



PEER REVIEW OF MEDICAL RECORDS PROGRAM [Companion Animals]

Thank you for your interest in the voluntary Peer Review of Medical Records Program (a component of the Quality Assurance Program for members of the CVO), the goal of which is to provide a standardized peer review of your medical records and constructive feedback on areas for attention or improvement. This information sheet explains the process and answers some frequently asked questions about the program.

How does the program work?

Once you submit sample medical records cases to the QA Program Manager (see [What do I need to submit?](#) below), a trained peer reviewer will be assigned the cases for review against a standardized set of records requirements, using a check-list approach. The peer reviewer also makes constructive comments and provides a summary sheet with overall recommendations. The completed assessment will be sent to you (along with the documents you submitted) for your consideration.

Do the records need to be my own?

Submissions may be made either by an individual veterinarian or by a practice (with records kept by different veterinarians). Records for a practice must be submitted by the practice owner or accompanied by the practice owner's **permission to participate in the program.**

Do I need permission from my clients to submit their records to the CVO?

No, because the CVO is permitted by law to review medical records of members for the purpose of quality assurance. The CVO maintains a strict privacy policy regarding the management of all documents and their contents.

Who will know the results of the review?

The review results and summary document are **100% confidential** and will not be shared with any CVO staff or committee. An anonymous copy of the documents will be kept by the Quality Assurance Program Manager for statistical purposes.

What do I need to submit?*

The records package submitted for review normally includes *8 sample cases*. Please include the following types of cases in your package, and highlight or note **the case type** and **date of the visit(s)** to be reviewed:

2 acute medical cases / 2 chronic medical cases / 2 surgical cases / 2 wellness cases

Each case submitted must contain copies of relevant components of the complete record, **dating back no more than 2 years.** Components (which are not necessarily kept in one place) might include:

Client/Patient identification form(s)	Laboratory reports
Client communications (<i>discharge instructions, home care templates, discussion notes</i>)	Digital copies of Radiographs and ultrasounds
Monitoring forms, flow sheets	Logs (<i>Radiograph, Surgery/Anaesthetic, Drugs</i>)
Consent forms	History/PE Templates
Master Problem list or Cumulative Patient Profile	Referral letters
Protocols (<i>surgical or other</i>)	Invoices (<i>you may black out prices if you wish</i>)
SOAP/DAP forms, Progress Notes	Certificates (<i>vaccine, other</i>)

For **computerized records**, make sure you send all screen views, and compile them in the proper order. For **radiographs**, only digital copies on a CD are accepted; the Inspector will not remove originals from your facility.

How long will it take to get the report?

The report is usually completed within 2-3 weeks of receipt at the CVO. The record copies will be returned to you with the Report.

Who do I contact with any questions about this process or program?

Please call Karen Smythe, CVO's Policy and Quality Assurance Program Manager, at 1-800-424-2856 ext. 2237 or send an e-mail to: ksmythe@cvo.org