

## Auditor Training Workshop – How to Deliver Effective Feedback

### Case Scenario #2

#### **Reviewer**

You have done a review of the files of this physician, and are now sitting down to discuss the review with him/her. Your review found that the records were generally fairly well done, and the care seems to meet the standard required. You do have some questions about things that seem to be missing, however.

Diabetes patient – last alb/creat ratio 2016? Lab result indicated possible hemoglobinopathy – was this followed up?

Chronic pain case – does the physician check eChart to ensure the patient is not getting things from other prescribers? Patient seems to have rx for Tylenol 3 – from this MD or elsewhere?

Information in bands section of electronic record not always up to date. Patients have active prescriptions for medications that don't have a diagnosis in the problem list, eg SSRI – for depression, or anxiety disorder. Allergy to ASA recorded in note, but not entered in band.

Physician doesn't seem to be using auto expire function of electronic record – helps them to see which meds are out of date, discuss how patients are taking their meds.

## Case Scenario #2

### **Reviewee**

You have recently had a chart review done by a College reviewer. You have received the report back, which has some suggestions for improvement. You have found this whole process to be quite stressful to go through, and are nervous about this meeting. You don't know if "they" understand the realities of day-to-day practice, and the demands that go along with it.

You are reassured that there were some positive comments, and that your care meets the standard.

You have some difficulty keeping up with keeping all of the charting, and don't always record everything that you do. You have been seeing your patients for many years, and feel that you know them well, and don't have to record every thing every time. You know that you don't always enter new diagnoses into the list of problems – especially for conditions that are not lifelong. You find it just extra work to do at times.

Regarding the review of the patient with chronic pain, you do have a way to check eChart, and do that on a regular basis, although it isn't recorded in the file.

You do recognize that using the auto expire function is a good idea. You realize that it would be a good prompt to review medications and compliance with your patients. If asked to come up with a solution, you will talk to the person who looks after the administration of the electronic record, and see if they can change that setting.