment schedule text to show that we've done this at some point.

Examples might be:

- "requested notes from Dr. Rogers/Dr. Wisnewski" [in taskbar, put in the day before visit]
- "requested ER report for asthma visit" [in schedule F7 notes at the time appointment was made]
- "Check spirometry every visit" [on HSR tab on front of chart]
- "deferred: need food, environmental panel at next visit" [in taskbar]
- taskbar tasks – ACT, spirometry – entered prior to the patient coming into the office [in taskbar]

Element 3/C/2 – Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
What they're looking for: does the child have an asthma action plan? Alternatively, we have documented
exactly what we want the child to take in the plan of the note.

Examples might be:

- Asthma Action Plan present in OP [in Asthma Plan section]
- Emphasized importance of taking Flovent 2 puffs with spacer daily; use albuterol 2 puffs only when symptomatic. [not just: "Continue Flovent and albuterol.]

Element 3/C/3 – Gives the patient/family a written plan of care
What they're looking for: did we actually **give** the family a copy of the asthma action plan?

Examples might be:

- "Asthma action plan printed for family."
- The date of the last AAP was a visit date, and the Audit Trail shows we printed it out.

Element 3/C/4 – Assesses and addresses barriers when the patient has not met treatment goals
What they're looking for: some kind of discussion that we are trying to help patients overcome barriers. Is
it the parent's lack of understanding, child is not motivated; or could there be financial, logistical, insurance, transportation barriers? Look for something specific for the family. These could be medication-related (see 3/D/5) or non-medication related. If the child is doing great, the answer will be N/A rather than No.

NCQA also writes, "A completed social history is acceptable as documentation that the clinician or care team has assessed the patient's progress and thus is meeting treatment goals. The practice may respond NA for this patient."

Examples might be:

- Grandma babysits three days a week, and she smokes inside the house. [logistical]
- The peak flow meter was too expensive and so family doesn't have it.
- Family lost the spacer/has not been using the spacer.
- Martha often forgets to take her morning Flovent.
- Insurance wouldn't approve ICS without a PA, so Mark hasn't had Advair in about 2 weeks.
- Family couldn't afford Singulair co-pay.
- Dad doesn't think he really has asthma and doesn't think he needs the medication so he hasn't
  given it at all.
- Car broke down and family couldn't get to the pharmacy to pick up meds.
- Family's neb machine broke and TennCare won't approve a new one [insurance/financial]

Element 3/C/5 – Gives the patient/family a clinical summary at each relevant visit
What they're looking for: did we provide the family with a summary of the visit, or the essentials of the visit, if the visit was "significant"? (We don't do this as often as we need to.) Visits where we institute new medications, change doses, etc. In a visit where things are going well and we haven't changed anything, mark as a "Yes" (there is no N/A) because it probably wasn't a "significant" visit.

Examples might be:

- Anything that qualifies as a Yes for 3/C/3.
- "Wrote out new dosing schedule for asthma for mom."

Element 3/C/6 – Identifies patients/families who might benefit from additional care management support
What they're looking for: for patients who are not meeting goals, we refer them to something outside our practice: a specialist if family needs a second opinion; a care management program through their insurance; a smoking cessation program for parents. Kids who are doing great count as a "yes" since there is no N/A option.

Examples might be:

- Amerigroup Asthma CM Program (in F2 section of chart)
- Americhoice Asthma Program (in F2 section of chart)

Element 3/C/7 – Follows up with patients/families who have not kept important appointments
What they're looking for: if we want them to follow up with us, or with someone else (e.g. pulmonologist,
allergist), what do we do when they cancel or no-show? If we just let it go, that's a No; however, if we call
the family to reschedule their appointment, that's a Yes. (If they don't cancel or no-show appointments, or
we don't schedule any followups because they're doing well, call it Not Applicable.)

Examples might be:

- Lori finds out that child no-showed with Dr. Rogers; Lori calls and gets appointment rescheduled. (yes)
- Family no-shows appointment with us; we send them a postcard, email, or try to contact them

by phone. (yes)
- Family no-shows appointment, then spontaneously shows up the next day before we can do anything (not applicable)
- Family no-shows 3 appointments but we don't take any action (no)

Element 3/D/1 – Reviews and reconciles medications with patients/families for more than 50 percent of care transitions

What they're looking for: that we check to see what meds a patient might have been prescribed outside our office for his/her asthma. An N/A would apply if the child has never been seen outside our office for asthma, i.e. there are no care transitions, or if he's never been on any meds for his asthma (not likely.)

Examples might be:

- "His previous PCP had him on Singulair, which worked well."
- "He was seen in ER four days ago for asthma exacerbation and got prescriptions for Prelone and azithromycin."
- "Dr. Rogers recently switched him from Pulmicort to Qvar."
- "He was discharged from CMC two days ago with a home neb machine and a steroid taper."

Element 3/D/2 – Reviews and reconciles medications with patients/families for more than 80 percent of care transitions

What they're looking for: exactly the same as 3/D/1.

Examples might be:

- anything that qualifies in 3/D/1.

Element 3/D/3 – Provides information about new prescriptions to more than 80 percent of patients/families

What they're looking for: We provide information on potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it. N/A would be indicated if we have not issued any new/different prescriptions to the family (refilled albuterol that they've been on for years), or if the child is on no meds for asthma (not likely.)

Examples might be:

- "Discussed how albuterol acts to relax airways."
- "Explained that Pulmicort is a preventive medication."
- "Explained that ICS have small risk of adult height loss, but untreated asthma is worse."
- "Reinforced importance of using Flovent every day to prevent airway inflammation."
- "Demonstrated use of MDI/spacer."

Element 3/D/4 – Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment

What they're looking for: The family understands what the medication is used for and/or how to use it.

Examples might be:

- "Demo neb given. Mom verbalized understanding."
- [phone note] "Explained to mom that albuterol is going to be the best cough medication during his cold. Mom verbalized understanding."

Element 3/D/5 – Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment
What they're looking for: like 3/C/4, but specifically medication related. If the patient is doing great with no barriers, this would be a "yes" (because we assessed patient response.)

Examples might be:

- Insurance wouldn't approve ICS without a PA, so Mark hasn't had Advair in about 2 weeks.
- Family couldn't afford Singulair co-pay.
- Dad doesn't think he really has asthma and doesn't think he needs the medication so he hasn't
  given it at all.
- She's been using MDI but lost her spacer.
- Car broke down and family couldn't get to the pharmacy to pick up meds.
- Family's neb machine broke and TennCare won't approve a new one [insurance/financial]
- Mom thinks Flovent is working well for her; she's taking it as directed.

Element 3/D/6 – Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates
What they're looking for: do we make a note of OTC use? This might include Zyrtec or Claritin for asthma or OTC cough/cold products. Because we use an EMR, all updates have dates (because the note or message has a date on it.) The answer is N/A if the child isn't taking any such products.

Examples might be:

- "She's on Zyrtec 1/2 tsp as well for allergies."
- "Mom gave her some Robitussin last night, but it didn't seem to help as much as her albuterol."

Element 4/A/1 – Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management
What they're looking for: that we gave them some useful teaching materials (usually handouts, sometimes
other media).

Examples might be:

- "Showed asthma video."
- "Our asthma packet given."
- The educational material MU box in the visit note is checked.

Element 4/A/2 – Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate
What they're looking for: because we use an EHR, this is the same as 4/A/1.

Examples might be:

- anything that's a "yes" for 4/A/1.

Element 4/A/3 – Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families
What they're looking for: do we have an asthma action plan or some other collaborative plan?

Examples might be:

- Asthma action plan updated/reviewed.

Element 4/A/4 – Documents self-management abilities for at least 50 percent of patients/families
What they're looking for: do we have an idea of how well the family is managing asthma at home? A "good" answer or a "bad" answer counts as a yes.

Examples might be:

- Mom has no idea how much albuterol dad is giving.
- Mom isn't sure whether to give albuterol or not when Melissa is coughing.
- We demonstrated albuterol MDI use; mom demonstrated understanding.
- ACT in chart [this has some questions about self-management]

Element 4/A/5 – Provides self-management tools to record self-care results for at least 50 percent of patients/families
What they're looking for: did we give families any "homework" or documentation assignments? We don't do this very often for asthma.

Examples might be:

- "Gave family calendar to keep track of albuterol use."

Element 4/A/6 – Counsels at least 50 percent of patients/families to adopt healthy behaviors
What they're looking for: counseling/coaching/encouragement to make positive changes. We do this a lot! You can look in well-child visit notes as well as in asthma-related notes!

Examples might be:

- "Smoking away from baby is important; TN quitline information given."
- "Exercise will help with asthma; just be sure she has her inhaler."

ADHD Chart Review Rubric

Element 3/C/1 – Conducts pre-visit preparations
What they're looking for: do we anticipate what we'll need at the visit before the child arrives? Look in messages, task lists, HSR section, appointment schedule text to show that we've done this at some point.

Examples might be:

- "Please bring forms to next visit." [in office note, phone message asking for refill, appointment text]
- "Please bring paperwork (school forms, IEP) to next visit."
- "Need notes from CMMH" [on schedule or at end of previous note]
- Next ADHD forms 5/10 [HSR, front of chart]

Element 3/C/2 – Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
What they're looking for: we have explained to family what specifically we want the short-term goal or long-term outcome to be, or we have a specific goal in mind.
though.

Examples might be:

- Ideally, we can adjust his medication so that sitting still won't be so difficult for him.
- We need to balance medication dosing for optimal school performance while making sure he doesn't lose weight.
- Let's monitor his school performance over the next month.
- According to his IEP/testing, he should be able to achieve at least a C in every subject.

Element 3/C/3 – Gives the patient/family a written plan of care
What they're looking for: For initial visits, the initial care plan is the checklist sheet we give to the family
that lists the materials that need to be gathered for the assessment. For repeat visits, we should be
documenting specific recommendations for the child's management. This would include the Cumberland
County ADHD form and the school management form (we get this sometimes, not all the time.) Either the
initial checklist or an ongoing list will count as a Yes.

Examples might be:

- He should sit closer to the teacher and be allowed extra time for tests.
- Return with completed forms, other items as indicated on checklist, and schedule follow up appointment.
- ADHD care plan sent to school. [ADHD care plan scanned in chart]
- In referral letters: "This patient is under my continuing care for ADHD. Please allow him to have
  additional time…"

Element 3/C/4 – Assesses and addresses barriers when the patient has not met

treatment goals
What they're looking for: some kind of discussion that we are trying to help patients overcome barriers. Is
it the parent's lack of understanding, child is not cooperative; school is not helpful; or could there be
financial, logistical, insurance, transportation barriers? Look for something specific for the family.

NCQA also writes, "A completed social history is acceptable as documentation that the clinician or care team has assessed the patient's progress and thus is meeting treatment goals. The practice may respond NA for this patient."

Examples might be:

- Family has been unable to schedule a counseling appointment because of time constraints. [logistical]
- Family used to go to LifeCare in Cookeville, but distance and travel expense became prohibitive
  [financial, transportation].
- Parents disagree about the best way to discipline him. [understanding, logistical]
- Dad thinks counseling is not necessary and so he hasn't scheduled it. [understanding]

Element 3/C/5 – Gives the patient/family a clinical summary at each relevant visit
What they're looking for: did we provide the family with a summary of the visit, or the essentials of the visit, if the visit was "significant"? (We don't do this as often as we need to.) Visits where we institute new medications, change doses, etc. are "significant." In a visit where things are going well and we haven't changed anything, mark as a "Yes" (there is no N/A) because it probably wasn't a "significant" visit.

Examples might be:

- Anything that qualifies as a Yes for 3/C/3.
- An OP printout of the visit.

Element 3/C/6 – Identifies patients/families who might benefit from additional care management support
What they're looking for: for patients who are not meeting goals, we refer them to something outside our practice: parenting classes, psychiatrist, counselor, HealthConnect, or other program. Kids who are doing great count as a "yes" since there is no N/A option.

Examples might be:

- "Counselor list given."
- "Will set up referral to HealthConnect."

Element 3/C/7 – Follows up with patients/families who have not kept important appointments
What they're looking for: if we want them to follow up with us, or with someone else (e.g. CMMH, psych), what do we do when they cancel or no-show? If we just let it go, that's a No; however, if we call
the family to reschedule their appointment, that's a Yes. (If they don't cancel or no-show appointments, or
we don't schedule any followups because they're doing well, call it Not Applicable.)

Examples might be:

- Lori finds out that child no-showed with psych; Lori calls and gets appointment rescheduled. (yes)
- Family no-shows appointment with us; we send them a postcard, email, or try to contact them
  by phone. (yes)
- Family no-shows appointment, then spontaneously shows up the next day before we can do anything (not applicable)
- Family no-shows 3 appointments but we don't take any action (no)

Element 3/D/1 – Reviews and reconciles medications with patients/families for more than 50 percent of care transitions
What they're looking for: that we check to see what meds a patient might have been prescribed outside our office for his/her ADHD. An N/A would apply if the child has never been seen outside our office for ADHD, i.e. there are no care transitions, or if he's never been on any meds for his ADHD (possibly if the child is mild ADHD or if we haven't prescribed anything yet.)

Examples might be:

- Vyvanse 30 mg daily From Dr. Looney [reference med in list]
- ROR signed for CMMH.
- Dr. Koucheki had him on Ritalin, but dad thinks it didn't work well.

Element 3/D/2 – Reviews and reconciles medications with patients/families for more than 80 percent of care transitions
What they're looking for: exactly the same as 3/D/1.

Examples might be:

- anything that qualifies in 3/D/1.

Element 3/D/3 – Provides information about new prescriptions to more than 80 percent of patients/families
What they're looking for: We provide information on potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it. N/A would be indicated if we have not issued any new/different prescriptions to the family (refilled the same dose of Methylin that they've been on for years), or if the child is on no meds for ADHD (possible, if it's a new/mild diagnosis.)

Examples might be:

- CHADD packet given [there is a medication section here.]
- Discussed how Ritalin works; side effects.
- Discussed pros and cons taking medication on weekends/holidays/summer.

Element 3/D/4 – Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment
What they're looking for: The family understands what the medication is used for and/or how to use it, or we get a sense that they DON'T understand. This is often not explicitly documented in the chart. Look for something that indicates that parents are asking intelligent questions about use of meds.

Examples might be:

- Mom wonders if he should be taking meds on weekends.
- Mom is very concerned that medication is habit forming.

Element 3/D/5 – Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment
What they're looking for: like 3/C/4, but specifically medication related. If they're doing great and taking their meds as prescribed, write "Not Applicable."

Examples might be:

- Insurance wouldn't approve Concerta without a PA, so Mark hasn't had it in about 2 weeks.
- Family couldn't afford Adderall co-pay.
- Dad doesn't think he really has ADHD and doesn't think he needs the medication so he hasn't given it at all.
- Mother was unable to pick up refill prescription.

Element 3/D/6 – Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates
What they're looking for: do we make a note of OTC use? This might include fish oil, vitamins, melatonin, or herbal supplements for ADHD. Because we use an EMR, all updates have dates (because the note or message has a date on it.) The answer is N/A if the child isn't taking any such products.

Examples might be:

- He's also on CalmChild, an herbal supplement, which mom buys over the Internet.
- No other meds.
- Melatonin helps with sleep.
- Ibuprofen OTC [in Medications]

Element 4/A/1 – Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management
that we gave them some useful teaching materials (usually handouts, sometimes other media).

- CHADD packet given.
- Recommended Barkley book "The Explosive Child."
- Parenting classes at the Stephens Center might be helpful; contact information given.
- The educational material MU box in the visit note is checked.

Element 4/A/2 – Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate
What they're looking for: because we use an EHR, this is the same as 4/A/1.

Examples might be:

- anything that's a "yes" for 4/A/1.

Element 4/A/3 – Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families
What they're looking for: did we document non-medical management elements of the plan? For

ADHD, these are usually school-based interventions or home behavioral programs.

Examples might be:

- Try sticker chart for good days at school.
- Consult with teacher to determine what classroom supports can be offered.

Element 4/A/4 – Documents self-management abilities for at least 50 percent of patients/families
What they're looking for: ask about the child's and family's strengths and environment. In ADHD appointments, this is usually found in the initial intake information, review of notes from counselor, etc. How is the parent doing managing the child's behavior? The "long forms" in the CBC-L/YSR/TRF series also ask for what the child's strengths are and what they enjoy doing.

Examples might be:

- Scanned CBC-L/YSR/TRF forms
- "Mom is overwhelmed and at her wits' end."
- "Dad thinks Jacob is just an active boy, like he was at that age, and has no concerns about his behavior."

Element 4/A/5 – Provides self-management tools to record self-care results for at least 50 percent of patients/families
What they're looking for: families document the child's progress, usually in home ADHD-IV forms.

Examples might be:

- "Results of recent ADHD-IV forms show..."

Element 4/A/6 – Counsels at least 50 percent of patients/families to adopt healthy behaviors
What they're looking for: counseling/coaching/encouragement to make positive changes which will benefit ADHD. We do this a lot — and stuff in well visit notes count.

Examples might be:

- "Sleep advice given"
- "Exercise advice given"
- "Avoid too much caffeine"
- "Exercise will help with asthma; just be sure she has her inhaler."

Obesity Chart Review Rubric

Element 3/C/1 – Conducts pre-visit preparations
What they're looking for: do we anticipate what we'll need at the visit before the child arrives? Look in messages, task lists, HSR section, appointment schedule text to show that we've done this at some point.

Examples might be:

- "requested notes from endocrinology" [in taskbar, put in the day before visit]
- "Check BP/BMI every visit" [on HSR tab on front of chart]
- "deferred: need food diary at next visit" [in taskbar]
- "She'll need fasting labs prior to next visit"
- taskbar tasks – height, weight, BMI – entered prior to the patient coming into the office [in taskbar]

Element 3/C/2 – Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
What they're looking for: that we're trying to personalize the experience for the patient. Not just "you need
to eat better and exercise more," but "I'd like you to reduce your sodas to 1 per week, and limit TV time to
30 minutes per day." The notation "discussed nutrition and activity" is NOT specific enough to count as a
Yes. We have to put something more specific to the child's situation. Treatment goals should also be personalized: not just "lose weight," but "I'd like to see you lose 20 lbs" or "let's get your BMI down to 30" etc.

Examples might be:

- She's going to try to go swimming this summer for activity and watch less TV.
- Recommended she cut down on bread/carbs; eat at least 5 servings of fresh/fruit and vegetables.
- Optimal weight loss for him would be 1 lb/week.
- If she maintains her current weight, within 6 months she will have "grown" into her target BMI.
- A good weight for her would be 75 lbs, i.e. a 20 lb loss.

Element 3/C/3 – Gives the patient/family a written plan of care
What they're looking for: did we give the family a written plan of what we want them to do? We don't do
this perhaps as much as we do; I'll perhaps list 2-3 things I want the family to do, but not always write it
down. Look for documentation that we actually gave the family a "personal weight loss prescription."

Examples might be:

- "Completed 5/2/1/0 plan for family,"
- "Reduce soda to 1 Coke/week and TV time to 1 hour/day; written out for family."

Element 3/C/4 – Assesses and addresses barriers when the patient has not met treatment goals
What they're looking for: some kind of discussion that we are trying to help patients overcome barriers. Is
it the parent's lack of understanding, child is not motivated; or could there be financial, logistical, insurance, transportation barriers? Look for something specific for the family:

Examples might be:

- Mother reports she's tried to reduce soda, but Mary sneaks food from the kitchen and gets her
  friends to buy her soft drinks at school. (logistical)
- Dad is a single parent and finds that fresh fruit/veggies too expensive; when he buys them, they usually go bad before they're eaten. (financial)
- Grandma babysits three afternoons a week and gives her Twinkies (logistical/understanding)
- The family is trying to get to the YMCA in Cookeville but distance makes it difficult. (transportation)

Element 3/C/5 – Gives the patient/family a clinical summary at each relevant visit
What they're looking for: we actually give the family something written to summarize progress.

Examples might be:

- anything that qualifies for 3/C/3.
- Printed out growth chart/BMI chart for mom to take home.

Element 3/C/6 – Identifies patients/families who might benefit from additional care management support
What they're looking for: for patients who are not meeting goals, we refer them to our dietician OR to something outside our practice: fitness program, tertiary care center, insurance program. A referral to Lacey counts as a "yes" here. Kids who are doing great count as a "yes" since there is no N/A option.

Examples might be:

- Amerigroup Obesity CM Program (in F2 section of chart)
- Americhoice Obesity Program (in F2 section of chart)
- Vanderbilt weight management center/bariatric center

Element 3/C/7 – Follows up with patients/families who have not kept important appointments
What they're looking for: if we want them to follow up with us, or with someone else, what do we do when they cancel or no-show? If we just let it go, that's a No; however, if we call
the family to reschedule their appointment, that's a Yes. (If they don't cancel or no-show appointments, or
we don't schedule any followups because they're doing well, call it Not Applicable.)

Examples might be:

- Family no-shows with Lacey; she calls and gets appointment
  rescheduled. (yes)
- Family no-shows appointment with us; we send them a postcard, email, or try to contact them

by phone. (yes)
- Family no-shows appointment, then spontaneously shows up the next day before we can do anything (not applicable)
- Family no-shows 3 appointments but we don't take any action (no)

Element 3/D/1 – Reviews and reconciles medications with patients/families for more than 50 percent of care transitions
What they're looking for: that we noted if anyone else has been treating the child for obesity, and if so, what meds they were on. Most of the time this is going to be N/A because there are no obesity medications for kids. (Exceptions would be for lipid meds or antihypertensives.)

Examples might be:

- "Dr. Tapiador started him on metformin 500 mg BID."

Element 3/D/2 – Reviews and reconciles medications with patients/families for more than 80 percent of care transitions
What they're looking for: exactly the same as 3/D/1.

Examples might be:

- anything that qualifies in 3/D/1.

Element 3/D/3 – Provides information about new prescriptions to more than 80 percent of patients/families
What they're looking for: We provide information on potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it. N/A would be indicated if we have not issued any obesity-related prescriptions to the child. (Exceptions would be for lipid meds or antihypertensives.)

Examples might be:

- ????

Element 3/D/4 – Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment
What they're looking for: parents understand that obesity-related medications (like lipid meds or antihypertensives) are not going to cause weight loss; they are for comorbidities.

Examples might be:

- Explained that metformin will help increase insulin sensitivity.

Element 3/D/5 – Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment
What they're looking for: if we Rx'd meds that patients aren't taking, do we understand why? Most of the time this is going to be N/A because there are no obesity medications for kids. (Exceptions would be for lipid meds or antihypertensives.)

Examples might be:

- He doesn't take his metformin because he doesn't like the diarrhea it causes.

Element 3/D/6 – Documents over-the-counter medications, herbal therapies and

supplements for more than 50 percent of patients/families, with the date of updates
What they're looking for: do we make a note of OTC use? This might include Zyrtec or Claritin for asthma or OTC cough/cold products. Because we use an EMR, all updates have dates (because the note or message has a date on it.) The answer is N/A if the child isn't taking any such products.

Examples might be:

- "He's taking OTC EnergyBoost because he heard it might help him lose weight."

Element 4/A/1 – Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management
What they're looking for: that we gave them some useful teaching materials (usually handouts, sometimes
other media).

Examples might be:

- "How can I help my child lose weight?" handout given.
- "How many calories should my child eat?" handout given.
- Red/yellow/green food handouts given/discussed.

Element 4/A/2 – Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate
What they're looking for: because we use an EHR, this is the same as 4/A/1.

Element 4/A/3 – Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families
What they're looking for: we've set specific goals, as in 3/C/2.

Examples might be:

- anything that counts as a yes in 3/C/2.

Element 4/A/4 – Documents self-management abilities for at least 50 percent of patients/families
What they're looking for: do we have an idea of how well the family is managing obesity at home? A "good" answer or a "bad" answer counts as a yes.

Examples might be:

- Mom doesn't feel empowered to change diet.
- Katie has trouble keeping track of portion sizes.
- Mary can manage OK at a la carte restaurants, but buffets are too tempting.

Element 4/A/5 – Provides self-management tools to record self-care results for at least 50 percent of patients/families
What they're looking for: did we give families any "homework" or documentation assignments?

Examples might be:

- "Gave family calendar to keep track of minutes walking."
- "Write down soda intake for a week, then bring back."
- "Return next time with diet diary (info given.)"

Element 4/A/6 – Counsels at least 50 percent of patients/families to adopt healthy behaviors

What they're looking for: counseling/coaching/encouragement to make positive changes. We do this a lot! You can look in well-child visit notes as well as in obesity-related notes!

Examples might be:

- "Limit juice."
- "Sleep is important for good weight maintenance."

CSHCN Chart Review Rubric

Element 3/C/1 – Conducts pre-visit preparations
What they're looking for: do we anticipate what we'll need at the visit before the child arrives? Look in messages, task lists, HSR section, appointment schedule text to show that we've done this at some point.

Examples might be:

- "requested notes from Dr. Rogers/Dr. Wisnewski" [in taskbar, put in the day before visit]
- "requested ER report for asthma visit" [in schedule F7 notes at the time appointment was made]
- "Check spirometry every visit" [on HSR tab on front of chart]
- "deferred: need food, environmental panel at next visit" [in taskbar]
- taskbar tasks – ACT, spirometry – entered prior to the patient coming into the office [in taskbar]

Element 3/C/2 – Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
What they're looking for:

Examples might be:

- —
- —

Element 3/C/3 – Gives the patient/family a written plan of care
What they're looking for:

Examples might be:

- —
- —

Element 3/C/4 – Assesses and addresses barriers when the patient has not met treatment goals
What they're looking for:

Examples might be:

- —
- —

Element 3/C/5 – Gives the patient/family a clinical summary at each relevant visit
What they're looking for:

Examples might be:

- —
- —

Element 3/C/6 – Identifies patients/families who might benefit from additional care management support

What they're looking for:

Examples might be:

- —
- —

Element 3/C/7 – Follows up with patients/families who have not kept important appointments
What they're looking for:

Examples might be:

- —
- —

Element 3/D/1 – Reviews and reconciles medications with patients/families for more than 50 percent of care transitions
What they're looking for:

Examples might be:

- —
- —

Element 3/D/2 – Reviews and reconciles medications with patients/families for more than 80 percent of care transitions
What they're looking for:

Examples might be:

- —
- —

Element 3/D/3 – Provides information about new prescriptions to more than 80 percent of patients/families
What they're looking for:

Examples might be:

- —
- —

Element 3/D/4 – Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment
What they're looking for:

Examples might be:

- —
- —

Element 3/D/5 – Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment
What they're looking for:

Examples might be:

- —
- —

Element 3/D/6 – Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates
What they're looking for:

Examples might be:

- —
- —

Element 4/A/1 – Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management
What they're looking for:

Examples might be:

- —
- —

Element 4/A/2 – Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate
What they're looking for:

Examples might be:

- —
- —

Element 4/A/3 – Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families
What they're looking for:

Examples might be:

- —
- —

Element 4/A/4 – Documents self-management abilities for at least 50 percent of patients/families
What they're looking for:

Examples might be:

- —
- —

Element 4/A/5 – Provides self-management tools to record self-care results for at least 50 percent of patients/families
What they're looking for:

Examples might be:

- —
- —

Element 4/A/6 – Counsels at least 50 percent of patients/families to adopt healthy behaviors
What they're looking for:

Examples might be:

- —
- —