**Purpose:** This worksheet and reviewer process developed by MMA’s Committee on Clinician Quality is designed to encourage excellence in medical care that is provided in a blame free environment with the goal of improving patient care.

**Procedure:** Reviewer(s) will use this worksheet for each chart reviewed. This form may not be appropriate for all reviews and modifications will be made as needed. All areas of the form MUST be completed and returned to the MMA. Upon the discretion of the Director for External Peer Review & Quality, these worksheets may be forwarded to the ordering facility.

|  |  |
| --- | --- |
| **Clinician Reviewed:**  | **Type of Review: 🞎 Routine 🞎 Focused** |
| **Specialty:**  | **Reviewer:**  |
| **Date of Service/Discharge:**  | **MR#**  |

**Case Summary:**

**Key Questions for Provider Reviewer:**

**General Questions for Reviewer:** Were appropriate tests, treats, medications or consults ordered/done? Were they done in a timely manner? Were appropriate preventive measures taken? Were care decisions/plan communicated?

(Make sure to complete Page 2!)

**Reviewer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_ **Conflict of Interest? \_\_No \_\_ Potential \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Review Time (in min):**\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  |  | **Overall Provider Care: Check one** |
|  | 1 | Acceptable |
|  |  |  |
|  | 2 | Opportunity for Improvement |
|  | 3 | Needs Improvement |
|  | 0 | Reviewer Uncertain, needs Committee discussion |

|  |  |  |
| --- | --- | --- |
|  |  | **Issue Identification** |
|  | A | No issues with provider care |
|  |  | Provider Care Issues: Check all that apply |
|  | B | Diagnosis ( Pt Care) |
|  | C | Clinical Judgment/Decision-making ( Pt Care) |
|  | D | Technique/Skills ( Pt Care) |
|  | E | Planning ( Pt Care) |
|  | F | Supervision: House Physician or Non-Physician Provider ( Pt Care) |
|  | G | Knowledge (Medical Knowledge) |
|  | H | Timely/Clear Communication (Comm/IP Skills) |
|  | I | Responsiveness (Professionalism) |
|  | J | Follow-up/Follow-through (Professionalism) |
|  | K | Policy Compliance (System based Practice) |
|  | O | Other: |

**Note:** If Overall Care = 1, **then** Issue must = (A);

If Overall Care = 2, 3 or 0, **then** Issue must = (B) through (O)

**Complete on all cases**

|  |  |  |
| --- | --- | --- |
|  |  | **Provider Documentation: Check all that apply** |
|  | 1 | No issue with provider documentation |
|  | 2 | Documentation does not substantiate clinical course/ treatment |
|  | 3 | Documentation not timely to communicate with other caregivers | **Documentation Issue Description:** |
|  | 4 | Documentation unreadable |
|  | 9 | Other: |

**Non-Provider Care Issues:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **System Issue: check all that apply** | **Systems issue description:** |
|  | 1 | No systems issues identified |
|  | 2 | Clinical support for non-physician practitioner |
|  | 3 | Incomplete medication reconciliation |
|  | 4 | Insufficient guidance in policies on best practice |
|  | 5 | System limits: Bed capacity (actual or staffed) |
|  | 6 | Care across multiple locations with multiple providers and information not readily available  |
|  | 7 | Clinical support for non-physician practitioner |
|  | 8 | Policy issues, if known. |

**Provider Reviewer Comments:**

If **Overall Provider Care** rated **Acceptable**, provide a **brief description** of the basis for reviewer findings:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **Overall Clinician Care rated Opportunity for Improvement, Needs Improvement** or **Uncertain**, please complete the following:

1. **Brief description of the basis for reviewer concerns:**
2. **Recommendations:**

**Non-Clinician Care Issues:** 🗖 Potential System or Process Issue 🗖 Potential Nursing/Ancillary Care Issue

**Issue Description**:

**Additional Comments (compliments or concerns)**

**Exemplary Nominations:** \_\_\_Provider Care \_\_\_ Provider Documentation\_\_\_Non-Provider Care

**Brief Description:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-Provider Care Issues:** \_\_ Potential System or Process Issue \_\_ Potential Nursing/Ancillary Care Issue

**Issue Description**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Reviewer Signature | Date: |

**As soon as you complete this review, please return to Director for External Peer Review & Quality at Maine Medical Association, PO Box 190, Manchester, ME 04351.**