Electronic Medical Records

College of Physicians and Surgeons of Ontario Peer Assessment: 
what every physician should know

by Jeffrey Habert, MD, CCFP, FCFP

The College of Physicians and Surgeons of Ontario Quality Assurance Program peer assessment process is, first and foremost, educational in nature, aligned with the belief that supporting physicians in their decision-making, and providing opportunities for quality improvement, helps doctors and patients.

In 2013, the College conducted 2,487 peer assessments, with 91% of physicians receiving a satisfactory grade.1 The following recommendations are intended to assist members to prepare in advance for the day a CPSO peer assessor calls you.

Pre-Assessment
1. Communicate with the assessor:
   a. Discuss the EMR you are using (where applicable). Ask the assessor if he or she is familiar with your EMR, and if they will require a quick tutorial to navigate your EMR. Arrange for the assessor to have a temporary password (do not have them use your password).
   b. Ask how they will select charts to review.
   c. Ask about the timing of the assessment — i.e., how long it will take to review charts, and at what point he or she will sit down to discuss the findings and give feedback (typically, it takes two hours with charts, then one hour discussion, but this varies based on area of practice and specialty).
2. Pick a date that is convenient for both of you — the assessor understands the daily demands of a busy practice, and the date for the assessment should work for you.
3. Select a staff member that will assist on the day of the assessment to:
   a. Retrieve requested charts,
   b. Provide the assessor with a quick tutorial on your EMR (if needed), and
   c. Assist you in responding to assessor enquiries during the assessment.
4. Visit the CPSO website and review the protocols at http://www.cpso.on.ca/CPSO-Members/Peer-Assessment/The-Assessment/. Pull some of your charts and do your own preliminary scan of your records.
5. The cumulative patient profile (CPP) is the backbone of the medical chart. Ensure you are using this document and ensure your CPPs are up-to-date and comprehensive. CPSO Medical Records policy states that maintaining a CPP is mandatory for family practice charts and strongly recommended for most other practices. The CPP should include:
   a. Present problems/medications/past health/surgery, allergies (use NKDA — no known drug allergies — if applicable).
   b. Social history and family history.
   c. Immunizations should be properly documented (if the CPP template you are using does not include an immunization section, find a way to document this). It is very important to be able to see routine adult immunizations (i.e., Tetanus, Influenza and Pneumovax).
   d. Well baby care: Integrate Rourke Baby Records, immunizations and growth charts into the EMR if possible.
   e. Preventive care section (this is very helpful if present on the CPP).
6. The importance of comprehensive and complete notes cannot be understated.

   a. Notes should follow the “SOAP” format:
      - “S” — Subjective (History)
      - “O”— Objective (Exam)
      - “A”— Assessment (Diagnosis)
      - “P” — Plan (Treatment and Investigations).

   b. It is essential to include the diagnosis (“A”). Do not assume it is self-evident or implied.

   c. Treatment plans (“P”) should be detailed:
      - Meds (dose, directions, length)
      - Investigations
      - Referrals
      - Followup
      - Instructions in case symptoms persist or worsen.

   d. Always document patient non-compliance, refusal of suggested investigations or treatments/interventions and that you discussed side-effects (e.g., no diabetes labs in two years because patient won’t do their blood work, or patient refuses colon cancer screening/mammogram, etc.).

   e. Take care when using templates. While templates and quick entries can be helpful, they must reflect what you have actually done. Do not use templates that are not indicative of your typical practice.

Assessment Day

1. Make sure administrative support is available.
2. Have pre-selected charts available (if paper), a list of names (if EMR), and be prepared for the assessor to ask for additional charts that day.
3. Make sure the assessor knows how to navigate the EMR to locate the CPP, medical notes, labs, investigations and consults.
4. Let the assessor know where to find preventive care interventions in the EMR:
   - Mammograms
   - Pap smears
   - FOBT/colonoscopy
   - BMD and PSA (if they are done)
   - Immunizations
5. Meet with the assessor at the scheduled interview time and ask to sit in front of the computer to access your files during the discussion.

Dr. Jeffrey Habert has been a CPSO Assessor for 12 years. He is a Lecturer, University of Toronto, Department of Family and Community Medicine, and an Investigating Coroner, City Of Toronto.

Reference


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