CPSO Peer Assessment and Your EMR

How to have a bullet-proof chart!

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Faculty / Presenter Disclosure

- **Faculty:** Dr. Jeff Habert

Relationships with commercial interests:

- **Amgen, Pfizer, BMS, Boehringer-Ingelheim, Eli-Lilly, Novo-Nordisk, Novartis, Bayer , Aralez, Astra-Zeneca, Lundbeck, Purdue, Janssen, Allergan, Servier**

- **MD Briefcase, Liv, MedPlan, Brandaide, Master Clinician Alliance, Academy, CTC, CPD Network, imc, Bridge Comm., Meducom, Antibody, CHRC, STA Comm., CCRN, Four Health Comm**

CPSO Peer Assessment

- Meant to be an educational, NOT a punitive process
- Over 80% are found to be satisfactory, with no further intervention
- No one is perfect, nor are they expected to be
- Willingness/Commitment to change and recognition of your own possible shortcomings (with respect to your charts and practice) are very favourable attributes
- BUT…….Assessment aside, how do we keep “good” charts

Peer Assessment Outcomes 2014-2016

Bottom Line:

- 80-83% assessments deemed to be satisfactory
- 11-14% are reassessed (12-15% over 70)
- 5-7% Interview (4-11% over 70)

CPSO Peer Assessment

- BUT……HOLD ON

- As of 2019: random Peer Assessments have been stopped
- Reassessments, Registration, Methadone, Change of Scope and 70/over 70 continue
- QI/QA model self directed (Fall 2019)
- Right Touch Regulation model

Pre-assessment Call: New Protocol (NOT specialists)

Chart Selection: New Assessment Protocol:

-New protocol involves YOU choosing 110 different patient names/individual visits from the EMR Calendar at least 6 months prior

-**Print** out those calendar pages/Day sheets, and beside them should indicate the main reason for visit

-You will be asked to select 14 charts that are representative of your practice (diabetes, bp, well baby, prenatal, mental health, etc.)

- Assessor will select 7 of 14 that you chose
- He will also select another 7-10 from the list of 110, to include the major areas suggested by CPSO protocol (i.e. Prev. Care, BP, Diabetes, Mental health, Well baby, Pain, Acute care

Essential EMR Components for Assessment: CPP

- The backbone of all charts (EMR and paper)
- CPSO Medical Records policy states that maintaining a CPP is mandatory (not just recommended)
- Make sure the assessor knows how to get in and out of the CPP (crucial)
- Try to ensure that all essential components of the CPP are present and hopefully maintained and populated

Essential EMR Components for Assessment: CPP (cont'd)

- Present problems, meds, past health / surgery, allergies (use NKDA)
- Social History and Family History
- Immunizations
- Preventative care section is very helpful if present on the CPP

Essential EMR Components for Assessment: Notes

- Most EMR programs will use a SOAP format
- Your notes should be in a SOAP format
- i.e. Subjective (history) / Objective (exam) / Assessment (diagnosis) / Plan (treatment / investigations)
- Notes should be comprehensive and complete (i.e., not just “exam normal”
- Templates and quick entries are helpful, but need to reflect what YOU have actually done (pre-populated templates are one of biggest problems seen with EMRs; all visits should not look the same)
- Diagnosis is essential

Essential EMR Components for Assessment: Notes (cont'd)

Plan:

- Document your treatment plan
- Meds: dose, directions, length
- Investigations
- Referrals
- Follow up

*****Always document patient refusal and instructions in case symptoms persist or worsen*****

Preventative Care and Health Maintenance

- Annual Health Exam/Preventative Care Visit:
  - Don’t use unrealistic detailed templates; should be practical and reflect what you actually do.
- Preventative care: Make it easy for the assessor to find
  - Mammograms
  - Pap smears
  - FOBT/colonoscopy
  - BMD and PSA (if done)
- Immunizations: VERY important to see routine adult immunization (i.e., Tetanus, Influenza and Pneumovax) in a central accessible list (i.e., CPP)
- Well Baby: Integrate Rourke and growth charts
  - Immunization lists on CPP, if possible

Most Common Deficiencies

- Incomplete or even absent CPP (need all essential components)
- Inadequate SOAP notes (typically lacking history and/or exam detail)
- Routine Immunizations lacking
- Preventative care issues: mammogram, pap, colon, etc.
- Routine labs lacking (i.e., no diabetic labs for >12 months, no lipids in CAD for years, no lytes, creatinine in hypertensive for years)
    - Issue of tying scripts to labs?
    - Is it the MD's responsibility to get labs done or keep prescribing?
- Major deviations from current clinical practice guidelines (i.e., No urine ACR or rare A1c in diabetics, LDL routinely >2.0 in high risk patients)

Post Chart Review Interview

- 45-90 min discussion with Assessor
- If you don't know something, just say so
- If a deficiency is found, and you agree, then state this and make a commitment to change (i.e., "immunization lists are a great idea" or "I need to be more proactive with Pneumovax" or "I should be doing urine microalbumins on my diabetics"

Pearls

- CPP
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- Comprehensive SOAP notes
- Centrally located / easily accessible preventative care (including immunizations)
- Don’t fret not doing or knowing something, but make a commitment to change / improve with the Assessor
- Always try to document patient refusal or non-compliance so it doesn’t appear to be your fault (i.e., no diabetes labs in 2 years because patient just doesn’t do their blood work)

Thank You!
Questions?

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