

<p>PATIENT RECORD NO. (From Facility Key document) _____ - _____ - _____</p> <p>MEDICAL REVIEWER INITIALS: _____</p>
--

To the Reviewer: Use the Medical Reviewer Instructions to assist you in completing each review. This document contains the definitions of the criteria for each question, and if applicable, the standards on which they are based (VA/Dept of Defense Clinical Practice Guidelines and AHRQ Guidelines)

Medical Officer Peer Review Instrument

SECTION A: Complete questions 1-14 for the MOST RECENT VISIT with the provider listed above (regardless of reason for visit)

- 1. Provider documentation is neat and legible**
 - 1 All/most documentation is illegible
 - 3 Some documentation is illegible
 - 5 Documentation is consistently legible

- 2. Vital signs are entered (BP, HR, RR, weight, temp if symptoms of infection)**
 - 1 No vital signs entered for visit
 - 3 Some vital signs entered for visit
 - 5 All vital signs entered for visit

- 3. Abnormal vital signs addressed (in assessment and/or plan)**
 - 1 None of abnormal vital signs addressed
 - 3 Some abnormal vital signs addressed
 - 5 All abnormal vital signs addressed
 - N/A No abnormal vital signs on this visit
 - IL Illegible

- 4. Pain level documented and addressed if applicable**
 - 1 Pain level not documented or addressed
 - 3 Pain addressed but level not documented; or level documented but pain not addressed
 - 5 Pain level documented and pain addressed
 - N/A Patient not in pain
 - IL Illegible

- 5. Pertinent history positives/negatives (for reason for visit) appropriately documented**
 - 1 No pertinent positives or negatives documented
 - 3 Some pertinent positives and negatives documented
 - 5 All pertinent positives and negatives documented
 - IL Illegible

- 6. Pertinent positives/negatives of exam appropriately documented**
 - 1 No pertinent positives or negatives documented
 - 3 Some pertinent positives and negatives documented
 - 5 All pertinent positives and negatives documented
 - IL Illegible

This Quality Assurance Document is Protected under the provisions of 14 U.S.C. 645

7. Previous laboratory and radiology reports are reviewed and appropriate follow up addressed

- 1 No previous laboratory reports addressed
- 3 Some previous laboratory reports addressed
- 5 All previous laboratory reports addressed
- N/A No previous laboratory reports found/ordered
- IL Illegible

8. Medical decision making appropriate (to reason for visit)

- 1 Medical decision making inappropriate
- 3 Some medical decisions inappropriate
- 5 Medical decisions appropriate
- IL Illegible

9. Plan consistent with diagnosis

- 1 Plan is inconsistent with diagnosis
- 3 Some aspects of plan consistent with diagnosis
- 5 Plan consistent with diagnosis
- IL Illegible

10. Appropriate laboratory tests ordered

- 1 No appropriate tests ordered
- 3 Some appropriate tests ordered
- 5 Appropriate tests ordered
- N/A No testing indicated
- IL Illegible

11. Drug utilization appropriate

- 1 Drugs utilized were inappropriate
- 3 Some drugs utilized were appropriate
- 5 All drugs utilized were appropriate
- N/A No drugs were utilized
- IL Illegible

12. Condition entered on Problem Summary List (DD2276)

- 1 Condition not listed on Problem List
- 5 Condition listed on Problem List
- N/A No diagnosis made/self limited
- IL Illegible

13. Patient instructions, including follow-up documented

- 1 No instructions or follow-up documented
- 3 Instructions/follow-up partially documented
- 5 Instructions and follow-up documented
- IL Illegible

14. Provider name printed or stamped

- 1 No
- 5 Yes IL Illegible

This Quality Assurance Document is Protected under the provisions of 14 U.S.C. 645

Review the reasons for each visit in the last 12 months with the provider. Answer question 15 and 16 based upon the reasons for those visits and the patient's problem list

15. Does the patient have hypertension? (Per the problem list, diagnosed by provider, or taking medications for hypertension)

Y Yes (If yes, complete ALL of the questions in Section B)

N No

16. Has the patient been seen for cervical dysplasia or a PAP smear in the past 12 months; OR does the patient have a history of cervical dysplasia?

Y Yes (If yes, complete ALL of the questions in Section C)

N No

If the answers to both question 15 and 16 are NO, then the review is COMPLETE; answer NO FURTHER QUESTIONS

SECTION B: Hypertension Review Tool

Questions 17-28 pertain to ALL of the visits for HYPERTENSION to the provider within the prior 12 months

17. BP documented at each visit AND rechecked during the visit if abnormal

1 BP not documented at each visit

3 BP documented at each visit but not consistently repeated if abnormal

5 BP consistently documented and rechecked if abnormal

IL Illegible

18. A BUN, creatinine and urinalysis have been obtained within the 12 months if the patient has chronic renal disease (refer to lab section)

1 None of the testing has been done in the last 12 months

3 Some of the testing has been done in the last 12 months

5 All of the testing has been done in the last 12 months

N/A Patient does not have renal disease

UNK Unknown if patient has chronic renal disease/no renal function measurements in chart

19. A serum potassium level has been obtained in the last 12 months if the patient is on diuretic medication

1 A potassium level has not been obtained in the last 12 months

5 A potassium level has been obtained in the last 12 months

N/A Patient is not on diuretic therapy

20. Lipid levels have been done within the past 6 months if the patient also has hyperlipidemia/prior abnormal lipid levels and is on lipid lowering medication or dietary management

1 Lipid levels have not been obtained in the last 6 months

5 Lipid levels have been obtained in the last 6 months

N/A Patient is not hyperlipidemic

UNK Unknown if the patient has hyperlipidemia as there are no prior lipid levels

21. An ECG has been done within the last 12 months if the patient has coronary artery disease/angina or congestive heart failure

1 An ECG has not been obtained in the last 12 months

5 An ECG has been obtained in the last 12 months

N/A Patient does not have coronary artery disease/angina or congestive heart failure

22. An FBS (or hemoglobin A1c) has been done in the last 12 months if the patient has had a prior abnormal FBS or is diabetic

1 An FBS/hemoglobin A1c has not been obtained in the last 12 months

5 An FBS/hemoglobin A1c has been obtained in the last 12 months

N/A The patient has not had an abnormal FBS/is not diabetic

23. Treatment plan documentation includes dietary and lifestyle modification instructions (diet, weight, exercise, smoking, alcohol)

1 Dietary/lifestyle modifications are not in any treatment plan (in the prior 12 months)

3 Dietary/lifestyle modifications are in a few treatment plans (in the prior 12 months)

5 Dietary/lifestyle modifications are addressed in most treatment plans (in the prior 12 months)

IL Illegible

24. Examination of the cardiovascular system, pulmonary system, and fundoscopic examination are documented within the last 12 months (or sooner if appropriate)

1 None of these elements are documented appropriately

3 Some of these elements are documented appropriately

5 All of these elements are documented appropriately

IL Illegible

25. A recommended follow up visit was given for no less than every 6 months

1 None of the visits had recommended follow up for 6 months or less

3 Some of the visits had recommended follow up for 6 months or less

5 All of the visits had recommended follow up for 6 months or less

IL Illegible

26. Patients with additional cardiovascular risk factors are identified (smoking, diabetes, chronic renal disease, hyperlipidemia)

1 There is no evidence of screening for these elements

3 There is evidence of screening for some of these elements

5 There is evidence of screening for all of these elements

IL Illegible

27. Patients with additional cardiac risk factors (smoking, diabetes, chronic renal disease, hyperlipidemia) are managed aggressively as evidenced by being seen frequently until blood pressure normalized

1 The patient was not seen frequently until blood pressure normalized

3 The patient was not consistently seen frequently until blood pressure normalized

This Quality Assurance Document is Protected under the provisions of 14 U.S.C. 645

- 5 The patient was consistently seen frequently until blood pressure normalized
- N/A The patient's blood pressure was always in normal range
- NCR The patient does not have additional cardiac risk factors

28. Patients with additional cardiac risk factors (smoking, diabetes, chronic renal disease, hyperlipidemia) are managed aggressively as evidenced by medication addition/adjustment as appropriate

- 1 Medication was not added/adjusted appropriately until BP controlled
- 3 Medication was not consistently added/adjusted appropriately until BP controlled
- 5 Medication was consistently added/adjusted appropriately until BP controlled
- N/A The patient's blood pressure was always in normal range
- NCR The patient does not have additional cardiac risk factors

SECTION C: PAP Peer Review Tool

Questions 29-35 pertain to ALL of the visits for PAP screening/Cervical dysplasia to the provider within the prior 12 months (Complete only if the answer to question 16 was "Yes")

29. Is there a copy of the last PAP smear in the medical records and is it current (see guidelines in Reviewer Instructions)?

- 1 No PAP smear in the record for the past 3 years
- 5 A PAP smear is in the record within the last 3 years
- N/A PAP screening not indicated (S/P hysterectomy or over age 65)

30. At the time of the PAP smear, was a thorough history gathered, including history of abnormal PAP smears and follow up, if applicable?

- 1 No/minimal history documented
- 3 Some pertinent history elements documented
- 5 Most/all pertinent history elements documented
- N/A No PAP smear in the record
- IL Illegible

31. At the time of the PAP smear, was an exam done including breast, external and internal genitalia, and STI testing as indicated?

- 1 Minimal exam/testing documented
- 3 Some pertinent examination/testing documented
- 5 Thorough examination/testing documented
- N/A No PAP smear in the record
- IL Illegible

32. If the entry PAP was abnormal, was there a waiver in the medical record?

- 1 No waiver in the record
- 5 A waiver was in the record
- N/A Entry PAP was not abnormal or not in record

33. If the patient is being followed for dysplasia, does the patient have one of the following within the last 12 months: interval PAP smear (at recommended interval); consultation note; biopsy report; or documentation of other procedures?

This Quality Assurance Document is Protected under the provisions of 14 U.S.C. 645

- 1 None of the above are present and no documentation of followup recommendations/consultation
- 3 None of the above are present however were recommended in previous followup instructions
- 5 One or more of the above are present in the record

34. Is there documentation of patient education in the last 12 months regarding need for follow up, repeat PAP, STI prevention, etc?

- 1 No documentation of patient education
- 3 Documentation of patient education on some aspects
- 5 Documentation of patient education on multiple aspects
- IL** Illegible

35. Is there a plan for repeat PAP smear within clinical guidelines?

- 1 No plan for repeat PAP smear
- 3 A plan is present for repeat smear, but not within clinical guidelines
- 5 A plan is in place for repeat PAP smear within clinical guidelines
- IL** Illegible