Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg Caring for Health / À l'écoute de notre santé **FAMILY MEDICINE-PRIMARY CARE OPERATING GUIDELINE**	**Practice Guideline:** **Optimizing EMR: Tasking, Generating Consult & Referral Letters and Documentation Best Practices**	**Guideline Number:** PCOG #32
	Approved By: Primary Care Management Team	**Pages:** *1 of 5*
	Approval Date: July 17, 2015	**Supercedes:** March 17, 2015

1. INTENT

1.1. To promote the Good Practices Guide (Key Concepts and Good Practices) and Regulated Health Professions Act across all Colleges to support the ability to respond to changes in practice environments, advances in technology and promote intra and inter-professional collaboration [1,2]

1.2. To promote a common vision within Family Medicine-Primary Care on the use of the Community Electronic Medical Record (EMR) within a shared database. It is important to establish a common understanding that functionality is required to align with Accreditation Canada's quality dimensions:

- Safety - keeping patient safe
- Client-Centred Services - putting clients and families first
- Continuity of Services – experiencing coordinated and seamless services
- Effectiveness – doing the right thing to achieve the best possible results

1.3. To provide a consistent and safe communication and documentation process of supporting collaborative communication between the Primary Care 'Home' Provider and a Primary Care Provider or Clinician who share and contribute to the EMR in the areas of ***Inter Office Messaging (Tasks and Mail Messages)***
(Refer to the Canadian Medical Protective Association - Electronic Records Handbook-2014 , CPSM Statement 178 Collaboration in Patient Care and the College of Registered Nurses of Manitoba - Quality Documentation for further information on safe communication and documentation practices)

1.4. To mitigate the primary areas where risk occurs with communication and documentation between clinic offices in the shared Community EMR instance:

- Inter Office Messaging (Tasks and Mail Messages***) "Task"*** and ***"Mail Message"*** functionality
- Documentation of Best Practices in a shared data base across and within intra and interprofessional practice teams

1.5. To validate by means of a random audit that Inter Office Tasking between either receiving or sending offices is not occurring. Any instance where Inter Office Tasking is occurring will be entered into RL6 as an Occurrence for Team Managers, Site Medical Leads and Directors responsible for Primary Care to investigate and take appropriate measures.

2. DEFINITIONS

Home Clinic - When a patient enrolls with a primary care clinic where they receive the majority of their primary care, it is called their home clinic. A home clinic will act as the home base for all of their health care needs. Patients may receive some of their health services from locations such as Quick Care Clinics, Teen Clinics, RAY, Midwifery, Latent TB services or Antenatal Home Care. As these particular sites and services do not

provide the patient with all aspects of their health care needs, they would not be considered a home clinic (PCOG #25 Enrolment Process in Primary Care)

Primary Care 'Home' Provider - Refers to Physicians or Nurse Practitioners as **most responsible** for managing the patient's basic health services (continuity of care) within the home clinic

Primary Care Provider - Refers to any Physician, Nurse Practitioner, Midwife, Social Worker, Occupational Therapy, Physical Therapist or Psychologist providing either episodic, specialty or sub-specialty services (i.e. Teen Clinic, Quick Care Clinic, Latent Tuberculosis and Methadone Services)

Clinicians - Refers to Primary Care Nurses, Home Care Antenatal Nurses Dieticians, Physician Assistants or Pharmacists

Clinical Support Staff (CSS): Refers to Primary Care Assistants and Unit Clerks

Inter Office Tasking – Sending tasks to another clinic office

Intra Office Tasking - Sending tasks within a clinic office

3. GUIDELINES

Inter Office Messaging (Tasks and Mail Messages)

3.1. In the interest of quality and patient safety, the Family Medicine-Primary Care Program Leadership supports the recommendation from the Clinical Advisory Group as follows:

Suspend and refrain from using Inter Office Tasking (sending tasks to another clinic) and Mail Messaging (sending mail between clinics) until enhancements enable the safest possible transmission.

While CSIS Inter Office Tasking training material exists on this topic, until an enhancement that permits safe transmission of health information between Family Medicine Primary Care, Acute Care and Community Health (Programs, Services or Sites) exists for this specific workflow functionality, all clinical team members shall refrain from using or receiving Inter Office Tasking and Mail Messaging.

The rationale for the decision was based on the following:

- The sending provider from another clinic cannot know when a Primary Care Home Provider is absent as there is no functionality in EMR to alert the sender (i.e. no out of office alert)
- The task remains unseen in the inbox of an absent Primary Care Home Provider as there is no efficient way to view another provider's task inbox or mail from their main screen
- Tasks sent to another clinic office are no longer visible to the sender

Communication and Documentation Process

3.2. A Provider who works in another clinic providing either episodic care or specialized services, shall advise of any information (i.e. prepare a summary of test results, active medical problems, treatment plans, etc.) for follow-up by the Primary Care Home Provider before the next appointment is expected to occur.

3.2.1 Complete a generic letter template by using a ***"Macro"*** and add the ***"Clinical Note"*** which provides the patient's clinical information as well as identify within the "***Clinical Note"*** a consult letter was sent to the Primary Care 'Home' Provider (APPENDIX A - Consult & Referral Request Letters and APPENDIX B **-** Generate Consult & Referral Letters in the EMR)

3.3. If the follow-up care is of a critical or urgent nature, contact the Primary Care 'Home' Provider directly via phone to facilitate the patient's follow-up care appointment and to transfer necessary medical information.
NOTE: Both 3.2.1 and 3.3 applies to a Primary Care 'Home' Provider external to the Community EMR.

3.4. As Intra Office ***Tasking*** and ***Mail messaging*** (within an office) remains an effective way of communicating and to ensure clinics are responsive to care, Site Medical Leads and/or Team Managers are responsible to review:

- Outstanding "Tasks" Report - of any absent provider at the end of each day
- Should absent providers tasks need to be reassigned; designate a CSS to reassign tasks CSIS - Reassigning of Tasks
  Reminder: *"Tasks*" rather than "***Mail messaging"*** should be used for clinical information as ***"Tasks"*** are always attached to the patient record.

3.5. In the event that an Inter Office Task occurs, it shall be reported through RL6 as a "near miss" or "patient safety" occurrence by the clinical team member who finds it. Managers, Site Medical Leads and Directors responsible for Primary Care should consult with Human Resources and Program Leadership before taking appropriate measures to rectify.

3.6. Family Medicine Primary Care Program and Managers, Site Medical Leaders and Directors responsible for Primary Care are jointly responsible to periodically audit both sending and receiving Inter Office Tasking

3.7. A unique challenge with shared EMRs is that other healthcare providers have access to the data and contribute to the record directly. A Primary Care 'Home' Provider may also receive data or records from other episodic, specialty or sub-specialty providers that are incorporated into a patient's EMR. These providers may be unfamiliar with each other's practices and may not consult with each other regularly, if at all. The importance of

accuracy is increased in these circumstances and all healthcare providers using the EMR record should make reasonable efforts to know who contributes to it, how often it is being accessed, and how information they have added should appear on the screen or printout.

4. REFERENCES

1. The Legislative Assembly of Manitoba Bill 18 Regulated Health Professions Act (retrieved electronically June 2014)
2. The Conference Board of Canada Report (2007) Liability Risks in Interdisciplinary Care Thinking Outside the Box Liability Risks in Interdisciplinary Care Thinking Outside the Box
3. The College of Physicians and Surgeons of Manitoba CPSM Statement 178 Collaboration in Patient Care
4. The Canadian Medical Protective Association Good Practices Guide Key Concepts and Good Practices Good Practices Guide Key Concepts and Good Practices (retrieved electronically June 2014)
5. The Canadian Medical Protective Association (2014) Canadian Medical Protective Association - Electronic Records Handbook-2014 (retrieved electronically June 2014)
6. The College of Registered Nurses of Manitoba (retrieved electronically June 2014) Documentation

- In consultation with Family Medicine Primary Care Program Leadership, Clinical Advisory Group, Crystal Letain, Manager of Health Information Services, Sandra Mann CSIS Project Lead, John Whiting CSIS Senior Data Analyst

5. PRIMARY AUTHORS

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6. ALTERNATE CONTACTS

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- Dr. José François – Medical Director, Family Medicine
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7. APPENDICES

- **APPENDIX A** - Consult & Referral Request Letters (Self Study Model)
- **APPENDIX B** - Generate Consult & Referral Letter in the EMR
- **APPENDIX C** - Documentation Best Practices in the Electronic Medical Record
- **APPENDIX D** - Communication from Quick Care Clinic (or Teen Clinic) to the Primary Care Home Provider

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SCOPE: Applicable to all WRHA Primary Care Direct Operated Clinics, Family Medicine Teaching Clinics, Quick Care Clinics, Midwifery Services, Home Care Antenatal, My Health Teams, and Hospital Home Teams

NOTE: WRHA Fee for Service staff ITDI who use Accuro will not be audited