Family Engagement Quality Improvement Project
Medical Record Review Tool Tip Sheet

Patient/Family Concerns

1. Is there documentation in the medical record indicating that patient/family concerns were elicited at the most recent visit?

   Details: What Counts?
   Family/caregiver were asked at least once about their concerns using one or more of the following methods:

   - Family/caregiver was asked about concerns on the phone when visit was scheduled
   - Pre-visit questionnaire was made available (electronic or paper copy) prior to the visit
   - Questionnaire eliciting concerns was distributed at check-in or during the encounter/visit
   - Face-to-face communication with family/caregiver during visit asking about concerns
   - Utilizing Patient Portals with families to obtain information about concerns prior to an office visit

   Documentation in the medical record can include a checkbox or free text.

1. Is there documentation in the medical record indicating patient/family concerns were addressed at the most recent visit or a plan to address the concerns was made?

   Details: What Counts?
   Patient/family concerns can be addressed in multiple ways including face-to-face interaction, resource referral, patient/family education, scheduling a follow-up visit to address specific concerns, etc.

   Documentation in the medical record can include a checkbox or free text.

Family Strengths

2. Is there documentation in the medical record indicating that family strengths were identified and discussed during the most recent visit?

   Details: What Counts?
   Family strengths build an environment that promotes optimal child and youth development. Below are a few examples of family strengths and how to identify them with families during patient encounters (adapted from the Strengthening Families Initiative):

- **Parental Resilience:** Identifying family/caregiver ability to solve problems, build and sustain relationships, and seek help when necessary.
- **Social Connections:** Identify social supports that families/caregivers have created and have access to, including but not limited to friends, family, neighbors, and community members.
- **Concrete Supports in Times of Needs:** Identify supports that families/caregivers have in order to thrive. These include needs in times of crisis as well as basic economic needs such as food, shelter, clothing, and health care.
- **Knowledge of Parenting and Child Development:** Identify activities that families/caregivers are doing with their child that are developmentally appropriate
- **Social and Emotional Competence of Children:** Identify activities that families/caregivers are doing to ensure child/youth's ability to interactive positively with others.

Identified family strengths should be documented and discussed with the family. This discussion can be documented in a medical record with a checkbox or free text.

Post-visit Medical Summary and/or Care Plan

3. Is there documentation in the medical record indicating that a post-visit medical summary or a comprehensive care plan was created or updated/maintained during a recent visit?

   Details: What Counts?
   A **post-visit medical summary** is a history of medical information that includes the following:
   - Basic demographics and contact information
     - Patient and family, with guardianship identified, if applicable
     - Contact information for patient and family, including cell phone numbers and email addresses
     - Medical Home
     - Emergency Contacts
   - Key medical, surgical, and injury history
   - Current medications, including medication reconciliation
   - Allergies
   - Immunization record
   - Insurance information
   - Special instructions

   Patients with chronic conditions benefit from an expanded post-visit medical summary that includes the following:

   - Basic demographics and contact information
     - Patient and family, with guardianship identified, if applicable
     - Medical home, including primary care provider and care coordinator

    - Emergency contacts
    - Specialists
    - Therapists
    - Home health agency
    - School attended and school contacts
- Chronic condition(s)
    - Secondary diagnoses
    - Complications
- Key medical, surgical, and injury history
    - Presence of surgically implanted devices or prostheses
    - Important hospitalizations
    - Key laboratory data and imaging results
- Medications
    - Current medications, including medication reconciliation
    - Past medications and reactions
    - Medication precautions, including medications needed during procedures (e.g., sub-acute bacterial endocarditis prophylaxis) and those to be avoided
- Special diets and dietary restrictions
- Immunization Record

For patients with complex conditions, a **comprehensive care plan** includes an expanded medical summary, an emergency treatment plan, and a dynamic, explicit plan of care, also known as an action plan.

Documentation in the medical record could include a checkbox or free text.

4. Is there documentation in the medical record indicating that a post-visit medical summary or comprehensive care plan was reviewed through an active form of family engagement and offered to the patient/family during a recent visit?

Details: What Counts?
Active forms of family engagement can include but are not limited to the following:

- Teach-back methodology
- Motivational interviewing
- Ask-me-3 framework

All of the aforementioned family engagement strategies are considered ways to enhance shared decision-making with families. Documentation in the medical record could include a checkbox or free text.

Communication of Age-Appropriate Screening Results

5. Is there documentation in the medical record that age-appropriate screening results were discussed with the family on the same day as the visit?

   Details/What Counts?
   Age-appropriate screenings include any/all listed in the Bright Futures Periodicity Schedule, as well as other screenings related to social determinants of health, as appropriate and necessary. Negative and positive results should be discussed with families/caregivers, documentation in the medical record could include a checkbox or free text.