CIS Minimum Use Norms

Bottom Line

Connect Care will organize training, communication, and feedback to promote adherence to the following clinical information system (CIS) use norms where Connect Care is the record of care:

Adverse reaction list

Allergies and adverse reactions should be reviewed at every first encounter and yearly:

- Validate recorded reactions and add those not previously recorded
- Ask if there are any new adverse reactions at every medication change

Problem list

The problem list should be reviewed at every first encounter and yearly:

- Enter missing or review active problems (health conditions for which ongoing treatment or monitoring is in play) and retire inactive problems
- Ask if there are new problems at all in-person encounters

Medication list

The current medication list should be reviewed at every first encounter and yearly:

- Enter or confirm (mark as taking) all current medications, mark medications not used, or expire medications no longer prescribed
- Ask if there are new/changed medications at all in-person encounters

Diagnosis

At least one visit diagnosis must be selected for every outpatient encounter or one primary diagnosis for every inpatient encounter.

Ordering

All tests, interventions and medications that can be ordered in the CIS must be ordered in the CIS.

Documentation

Documentation of all encounters (ambulatory, inpatient, virtual, etc.) must be placed within the CIS, irrespective of how recorded (keyboard, speech recognition, dictation, transcription). Best practice is to document in notes and if needed pull the note into a communication sent to non-Connect Care providers.

Professional Billing

All billable services, including telephone advice and prescription refills should be recorded in the CIS for all prescribers who are required or elect to do this.

Encounters

All encounters should be closed in a timely fashion and, in any case, no longer than 3 weeks after provision of service.

Individuals can self-monitor compliance with all of the above norms. Anonymized information about group compliance will be provided to user groups, area councils, specialty workgroups and quality councils.

Objectives

Improper or inconsistent CIS use can compromise clinical service and safety. Accordingly, all CIS users share interest in peer-endorsed minimum use for meaningful use. Appropriate feedback can facilitate user and program-level continuing improvement.

The intent of Connect Care CIS minimum use norms is to:

- Improve the clinical utility of the AHS Connect Care clinical information system (CIS).
- Improve ability of CIS users to find important information in consistent locations.
- Enable use of CIS search functions for finding specific encounters and notes.
- Facilitate quality improvement, patient safety, clinical research, chronic disease management and health service planning.
- Minimize risks to patients arising from missing, misplaced or miscommunicated information.
- Enable multi-provider and multi-disciplinary cross-covering (after hours, holidays, emergent, etc.).
- Share information burdens among all users to decrease everyone's burden.
- Comply with Alberta Health Services, College of Physicians and Surgeons of Alberta (CPSA), accreditation, AHS medical staff bylaws and health record regulations.

Applicability

CIS minimum use norms apply to all Clinicians who see patients where Connect Care is the record of care. Clinicians may comply directly or ensure compliance with the help of other members of the health care team.

Accountability

The Connect Care Council oversees development, monitoring and optimization of minimum use norms.

Support

Each minimum use norm will be supported by online e-learning modules, post-launch user training and support, and group and individual feedback.

Incentives

Clinical programs requesting new chronic disease registries, clinical decision supports, custom reports, research supports and other clinical improvement supports will be asked to review their CIS minimum use compliance indicators. Programs non-compliant to the point that research, quality improvement and productivity measures would be unreliable, will be encouraged to raise compliance levels. Those programs with the greatest likelihood of reliable CIS clinical content will be given higher priority in the allocation of clinical improvement development resources.

Compliance

Connect Care Area Councils and their Specialty Workgroups will be provided with reports about CIS minimum use compliance, together with anonymized measures from other programs and from the entire CIS clinician population. These comparisons are descriptive, not prescriptive, and are intended to stimulate a deeper look at outlier groups in order to discover impediments to minimum use and recommend interventions to improve use.

Norms

Each clinical program will organize CIS training, communication, and feedback to promote adherence to the following expectations of members. Minimum use norms constitute a subset of practices essential to safe patient care and coordination.

Adverse Reaction Management

Allergies and adverse reactions should be reviewed by the responsible clinician or designate at every first encounter, yearly thereafter (if patients are seen that frequently), at every transfer, and every time a new medication is prescribed:

- Ask about allergies and adverse reactions at the first encounter.
- Ask whether reactions have changed since the last encounter.
- Validate previously recorded reactions and edit as necessary.
- Enter all new reactions not previously recorded.
- Review reactions yearly if patient is seen that frequently.
- If no allergies or reactions are reported, or unable to assess, use the indicated checkbox.

Compliance:

- Use the “Mark as Reviewed” or “Unable to Assess” buttons to document compliance.

Regulation:

- CPSA charting standards, AHS policies and health facility accreditation requirements.

Dependencies:

- Automatically checked for drug-reaction interactions during medication and immunization ordering, with possible clinical decision support triggers.
- Commonly pulled into progress note and communication templates.
- Automatically appear in after-visit summaries for patients.
- Exposed in both patient and physician portals.
- Part of standardized CIS minimum data (Continuity of Care Document) that could be exported to the Provincial Electronic Health Record (Netcare).

Significance:

- Failure to comply puts patients at risk.
- Failure to comply has cascading impacts on other parts of the CIS and on decision supports.

Feedback:

- Responsible prescribers will be provided with dashboard elements showing the percentage of all patients cared for by the physician in the last year where the allergies/reactions have been marked as reviewed. Comparative measures averaged for the prescriber’s clinical area the entire clinician population will be provided for comparison.
- Area Councils, Specialty Workgroups, User Groups and Quality Councils will be provided with anonymized reports showing the percentage of patients cared for by physicians in the clinical area where the allergies/reactions have been marked as reviewed within the last year. Comparative measures for other areas will be provided in-system.

Problem List Management

The list of active and ongoing medical problems should be reviewed at first encounter, every care transfer, and yearly (if seen that frequently):

- Enter or validate active medical problems (all current health conditions for which treatment or monitoring is in play) at a first in-person encounter and ask if any new problems have arisen at all subsequent encounters.
- Ensure that all chronic diseases affecting the patient are recorded.
- Resolve problems that are no longer active, if relevant to the encounter specialty.
- One or more problems can be selected as visit diagnoses, easing subsequent work.
- Health conditions can be promoted to the problem list from the past medical history, reason for visit, or plan of care notes; or demoted from the problem list to the past medical history.

Compliance:

- A “Mark as Reviewed” button can be used to affirm compliance.

Regulation:

- CPSA charting standards, AHS Clinical Documentation Framework.

Dependencies:

- Key to creating valid chronic disease registries.
- Pulled into almost all note and communication templates.
- Automatically appear in after-visit summaries for patients.
- Exposed in both patient and physician portals.
- Part of a standardized minimum data set (continuity of care document) that could be exchanged with Electronic Medical Records and other health information systems.
- Checked by and affect the performance of health maintenance reminders and care plans.
- Determine patient eligibility for clinical research protocols.
- Affect smart sets, order sets, best practice advisories and quality improvement tools.

Significance:

- Consistent completion of problem lists eases the work of clinical documentation for future visits and for colleagues.
- Problem list inattention has cascading impacts on documentation, decision and inquiry supports.

Feedback:

- Responsible physicians will be provided with dashboard elements and links to reports showing the percentage of all patients cared for by the physician in the last year where the problem list has been marked as reviewed. Comparative measures averaged for the physician’s clinical area the entire provider population will be provided to individuals, Area Councils, Specialty Workgroups, User Groups and Quality Councils for comparison.

Medication List Management

The current medication list should be reviewed at any first in-person encounter, at every care transfer, yearly (if seen that frequently), and every time a new medication is prescribed. A "best possible medication history", including review of over-the-counter and alternative medications, should be obtained at care transitions. Thereafter the work of medication review is simplified by noting changes. Even follow-up visits should query whether any medication has been added, changed or discontinued.

- Enter or validate (mark as taking) all current medications.
- Mark medications not used or expire medications no longer active.
- Annotate (using the provided note/comment button) any medication that is not being taken as expected.

Compliance:

- Any "Mark as Reviewed" button can be used to affirm compliance.

Regulation:

- CPSA charting standards, AHS charting policies, CMPA recommendations and health facility accreditation standards.

Dependencies:

- Pulled into almost all progress note and communication templates.
- Automatically appear in after-visit summaries for patients.
- Exposed in both patient and physician portals.
- Checked for possible interactions or contraindications with every new medication order.
- Important to best practice advisories and medication recall alerts.

Significance:

- All primary and specialist care services can be affected by the medications a patient takes.
- Consistent attention to medication lists eases the work of clinical documentation for colleagues.
- Failure to comply is a Patient Safety issue, with direct effects on decision supports affecting appropriate medication use and protection against medication-associated harms.

Feedback:

- Responsible physicians will be provided with dashboard elements and links to reports showing the percentage of all patients cared for by the physician in the last year where the medications have been marked as reviewed. Comparative measures averaged for the physician's clinical area the entire provider population will be provided for comparison.
- Area Councils, Specialty Workgroups, User Groups and Quality Councils will be provided with anonymized reports showing the percentage of patients cared for by physicians in the Area where the medications have been marked as reviewed within the last year. Comparative measures for other areas will be provided in-system.

Diagnosis Management

At least one visit diagnosis must be selected for every outpatient encounter or one most responsible diagnosis for every inpatient encounter.

- If multiple diagnoses were primary, all should be listed after selecting one most responsible diagnosis.
- A diagnosis can be promoted from a problem list or chief complaint.

Compliance:

- The diagnosis must be non-null to close an encounter and comply with this norm.

Regulation:

- Alberta Health Care Insurance billing requirements, workman's compensation, private insurance service approvals and CIHI reporting requirements.
- Fee-for-service and alternate payment relationship clinicians are required to record a diagnosis for all outpatient or inpatient health encounters with patients.

Dependencies:

- Used during checks for patient eligibility for research studies, chronic disease registries, and special health maintenance needs.
- Important to the reliable performance of some best practice advisories.

Significance:

- The viability of alternate payment relationships can depend outcome tracking by visit diagnoses.
- The likelihood that fee-for-service clinicians will be compensated for services performed is affected by visit diagnoses.
- Health service utilization and performance measures are keyed to diagnoses.

Feedback:

- Responsible physicians will be provided with dashboard elements and links to reports showing the percentage of all patients cared for by the physician in the last year where the encounter diagnoses have been appropriately recorded. Comparative measures averaged for the physician's clinical area the entire provider population will be provided for comparison.
- Area Councils, Specialty Workgroups, User Groups and Quality Councils will be provided with anonymized reports showing the percentage of patients cared for by physicians in the Area where encounter diagnoses have been provided within the last year. Comparative measures for other areas will be provided in-system.

Order Management

All tests, procedures and interventions that can be ordered in the CIS must be ordered in the CIS.

- Medications should not be ordered using paper prescription pads.
- Medication refills should be ordered in the CIS.
- Tests should not be ordered using paper test requisition forms.
- Completion of the problem list prior to ordering allows orders to be associated with problems.

Compliance:

- Orders may be CIS-recorded as discrete medication, test or procedure orders.
- Orders may also be recorded as parts of smart sets, order sets, order panels, protocols or therapy plans.

Regulation:

- CPSA charting standards, CMPA guides
- AHS policy that all orders must be CIS-entered where Connect Care is the record of care.

Dependencies:

- Affect performance of health maintenance reminders, best practice advisories, medication interaction checks, allergy alerts and clinical research protocols.
- Essential to appropriate results and reports routing.
- Required for multi-disciplinary team communication, care coordination and care pathways.

Significance:

- Clinical decision supports and quality improvement checks are heavily reliant on properly entered orders.
- It is difficult to monitor compliance with clinical practice guidelines if health care interventions (diagnostic and therapeutic) are not ordered in-system.

Feedback:

- Responsible physicians will be provided with dashboard elements and links to reports showing the percentage of all orders signed; typically, part of “pulse” reports. Comparative measures averaged for the physician’s clinical area the entire provider population will be provided for comparison.
- Area Councils, Specialty Workgroups, User Groups and Quality Councils will be provided with anonymized reports showing the percentage of patients cared for by physicians in the Area where orders are entered and signed in the CIS.

Documentation Management

Documentation of all ambulatory care visits must be placed within the CIS, irrespective of how recorded (keyboard, voice recognition, dictation, transcription).

- Encounter findings, assessments and plans should be documented in an appropriate encounter note (e.g., progress note, procedure note, etc.).
- When formal external communications are indicated, clinicians should pull note information into a communication (e.g., letter, message, etc.) sent to the patient's circle of care, as appropriate.
- The practice of entering "see letter" or "see attachment" in a note defeats the purpose of within-CIS clinical documentation.

Compliance:

- This norm is satisfied if a different clinician can review encounter documentation and discern the assessment and interventions performed, conclusions reached, and plans formed by the responsible clinician.
- Chronic disease management notes, attached to pertinent problems, are also compliant.

Regulation:

- CPSA charting standards, CMPA recommendations and AHS medical staff bylaws.

Dependencies:

- A powerful feature of a CIS is its ability to support searching for all clinical documentation pertaining to a particular issue or problem. Note content is searched but attached letters and media contents are not.
- Many CIS-based clinical documentation tools and automations – which can significantly decrease informational burdens – are note-dependent.

Significance:

- Consistent placement of clinically important observations in encounter notes decreases the chance that information will be missed by the health care team.

Feedback:

- Encounter note quality (length, copied content, structured content) feedback will be made available to providers and in anonymized form to Area Councils, User Groups, Quality Councils and Specialty Workgroups.
- Reports will be developed to reflect the proportion of all patient encounters where an encounter note contains less than 50 characters in the last year, 6 months and 3 months. The associated metric will be provided for individual and for anonymized group feedback.

Professional Billing Management

All billable health care services, including telephone advice, telehealth consultations and prescription refills must be documented and billed in the CIS for all clinicians who are required, or choose, to use Connect Care professional billing services.

Compliance:

- Compliance is indicated by use of a Connect Care professional billing activity to record billable services associated with patient encounters.

Regulation:

- Eligible fee-for-service and alternate payment relationship clinicians are required to record at least one billing code for encounters, procedures and services.

Dependencies:

- Billing documentation is required for clinician or program compensation for services rendered.
- Successful billing depends upon association with one or more diagnoses.

Significance:

- The viability of alternate payment relationships can depend upon consistent and timely billing.
- AHS clinician employment contracts require complete and timely professional billing records.

Feedback:

- Billing activity use reports are available to all prescribers who are required, or choose, to use Connect Care professional billing services. Anonymized group compliance feedback may be generated by billing offices (e.g. alternate relationship plans) where agreements or contractual obligations exist.

Encounter Management

All outpatient encounters must be closed in a timely fashion and, in any case, no longer than 3 weeks after provision of a service. Inpatient charts must be completed within 3 weeks of discharge.

- Encounters can and should be closed when a clinician's work is complete.
- Subsequent incomplete tasks, such as letter editing and distribution, can occur after an encounter is closed or at discharge. Zone medical staff bylaws may stipulate different time allowances.

Compliance:

- An outpatient encounter must be explicitly closed using the "close encounter" button present in many parts of CIS encounter navigators.

Regulation:

- This complies with CIS charting norms acknowledged by all CIS users at the time of their original enrollment and training.
- Closing encounters is required to allow others to view important chart content, and so is a patient safety issue.

Dependencies:

- An open encounter signals to the rest of the health care team that the clinician has not completed assessment, planning and/or communication.
- An open encounter can prevent other health care providers from benefiting from the physician's work or contributing their own work.
- Some dynamic clinical documentation content (e.g. progress note data token) is not "locked in" until an encounter is closed.

Significance:

- Embedded links or meta-data could be changed or updated in past encounters that remain open and so not reflect the true status of the variables at the time of the encounter.
- Unresolved encounters constitute a patient safety threat and are an accreditation marker of incomplete care.

Feedback:

- The proportion of clinician encounters remaining open is provided to all CIS prescribers, including group comparators, as part of their "pulse" feedback dashboard.
- Anonymized group feedback will be available to Area Councils, User Groups and Specialty Workgroups.