Self-Assessment

Clinician Communication

General Instructions for the SAFER Self-Assessment Guides

The SAFER Guides are designed to help healthcare organizations conduct self-assessments to optimize the safety and safe use of electronic health records (EHRs) in the following areas.

- High Priority Practices
- Organizational Responsibilities
- Contingency Planning
- System Configuration
- System Interfaces
- Patient Identification
- Computerized Provider Order Entry with Decision Support
- Test Results Reporting and Follow-up
- Clinician Communication

Each of the nine SAFER Guides begins with a Checklist of recommended practices. The downloadable SAFER Guides provide fillable circles that can be used to indicate the extent to which each recommended practice has been implemented. Following the Checklist, a Practice Worksheet gives a rationale for and examples of how to implement each recommended practice, as well as likely sources of input into assessment of each practice, and fillable fields to record team members and follow-up action. In addition to the downloadable version, the content of each SAFER Guide, with interactive references and supporting materials, can also be viewed on ONC's website at www.healthit.gov/SAFERGuide.

The SAFER Guides are based on the best evidence available at this time (2016), including a literature review, expert opinion, and field testing at a wide range of healthcare organizations, from small ambulatory practices to large health systems. The recommended practices in the SAFER Guides are intended to be useful for all EHR users. However, every organization faces unique circumstances and will implement a particular practice differently. As a result, some of the specific examples in the SAFER Guides for recommended practices may not be applicable to every organization.

The SAFER Guides are designed in part to help deal with safety concerns created by the continuously changing landscape that healthcare organizations face. Therefore, changes in technology, practice standards, regulations and policy should be taken into account when using the SAFER Guides. Periodic self-assessments using the SAFER Guides may also help organizations identify areas in which it is particularly important to address the implications of change for the safety and safe use of EHRs. Ultimately, the goal is to improve the overall safety of our health care system.

The SAFER Guides are not intended to be used for legal compliance purposes, and implementation of a recommended practice does not guarantee compliance with HIPAA, the HIPAA Security Rule, Medicare or Medicaid Conditions of Participation, or any other laws or regulations. The SAFER Guides are for informational purposes only and are not intended to be an exhaustive or definitive source. They do not constitute legal advice. Users of the SAFER Guides are encouraged to consult with their own legal counsel regarding compliance with Medicare or Medicaid program requirements, HIPAA, and any other laws.

For additional, general information on Medicare and Medicaid program requirements, please visit the Centers for Medicare & Medicaid Services website at www.cms.gov. For more information on HIPAA, please visit the HHS Office for Civil Rights website at www.hhs.gov/ocr.

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Introduction

The *Clinician Communication SAFER Guide* identifies recommended safety practices associated with communication between clinicians and is intended to optimize the safety and safe use of EHRs. Processes relating to clinician communication are complex and vulnerable to breakdown. In the EHR-enabled healthcare environment, providers rely on technology to support and manage their complex inter-clinician communication processes. If implemented and used correctly, EHRs have potential to improve the safety and safe use of clinician communication.

Communication is a key aspect of nearly all patient care processes and has enormous potential to impact patient safety.[1, 2, 3, 4, 5, 6] Communication breakdowns between clinicians are one of the most common causes of medical errors and patient harm. Communication processes have become increasingly integrated into EHRs.[7, 8] These include sending and receiving referral and consult communication, communication about transitioning a patient from the inpatient to the outpatient setting, and communicating clinical messages with the EHR. Several attributes of EHR-based communication can result in a disconnect between the sender and the receiver of clinical information, including the sender's uncertainty about whether or when a message has been received, and a mismatch between single patient versus multiple patient interactions. Messages may be incomplete, misdirected, or directed to an unavailable clinician, and may overload the recipient.[5, 9]

This self-assessment is intended to increase awareness of practices that can improve the safety of EHR-based communication, and support the proactive evaluation of particular risks. It can help identify and evaluate sources of potential communication breakdowns, with a focus on processes related to electronic communication between clinicians. The self-assessment specifically targets three high-risk processes: consultations and referrals, discharge-related communications, and patient-related messaging between clinicians.

Completing the self-assessment in the Clinician Communication SAFER Guide requires the engagement of people both within and outside the organization (such as EHR technology developers). Because this guide is designed to help organizations prioritize EHR-related safety concerns, clinician leadership in the organization should be engaged in assessing whether and how any particular recommended practice affects the organization's ability to deliver safe, high quality care. Collaboration between clinicians and staff members while completing the self-assessment in this guide will enable an accurate snapshot of the organization's EHR communication status in terms of safety. Even more importantly, collaboration should lead to a consensus about the organization's future path to optimize EHR-related safety and quality: setting priorities among the recommended practices not yet addressed, ensuring a plan is in place to maintain recommended practices already in place, dedicating the required resources to make necessary improvements, and working together to mitigate the highest priority communication-related safety risks introduced by the EHR.

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Table of Contents

The SAFER Self-Assessment Guides were developed by health IT safety researchers and informatics experts:

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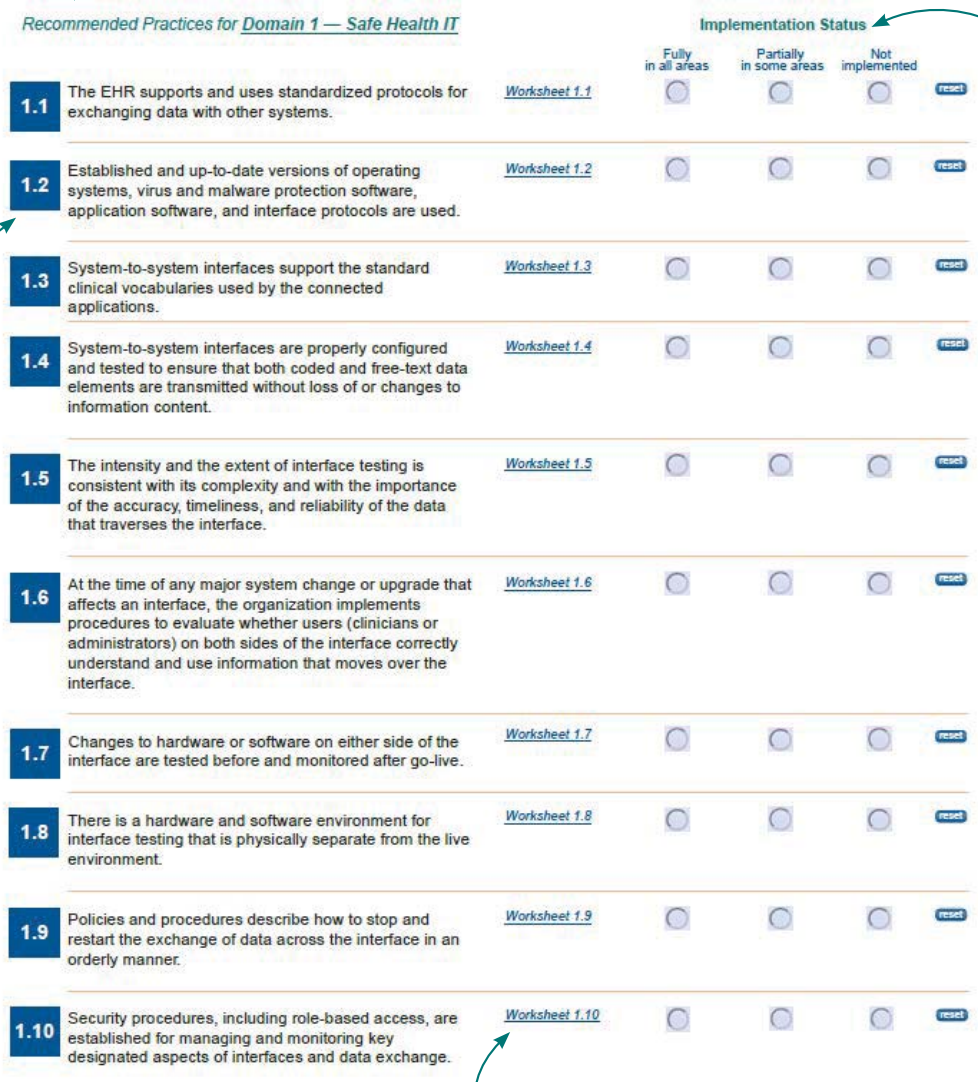
The *Checklist* is structured as a quick way to enter and print your self-assessment. Your selections on the checklist will automatically update the related section of the corresponding *Recommended Practice Worksheet*.

The *Domain* associated with the *Recommended Practice(s)* appears at the top of the column.

The *Recommended Practice(s)* for the topic appear below the associated *Domain*.



Select the level of implementation achieved by your organization for each *Recommended Practice*.

Your *Implementation Status* will be reflected on the *Recommended Practice Worksheet* in this PDF.

To the right of each *Recommended Practice* is a link to the *Recommended Practice Worksheet* in this PDF.

The Worksheet provides guidance on implementing the Practice.

*Recommended Practices for **Domain 1 — Safe Health IT***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
1.1	Urgent clinical information is delivered to clinicians in a timely manner, and delivery is recorded in the EHR.	*Worksheet 1.1*	○	○	○	reset
1.2	Policies and training facilitate appropriate use of messaging systems and limit unnecessary messaging.	*Worksheet 1.2*	○	○	○	reset
1.3	The EHR includes the capability for clinicians to look up the status of their electronic communications (e.g., sent, delivered, opened, acknowledged).	*Worksheet 1.3*	○	○	○	reset
1.4	Messages clearly display the individual who initiated the message and the time and date it was sent.	*Worksheet 1.4*	○	○	○	reset

*Recommended Practices for **Domain 2 — Using Health IT Safely***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
2.1	The EHR facilitates provision of all necessary information for referral and consult request orders prior to transmission.	*Worksheet 2.1*	○	○	○	reset
2.2	The EHR facilitates accurate routing of clinician-to-clinician messages and enables forwarding of messages to other clinicians.	*Worksheet 2.2*	○	○	○	reset
2.3	Clinicians are able to electronically access current patient and clinician contact information (e.g., email address, telephone and fax numbers) and identify clinicians currently involved in a patient's care.	*Worksheet 2.3*	○	○	○	reset
2.4	Electronic message systems include the capability to indicate the urgency of messages.	*Worksheet 2.4*	○	○	○	reset
2.5	The EHR contains a copy of clinician-to-clinician communications.	*Worksheet 2.5*	○	○	○	reset
2.6	The EHR displays time-sensitive and time-critical information more prominently than less urgent information.	*Worksheet 2.6*	○	○	○	reset
2.7	Both EHR design and organizational policy facilitate clear identification of clinicians who are responsible for action or follow-up in response to a message.	*Worksheet 2.7*	○	○	○	reset

*Recommended Practices for **Domain 3 — Monitoring Safety***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
3.1	Mechanisms exist to monitor the timeliness of acknowledgment and response to messages.	*Worksheet 3.1*	○	○	○	reset

A multi-disciplinary team should complete this self-assessment and evaluate potential health IT-related patient safety risks addressed by this specific SAFER Guide within the context of your particular healthcare organization.

This Team Worksheet is intended to help organizations document the names and roles of the self-assessment team, as well as individual team members' activities. Typically team members will be drawn from a number of different areas within your organization, and in some instances, from external sources. The suggested Sources of Input section in each Recommended Practice Worksheet identifies the types of expertise or services to consider engaging. It may be particularly useful to engage specific clinician and other leaders with accountability for safety practices identified in this guide.

The Worksheet includes fillable boxes that allow you to document relevant information. The Assessment Team Leader box allows documentation of the person or persons responsible for ensuring that the self-assessment is completed. The section labeled Assessment Team Members enables you to record the names of individuals, departments, or other organizations that contributed to the self-assessment. The date that the self-assessment is completed can be recorded in the Assessment Completion Date section and can also serve as a reminder for periodic reassessments. The section labeled Assessment Team Notes is intended to be used, as needed, to record important considerations or conclusions arrived at through the assessment process. This section can also be used to track important factors such as pending software updates, vacant key leadership positions, resource needs, and challenges and barriers to completing the self-assessment or implementing the Recommended Practices in this SAFER Guide.

Assessment Team Leader

Assessment Completion Date

Assessment Team Members

Assessment Team Notes

reset page

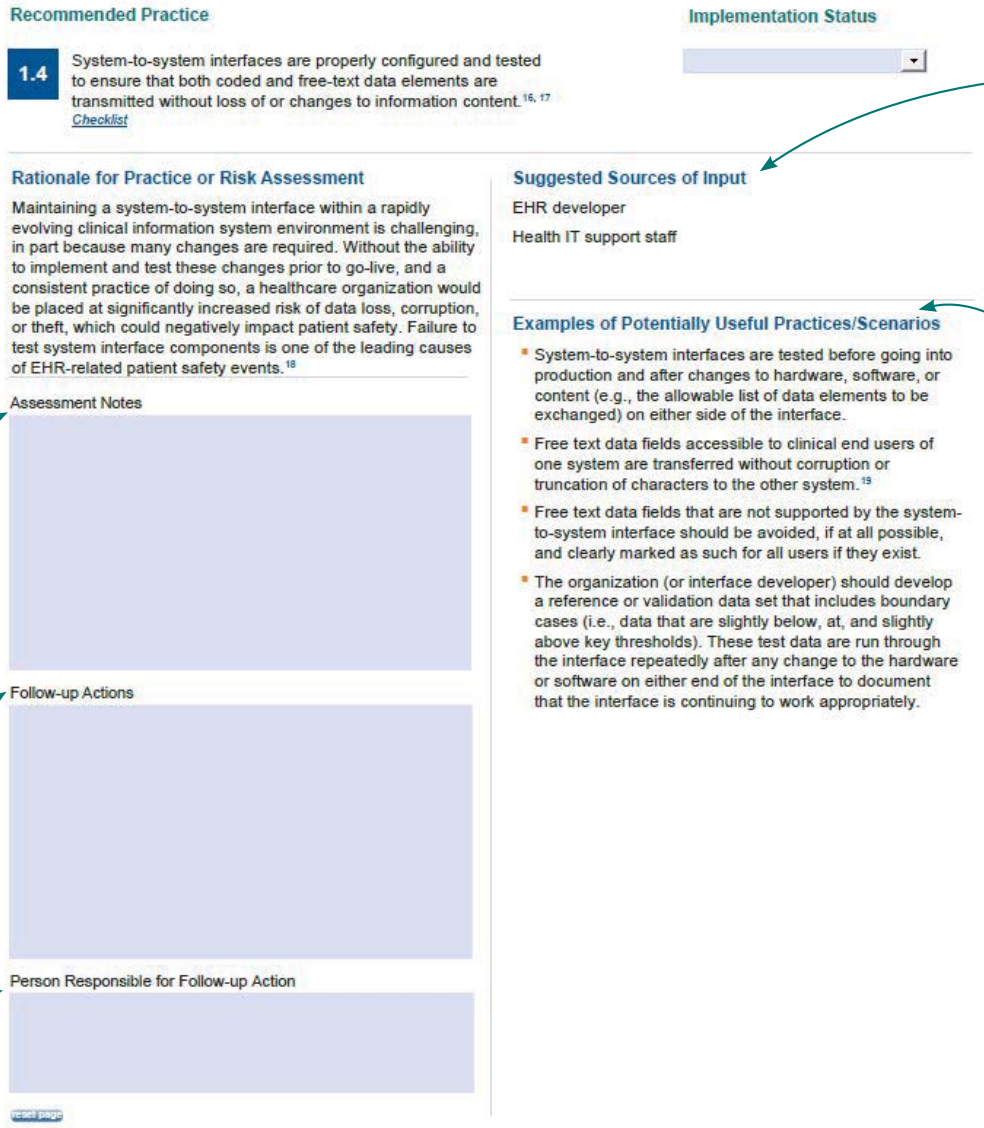
Each *Recommended Practice Worksheet* provides guidance on implementing a specific *Recommended Practice*, and allows you to enter and print information about your self-assessment.

The *Rationale* section provides guidance about "why" the safety activities are needed.

Enter any notes about your self-assessment.

Enter any follow-up activities required.

Enter the name of the person responsible for the follow-up activities.



The *Suggested Sources of Input* section indicates categories of personnel who can provide information to help evaluate your level of implementation.

The *Examples* section lists potentially useful practices or scenarios to inform your assessment and implementation of the specific *Recommended Practice.*

Recommended Practice

1.1 Urgent clinical information is delivered to clinicians in a timely manner, and delivery is recorded in the EHR.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

If active measures are not taken to inform clinicians of the presence of critical information, this information may be missed by clinicians resulting in delays in care.[10, 11] If primary care physicians (PCPs) do not receive a timely discharge summary they may incorrectly restart or change medications for which contraindications have been identified during hospitalization.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- The organization has a policy for verbal delivery of critical information that supplements use of the EHR.
- Hospitals have policies and procedures to address timely electronic delivery of important clinical information. For example, hospital discharge summaries are delivered to clinicians responsible for follow-up within two business days.
- Messages are automatically forwarded to an alternate clinician if not responded to within a time period appropriate to the time-urgency of the message.
- The EHR allows automatic forwarding of messages to a designated surrogate clinician during a specific time period or circumstance, such as when the clinician is absent.
- Messages that are delivered to a pool that several clinicians are held accountable for should have clear individual responsibilities and a hierarchy for follow-up, as well as a means for escalating messages that are not dealt with in a timely manner.[12]
- When a patient transitions to another setting, a clinician provides a summary of care record to the receiving hospital or clinician in a timely manner. The summary record should include, at a minimum, the Common Meaningful Use Data Set.[13]

Recommended Practice

1.2 Policies and training facilitate appropriate use of messaging systems and limit unnecessary messaging.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Information overload is a significant problem in EHR systems. When a large amount of information that is not clinically relevant is transmitted through the same channels as information with high urgency, the latter may be missed, leading to potential patient harm.[5, 9, 14, 15]

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Examples of Potentially Useful Practices/Scenarios

- The organization implements a comprehensive policy on clinician-to-clinician messaging that specifies what should and should not be transmitted.
- Messages are sent only to persons who may need to act on them. “Reply all” is used only when necessary.
- Mechanisms are in place to allow communication of non-clinical information (e.g., appointment requests) in a way that does not impact communication of clinical information (e.g., abnormal laboratory results).
- The organization ensures that clinicians have sufficient non-face-to-face time built into their daily schedules to safely manage the clinical information delivered.[15]
- Clinics employ a team-based strategy to manage non-face-to-face activities, assigning tasks to other team members where physician decision making is not needed.
- EHR messaging systems allow sorting of messages by urgency and type.

Recommended Practice

1.3 The EHR includes the capability for clinicians to look up the status of their electronic communications (e.g., sent, delivered, opened, acknowledged).[1]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Delays in care may result from referrals, consults, and clinician-to-clinician messages that do not receive timely attention.[1,16, 17, 18]

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- A real-time tracking system allows referring clinicians to determine the status of all their referrals and consults transmitted and allows specialists to identify all their referrals and consults that are pending.[19, 20, 21]
- Clinicians and specialists are able to create a report of all their referrals and consults including the status of each. Clinicians are able to identify whether their sent messages have been opened (e.g., “read receipt”).
- The EHR automatically notifies the ordering clinician or team when referrals or consults are canceled or completed. Clinicians are notified if a message they sent has not been opened within a pre-specified number of days.
- The EHR can track whether a message was received or not.
- Outpatient practices with messaging systems that are not fully integrated into the EHR use additional tracking strategies to enable follow-up.
- The organization implements policies to encourage closed-loop (i.e., in-house or in-practice) referral and consult tracking.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Recommended Practice

1.4 Messages clearly display the individual who initiated the message and the time and date it was sent.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

In order to make informed and appropriate decisions, clinicians need to know the source and timing of a message.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- The EHR message interface prominently shows the date, time, and sender's name, physical address, telephone number, and electronic contact information.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

reset page

Recommended Practice

2.1 The EHR facilitates provision of all necessary information for referral and consult request orders prior to transmission.[1, 22, 23]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Referral and consult processing and routing may be delayed if information provided with the request is inadequate, resulting in care delays. Referral and consultation requests without certain fields filled, such as "specialty" or "reason for referral," might be delayed.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Templates are used to facilitate completion of electronic referrals and consults to meet specialists' requirements.
- The EHR enables automatic pre-population of fields in the referral template when possible (e.g., demographic data, current medication list, recent relevant laboratory test results).[1]
- Referral template user interfaces should be designed to minimize cognitive load on the provider making the referral.[21]
- Clinicians are prompted when certain key fields, such as the "reason for referral" or "specialty" field, are left blank.[17, 20]
- Organizational policies and procedures facilitate the creation of collaborative care agreements that define both primary care (or referring) provider and specialist physician expectations and accountability about referral content, required information, and shared care. These types of collaborative efforts between referring providers and specialists that facilitate communication and clarify referral expectations can reduce referral denials.
- Referral requests should include, at a minimum, the Common Meaningful Use Data Set.[24]

Recommended Practice

2.2 The EHR facilitates accurate routing of clinician-to-clinician messages and enables forwarding of messages to other clinicians.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Delays in patient care may result when important information is inadvertently transmitted to an incorrect recipient and cannot be redirected to the correct one.

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- In the EHR, “To:” and “From:” fields are visible on the message inbox and at the top of message content.
- The EHR supports forwarding of incorrectly routed messages to other clinicians.
- Clinicians can forward messages they received incorrectly to the correct recipients.
- Mechanisms exist for tracking acknowledgment and acceptance of forwarded notifications.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Recommended Practice

2.3 Clinicians are able to electronically access current patient and clinician contact information (e.g., email address, telephone and fax numbers) and identify clinicians currently involved in a patient's care.[25]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Patient care delays result from time spent searching for correct clinician contact information, a patient's treating clinician, or a provider's care team members. Care delays may also result from incorrect message routing based on inaccurate contact information.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Examples of Potentially Useful Practices/Scenarios

- The EHR system is updated at least monthly with a contact list of all practicing clinicians, and, for hospitals, includes clinician coverage schedules.
- A procedure exists for clinicians and staff to flag missing and incorrect contact information for review by individuals who can investigate and make corrections.
- The organization has a process for maintaining current contact information for the EHR provider directory.
- The organization should maintain up-to-date patient care team information within the EHR.
- The organization has a process for patients to review and correct their contact information listed in the EHR, including their preferred method of communication.

Recommended Practice

2.4 Electronic message systems include the capability to indicate the urgency of messages.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Communicating the urgency of a message, such as a referral or consult, is necessary to facilitate triaging and ensure timely follow-up.

Suggested Sources of Input

EHR developer

Examples of Potentially Useful Practices/Scenarios

- The EHR has functionality to allow clinicians to flag referrals or consults as urgent when needed.
- High urgency messages are presented in a manner that makes the urgency level immediately apparent to the recipient.
- There are escalation processes for high priority or urgent messages that are not responded to within the specified time period, including an alternate communication method.
- Specialists have immediate access to all their referral and consult requests, and can triage patients and schedule appointments based on urgency.
- Messages that are administrative in nature are clearly differentiated from clinical alerts.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Recommended Practice

2.5 The EHR contains a copy of clinician-to-clinician communications.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Clinicians may miss important information related to a particular patient because it is hidden in secondary data repositories or in paper-based record storage. Delays in care may result when specialist recommendations (e.g., to order further testing) are not received by the ordering clinician.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Suggested Sources of Input

EHR developer

Examples of Potentially Useful Practices/Scenarios

- Written clinician-to-clinician communication that contains any information about a patient's diagnosis, treatment, or care is documented into or scanned into the EHR.
- If clinical messaging systems external to the EHR are used, copies of patient-related messages are stored in the EHR.

Recommended Practice

2.6 The EHR displays time-sensitive and time-critical information more prominently than less urgent information.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Clinicians may miss urgent information when it is commingled with other less urgent messages, resulting in delayed care. A clinician may miss a small section of relevant and important information within several pages of a referral or consult note sent to him or her.

Suggested Sources of Input

EHR developer

Examples of Potentially Useful Practices/Scenarios

- Messages with critical or urgent information are made visually distinct (e.g., visually highlighted).
- The EHR allows sorting of clinician-to-clinician messages by urgency.
- When sending notes/documentation to other clinicians (e.g., for co-signing), the EHR allows the sender to add recipient-specific explanatory messages, highlighting, or markup.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Recommended Practice

2.7 Both EHR design and organizational policy facilitate clear identification of clinicians who are responsible for action or follow-up in response to a message.[1]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

On messages addressed to multiple recipients, each recipient may incorrectly assume that the other recipient(s) will take follow-up action, leading to no action being taken at all.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Examples of Potentially Useful Practices/Scenarios

- The EHR supports the ability to assign and track actions and responsible parties for inbound messages.
- Message screens display a "responsible clinician" indicator.
- The system supports forwarding and accepting responsibility for follow-up.
- The EHR is able to capture and display when responsibility for follow-up action is accepted by a clinician.
- A comprehensive policy outlining responsibility for follow-up action for certain situations (e.g., no-shows) is implemented.[17]

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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Recommended Practice

3.1 Mechanisms exist to monitor the timeliness of acknowledgment and response to messages.[1, 26]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

System problems related to delayed acknowledgment of clinician-to-clinician messages may go unnoticed if monitoring systems are not in place and checked regularly.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Referring clinicians, specialists, and/or leadership are electronically notified when no action is taken on a referral or consult request or a clinician-to-clinician message within a set number of days (e.g., 14).
- The organization conducts several process measurements related to important communication (e.g., completed referrals, no-shows/missed appointments, denied or canceled referrals).
- Referrals and consult response times are tracked by organization leadership, and feedback is provided to each service involved.[21, 27]
- Messaging is periodically monitored to understand and improve quality of communication.
- Policies and procedures are in place to prevent messages from getting lost in the system, such as messages sent to clinicians no longer employed by the organization.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

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