PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

Assessment Framework and Scoring Rubric

Family Practice

The Physician Practice Enhancement Program (PPEP) is a collegial program that proactively assesses and educates physicians to ensure they meet appropriate and current standards of practice throughout their professional lives. Our vision is to promote a culture of quality improvement among BC's physicians.

We seek to support the success of continuous quality improvement in community-based physicians' medical practice by highlighting areas of excellence and identifying opportunities for professional development.

Table of Contents

Introduction to the BC Assessment Tool

The Physician Practice Enhancement Program (PPEP) BC Assessment Tool (BCAT) is the College of Physicians and Surgeons of Ontario's (CPSO) Peer Assessment Framework, used with permission and in collaboration with the CPSO, which has been slightly modified to capture provincial differences. It provides a structure for the assessment report and evaluation criteria. The framework consists of eight assessment domains organized into four broad categories borrowed from the "SOAP" format (see table below).

SUBJECTIVE	OBJECTIVE	ASSESSMENT	PLAN
1. History	2. Examination 3. Investigation	4. Diagnosis	5. Management plan 6. Medication 7. Follow-up and monitoring 8. Documentation for continuity of care

The scoring rubrics (detailed below) support consistency, discipline-specificity, and transparency in the assessment process. For each domain, high-quality care is defined and general evaluation criteria are provided to guide assessor evaluation. A working group of CPSO peer assessors developed the criteria and sought feedback from practising physicians and specified physician specialty organizations to ensure the relevance and appropriateness of the tools. The criteria in the rubric are periodically reviewed to ensure they are up to date.

Assessors use the scoring rubrics to assist in their decision-making when completing the assessment report. The rubrics are **not** intended to be used in "scoring" individual patient records, but rather to describe the overall trend in care, considering all information gathered during the patient records review and the physician interview. The global rating scores for each of the eight domains are expressed on a three-point scale (see below). Narrative detail provided in the assessment report for each of the domains provides the critical information regarding validation of appropriate care and opportunities for improvement.

Global rating scores

1 – Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.

2 – Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.

3 – Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.

Scoring Rubrics: Family Practice

Note: The elements of quality listed below are intended to be extensive in order to apply to a diverse range of possible patient presentations. It is acknowledged **that not every element of quality will be relevant for every medical record or patient visit**. By following the **caveat statements** ("including relevant details of," "as required," etc.), the assessor will use medical expertise and professional judgement to determine which elements of quality are relevant for a given patient interaction.

College practice standards and guidelines: Many elements of quality are linked to specific College practice standards and professional guidelines (e.g. *Medical Records*, *Safe Prescribing of Opioids and Sedatives*, etc.). Relevant College standards and guidelines are linked in the header of each rubric. Where a perceived difference exists between the present content and College standards and guidelines, the relevant College standards and guidelines will take precedent.

The following are the descriptions, elements of quality, and scoring rubrics for each of the eight domains:

History

Description

A record of information gathered through questioning the patient or others (e.g. family members, substitute decision-maker) and reviewing pertinent documents to determine the next steps in care.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Demographic information** was documented, including:
   - age/date of birth
   - gender
   - patient contact information
   - health insurance information (e.g. Medical Services Plan of BC)

b. **Presenting illness histories** were documented, including **relevant details** of:
   - onset and evolution
   - symptom description, duration, aggravating and relieving factors
   - pertinent positives and negatives
   - targeted functional inquiry
   - functional status (activities of daily living)

c. **Review of systems** was documented

d. **Medical histories** were documented, including **relevant details** of:
   - past medical conditions/medical comorbidities (with reference to cumulative patient profile (CPP), as appropriate)
   - past and ongoing medical treatment and surgeries
   - immunization records (including adult immunizations such as tetanus-diphtheria, influenza and pneumococcal vaccines, as clinically indicated)
   - allergies and sensitivities (medications, food, environment) or lack thereof
   - family medical histories

e. **Medication histories** were documented, including **relevant details** of:
   - current and past medications
   - recent changes in medication (recent starts, discontinuations, dose changes)
   - alternative and complementary treatments
   - drug benefit coverage

f. **Social histories** were documented, including **relevant details** of:

- education/occupation
- marital/relationship status
- social support
- lifestyle (smoking, exercise, diet, use of recreational drugs/alcohol, misuse of prescribed medications)
- legal guardians (e.g. power of attorney) as relevant

g. **Reproductive and sexual histories** were documented, including **relevant details** of:

- current activity
- past or current pregnancies (gravida, term, preterm, abortion, living (GTPAL))
- past or current sexually transmitted infections (STIs)
- sexual orientation

h. **Mental health histories** were documented, including **relevant details** of:

- past and current psychiatric conditions
- previous treatments and/or hospitalizations
- family history of mental health issues
- past or current family violence/abuse
- assessment of family and community supports
- impact of mental health on functioning (at home, work, school, community)
- assessment of suicidality/homicidality

EVALUATION CRITERIA FOR HISTORY	
Score	**Opportunities for improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • review of systems was often inadequately documented when appropriate • pertinent positives and negatives were often not noted when appropriate • pertinent family histories relevant to presenting complaints were often not documented • chronic condition flow sheets were often not used to their full capacity • pertinent immunization histories relevant to presenting complaints were often not documented (explicitly or via reference to CPP)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • presenting illness histories were often inadequately documented (e.g. presenting complaints lacked sufficient detail regarding onset, duration, associated signs and symptoms) • significant past medical histories relevant to presenting complaints were consistently not noted (explicitly or via reference to CPP) • psychosocial histories were consistently not noted (explicitly or via reference to CPP), and assessments of homicidality/suicidality were not completed when relevant • current medications were often not noted when appropriate (explicitly or via reference to CPP) • drug allergies were often not documented when appropriate (explicitly or via reference to CPP) • developmental milestone histories in well-child care were often not documented clearly

Examination

Description

Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Physical examinations** were completed based on presenting complaint, with **relevant documentation** of:
   - pertinent positive and negative findings
   - physical measurements and vital signs with abnormal vital signs highlighted where appropriate
   - relevant descriptive information (e.g. dimensions indicating spread of cellulitis at presentation, quality of respiratory sounds, description of rash)
   - illustrations of conditions, where appropriate (e.g. location of rash, laceration, abdominal tenderness)

b. **Psychological examinations** were completed **when indicated** with **relevant documentation** of:
   - mental status examinations (MSEs) (e.g. mood and affect including risk of harm to self/others), appearance, attitude, behavior, speech, thought process, thought content, perception, cognition, insight and judgment)
   - interplay of psychological and physiological factors

c. **Standardized measures** were completed **when indicated**, with **relevant documentation** of:
   - scoring flow sheets (e.g. PHQ-9, mini mental state exam, pain scale)

EVALUATION CRITERIA FOR EXAMINATION	
Score	**Opportunities for improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • examinations sometimes included components not relevant to the presenting complaints • mental status examinations were present but could be expanded upon
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • descriptions of general appearance, level of alertness, and comfort level were minimal when appropriate • relevant physical measurements were not consistently present (e.g. height, weight, and BMI for preventive care and other assessments) • physical examinations tended to lack focus on presenting complaints and relevant histories • physical examinations were often not thorough enough to fully assess current presentations (e.g. repeated diabetic assessments with no evidence of a foot examination) • important and relevant descriptive information (e.g. dimensions indicating spread of cellulitis at presentation) was often not included • illustrated/described conditions (e.g. location of rash, laceration, abdominal tenderness) were often not included when appropriate • observations tended to be poorly described • key elements of examinations (e.g. pertinent positive and negative findings) were often not documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • pertinent vital signs (e.g. temperature and weight in child with infectious complaint) were consistently not documented • mental status examinations were often not included when relevant

Investigation

Description

Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Investigations** were **selected** appropriately as demonstrated by:
   - rationale (e.g. based on histories, examinations, presenting conditions and appropriate screenings)
   - consideration of differential diagnosis
   - review of previous investigations and findings as relevant
   - urgency (e.g. life-threatening conditions prioritized)
   - consideration of judicious use of resources (e.g. evidence to support clinical decision-making)

b. **Investigations** were **reviewed** appropriately as demonstrated by:
   - accuracy of interpretations
   - pertinent normal and abnormal information noted for consideration in management plans

c. **Patient engagement** regarding discussion of investigations, risks and benefits were completed as relevant:
   - documentation demonstrated appropriate patient discussion of investigations such as integrated prenatal screening (IPS), prostate specific antigen (PSA)

d. **Effective test result management system(s)** were implemented to ensure that all test orders, results, and interpretations were recorded, with high risk patients and clinically significant test results identified.

EVALUATION CRITERIA FOR INVESTIGATION	
Score	**Opportunities for improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • investigation benefits and risks, when indicated, were sometimes absent from documentation • investigations occasionally did not include "red flag" possibilities
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • investigations were often not documented • some tests ordered were not appropriate for presenting complaints (or for ancillary/opportunistic conditions) • evidence-based/consensus guidelines were often not followed (e.g. Canadian Diabetes Association's diabetes management guidelines; Canadian Hypertension Education Program's blood pressure guidelines; Anti-Infective Review Panel's Anti-infective Guidelines for Community-acquired Infections; Ottawa Ankle Rules) • overall there was a tendency to over investigate (e.g. X-rays, blood work ordered when not clinically indicated)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • appropriate tests based on histories and physical examinations were often not ordered/performed • investigations were often not reflective of differential diagnoses • an effective test results management system was not in place (e.g. test results were often not reviewed and recorded and/or potentially clinically significant abnormal test results were not followed up on)

Diagnosis

Description

The identification of a possible disease, disorder, or injury in a patient.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Diagnostic conclusions** were appropriate, considering:

- alignment with histories (medical, surgical, allergies, medications, family, risk factors), examinations, and investigations (including physiological and psychosocial issues)
- consideration of most/least likely and other possible causes
- consideration of comorbidities and presenting symptoms
- noting acuity and/or severity as relevant

b. **Differential, working and/or final diagnoses were clearly stated.** Examples include, but are not limited to:

- **final diagnoses** were clearly **documented, as appropriate**
- **differential diagnoses** were documented when final diagnoses were not yet determined (e.g. “chest pain – not yet diagnosed”); **or** when diagnoses were unlikely but still were to be considered if investigations or clinical course tended to rule out initial/working diagnosis; **or** when potentially serious diagnoses were considered but were thought to be unlikely
- **diagnoses were qualified** (e.g. “controlled,” “not controlled,” “improving,” “worsening”), **as relevant**

EVALUATION CRITERIA FOR DIAGNOSIS	
Score	**Opportunities for improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • risk factors were occasionally not adequately considered in diagnostic methods
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • MSP/ICD9 diagnostic codes were often used rather than more specific written diagnoses • differential diagnoses were often not considered when appropriate • patient risks were often not adequately considered in diagnoses (e.g. Framingham or other similar framework not considered for assessment of cardiovascular risk) • chronic diseases and their role in presentations were often not adequately considered in diagnoses (e.g. diabetes with presentation of chest pain) • psychosocial factors were often not taken into consideration in diagnoses
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • final diagnoses or differential diagnoses were consistently not clearly stated and needed to be inferred from plans or medications prescribed • diagnoses were often inappropriate based on documented assessments

Management plan

Description

A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Management plans** were **developed appropriately**, as **demonstrated by**:

- treatment plans consistent with and appropriate given histories, examinations, and results of investigations
- appropriate pre-treatment screening for contraindications or cautions
- consideration of comorbidities in treatment plans
- consideration of acuity of the patient's presenting complaint and accompanying safety issues
- relevance of ordered/conducted tests, procedures, referrals and reassessments
- employment of patient safety and infection control measures as warranted
- consideration of judicious use of resources (e.g. referrals and requisitions)
- consideration of patient circumstances and costs (e.g. coverage for medication; physiotherapy)
- documentation of outstanding preventative health topics to be addressed at future appointments

b. **Management plans** were **implemented and recorded appropriately**, with **relevant details** of:

- CPP updated regarding chronic and ongoing conditions
- purpose of treatment
- indicators of treatment progress
- treatment outcomes (e.g. patients' responses, good/bad effects, treatment errors, and suggestions for improvement)
- discussions of patients' expectations and compliance related to treatment processes
- explanations to patients regarding management plan, options, risks/benefits and potential side effects to enable an informed consent
- advice and education material given to patients/family
- prompt and appropriate responses to unexpected or adverse intra-procedural events and complications

- follow-up plan, including recommendations for return appointments
- documentation of advanced care, directives or plan, as appropriate

EVALUATION CRITERIA FOR MANAGEMENT PLAN	
Score	Opportunities for improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • written advice sheets were sometimes not provided to patients when indicated • follow-up plans were sometimes not clearly stated • documentation of advanced care directives were sometimes not made when relevant
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • appropriate consultations for ongoing care or acute/chronic conditions were not considered and documented • appropriate reassessments of patients following treatments were often not considered and documented when appropriate • rationale for management plans were often not documented when diagnoses not evident • consent procedures/discussions were often not documented when appropriate (e.g. treatment for patients with dementia, treatment of minors) • refusal of consent and the discussions that took place were often not documented • discussions regarding patient non-compliance were often not noted

EVALUATION CRITERIA FOR MANAGEMENT PLAN	
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • appropriate procedures were often not performed when relevant • management plans were often not appropriate for the presenting complaints • management plans did not consistently take into consideration the acuity of the patients' presenting complaints (e.g. symptoms consistent with DVT or angina are not managed/handled as emergency presentations) • necessary reassessments were often not performed • management plans often failed to address diagnostic conclusions or patients' presenting complaints • management advice given to patients/substitute decision-makers was often not completed and/or documented • advice given to patients regarding the circumstances under which they should seek urgent/follow-up care and with whom was often not documented • treatment information was often not provided to patients or substitute decision-makers • patients' capability of consenting was often not determined/documented when appropriate • patients were often not notified of treatment options based on clinically significant results of tests

Medication

Description

The prescribing, titrating and tapering of drugs to reach intended drug therapy goals.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*, *Safe Prescribing of Opioids and Sedatives*

Elements of quality

a. **Medications** were selected appropriately considering:
   - diagnosis
   - patient characteristics (e.g. age, sex, sensitivity/allergy profile)
   - goals of pharmacological treatment

b. **Prescriptions** were comprehensively documented, including **relevant details** of:
   - name of the drug
   - dosage
   - quantity/repeats
   - route

c. **Information provided to patients** was appropriate, including **relevant details** of:
   - risks/benefits
   - side effects (nuisance and serious)
   - contraindications and precautions
   - indications for follow-up (e.g. what to do if side effects occur)

d. **Medication monitoring** was appropriate, as demonstrated by:
   - CPP updates
   - ongoing tests, examinations, and investigations (i.e. follow-up plan with time frame for re-evaluation)
   - medication list updated with changes and rationale for changes
   - medication side effects monitored at appropriate intervals
   - evidence of annual review of chronic medications and discussions with patients regarding the pros and cons of medications as health and age changes
   - responsible persons identified for monitoring medications, as appropriate
   - substance misuse issues addressed, as appropriate

- opioid narcotic contracts used when appropriate (see QI Resource 3: Chronic Non-Cancer Pain Management)

e. **When drug samples** were provided:

- documentation of drug samples given included:
  - date provided
  - name of the drug
  - drug strength
  - quantity or duration of therapy
- samples given to patients have not passed their expiry dates

EVALUATION CRITERIA FOR MEDICATION	
Score	Opportunities for improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • when drug samples were given, details of the drug and the need for follow-up were sometimes not documented • rationale for the selection of medication was sometimes not clear from documentation • discussions regarding potential side effects of medications were sometimes not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • relevant discussions with patients (e.g. regarding side effects, indications for follow-up) were often not documented • continuation of medications and/or polypharmacy was often inappropriate given patient conditions • inappropriate medications were often prescribed (e.g. antibiotics for viral infections, or narcotics for first line management of chronic non-cancer pain), without plausible rationale documented (e.g. rapid strep test negative but clinical presentation suggestive of strep throat)

EVALUATION CRITERIA FOR MEDICATION	
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • relevant medication information (e.g. medication name, quantity, dose, duration) was consistently not documented • inappropriate or contraindicated medications, doses, or quantities of medication, which could result in harm, were given to one or more patients (e.g. amoxicillin prescribed when allergy to penicillin noted in the CPP) • appropriate medications were often not prescribed for clinical conditions in accordance with current, generally accepted clinical practice guidelines

Follow-up and monitoring

Description

The ongoing observation and assessment of the patient's progress to assess treatment efficacy and need for treatment change or termination.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Investigations and laboratory reports** were followed up appropriately, as demonstrated by:
   - relevant **follow-up** tests ordered
   - abnormal results followed-up in a timely fashion

b. **Patient monitoring and follow-up** were appropriate, as demonstrated by:
   - a regularly updated CPP
   - coordination of ongoing care between family practitioner and specialist
   - interdisciplinary coordination of care between family practitioner and other health-care professionals practising in same clinical setting (e.g. nurse practitioner, physician assistant, etc.)
   - prompt attention to emergency problems
   - documentation of patient progress relative to goals

c. **Linkage to next visit** was appropriate, as demonstrated by documentation of:
   - expectation for patient follow-up (time, place)
   - investigations, treatments and/or actions to be completed by patient prior to next appointment
   - possible complications and/or adverse events that would be expected to trigger an earlier assessment/appointment
   - summary of expected disease course/progression/resolution during time to next follow-up appointment

d. **Documentation of chronic disease** was appropriate, as demonstrated by documentation of relevant:
   - targets (met or unmet)
   - flow sheets used and the populated to demonstrate disease stability/progression over time
   - tests ordered and documented to ensure patient stability or recognize disease progression over time

EVALUATION CRITERIA FOR FOLLOW-UP AND MONITORING	
Score	**Opportunities for improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • recommendations for follow-up appointments were occasionally not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • indeterminate test results (e.g. urine C&S specimen contaminated, indeterminate STI blood or urine test) were often not followed up on • interdisciplinary coordination of care was not evident when appropriate • appropriate urgent consultations/patient visits were arranged but documentation of reasons was often unclear or absent • rationale for changes to patient treatments were often not documented • flow charts (or equivalent) for planned chronic disease management were often not being used proactively
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • relevant follow-up tests were consistently not ordered • investigations and laboratory reports were not followed up appropriately • immediate consultations, referrals or transfers were not considered when appropriate • treatment plans were often not modified according to test results (e.g. urinary culture growth resistant to prescribed antibiotic, warfarin dose adjustments due to abnormal INR) or specialist recommendations

Documentation for continuity of care

Description

Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

Key College of Physicians and Surgeons of BC practice standards/professional guidelines and PPEP assessment standards: *Medical Records*, *Unified Medical Record*

Elements of quality

a. **Communication as a referring source** was effective, as demonstrated by:
   - clear and comprehensive articulation of consultation requests and referrals including details of:
     - reason for referral with sufficient clinical detail to assess urgency of consultation
     - results of investigations to date relevant to reason for referral
     - results of treatments already/previously initiated
     - patient history (past history, family history, medications and allergies)

b. **Communication with other treating professionals** was effective, including details of:
   - change in patient condition
   - complications potentially requiring alternate approach
   - new conditions
   - investigation results

b. **Documentation adhered to the record keeping requirements specified by the College of Physicians and Surgeons of BC practice standard *Medical Records*, PPEP assessment standard *Unified Medical Record*, and best practices**
   - The medical record must be written in readable English and:
     - contain detailed description of **all** patient encounters (including those made in person, by telephone, or electronically by email, etc.)
     - contain a complete, up-to-date problem list
     - contain a complete, up-to-date medication list
     - contain a current record of allergies (or lack thereof)
     - contain current (when possible) immunization records (including adult immunizations such as tetanus-diphtheria, influenza and pneumococcal vaccines, as clinically indicated)
     - contain results of investigations
     - contain copies of referral letters/notes to other physicians

- contain health insurance information (e.g. Medical Services Plan of BC)
- contain all written communications received from other physicians and health-care providers relevant to the patient's medical care, for example:
  - consultation letters
  - records of visits to other clinics or emergency rooms
  - discharge summaries
  - operative reports
  - reports of treatments by other health-care professionals
- encounter notes contain essential, appropriate and relevant information about the patient visit including reason for the visit, what was found during the visit, and what was done during the visit
- SOAP-like format charting used
- physicians complete the CPP for every patient
- CPP includes appropriate and relevant information on a patient
- abbreviations were appropriate (i.e. no potential for confused interpretation by the range of health-care providers who might need to access the record)
- in the case of shared records, it is clear who made the entry
- information was presented in a systematic and chronological manner
- most responsible physician ensures trainee entries were accurate
- clinical notes told the story of the patient's health-care conditions and allowed other health-care providers to read and understand the patient's health concerns or problems
- templates were used appropriately, including pre-populated templates
- an effective system exists for recording and managing test findings and follow-up
- patients' charts filed by name (i.e. **not** by date of encounter)

EVALUATION CRITERIA FOR DOCUMENTATION FOR CONTINUITY OF CARE	
Score	Opportunities for improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • medical records were mostly legible (some words were unreadable, but charts could be understood by a clinician) • abbreviations were sometimes inappropriate (i.e. potential for confusion by other health-care providers) • CPPs could be more comprehensive
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • medical records were somewhat illegible (many words were unreadable; meaning of charts was sometimes unclear) • Public Health was sometimes not notified regarding suspected or confirmed reportable communicable diseases, food poisoning, dog bites, and other mandatory notifiable conditions • transfer of patients to hospital emergency departments was not consistently documented • consultation requests to and from family practice office were not consistently documented • physician-patient encounters, including telephone contact, were often not documented, not dated, and, in the case of shared records, it was not clear who made the entry • information was not presented in a systematic and chronological manner • templates (including pre-populated templates) were often used inappropriately or not completed in full • communication to consultants was often inadequately documented

EVALUATION CRITERIA FOR DOCUMENTATION FOR CONTINUITY OF CARE	
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • medical records were often illegible (most words unreadable; meaning of charts was generally unclear) • trainee entries were often not checked for accuracy • CPPs were not used and/or not kept up to date • coordination of care between referring physician and consultant/specialist was not evident • overall, the clinical notes did not tell the story of patients' health-care conditions in a way that would allow other health-care providers to understand them

Quality Improvement Resources

Quality improvement resources provide (QIRs)a reference for topics that are of particular relevance to the discipline and which may arise during peer assessment. They are intended to promote a common framework for assessor feedback and to provide educational material for physicians. The resources are developed by CPSO peer assessors, modified by PPEP medical advisors for BC use, and regularly reviewed and updated. They vary by discipline but may include information relative to specific patient populations, conditions, procedures, therapeutic modalities or examples of appropriate documentation formats.

These quality improvement resources are not clinical standards, clinical guidelines, or intended to replace the knowledge, professional skill and judgment of physicians. They are, however, intended to be educational tools for BC physicians. The primary aim of the assessment is to ensure that patients are receiving good care, and that the physician is recording that care such that another physician could assume care effectively and efficiently. We recognize that some physicians may use alternate resources or may document differently than those outlined in the practice guidelines; good care can still be determined by the assessor as long as the physician can clarify their management rationale.

Quality Improvement Resources for Family Practice

Note: The QIRs for family practice have been selected to reflect some of the most common chronic disease/ongoing care/preventive health presentations in this clinical environment. QI resources for common acute presentations (e.g. respiratory tract infections, urinary tract infections, low back pain, etc.) have been developed by walk-in clinic assessors and are also available as educational resources.

1. Diabetes mellitus type 2
2. Depression/anxiety
3. Chronic non-cancer pain management
4. Preventive health: cervical cancer screening
5. Preventive health: breast cancer screening and breast mass management
6. Preventive health: immunization (child and adult)

Importance of Cumulative Practice Profile (CPP) for Family Practice

Information such as past medical history, comorbidities, past investigations and procedures, etc., may be most appropriately recorded by the physician (and located by the peer assessor) in the CPP rather than in the day of encounter/visit record.

QI Resource 1: Diabetes Mellitus Type 2

Last reviewed: July 2018 / Next planned review: 2020

Quality improvement resources (QIRs) provide a reference for topics that are of particular relevance to a medical discipline and which may arise during peer assessment. They are intended to promote a common framework for assessor feedback and to provide educational material for physicians.

QIRs are developed by CPSO peer assessors, modified by PPEP medical advisors for BC use, and regularly reviewed and updated in accordance with an established cycle. They are not clinical standards, clinical guidelines, or intended to replace the knowledge, professional skill and judgment of physicians. QIRs are intended to be inclusive of many potential elements of quality of care related to a specific topic; however, they are not exhaustive. In addition, not all elements listed in a QIR will be applicable for every patient encounter, assessment, or plan of care.

SUBJECTIVE

- Initial visit/diagnosis
    - Diagnostic criterion, date documented on diagnostic visit notes and CPP
    - FPG ≥ 7.0 mmol/L or A1c ≥ 6.5% (in adults) or two-hour plasma glucose (75 gm OGTT) ≥ 11.1 mmol/L or random PG ≥ 11.1 mmol/L in a patient with symptoms of hyperglycemia (e.g. polyuria, polydipsia, and unexplained weight loss)
    - Confirmatory test ordered if appropriate[1]
    - Initial treatment as per CDA Guidelines with goal to reach target hemoglobin A1c in three to six months
    - Documented presence/absence of associated chronic disease (e.g. obesity, dyslipidemia, cardiac disease, vascular disease, obstructive sleep apnea, hypertension)
    - Appropriate follow-up arranged to include appropriate laboratory investigation
        - Next visit within three months depending on acuity of presentation
        - Laboratory investigation to include hemoglobin A1c and renal function
        - Appropriate investigation or referral for associated diagnoses (e.g. cardiology referral for associated or suspected cardiac disease, sleep study)
        - Referral to Diabetes Education and/or specialist as appropriate
        - Clear documentation as to transfer of care versus shared care versus primary care
    - Initiate diabetes care flowsheet
- Subsequent visits
    - Symptom review with particular attention to:

[1] Confirmatory tests are ordered as in the BC Guidelines

SUBJECTIVE

        - hypoglycemia
        - symptoms of macrovascular complications (e.g. coronary artery disease, congestive heart failure, peripheral arterial disease, TIA, stroke)
        - symptoms of microvascular disease (e.g. retinopathy, neuropathy)
        - document most recent eye exam by eye care professional (every one to two years)
    - Review glucose logbook (when self-monitoring of blood glucose is appropriate)
        - Range from high to low
        - Do logbook readings match hemoglobin A1c? (e.g. high numbers in logbook with normal A1c suggestive of hidden hypoglycemic events)
    - Antihyperglycemia medications (name, dose)
    - Other medication review if appropriate (should be easily found on the chart if not in the visit note)
        - ACEI/ARB
        - Statin
        - Aspirin/thrombosis protection
    - Review of laboratory data – hemoglobin A1c, creatinine/eGFR and urine albumin-to-creatinine ratio (ACR) at appropriate intervals
        - Renal function; is there any indication for adjustment of medication doses?
- Long term management - periodic overview visits to ensure that periodic monitoring and preventative measures are being done (annual flu shots, ophthalmology assessments, ACRs, etc.)
    - Annual review? Done recently (12 to 18 months) or planned?
    - Flow sheet (CDA example: CDA Guidelines, online Appendix 2)

OBJECTIVE

- Vital signs: weight, blood pressure, pulse including regularity
- Heart and lung auscultation
- Presence or absence of peripheral edema
- Foot exam annually (or more frequent if high risk) including monofilament assessment

ASSESSMENT

- List of diagnoses/comorbidities in addition to diabetes
- Identify targets reached/not reached

PLAN

- Continue present treatment/note any change in treatment
    - A – A1c – establish glycemic target, choice of agent and rationale[2,3]
    - B – Blood pressure target – choice of agent and rationale[2,3]
    - C – Cholesterol target – choice of agent and rationale[2,3]
    - D – Drugs for vascular protection – statin, ACEI or ARB or ASA as appropriate
    - E – Exercise/eating – lifestyle management discussed or referral made
    - S – Smoking cessation discussed if appropriate
    - V – Vaccines – pneumococcal and annual influenza as recommended
- Microvascular screening
    - E – Eye exam annually
    - F – Foot exam annually, discuss foot care
    - R – Renal – assess urine, albumin-to-creatinine ratio (ACR), creatinine/eGFR and treat with ACEI or ARB as appropriate and refer if needed
- Directions for next visit including requisitions for appropriate blood work
- Referral to Certified Diabetes Educator (CDE), consultant as appropriate
- Annual review? Recent or planned?
- Advice regarding lifestyle and social habits
- Other considerations:
    - Medications used? Appropriate?
        - Glyburide has a tendency to prolonged hypoglycemia, particularly in the elderly.
        - Sulfonylureas generally lead to a shorter time frame until insulin is required. Other choices may prolong the length of time until insulin is required.
        - Hemoglobin A1c at target? Guidelines suggest reaching target within six months.

[2] 2013 CDA targets: A1C 6.5%, 7.0%, or 8.5% depending on population; BP 130/80; LDL ≤2.0 mmol/L
[3] 2015 BC Guidelines targets: A1C 6.5%, 7.0%, or 8.5% depending on population; BP 140/90; no specific target LDL level

PLAN

        - Are newer medications being appropriately considered? (dipeptidyl peptidase-4 [DPP-4] inhibitor, glucagon-like peptide-1 [GLP-1] agonist, sodium-glucose co-transporter 2 [SGLT-2] inhibitor)
        - Are medication doses being appropriately adjusted for renal function?
    - Patient information sheets/websites (as appropriate)
    - Integration of diabetes history, physical, treatment, and monitoring into CPP, as appropriate (including Type 2 diabetes flow sheet)
- Appropriate care adjustments if targets not met according to current CDA or BC guidelines[4,5]

Recommended Guidelines/Resources

Guidelines

- Diabetes Canada Clinical Practice Guidelines – Full 2018 Guidelines http://guidelines.diabetes.ca/Browse.aspx
- Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and. Management of Diabetes in Canada. Can J Diabetes. 2018;42(Suppl. 1):S1-S325 http://guidelines.diabetes.ca/docs/CPG-2018-full-EN.pdf
- Diabetes Canada 2018 Clinical Practice Guidelines Quick Reference Guide http://guidelines.diabetes.ca/docs/CPG-quick-reference-guide-web-EN.pdf
- BC Guidelines Diabetes (2015) https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/diabetes_care_full_guideline.pdf

Applications

- Diabetes Canada Clinical Practice Guidelines App (http://guidelines.diabetes.ca/app)
    - App Store https://itunes.apple.com/ca/app/cda-clinical-practice-guidelines/id882554622?mt=8
    - Google Play https://play.google.com/store/apps/details?id=ca.diabetes.guidelines.cpg

[4] 2013 CDA targets: A1C 6.5%, 7.0%, or 8.5% depending on population; BP 130/80; LDL ≤2.0 mmol/L
[5] 2015 BC Guidelines targets: A1C 6.5%, 7.0%, or 8.5% depending on population; BP 140/90; no specific target LDL level

QI Resource 2: Depression/Anxiety

Last reviewed: July 2016 / Next planned review: 2019

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SUBJECTIVE

- **Current signs/symptoms of depression:** Fatigue, loss of energy, depressed mood, sleep disturbances, feelings of guilt/worthlessness, anhedonia, poor concentration, appetite changes, sleep disturbance, homicidal/suicidal ideation and/or attempt, decreased libido, previous episodes with similar symptoms? Seasonal symptoms? Post-traumatic stress? Panic attacks? Obsessive-compulsive behaviour
- **Current signs/symptoms of anxiety:** Panic attacks vs. generalized anxiety, obsessive-compulsive thoughts or behaviours? History of traumatic event, avoidance behavior, social anxiety
- Rule out manic or hypomanic episodes and psychotic symptoms
- **Onset and duration of signs/symptoms:** Evolution of symptoms, acute vs. sub-acute vs. chronic, cyclical, seasonal, association with menses
- Recreational drug use and alcohol use
- **Social context:** Acute stressors, relationship issues, history of abuse, living situation, social supports, finances, work history, access to medication and/or firearms
- **Past history/comorbid conditions:** Previous psychiatric history, previous suicide/self-harm attempts, history of head injuries, seizures, cerebrovascular accidents (CVA), thyroid disease, anemia
- **Family history:** Family history of psychiatric conditions
- **Past treatments:** Past use of psychotropics or counseling, drug allergies/adverse effects
- **Current medications:** Prescription medications, over-the-counter medications, herbal remedies
- **Review of systems:** E.g. anemia, thyroid (weight gain/loss, hair loss), CVS (shortness of breath, palpitations), neurological (evidence of localizing/focal signs)

OBJECTIVE

- **Physical exam:** Vitals (HR, RR, BP), chest and CV exam as appropriate
- **Mental status exam:** Appearance, psychomotor changes, mood and affect, speech pattern, thought form and content (including presence of suicidality/homicidality, delusions), perceptual disturbances, insight and judgment, cognition (MMSE/MoCA as appropriate)
- **Neurological:** As appropriate (if history suggestive of major neurocognitive disorder, CVA, or focal neurologic complaints)
- Consider periodic assessment with a standardized questionnaire

ASSESSMENT

- Depressive disorder – DDx: Major depressive disorder, persistent depressive disorder, seasonal affective disorder, bipolar I or II disorder, depression due to another medical condition, substance-induced depressive disorder, adjustment disorder
- Anxiety or trauma disorder – DDx: Generalized anxiety disorder, panic disorder, social anxiety disorder, PTSD, specific phobia anxiety due to another medical condition, substance-induced anxiety disorder, adjustment disorder
- Underlying medical disorder (hypo- or hyperthyroidism, anemia, etc.)

PLAN

- Laboratory investigations (e.g. CBC, TSH, glucose)
- Baseline rating scales (e.g. patient health questionnaire (PHQ-9), generalized anxiety disorder 7-item scale (GAD-7))
- Medication prescribed, dosage, quantity, review side effects and interactions with present medications, monitor for discontinuation syndrome or other adverse reactions
- Suicidal and/or homicidal risk assessment and management (e.g. resources, crisis lines)
- Counselling (documentation of what was discussed, physician's input and patient's response during the encounter - note duration of intervention)
- Discussion with family and/or caregivers (if appropriate)
- Discussion regarding return to school/work, financial assistance, fitness to drive
- Referral to psychologist, psychiatrist, community resources, social services (if appropriate)
- Clear and appropriate follow-up plans
- Urgent versus non-urgent referral to hospital: proper use of BC Mental Health Act Forms (Form 4) for certification if indicated
- Patient information sheets/websites (as appropriate)

PLAN
• Integration of depression/anxiety history (including risk factors), physical, treatment, and monitoring into CPP, as appropriate

Recommended Guidelines/Resources

Online Resources

- BC Guidelines Anxiety and Depression in Children and Youth (2010) http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/anxiety-and-depression-in-youth
- BC Guidelines Major Depressive Disorder in Adults (2013) http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/depression-in-adults
- Canadian Task Force on Preventive Health Care (2013). Recommendations on screening for depression in adults. Canadian Medical Association Journal, 185 (9), 775-782. www.cmaj.ca/content/185/9/775.full.pdf
- BC Guide to the Mental Health Act (2005) http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf
- BC Mental Health Act forms http://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms

Tests and Questionnaires

- Hamilton Rating Scale (HAMD-7) 7-item rating scale www.mdpu.ca/documents/hamd7.pdf
- Beck Depression Inventory http://www.hr.ucdavis.edu/asap/pdf_files/Beck_Depression_Inventory.pdf
- Edinburgh postnatal depression scale (EPDS) for pregnant and post-partum females http://www.perinatalservicesbc.ca/health-professionals/professional-resources/health-promo/edinburgh-postnatal-depression-scale-(epds)
- Generalized anxiety disorder 7-item scale (GAD-7) https://www.dhs.wisconsin.gov/mh/conferences/generalized-anxiety-scale-2-11-16.pdf
- Patient health questionnaire (PHQ-9) http://www.ubcmood.ca/sad/PHQ-9.pdf
- Kroenke, K., Spitzer, R.L., Williams, J.B. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. Journal of General Internal Medicine, 16(9), 606-613. www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/
- Geriatric depression scale (short form) http://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF

QI Resource 3: Chronic Non-cancer Pain Management

Last reviewed: September 2017 / Next planned review: September 2020

Chronic non-cancer pain includes any painful condition that persists for three months or longer and is not associated with malignant disease (DeGroote, 2017).

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SUBJECTIVE

- **Initial assessment** (may be done over several patient appointments)
    - The patient's pain is well described including the type, cause and nature of the pain including past investigations and previous interventions
    - The patient's functional impairment is described and documented
    - Medical history including past medical and surgical history, allergies (to opioids), family history of substance use/addiction and psychiatric history is documented
    - Previous history of addiction (illicit drugs or alcohol) is considered and documented
    - Documented discussion with patient that non-pharmacological modalities and non-opioid pharmacotherapy modalities are preferred for chronic non-cancer pain and that potential benefit of long-term opioid treatment (LTOT) is modest and risk significant
    - Advise patient that LTOT is not indicated for certain medical conditions including headache disorders, fibromyalgia and axial low back pain
- **Follow-up patient visits**
    - Pain intensity and quality is reassessed using a numerical scale
    - Function is assessed and functional goals are considered
    - Side effects to medications are elicited including constipation, nausea, vomiting and sedation
    - Consider possible associated psychiatric concerns and mental health concerns (e.g. depression)
    - Reassessment of use of opioids if there has been a trial and pain has not improved

OBJECTIVE

- **Initial assessment**
  - Physical examination is problem based, clearly documented and supports diagnosis
  - Investigations and consultations confirm diagnosis and prescribed treatment
  - The pain intensity is documented preferably using a numerical scale
  - Review patient's current medications (using PharmaNet profiles when access is available) before prescribing opioids, sedatives or stimulants
- **Follow-up visits**
  - Physical examination is carried out with changes in patient history or condition
  - Documentation of the five A's: activity, analglesia, adverse effects, aberrant behaviours, affect
  - The pain intensity and functional goals are documented preferably using a numerical scale at every visit
  - Investigations and/or consultations are arranged as indicated with changes in patient pain profile, medication complications, etc.

ASSESSMENT

- **Initial assessment**
  - Diagnosis is clearly stated and is supported by investigations (X-rays, CT/MRI) and consultant notes
  - Addiction risk is considered – completion of "Opioid Risk Tool" and/or "CAGE questionnaire" ideally
  - Trial of tapering and referral to a pain clinic /or addiction medicine consultant when indicated
- **Follow-up patient visits**
  - Random urinary drug screening (rUDS) is carried out at least annually
  - Compliance to medications is assessed
  - If opioid misuse is determined according to DSM-V criteria for substance use disorder, consideration be given to referrals for addiction, suboxone, methadone maintenance therapy, counselling
  - If patient is using ≥ 90 mg morphine equivalent per day, consideration should be given to tapering opioids and/or referral to specialist (as appropriate)

PLAN

- **Initial assessment**
  - Review goal of therapy: pain reduction and improved function (with or without pain elimination)
  - Prescribed medications are indicated for diagnosis (e.g. opioids are not effective for fibromyalgia)
  - Alternative non-opioid medications are prescribed where appropriate for the pain syndrome
  - Physical therapy/modalities, education and counselling are prescribed where appropriate
  - Always prescribe the lowest effective dosage of opioid medication, document careful reassessment if increasing the dose > 50 mg morphine milligram equivalents (MME) per day and avoid increasing the dose to > 90 MME per day; weak opioids are tried first and long acting narcotics are prescribed preferentially where appropriate
  - The quantity and prescription intervals take into consideration previous patient addictive behaviors (e.g. smaller amounts of narcotics are prescribed for patients at higher risk of addiction)
  - Narcotic prescribing agreement is signed in patient chart and easily referenced
- **Follow-up patient visits**
  - At each patient visit pain level, compliance, medication side effects and patient function are assessed
  - The patient is reassessed more frequently at the "watchful dose" of > 50 MME
  - Pain medications are prescribed in a stepwise fashion, slowly titrated and their effect is assessed at appropriate intervals
  - Morphine equivalent dose is documented and used to determine doses with changes in prescribed opioids
- **General**
  - Patient information sheets/websites (as appropriate)
  - Integration of chronic non-cancer pain history, physical, treatment, and monitoring into CPP, as appropriate

Recommended Guidelines/Resources

- College of Physicians and Surgeons of BC, practice standard *Safe Prescribing of Drugs with Potential for Misuse/Diversion*
  https://www.cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf

- 2017 Canadian Guideline for Opioid Therapy and Chronic Non-Cancer Pain (and additional resources). Last accessed: June 23, 2017. http://nationalpaincentre.mcmaster.ca/guidelines.html

QI Resource 4: Preventive Health – Cervical Cancer Screening

Last reviewed: July 2016 / Next planned Review: 2020

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SUBJECTIVE

- Symptoms
    - Post-coital bleeding, irregular vaginal bleeding
    - May be nonspecific with vaginal discharge (watery, purulent or foul smelling), pelvic or lower back pain
- Review of risk factors
    - History of HPV infection, multiple sexual partners, early age of sexual activity, acquiring of a new sex partner, male sex partner with higher lifetime number of sexual partners
    - History of cervical dysplasia (individualized screening – yearly Pap smear)
    - History of condom use, HPV vaccine
    - Smoking and second-hand smoke exposure
    - Long-term use of hormonal contraceptives (>5 years)
    - >5 full-term pregnancies
    - History of sexually transmitted diseases
    - Poor diet (low antioxidants)
    - History of immunosuppressant therapy (yearly Pap)

OBJECTIVE

- Pelvic exam including visualization of the cervix noting any abnormalities (e.g. visible cervical lesion; ulcers; raised, friable lesions)
- BCCA guidelines: Average risk women between the ages of 25 to 69 should be screened with Pap testing every three years. Screening can stop at age 69 if results have all been normal.

ASSESSMENT
• Documentation of patient's risk category in the CPP • Pap result normal, intermediate (ASCUS, AGUS, dysplasia (LISL, HSIL))[6], squamous cell carcinoma, adenocarcinoma

PLAN
• Evidence of discussion of risk factors for cervical cancer with patient and discussion regarding safe sex, reduction of risks, HPV vaccine, use of condoms, cigarette smoking cessation and limiting number of partners discussion re: patient risk category • Discussion of the importance of follow-up of test results and what the next step is in case of abnormal findings (ASCUS – consider HPV testing, colposcopy; AGUS – consider colposcopy, endocervical, curettage and endometrial sampling; dysplasia (LSIL, HISL), squamous cell carcinoma, adenocarcinoma – consider colposcopy and biopsy) • Patient information sheets/websites (as appropriate) • Documentation of "tracking" in CPP with reminders of date last screening test was performed and when it is next due

Recommended Guidelines/Resources

- BC Cervical Cancer Screening Policy
  http://www.bccancer.bc.ca/screening/health-professionals/cervix
- Genital Tract Cancers in Females: Human Papillomavirus Related Cancers (cervical, vaginal and vulvar)
  http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/hpv-cancers
- BCCA Screening for Cancer of the Cervix An Office Manual for Health Care Providers
  http://www.bccancer.bc.ca/screening/Documents/CCSP_GuidelinesManual-ScreeningForCancerOfTheCervix.pdf

[6] ASCUS = Atypical Squamous Cells of Undetermined Significance; AGUS = Atypical Glandular cells of Undetermined Significance; LSIL = Low grade Squamous Intraepithelial Lesion; HSIL = High grade Squamous Intraepithelial Lesion

QI Resource 5: Preventive Health – Breast Cancer Screening and Breast Mass Management

Last reviewed: July 2016 / Next planned review: 2020

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SUBJECTIVE

- **Purpose of visit:** Is this a visit to discuss/refer for routine screening? Is this a first or follow-up visit for breast mass presentation?
- **Current signs and symptoms:** Palpable mass? Variation with menstrual cycle; changes in breast tissue, skin; nipple discharge; breast feeding
- **Onset and duration of signs/symptoms**
- **Past history/comorbid conditions:** breast CA, benign cysts, breast surgery, past mammograms or breast imaging
- **Family history:** breast CA, family member with known BRCA1/2
- Medication allergies
- **Current medications:** Hormone replacement therapy (HRT), oral contraceptive pill (OCP), other prescription medications, herbal/naturopathic remedies
- **Risk factors:** Smoking, family history of breast CA, early onset menstruation, late menopause, past history of radiation exposure, sedentary lifestyle, exposure to hormones (OCP, HRT, in vitro fertilization (IVF)), alcohol consumption
- **Review of systems, as relevant:** night sweats, weight loss, etc.
- **BCCA Screening Mammography Program** (as of February 2014):
    - Average risk women aged 50 to 74 should have a screening mammogram every two years.
    - Average risk women aged 40 to 49 should review the pros and cons of screening with their MD to make a personal decision about mammography.
    - Higher than average risk women aged 40 to 74 with a first-degree relative with breast cancer should have a screening mammogram every year.
    - High-risk women including known BRCA1 or BRCA2 mutation, first degree family relatives of BRCA1 and/or BRCA2 who choose not to be tested, and those with prior

SUBJECTIVE

lymphoproliferative diseases at a young age (between the ages of 10 and 30 years old) treated with chest radiation are candidates for screening with breast MRI.

- Women should know what their breasts normally look and feel like, and what changes to look for.[7]

OBJECTIVE

- **Vital signs:** temperature (if mastitis suspected)
- **Bilateral clinical breast exam:** Skin changes, dimpling of the breast, nipple discharge, palpable mass (firm, soft, matted), axillary lymph nodes, supra-/infra-clavicular lymph nodes as appropriate for clinical situation (e.g. breast mass workup vs. screening)
- **Interpretation of investigations** (if applicable)

ASSESSMENT

- **Diagnosis**
  - Asymptomatic patient in for breast cancer screening. Does patient qualify for high-risk screening category? (See **plan section** below.)
  - Breast mass NYD or specific breast mass diagnosis (e.g. mastitis)

PLAN

- For average risk or higher than average risk patients, review the BC Screening Mammography Program recommendations and entry protocol
- For high-risk patients, discussion with patient (and appropriate referral) re: screening with breast MRI; all screening tests, referrals or monitoring should have clearly defined follow-up plans to review results
- Patient information sheets/websites (as appropriate)
- Integration of breast cancer screening into CPP, as appropriate

[7] On a population basis routine (e.g. monthly) breast self-examination (BSE) has not been demonstrated to save lives from early detection of breast cancer.

Recommended Guidelines/Resources:

Guidelines

- BCCA Screening Mammography Program—Physician Protocol for Screening Mammograms http://www.bccancer.bc.ca/screening/Documents/SMP_GuidelinesManual-PhysicianProtocolForScreeningMammograms.pdf
- BC Guidelines Breast Disease and Cancer: Diagnosis http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/breast-cancer-and-disease-diagnosis
- Diagnostic imaging for breast symptoms. BC Ministry of Health. Effective date: October, 2013. www.bcguidelines.ca/guideline_breast_cancer_diagnosis.html

QI Resource 6: Preventive Health – Immunization (Child and Adult)

Last reviewed: July 2016 / Next planned review: 2020

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SUBJECTIVE

- Reason for potential active immunization (inactivated/subunit or live vaccines) – routine childhood/adult or travel-related or age-related (e.g. herpes zoster vaccine) or situational (e.g. wound; animal bite; public health/school prompted) or medically indicated (e.g. history of splenectomy)
- Reason for potential passive immunization (e.g. human immune globulin for a limited number of clinical situations involving measles, hepatitis A, or rubella exposure) or specific immune globulins (e.g. rabies immune globulin, hepatitis B immune globulin, or varicella zoster immune globulin)
- Relevant current and past history elicits contraindications to immunization and past reactions to vaccines/injections
- Personal immunization history (what has been previously administered and when and where) and relevant family history (e.g. family history of overwhelming infection or fatality after administration of a live vaccine)
- Current medications; relevant review of systems; food (e.g. egg) and medication allergies
- Medications review to include queries regarding current or intended use of anti-TNF9 agents/biologics (infliximab, adaluminab, etc.) and other immunosuppressives/immunomodulators (methotrexate, interferon, etc.), which may be used to treat autoimmune-mediated conditions

OBJECTIVE

- Temperature (as appropriate) and general appearance/level of distress, particularly if patient appears pre-syncopal or seems anxious
- Examination of area to be considered for injection (e.g. skin/muscle/bleeding as relevant) or oral administration (e.g. if concerns re. swallowing/gag reflex)
- Investigations (e.g. serology results for hepatitis B, rubella, etc.) interpreted appropriately

ASSESSMENT

- Diagnosis – type of active or passive immunization specified plus underlying reason (routine childhood/adult or travel-related or age-related (e.g. herpes zoster vaccine) or situational (e.g. wound; animal bite; public health/school prompted; certain disease exposures) or reasons for declining to immunize specified

PLAN

- Vaccines administered in accordance with current BC guidelines/requirements
- Catch-up immunization schedule implemented for previously unimmunized/under-immunized persons or persons with inadequate immunization records (e.g. refugees, immigrants, etc.) in accordance with current BC guidelines
- Pro-active promotion/information on vaccines not publicly funded
- Pre-vaccination counselling (risks/benefits/side-effects, etc.) documented and ability to consent determined (e.g. parent/legal guardian for young child)
- Education to balance anti-immunization misinformation, as appropriate, to lead to fully informed decision-making by patient or decision-maker (e.g. child's parent); documented discussion with signed parental refusal
- Education/information/promotion of public health/school-administered vaccines (e.g. HPV for BC grade 6 female students) and proactive promotion/information on non-publicly funded vaccines (e.g. herpes zoster vaccine)
- Proactive/opportunistic measures taken to ensure maximal vaccine uptake and protection in general patient population (e.g. annual influenza immunization) and to ensure that persons about to be put on immunosuppressive medications/biologics (e.g. anti-TNF10 agents) are immunized prior to treatment (which may require coordination with patient's specialist – gastroenterologist for inflammatory bowel disease, rheumatologist for rheumatoid arthritis, etc.)
- Non-publicly funded "travel" vaccines (e.g. hepatitis A) administered appropriately or patient referred appropriately (e.g. to travel clinic for yellow fever vaccine)
- Appropriate referral for immunization agents not typically available in office (e.g. varicella zoster immune globulin)
- Discussion re: possible analgesic (e.g. topical EMLA)/anti-pyretic use prior to/after immunization administration
- Appropriate administration technique (including separate syringes for each vaccine – different vaccines are not to be mixed in one syringe)
- Documentation in clinical record of type of vaccine administered, route (e.g. subcutaneous, intramuscular), location (e.g. right arm), expiry date, lot number
- Patient given record of immunization(s) given (e.g. "yellow card"), as appropriate

PLAN
• Advice/treatment for post-immunization monitoring/side-effects given • Vaccine recipients supervised in office for 15 to 30 minutes following immunization • In-office anaphylaxis following vaccine administration handled appropriately (epinephrine administration, 911 – rapid transport to emergency department, etc.) • Tetanus status checked/immunization ensured (if required) in event of wounds in accordance • Follow-up with local public health unit (mandatory reporting of dog bites, etc.) to determine if/when/how rabies vaccine should be administered • Adverse events following immunization (AEFIs) reported/documented in accordance with current reporting guidelines/recommendations • Patient information sheets/websites (as appropriate) • Integration of immunization history/administration into CPP

Recommended Guidelines/Resources:

Guidelines

- BC Immunization Schedules (February 2016)
  http://www.healthlinkbc.ca/toolsvideos/immunization/
- BC Routine Immunization Schedule (December 2015)
  http://www.healthlinkbc.ca/pdf/routine-immunization-schedule.pdf
  http://www.immunizebc.ca/vaccine-schedules
- Canadian Immunization Guide (Public Health Agency of Canada). Last modified: May, 2015.
  www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php
- Canadian Adverse Event Following Immunization Surveillance System (including reporting form) (CAEFISS). Last modified: Dec, 2015.
  http://www.phac-aspc.gc.ca/im/vs-sv/index-eng.php
- National Advisory Committee on Immunization (NACI). Last modified: July, 2016.
  www.phac-aspc.gc.ca/naci-ccni
- Committee to Advise on Tropical Medicine and Travel (CATMAT). Last modified: May, 2016.
  www.phac-aspc.gc.ca/tmp-pmv/catmat-ccmtmv/index-eng.php
- Immunize Canada. Last modified: July, 2016.
  www.immunize.ca/en/default.aspx
- Adult Immunization – vaccines recommended for adults
  http://www.immunizebc.ca/sites/default/files/docs/whatvaccinesdoadultsinbcneed.pdf

Addendum

While not an immunization, **tuberculin skin testing** (TST; i.e. Mantoux test with purified protein derivative (PPD)) is another procedure with which family practitioners should be familiar. This includes

indications (e.g. routine health-care workplace screening vs. higher risk population, such as refugees based on country of origin, screening vs. known close contact of person with active pulmonary TB; 1-step vs. 2-step); appropriate technique (i.e. intradermal, not subcutaneous, injection); interpretation (i.e. mm induration, not “negative” or “positive”); knowledge re: “BCG effect”; and appropriate follow-up (CXR, etc., if significant TST induration).

Recommended Guideline/Resource: Canadian Tuberculosis Standards. Health Agency of Canada, 7th Edition. February, 2014. https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/tbpc-latb/pubs/tb-canada-7/assets/pdf/tb-standards-tb-normes-appe-eng.pdf