ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

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Quality Assurance Plan for Controlled Prescribing

APP and Certification: _____ AL License #: _____

Collaborating/ Supervising Physician Name: _____

Specialty of Collaborating/Supervising Physician: _____

QUALITY ASSURANCE: The mechanism for quality assurance shall be as follows: Specify a plan for quality assurance management with defined quality outcome measures for evaluation of the prescribing of controlled substances by the Advanced Practice Provider and include a review of a meaningful sample of medical records plus all adverse outcomes. The term "medical records" includes, but is not limited to, electronic medical records. Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings conclusions, and, if indicated, recommendations for change.

Patient Group:	**Sample Size**	**Review**	**Designated Personnel** (Individual who will compile data)
Patients Receiving Controlled Substances	10%	Quarterly	***Provide who will compile data**
Adverse Outcomes	100 %	Immediately	Physician and APP

Each Quality Assurance/Adverse Outcome document review will include the following:

1. Identified medical records, based on controlled substance prescribing
2. Summary of the quality assurance findings and conclusions presented to APP and collaborating/ supervising physician
3. Recommendations for change, if indicated
4. Summary Statement
5. Adverse Outcome Report
6. Date of review, and signature of APP and collaborating/ supervising physician

The completed quality assurance reviews are to remain on file at the practice site.

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information, and belief.

_____	_____	_____
Print Name of Physician	Signature of Physician	Date
_____	_____	_____
Print Name of APP	Signature of APP	Date

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COLLECTIVE QA REPORT: PRESCRIBED MEDICATIONS

Required Quarterly Review: Q1 ____ Q2 ____ Q3 ____ Q4 ____ Date of Review: _____

Total # of Patients Seen: _____ Adverse Outcomes: Yes _____ No _____

SUMMARY STATEMENT: On the above date, **ten percent (10%)** of charts, with identifiers listed below, were chosen at random and reviewed for quality monitoring. The charts were reviewed for the following prescribed medication indicators:

1. Medications are prescribed per FDA guidelines (per PDR or Product Insert)
2. Proper chart documentation of medication name, dosage, and directions for use are present and legible
3. Medications prescribed are appropriate for the patient diagnosis according to practice protocol
4. Controlled medications were ordered according to regulations of the BME
5. When the PDMP was reviewed, were there any concerning prescribing patterns?
6. Has the physician physically seen the patient as required by the QACSC/LPSP protocols?
7. Was the physician's medical decision-making, evaluation, and consultation regarding the continuation or escalation of therapy appropriately documented in the medical record?
8. Were Risk Mitigation Strategies utilized and documented?
9. The patient's risk for substance abuse and addiction must be evaluated using the Screening to Brief Intervention (S2BI) tool. Was this completed?
10. If positive, were the results reviewed with the physician and documented in the patient's chart prior to initiating the prescription or therapy?

Chart #/ Identifier			
Date of Service			
D=Discussed –noted changes needed √ = Appropriate **NA=**Not applicable	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Chart #/ Identifier			
Date of Service			
D=Discussed –noted changes needed √ = Appropriate **NA=**Not applicable	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Chart #/ Identifier			
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D=Discussed –noted changes needed √ = Appropriate **NA=**Not applicable	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Chart #/ Identifier			
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D= Discussed-noted changes needed √= Appropriate **NA=** Not applicable	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Physician has reviewed /discussed all the above with APP. All adverse events have been reviewed and ***noted with the letter A.***

Physician Signature: _____ Date:_____

APP Signature: _____ Date: _____

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SUMMARY OF FINDINGS
Controlled Prescribing QA

Quarter (1, 2, 3, 4): _____ **Date Reviewed: _____**

Number of Charts Audited: _____

Summary of Findings:

_____ No specific prescribing issues identified

_____ Certain prescribing issues are in question (see comments)

_____ Adverse Event findings identified (see Adverse Event Review/Report)

_____ PDMP Reviewed/ Discrepancies Reported (Optional My Rx Report reviewed)

Comments/Discussions/Changes to be made (if any):

Physician Name/Signature: _____ Date:_____

APP Name/Signature: _____ Date:_____

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ADVERSE EVENT REVIEW/ REPORT

Office Name: _____

Address: _____

Phone Number: _____

Patient Identifier: _____ DOB: _____

Physician Name:_____ License Number_____

APP Name: _____ License Number: _____

Date of Adverse Event: _____ Patient Age/ Gender: _____

Indicate the Adverse Event:

_____

Patient Hospitalized: Yes _____ No _____

Patient Outcome: Full Recovery _____ Disability _____ Death _____ Pending _____

Provide a brief narrative description of the adverse event and include any recommendations for change:

Signature of Physician: _____ Date: _____

Signature of APP: _____ Date: _____