Practice Enhancement Program
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1. OVERVIEW OF THE PRACTICE ENHANCEMENT PROGRAM

The Saskatchewan Medical Association (SMA) and the College of Physicians and Surgeons met in May of 1994 and were in agreement to jointly advance the establishment of a working group to develop a Practice Assessment and Enhancement Program in Saskatchewan. The first meeting was held August of 1994 with representatives from both the SMA and the College of Physicians and Surgeons of Saskatchewan. The committee studied existing programs in other provinces in order to develop a program which would offer the physicians of Saskatchewan a positive means of assessing their practice.

The fundamental purpose of the program is educational and thus has become known as the Practice Enhancement Program (PEP). The program is based on the assumption that an experienced physician can review another physician’s office facilities, procedures and medical records to determine the quality of care being provided by that physician. Patient Questionnaires are also used to ascertain the patient’s perspective of the quality of care provided by the physician. As assessments are completed and specific needs for enhancement are observed, the Practice Enhancement Program will work to offer educational resources to improve the skills in specific areas.

Fifteen pilot assessments were carried out on volunteer practices in 1996 by PEP committee members to test and fine tune the assessment tools. The cost of each visit was approximately $1500 consisting of the honorarium paid to two assessors and the travelling expenses of the assessors, plus the cost of the Committee meetings.

In March of 1996 an office was set up for the Practice Enhancement Program in the Continuing Medical Education department of the College of Medicine, University of Saskatchewan. The program is administered by a committee of six Saskatchewan Physicians and staffed by a Coordinator and Program Assistant.

The Practice Enhancement Program now brings the opportunity for office assessments to randomly selected physicians throughout Saskatchewan. As feedback is received from these assessments, the Program will continue to improve and develop in the area of educational enhancement.

The program is funded jointly by the Saskatchewan Ministry of Health, the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan.

Ontario and British Columbia have found that 78-80% of the physicians assessed, or 4 out of 5 physicians, have no significant deficiencies in either their medical records or their quality of patient care. 15% of the physicians assessed had deficient medical records but no indication of deficient quality of care, 7% had medical records so deficient that the quality of care could not be determined or there was concern about the quality of care. British Columbia further reports that physicians do improve when they are given specific information identifying deficiencies and advice on how to correct them.
It is hoped that physicians will welcome this program as an opportunity to enhance their practice. In all walks of life there is need for review and assessment of performance in order to offer the best quality of service or care. The PEP experience allows the physician to receive feedback from their patients and peers. Positive feedback is reassuring and affirming; trouble spots pointed out provide incentive to improve one’s facilities and to develop skills through participating in various educational opportunities.

British Columbia summarized their experience this way - 'It works because the purpose is educational and not disciplinary. The conditions of learning are more conducive in this environment - the assessors are not inspectors, but physicians who were in practice the day before the assessment and will probably be in practice the day after the assessment.’
PRACTICE ENHANCEMENT PROGRAM

1.a Protocol

Purpose:
The Practice Enhancement Program is an educational program designed to offer the physicians of Saskatchewan a report of the health of their practices through a practice-based assessment process and to encourage continual improvement of physicians’ clinical skills and office practices in order to provide high quality patient care to Saskatchewan residents.

Funding:
The Practice Enhancement Program is supported through equal funding annually from the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Ministry of Health and the Saskatchewan Medical Association and is accountable to each organization for providing annual aggregate statistical information on assessments completed and financial program expenditure.

Organization:
The Practice Enhancement Program is administered by a committee of 6 Saskatchewan physicians appointed by the College of Physicians and Surgeons of Saskatchewan, three of whom are nominated by the Saskatchewan Medical Association. The committee is Co-chaired by a nominee from the College of Physicians and Surgeons of Saskatchewan and a nominee from Saskatchewan Medical Association.

The PEP committee functions independently of the organizations represented. Information obtained in the process of an office assessment remains the property of the Practice Enhancement Program and cannot to be used by any committee of the funding organizations for any disciplinary purpose.

The program is based on the assumption that an experienced physician can review another physician’s office facilities, procedures and medical records and, in combination with feedback from patients of that physician, come to a valid determination of the quality of care being provided by that physician. The committee meets regularly to review information gathered by the assessors and to make the final decision on the quality of care provided by each physician. This will enable unbiased and objective categorization of quality of care.

The tracking of aggregate information will be maintained by the Practice Enhancement Program Office. Information will be reported to the three supporting organizations as follows:

- minutes of committee business meetings
- annual non-nominal statistics of program activity
- quarterly and year end fiscal reporting
Assessors:
Assessments will be carried out by trained Saskatchewan Physician Assessors selected by the Practice Enhancement Program Committee based on the following criteria:

The physician assessor:

1. has had an office assessment carried out on his/her practice.
2. will have practiced in Saskatchewan for 5 or more years, and must be currently in practice.
3. must be willing to commit to carrying out 4 to 10 assessments per year.
4. Will not have been the subject of a review with adverse conclusion within the last 5 years from the College of Physicians and Surgeons of Saskatchewan, the Joint Medical Professional Review Committee, or any significant body determining adequate competency.
5. is not a current member of the College Council, SMA Board or the Joint Medical Professional Review Committee (JMPRC).

Selection of Physicians Eligible for Assessment:

1. All Saskatchewan practicing physicians are eligible to participate at least once every five (5) years.

2. Possible exemptions:
   a) physicians completing a residency within the previous five (5) years
   b) physicians in exclusively administrative roles, hospital-based practice such as administrative medicine and laboratory medicine (e.g. no office-based practice)
   c) physicians who have been assessed within the past five (5) years
   d) physicians who have not practiced in Saskatchewan, or at their current practice location, for at least three years.

3. Selection is based on a stratified randomized selection (within identified groupings of doctors, individuals will be randomly selected.)

   Groupings:
   greater than 65 years of age
   50 - 64 years of age
   less than 50 years of age
   family physicians
   specialists

4. Under no circumstances will assessments be conducted on physician practices referred to the Practice Enhancement Program or requested by a physician to fulfill a requirement of another agency.
Committee of the

PRACTICE ENHANCEMENT PROGRAM

1.b Terms of Reference

Purpose:
The Committee of the Practice Enhancement Program, a standing committee of the College of Physicians and Surgeons of Saskatchewan, functions independently to "establish, develop and administer an ongoing program of peer assessment of the office practice of members of the College in the member’s chosen field to the end that the public may be served by helping members of the College to maintain proper standards of practice in the care of patients and the keeping of records" (Bylaw).

Tasks include:
- the review of Final Reports of assessments carried out by the physician assessors to determine the quality of a physician’s practice in the effort to ensure competent physicians providing correct medical service
- the training of physician assessors
- the fine-tuning of assessment instruments
- enabling appropriate remediation and enhancement for physicians
- the design of appropriate instruments for assessments of specialty groups

Reporting:
Program activities will be reported to the three supporting organizations, College of Physicians and Surgeons of Saskatchewan, Saskatchewan Medical Association and the Saskatchewan Ministry of Health as follows:

- minutes of committee business meetings
- annual statistics of program activity
- semi-annual and year end fiscal reporting

Membership:
- The Practice Enhancement Program committee, as a standing committee of the College of Physicians and Surgeons of Saskatchewan, will have a membership composed of six persons appointed by the Council, three of whom shall be nominated by the Saskatchewan Medical Association.
- honoraria and travel expenses will be paid as per the guidelines of PEP’s three funding bodies
Officers:

The committee will be co-chaired by:

- a nominee of the College of Physicians and Surgeons of Saskatchewan
- a nominee of the Saskatchewan Medical Association

Staff:

- a staff Coordinator and a Program Assistant will manage and coordinate the work of the committee and activities of the Program
- a pool of trained assessors will carry out the assessments

Meetings:

The committee will meet regularly, as necessary, to ensure program delivery and operations.

Governance:

PEP is enabled under specific bylaws of the College of Physicians and Surgeons of Saskatchewan (attached).
1.b.i College of Physicians and Surgeons of Saskatchewan – Bylaws

(10) PRACTICE ENHANCEMENT COMMITTEE

(a) There shall be a standing committee appointed pursuant to Section 6(2)(p) and 6(2)(q) of the Act for the purpose of peer assessment of medical office practices which shall be known as the Practice Enhancement Committee.

(b) The purpose of the Practice Enhancement Committee is to establish, develop and administer an ongoing program of peer assessment of the office practice of members of the College in the member’s chosen field to the end that the public may be served by helping members of the College to maintain proper standards of practice in the care of patients and the keeping of records.

(c) The Practice Enhancement Committee shall be composed of six persons appointed by the Council, three of whom shall be nominated by the Saskatchewan Medical Association.

(d) The members of the Practice Enhancement Committee shall be appointed by the Council annually. The Council may fill a vacancy in the Committee by appointing such person or persons as the Council thinks appropriate.

(e) Subject always to the direction of the Council, the Practice Enhancement Committee shall conduct its business in such manner and may adopt, use and vary such programs and forms as it sees fit.

(f) The Practice Enhancement Committee may from time to time appoint any one or more of its members or other persons as assessors and delegate to persons so appointed the authority to conduct an assessment and to report thereon to the Practice Enhancement Committee.

(g) Every member of the College whose standards of practice are the subject of an assessment as part of a peer assessment program shall co-operate fully with the Practice Enhancement Committee and with its assessors. The co-operation required of a member includes:

(i) permitting assessors appointed by the Practice Enhancement Committee to enter and inspect the premises where the member engages in the practice of medicine;

(ii) permitting assessors appointed by the Practice Enhancement Committee to inspect the member’s records of the care of patients;

(iii) providing to the Practice Enhancement Committee or its assessors information requested by the Practice Enhancement Committee or the assessors in respect of the care of patients by the member or the member’s records of the care of patients;
(iv) providing the information mentioned in paragraph 18(10)(g)(iii) in the form requested by the Practice Enhancement Committee or its assessors; and

(v) conferring with the Practice Enhancement Committee or its assessors when requested to do so by the Practice Enhancement Committee or its assessors.

(h) Where the Practice Enhancement Committee forms the opinion that the information it has gathered respecting a physician indicates that:

(i) the public is at an immediate risk of harm; or

(ii) the physician has failed, after due notice, to comply with provisions of these bylaws pertaining to the Practice Enhancement Program, or has otherwise failed or refused to co-operate with the Practice Enhancement Committee in its assessment; or

(iii) the physician has refused to undertake remedial measures recommended by the Committee and the Committee considers that such refusal is unreasonable; or

(iv) the physician has done or failed to do something that is a serious breach of ethics; it shall report the matter to the Council in accordance with paragraph 18(10) (i) and 18(10)(j).

(i) Where the Practice Enhancement Committee concludes that one or more of the conditions in paragraph 18(10)(h) have been satisfied, the Practice Enhancement Committee shall report the matter to the College. When reporting such matter to the College, the Practice Enhancement Committee shall, at first instance, provide only sufficient information to permit the College to fulfill its responsibilities pursuant to The Medical Profession Act, 1981. Such information shall, at first instance, be limited to:

(i) where the Committee has formed the opinion that the public is at immediate risk of harm, the name of the physician, the conclusion of the Committee and general information pertaining to the harm perceived by the Committee;

(ii) where the Committee has formed the opinion that the physician has failed, after due notice, to comply with the provisions of these bylaws pertaining to the Practice Enhancement Program, or has otherwise failed or refused to cooperate with the Practice Enhancement Committee in its assessment, the name of the physician and sufficient particulars of the physician’s failure or refusal to permit the College to appoint a Preliminary Inquiry Committee to investigate such failure or refusal, or to permit the Council to lay a charge of unbecoming, improper, unprofessional or discreditable conduct against the physician;

(iii) where the Committee has formed the opinion that the physician has refused to undertake remedial measure recommended by the Committee and the Committee considers that such refusal in unreasonable, the name of the physician, information respecting the
remedial measures recommended by the Committee and information pertaining to the physician’s refusal;

(iv) where the Committee has formed the opinion that the physician has done or failed to do something which a serious breach of ethics, the name of the physician and sufficient particulars of the physician’s action or failure to permit the College to appoint a Preliminary Inquiry Committee to investigate such action or failure, or to permit the College to lay a charge of unbecoming, improper, unprofessional or discreditable conduct against the physician;

(j) Notwithstanding paragraph (10)(i), if the physician with respect to whom the report is made applies to a court to prevent action being taken by the College, or if the physician seeks to quash an action taken by the College, or to appeal from a decision made by the College, or if the physician should oppose the appointment of a Preliminary Inquiry Committee or a Competency Committee by the College, the Practice Enhancement Committee shall provide to the College such additional information as may be necessary to provide the Court or the College with full information pertaining to the factual basis for the Committee’s opinion.

(k) Notwithstanding paragraphs (10)(i) and (10)(j) above, the Committee may, in its absolute discretion, provide additional information to the College relating to the matters in paragraph 10(h) above, if the Committee concludes that the information is required by the College to protect the public interest.

(l) The Practice Enhancement Committee shall keep confidential all information gathered in the course of an assessment of an individual, and shall disclose such information only in accordance with the provisions of paragraphs (10)(h), 10(i), 10(j) and 10(k). The Practice Enhancement Committee may provide information to the Council of a general nature, which does not identify the physicians involved, to permit the Council to assess the Practice Enhancement Program and to prepare reports of a general nature to the members of the College. The Council shall maintain confidential all information which it obtains from the Practice Enhancement Committee and shall not utilize such information unless:

(i) If the Practice Enhancement Committee has provided this information to the Council pursuant to paragraphs (10)(h), (10)(i), (10)(j) or 10(k) above, the information may be used solely for the purpose of determining whether to lay a charge of unbecoming, improper, unprofessional or discreditable conduct, or to appoint a Preliminary Inquiry Committee or a Competency Committee, or for the purpose of an interview conducted by the Council or a Committee appointed by the Council, and for no other purpose; or

(ii) For the purpose of preparing a report of a general nature by the Council to the members of the College. Such information shall not identify the physicians involved.

(m) A witness before a discipline hearing committee or a competency hearing committee is not liable to be asked and is not permitted to answer any question or make any statement with respect to any proceeding before a Practice Enhancement Committee, and may not be asked to produce
and is not permitted to produce any report, statement, memorandum, recommendation, document, information, data or record that is:

(i) prepared exclusively for the use of or made by; or

(ii) used exclusively in the course of, or arising out of, any investigation by a Practice Enhancement Committee.

(n) No report, statement, memorandum, recommendation, document, information, data or record mentioned in paragraph (10)(m) is admissible as evidence before a Discipline Hearing Committee or a Competency Committee.

(o) Paragraphs (10)(m) and (10)(n) do not apply to hearings before a Discipline Hearing Committee on a charge that a physician is guilty of unbecoming, improper, unprofessional or discreditable conduct for failing or refusing to co-operate with the Practice Enhancement Committee or for failing to comply with the provisions of these bylaws pertaining to the Practice Enhancement Program.

(p) The Practice Enhancement Committee shall report to the Council and the Saskatchewan Medical Association on its activities and programs of assessment at such times and in such manner as the Council may from time to time direct.

(q) The Practice Enhancement Committee will select the members of the College to be assessed and in doing so will endeavour to have due regard for the distribution of medical practitioners in the province and the differences in practices and specialties to the end that the benefits of the activities of the Practice Enhancement Committee may be fairly extended to the public and the members of the College throughout the province.
2. Committee Members/Funders

PEP Committee

Co-Chairs
Dr. George Carson
Dr. Brian Laursen

Committee Members
Dr. Karen Holfeld
Dr. Andries Muller
Dr. Yellepeddy Nataraj
Dr. Ivelin Radevski

Program Coordinator
Ms. Joanne Peat

Program Assistant
Ms. Jody Semenoff

PEP Funding

The College of Physicians and Surgeons of Saskatchewan

Saskatchewan Medical Association

Saskatchewan Ministry of Health
PRACTICE ENHANCEMENT PROGRAM

2.a The Assessment Process

1. Physician Selection – annual selection is based on a stratified random selection (within identified groupings of doctors, individuals will be randomly selected.)

   **Groupings:**
   - greater than 65 years of age]
   - 50 - 64 years of age]
   - less than 50 years of age]

   Specialists will be assessed by entire specialty section (eg. dermatology, pediatrics, etc.) as determined by the PEP Committee.

2. **Pre-visit Questionnaire** – establishes a demographic and professional profile of the physician being assessed. This information will also determine eligibility for assessment.

3. **Physical Facilities & Practice Organization Questionnaire** – Completed by each physician selected for assessment prior to the office visit as a tool for gathering consistent data from each assessment regarding medical facilities and practice setup. A Facilities Report is provided to each physician assessed.

4. **Patient Questionnaire** (family physicians & specialists) – sent by PEP to 60 patients selected by the physician to survey patient impressions in areas such as communication, availability, staff performance and preventative medicine. A summary report is created from all patient responses and presented to the assessed physician.

5. **Referred Specialist Questionnaire** (family physicians only) – sent by PEP to survey the quality of referrals sent by family physicians to specialists. A list of specialist physicians that a family physician has referred patients to recently will be provided to PEP from the Medical Services Branch of Saskatchewan Health (no financial information is received or reviewed by PEP). Twenty specialist names will then be randomly chosen for distribution of this questionnaire.

6. **Referring Physician Questionnaire** (specialists only) – sent by PEP to 20 referring physicians selected by the specialist to survey how colleagues perceive the specialist’s services in areas such as communication, availability, and patient satisfaction. A summary report is created from all patient responses and presented to the assessed physician.
7. **Full Office Assessment**

*Office visit* – a physician assessor visits the office and assesses the physical facility, staff and equipment.

*Chart* review – The assessor reviews at least 20 patient charts, using a predetermined format to assess medical chart content and quality of care.

*Physician interview* – immediately after the office visit, the assessor meets with the physician being assessed and reviews the results of the assessment. The assessor also presents the results of an annual profile, received from the Medical Services Branch of the Saskatchewan Ministry of Health, so that the assessed physician can see a description of the demographics of his/her practice as well as to see how his/her practice profile compares to their peer group. This annual MSB profile is provided on this informational basis alone. PEP does not receive or review any financial information from Saskatchewan Health. During the interview, the assessor may point out areas of strength in the practice and also areas for possible improvement.

8. **Final Report** – the assessor’s report is submitted to the PEP committee which determines the final category for the assessed physician. The Final Report is then sent to the assessed physician. In many cases, recommendations for improvement are made but no follow-up review is needed. In some cases, PEP makes recommendations for improvement and arranges to review the practice again. This may take the form of a follow-up letter to ensure that critical deficiencies have been corrected or may require another office visit. A very small number of practices (in other jurisdictions, 1% or less) may be found very deficient or dangerous to patients. In these cases, PEP does not pursue the assessment further and is required to report to The College of Physicians and Surgeons of Saskatchewan.

9. **Post-assessment Questionnaire** – sent to the assessed physician with the Final Report as an invitation to provide feedback to PEP on the assessment process and its value.

10. **Survey of Assessee Feedback** – sent to assessed physicians six months after their final reporting package has been received to determine the value and measure any impact and/or patterns of practice change resulting from their PEP assessment.

1. **Quality of Care**
   - Documented investigation appropriate to patient’s complaint/condition
   - Appropriate diagnoses are reached
   - Management plan and medication prescribed are appropriate to condition being treated
   - Indications for surgical and other procedures are documented and appropriate
   - Adequacy of treatment of both acute and chronic conditions
   - Counselling and psychotherapeutic sessions are appropriately indicated
   - Utilization of support and community resources
   - Practice guidelines are being followed
   - Evidence of appropriate investigations and follow-up of results
   - Assessment of lifestyle and preventive health issues
   - Arrangements are made for the physician’s patients to be cared for in his/her absence
   - Emergency problems are dealt with promptly and effectively

2. **Medical Records**
   - Adequate notes for reader to follow present management
   - Stress quality of legibility
   - Patient identity is clearly evident on each chart component
   - Describe organization within charts, retrieval of items
   - Use of standard forms (cumulative patient profile, flow sheets, medications, history summary, etc.)
   - S.O.A.P. type or narrative notes covering all areas
   - Diagnosis and treatment plan are clearly stated
   - Allergies and drug reactions clearly documented, as well as dates of immunizations
   - Documentation of medications – type, duration, evidence of regular review
   - Significant positive and negative findings are recorded
   - System for acknowledgement and follow-up of abnormal test results
   - Retention of pathology reports, hospital discharge summaries, operative notes, etc.
   - Use of pediatric growth charts and Saskatchewan Prenatal Forms
   - Documented evidence that periodic general assessments are performed
   - Documented evidence that lifestyle and health maintenance issues are discussed
   - Identification of physicians making chart entries
   - Evidence of progress notes for management of chronic conditions
   - Recording in charts of significant telephone advice given

3. **Physical Facilities and Practice Organization**
   a. **General Office Facilities**
      - Adequacy of total area - describe size, design, atmosphere, cleanliness, maintenance
      - Accessibility – wheelchair, parking, etc.
- Waiting rooms – comfort, current reference and reading materials, toys
- Examining rooms – adequate size and equipment, private
- Washrooms – accessibility, cleanliness

b. **Telephone System**
- Number of incoming lines and available staff for answering
- Are fax, e-mail services available
- Scheduled call back time or other means of returning calls
- System to ensure incoming messages are appropriate directed and acknowledged
- Physician’s contactability – during office hours as well as after hours on-call system

c. **Appointment System**
- Does it satisfactorily accommodate patients
- Booking rate (patients per hour) for new or full assessments
- Booking rate (patients per hour) for repeat patients
- Waiting time for appointments, waiting time in waiting room
- Does physician keep to appointment schedule
- System for urgent or emergency appointments
- Is a Day Sheet maintained – manual or computerized
- Mechanism to ensure patients are not missed in the waiting room

d. **Filing System**
- Chart types: EMR or paper charts – family or individual
- Is the filing system efficient and accessible
- How are the charts coded
- System to avoid mis-filing

e. **Medical Instruments and Equipment**
- Ensure equipment, including minor surgical materials, is appropriate to the type of practice
- Appropriate sterilization procedures in place
- System for managing biomedical waste and medication disposal

f. **Drug Supplies and Samples**
- Ensuring appropriate drugs are available and appropriately stored
- Maintaining current list of drugs on hand, monitoring expiration dates
- Narcotic/controlled drug security

g. **Emergency Facilities**
- Emergency tray/cart – appropriately stocked, centrally stored, readily available
- Availability of Adrenalin and appropriate syringes for administration
- Presence of 9-1-1 service in community or alternate emergency personnel
- List of minimal drugs and supplies in the clinic, monitoring of expiration dates
- Knowledge of office staff in the event of an emergency of disaster
h. Laboratory Investigations
- Type of investigations available
- Are they accessible on-site or close by

i. Personnel
- Number of staff persons, duties and training
- Documented plans in place for handling emergencies in the office
- Regular staff meetings/communications
- Documented job descriptions and office policies

j. Walk-in Clinics (See CPSS Guidelines – attached)
- Determine whether physician provides ongoing or episodic care
- Evidence of patient education regarding importance of regular visits to their family physician
- Determine patients’ family physician and document information in charts
- Mechanism for provision of information to patients’ family physician
- System for handling non-urgent referrals
- Provision for after hours coverage
- Establishment of clinic policies and standards for employed physicians

k. Miscellaneous Observations
- System for handling telephone requests for repeat prescriptions from patient or pharmacy
- System for handling incoming reports, test results
- System for handling consultations and referrals
- Policy in place when a patient is dressing/undressing, is appropriate draping provided
- Accessibility of reference materials for physicians and patients – hardcopy, electronic
POLICY: CLINICS THAT PROVIDE CARE TO PATIENTS WHO ARE NOT REGULAR PATIENTS OF THE CLINIC

PREAMBLE
The College of Physicians and Surgeons of Saskatchewan (CPSS) has responsibility to set standards and policies that result in high quality care for patients regardless of their point of contact with physicians in the health care system. For reasons of convenience or ease of access, patients often turn to episodic services such as walk-in or "no-appointment" physician visits in clinics. Physicians are expected to manage these episodic encounters to provide optimal continuity of care.

An excerpt from the Canadian Medical Association and CPSS Code of Ethics provides the basis for this policy.

Responsibilities to the Patient
19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.

This policy is intended to apply to episodic care provided in medical practices, such as, but not limited to:

1. Walk-in clinics.
2. Appointment-based family practice clinics
3. Primary health care clinics
4. Minor emergency clinics

POLICY
1. Physicians are expected to provide the same standard of care to patients irrespective of the practice setting in which such care is provided and irrespective whether the patient is, or is not, a regular patient of the clinic
where the physician works.

2. **Personal Family Physicians** - When being registered at a clinic, patients must be asked if they have a family physician who they usually see for care and, if so, the name of that family physician must be recorded on the patient's record.

   a) Patients who have a family physician must be advised that information about the current visit will be sent to their family physician and given the option to request that this not be done. Written documentation of such a request must be obtained in each and every case.

   b) Patients who do not have a family physician must be encouraged to establish a patient/doctor relationship with a family physician. Suggestions should be made to patients about the value of such a continuing care arrangement. The establishment of such a care arrangement should be facilitated if possible, either within the clinic or with another physician or clinic.

3. **Patient Records** – Physicians must document each patient visit in accordance with accepted standards of care and guidelines for medical record-keeping. Acceptable documentation includes an accurate and complete account of each patient visit including information such as related history, assessment, treatment, investigations, and follow-up. Suitable administrative systems must be in place to send information about the visit to the patient’s family physician or primary care clinic, if the patient has one.

4. **Prescribing** – it is advisable for physicians to use PIP (Pharmaceutical information Program), particularly when dealing with patients who require prescriptions for controlled substances.

5. **Imaging and Laboratory Services** – Physicians who own and operate a diagnostic imaging unit or laboratory services within their clinic shall adhere to the Council’s policy with regard to radiological supervision of diagnostic imaging units and other related standards of good practice.

6. **Multi-Physician Clinics** – In clinics where more than one physician practices, a managing physician shall be designated to:

   a) be responsible for implementing appropriate arrangements to handle follow up of test results by other physicians, follow up of test results after hours, and handling of urgent cases, and

   b) develop and implement a policy manual which gives clear direction to the physicians employed in the clinic with regard to the policies and standards they shall observe while practicing in that clinic.

7. **Other Guidelines and Policies** – physicians who work in or manage clinics which provide episodic care should be aware of and compliant with the policy **Standards For Primary Care** and the policy **Medical Practice Coverage**.
References:
CPSBC- Walk-In Clinics- Standard of Care, Primary Care Multi-Physician Clinics
CPSA- Episodic Care Standard of Practice 15 and Preventing Follow-up Care Failures Standard 27
CMA- Code of Ethics
CMPA- Responsibility for Follow Up of Investigation, June 2008 IL08020-I-E

Adopted by Council: March 26, 2015
To be Reviewed
POLICY: CLINICS THAT PROVIDE CARE TO PATIENTS WHO ARE NOT REGULAR PATIENTS OF THE CLINIC

PREAMBLE
The College of Physicians and Surgeons of Saskatchewan (College) has responsibility to set standards and policies that result in high quality care for patients regardless of their point of contact with physicians in the health care system.

The Code of Ethics of the Canadian Medical Association establishes expectations for physicians which include expectations that physicians will provide appropriate care to their patients, whatever practice setting they may work in. The Code of Ethics is the foundation for this document.

Fundamental Responsibilities

1. Consider first the well-being of the patient.

2. Provide for appropriate care for your patient, including physical comfort and spiritual and psychological support, even when cure is no longer possible.

4. Practice the art and science of medicine competently and without impairment.

Responsibilities to the Patient

19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient or until the patient has been given reasonable notice that you intend to terminate the relationship.

DEFINITION
In this document the College adopts the definition of “chronic disease” from World Health Organization “diseases of long duration and generally slow progression.”

Examples of chronic diseases are the following (but not limited to):

- Diabetes
- Hypertension
- Asthma
THE STANDARD

The College expects that appropriate care will be provided to all patients, in whatever practice setting that care is provided.

This standard applies to all physicians providing primary care in all practice settings, including walk-in clinics, family practice clinics, primary health care clinics and minor emergency clinics.

Physicians who provide primary care will:

1) Ensure that any practice location in which they work has appropriate systems in place to review and, if appropriate, provide follow-up care in response to any investigations ordered by the physician. When possible, the results of such investigations should be reviewed by the physician who has ordered the investigations and, when not possible, investigations results will be reviewed by a qualified medical colleague;

2) Ensure that any practice location in which they work has appropriate systems in place to review and, if appropriate, provide follow-up care in response to consultant’s reports requested by the physician. When possible, consultant’s reports should be reviewed by the physician who requested the consultation and, when not possible, such reports will be reviewed by a qualified medical colleague;

3) Ensure that any practice location in which they work has appropriate systems in place to contact a patient when follow-up care is necessary and to document all contacts and attempts to contact the patient;

4) Ensure that any practice location in which they work has appropriate systems in place to respond to “critical” diagnostic test results reported by a laboratory or imaging facility for urgent attention after regular working hours or in the absence of the ordering physician;

5) Remain responsible for any follow-up care required as a result of any investigations ordered or consultations requested by the physician unless another physician has accepted the responsibility to provide the follow-up care.

6) Ensure that any practice location in which they work has appropriate systems in place to comply with the policy of the College on Medical Practice Coverage which states ”All physicians involved in direct patient care have an obligation to arrange for 24-hour coverage of patients currently under their care.”
7) With respect to each patient encounter:
   a) Obtain and document a history appropriate to the patient’s presenting concerns,
   b) Collect information about relevant past medical history, drug reactions, current medication, allergies and active health problems;
   c) discuss and document:
      i. diagnoses reached,
      ii. investigations ordered,
      iii. treatment and advice given,
      iv. procedures performed,
      v. referrals made, and
      vi. follow-up planned
   d) Observe, examine and document relevant physical findings both positive and negative;
   e) Assess the patient to determine if the investigation of the patient’s medical condition should include ordering laboratory tests, diagnostic imaging, a referral to a consultant or other investigatory methods;
   f) If the physician intends to only provide episodic care to the patient, to so advise the patient and encourage the patient to establish a patient/doctor relationship with a family physician. The physician will advise the patient of the value of such a continuing care arrangement. The establishment of such a care arrangement should be facilitated if possible, either within the clinic or with another physician or clinic;

8) If the physician does not intend to provide comprehensive care to a patient who is not a regular patient of the Clinic, and who has attended the clinic for management of a chronic disease, the physician will assess whether appropriate medical care requires that investigations should be ordered or a referral to a consultant be made. The physician will:
   a) if the patient has a family physician:
      i. advise the patient to arrange any non-urgent consultations through the patient’s family physician; or
      ii. unless the patient is non-compliant with the physician’s recommendations, arrange any urgent consultations with an appropriate consultant and, when doing so, advise the consultant of the patient’s family physician so the consultant will keep that family physician informed and involved in the patient’s ongoing care.
   b) if the patient does not have a family physician, the physician will provide standardized care for the specific chronic condition and instruct the patient to find a family physician;
   c) document the discussion with the patient and, if the patient is not compliant with the physician’s recommendations, document that fact.

9) If the physician intends to only provide episodic care to a patient, ensure that the clinic is compliant with the College policy Clinics That Provide Care To Patients Who Are Not Regular Patients Of The Clinic.
3.b PEP - Outline for Interview with Physician

This outline is provided to give a format for the interview at the end of an office assessment. Intended as a memory aid rather than a rigid guide, it may be modified at the discretion of the assessor.

**Purpose of interview**

- to review all parts of the practice assessment and provide suggestions for improvement
- The final assessment is made by the PEP committee, based on all the information gathered during the assessment process.

**Topics for Discussion**

- Patient Questionnaire Summary Report (*often good to start with this – usually some positive comments*)
- MCIB profile
  - Doesn’t contain any financial information
  - Provided so you can see where you stand in your peer grouping
- Office assessment (Use notes made in Medical Office Assessment Form (R-2))
- Chart review (Use notes made in Guidelines for Chart Review Form (CR-1))
  - Content of medical record
  - Quality of care review
- Any questions or comments from physician?
- After the PEP committee reviews the assessor’s report, you will receive a copy of the final report and a letter giving the committee’s final assessment (*indicate that this may be up to two months from date of assessment*).
- PEP will also send you a Post Assessment Questionnaire asking for your feedback regarding your impression of the PEP assessment and whether the suggestions were helpful.
3.c PEP Assessment Categories

The categories listed below are for the use of the Practice Enhancement Committee for the purpose of tracking assessment outcomes and reporting aggregate information.

The category assigned to a particular physician is not reported to the physician on the Physician’s Final Report.

Category 1: Consistent good care
Category 2: Acceptable, but significant need for improvement in specified areas
Category 3: Immediate cause for concern

Follow-up action per category:

Category 1: Full accreditation, no review for 5 years
Category 2: Necessitates planned follow-up
Category 3: Referral to the College of Physicians and Surgeons of Saskatchewan

Note: Illegibility precludes assessment (reaching a conclusion about care). A review will be carried out within six months, which might include chart-stimulated recall.
4. Assessment Tools - Letters (GP)

Letter 1  Letter of Introduction
Letter 2  Letter of Eligibility
Letter 3  Referred Specialist Questionnaire Cover Letter
Letter 4  Patient Questionnaire Cover Letter
Letter 5  Confirmation of Assessment Date
Letter 6  Final Reporting Letter
Certificate of Participation
**Practice Enhancement Program**  
4.a Worksheet for Arranging Assessment (GP 2012)

Physicians Name:  Dr. «FirstNam» «Lastname»  
Phys. ID: «Phys_ID»  
«Address»  
«Street»  
«City»  «Province»  «Postal»

Phone:  «Phone»  Fax:  «Fax»  Age:  «DOB»

Name of Assessor: ____________________________________________

**PROCESS**

<p>| | |</p>
<table>
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<tr>
<td>1.</td>
<td>TYPE OF ASSESSMENT</td>
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</table>
|    | a) Random selection  
|    | b) Partner selected/Physician requested  
|    | c) 2nd Assessment  
|    | d) prev. deferred |
| 2. | Introduction Letter is sent to the physician to be assessed.  
|    | With this letter is sent:  
|    | a) 'For Your Information' sheet (orange)  
|    | b) Physician Pre-visit Questionnaire (Q-2)  
|    | c) Return Envelope |
| 3. | Pre-visit Questionnaire (Q-2) not returned:  
|    | If not returned within one month:  
|    | a) send 1st Q-2 Reminder letter  
|    | b) send 2nd Q-2 Reminder letter  
|    | c) send Final Reminder letter by Registered Mail |
| 4. | Pre-visit Questionnaire (Q-2) returned: |
| 5. | When Pre-Visit Questionnaire (Q-2) is returned – Status is Determined  
|    | (E-Eligible; I-Ineligible; R-Retired; D-Deferred)  
|    | a) Deferral letter is sent  
|    | b) Exemption letter is sent (sometimes, depending on reason) |
| 6. | If Eligible, then send out Eligible letter:  
|    | With Eligible letter send:  
|    | a) Patient Questionnaire (Q-1)  
|    | b) Referred Specialist Questionnaire (Q-5)  
|    | c) Cover letters to be signed and returned (2)  
|    | d) Form for list of 60 names:  Q-1a (Pt List)  
|    | e) Physical Facilities & Practice Organization Questionnaire (Q-4)  
|    | f) Full Medical Office Assessment Form for Information (R-2) (long form)  
|    | g) Return Envelope |

**DATE**  
2012
7. **Eligible Information not returned (above):**

If not returned within one month:
- a) send 1st Q-1a Reminder letter
- b) send 2nd Q-1a Reminder letter
- c) send Final Reminder letter by **Registered Mail**

8. Signed letters (2), Pt list (1), and Q-4 are returned

9. Patient Questionnaire (Q-1) sent to 60 patients  
   Referred Specialist Questionnaire (Q-5) sent to 20 physicians

10. After 6-8 weeks and all questionnaires are entered in D/B then send out a ‘Can U Assess’ letter to the assessor. Wait for a reply. If yes, then send out ‘Confirmation Letter’ to the physician to make sure they agree with assessor. If no reply within one week, then assume all is well and continue.

   Letter sent to:  
   - a) Assessor(s) “Can U Assess”  
   - b) Physician to be Assessed “Confirmation Letter” (fax & mail)

11. Assessor’s Package assembled and forwarded:
   - Copy of Confirmation letter (above)  
   - Pre-Visit Questionnaire Report (Q-2R)  
   - Patient Questionnaire Summary Report (Q-1R)  
   - Referred Specialist Questionnaire Report (Q-5R)  
   - Physical Facilities & Practice Organization Questionnaire Report (Q-4R)  
   - Medical Office Assessment Form (R-2) Short Form  
   - Final Report Requirements (R-4) (Generic)  
   - Chart Review Guidelines (C-1) short form (Generic)  
   - Assessment Chart Review Form (Generic)  
   - Outline for Physician Interview  
   - Assessor’s Expense Claim Form  
   - PEP Business Cards  
   - XPRESS Post Return Envelope  
   - Cassette tape/Computer diskette  
   - Pep Assessor Form (green)  
   - MCIB Explanation (light blue)  

   - MCIB Report  
   - Patient Questionnaire Summary Report (Q-1R)  
   - PEP Sample Medical Chart  
   - PEP Resource List

12. Assessment is carried out.

13. **Final Report** Package Sent Out:
   - Post-visit letter with Final Report (R-4),  
   - Post Assessment Questionnaire (Q-3)  
   - When 3-6 months follow-up assessments are required to determine quality of care, do not forward Q-3 until the completion of the second visit.

   **Certificate goes to all participantseven if follow-up is required.**
October 10, 2012

Dr. «FirstNam» «Lastname»
«Address»
«Street»
«City» «Province» «Postal»

Dear Doctor «Lastname»:

RE: Practice Enhancement Program – 2011 Assessment Selection

The Practice Enhancement Program (PEP) was developed as part of all Saskatchewan physicians’ commitment to continuous improvement of their practices. This program is designed to provide the physicians of Saskatchewan with a snapshot of the health of their practices. The purpose of the program is educational. The selection of physicians for participation in the program is by random selection. You are one of the physicians randomly selected for assessment in 2011. Participation in the program is mandatory. This selection is not the result of any complaint or concern about your practice.

For physicians who practice in group practices, we have agreed to offer the opportunity for an assessment to one or two other physicians within your group practice at the same time as your assessment. This offer comes in response to inquiries made by practices assessed in the recent past. If there are one or two other physicians in your practice who would be interested in assessment at the same time as yours, please inform the PEP office promptly.

The Practice Enhancement Program was created as a joint initiative of the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan. In January 1997, Sask Health joined in the sponsorship of the program. The program operates under the Medical Profession Act so that information gained in a practice assessment is protected against disclosure. Information about individual doctors is maintained in confidence within the Program and is not disclosed to the three sponsoring organizations.
The goal of the Program is to improve care to the public by assisting physicians to maintain acceptable standards and, where appropriate, improve the quality of the care they provide including the facilities for providing that care, and the records they keep. Where areas for improvement are identified, suggestions to achieve that improvement will be made. Experience elsewhere indicates that the majority of physicians have no significant practice or record keeping deficiencies, although each of us can improve in some way. Of those with deficiencies, four out of five make improvements that correct these deficiencies after they have been pointed out. Only in the rare case of discovering evidence that the practice poses immediate risk to the public (likely less than 1% of all physicians assessed) is PEP obliged by the bylaws of the College of Physicians and Surgeons to report that physician to the College.

Enclosed with this letter please find:

1. **Physician Pre-Visit Questionnaire (Q-2)** - To be completed and returned to the PEP Office within three weeks of receipt of this letter.  
   Note: Based on the information provided some physicians will be exempted from assessment, or will have assessment deferred. Some reasons for such exemption are defined in the enclosed note. If there is some reason why you believe your practice should not be assessed, please state that reason on a separate page and it will be considered by the PEP Committee.

Once the enclosed Physician Pre-Visit Questionnaire (Q-2) has been returned to the PEP office, your eligibility for assessment will be determined and further information will be sent to you.

The assessment process includes distribution of a Patient Questionnaire and a Referred Specialist Questionnaire by PEP to provide feedback to you and the assessment committee. You will be asked to complete a Facilities Questionnaire to compile information regarding your facility and practice organization. Summary reports of the Patient Questionnaire, Referred Specialist Questionnaire, and the Facilities Questionnaire will be provided to you at the time of assessment.

The assessment will consist of an inspection of your office facilities, a review of the above summary reports, a chart review of selected patient records and other relevant issues that may arise. A description of the demographics of your practice from the Medical Services Branch of Saskatchewan Health will be provided for your information and to gain insight into your own practice. Please note that PEP does not receive or review any financial information from MSB.

The assessment takes place in your office and will take about three hours of time including up to one hour of discussion time with you at the end. You are welcome to be present for any part of the assessment but you are only required for the last hour. Please have a staff member present during the entire assessment. You will be informed of the name of the physician assigned as the assessor. If there is a reason why you believe you should have a different assessor please notify the program promptly. You may reject a specific assessor for a specific cause, but may not reject every assessor, as participation in PEP is required.
Once an agreed upon assessor is assigned, that physician will call you to arrange for the visit to your practice. To reduce travel and costs we try to assign several practices in one area, so there may be a delay before your assessment is carried out.

Following the Practice Enhancement Program Committee’s review of the information provided by the assessor, a Final Report will be forwarded to you. This process may take up to two months to complete.

We look forward to your participation in the Practice Enhancement Program. We believe this will be of assistance to you. If you have any questions or concerns, please do not hesitate to contact the PEP office to speak to either of us or the program Coordinator, Ms. Joanne Peat.

Sincerely yours,

Dr. B. W. Laursen, Co-Chair  
Co-Chair, Practice Enhancement Program

George D. Carson, M.D., FRCSC  
Co-Chair, Practice Enhancement Program

/jp
Enclosure (1)
October 10, 2012

Dr. «FirstName» «Lastname»
«Address»
«Street»
«City» «Province» «Postal»

Dear Doctor «Lastname»:

RE: Practice Enhancement Program – Eligibility for Assessment

Thank you for completing and returning the Physician Pre-visit Questionnaire (Q-2) to the PEP office. This will confirm that you are eligible for a practice assessment. Following is a list of attachments and instructions for the assessment process:

1. The assessment process includes distribution of several questionnaires by PEP in order to provide feedback to you and the assessment committee.

   a. Patient Questionnaire (Q-1): *(Sample enclosed for your information)*
      The enclosed Patient Questionnaire will be distributed by the PEP office to sixty (60) of your patients. An opportunity has been provided under Question 8, Page 4 of this questionnaire for you to ask one or two additional questions if you wish. Please add your questions and return a copy of the Patient Questionnaire to the PEP office.

   b. Referred Specialist Questionnaire (Q-5) *(Sample enclosed for your information)*
      The purpose of the enclosed Referred Specialist Questionnaire is to survey the quality of referrals sent by family physicians to specialists. A list of specialist physicians that you have referred patients to recently will be provided to PEP from the Medical Services Branch of Saskatchewan Health (no financial information is received or reviewed by PEP). Twenty specialist names will then be randomly chosen for distribution of this questionnaire.

2. Patient List (Q-1a): *(Please complete & return within three weeks)*
   Please complete the enclosed list with the names and addresses of sixty (60) randomly selected patients and return the list to our office.

3. Cover Letters (2) to Patients and Referred Specialists: *(Please sign & return within three weeks)*
   Please sign and return a copy of each of the two covering letters. They will be distributed by PEP with the 60 Patient Questionnaires and 20 Referred Specialist Questionnaires. You will receive a report generated from responses to each of those questionnaires.
4. **Physical Facilities & Practice Organization Questionnaire (Q-4): (Please complete & return within three weeks)**
   The purpose of this questionnaire is to collect standardized information prior to each assessment regarding facility and practice organization. Please complete the questionnaire yourself or have a staff member do so. A Facilities Report reflecting the responses will be provided at the time of assessment.

5. **Full Medical Office Assessment Form (R-2): (Enclosed for your information)**

   The prompt return of the above documents as noted in #2, #3 and #4 above (prepaid envelope provided) will enable us to proceed with your assessment. Summary reports of each of these questionnaires will be provided to you during your assessment.

   We will begin by distributing the Patient Questionnaires and Referred Specialist Questionnaires from the PEP office. After allowing at least six to eight weeks for the return of the completed questionnaires to our office, we will notify you of the assessor’s name who will visit your practice and schedule an acceptable assessment date.

   If you have any questions or concerns, please do not hesitate to call the PEP office.

   Sincerely,

   Joanne Peat, Coordinator
   Practice Enhancement Program

   Enclosures (7)
   /Js
Dear Patient:

Re: Practice Enhancement Program for Dr. «FirstNam» «Lastname»

As part of my commitment to Continuing Medical Education and self-improvement, I am participating in the Practice Enhancement Program by and for Saskatchewan Physicians. Part of this program involves a survey of patient satisfaction with my practice. I am writing to ask if you would participate by completing a patient questionnaire.

This questionnaire will provide the Practice Enhancement Program with your perceptions of the quality of care you receive in my office. You are asked to respond to questions on satisfaction level, office facilities, unmet needs, after hours coverage and preventive medicine.

The questionnaire is enclosed. Please complete the questionnaire and return it as soon as possible in the envelope provided without your name and address. Your response will therefore remain confidential.

The completed questionnaires will remain at the Practice Enhancement Program office for data processing. **I will not see the completed questionnaire.**

I will receive feedback about my practice and ways in which I may enhance it. If you have additional comments there is space provided at the end of the questionnaire.

I would like to thank you for your assistance in completing and returning this questionnaire.

Yours truly,

Dr. «FirstNam» «Lastname»

/Js
Enclosure
Dear Doctor:

Re: Practice Enhancement Program for Dr.

As part of my commitment to Continuing Medical Education and self-improvement, I am participating in the Practice Enhancement Program by and for Saskatchewan Physicians. Part of this program involves a survey of patient referrals that I make to specialists. I am writing to ask if you would participate by completing a physician questionnaire.

This questionnaire will provide the Practice Enhancement Program with your perceptions of the quality of referrals you receive from my office. You are asked to respond to questions on the referral process, accessibility and patient satisfaction.

Please complete the enclosed questionnaire and return it as soon as possible in the envelope provided. You do not need to include your name and address. Your response will therefore remain confidential. The completed questionnaires will remain at the Practice Enhancement Program office for data processing. I will not see the completed questionnaire. I will receive feedback about my practice and ways in which I may enhance it. If you have additional comments there is space provided at the end of the questionnaire. If you have any questions or need additional information about the program please feel free to call the PEP office and arrange to speak to the Co-Chairs of the program committee, Dr. Brian Laursen, Dr. George Carson or the Coordinator, Ms. Joanne Peat.

I would like to thank you for your assistance in completing and returning this questionnaire.

Yours truly,

Dr. /js
Enclosure

Email: joanne.peat@usask.ca
Website: www.pepsask.ca
Fax

To: Dr. *  From:  
Fax: *  Date: October 10, 2012  
Re: Assessment Booking  Pages: One  

Dear *:

The following physician has been randomly selected for assessment:

Name: Dr. *  D.O.B.: *

Address: *

Graduated: *

Describes practice as: *.

Dr.* is now ready for assessment. Please indicate (by return fax) whether you would be willing/able to conduct this practice assessment. Upon receipt of your confirmation, correspondence will be sent to Dr. * advising that you will be the assessor. Scheduling instructions and an assessment package will then be forwarded to you. If you would like the PEP office to schedule this assessment, please fill in your dates of availability.

☐ Yes, I will conduct this assessment and I am available to do so on the following dates:

1.  2.  3.

☐ Yes, I will conduct this assessment but prefer to schedule at my convenience.

☐ No, I am unable/unwilling to conduct this assessment because  

Thank you
October 10, 2012

Dr. *

Dear Doctor *:

RE: Practice Enhancement Program – Arrangement for Assessment

This letter is to arrange the visit to your practice by the Practice Enhancement Program assessor, Dr. *. If there is any reason that you feel you should have a different assessor, please notify the PEP office as soon as possible.

Dr. * will contact you sometime in the near future to arrange the date of the visit, unless we hear from you otherwise.

The assessor acts as an observer and collector of information using the structured, objective evaluation instruments developed by the Practice Enhancement Program committee. The assessor submits a summary report for review by the committee and the committee forwards the final report to you when complete.

The assessment will take about three hours of time including up to one hour of discussion with you. You are invited to be present for any part of the assessment but you are only required for the last hour. Please have a staff member present during the assessment.

If you have any questions or concerns, please call the PEP office.

Sincerely,

Joanne Peat, Coordinator
Cc  Dr. *
October 10, 2012

Dr. *

Dear Doctor *

RE: Practice Enhancement Program – Assessment Final Report

The Practice Enhancement Program Committee has completed the assessment of your practice by carefully reviewing the returned Patient Questionnaires, your Physician Pre-Visit Questionnaire, and a summary report from the Medical Office Assessment Form, which was prepared by the Assessor who visited your office. The Final Report accompanies this letter.

You have been given a Category 1 rating as a result of your practice assessment. As you may be aware, Category 1 means consistent good care was found with no significant concerns re; patient care or records.

The recommendations in the final report are intended as suggestions to help improve your practice. Suggestions like these have improved efficiency, safety, or patient care in other physicians’ practices. The list of recommendations is not intended to be critical, but rather, helpful. You may adopt them as you see fit, according to the needs of your practice. Occasionally the Final Report contains recommendations that we feel are essential to safe and effective medical practice. If so, these essential recommendations are identified below and we will arrange follow-up with you to monitor their implementation.

- List Recommendations here

A Resource List is enclosed which outlines a variety of practice enhancement information available through the PEP office. Please visit our website or contact the PEP office if you wish copies of, or access to, any of the resource materials.

For your convenience, space has been provided in the Final Report (Action Taken by Physician Assessed) to enter the actions taken by yourself to address the suggestions made by the Practice Enhancement Program Committee. If you wish to discuss the assessment we would be pleased to meet with you.
For information on continuing medical education programs, please contact the Division of Continuing Professional Learning, University of Saskatchewan, at 966-7787. If you wish to speak personally with the Assistant Dean of Continuing Professional Learning, you may make those arrangements through calling this number.

We would like to give you the opportunity to assess the way in which your office practice was reviewed. Please complete the attached Post Assessment Questionnaire and return it this office. We invite you to comment as freely as you wish.

We hope that your participation in this program and the discussion at the time of the visit to your office was of value to you. A Certificate of Participation in the PEP Program is enclosed.

Sincerely yours,

Dr. B. W. Laursen, Co-Chair
Co-Chair, Practice Enhancement Program

George D. Carson, M.D., FRCSC
Co-Chair, Practice Enhancement Program

/jp
Enclosures
October 10, 2012

Dr. *

Dear Doctor *:

RE: Practice Enhancement Program – Assessment Final Report

The Practice Enhancement Program Committee has completed the assessment of your practice by carefully reviewing the returned Patient Questionnaires, your Physician Pre-Visit Questionnaire, the Physical Facilities & Practice Organization Questionnaire (Q4) and a summary report from the Medical Office Assessment Form, which was prepared by the Assessor who visited your office. The Final Report from the PEP Committee and a copy of the Facilities Report accompany this letter.

You have been given a Category 2 rating as a result of your practice assessment. As you may be aware, Category 2 means that some deficiencies have been noted in your practice and that a follow up visit is required.

The Final Report contains requirements that we feel are essential to safe and effective medical practice. These essential recommendations are identified below and we will arrange a follow-up visit with you after six month’s time to monitor their implementation. Recommendations like these have improved efficiency, safety, or patient care in other physicians’ practices. The list of recommendations is not intended to be critical, but rather, helpful.

• List Recommendations here

A Resource List is enclosed which outlines a variety of practice enhancement information available through the PEP office. Please contact us if you wish copies of the resource materials or visit our website to access the information. We have also enclosed some specific resource examples which may be of interest to you.

If we can be of assistance to you in trying to correct deficiencies and achieve improvement in the quality of your practice then we would, of course, be more than willing to do so. Although the results of this assessment of your practice will no doubt be disappointing to you, the Practice Enhancement Program Committee does hope that on reflection, you will find the identification of problems and suggestions for improvement to be of value. It is one of the principles of the Practice Enhancement Program that virtually all physicians really want to do a good job and that all of us can improve our practices.
If clarification can be provided about any of the points in this letter or the report given to you, please do not hesitate to be in touch with us through the Practice Enhancement Program. For information on Continuing Medical Education programs, please contact the Division of Continuing Professional Learning, University of Saskatchewan, at 966-8072. If you wish to speak personally with the Assistant Dean of Continuing Professional Learning, you may make those arrangements through calling this number.

We will be in contact with you to arrange a revisit to your practice after six months to review the specific concerns noted above. For your convenience, space has been provided in the Final Report (Action Taken by Physician Assessed) to enter the actions taken by yourself to address the suggestions made by the Practice Enhancement Program Committee. If you wish to discuss the assessment we would be pleased to meet with you. If you have any questions or concerns, please do not hesitate to contact the PEP office to speak to either of us or the program Coordinator, Ms. Joanne Peat.

Sincerely yours,

/jp
Enclosures
June 19, 2004

REGISTERED MAIL

Dr. ***

Dear Dr. ***:

RE: Practice Enhancement Program – Assessment / Reassessment Results

The committee of the Practice Enhancement Program of Saskatchewan has given lengthy consideration to the results of your practice assessment conducted on *** and the recent reassessment of your practice conducted on ***. The committee had extensive deliberations about the results of your assessment before reaching our conclusion.

We regret to inform you that we found widespread and significant deficiencies in your practice. These are so pervasive and severe that we have concluded that your practice represents a significant threat to the safety and well being of the citizens of Saskatchewan. Thus we assigned to your practice a Category 3 designation.

According to the bylaws of the College of Physicians and Surgeons of Saskatchewan, the authority under which the Practice Enhancement Program of Saskatchewan operates, PEP is obliged when we think we have found very serious performance deficiencies in practice to assign a Category 3 classification and to inform the College of Physicians and Surgeons of this finding. Thus we inform you by this letter that we are also writing on behalf of the Practice Enhancement Program to the Registrar of the College of Physicians and Surgeons. You will hear from the College in due course and they will undertake with you the further assessments or requirements for practice enhancement that are concluded to be appropriate.

Sincerely yours,

Dr. B. W. Laursen, Co-Chair, Practice Enhancement Program
George D. Carson, M.D., FRCSC Co-Chair, Practice Enhancement Program

Dr. B. W. Laursen, Co-Chair, Practice Enhancement Program
George D. Carson, M.D., FRCSC Co-Chair, Practice Enhancement Program
5. Assessment Tools - Questionnaires (GP)

**QUESTIONNAIRES**
**USED FOR GP ASSESSMENTS**

<table>
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<tr>
<th>Q</th>
<th>Questionnaire</th>
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<tr>
<td>Q - 2</td>
<td>Physician Pre-Visit Questionnaire</td>
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<tr>
<td>Q - 1</td>
<td>Patient Questionnaire</td>
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<tr>
<td>Q - 5</td>
<td>Referred Specialist Questionnaire</td>
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<tr>
<td>Q - 4</td>
<td>Physical Facilities &amp; Practice Organization Questionnaire</td>
</tr>
<tr>
<td>Q - 3</td>
<td>Physician Post Assessment Questionnaire</td>
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<tr>
<td>Q - 6</td>
<td>Survey of Assessee Feedback</td>
</tr>
</tbody>
</table>
Physician Pre-visit Questionnaire

Please complete – BY PRINTING LEGIBLY FOR DATA ENTRY PURPOSES – and return this questionnaire within three (3) weeks to:

Practice Enhancement Program
CPL, U of S, Box 60001, RPO University
Saskatoon, SK S7N 4J8

A. **Demographic Data**

1. Surname: _______________________  2. Given Names: ___________________
2. Date of Birth: Day ____ Month ____ Year ____  4. □ Female □ Male
3. Office Address:
5. Do you have access to the Internet?     Yes □ No □
6. Do you use Email?       Yes □ No □
7. If so, what is your E-mail address?  ____________________________________
8. What is your preferred mode of communication?  Mail □ Email □ Fax □
9. Year of Graduation (medical school) ____________________________________
10. Medical Degree from University of _____________________________________
11. Location of University _______________________________________________
12. If you are not engaged in clinical practice please sign and return this form.

Signature _______________________________ Date _________________________
## B. Educational Information & Practice History

*Please specify type of postgraduate training - e.g. Internship - Rotating, Residency - Psychiatry.*

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Location</th>
<th>Postgraduate Training</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td>16a.</td>
<td>16b</td>
<td>16c.</td>
</tr>
<tr>
<td>17.</td>
<td>17a.</td>
<td>17b.</td>
<td>17c.</td>
</tr>
<tr>
<td>18.</td>
<td>18a</td>
<td>18b.</td>
<td>18c.</td>
</tr>
</tbody>
</table>

List the places you have practiced and the years you practiced there:

<table>
<thead>
<tr>
<th>Community</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.</td>
<td>19a.</td>
</tr>
<tr>
<td>20.</td>
<td>20a.</td>
</tr>
<tr>
<td>21.</td>
<td>21a.</td>
</tr>
</tbody>
</table>

22. Please use the following table (or submit an official transcript from CRPC or RCPSC) to indicate your CME participation in each of the suggested formats during the last two years.

<table>
<thead>
<tr>
<th>Activity</th>
<th>0 - 10 hours</th>
<th>11 - 20 hours</th>
<th>21 - 35 hours</th>
<th>36 - 50 hours</th>
<th>50 + hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>U of S CPL Conferences</td>
<td></td>
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<tr>
<td>Out-of-Province Conferences</td>
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<tr>
<td>Out-of-Country Conferences</td>
<td></td>
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</tr>
<tr>
<td>District Medical Society Meetings</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Videoconferences via Telehealth Saskatchewan</td>
<td></td>
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<tr>
<td>Videoconferences from other sources</td>
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<tr>
<td>PBSGL</td>
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<tr>
<td>RxFiles</td>
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<tr>
<td>MDcme</td>
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<td>CAPRE</td>
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<tr>
<td>Other online sources</td>
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<tr>
<td>Rounds</td>
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<tr>
<td>PEARLS</td>
<td></td>
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<tr>
<td>Practice Performance Audits</td>
<td></td>
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<tr>
<td>Personal Learning Plans</td>
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<tr>
<td>Journal Clubs</td>
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<tr>
<td>Consulting books &amp;/or journals</td>
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<tr>
<td>Pharmaceutical/industry sponsored events</td>
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<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
C. Description of Practice

General/Family Physicians:

23. Are you a member of the College of Family Physicians of Canada? Yes □ No □

24. Are you a Certificant of the College of Family Physicians of Canada? Yes □ No □

25. If yes, year Certificate obtained

26. Are you engaged in: □ solo practice or □ group practice?

27. Have you chosen to limit your practice to a specific area (e.g. sports medicine)?

28. Briefly describe the nature of your practice.

29. Briefly describe arrangements for patient care when you are not available.

Specialists:

30. Are you a certified specialist in the Royal College of Physicians and Surgeons of Canada? Yes □ No □

31. (a) If yes, specialty________________________  (b) Year obtained __________

32. Briefly describe the nature of your practice.

33. Are you engaged in: □ solo practice or □ group practice?

34. Briefly describe arrangements for patient care when you are not available.
D. **Academic / Teaching Involvement**

35. Do you have a faculty appointment?  
   Yes □  No □

36. If yes, please specify:  
   Community Based □  University Based □

37. In addition to your faculty teaching activities, do you provide care to private patients who would not be involved in your teaching process?  
   Yes □  No □

38. Do medical students or residents attend your office for teaching purposes?  
   Yes □  No □

E. **Distribution of Work**

*Hours of Work:*

39. In a typical workweek, state the number of hours spent
   
   a) In direct patient care in clinic or office  
      _____ hours
      On hospital in-patients  
      _____ hours
      On hospital out-patients  
      _____ hours

   b) In clinic management (not related to patient care)  
      _____ hours

   c) On paperwork  
      _____ hours

   d) Telephone consultations  
      _____ hours

   e) Other  
      _____ hours

   f) On call (or in extended hours clinic)  
      _____ hours

40. **TOTAL HOURS** (not including on call)  
    _____ hours

If relevant, how many hours do you spend each week:

41. Working in a “Walk-In Clinic” (or similar facility)  
    _____ hours

42. Name of “Walk-In Clinic”:  
    ______________________________________

43. Working for a house call agency?  
    _____ hours

44. Assisting in the operating room?  
    _____ hours

*Patient Volumes:*

45. In a typical work week, state the number of patients you would expect to see
   
   a) In your office  
      _____ patients

   b) Out of normal office hours  
      _____ patients

   c) Scheduled Out Patient visits  
      _____ patients

   d) Homes for the aged, extended care facilities  
      _____ patients

46. **TOTAL PATIENT VISITS per WEEK**  
    _____ patients
Other:

47. Do you perform other contractual or sessional work? Yes □ No □

48. If yes, please describe:

49. What percent of your patients are referred by other physicians? __________%

50. Do you perform surgical procedures in your office? Yes □ No □

F. Hospital Practice

51. Do you have Hospital Appointment/Privileges Yes □ No □

52. Name of Health Region in which you hold your primary privileges / membership:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

53. Please provide a copy of your privileges as granted by the region (available from the Senior Medical Officer of the Regional Health Authority).

G. Assessment Information

54. If an assessment is to be performed, please indicate your preferences for the visit:

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P.M.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

55. Are your records maintained in English? Yes □ No □

If no, in which language? ________________________________

56. Are your records maintained in a computer base? Yes □ No □

If so, which EMR system is being used? ___________________________

57. Date Completed: ___________ Signature _____________________
Listed below are a number of statements about your medical care. Think about the medical care you have received from the doctor who sent you this questionnaire.

**Please check the answer that best corresponds to your feelings:**

1. I understand my doctor’s instructions to me.
   - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

   - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

4. My doctor’s explanations are clear and understandable.
   - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

6. When I have medical tests, my doctor explains how I will get the results.
   - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

8. My doctor treats me with respect.
   - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

10. My doctor is too businesslike and impersonal with me.
    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

12. My doctor spends enough time with me.
    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

14. Before deciding what is wrong with me, my doctor talks to me and/or examines me.
    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

18. My doctor does his or her best to keep me from worrying needlessly about my health.
    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable

20. It takes too long to get an appointment with my doctor.
    - □ Always  □ Mostly  □ Occasionally  □ Never  □ Not Applicable
22. I spend too much time in the waiting room before my doctor can see me.
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

24. I can reach my doctor by telephone if I want to discuss a medical problem.
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

26. If I need to, I can see a doctor on short notice.
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

28. In an emergency, I can reach my doctor (or the doctor covering for my doctor).
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

30. The receptionist in my doctor’s office is friendly.
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

32. The nurse in my doctor’s office is friendly.
   □ Always □ Mostly □ Occasionally □ Never □ Not Applicable

Listed below are health problems or symptoms that a person may experience. If you had the problem, how **comfortable** would you feel discussing it with your doctor?

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Comfort in Discussing with my Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being Tired</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>2. Trouble Sleeping</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>3. Headaches</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>4. Arthritis</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>5. Dizziness</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>6. Chronic Pain</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>7. Chest Pain</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>8. Depression</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>9. Anxiety/Nervousness</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>10. Sexual Problems</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>11. Joint Pain</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
<tr>
<td>12. Problems at work</td>
<td>□ Very Comfortable □ Fairly Comfortable □ Fairly Uncomfortable □ Very Uncomfortable</td>
</tr>
</tbody>
</table>
### The following are questions about general health and prevention of illness.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the doctor or nurse check your blood pressure at least every year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has your doctor ever talked with you about exercising?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has your doctor ever talked with you about nutrition, diet or the foods you eat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has your doctor ever talked with you about your weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. a) Do you smoke?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Did your doctor ever say you should quit smoking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Has your doctor ever offered counselling on how to stop smoking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you drink alcoholic beverages (such as wine, beer or spirits)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If “No”, skip to question #7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If “yes” a) Do you normally have more than one or two drinks per day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your doctor ever discussed your drinking habits with you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In the past 5 years, have you had a general checkup?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Has your doctor discussed with you the relevancy of immunization?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. What is your gender?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. If you are female, please answer the following questions. If you are male, please skip to question #11.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Have you had a breast examination in the past 5 years?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Have you had a mammogram in the past 5 years?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Has anyone in the doctor’s office shown you how to examine your own breasts for lumps in the past 5 years?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Background questions

1. **How old are you?**
   - **_________** Years

2. **What is your highest level of education?**
   - □ Grade 8 or less
   - □ Less than Grade 12
   - □ High School Graduate
   - □ Post-Secondary or some university
   - □ University graduate

3. **How tall are you?**
   - **______** feet  **______** inches

4. **How much do you weigh?**
   - **_____** pounds

5. **In general would you say your health is**
   - □ Excellent
   - □ Very Good
   - □ Good
   - □ Fair
   - □ Poor

6. **Do you still go to this doctor (that is, the doctor that sent you this questionnaire) for your medical care?**
   - □ Yes  □ No  □ Uncertain

7. **Do you also see other health care providers?**
   - No → (skip to question #8)
   - Yes → (please check all that apply)
     - □ General practitioner
     - □ Medical specialist
     - □ Chiropractor
     - □ Physiotherapist
     - □ Massage therapist
     - □ Herbalist or vitamin therapist
     - □ Reflexologist
     - □ Acupuncturist
     - □ Other (please specify)

---

1. **Additional questions from physician:**

---

d) Have you had a PAP test in the past 5 years?  □ Yes  □ No  □ Uncertain

1. If you are male, please answer the following question. If you are female, please skip to next question.

   a) Have you had a prostate/rectal examination in the past 5 years?  □ Yes  □ No  □ Uncertain
5.c PRACTICE ENHANCEMENT PROGRAM
Questionnaire for Specialists Referred to by Family Physicians

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It is clear from the referral letter what is expected of the consultant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>The diagnosis by the referring physician is appropriate to your specialty.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>The referral letter is supported by the appropriate history, clinical findings and investigations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>The diagnosis of the referring physician appears appropriate based on the clinical presentation and investigations carried out prior to referral.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Additional Comments:
5.d Physical Facilities & Practice Organization Questionnaire

Dr. _______________________________ Date: ___________________

BACKGROUND: This questionnaire has been designed by the Practice Enhancement Program Committee as part of the PEP assessment process. It has three purposes: First, to standardize the information collected at each assessment regarding facility and practice organization; second, to consistently gather this information directly from those who know it best – yourself and your staff; and third, it is intended to minimize the disruption to your practice at the time of the office assessment.

INSTRUCTIONS: Completion of this Facilities Questionnaire is a mandatory requirement of your PEP assessment. A Facilities Report reflecting your responses will be provided at the time of your assessment. The PEP Committee may ask your assessor to confirm any or all information in the Facilities Report. Recommendations may then be made by the PEP Committee based on the Facilities Report.

CONTENTS:

A. General Office Facilities Questions 1 – 18 Page 2
B. Communications Questions 19 – 33 Page 3
C. Appointment System Questions 34 – 40 Page 4
D. Filing System Questions 41 – 48 Page 5
E. Medical Instruments and Investigative Equipment Questions 49 – 54 Page 6
F. Drugs and Injectibles Questions 55 – 63 Page 8
G. Emergency Facilities Questions 64 – 73 Page 9
H. Laboratory Investigations Question 74 Page 10
I. Personnel Questions 75 – 77 Page 10
J. Walk-In Clinic Procedures Questions 78 – 88 Page 11
K. Miscellaneous Office Policies Questions 89 – 100 Page 13
L. Health Information Protection Act Questions 101 – 114 Page 15
A. General Office Facilities

Please list the name and address of the specific Medical Facility where your assessment will take place.

____________________________________________________________________________________

1. What is the total area of your medical facility in approximate square footage? ______ sq. ft.

2. Is the medical facility wheelchair accessible? Yes ☐ No ☐

3. What is the total number of persons working in your medical facility?
   
   No. of staff persons ________________  No. of physicians ________________

4. What is the maximum number of physicians working in the facility at any one time? ______ physicians

5. What is the size of the waiting area in approximate square footage? _______ sq. ft.

6. How much seating is provided in the waiting area?
   
   0 – 10 people ☐ 11 – 20 people ☐ Over 20 people ☐

7. Is there a mechanism to ensure a patient is not missed in the waiting room? Yes ☐ No ☐

8. Are current reading materials available for patients? Yes ☐ No ☐

9. Are toys, books, etc. provided for children? Yes ☐ No ☐

10. State the number of public washrooms available in your medical facility? ________ washrooms

11. Is at least one public washroom accessible from the waiting area (without accessing other parts of the medical facility)? Yes ☐ No ☐

12. Is at least one washroom wheelchair accessible? Yes ☐ No ☐

13. Are separate washrooms available (for patients) for specimen collection, etc.? Yes ☐ No ☐

14. How many examination rooms are available per physician? ________ rooms.
15. Is at least one examination room wheelchair accessible?  
   Yes ☐  No ☐

16. Is privacy provided in examination rooms by:  
   Having the foot of examination tables face away from the door?  Yes ☐  No ☐  
   Providing draping and/or gowns for patients during examinations? Yes ☐  No ☐

17. How often are cleaning services provided in your medical facility?  
   Every day ☐  Several times per week ☐  Once per week ☐  
   Several times per month ☐  Other ☐

   Describe ‘Other’______________________________

18. Who is responsible for the cleaning services provided?  
   Friends ☐  Relatives ☐  Professional agency ☐  Office Staff ☐  
   Other ☐  
   Describe ‘Other’______________________________

   Comments (General Office Facilities): ________________________________  
   ________________________________

B. Communications

19. How many incoming telephone lines are available in your medical facility? _________ lines

20. Does the doctor have a cell phone for:  
   a) Use during office practice  Yes ☐  No ☐  
   b) Use during on call  Yes ☐  No ☐

21. How many private outgoing lines are available in your medical facility? _________ lines

22. What is the number of staff persons available at one time for answering telephones? _________ persons

23. a) Is there a facsimile machine available in your medical facility? Yes ☐  No ☐

   b) Does the fax machine have a dedicated line? Yes ☐  No ☐  Not applicable ☐

24. Does the doctor communicate with patients using the internet?  
   Yes ☐  No ☐

25. Does the doctor communicate with other physicians using the internet?  
   Yes ☐  No ☐
26. Does your medical facility use an internal paging system for contacting physicians?
   Yes ☐   No ☐

27. Is there a system for ensuring in-coming messages are directed appropriately to physicians?
   Yes ☐   No ☐

28. When does the doctor normally return routine telephone calls from patients?
   - Immediately upon receipt of call ☐
   - Between patient visits ☐
   - Daily scheduled time ☐
   - Other ☐
   Describe ‘Other’

29. When does the doctor normally return emergency telephone calls from patients?
   - Immediately upon receipt of call ☐
   - Between patient visits ☐
   - Daily scheduled time ☐
   - Other ☐
   Describe ‘Other’

30. How does your medical facility receive lab results? (Choose all that apply)
   - By mail ☐
   - By fax ☐
   - Electronically ☐
   - Other ☐
   Describe ‘Other’

31. Does your medical facility have an answering service available after hours?
   Yes ☐   No ☐

32. What arrangements are in place to look after your patients after hours?
   - Always available yourself ☐
   - Share call within your own practice group ☐
   - Share call with physicians outside your practice group ☐
   - Unavailable after office hours ☐
   - Other ☐
   Describe ‘Other’

33. When one of your patients is admitted to hospital for a problem that would normally be managed by a family physician, is it your practice to: (Choose all that apply)
   a) Care for your patient yourself exclusively ☐
   b) Transfer care of your patient to another colleague ☐
   c) Transfer care of your patient to a specialist ☐
   d) Other ☐
   Describe ‘Other’
Comments (Communications):  

__________________________________________  

__________________________________________  

C. **Appointment System**

34. How much time is scheduled for each of the following types of appointments (in minutes)?

- New patients: ______ minutes
- Full assessments: ______ minutes
- Repeat/routine visits: ______ minutes
- Consultations: ______ minutes

35. What is the typical waiting time for appointments (in days)?

- New patients: ______ day(s)
- Full assessments: ______ day(s)
- Repeat/routine visits: ______ day(s)
- Consultations: ______ day(s)

36. What is the average booked patient wait time while in the waiting room? ______ minutes

37. How does the doctor accommodate urgent/emergency appointments? (Choose all that apply)

- They are worked into the daily schedule  □
- Daily spaces are reserved  □
- Someone else sees the patient  □
- No urgent appointments are made  □
- Other □

Describe ‘Other’: __________________________________________

38. Does your medical facility use a ‘Day Sheet’ for booking purposes?

- Yes  □
- No  □

39. Does your medical facility use a ‘Day Sheet’ for billing purposes?

- Yes  □
- No  □

40. Is the appointment system in your medical facility computerized?

- Yes  □
- No  □

Comments (Appointment System):  

__________________________________________  

__________________________________________
D. **Filing System**

41. How are the medical records maintained in your medical facility?
   - As hardcopy (paper) charts
   - Electronic (computerized)
   - Some of each
   - Other
   Describe ‘Other’

41.a) If electronic, please specify:
   - Optimed
   - Med Access
   - Practice Solutions
   - Nightingale
   - Other
   Describe ‘Other’

42. Where are the hardcopy (paper) medical records stored for current patients?
   - Onsite
   - Offsite
   - Not applicable
   - Other
   Describe ‘Other’

43. Where are the hardcopy (paper) medical records stored for non-current patients?
   - Onsite
   - Offsite
   - Not applicable
   - Other
   Describe ‘Other’

44. Is there a backup system in place for restoring electronic medical records?
   - Yes
   - No
   - Not applicable

45. What type of patient charts are used?
   - Family
   - Individual
   - Other
   Describe ‘Other’

46. How are charts filed/coded:
   - Alphabetically
   - Numerically
   - Other
   Describe ‘Other’

47. Are date stickers used on the medical charts?
   - Yes
   - No
   - Not applicable

48. Do your charts have a coding system to facilitate patient identification (Example: colored stickers)?
   - Yes
   - No
   - Not applicable

Comments (Filing System):

________________________________________________________________________

________________________________________________________________________
E. Medical Instruments and Investigative Equipment

49. What Procedures are routinely done in your medical facility?

a. Suturing  Yes ☐  No ☐
b. Removal of skin lesions  Yes ☐  No ☐
c. Insertion/removal of intrauterine devices  Yes ☐  No ☐
d. Suture/staple removal  Yes ☐  No ☐
e. Cryotherapy  Yes ☐  No ☐
f. Endometrial biopsies  Yes ☐  No ☐
g. ECG  Yes ☐  No ☐
h. Spirometry (pulmonary function tests)  Yes ☐  No ☐
i. Vasectomies  Yes ☐  No ☐
j. Removal of foreign bodies from eyes and/or skin  Yes ☐  No ☐
k. Syringing of ears  Yes ☐  No ☐
l. Nasal packing  Yes ☐  No ☐
m. Wedge excisions of toenails  Yes ☐  No ☐
n. Other
Describe ‘Other’________________________________________________________________________

50. What Instrumentation is available for the procedures performed in your medical facility?

a. Suturing instruments/materials  Yes ☐  No ☐
b. Forceps  Yes ☐  No ☐
c. Long scissors  Yes ☐  No ☐
d. Eye tray  Yes ☐  No ☐
e. Topical/local for eyes  Yes ☐  No ☐
f. ECG machine  Yes ☐  No ☐
g. Liquid nitrogen  Yes ☐  No ☐
h. Ear syringe  Yes ☐  No ☐
i. Other □ Yes □ No □

Describe ‘Other’

51. What Sterilization Procedures are used in your medical facility? (Choose all that apply.)

   Autoclave □ Chemical □ Other □

Describe ‘Other’

52. Biomedical Waste – Please indicate the method of disposal of the following:

<table>
<thead>
<tr>
<th></th>
<th>Ordinary Garbage</th>
<th>Hospital / Pharmacy</th>
<th>Professional Waste Mngmt</th>
<th>Other</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Syringes, specula, etc.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Sharps (needles, blades)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Dressings, gloves</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Disposables</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Unwanted medications</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Describe ‘Other’

53. Are ‘Sharps’ containers provided in or immediately outside each examining room?

   Yes □ No □

54. Are the ‘Sharps’ containers accessible by children?

   Yes □ No □
F. Drugs and Injectibles

55. Are any narcotic/controlled drugs kept onsite?  
Yes ☐  No ☐

56. Are all narcotic/controlled drugs stored in a locked storage container/location?  
Yes ☐  No ☐  Not applicable ☐

57. Are any non-controlled drugs kept onsite?  
Yes ☐  No ☐

58. Are all non-controlled drugs stored in an area inaccessible to patients?  
Yes ☐  No ☐  Not applicable ☐

59. Is there a current inventory of drugs and supplies kept in your medical facility?  
Yes ☐  No ☐

60. How often are drug expiry dates checked?  
Monthly ☐  Quarterly ☐  Yearly ☐  Not applicable ☐  Other ☐

       Describe ‘Other’  

61. Are temperature-sensitive drugs (e.g. vaccines) drugs kept onsite?  
Yes ☐  No ☐

62. Is a refrigerator used to store temperature-sensitive drugs (i.e. vaccines)?  
Yes ☐  No ☐  Not applicable ☐

63. Is the temperature monitored in the refrigerator used to store temperature-sensitive drugs (i.e. vaccines)?  
Yes ☐  No ☐  Not applicable ☐

Comments (Drugs & Injectibles):  

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
G. Emergency Facilities

The SMA Council on Health and Emergency Services agrees that every office should have:

a) The ability to open the airway, b) A decent suction apparatus and c) An ambu-bag or equivalent.

64. Does your medical facility have the following medical emergency equipment:
   a. Ambu-bag Yes ☐ No ☐
   b. Suction apparatus Yes ☐ No ☐
   c. Airway equipment Yes ☐ No ☐

65. Is Oxygen available at all times in your medical facility? Yes ☐ No ☐

66. Is Adrenalin available at all times in your medical facility? Yes ☐ No ☐

67. Are emergency equipment and associated supplies stored together for easy access in an emergency? Yes ☐ No ☐

68. Do all office staff know where emergency supplies are stored? Yes ☐ No ☐

69. Are 9-1-1 services available in the community? Yes ☐ No ☐

70. Is it possible for appropriate emergency personnel to reach your medical facility within five (5) minutes? Yes ☐ No ☐ Not applicable ☐

71. Does your medical facility have a documented plan to follow in the event of the following:
   a. Fire / Evacuation Yes ☐ No ☐
   b. Disruptive Patients Yes ☐ No ☐
   c. Need to Obtain Security Yes ☐ No ☐

72. Are emergency plans posted in the medical facility for easy reference? Yes ☐ No ☐ No Emergency Plans ☐

73. Are all office staff made aware of what steps to take in the event of an emergency in the office? Yes ☐ No ☐
H. Laboratory Investigations

74. What access does your medical facility have to Laboratory Investigations?

<table>
<thead>
<tr>
<th></th>
<th>On-site</th>
<th>Off-site (less than 2 blocks away)</th>
<th>Off-site (more than 2 blocks away)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinalysis</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pregnancy Tests</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Blood Sugars</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>ECG</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pulmonary Function Testing</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Describe ‘Other’

Comments (Laboratory Investigations):

I. Personnel

75. Please provide a breakdown of the staff in your medical facility as follows:

<table>
<thead>
<tr>
<th></th>
<th>How Many</th>
<th>Formally Trained (outside facility)</th>
<th>Trained on the job</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How many total employee(s) part time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. How many total employee(s) full time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Registered Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Licensed Practical Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Position</td>
<td>How Many</td>
<td>Formally Trained (outside facility)</td>
<td>Trained on the job</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------</td>
<td>-------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>e. Special Care Aid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Lab Technician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Receptionist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Secretary/Typist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Medical Office Assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Office Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

76. Are there documented job descriptions for each staff position?  
Yes □  No □

77. How often are staff meetings held to assist with communication within your medical facility?  
Monthly □  Quarterly □  Yearly □  Never □  Other □

Describe 'Other': _________________________________________________________

Comments (Personnel): __________________________________________________

**J. Walk-In Clinic**  
Please choose □ ‘Not Applicable’ if this section does not apply to your medical facility.

78. At registration, is the name of the patient’s family physician documented on their chart?  
Yes □  No □

79. If patients do not have a personal family physician, are they encouraged to establish a patient/doctor relationship with a personal family physician?  
Yes □  No □
80. Are patients’ family physicians promptly provided with copies of pertinent notes related to each patient visit (unless specifically requested not to by the patient)?
   Yes ☐ No ☐

81. Are patients’ family physicians promptly provided with copies of significant investigations generated at each patient visit (unless specifically requested not to by the patient)?
   Yes ☐ No ☐

82. Is there a means to indicate in the medical charts whether each patient is coming regularly or episodically?
   Yes ☐ No ☐

83. Do you accept responsibility as primary care provider for patients attending this facility on a regular basis?
   Yes ☐ No ☐
   a) If ‘No’, are patients formally advised of this? Yes ☐ No ☐ Not applicable ☐

84. How are routine (non-urgent) referrals to specialists handled?
   a) Consultations are arranged by the Walk-in Clinic.
      Yes ☐ No ☐
   b) The consultant is advised of the name of the patient’s family physician.
      Yes ☐ No ☐
   c) Patients are encouraged to make arrangements for consultation through their family physician.
      Yes ☐ No ☐
   d) Other ☐ Describe ‘Other’: ________________________________

85. How are urgent referrals to specialists handled?
   a) Consultations are arranged by the Walk-in Clinic.
      Yes ☐ No ☐
   b) The consultant is advised of the name of the patient’s family physician.
      Yes ☐ No ☐
   c) Patients are encouraged to make arrangements for consultation through their family physician.
      Yes ☐ No ☐
   d) Other ☐ Describe ‘Other’: ________________________________

86. Who is responsible for follow-up of abnormal test results?
   a) Your clinic ☐ b) Patient’s family physician ☐ c) Other ☐
87. Are there policies established which give clear direction to the physicians employed in the Walk-in Clinic as to the policies and standards to observe while practicing in the Walk-in Clinic?
   Yes ☐   No ☐

88. Are these policies documented in a policy manual?   Yes ☐   No ☐   Not Applicable ☐
   Comments (Walk-in Clinic): ____________________________________________________________

   ____________________________________________________________

K. Miscellaneous Office Policies

89. How does the doctor handle requests for medical records from other physicians?
   a) The original chart, or some original chart content, is sent. Yes ☐   No ☐
   b) Relevant portions of the chart are photocopied and sent. Yes ☐   No ☐
   c) A summary sheet or cumulative profile is sent. Yes ☐   No ☐
   d) Other ☐   Describe ‘Other’ ____________________________________________________________

90. How does the doctor handle telephone requests for repeat prescriptions from patients?
   a) Repeat prescriptions are authorized over the telephone or by fax. Yes ☐   No ☐
   b) The patient is asked to make an appointment to see the physician prior to authorization of the prescription. Yes ☐   No ☐
   c) Other ☐   Describe ‘Other’ ____________________________________________________________

91. How does the doctor handle telephone requests for repeat prescriptions from pharmacists?
   a) Repeat prescriptions are authorized over the telephone or by fax. Yes ☐   No ☐
   b) The patient is asked to make an appointment to see the physician prior to authorization of the prescription. Yes ☐   No ☐
   c) Other o   Describe ‘Other’ ____________________________________________________________

92. Is there a policy in place to determine possession of patient records in the event that the
93. How does the doctor handle incoming Lab Reports, X-ray Reports, and Consultation Reports?

a) Reports are brought to the attention of the appropriate physician.
   Yes ☐ No ☐

b) Reports are initial led by the appropriate physician prior to being filed.
   Yes ☐ No ☐

c) Any follow-up management is documented in patient charts.
   Yes ☐ No ☐

d) Notification of abnormal test results is documented in patient charts.
   Yes ☐ No ☐

e) Other ☐
   Describe ‘Other’ ________________________________
94. With regard to routine (non-urgent) referrals, how does the doctor handle the following:

<table>
<thead>
<tr>
<th></th>
<th>Letter (Mail or Fax)</th>
<th>Telephone</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Communication with the consulting physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b) Communication with the referring physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c) Other ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe “Other”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

95. With regard to urgent referrals, how does the doctor handle the following:

<table>
<thead>
<tr>
<th></th>
<th>Letter (Mail or Fax)</th>
<th>Telephone</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Communication with the consulting physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b) Communication with the referring physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c) Other ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe “Other”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

96. Does the doctor have a policy of leaving the examining room giving privacy to a patient when they are dressing/undressing? Yes ☐ No ☐

97. Does the doctor have a policy which offers a chaperone during patient examinations? Yes ☐ No ☐

98. Does your medical facility have current medical literature/reference material available for physicians? Yes ☐ No ☐

99. Does your medical facility have current medical literature/reference material available for patients? Yes ☐ No ☐

100. How does your medical facility access current medical literature? (Choose all that apply)

Provided on-site ☐ Internet access ☐ Available from Hospital ☐

No information available ☐ Other ☐

Describe ‘Other’ __________________________________________________________
I. Health Information Protection Act Compliance

Patient Resources

101. Are patients advised by posters and/or patient brochures about:
   • The possible uses of their information;
   • Their right of access to their records; and,
   • Their right to request amendments to their records

   Yes  ☐  No  ☐

102. Are there forms available for patients to request copies of or access to their records?

   Yes  ☐  No  ☐

103. Are there forms available for patients to request copies of their records be provided to third parties (lawyers, insurance companies, etc.)?

   Yes  ☐  No  ☐

Confidentiality of patient information within the clinic

104. Has a privacy officer been appointed to deal with issues relating to patient confidentiality and The Health Information Protection Act?

   Yes  ☐  No  ☐

105. Have the employees of the clinic signed confidentiality agreements?

   Yes  ☐  No  ☐

106. Does the clinic have a process in place to limit employee access to only pertinent patient information the employees require in order to do their job?

   Yes  ☐  No  ☐

107. Have the employees of the clinic received training relating to Health Information Protection Act requirements and patient confidentiality?

   Yes  ☐  No  ☐

Security of Patient Information
5.e Post Assessment Questionnaire Q-3

Thank you for participating in the Practice Enhancement Program (PEP). In order to offer the best possible assessments to Saskatchewan physicians, your observations about your assessment and comments about the program would be useful and appreciated.

Please complete the following questions. Your responses will allow us to make improvements to the PEP program.

A) Quality of Care

1. Do you agree with the comments made by the assessor?

<table>
<thead>
<tr>
<th>No comments made</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Do you agree that the areas requiring attention have been appropriately identified?

<table>
<thead>
<tr>
<th>No areas identified</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Specific suggestions for improvement were made with respect to areas requiring attention

<table>
<thead>
<tr>
<th>No suggestions made</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you agree with the suggestions for improvement?

<table>
<thead>
<tr>
<th>No suggestions made</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Your Comments:

### B) Content of the Medical Records

1. Do you agree with the comments made by the assessor?  
   ![Agreement Options]

2. Do you agree that the areas requiring attention have been appropriately identified?  
   ![Agreement Options]

3. Specific suggestions for improvement were made with respect to areas requiring attention  
   ![Agreement Options]

4. Do you agree with the suggestions for improvement?  
   ![Agreement Options]

5. Your Comments:

### C) Physical Facilities

1. Do you agree with the comments made by the assessor?  
   ![Agreement Options]

2. Do you agree that the areas requiring attention have been appropriately identified?  
   ![Agreement Options]

3. Specific suggestions for improvement were made with respect to areas requiring attention  
   ![Agreement Options]
4. Do you agree with the suggestions for improvement?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Your Comments:

---

**D) Personnel**

1. Do you agree with the comments made by the assessor?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2. Do you agree that the areas requiring attention have been appropriately identified?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3. Specific suggestions for improvement were made with respect to areas requiring attention

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4. Do you agree with the suggestions for improvement?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Your Comments:

---

**E) Requests-Lab Tests-Referrals etc**

1. Do you agree with the comments made by the assessor?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
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2. Do you agree that the areas requiring attention have been appropriately identified?

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3. Specific suggestions for improvement were made with respect to areas requiring attention

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<th>Strongly Agree</th>
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4. Do you agree with the suggestions for improvement?

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<th>Disagree</th>
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5. Your Comments:

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F) Appropriate Use of Medications

1. Do you agree with the comments made by the assessor?

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<th>Strongly Agree</th>
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<th>Strongly Disagree</th>
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4. Do you agree with the suggestions for improvement?

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<th>Disagree</th>
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5. Your Comments:

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G) Comments on Interview

1. Do you agree with the comments made by the assessor?

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<th>Agree</th>
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<th>Disagree</th>
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<th>Disagree</th>
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<td>No suggestions made</td>
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4. Do you agree with the suggestions for improvement?

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<th>Neutral</th>
<th>Disagree</th>
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</table>

5. Your Comments:

H) The information received from the Patient Questionnaires was useful.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
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<tbody>
<tr>
<td>No Opinion</td>
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</table>

Your Comments:

I) Enough information was forwarded to you prior to the assessment.

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<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
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<tr>
<td>No Opinion</td>
<td></td>
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</table>

Your Comments:

J) Resources are available to facilitate practice change? (e.g. CME, Tutorials)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
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<tbody>
<tr>
<td>No Opinion</td>
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</tbody>
</table>

Your Comments: If you do not have access to adequate resources, please state what resources you would need and also suggest how you think they could be provided.
How much of your time was taken up by this assessment? ________ Hrs

Do you have any suggestions to improve the process of the Practice Enhancement Program?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Is there any additional information you would like from a practice assessment?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

We want to provide you with a questionnaire that is quick, easy to complete, and covers what you feel are the important issues.

Please provide us with some comments so that we can be responsive to your needs. For example, was the questionnaire easy to fill out? Was it easy to read? Did it take too much time? Did it address the important issues?

We appreciate your time and effort in providing us with feedback.

Your Comments about this Questionnaire:
This Survey of Assessee Feedback is sent to physicians six months+ after receiving the Final Report from their PEP assessment to determine the value and measure any impact and/or patterns of practice change resulting from a PEP assessment. We appreciate your participation.

<table>
<thead>
<tr>
<th>Question</th>
<th>1 = Most Agreed/Implemented</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Least Agreed/Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My PEP report was easy to understand</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Specialists: Feedback from Family Physicians was valuable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Family Physicians: Feedback from Specialists was valuable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Feedback from patients was valuable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The PEP program promotes quality improvement</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Participation in the PEP program was easy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Based on my PEP report I have contemplated practice change</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Changed aspects of patient care (investigations, education, preventive care, etc.)</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Changed aspects of practice management (privacy issues, record keeping, health &amp; safety issues)</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Changed how I communicate with patients</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Changed how I communicate with Specialists (for Family Physicians)</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Changed how I communicate with Family Physicians (for Specialists)</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Changed my pattern of CME</td>
<td>YES</td>
<td>NO – Don’t Agree</td>
<td>NO – Don’t Need To</td>
<td></td>
<td></td>
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<tr>
<td>15. Changed other areas of my practice (please explain):</td>
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</table>

Thank you for taking this opportunity to help evaluate the impact of PEP on medical practice.
6. FORMS & TOOLS USED FOR GP ASSESSMENTS

Assessment Package Outline
Chart Review Form
CR – 1  Chart Review Checklist
R – 2  Assessment Checklist
Outline for Physician Interview
R – 4  Final Report Description
  - Format
  - Requirements
  - Recommendation Summary
  - Sample
R - 1 (MCIB)  MCIB Report (numeric format)
Certificate of Participation
EX - 1  Assessor’s Expense Claim Form
TO: Dr. **

DATE: October 3, 2012

RE:  
Assessment Package for Dr. **
Assessment Date: **

A. For your own use/information:
1. Pre-Visit Questionnaire Report (Q2R) and copy of privileges
2. Patient Questionnaire Summary Report (Q1R)
3. Referred Specialist Questionnaire Summary Report (Q5R)
   A copy will be provided to the assessee with the Final Report.
5. * Medical Office Assessment Form (R-2)
6. Final Report format (R-4)
7. * Guidelines for Chart Review (CR-1)
8. Chart Review Form
9. Outline for Physician Interview
10. Assessor’s Expense Claim Form
11. PEP Business Cards
12. XPRESS Post Return Envelope
13. Cassette tape

B. For the physician you are assessing:
1. MSB Report
2. Patient Questionnaire Summary Report (Q1R)
3. Referred Specialist Questionnaire Summary Report (Q5R)

I look forward to receiving your Final Report. Please submit it to the PEP office within **two weeks** of the completion of the assessment

Sincerely,

Joanne Peat

Enclosures

Items *5 and *7 are now being entered into the PEP database for research purposes – please complete and return these documents. Thank you.
## 6.b Assessment - Chart Review Form

<table>
<thead>
<tr>
<th>Chart #</th>
<th>Patient Name</th>
<th>Comments</th>
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<td>2</td>
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<td>3</td>
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<td></td>
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<tr>
<td>Hypertension</td>
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<td>9</td>
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<tr>
<td><strong>Asthma</strong></td>
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<td></td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
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<td>Pediatrics</td>
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<td><strong>Ischemic HD</strong></td>
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<tr>
<td><strong>Additional Charts and/or Comments:</strong></td>
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</table>
6.c Chart Review Checklist - CR-1

Practice Enhancement Program
GUIDELINES FOR CHART REVIEW

Name of Physician Assessed: ____________________________Phys I.D. ________
Name of Assessor: ____________________________
Date of Assessment: ____________________________

ASTHMA

Diagnosis
1. Has asthma been supported by objective lung function tests? □ YES □ NO
2. Has physician considered differential diagnosis? (is it asthma?) □ YES □ NO

Monitoring
3. Does the physician use objective measures for asthma control? □ YES □ NO
e.g. pulmonary function testing or 30 second asthma test
4. Does the physician assess the severity of the asthma? □ YES □ NO

Management
5. Has the physician obtained objective evidence of allergies? □ YES □ NO

6. Has the physician discussed with the patient ...
   a) possible asthma triggers? □ YES □ NO
   b) lifestyle and work issues? □ YES □ NO
   c) inhaler technique? □ YES □ NO
   d) regime adherence? □ YES □ NO
   e) aims for asthma control?
      o No night time awakenings □ YES □ NO
      o Three or fewer days with symptoms and doses of rescue medication/week □ YES □ NO
      o No negative effect on normal activity, exercise, function or quality of life.

7. Are medications appropriate to symptomatology? □ YES □ NO
   e.g. Mild Asthma
      Occasional use of short acting B2 agonists or low dose inhaled steroids
   Moderate Asthma
      Regular use of low dose corticosteroids with addition as necessary of
      Mid-dose inhaled corticosteroids
      Long acting B2 agonists
      or Leukotriene receptor antagonists
   Severe Asthma
      Short acting inhaled B2 agonists plus High dose inhaled corticosteroids plus Long acting B2 agonists
      or Leukotriene receptor antagonists.

8. Are specialist referrals made for patients who are inadequately controlled? □ YES □ NO

Source: Canadian Asthma Guidelines 1999 with assistance from Dr D. Cockcroft

Developed and reviewed by the Practice Enhancement Program March 2010
The 30 Second Asthma Test

1. Do you cough, wheeze, or have a tight chest because of your asthma? (4 or more days a week) □ YES □ NO
2. Do coughing, wheezing, or chest tightness wake you at night? (1 or more times a week) □ YES □ NO
3. Do you stop exercising because of your asthma? (in the past 3 months) □ YES □ NO
4. Do you ever miss work or school because of your asthma? (in the past 3 months) □ YES □ NO
5. Do you use your blue inhaler 4 or more times a week? (except one dose/day for exercise) □ YES □ NO

If you answer ‘Yes’ to one or more questions, see your doctor and ask how you can feel better.

Assessor’s Comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Reviewed by the PEP Committee March
Practice Enhancement Program

GUIDELINES FOR CHART REVIEW

Cardiovascular Risk Factor Management

It is generally accepted that the significant risk factors are:

**Family History**
1. Is there evidence that a family history has been taken and the patient informed if there is a risk?  □ YES  □ NO

**Obesity**
2. Is there evidence that the patient has been weighed and overweight patients given information or diet advice?  □ YES  □ NO
3. Is BMI measured as opposed to weight measurement?  □ YES  □ NO
3b. Is waist circumference measured?  □ YES  □ NO

**Smoking**
4. Is there evidence that the physician has inquired about smoking history and if necessary counselled smoking cessation, with advice on quitting strategies?  □ YES  □ NO

**Sedentary Lifestyle**
5. Is there evidence of advice on exercise counselling for patients at risk?  □ YES  □ NO

**Elevated Lipids**
6. Is there evidence of cholesterol estimation in appropriate groups (F.H. post-menopausal women, men over 50) and of diet advice if indicated?  □ YES  □ NO
7. Are optimal lipid values based on risk score?  □ YES  □ NO

**Diabetes**
8. Is there evidence of blood sugar levels being checked, particularly in patients with a F.H., and of good control in diabetics? □ YES  □ NO

**Hypertension**
9. Is there evidence that blood pressure is checked periodically, and attempts made to control it within accepted levels?  □ YES  □ NO

Reviewed by the PEP Committee March 2010.
Practice Enhancement Program

GUIDELINES FOR CHART REVIEW

DEPRESSION

Assessment and Diagnosis

Has the physician described or identified the following:

1. The DSM IV diagnostic criteria of Major Depression.   □ YES □ NO
2. The subtypes of Depression where applicable.          □ YES □ NO
3. The precipitating factors such as psychosocial stressors and poor compliance with treatment. □ YES □ NO
4. The relevant co morbid disorders e.g., Substance Abuse, Personality Disorder, Anxiety Disorders. □ YES □ NO
5. The risk of suicide (suicidal ideas, plans or intent). □ YES □ NO
6. Risk of serious violence against others.              □ YES □ NO
7. Past history of psychiatric illness and therapies.   □ YES □ NO
8. Family history of psychiatric illness.                □ YES □ NO

Management

Has the physician provided the patient with:

9. Appropriate psychotherapeutic interventions such as psychoeducation or supportive therapy. □ YES □ NO
10. Appropriate psychopharmacological interventions.     □ YES □ NO
11. Referral to psychiatry if necessary                  □ YES □ NO
12. Appropriate use of community mental health services □ YES □ NO
13. Follow up plan to assess the response to treatment, compliance with treatment plan and side effects of medications □ YES □ NO
14. Long term treatment of depression which may include maintenance treatment, relapse prevention and a gradual reduction and discontinuation of medications when the patient’s mental state has been stable and well for an extended period of time. □ YES □ NO

Reviewed by the PEP Committee March 2010.
DIABETES

**Diagnosis** – criterion met:
- FPG ≥ 7.0 mmol/l □ YES □ NO
- Casual PG ≥11.1 □ YES □ NO
- plus symptoms of diabetes □ YES □ NO
- 75g OGTT 2hour PG ≥11.1 mmol/l □ YES □ NO

**Identification of Type**
- Type 1 □ YES □ NO
- Type 2 □ YES □ NO
- Non Type 1 Type 2 □ YES □ NO

**Management**
- a) Lifestyle Modification:
  - Diet □ YES □ NO
  - Weight □ YES □ NO
  - Exercise □ YES □ NO
  - Glucose monitoring □ YES □ NO
  - Education – DE referral □ YES □ NO
- b) Medication – includes the following:
  - Sulphonamides □ YES □ NO
  - Biguanides □ YES □ NO
  - Alpha glucosidase inhibitors □ YES □ NO
  - Thiazolidinediones □ YES □ NO
  - Insulin □ YES □ NO

**Continuing Care** – evidence of the following:
- a) Glucose monitoring – verification of monitor □ YES □ NO
- b) Measurement of long term control i.e. A1C q3-4months □ YES □ NO
- c) Evidence of appropriate management to achieve control □ YES □ NO
- d) Patient follow-up □ YES □ NO
- e) Evaluation of co-morbid conditions
  - i) Renal – urine ACR / microalbuminuria, U/A, serum creatinine, creatinine clearance □ YES □ NO
  - ii) CVS – hypertension, peripheral vascular disease, cardiac status □ YES □ NO
  - iii) Lipids – periodic measurement and appropriate treatment □ YES □ NO
  - iv) Psychologic aspects □ YES □ NO
  - v) Hypoglycemia □ YES □ NO
  - vi) Obesity □ YES □ NO
  - vii) Neuropathy □ YES □ NO
  - viii) Footcare □ YES □ NO
  - ix) Retinopathy □ YES □ NO
  - x) Erectile Dysfunction □ YES □ NO
- f) Pre-pregnancy planning □ YES □ NO

## PEP Chart Review for Hypertension

The **diagnosis** should be supported by 2 or more readings which are averaged but should differ by £10mm Hg for the discovery of hypertension and must average >90mmHg diastolic or >140mmHg systolic. Reassess ³3 times over 6 months, or over a shorter duration if the elevation is severe. Home BP monitoring, automated office blood pressure monitoring or ambulatory monitoring can shorten the diagnostic process.

**Treatment** (lifestyle modification with or without drug therapy) should be prescribed for those with sustained BP of >140/90 over 90mmHg (either/or). Drug treatment should be started immediately for all patients whose average baseline blood BP is 160 / 100 or more. For those with 140 – 150 / 90 – 100, a trial of lifestyle modification (6 – 12 months). A mercury sphygmomanometer or a calibrated aneroid/automated system should be used. Cuffs of appropriate size should be used.

**Assessment** of the cardiovascular risk factors should be undertaken initially and From time to time (at least every 1 – 2 years) during therapy.

**Monitoring** of treatment should be done to ensure that a goal BP of £140/90mmHg (both) is achieved for most patients. For those with diabetes or renal disease the goal is 130/80. Other procedures done in follow-up may include:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Initial</th>
<th>Sequential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left ventricular hypertrophy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chest x-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Echocardiography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and ECG</td>
<td></td>
<td></td>
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<tr>
<td>Cerebrovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound, if indicated by history and physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. Urinalysis, Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and glucose estimation if indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislipidemia - Lab Tests: Electrolytes, Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cyanide, FBS, CBC, lipid profile, urinalysis, ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pheochromocytoma (in selected cases when indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 24 hour urine for Metanephine &amp; Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperaldosteronism (in selected cases when indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma aldosterone and plasma renin activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance or Adherence to Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment should be frequent, at least monthly, during initiation of therapy and until the target blood pressure is achieved.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once the target BP is achieved monitoring should be:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No less often than every year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>And no more often than every three months (consider home monitoring)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.d Office Assessment Checklist R-2

Practice Enhancement Program
Medical Office Assessment Form

Name of Physician Assessed: ___________________ Phys I.D. __________
Name of Assessor: ______________________________
Date of Assessment: ____________________________

Definitions - For the purpose of this report

N/A not applicable or not answered
Always self-explanatory
Usually means in MORE than 50% of files reviewed
Sometimes means in LESS than 50% of files reviewed
Never self-explanatory

A. QUALITY OF THE PHYSICIAN’S CARE

Note: If you find evidence of inadequate patient care, please identify the patient’s name and chart number to support your opinion.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The documented investigation is appropriate to complaint/condition.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>The documented chief complaint, history, physical findings and investigation reports lead to the making of an appropriate diagnosis.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>The management plan (excluding prescribed medication) is appropriate to the condition being treated.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4.</td>
<td>The medication prescribed is appropriate to the condition being treated.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5.</td>
<td>The indications for surgical, obstetrical, gynecological and other procedures are documented (if relevant).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6.</td>
<td>a) Adequacy of treatment including follow up care of acute conditions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>b) Adequacy of treatment including follow up care for chronic conditions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7.</td>
<td>Counselling sessions are appropriately documented and indicated.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### A. QUALITY OF THE PHYSICIAN’S CARE – Cont’d

<table>
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<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
<td>8.</td>
<td>psychotherapeutic sessions are indicated and appropriately documented to include the physician’s input and the patient’s response.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>9.</td>
<td>The records indicate that the physician is aware of and utilizes the various supportive social agencies in his/her community (e.g. public health nurse, home care, meals on wheels, etc.).</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>10.</td>
<td>The records indicate that emergency problems are dealt with promptly and effectively.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11.</td>
<td>Referrals to other physicians appear, from the record, to be appropriate.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>12.</td>
<td>There are appropriate arrangements in place for the physician’s patients to be taken care of in his/her absence.</td>
<td>□</td>
<td>□</td>
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**Comments regarding Quality of Care**

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________
B. MEDICAL CHART STRUCTURE & ORGANIZATION

Medical Records should be selected from patients who have been seen by the doctor in the previous 3 months. The peer physician should review a total of 20 charts representative of the practice.

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<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A record system in place which allows for ready retrieval of an individual patient file.</td>
<td></td>
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<tr>
<td>2. The record is legible.</td>
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<tr>
<td>3. The patient’s identity is clearly evident on each component of the file.</td>
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<td>4. Each patient file clearly shows full name, address, date of birth &amp; sex.</td>
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<tr>
<td>5. The date of each visit or consultation is recorded.</td>
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<td>6. The family history, functional inquiry past history (including significant negative observations) is recorded and maintained.</td>
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<td>7. Allergies are clearly documented.</td>
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<td>8. Dates of immunizations (if relevant) are clearly visible.</td>
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<tr>
<td>9. a) A ‘cumulative patient profile’ (summary sheet) relating to each patient is present.</td>
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<tr>
<td>9. b) The ‘cumulative patient profile’ (summary sheet) is consistently maintained.</td>
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<tr>
<td>10. The chief complaint is clearly stated.</td>
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<tr>
<td>11. The duration of symptoms is noted.</td>
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<tr>
<td>12. An adequate description of the symptoms is present.</td>
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<tr>
<td>13. Positive physical findings are recorded.</td>
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</tbody>
</table>
### B. MEDICAL CHART STRUCTURE & ORGANIZATION – Cont’d

<table>
<thead>
<tr>
<th></th>
<th>14. Significant negative physical findings are recorded.</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>N/A</th>
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<tbody>
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<td></td>
<td>15. Requests for laboratory test, x-rays, and other investigations are documented.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>16. Requests for consultations are documented.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<td></td>
<td>17. The diagnosis or provisional diagnosis is recorded.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<td></td>
<td>18. The treatment plan and/or treatment is recorded</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
<td>□ □</td>
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<tr>
<td></td>
<td>19.a) Doses of prescribed medications are noted.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
<td>□ □</td>
</tr>
<tr>
<td></td>
<td>b) Duration of prescribed medications are noted.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>20. Pathology reports are retained.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>21. Hospital discharge summaries are retained.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>22. Operative notes are retained.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>23. There is a system in place to clearly show that abnormal test results come to the attention of the physician (e.g. does the physician initial reports?).</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>24. There is documented evidence that an appropriate follow-up has taken place following receipt of such abnormal test results.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>25. In the event that more than one physician is making entries in the patient file, is each physician identifiable?</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
<td>□ □</td>
</tr>
<tr>
<td></td>
<td>26. Pediatric growth charts are used.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
<td>□ □</td>
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<tr>
<td></td>
<td>27. Saskatchewan Prenatal Forms are used.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>28. Progress notes relating to the management in the office of patients suffering from chronic conditions are noted.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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<tr>
<td></td>
<td>29. There is documented evidence that periodic general assessments are being performed.</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
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</tbody>
</table>
B. MEDICAL CHART STRUCTURE & ORGANIZATION – Cont’d

30. There is documented evidence that health maintenance is periodically discussed (e.g. re: smoking, alcohol consumption, obesity, lifestyle, etc.)

31. There is evidence that the physician periodically reviews the list of medications being taken by patients suffering from multiple or chronic conditions.

32. Telephone calls to patients are recorded.

33. Repeat prescriptions and drug reactions are recorded.

34. Is it possible to determine why the patient came to the doctor, what was found out, and what was done?

Comments regarding Medical Chart Structure & Organization

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
## Walk-In Clinic (if applicable)

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At registration, is the name of the patient’s family physician documented in the patient’s chart?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. If patients do not have a personal family physician, are they encouraged to establish a patient/doctor relationship with a personal family physician?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Are patients’ family physicians promptly provided with copies of pertinent notes related to each patient visit (unless specifically requested not to by the patient)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Are patients’ family physicians promptly provided with copies of significant investigations generated at each patient visit (unless specifically requested not to by the patient)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Does the physician accept responsibility as primary care provider for patients attending this facility on a regular basis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Is there a means to indicate in the medical charts whether each patient is coming regularly or episodically?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

Comments/recommendations regarding Walk-In Clinic:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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C. PHYSICAL FACILITIES AND PRACTICE ORGANIZATION

Note: After comparing information provided in the Facilities Questionnaire (Q4) to the actual clinic environment, please provide any comments/discrepancies/recommendations here.

Comments/recommendations regarding Physical Facilities and Practice Organization

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

D. COMMENTS ON INTERVIEW WITH PHYSICIAN

Please describe briefly the topics that were discussed during the interview and any advice that was given. Include comments, if appropriate, clarifying documentation, diagnosis, investigations, management of patients, and any other areas of concern that were discussed during the interview.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please indicate the length of time you spent:

a. Reviewing charts: _________

b. Interviewing the physician: _________

Recommended as an assessor Yes ☐ No ☐

(This recommendation should be made to the committee in the Final Report. The invitation to become an assessor will be at the discretion of the Practice Enhancement Program Committee. A list of recommended physicians will be kept in the office and the committee, as necessary, will initiate the invitation. The Assessor does not discuss the invitation with the physician at the time of the assessment)
This outline is provided to give a format for the interview at the end of an office assessment. Intended as a memory aid rather than a rigid guide, it may be modified at the discretion of the assessor.

**Purpose of interview**

- to review all parts of the practice assessment and provide suggestions for improvement
- The final assessment is made by the PEP committee, based on all the information gathered during the assessment process.

**Topics for Discussion**

- Patient questionnaire (*often good to start with this – usually some positive comments*)
- MCIB profile
  
  Doesn’t contain any financial information
  Provided so you can see where you stand in your peer grouping
- Office assessment (Use notes made in Medical Office Assessment Form (R-2))
- Chart review (Use notes made in Medical Office Assessment Form (R-2))
  
  Content of medical record
  Quality of care review
- Any questions or comments from physician?
- After the PEP committee reviews the assessor’s report, you will receive a copy of the final report and a letter giving the committee’s final assessment (*indicate that this may be up to two months from date of assessment*).
- PEP will also send you a questionnaire asking for your feedback regarding your impression of the PEP assessment and whether the suggestions were helpful.
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<tbody>
<tr>
<td>134.12</td>
<td>Prostate biopsy</td>
<td>55</td>
<td>55</td>
<td>55</td>
<td>55</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>126.12</td>
<td>Renal biopsy</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>126.13</td>
<td>Lung biopsy</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
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<td>126.14</td>
<td>Liver biopsy</td>
<td>40</td>
<td>40</td>
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<tbody>
<tr>
<td>126.15</td>
<td>Breast biopsy</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
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<td>126.16</td>
<td>Rectal biopsy</td>
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<tbody>
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<td>126.17</td>
<td>Esophageal biopsy</td>
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<td>80</td>
<td>80</td>
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<tr>
<td>126.18</td>
<td>Gallbladder biopsy</td>
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<tbody>
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<td>Urinary bladder biopsy</td>
<td>100</td>
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<tr>
<td>126.20</td>
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<td>110</td>
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<tbody>
<tr>
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<td>Nasal biopsy</td>
<td>120</td>
<td>120</td>
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<td>120</td>
<td>120</td>
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</tr>
</tbody>
</table>
6.f.ii MSB Numeric Explanation

MCIB Profile 98.6.17

1. **Identification Data**

Dr #****  Group (e.g. rural/urban solo/group) **  Grad Place**
Grad year**  Birth year**  Number in group 118

Family Physician Groups are; B1... FP’s in Metro Association practice (Regina and Saskatoon)
B2... FP’s in Urban Association practice
B3... FP’s in Metro Solo practice
B4... FP's in Urban Solo practice
B5... FP’s in Rural Association practice
B6... FP’s in Rural Solo practice
B7... FP’s who are paid on a Global or Alternate payment system basis

2. **Discrete patients seen in**

   a. Current Year OWN  RANK (in same group e.g urban/solo) MEAN (of same group)
   b. Current and previous year

3. Discrete Patients seen in

   a) Current year only  1342  56  1490
   b) each of current and previous year 1274  46  1164

   Total Discrete Patents  2616  53  2653

   i.e. This physician came 56th in his peer group of 118 physicians in patients seen in current year, 46th in patients seen in this year and previous year, and 53rd overall. He is roughly in the centre of the group. The higher the rank the more patients seen. These figures give an idea of whether the patient load is increasing or decreasing, in this case rising a little.

4. **Total services provided by doctor**

   - all office visits, house calls, Pap smears, deliveries etc.

5. Total Services provided by Dr.  11707  43  10550

6. Services per discrete patient

   a) provided by Dr.  4.48  33  3.99

7. a) Total Patient Contacts  8781  51  6672

   i.e. This physician came 43rd out of his peer group of 118 in total services provided, with each individual patient seen receiving 4.48 services (average per member of his group 3.99, so above average) in 8,781 patient contacts.
## Services provided by doctor per 100 discrete patients

<table>
<thead>
<tr>
<th>Services Provided by Doctor /100</th>
<th>Own</th>
<th>Rank</th>
<th>Mean</th>
<th>(Mean)</th>
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</thead>
<tbody>
<tr>
<td>A. Major Assessments</td>
<td>46.5</td>
<td>1</td>
<td>15.2</td>
<td>15.2</td>
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<tr>
<td>B. Other Assessments</td>
<td>225.8</td>
<td>65</td>
<td>240.0</td>
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<tr>
<td>C. Routine Call Special Care</td>
<td>11.5</td>
<td>53</td>
<td>19.1</td>
<td>21.3</td>
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<tr>
<td>E. Hospital Care Days</td>
<td>26.8</td>
<td>80</td>
<td>40.8</td>
<td>42.6</td>
</tr>
<tr>
<td>F. Consultation</td>
<td>0.0</td>
<td>0</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>G. Psychotherapy</td>
<td>5.5</td>
<td>46</td>
<td>8.4</td>
<td>8.7</td>
</tr>
<tr>
<td>H. Laboratory Tests</td>
<td>77.7</td>
<td>12</td>
<td>32.3</td>
<td>39.3</td>
</tr>
<tr>
<td>J. Other Diagnostic or Therapeutic Procedures</td>
<td>28.6</td>
<td>35</td>
<td>26.40</td>
<td>26.4</td>
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<tr>
<td>K. Major Surgery</td>
<td>0.2</td>
<td>19</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>L. Minor Surgery</td>
<td>10.6</td>
<td>31</td>
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<tr>
<td>M. Obstetrics</td>
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<td>0.9</td>
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<tr>
<td>N. Anesthesia</td>
<td>11.0</td>
<td>8</td>
<td>2.1</td>
<td>6.9</td>
</tr>
<tr>
<td>O. Surgical Assist</td>
<td>0.0</td>
<td>0</td>
<td>1.00</td>
<td>2.2</td>
</tr>
</tbody>
</table>

i.e. This physician ranked 80th out of 118 in hospital care days (look for discharge summaries), first out of 118 for 3B’s (Look for complete medicals in file) and 14th for obstetrics (look for pre-natal sheets).

Number of Pap smears may reflect preventive care, but can be misleadingly diluted if this physician sees a lot of patients once only e.g. sessions in walk-in clinic or emergency room.

All surcharges reflects out of hours calls, should in general agree with numbers of patients seen outside office hours reported in pre-visit questionnaire.

In general, this gives an idea of which aspects of medicine the physician concentrates on, thus, a high rank in Obstetric services will suggest that plenty of obstetric files should be viewed, and a large amount of minor surgery could be a hint to check sterilization procedures and equipment (unless all done in a hospital setting).
Services requested by Doctor

1.1 Services requested by Doctor

D. Consultations 22.4 12 12.8 12.8
E. Psychotherapy 3.1 16 1.6 1.8
F. Lab Tests Paid by MSP 1.3 21 1.1 1.3
G. Radiology 0.0 0 1.2 1.5
F. Other Diagnostic Procedures 28.7 52 30.2 30.2
K. Obstetrics 0.4 12 0.4 0.5

D. Twice the average number of referrals, could reflect poor case management skills.
E. Psychotherapy may not show up in sample of files read since only 3.1 services per 100 patients seen.
F. Lab tests, about average.
Other services about average also.

Percentage of discrete patients by age and sex

<table>
<thead>
<tr>
<th></th>
<th>Own: % of Pat</th>
<th>Group: % of Pat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-05</td>
<td>6.50</td>
<td>6.19</td>
</tr>
<tr>
<td>6-14</td>
<td>6.35</td>
<td>6.11</td>
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<tr>
<td>15-24</td>
<td>5.01</td>
<td>5.85</td>
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<tr>
<td>25-44</td>
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<td>45-64</td>
<td>8.30</td>
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<td>65+</td>
<td>9.06</td>
<td>8.73</td>
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<tr>
<td>Female</td>
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<tr>
<td>0-05</td>
<td>5.66</td>
<td>5.56</td>
</tr>
<tr>
<td>6-14</td>
<td>5.85</td>
<td>6.20</td>
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<td>15-24</td>
<td>8.18</td>
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<td>25-44</td>
<td>16.67</td>
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<td>9.44</td>
<td>9.73</td>
</tr>
<tr>
<td>65+</td>
<td>10.09</td>
<td>11.11</td>
</tr>
</tbody>
</table>

This gives demographic picture of practice. A very similar patient mix to rest of group, whole range of care from infant to elderly, no specific concentration on any group.

Women physicians often show a high percentage of female patients between 20 and 35 (obstetrics) or over 50 (menopause). A high incidence of young male patients between 14 and 25 could suggest an interest in Sports medicine. These figures can be useful in recommending a CME prescription in the absence of any obvious CME gaps.
6.g The Final Report - Description

The Final Report is the *most essential and significant part* of the assessment process. The report, along with the physician interview, *provides the assessed physician with a snapshot* of his/her practice including both the positive aspects and the areas that could use some improvement. Through review of the report the committee makes the final decision as to the category to assign the physician and whether or not follow-up is necessary.

Remember that the committee does not have the same background information you do. *You are the eyes and ears of the program* so include enough information through narrative comments in the report to give a short overview of the practice under all the categories outlined in the Final Report Format. In particular, *include enough detail* to allow the Committee to understand how/why a conclusion was reached.

**Tools/Resources to create Final Report:**

- **Medical Office Assessment Form R-2**
- **Guidelines for Chart Review CR-1**
  
  These are your resources for completing the Final Report. It contains all pre-determined assessment criteria with tick boxes and places for notes. Use these during chart review and in determining Quality of Care re; management of each disease entity.

  *These are confidential documents and the data from them is entered in the PEP database. Please return them with your report.*

- **Final Report Requirements** for outline of specific PEP requirements.
- **Samples of Final Reports – provided in binder**

**General Information:**

1. **Patient Identification:** In some reports, specific cases/charts with patients listed as Patient A, etc can be included to support comments. Please do not include patient identification in Final Reports. If deficiencies have been discovered in specific files, record the name/file number on
the *Full Medical Office Form* so this information can be forwarded to the physician to support recommendation in the correction of the deficiency.

2. **Complete the ratings** of “MEETS STANDARD”, OR “SIGNIFICANT IMPROVEMENTS REQUIRED” before you submit your report. You are the observer of the medical practice and have the information to make the decision. If the committee questions the rating, you will be contacted for more information.

3. **Wording the recommendations positively** rather than prescriptively keeps with our goal of offering an educational experience.

   For example: *'Must implement SOAP immediately’* could be worded
   
   *It is recommended that Dr. ? adopt the SOAP or a like formula for record keeping* - Or
   
   *Consider using the SOAP or similar format for record keeping.*

4. **Report to be submitted** to PEP office within *two weeks* of the completion of the assessment as follows:
   
   a) Computer Compact Disk - PEP Office uses *Microsoft Word*. The Final Report Format will be provided on CD upon request.
   
   b) Dictated – use the headings in the Final Report Format – a Dictaphone machine will be assigned to each assessor, tapes will be sent for each assessment
      
      o In addition to the standard dictation machine, PEP now has digital Dictaphones available for electronic transmission of dictation

   c) E-mail – the PEP office currently *discourages e-mail transmission of Final Reports* due to confidentiality risks (unless arrangements are made for the removal of any identifiers prior to transmission).

   Final Reports must be couriered or mailed to the office. **Return all information in the self-addressed Xpress-Post envelope provided to you with your assessment package.**

   *Please Note:* A draft copy of the transcribed report will be sent to you for your review prior to being submitted to the PEP committee.

5. **Committee Review:** The committee will meet within approximately 6-weeks of the assessment to review the Final Report. The Final Report will be ready to forward to the assessed physician shortly thereafter. This process, from the initial date of assessment to the physician’s receipt of his/her Final Report, may take up to two months to complete.

   The assessor may be asked to join the meeting in person or by teleconference to discuss the content of the final report.
Physician Name:  
Address:  

Assessor/s:  
Assessment Date:  

I. Professional Profile:  
- always include age  
- medical school; place & date of graduation  
- dates & places of all residencies, other post graduate education  
- post graduate exams and certification  
- membership in CFPC or RCPSC (or equivalent)  
- places and dates of previous employment  

II. Current Practice Profile:  
- group or solo practice  
- scope of practice eg. family practice with/without obstetrics, subspecialties  
- coverage arrangements  
- any other special interests in medicine  
- affiliated with academic medicine, faculty appointment  
- CME activities  
- DO NOT include any MCIB information  
- amount of on-call time/week  
- amount of holiday time  
- proportion of hospital work vs. office practice  

III. Recommendations:  
- amalgamation of ‘Suggestions’ from rest of report  
- brief and limited number, one declarative sentence each  
- positive wording (e.g. Consider adopting . . ., Suggest changing . . ., Recommend that . . .etc.)  
NOTE: For every ‘Concern’ listed, there must be a corresponding ‘Suggestion’ and vice-versa. ‘Suggestions’ from each category then become ‘Recommendations’ on the face page.

*Please indicate a rating ‘√’ for each section.

<table>
<thead>
<tr>
<th>IV. Quality of Care</th>
<th>o Meets</th>
<th>o Significant</th>
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<tbody>
<tr>
<td>Improvements</td>
<td>Standard Required</td>
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</table>

**Comments/Specific Incidents:**

- Do not describe the documentation here, more appropriate in Content of Medical Records
- Do include enough detail to allow the Committee to understand how/why a conclusion was reached
- Describe management of disease entities from chart review
- Is documented investigation appropriate to patient’s complaint/condition
- Are appropriate diagnoses reached
- Are management plans and medications prescribed appropriate to condition being treated
- Are indications for surgical and other procedures documented and appropriate
- State whether counselling and psychotherapeutic sessions are appropriately indicated and recorded
- Is there utilization of support and community resources
- Are current practice guidelines being followed
- Is there evidence of appropriate investigations and follow-up of results
- Is there obvious assessment of lifestyle and preventive health issues
- Are arrangements made for the physician’s patients to be cared for in his/her absence
- Are emergency problems dealt with promptly and effectively
- Describe adequacy of treatment of both acute and chronic conditions
- Describe management of specific disease entities (hypertension, diabetes, asthma, depression, paediatrics, etc.)

**Concerns:**

<table>
<thead>
<tr>
<th>Suggestions:</th>
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<td>Action Taken By Physician Assessed:</td>
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## V. Structure and Organization

### Significant Improvements of Medical Records

#### Meets Standard

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<thead>
<tr>
<th>Comments:</th>
<th>Concerns:</th>
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<tbody>
<tr>
<td>The medical record should tell a story about the patient that will allow for a <strong>rapid and complete understanding</strong> of medical history, current treatment and any other factors that may impact care.</td>
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- Stress quality of legibility – When there is difficulty reading charts the assessor must state unequivocally that either an assessment could be made of quality of care or it could not.
- Are there adequate notes for reader to follow present management
- Is patient identity clearly evident on each chart component
- Describe organization within charts, retrieval of items
- Use of standard forms (cumulative patient profile, flow sheets, medications, history summary, etc.)
- Is there S.O.A.P. type or narrative notes covering all areas
- Are diagnosis and treatment plan clearly stated
- Are allergies and drug reactions clearly documented, as well as dates of immunizations
- Are medications documented – type, duration, evidence of regular review
- Are significant positive and negative findings recorded
- Is there a system for acknowledgement and follow-up of normal and abnormal test results
- Are pathology reports, hospital discharge summaries, operative notes, etc. retained in charts
- Use of pediatric growth charts and Saskatchewan Prenatal Forms
- Is there documented evidence that periodic general assessments are performed
- Is there documented evidence that lifestyle and health maintenance issues are discussed
- Is there identification of physicians making chart entries
- Is any significant telephone advice recorded in charts Evidence of progress notes for management of chronic conditions
- Describe **documentation** regarding specific disease entities (hypertension, diabetes, asthma, depression, paediatrics, etc.)
VI. A. Patient Questionnaire (Q1)

1. Accessibility (Questions 11-15)
2. Communication (Questions 1-4)
3. Care (Questions 5-10)
4. Staff (Questions 16-17)
5. Preventive care (Page 3 of Pt. Quest. Summary)

- amalgamation of comments/concerns from Patient Questionnaire Summary Report

VI. B. Referred Specialist Questionnaire (Q5)

- amalgamation of comments/concerns from Referred Specialist Questionnaire Summary Report

VII. Walk-in Clinic

<table>
<thead>
<tr>
<th>Comments:</th>
<th>Concerns:</th>
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<tr>
<td>- Determine whether physician provides ongoing or episodic care</td>
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<td>- Evidence of patient education regarding importance of regular visits</td>
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<tr>
<td>to their family physician</td>
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<tr>
<td>- Determine patients’ family physicians and document information in</td>
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<tr>
<td>charts</td>
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<tr>
<td>- Mechanism for provision of information to patients’ family physicians</td>
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<td>- System for handling non-urgent referrals</td>
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<tr>
<td>- Provision for after hours coverage</td>
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<tr>
<td>- Establishment of clinic policies and standards for employed physicians</td>
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<table>
<thead>
<tr>
<th>Suggestions:</th>
<th>Action Taken By Physician Assessed:</th>
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VIII. Physical Facilities & Practice

Organization Questionnaire

Improvements

- Meets
- Significant Standard
- Required

Comments/Specific Incidents:

- summarize any deficiencies noted in the Facilities Report and confirmed at the time of assessment
- continue to list any recommendations made as a result of your observations and include them in the III. Recommendations section on Page 1

Concerns:

Suggestions:

Action Taken By Physician Assessed:

IX. SUMMARY

- any specific concerns re; care and/or records
- include and compliment specific good points/observations
- general comments and impression of practice
6.g.ii Final Report Format Outline

Name: Dr.

Address:

Assessor/s: Dr. Assessment Date:

I. Professional Profile:

II. Current Practice Profile:

III. Recommendations:

IV. Quality of Care

√ Meets Standard

☐ Significant Improvements Required
### V. Structure and Organization of Medical Records

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<th>Concerns:</th>
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<th>Action Taken By Physician Assessed:</th>
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</table>

- **√ Meets Standard**
- **☐ Significant Improvements Required**

#### VIa. Patient Satisfaction Questionnaire (** out of 60 questionnaires returned)**

1. Accessibility (Questions 11-15)
2. Communication (Questions 1-4)
3. Care (Questions 5-10)
4. Staff (Questions 16-17)
5. Preventive Care (Page 3 of Pt. Quest.)

#### VIb. Referred Specialist Questionnaire (** out of 20 questionnaires returned)**
### VII. Walk-in Clinic

√ Meets Standard

The following comments and recommendations (if any) are made pursuant to information provided in the Physical Facilities & Practice Organization Questionnaire (Q4), Section J #78 – 88.

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<tr>
<th>Suggestions:</th>
<th>Action Taken By Physician Assessed:</th>
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</table>

### VIII. Office Visit: Physical Facilities and Practice Organization

√ Meets Standard

The following comments and recommendations (if any) are made pursuant to information provided in the Physical Facilities & Practice Organization Questionnaire (Q4). Observations were then made by the PEP assessor at the time of your assessment and details from the Facilities Report (copy attached) were verified.

<table>
<thead>
<tr>
<th>Comments:</th>
<th>Concerns:</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Suggestions:</th>
<th>Action Taken By Physician Assessed:</th>
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</table>

**SUMMARY**
PRACTICE ENHANCEMENT PROGRAM

6.g.iii Recommendation Summary

I. Quality of Care

1. Develop an on-call rotation system for after hours.
2. More emphasis on quality CME to reflect guidelines similar to College of Family Physicians of Canada with relation to MAINPRO-M1 or MAINPRO-C type of continuing medical education activities or the Royal College of Physicians and Surgeons of Canada for Maintenance of Certification.
3. Use more discretion in performing investigations. Do not order investigations routinely. Each investigation must be warranted by a specific clinical question or be part of a guideline for the specific condition or be a screening test of established value.
4. This physician has not had a vacation in several years and recommendations were made in regard to holidays. Stress levels, work loads and sufficient rest were all discussed. This is important both for the well-being of the physician and for patient safety. Suggest accessing the SMA’s locum tenens service.
5. Recommend scheduling more consistent general assessments where the underlying condition warrants.
6. More emphasis on doing and documenting preventative medicine and lifestyle counselling.
7. Consider blood pressure checks on a more consistent basis where the underlying condition warrants.
8. Perform more consistent pap smears on appropriate patient population.
9. Schedule regular medication reviews.
10. Implement an objective measure of pulmonary function evaluation in the management of asthma patients.
11. The need for counselling and psychotherapeutic sessions must occur in family practice and therefore provide and document these sessions.
II. Content of Medical Record

12. Consider adopting the S.O.A.P. formula or similar system for record keeping. This will ensure that all elements of the patient’s visit are recorded.

13. Establish ways to improve legibility. This may be accomplished by means of typed or printed notes (write slower, more deliberately and use a consistent entry model, i.e. S.O.A.P. or similar format) or through the use of handheld or voice activated dictation systems. Consider implementing an Electronic Medical Record.

14. Utilize and maintain Pediatric Growth Charts. Consider gender specific growth charts to capture height, weight and head circumferences for children to the age of two years.

15. Recommend selectively the consistent use and maintenance of a Cumulative Patient Profile to assist in providing continuity of care.

16. Develop a medication flow sheet to include a full list of medications prescribed, duration of and amount of prescriptions.

17. Consider taking measures to organize chart contents to provide easy identification and access to patient information.

18. Consider the selective use of laboratory flow sheets which would allow a quick and a complete overview of lab results at a glance.

19. Initial, or otherwise indicate, that all incoming lab results/reports have been seen and any appropriate follow up arranged.

20. PEP encourages the selective use of flow sheets to improve the quality of patient care and clinical practice.

21. Document preventive care or emphasize such care in the medical records, particularly for chronic cases.

22. Provide more detailed documentation regarding management of chronic care.

23. Provide more in-depth medical history, especially when it relates to complete or general assessments. This would reflect appropriate medical care. Particular attention should be given to family history, social history, systemic review, and significant past medical and surgical history.

24. Record all significant telephone calls in the charts including any telephone advice given or action taken. Have charts pulled to go along with any phone call messages and/or prescription refill requests in order to permit recording of any details.

25. Recommend use and comprehensive completion of Saskatchewan Prenatal Forms.

26. Always measure and record the symphysis to fundal heights on the standard antenatal record.

27. Indicate negative findings as well as positive information in the medical record.

28. When medical practice deviates from the norm, indicate on the medical record reasons for such practice (e.g. non-compliant patient).

29. Consider documentation of date checks on pharmaceutical drug samples and emergency crash kit drugs on a regular interval.

30. Incorporate use of clinical practice guideline flowsheets, especially for chronic patients such as diabetics, hypertensives and coronary heart disease patients, to ensure consistency and expediency in monitoring of risk factors.
32. Patients with depression should have appropriate history taken and advice given should be consistently documented.
33. For depressed patients always enquire about suicide risk and risk of harm to others and document this.
34. Ensure that patient identity is evident on all components of the chart.
35. Ensure that all chart entries are signed including co-signing those of residents. Not required in a solo practice.
36. Suggest using CDM flowsheet for optimal chronic disease management.

III. Office Facilities

36. Consider wheel-chair accessibility to the clinic and to facilities within the clinic.
37. Patients have complained that the walls between the consulting rooms are thin and it is therefore easy to hear conversations in the next room. The clinic could consider ways of dealing with this privacy issue such as background music.
38. Consider increasing the number of examining rooms in the clinic.
39. Consider arranging examination tables to face away from the door to ensure patient privacy.
40. Establish a policy to ensure patient privacy when undressing in examination rooms.

IV. Telephone System

41. It is recommended that an answering service be initiated to direct calls after hours to the appropriate emergency on-call service and location
42. Consider increasing the number of incoming telephone lines
43. Consider having a private line for physician referral use

V. Appointment System

44. Suggest development of a system to ensure patients in waiting room are not neglected or missed.
45. Consider increasing the time scheduled for each appointment to reflect the
doctor’s personal practice style. This should help to reduce waiting times.

46. Consider leaving some vacant appointments in each day to accommodate
patients who must be seen urgently and at short notice

**VI. Filing System**

47. Filing system lacks input from previous medical records that have been
segregated. Recommend that a summary be provided from the old charts to
reflect an up-to-date historical perspective.

48. Color-coding of charts in filing cabinets would make retrieval of misplaced charts
easier.

49. Make transition from family to individual charts

50. Consider transition to EMR system

**VII. Medical Instruments & Investigative Equipment**

51. Follow CPSS Guidelines for Infection Control and Waste Management.

52. Dispose of unwanted medications through the local pharmacy or drug reps.
 Never flush them down the toilet or place them in the regular garbage.

53. Place sharps containers in each examining room and out of children’s reach.

54. Hazardous medical waste such as contaminated dressings, gloves, speculum
and syringes are more appropriately disposed of either through a local hospital
or a company dedicated to this type of disposal.

**VIII. Drugs & Injectibles**

55. Maintain a current list of emergency drugs and supplies to be stored in the
treatment area or crash cart so it is easily available in emergencies.

56. Obtain Adrenalin for availability in the case of an allergic reaction. Keep
syringes etc. with it for rapid use if needed.

57. Develop an inventory of drugs in the office and monitor dates of expiry.

58. Consider disposing of unwanted or outdated medications through the local
pharmacy or drug company representatives.

59. Secure narcotic/controlled drugs in locked storage.

60. Install a high/low thermometer in the fridge where temperature-sensitive
medications and serums are stored.

**IX. Emergency Facilities**

61. Recommend keeping a stretcher at all times in the office in view of the fact that
there is no immediate 911 service available.

62. Consider stocking a container or cart with all available emergency equipment
and storing it in a central location.

63. Consider a nebulizer if there is a strong presence of pediatrics in the clinic.

64. Consider documenting and implementing a disaster/fire plan in the event of an
emergency and a plan for dealing with disruptive patients, security risks, etc.

65. Educate staff members on the procedures in the event of an emergency.
X. Personnel

66. Consider writing job descriptions and office policy into a manual to assist both with training and giving employees a clear understanding of what a particular job entails.

67. Consider having regular staff meetings and annual performance reviews to assist with communication.

XI. Walk-in Clinic

68. Adopt the College of Physicians and Surgeons of Saskatchewan Guidelines for Ethical Operation of Walk-In Clinics.

69. Send legible copies of ER/Walk-In clinic reports to family physicians including significant laboratory and diagnostic investigations.

70. Implement a system for documenting a walk-in patient’s family physician in the chart.

71. Recommend patients who require non-urgent referrals to specialists be directed to their own family physicians accompanied with a written summary of visit findings.

72. Establish a system that provides clear distinction for those patients receiving episodic care and those patients receiving ongoing comprehensive care.

73. Consistently document who is responsible for follow-up care for those patients who have seen multiple physicians at this clinic.

74. Implement a policy whereby all patients are asked to identify whom their family physician is, and whether the findings of this visit are to be forwarded to him/her. The default practice must be to send the information.

75. Advise patients to obtain a family physician if a patient does not already have one. Suggestions should be made to patients about the value of such a continuing care arrangement and the establishment of such a care arrangement should be facilitated.

76. Create and follow a policy whereby non-urgent specialist referral should be made by the patient’s own family physician and the patient’s physician be apprised of the need for same in writing.

77. Charts of the patients who do receive continuing care in the Walk-in Clinic should indicate by some mechanism, such as a different colored stamp or the attachment of a colored dot or other indicator, the date of occurrence of periodic annual assessments. This would have the effect of indicating when such events occurred and being a prompting reminder as to when subsequent assessments would be due.

XII. Miscellaneous

78. Send photocopies of relevant information from medical charts in response to requests for patient records, thus retaining possession of the original file. This recommendation is supported by the CPSS and is adopted policy of the SMA Legislative Committee.

79. Initiate communication with consultants by writing referral letters.

80. Develop a policy of management of patient records in the event the physician leaves this practice.

81. Offer the presence of a chaperone during sensitive examinations. Physicians should post a notice for patients advising them of their right to request a chaperone during sensitive examinations. For example: “Please Tell Us … if you want a friend or a member of our staff to be present during your examination.”

82. Adopt the principles of ‘A Guide to Compliance with Privacy (HIPA) Legislation’ compiled by the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan. This information is available at the SMA website www.sma.sk.ca
Name: Dr. ABC

Address: Saskatoon, Sask.

Assessor/s: Dr. XYZ Assessment Date:

I. Professional Profile:

Dr. ABC is a 46-year-old female family physician practicing in Saskatoon. She received her medical degree from the University of Orange Free State, Bloemfontein, South Africa, in 19???. She completed her internship at One-Military Hospital, Pretoria, South Africa, in 19???. Dr. ABC practiced at the Military Hospital, Pretoria, 19???. She practiced at Lloydminster, Sask. for six months in 19?? and then returned to Pretoria to practice from 19?? to 20???. She has practiced in Saskatoon from 20?? to the present. She is not a member of the College of Family Physicians of Canada, but is enrolled in the CFPC MainPro program.

II. Current Practice Profile:

Dr. ABC is in a group practice of nine physicians. Her practice consists of general family medicine without obstetrics. She shares after-hours call equally with the other members of her group. They employ a professional call-answering service. When her patients are admitted to hospital she transfers their care to a specialist. In a typical workweek she spends 38 hours in office practice and 15 hours doing paper work. In addition she spends seven hours per week in the walk-in clinic that the practice conducts. She estimates she sees 150 patients weekly.

III. Recommendations:

1. Review procedures for creating and maintaining current medication lists to avoid duplication.

2. Consider extending the use of chronic disease management forms.

3. Implement an objective measure of pulmonary function evaluation such as the 30 Second Asthma Test in the management of asthma patients.

4. Ensure the recording of suicide risk in the charts of depressed patients.

5. Unless specifically requested by the patients not to do so, physicians in walk-in clinics should establish mechanisms whereby the patients’ family physicians are promptly provided with copies of the assessment and treatment of patients.

6. Recommend patients who require non-urgent referrals to specialists be directed to their own family physicians accompanied with a written summary of visit findings.
7. Follow CPSS Guidelines for Infection Control and Waste Management. Ensure all biohazardous material is labeled before disposal.

8. Continue with attempts to ensure privacy in the examining rooms where the foot of the table faces the entry door.

### IV. Quality of Care

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### V. Structure and Organization of Medical Records

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**Comments:**

Dr. ABC uses Accuro Optimed, an approved EMR system, for maintaining her records. The record is consistently legible and easy to follow. This enables an accurate assessment of medical care. The patient’s identity is clearly evident on all components of the record. A SOAP format is consistently used. When the history is displayed the past medical history, surgical history, medication list, family history, allergy history, immunization history, and social history are simultaneously visible. All these components appeared to be up to date and reviewed. Some duplication was noted in the list of current medications.

The diagnosis and treatment plan were easy to discern. The record contained the significant positive and negative findings. Each physician making an entry in the chart is identified. There is a system for acknowledging and following normal and abnormal tests. One patient was noted to have a significantly low hemoglobin. This had not yet been addressed and was brought to Dr. ABC’s attention. Based on her generally thorough care, this appeared to be an unusual occurrence.

Pathology reports, hospital discharge summaries, operative notes, etc., are retained in the chart and easily retrieved. Saskatchewan Growth Charts, Rourke Development Charts are present and completed.

**Concerns:**

Some duplication was noted of medications on the medication list. Some discontinued medications still showed on the current medication list.

Chronic disease management charts were noted only for diabetes.

Suicide risk was not recorded.
There is ample evidence that lifestyle and health maintenance issues are addressed. There were numerous records of telephone advice given to patients.

Chronic disease charts contained copious evidence of consistent follow-up. Chronic disease management records were in place for diabetic patients.

Asthma records contained good documentation of diagnostic criteria and follow-up management. Some contained consultants’ reports that included pulmonary function reports. Dr. ABC’s clinic has a spirometer and one of the staff has been recently trained in its use. The charts did not contain evidence of the use of the an objective measure of pulmonary function such as the 30 Second Asthma Test.

Cardiovascular Risk Management charts all contained extensive records of careful diagnosis and follow-up. Lipid values were carefully monitored as was blood glucose. ECG records, echocardiograms, and consultant notes were usually present. Dr. ABC’s notes demonstrated she counsels patients on the need for weight control and exercise. Exercise tolerance reports and letters from the Live Well program were present. Patient responses confirm she counsels on smoking cessation. Some of the records included BMI calculations.

Depression charting showed good detail regarding symptoms, diagnosis and management. The treatment plans were easy to follow. Sufficient detail was included of counselling sessions to understand the course of treatment. Suicide risk assessment or risk of harm to others was not recorded. An assessment tool such as the PHQ9 would help give structure to the charting.

Diabetes records contained ample diagnostic and treatment data. The charts reviewed contained chronic disease management charting. These were generally well completed. Records of visits to community resources such as the diabetic educators were included. Home glucose monitoring reports were included. Hemoglobin A1C, renal function data, and lipid values were recorded. Ophthalmology consultations were present.

Hypertension records contained good detail, including home blood pressure monitoring results. Blood glucose, renal function, and lipids were monitored consistently.

Pediatric records all contained fully completed Rourke and Growth charts.

Suggestions:

Review procedures for creating and maintaining current medication lists to avoid duplication.

Consider extending the use of chronic disease management forms.
VIa. Patient Satisfaction Questionnaire (42 out of 60 questionnaires returned)

1. Accessibility (Questions 11-15) Some patients expressed difficulty in reaching Dr. ABC by phone.
2. Communication (Questions 1-4) Dr. ABC communicates well with her patients.
3. Care (Questions 5-10) Her patients express appreciation for her care. Two of the written responses observed she appears rushed during the visits.
4. Staff (Questions 16-17) Patients regard the staff as friendly.
5. Preventive Care (Page 3 of Pt. Quest.) These results confirm Dr. ABC gives attention to preventive care.

VIb. Referred Specialist Questionnaire (13 out of 20 questionnaires returned)

Consultants give Dr. ABC good marks for her referrals and patient care.

VII. Walk-In Clinic

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At registration the patient’s family physician is recorded on the chart. Those not having a family physician are encouraged to obtain one. This clinic has three physicians, including Dr. ABC, who are accepting new patients. The clinic does not routinely forward copies of the visit notes to the family doctor, but they are provided with copies of significant investigations generated. Some consultations are arranged by the walk-in clinic although in some cases the patient is requested to arrange the referral through the family doctor. Urgent referrals are made by the walk-in doctor. The clinic accepts responsibility for follow-up of all abnormal tests. After hours coverage for the walk-in patients is handled by the clinic doctor on call.

| Concerns: |
The clinic does not routinely forward copies of the visit notes to the family doctor.
Some non-urgent consultations are arranged by the walk-in clinic doctor.

| Suggestions: |
Unless specifically requested by the patients not to do so, physicians in walk-in clinics should establish mechanisms whereby the patients’ family physicians are promptly provided with copies of the assessment and treatment of patients.
Recommend patients who require non-urgent referrals to specialists be directed to their own family physicians accompanied with a written summary of visit findings.

| Action Taken By Physician Assessed: |
### VIII. Office visit: Physical Facilities

#### And Practice Organization

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#### Comments:

This clinic facility continues to be an efficiently operated, modern and clean facility since last assessed in 20??.

The equipment is well cared for. Patient confidentiality is good. Sharps disposal is good and handled by a professional waste disposal company. Medication is safely monitored and stored. Emergency equipment is adequate.

Deficiencies noted at the last visit were discussed with the manager. Some biohazardous material still goes in the regular garbage without being labelled. This will be addressed. Some of the examining rooms have the foot of the table facing the door. Consideration is being given to purchasing new tables that can be used from either side in an attempt to resolve this. The doors to the rooms do open in a manner that shields the foot of the table.

The refrigerator used for storage of temperature sensitive material now has a high/low recording thermometer.

All HIPA provisions are adequately met.

#### Concerns:

Some biohazardous material goes into the regular garbage without being labelled.

Some examining tables have the foot of the table facing the entry door.

#### Suggestions:

Follow CPSS Guidelines for Infection Control and Waste Management. Ensure all biohazardous material is labeled before disposal.

Continue with attempts to ensure privacy in the examining rooms where the foot of the table faces the entry door.

#### Action Taken By Physician Assessed:

#### SUMMARY

Dr. ABC is a 46-year-old female physician providing high quality of care in a modern facility in Saskatoon.
Certificate of Participation

Practice Enhancement

Dr. ABC
Regina, SK
2012

Is recognized for participation in the Practice Enhancement Program.

Dr. B.W. Loeussen, Co-Chair
Dr. G.D. Carson, Co-Chair

Signed
ADD / ADHD

Canadian ADHD Practice Guidelines CADDRA 2007-2008
http://www.caddra.ca/joomla/index.php?Itemid=70

ADEQUATE MEDICAL RECORDS

PEP Sample Medical Chart – Chart – distributed at time of assessment, including samples of:
- Cumulative Patient Profile (CPP)
- Lab Flow charts
- Motor Vehicle Accident Questionnaire
- Patient Health Questionnaire
- Patient History Summary
- Chart Review Guidelines (Asthma, Cardiovascular Disease, Depression, Diabetes, Hypertension)

Checklist from Atlantic Provinces Medical Peer Review.

Web site: www3.nb.sympatico.ca/apmpr

Computer Dictation Software information. Web site: www.cma.ca/cmaj

Medical Record Keeping Courses
College of Physicians & Surgeons of Ontario. Web site: www cpso.on.ca

College of Physicians & Surgeons of Alberta. Web site: www cpsa.ab.ca

Document on Physician’s Office Medical Records from the College of Physicians and Surgeons of Alberta. Web site: www cpsa.ab.ca
PEP Resources

☐ S.O.A.P. – an outline of the S.O.A.P. format for recording of clinical notes
☐ ‘Your Paper Shield / Records Seen as Final Authority’ – Family Practice, Jan. 6, 1999
☐ CMPA article – ‘Good Notes vs Bad Notes’. Web site: www.cmpa.org
☐ Retention of Patient Records
  - letter from the SMA outlining the recommendations of the CMPA
  - CPSS Bylaw #46. Web site: www.quadrant.net/cpss

☐ AFTER HOURS CARE COVERAGE

☐ ANAPHYLAXIS MANAGEMENT

☐ ANTIBIOTICS
  - pamphlet developed by: Community Drug Utilization Program, Saskatoon District Health. Web site: www.sdh.sk.ca

☐ AUDIOVISUAL PROGRAMS & TEACHING AIDS
  - videotapes available from Continuing Medical & Nursing Education, U of S, 1-1-1-7790 (Obstetric and Newborn Care, Cancer Education, Gerontology, Patient Assessment, Cardiology). Web site: www.usask.ca/nursing/cne

☐ CHELATION THERAPY: Standards for Performance (CPSS Guidelines)
  For copies of specific guidelines/policies, contact:
  College of Physician and Surgeons of Saskatchewan
  Tel: (306) 244-7355 Fax: (306) 244-0090 Email: cpss@quadrant.net

☐ CHOLESTEROL TESTING & TREATMENT GUIDELINES (Health Services Utilization and Research Commission - November 1995)
  Web site: www.sdh.sk.ca/hsurc

☐ COMMUNICATION
  ☐ Educational Workshops for Physician-Patient Communication (pamphlet available), Oregon Foundation For Medical Excellence. Web site: http://tfme.org
  Web site: www.nursing.mcgill.ca/
PEP Resources

- COUNSELLING – for physician counselling services, contact:
  Dr. Viv Gooding
  215 – 5th Avenue North, Saskatoon SK S7K 2P2 Phone: (306)653-0002

- DIABETES MANAGEMENT
  - Diabetes Flowsheet/Guidelines

- DRUG & EQUIPMENT LIST
  - Suggested list developed by the Saskatchewan Medical Association, January 1995

- DRUG WITHDRAWAL PROTOCOLS

- EDUCATIONAL RESOURCES
  - Remediation and Enhancement Program: This program will provide individualized enhancement and remediation for Saskatchewan physicians who require improvements in certain areas of their practice. Contact: Dr. Penny Davis at Continuing Professional Learning, University of Saskatchewan Box 60001 RPO University, Saskatoon SK S7N 4J8 (Phone: 306-966-7787). Web site: www.usask.ca/cme/
  - Oregon Foundation for Medical Excellence – Booklet of Educational Programs & Research Projects available. Web site: http://tfme.org
EMERGENCY EQUIPMENT

- ‘To Suck Is To Save’ – article from P.A. Pearls, Jim Cross, MD
- Suggestions from the Saskatchewan Medical Association regarding availability of emergency equipment in all physicians offices (suction/airways/ambu-bag), includes product acquisition information
- Description of emergency kit available from BDM Inc., Cambridge, ON
  Web site: www.bdmcan.com/

FORMS AND QUESTIONNAIRES - PEP Sample Medical Chart – distributed at time of assessment, including samples of:
- Cumulative Patient Profile (CPP)
- Lab Flow charts
- Motor Vehicle Accident Questionnaire
- Patient Health Questionnaire
- Patient History Summary
- Chart Review Guidelines (Asthma, Cardiovascular Disease, Depression, Diabetes, Hypertension)

PEP Resources

- GUIDELINES
  - CMA Infobase for Canadian Clinical Practice Guidelines (more than 2000 guidelines)
    Web site: www.cma.ca/cpgs or call toll free: 1-800-663-7336
- Index of Guidelines developed by the College of Physician and Surgeons
  For copies of specific guidelines/policies, contact:
  College of Physician and Surgeons of Saskatchewan
  Tel: (306) 244-7355 Fax: (306) 244-0090 Email: cpss@quadrant.net
- PEP Chart Review Guidelines (Asthma, Cardiovascular Disease, Depression, Diabetes, Hypertension) Web site: www.lights.com/pep
- HIPA – Health Information Protection Act
  - Privacy Toolkit and Checklist for Compliance with HIPA
    Website: www.sma.sk.ca
- Infection Control in the Physician’s Office (from the College of Physicians and Surgeons of Ontario) Web site: www.cpso.on.ca
- OFFICE DESIGN & MANAGEMENT
  - Office Management - Educational Seminar:
    Mr. Garry B. Peters, BAC, CIM
    Business Manager, Associate Medical Clinic
    #400, 20 – 14th Street West, Prince Albert SK S6V 5R3
    Phone:(306) 953-1677 Fax: 953-1689 Email: gpeters.amc@sk.sympatico.ca
- Provides an overview of the efficiency and proper operation of a medical practice. A written evaluation will be provided to the physician with a guide to more income, less expense and more free time.

- Office Management – Articles (copies available through PEP office)
  - Information also available through MD Management. **Web site: [www.cma.ca/mdm](http://www.cma.ca/mdm)**
  - OFFICE TRAINING MANUAL / RECEPTIONIST JOB DESCRIPTION - sample from a physician’s office is available through PEP

- **PALLIATIVE CARE**

- **PEdiCtiC GROWTH CHARTS** – To Order: Saskatchewan Prenatal Records, S.P.M.C. Distribution Centre, 110 Henderson Drive, Regina SK S4P 3V7
  - Phone: (306) 787-2056; Fax: (306) 787-0194

- **PENtAL RECORD** – To Order: Saskatchewan Prenatal Records, S.P.M.C. Distribution Centre, 110 Henderson Drive, Regina SK S4P 3V7
  - Phone: (306) 787-2056; Fax: (306) 787-0194

**PEP Resources**

- **ROurKE BABY RECORDS** – Orders to: McNeil Consumer Products Company, 890 Woodlawn Rd W., Guelph, ON N1K 1A5: Phone:1-800-265-7323; Fax: (519)826-6205

- Resources/form from the Canadian Pediatrics Society:
  - [http://www.cps.ca/english/statements/n/nutritionnotegrowth.htm](http://www.cps.ca/english/statements/n/nutritionnotegrowth.htm)
  - [http://www.cps.ca/english/statements/cp/rourke/rourkebabyrecord.htm](http://www.cps.ca/english/statements/cp/rourke/rourkebabyrecord.htm)

- **sAFETY & SECURITY**

- **SPARC** – Saskatchewan Physicians At Risk Committee
  - Informational brochure developed by the Saskatchewan Medical Association which includes a contact list of medical resource persons available for confidential assistance. For more information contact the SMA. **Web site: [www.cma.ca/inside/divisions/sma.htm](http://www.cma.ca/inside/divisions/sma.htm)**
STERILIZATION / WASTE MANAGEMENT

- Guidelines for Infection Control and Waste Management (CPSS). For copies of specific guidelines/policies, contact:
  College of Physician and Surgeons of Saskatchewan
  Tel: (306) 244-7355    Fax: (306) 244-0090
  Email: cpss@quadrant.net

- Biomed Recovery & Disposal – distributor of biomedical waste and packaging containers: P.O. Box 334 Aberdeen SK S0K 0A0
  Phone: (306)253-4476  Fax: (306)253-4338  (Information & Pricing)
  Web site: www.interspin.com/biomed

- Assoc. for Professionals in Infection Control and Epidemiology, Inc.
  Information on Infection Control and Applied Epidemiology: Characteristics of Autoclave Sterilization, etc. available.
  Website: www.apic.org/


TRANSFER OF PATIENT RECORDS

- Report from Legislative Committee (SMA)
  Sample letter including minimal fee for this service

- Guidelines – Provision and Transfer of Patient Records (CPSS)
  A Matter of Records: Retention and Transfer of Clinical Records from the Canadian Medical Protective Association

VACCINATION INFORMATION

  To order call 1-888-855-2555 or order online from

- Saskatchewan Immunization Manual – Order from Public Health (306) 655-4149
PEP Resources

- WALK-IN CLINICS
  - Guidelines: For the Ethical Operation of a Walk-In Clinic in Saskatchewan (CPSS)

  For copies of specific guidelines/policies, contact:
  College of Physician and Surgeons of Saskatchewan
  Tel: (306) 244-7355   Fax: (306) 244-0090
  Email: cpss@quadrant.net

We always welcome new suggestions and resources for practice enhancement.
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