FPSC Information Sharing Task Group

Team Charting within Primary Care Networks

Team Charting Principles

Purpose

The purpose of this document is to provide guidance to primary care practices[1], new care teams and health authorities on where team members will chart within the Primary Care Networks (PCNs). The recommendation has been approved by the GPSC[2] and includes a set of core principles that will guide where team members[3] within primary care practice should chart, with consideration of best practices for the team and the patient's best interests.

Background

New care team members deployed into Primary Care Networks (PCNs) will need to document the care they provide. While there may be some benefits to both primary care practices and health authorities for new care team members to chart in their respective clinical information systems, double charting is inefficient, unsafe, and works against the concept of a single source of truth. Health authorities' clinical information systems and electronic medical records are often different from the electronic medical records (EMRs) used by community physicians, with limited ability to share information between the two care settings.

This guidance on team charting to support information sharing will be included in the Information Sharing Agreement (ISA) being developed by the GPSC Information Sharing Task Group. However, health authorities are hiring nurses, pharmacists and allied health staff and are looking for direction now. This guidance will take effect immediately but will be re-considered as technical solutions are implemented and/or new requirements are identified.

Scope

New care team members seeing patients in a primary care practice, charting in the practice's EMR directly or via remote access.

Assumptions

- The principles and recommendations set forth in this document assume staff hired by the regional health authority are located and provide care within a primary care practice, and/or have access to the practice EMR for remote charting.
- At least initially, few PCNs will use a full co-location model. For example, in some communities, care team members may see patients within Urgent and Primary Care Centres, health authority facilities and other locations outside of the primary care practice. In such cases, the below principles should be applied and where possible clear expectations should be set to facilitate information sharing for direct care.

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[1] In this document, primary care practice (the clinic) is used to encompass all of the following: a Patient Medical Home, a Nurse Practitioner Primary Care Clinic, a First Nation's led Clinic, or an Urgent and Primary Care Centre.

2 These principles were presented and approved by the Family Practice Services Committee (FPSC) on September 12 2019.

[3] Care team members throughout this document is used to refer to physicians, nurse practitioners, nurses, allied health professionals, clinical pharmacists and other members providing care within the primary care practice/patient medical home (PMH).

- Care teams that are co-located and are able to chart in one system contribute to the quadruple aim and primary care transformation.
- The principles below are in alignment with BC College and CMPA/CNPS standards.
- The principles will be included in the overall PCN Information Sharing Agreement.
- The practice's electronic medical record is referred to as the EMR.

Team Charting Principles

Principles for Team Charting within Primary Care Networks

1. **Chart once:** Whenever possible, care team members should only chart in one system.
2. **Chart in the clinic EMR:** Care team members should chart in the EMR of the primary care practice in which they are working either directly, or indirectly via integrated chart notes*.
3. **Patient-centric:** The primary care practice manages the most complete longitudinal patient record in the community.
4. **Information accessibility:** Information will be made accessible to care team members (and organizations) when needed for patient care. Information for other required purposes will be made accessible under mutually agreeable governance, privacy and security provisions.
5. **Brief and Actionable:** Care team members consider brevity in charting actions and encounter summaries.
6. **Maintain Data Standards:** Charting should be optimized for team performance, patient safety, clinical decision support and reporting and should meet minimum charting requirements of the primary care clinic in which they are working.

* Integrated chart notes are bidirectional, shared, read-only chart notes which integrate directly across systems.

A detailed table and description of the context and rationale for each principle is provided in **Appendix A**.

Implementation into Practice

The adoption of these principles in practice will expose gaps and challenges for the care teams involved as teams will be transitioning to new models of working together and sharing information. **Appendix B** outlines a list of implementation considerations including guidance and change management support.

Next Steps

We encourage PCN communities and your respective health authority, Division of Family Practice, primary care practices and care team members to come together to start discussing how you can approach the operationalization of these principles.

This document is available on the PCN Toolkit Website. For further questions, please reach out to fpscinfosharing@doctorsofbc.ca.

APPENDIX A: Team Charting Principles Description

Principle	Context	Why is it important?
Chart once. Whenever possible, care team members should only chart in one system.	Care team members employed by health authorities have designated clinical information systems and processes to document care provided. Connecting to a team-based care model in community may imply that there is duplication in documentation across multiple systems or that information is scattered across systems. Multiple patient records impact continuity of care and can pose patient safety issues.	• Co-location for care provision and co-charting in one system is ideal for patient care continuity and should be encouraged to achieve true primary care transformation. • Some situations may make it impractical for team members to chart in the primary care practice EMR, but the downside of separate records should be minimized as much as possible through defined information sharing practices. • Other situations may require duplicate charting of very selected information which too, should be minimized. • If there is a need to chart in multiple systems, teams should have access to read only patient information that inserts automatically into the patient chart without going into an inbox.
Chart in the clinic EMR. Care team members should chart in the EMR of the primary care practice in which they are working, either directly or indirectly via integrated chart notes (*integrated chart notes are bidirectional shared read-only chart notes which integrate directly across systems).	Care team members joining a PCN will need guidance on where to document the care provided. Some care team members will continue to chart in the health authority clinical information systems and see referred patients, following referral workflows to share information with the primary care provider. Other health authority staff will be co-located in the primary care practice and/or have access to the clinic EMR.	• Safe and effective integrated care demands an integrated view of patient information for all care team members, including the physician and/or NP. • In the community, the clinic EMR usually has the most complete longitudinal record and as much as possible, should be the record of choice for all team members. • Workflow needs for all care team members means more than just access to information. Other needs include messaging about patients, task management and scheduling. This requirement is usually best achieved in a single record.
Patient centric: The primary care practice/patient medical home (or most responsible provider) manages the most complete longitudinal patient record in the community.	Primary care transformation is about moving care away from acute based models to community-based systems. Our current health authority and primary care practice clinical information systems do not have a way of seamlessly sharing information.	• In our current state, systems with limited interoperability prevent care teams and patients of having access to one holistic and integrated patient record. • The primary care clinic's chart currently provides the most complete record for any patient.
Information Accessibility: Information will be made accessible to care team members (and organizations) when needed for patient care. Information for other required purposes will be made accessible under mutually agreeable governance, privacy and security provisions.	Parties within the PCN may require access to the clinic EMR for multiple reasons including evaluating direct patient and team-based care, system quality improvement, complaint resolution and performance monitoring.	• PCN parties may undertake various quality improvement initiatives or have specific reporting requirements needing access to the data from the clinic EMR. • Data may be required by various parties within the PCN to meet MoH reporting requirements, conduct PCN service planning, and for care delivery improvement initiatives. • Information may also be requested and required by patients and by health authorities when responding to patient complaints regarding health authority staff who worked/are working in the primary care clinic. Primary care practices and PCNs need to ensure that information is accessible to patients, and those team members and organizations who need it when they need it.
Brief and Actionable: Care team members should consider brevity in charting actions and encounter summaries.	There are assumptions that proper documentation practices are in place. With the introduction of Team Based Care comes an opportunity to emphasize the need for documentation standards and consistency. Notes should be brief, actionable and be clear about responsibility.	• Medical records enable care teams to communicate about patient care. They also enable evaluation of the care provided for quality improvement. • Colleges and professional associations provide guidance on best practices for care documentation. CMPA's good practice guide on documentation, and the CNPS Quality Documentation: Your Best Defence outline some common best practices.
Maintain Data Standards: Charting should be optimized for team performance, patient safety, clinical decision support and reporting and should meet agreed upon minimum charting requirements.	Adoption of clinical data standards enables consistency in documentation of care and enables partners to more easily evaluate the continuity of care, outcomes and benchmark against other organizations. Best practices exist on what data standards to follow, but PCNs may decide to be explicit about the basic data standard requirements for the parties within their teams. In such cases, a Memorandum of Understanding can be created around specific data requirements.	• Core discreet data elements are essential for clinical decision support, sharing of information with other providers (interoperability) and meaningful reporting for quality improvement. • Each care team should agree upon their core data set, informed by PCN, provincial and international best practice. • The data standard requirements should complement clinician workflows and support patient care delivery. They should not be so exhaustive that they take away time from patient care or impose costs to the physician. • Achieving interoperability is dependent on care teams following consistent documentation practices and data standards.

APPENDIX B: Related Implementation Considerations

	Implementation Challenge	Implementation Considerations
1.	In some communities, one care team member might be deployed across different primary care practices. Each clinic has its own workflows and potentially its own EMR.	Care team members deployed across multiple primary care practices, may potentially chart in more than one PMH EMR. The learning curve for these providers may be challenging in communities where multiple different PMH EMR systems are used. Change Management and workflow support will be required to help teams integrate within the primary care clinic and PCN. Operationalization of PCNs and Patient Medical Home models will require careful analysis of nurse and allied care team deployment to optimize workflows and minimize challenges of learning multiple EMR systems and clinic workflows.
2.	What supports are available to educate and onboard new care team members to primary care practice workflows and EMR systems?	It is expected that clinic EMR training and onboarding to the clinic's workflows will be the responsibility of the primary care clinic. Costs will come out of the Ministry Funded Change Management Supports for the PCN. Clinics may choose to take advantage of the PSP's EMR Functionality small group learning sessions that are open to Allied Health Providers.
3.	Who is responsible for additional licensing costs that an EMR vendor charges for new care team members joining the primary care practice?	Each EMR vendor has a different licensing model and costs. The 15% overhead allocated to Allied Health Providers is expected to cover any EMR licensing fees.
4.	How do I ensure additional staff treat patient records in the EMR appropriately?	The primary care practice will internally need to manage any privacy/confidentially statements for all team members to sign. It is recommended that clinicians refer to the BC Physician Privacy Toolkit: A guide for physicians in private practice. The Toolkit provides a sample Confidentiality Agreement for Health Authority Employees Working in a Physicians Private Practice. The PCN Information Sharing Task Group is contemplating enhancements to the DOBC confidentiality agreement and will issue a template in late fall, 2019. Care teams, staff and primary care practice/PCN support teams such as the FPSC Practice Support Program, Divisions of Family Practice, Doctor's Technology Office, and partners need to be aware of best practices around information sharing and information sharing agreements.
5.	As a physician/Nurse Practitioner, am I responsible for reviewing everything that new care team members chart in my PMH EMR?	The primary care practice is the custodian of the medical record. Patients have ownership of the information, but the custodian of the file has control of the record. New care team members will contribute to the record in co-located models, following respective professional standards of care and documentation. As independent professionals, team members are responsible for their own work. Physicians and Nurse Practitioners are NOT responsible for reviewing the minutiae of team members' work.

6.	What if a physician/Nurse Practitioner does not want new care team members charting in their clinic EMR?	Further guidance on this topic is required from the FPSC Team Based Care Working Group. Furthermore, awareness and change management efforts will be needed to help clinicians understand that signing onto the PCN will require a transformative change in practice.
7.	How do I as a health authority manage and review the work of staff deployed in primary care clinics if I can't see what they chart?	Successful implementation of team charting may require the provision of access to patient information to parties within the PCN for quality improvement purposes. Accessibility to the patient record may not be the same for every provider/party involved in the PCN, following standard access controls. For example, a social worker does not need to see all of the data in an oncology report. How this is managed in community requires guidance and information access management plans at the local level and resources to support this work. Separately, the Ministry's HR guidelines indicate that health authorities do NOT need to review patient charts in order to evaluate their staff's performance.
8.	As PCNs begin implementation of Team Based Care, new challenges will emerge over time requiring guidance.	Is there a designated group that will maintain responsibility to manage escalations and resolve implementation related issues as they arise? The FPSC Information Sharing Task Group is a time-limited entity. Alternatively, parties can raise issues with one another and/or their Primary Care Network Steering Committee for resolution. The FPSC Team Based Care Working Group is also a resource moving forward.
9.	How will information accessibility be supported?	Appropriate IT infrastructure, governance, security, and confidentiality measures will need to be in place to ensure that information is accessible to those team members and organizations who need it when they need it. This will require resources, guidance and support for primary care clinics and for PCNs. Much of this will be made available in the Information Sharing Agreement Implementation Toolkit that the FPSC Information Sharing Task Group will create and release by the end of 2019.
10.	How is the FPSC Team Based Care Working Group connected to this work?	The Team Based Care (TBC) working group has been involved at various stages of development of the principles. That group has received and reviewed the principles and is cognizant of the supports needed within PCNs to support Information Sharing.