EMR Certification

Primary Care Quality Indicator Reminders and Data Extract Specification

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1 Introduction

1.1 Purpose

The purpose of this document is to describe requirements related to the primary care quality indicators that Manitoba Health, Seniors and Active Living (MHSAL) has adopted for measuring quality processes in primary care and to describe the data to be included in Manitoba's Primary Care Data Extract.

1.2 Background

PRIMARY CARE QUALITY INDICATORS (PCQI)

The Primary Care Quality Indicators are based on a set of evidence-based measures developed by the Canadian Institute for Health Information (CIHI) in 2006[1]. Since their initial implementation, an Indicator Advisory Committee led the development and implementation of new indicators, and retired previous indicators. These measures are used by clinics to support individual and population-based care planning and by Manitoba Health to support Chronic Disease Management tariffs, and Comprehensive Care Management tariffs.

MHSAL currently uses primary care quality indicators organized into the following eight categories:

- Prevention
- Diabetes Management
- Asthma Management
- Congestive Heart Failure Management
- Hypertension Management
- Coronary Artery Disease Management
- Osteoporosis Management
- Chronic Obstructive Pulmonary Disease Management

[1] Canadian Institute for Health Information, *Enhancing the Primary Health Care Data Collection Infrastructure in Canada, Report 2* (Ottawa: Canadian Institute for Health Information, 2006).

RELATED DOCUMENTS

Table 1: Related Documents

DOCUMENT
Primary Care Quality Indicators Guide v3.0
PCQI Reminders and Data Extract Assessment Guide
eHealth_hub – Home Clinic Enrolment Service Interface Specification

GLOSSARY

Table 2: Terms and Acronyms

TERM OR ACRONYM	DEFINITION
Enrolment	The process by which a Client is recognized to have the Home Clinic as their primary provider of care and the Home Clinic agrees to provide comprehensive continuous primary care and to coordinate care with other health-care providers. See Enrolment Methods Overview for additional information.

2 Clinical Reminders

INTRODUCTION

Evidence supports the importance of clinical decision support within Electronic Medical Record (EMR) systems, and the positive impact it has on patient care. This section contains requirements pertaining to the implementation of clinical reminders for Manitoba's PCQI. Requirements include:

- general requirements and guidelines for clinical reminder functionality;
- data that must be able to be captured to support clinical reminders; and
- guidelines that inform when a reminder should be displayed and when reminders no longer need to be displayed.

REQUIREMENTS STRUCTURE

For ease of review and understanding, all functional and non-functional requirements are documented in a consistent manner. For each requirement, the following information is provided:

- **ID** – a unique identifier assigned to the requirement by Manitoba.
- **Requirement** – a concise statement describing the requirement.
- **Guidelines** – these additional instructions constitute part of the requirement, and are relevant to implementation of the requirement in the EMR product. As such, these guidelines form part of the assessment criteria and are included in the planned product assessment.
- **Additional Notes** – relevant information or examples intended to give additional context to the requirement and to improve understanding.
- **Status** – each requirement is clearly identified as:
    - New (not included in previous specifications);
    - Updated (modification to intent of the requirement); or
    - Previous (unchanged from last issuance of core requirements).

  Note: data capture requirements vary slightly from the format described above.

- **Assessment** – the method of assessment specific to the requirement. Relevant assessment options include:
    - Verification – leveraging the Certification Environment, Manitoba will verify the product's ability to meet requirements. Clinical and administrative resources may be involved in the verification process.
    - Demonstration – applicants will demonstrate key functions within their EMR product. Demonstrations may be conducted in person, by remote means (e.g. teleconference and Internet) or through recorded video.

ASSESSMENT

General requirements, data capture and reminder requirements will be assessed through the assessment methods defined within the Applicant Guide to EMR Certification. The method of assessment is stated in the "Assessment" column for each requirement.

2.1 General

Table 3: General Clinical Reminders Requirements

ID	REQUIREMENT	GUIDELINES	ADDITIONAL NOTES	STATUS	ASSESSMENT
PCG-01	Ability to generate decision support reminders.	At a minimum, automatically alerts the clinician when an item or action: - is overdue; or - will become due in the next 1 to 90 days (soon to be overdue) All reminders must be visible within the EMR. Overdue and soon to be overdue reminders must be distinguishable from one another. Reminders must not appear in relation to a patient's inactive problems. Reminders represented as tasks in the provider's work queue are not an acceptable solution.	e.g. overdue items in red and soon to be overdue in yellow e.g. clinician sets the patient's diabetes diagnosis to 'inactive'. Diabetes reminders would no longer appear for this patient. e.g. clinician will be able to enter chart data (e.g. labs, encounter notes, etc.) when a reminder exists within patient record	Previous	Demonstration

ID	REQUIREMENT	GUIDELINES	ADDITIONAL NOTES	STATUS	ASSESSMENT
		Existing reminders must not prevent a user's interaction with the EMR.			
PCG-02	Ability to disable reminder function.	Must be able to turn off Primary Care Quality reminders at the individual provider level.	e.g. a dermatologist could turn off all primary care reminders	Previous	Demonstration
PCG-03	Provides integration between components such that data does not require re-entry to support primary care quality indicators.	At a minimum, integration is required for the following data element categories: - General Care - Health Concerns - Allergies - Lab Test - Medications - Risk Factors - Immunizations	e.g. provider could choose which field to use for capture of blood pressure measurement and map it to the appropriate reminder	Previous	Demonstration

2.2 Data Capture

The following table contains data elements uniquely required to support the Primary Care Data Extract. Certified EMR Products must be capable of capturing and storing these data elements.

Table 4: Data Capture Requirements

ID	DATA ELEMENT	DESCRIPTION	GUIDELINES	ADDITIONAL NOTES	STATUS	ASSESSMENT
PCDC-01	EMR Data Transport and Repository (EDTR) Clinic Identifier	Identifier assigned to clinic by MHSAL for use with data extract submissions.			Previous	Verification
PCDC-02	Cigarette / Tobacco Product	Date of the patient's last cigarette /	It would be acceptable if this were incorporated with other risk		Previous	Verification

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
		tobacco product.	factor data elements. Must allow for: - full date (dd/mm/yyyy) - partial date (mm/yyyy or yyyy)			
PCDC-03	Chronic Obstructive Pulmonary Disease (COPD) at risk screening questions from the Canadian Thoracic Society (CTS)	Screening questions endorsed by the CTS. Used for COPD at risk screening.	Questions must include: 1. Do you cough regularly? 2. Cough up phlegm? 3. Short of breath with simple chores? 4. Wheeze with exertion or at night? 5. Frequent colds that persist? Must be able to save responses to each question, as well as the date it was administered. Provider must be able to save without entering a response for each question.		Previous	Demonstration
PCDC-04	Information Type	Type of educational material / information reviewed with and/or provided to the patient.	Specific information may include: - handouts - counselling - risks - benefits	e.g. vaccination counselling, physical activity advice	Previous	Verification
PCDC-05	Information Provided / Reviewed Date /	The date/time that the information was reviewed with and/or			Previous	Verification

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
	Time	provided to the patient.				
PCDC-06	Exemption Type	Exemption from performing a specific screening activity.		e.g. breast cancer screening	Previous	Verification
PCDC-07	Exemption Reason	Reason for patient exemption from screening activity.		e.g. patient had double mastectomy	Previous	Verification
PCDC-08	Exemption Duration	The length of time the exemption is valid.		e.g. 12 months, 5 years	Previous	Verification
PCDC-09	Framingham Risk Score	Score resulting from the Framingham risk assessment.	It would be acceptable if this were incorporated with other risk factor data elements.	e.g. 18 points	Previous	Verification
PCDC-10	Framingham Risk Percent	Percent risk resulting from the Framingham risk assessment.	It would be acceptable if this were incorporated with other risk factor data elements.	e.g. 8%	Previous	Verification
PCDC-11	Enrolment Start Date	Represents the date the patient was enrolled with the clinic.	Must allow capture of historical dates, including 01/01/1899. Note: If already certified to eHealth_hub - Home Clinic Enrolment Service Specification, this requirement is optional.		Previous	Verification
PCDC-12	Enrolment End Date	Represents the date the patient enrolment was terminated.	Note: If already certified to eHealth_hub - Home Clinic Enrolment Service Specification, this requirement is optional.		Previous	Verification
~~PCDC-13~~	~~Enrolment~~	~~The reason that the~~	~~At a minimum, the list of~~		Retired	Verification

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
	~~Termination Reason~~	~~enrolment was terminated.~~	~~values must include:~~ ~~• Patient deceased~~ ~~• Patient moved out of area~~ ~~• Patient left jurisdiction (province)~~ ~~• Patient added in error~~ ~~• Patient no longer in Primary Care~~ ~~• Provider initiated termination~~ ~~• Patient request~~ ~~• Other~~			

2.3 Reminder Guidelines

Reminder guidelines are intended to inform the conditions under which clinical reminders should be displayed to providers and the conditions under which they no longer need to be displayed.

PREVENTION

Table 5: Prevention Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
PRV001	Cervical Cancer Screening	All the following conditions are true: • patient is female • patient is at least 21 years of age but not older than 69 • patient is not exempt from having a pap smear exam	The date of last pap smear occurred within last 36 months	Previous	Demonstration
PRV002	Colon Cancer	The patient is at least 50 years of	One or more of the following	Previous	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
	Screening	age but not older than 74	conditions is true: • date of last fecal occult blood test (FOBT) occurred within last 24 months • date of last colonoscopy occurred within last ten years		
PRV003	Breast Cancer Screening	All the following conditions are true: • patient is at least 50 years of age but not older than 74 • patient is female • patient is not exempt from mammograms	The date of last mammogram test occurred within last 24 months	Previous	Demonstration
PRV004	Dyslipidemia Screening for Women	All the following conditions are true: • patient is at least 50 years of age but not older than 69 • patient is female • no statins prescribed in last 12 months	The date of last lipid test occurred within last 60 months	Previous	Verification
PRV005	Dyslipidemia Screening for Men	All the following conditions are true: • patient is at least 40 years of age but not older than 69 • patient is male • no statins prescribed in last 12 months	The date of last lipid test occurred within last 60 months	Previous	Verification
PRV006	Diabetes Screening	All the following conditions are true: • patient is at least 40 years of age but not older than 74 • patient is not diagnosed with diabetes	One or more of the following conditions is true: • date of last fasting blood sugar screening occurred within last 36 months • **date of last A1c test occurred within last 36**	Previous	Demonstration of condition in bold text Verification of remaining condition

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
			months		
PRV007	MMR Immunization	The patient is 7 years of age	One or more of the following conditions is true: • parents were provided childhood immunizations counselling • patient received last MMR vaccination	Previous	Verification
PRV008	Influenza Immunization 65+	The patient is 65 years of age or greater	One or more of the following conditions is true: • patient was provided influenza immunization counselling within last 12 months • patient received an influenza vaccination within the last 12 months	Previous	Verification
PRV009	Pneumococcal Immunization 65-70	All the following conditions are true: • patient is 65 years of age or greater but not older than 70 • patient did not receive a pneumococcal immunization	One or more of the following conditions is true: • patient was provided pneumococcal vaccination counselling within the last 12 months • **patient received a pneumococcal vaccination**	Previous	Demonstration of condition in bold text Verification of remaining condition
PRV010	Blood Pressure Measurement	The patient is 18 years of age or greater	The patient received a blood pressure measurement within last 24 months	Previous	Verification
PRV011	Advice on Physical	The patient is 12 years of age or	The patient was provided exercise /	Previous	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
	Activity	greater	activity advice within last 24 months		
PRV012	Smoking Cessation Counselling	All the following conditions are true: • patient is 12 years of age or greater • patient is a current smoker	The patient was provided with smoking cessation counselling in last 24 months	Previous	Demonstration
PRV013	Obesity / Overweight Screening	The patient is 12 years of age or greater	The patient was provided an obesity / overweight screening within last 24 months	Previous	Demonstration
PRV014	Chronic Obstructive Pulmonary Disease (COPD) At Risk Screening	All the following conditions are true: • patient is not diagnosed with COPD • patient is 40 years of age or greater • patient is a current or a former smoker	All the following conditions are true: • patient was provided a COPD at risk screening within last 24 months • patient was provided a CTS questionnaire which they answered	Previous	Verification
PRV015	COPD Screening Using Spirometry	All the following conditions are true: • patient is 40 years of age or greater • patient is not diagnosed with COPD • patient is a current or former smoker • patient has responded yes to one or more of the questions on the CTS questionnaire	The patient was provided a spirometry screening within last 24 months	Previous	Demonstration
PRV016	Smoking Status	The patient is 12 years of age or greater	The date of last smoker screening occurred within last 24 months	Previous	Verification

DIABETES MANAGEMENT

Table 6: Diabetes Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
DIA001	A1c	The patient is identified as diabetic	The patient was provided an A1c test within last 6 months	Previous	Verification
DIA002	Nephropathy Screening	All the following conditions are true: • patient is identified as diabetic • patient is 12 years of age or greater	One or more of the following conditions is true: • patient has a documented nephropathy • patient received a nephropathy test within the last 12 months	Previous	Verification
DIA003	Fundoscopic Exams	All the following conditions are true: • patient is identified as diabetic • patient is 15 years of age or greater	One or more of the following conditions is true: • **patient received a fundoscopic referral in last 12 months** • patient received a fundoscopic exam within last 12 months	Previous	Demonstration of condition in bold text Verification of remaining condition
DIA004	Foot Exam	The patient is identified as diabetic	The patient received a foot exam within last 12 months	Previous	Verification
DIA005	Dyslipidemia Screening	All the following conditions are true: • patient is identified as diabetic • patient is less than 75 years of age • no statins prescribed in last 12 months	The patient received a lipid test within last 60 months	Previous	Demonstration
DIA006	Blood Pressure Measurement	The patient is identified as diabetic	The patient received a blood pressure measurement within last	Previous	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
			12 months		
DIA007	Obesity / Overweight Screening	The patient is identified as diabetic	The patient received an obesity / overweight screening within last 12 months	Previous	Verification

ASTHMA MANAGEMENT

Table 7: Asthma Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
AST001	Asthma Action Plans	The patient is identified as asthmatic	The patient has had their asthma action plan developed and / or reviewed within last 12 months	Previous	Demonstration

CONGESTIVE HEART FAILURE (CHF) MANAGEMENT

Table 8: CHF Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
CHF001	Obesity / Overweight Screening	All the following conditions are true: • patient is identified as having CHF • patient is 18 years of age or greater	The patient received an obesity / overweight screening within last 12 months	Previous	Verification
CHF002	ACE Inhibitor	All the following conditions are true: • patient is identified as having CHF patient is 18 years of age or greater	One or more of the following conditions is true: • patient has been prescribed an ACE inhibitor or ARB medication within last 12 months • patient received exemption	Previous	Demonstration of reminder active Verification of remaining condition

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
			from ACE inhibitor or ARB medication within last 12 months		
CHF003	Dyslipidemia Screening	All the following conditions are true: • patient is identified as having CHF • patient is 18 years of age or greater but less than 75 • no statins prescribed in last 12 months	The following condition is true: • patient received a lipid test within last 60 months	Previous	Verification
CHF004	Blood Pressure Measurement	All the following conditions are true: • patient is identified as having CHF • patient is 18 years of age or greater	The following condition is true: • patient received a blood pressure measurement within last 12 months	Previous	Verification
CHF005	Diabetes Screening	All the following conditions are true: • patient is identified as having CHF • patient is not identified as diabetic • patient is 18 years of age or greater	One or more of the following conditions is true: • patient received a full fasting blood sugar test within last 12 months • patient received an A1c test within last 12 months	Previous	Verification

HYPERTENSION MANAGEMENT

Table 9: Hypertension Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
HYP001	Diabetes Screening	All the following conditions are true: • patient is identified as having hypertension • patient is not identified as diabetic • patient is 18 years of age or greater	One or more of the following conditions is true: • patient received a full fasting blood sugar test within last 12 months • patient received an A1c test within last 12 months	Previous	Verification
HYP002	Dyslipidemia Screening	All the following conditions are true: • patient is identified as having hypertension • patient is 18 years of age or older but less than 75 • patient is not exempt from dyslipidemia screening • no statins prescribed in last 12 months	The following condition is true: • patient received a lipid test within last 60 months	Previous	Verification
HYP003	Renal Dysfunction Screening	All the following conditions are true: • patient is identified as having hypertension • patient is 18 years of age or greater	The following condition is true: • patient received a test to detect renal dysfunction within the last 12 months	Previous	Demonstration
HYP004	Blood Pressure Measurement	All the following conditions are true: • patient is identified as having hypertension • patient is 18 years of age or greater	The following condition is true: • patient received a blood pressure measurement within last 12 months	Previous	Demonstration
HYP005	Obesity /	All the following conditions are	The following condition is true:	Previous	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
	Overweight Screening	true: • patient is identified as having hypertension • patient must be 18 years of age or greater	• patient received an obesity / overweight screening within last 12 months		

CORONARY ARTERY DISEASE (CAD) MANAGEMENT

Table 10: CAD Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
CAD001	Diabetes Screening	All the following conditions are true: • patient is identified as having CAD • patient is not identified as having diabetes • patient is 18 years of age or greater	One or more of the following conditions is true: • patient received a full fasting blood sugar test within last 12 months • patient received an A1c test within last 12 months	Previous	Verification
CAD002	Dyslipidemia Screening	All the following conditions are true: • patient is identified as having CAD • patient is 18 years of age or greater but less than 75 • no statins prescribed in last 12 months	The following condition is true: • patient received a lipid test within last 60 months	Previous	Verification
CAD003	Blood Pressure Measurement	All the following conditions are true: • patient is identified as having CAD • patient is 18 years of age or	The following condition is true: • patient received a blood pressure measurement within last 12 months	Previous	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
		greater			
CAD004	Obesity / Overweight Screening	All the following conditions are true: • patient is identified as having CAD • patient must be 18 years of age or greater	The following condition is true: • patient received an obesity / overweight screening within last 12 months	Previous	Verification
CAD005	Lipid Reduction Counselling	All the following conditions are true: • patient is identified as having CAD • patient must be 18 years of age or greater but not older than 74 • LDL level>2.0 mmol/L within the last 12 months	One or more of the following conditions is true: • **patient received lipid reduction counselling in last 12 months** • patient received a prescription for lipid lowering medication within last 12 months	Previous	Demonstration of condition in bold text Verification of remaining condition
~~CAD006~~	~~Beta Blockers~~	~~All the following conditions are true:~~ ~~• patient is identified as having CAD~~ ~~• patient has had an acute myocardial infarction (AMI)~~ ~~• patient must be less than 75~~ ~~• patient is not identified as having asthma~~	~~The following condition is true:~~ ~~• patient is currently prescribed beta blockers~~	Retired	~~Verification~~

OSTEOPOROSIS MANAGEMENT

Table 11: Osteoporosis Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
OST001	Osteoporosis screening	All the following conditions are true: • patient is 50 years of age or greater • patient received a bone density post-fracture notification letter on or after their 50th birthday	One or more of the following is true: • patient received a bone mineral density test after the date of the post-fracture notification letter • patient had their osteoporosis action plan created or reviewed after the post-fracture notification letter • patient received a prescription for an osteoporosis medication after receiving the post-fracture notification letter	Previous	Verification
OST002	Osteoporosis on-going care	All the following conditions are true: • patient is 50 years of age or greater • One or more of the following conditions is true: ▪ patient is identified as having osteoporosis ▪ patient has an osteoporosis action plan ▪ **patient received a prescription for an osteoporosis medication within the last 60 months**	One or more of the following is true: • patient had their osteoporosis action plan reviewed within the last 12 months • **patient received a prescription for an osteoporosis medication within the last 12 months**	Previous	Demonstration of conditions in bold text Verification of remaining condition

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) MANAGEMENT

Table 12: COPD Management Reminder Guidelines

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
COP001	Smoking Status Assessment	The patient is identified as having COPD	The date of last smoker screening occurred within last 12 months	Previous	Verification
COP002	Smoking Cessation Counselling	All the following conditions are true: • patient is identified as having COPD • patient is a current or a former smoker	The patient was provided with smoking cessation counselling in last 12 months	Previous	Verification
COP003	Influenza Immunization	The patient is identified as having COPD	One or more of the following conditions is true: • patient was provided influenza immunization counselling within last 12 months • patient received an influenza vaccination within the last 12 months	Previous	Verification
COP004	Pneumococcal Immunization	The patient is identified as having COPD	One or more of the following conditions is true: • patient was provided pneumococcal vaccination counselling within the last 12 months • patient received a pneumococcal vaccination	Previous	Verification

3 Primary Care Data Extract

3.1 Introduction

The Primary Care Data Extract is used to provide patient care data to MHSAL through its agent, Manitoba eHealth. The information will be collected, compiled and analysed in support of provincial programs. For example, data is used to validate chronic disease tariff claims and to provide feedback to participating clinics in support of quality care in clinical practice.

This section describes the data to be included in the Primary Care Data Extract, including the format and order of each data element within the extract.

3.2 General Extract Requirements

Table 13: General Data Extract Requirements

ID	REQUIREMENT	GUIDELINES	ADDITIONAL NOTES	STATUS	ASSESSMENT
PCDE-01	Ability to generate the Primary Care Data Extract files	At a minimum, must allow user to set parameters for: - Clinic/office/site to include in the data set - Providers to include in the data set - Include patients not currently assigned to a provider (yes/no) - Destination folder for the output Function must be able to be performed by a typical end user. It is not acceptable to require vendor intervention to complete this function.		Previous	Demonstration

3.3 General Extract Rules

Table 14: General Data Extract Rules

ID	RULE	ADDITIONAL NOTES	STATUS	ASSESSMENT
GER-01	Extract file names generated by the EMR must be: • demographic.csv • asthma.csv • diabetes.csv • prevention.csv • CHF.csv • hypertension.csv • CAD.csv • osteoporosis.csv All files must be in comma-separated values (.csv) format.		Previous	Verification
GER-02	The extract must conform to the exact Primary Care Data Extract structure defined in sections 3.4 to 3.11.		Previous	Verification
GER-03	The demographic file will include one record per patient who visited the clinic in the last 60 months. Patients with only no show or cancelled appointments during this period will be excluded.	e.g. a patient cancels an appointment in January 15, and has had no other appointments in the last 60 months. If an extract is generated at the end of January, this patient's data would be excluded.	Previous	Verification
GER-04	All files must contain the most up-to-date information for that patient as of the date the extract is generated.		Previous	Verification
GER-05	The prevention file will include one record per patient listed in the demographic file extract.	i.e. the prevention file will have the same number of patient records as the demographic file.	Previous	Verification

ID	RULE	ADDITIONAL NOTES	STATUS	ASSESSMENT
GER-06	Only patients who visited the clinic in the last 60 months and have an active health concern for the chronic condition will be included in the relevant chronic disease file. Osteoporosis is the exception to this rule.	e.g. only patients with active diabetes diagnosis will be in the diabetes file. i.e. every patient in a chronic disease file will also be in the demographic file as per GER-03.	Previous	Verification
GER-07	Patients will also be included in the osteoporosis file when patient visited the clinic in the last 60 months and has at least one of the following: - received a post fracture notification letter - prescription for osteoporosis medication within last 60 months - osteoporosis action plan	i.e. every patient in the osteoporosis file will also be in the demographic file as per GER-03.	Previous	Verification
GER-08	Chronic disease diagnosis dates must always be the original diagnosis date.	e.g. patient is originally diagnosed with COPD on January 1, 2010, and subsequently receives a second COPD-related diagnosis on March 1, 2013. The COPD diagnosis date submitted in the extract will remain January 1, 2010.	Previous	Verification
GER-09	It is not acceptable to force zeros (0) if data is not captured in applicable discrete data field.	e.g. if not all CTS questions are answered, extract must not contain a forced zero (0) value for that question. Values must be left blank.	Previous	Verification

3.4 Demographic Data

The following table represents the basic demographic data elements included in the Primary Care Data Extract.

Table 15: Demographic Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
DD-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: ##### (4 or 5 characters)	Previous
DD-02	2	Provider Identifier	The identifier for the provider delivering ongoing primary care services to the patient. For physicians and nurse practitioners, the value would be their billing ID.	Type: Character Format: ##### (4 or 5 characters)	Previous
DD-03	3	EMR Patient Identifier	The unique identifier assigned by the EMR for the patient record.	Type: Character Format: ######### (Max length, may be shorter)	Previous
DD-04	4	Personal Health Identification Number (PHIN)	Manitoba Personal Health Identification Number (PHIN) is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Character Format: ######### (must be 9 numeric characters)	Previous
DD-05	5	Manitoba Health Registration Number	The identifier assigned to Manitoba individuals or families. Used, in the absence of a valid Patient Identifier, to identify Manitoba patients or families	Type: Character Format: ###### (Must be 6 numeric characters	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			using primary care services.		
DD-06	6	Date of Birth	Used to determine age, which is necessary for several indicators.	Type: Date Format: MMDDYYYY	Previous
DD-07	7	Administrative Sex	Used to determine eligibility for several indicators.	Type: Character Format: 'M' or 'F' or "U"	Previous
DD-08	8	Postal/Zip Code	Used to determine the general geographical location of a client's residence.	Type: Character Formats: • postal code: A#A #A# • zip code: ##### • zip code, extended: #####-####	Previous
DD-09	9	(None)	Retired	Blank	Previous
DD-10	10	Date of last visit	The date of the patient's most recent visit to the clinic.	Type: Date Format: MMDDYYYY	Previous
DD-11	11	(None)	Retired	Blank	Previous
DD-12	12	Enrolment Start Date	The date the client was included on the roster.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			Note: If already certified to and using Home Clinic Enrolment Service Specification, submission of this data is optional (may be left blank).		
DD-13	13	Enrolment End Date	The date the client was removed from the roster. Note: If already certified to and using Home Clinic Enrolment Service Specification, submission of this data is optional (may be left blank).	Type: Date Format: MMDDYYYY	Previous
DD-14	14	Patient Identifier	The health number assigned to the patient by a recognized issuing authority (provincial, territorial or federal).	Type: Variable length string (Max 30 characters) • A valid health card number for the issuing province, territory or federal authority • UNK (unknown) • NA (not applicable)	Previous
DD-15	15	Patient Identifier Type	Represents the type of patient identifier. The element is constrained to provincial, territorial or federal identifier types.	Type: Character Format: AAAAA Field must contain one of the following values (JHN=Jurisdictional Health Number):	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
				Value **Description** JHNAB Alberta JHNBC British Columbia JHNMB Manitoba JHNNB New Brunswick JHNNL Newfoundland JHNNS Nova Scotia JHNNT Northwest Territories JHNNU Nunavut JHNON Ontario JHNPE Prince Edward Island JHNQC Quebec JHNSK Saskatchewan JHNYT Yukon JHNAF Armed Forces JHNVA Veterans Affairs JHNFN First Nations JHNCO Correctional Institution JHNRC RCMP JHNCI Immigration Other Other	

3.5 Prevention

The following represents the data elements that need to be collected and extracted in the prevention file.

Table 16: Prevention Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
PR-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
PR-03	3	Date of last cervical cancer screening	The date of the last pap test.	Type: Date Format: MMDDYYYY	Previous
PR-04	4	Exemption from cervical cancer screening	This is a true / false value.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-05	5	Date cervical cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of cervical cancer screening.	Type: Date Format: MMDDYYYY	Previous
PR-06	6	Date of last colon cancer screening	The date of the last FOBT test.	Type: Date Format: MMDDYYYY	Previous
PR-07	7	Date colon cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of colon cancer screening.	Type: Date Format: MMDDYYYY	Previous
PR-08	8	Date of last breast cancer screening	The date of the last mammography test.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-09	9	Exemption from breast cancer screening	This is a true / false value.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-10	10	Date breast cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of breast cancer screening.	Type: Date Format: MMDDYYYY	Previous
PR-11	11	Date of last lipid test	The date of the last lipid test. For dyslipidemia screening.	Type: Date Format: MMDDYYYY	Previous
PR-12	12	Date dyslipidemia screening advice was last provided	The date that the patient was most recently given advice about the benefits of dyslipidemia screening.	Type: Date Format: MMDDYYYY	Previous
PR-13	13	Date of last fasting blood sugar screening	Collected for all patients. The date of the last fasting blood sugar test.	Type: Date Format: MMDDYYYY	Previous
PR-14	14	Date fasting blood sugar screening advice was last provided	The date that the patient was most recently given advice about the benefits of fasting blood sugar screening.	Type: Date Format: MMDDYYYY	Previous
PR-15	15	Date of childhood immunizations counselling	The date on which all immunizations recommended by age seven have been confirmed or the date on which parents or guardians have been counselled on the recommended immunizations.	Type: Date Format: MMDDYYYY	Previous
PR-16	16	Date of last influenza vaccination counselling	The date of the patient's last influenza vaccination counselling.	Type: Date Format: MMDDYYYY	Previous
PR-17	17	Date of pneumococcal	The date the patient's pneumococcal	Type: Date	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		vaccination	vaccination was given.	Format: MMDDYYYY	
PR-18	18	(None)	Retired	Blank	Previous
PR-19	19	(None)	Retired	Blank	Previous
PR-20	20	Date of last blood pressure measurement	The date the patient received a blood pressure measurement. Collected for all patients.	Type: Date Format: MMDDYYYY	Previous
PR-21	21	Date blood pressure screening advice was last provided	The date the patient was most recently given advice about the benefits of blood pressure screening.	Type: Date Format: MMDDYYYY	Previous
PR-22	22	Sedentary patient	True / false value to indicate if the patient undertakes regular physical activity, more specifically, whether a patient performs at least 20 minutes of light exercise three times per week. Used to determine eligibility for Physical Activity Advice indicator.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-23	23	Date of last physical activity advice	The date the patient was most recently given advice about the benefits of physical activity. Collected for all patients 12 of age and over who are sedentary (as defined above).	Type: Date Format: MMDDYYYY	Previous
PR-24	24	(None)	Retired	Blank	Previous
PR-25	25	Date smoking cessation	The date that the patient was most	Type: Date	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		counselling was last provided	recently given counselling about the benefits of quitting smoking.	Format: MMDDYYYY	
PR-26	26	Date of last influenza vaccination	The date of the patient's last influenza vaccination.	Type: Date Format: MMDDYYYY	Previous
PR-27	27	Date of last pneumococcal vaccination counselling	The date of the patient's last pneumococcal vaccination counselling.	Type: Date Format: MMDDYYYY	Previous
PR-28	28	Date of last obesity / overweight screening	The date of the last obesity / overweight screening. Collected for all patients.	Type: Date Format: MMDDYYYY	Previous
PR-29	29	Date of last colonoscopy	The date of the patient's last colonoscopy.	Type: Date Format: MMDDYYYY	Previous
PR-30	30	Date of MMR immunization	The date on which all MMR immunizations recommended by age seven have been confirmed.	Type: Date Format: MMDDYYYY	Previous
PR-31	31	Date of last PHQ-2 administration	Date of last PHQ-2 administration is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Date Format: MMDDYYYY	Previous
PR-32	32	The character response to the PHQ-2 questions	The character response to the PHQ-2 questions is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Character Format: #	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-33	33	Date a depression screening follow-up assessment occurred	Date a depression screening follow-up assessment occurred is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Date Format: MMDDYYYY	Previous
PR-34	34	Depression screening follow-up outcome selected	Depression screening follow-up outcome selected is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Character Format: # Character to be exported: a selected - 1 b selected - 2 c selected - 3 d selected - 4 b AND c selected - 5	Previous
PR-35	35	Date of active depression diagnosis	Date of active depression diagnosis is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Date Format: MMDDYYYY	Previous
PR-36	36	Smoking status	Used to determine eligibility for indicator.	Type: Numeric Values: 1 – Current smoker 2 – Former smoker 3 – Never a smoker	Previous
PR-37	37	Date of last cigarette /	The date of the last time the patient	Type: Date	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		tobacco product	consumed a product containing tobacco. Used to determine if a "former smoker".	Format: MMDDYYYY	
PR-38	38	Date of last smoker screening	The date of the last time the patient's smoking status was visited.	Type: Date Format: MMDDYYYY	Previous
PR-39	39	Character response to CTS questions	Response to the 5 screening questions endorsed by the CTS. # Question 1 Do you cough regularly? 2 Cough up phlegm? 3 Short of breath with simple chores? 4 Wheeze with exertion or at night? 5 Frequent colds that persist?	Type: Binary Format: 5 character value required 0 – No 1 – Yes Examples: 01 01 How this translates to responses: # Answer 1 No 2 Yes 3 (blank) 4 No 5 Yes	Previous
PR-40	40	Date of last COPD at risk screening	The date of the last time the patient was assessed for risk of COPD.	Type: Date Format: MMDDYYYY	Previous
PR-41	41	Date of last spirometry test	The date of the patient's last spirometry test.	Type: Date Format: MMDDYYYY	Previous
PR-42	42	COPD diagnosis	Indication that the patient has an active	Type: Numeric	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			diagnosis of COPD.	Values: 0 – Not diagnosed with COPD 1 – Diagnosed with COPD	
PR-43	43	Date of COPD diagnosis	The date of the first COPD related diagnosis.	Type: Date Format: MMDDYYYY	Previous
PR-44	44	Date of last A1c test	Preventative diabetes screening	Type: Date Format: MMDDYYYY	Previous
PR-45	45	Date of last statin prescription	The most recent date a qualifying medication was prescribed to the patient.	Type: Date Format: MMDDYYYY	Previous

3.6 Diabetes Management

The following represents the data elements that need to be collected for Diabetes Management.

Table 17: Diabetes Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
DI-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
DI-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
DI-03	3	Patient has Diabetes	Indication that the patient has an active diagnosis of diabetes, type 1 or type 2.	Type: Character Format: 1 – true or yes	Previous
DI-04	4	Date of last A1c test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-05	5	Date of last nephropathy test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-06	6	Patient has documented nephropathy	Collected for all diabetic patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
DI-07	7	Date of last fundoscopic exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-08	8	Date of last foot exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-09	9	Patient has documented peripheral neuropathy	Collected for all diabetic patients.	Type: Binary Format:	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
				0 – false or no 1 – true or yes	
DI-10	10	Date of last lipid test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-11	11	Date of last blood pressure measurement	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-12	12	Date of last obesity / overweight screening	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-13	13	Date of last fundoscopic exam referral	Collected for all diabetic patients. This is the date of the fundoscopic referral, and not the date of the exam itself.	Type: Date Format: MMDDYYYY	Previous

3.7 Asthma Management

The following represents the data elements that need to be collected for Asthma Management.

Table 18: Asthma Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
AS-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
AS-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
AS-03	3	Patient has asthma	Indication that the patient has an active diagnosis of asthma.	Type: Character Format: 1 – true or yes	Previous
AS-04	4	(None)	Retired	Blank	Previous
AS-05	5	(None)	Retired	Blank	Previous
AS-06	6	(None)	Retired	Blank	Previous
AS-07	7	Patient has an asthma action plan	Collected for all asthma patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
AS-08	8	The date of the most recent asthma action plan review	The date of the last asthma action plan review or the date asthma action plan was developed (if no subsequent review was made). Collected for all asthma patients.	Type: Date Format: MMDDYYYY	Previous

3.8 Congestive Heart Failure Management

The following represents the data elements that need to be collected for Congestive Heart Failure Management.

Table 19: CHF Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
CF-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
CF-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
CF-03	3	Patient has Congestive Heart Failure	Indication that the patient has an active diagnosis of congestive heart failure.	Type: Character Format: 1 – true or yes	Previous
CF-04	4	(None)	Retired	Blank	Previous
CF-05	5	Date of last obesity / overweight screening	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-06	6	(None)	Retired	Blank	Previous
CF-07	7	Date of last lipid test	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-08	8	Date of last blood pressure measurement	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-09	9	Date of last fasting blood sugar test	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-10	10	Date of last A1c test	Preventative diabetes screening.	Type: Date Format: MMDDYYYY	Previous
CF-11	11	Date of last ACE inhibitor or ARB prescription	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
CF-12	12	Exemption from ACE inhibitor or ARB prescription	To allow an exemption for patients who do not require ACE inhibitor or ARB prescription.	Type: Numeric values Format: 1 – LVEF>=40% 2 – Other	Previous
CF-13	13	Date of last exemption from ACE inhibitor or ARB prescription	This is the last date the patient was assessed for being exempt from ACE inhibitor or ARB prescription.	Type: Date Format: MMDDYYYY	Previous

3.9 Hypertension Management

The following represents the data elements that need to be collected for Hypertension Management.

Table 20: Hypertension Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
HY-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
HY-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
HY-03	3	Patient has hypertension	Indication that the patient has an active diagnosis of hypertension.	Type: Character Format: 1 – true or yes	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
HY-04	4	Date of last fasting blood sugar test	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-05	5	Date of last lipid test	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-06	6	Date of last test to detect renal dysfunction (e.g. serum, creatinine)	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-07	7	Date of last blood pressure measurement	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-08	8	Date of last obesity / overweight screening	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-09	9	Exemption from dyslipidemia screening	To allow an exemption for patients at low cardiovascular risk.	Type: Numeric values Format: 1 – Framingham Risk Score<10% 2 – Disease stable	Previous
HY-10	10	Date of last exemption from dyslipidemia screening	This is the last date the patient was assessed for being at low cardiovascular risk.	Type: Date Format: MMDDYYYY	Previous
HY-11	11	Date of last A1c test	Preventative diabetes screening.	Type: Date Format: MMDDYYYY	Previous

3.10 Coronary Artery Disease Management

The following represents the data elements that need to be collected for Coronary Artery Disease Management.

Table 21: CAD Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
CA-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
CA-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
CA-03	3	Patient has Coronary Artery Disease	Indication that the patient has an active diagnosis of coronary artery disease.	Type: Character Format: 1 – true or yes	Previous
CA-04	4	Date of last fasting blood sugar test	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-05	5	Date of last lipid test	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-06	6	Date of last blood pressure measurement	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-07	7	Date of last obesity / overweight screening	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-08	8	LDL level >2.0 in last 12 months	Collected for all CAD patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
CA-09	9	Date of last lipid	Collected for all CAD patients.	Type: Date	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		reduction counselling		Format: MMDDYYYY	
CA-10	10	Date of last lipid lowering medication prescription	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-11	11	Patient has had acute myocardial infarction	True / false value to determine eligibility for beta blockers.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
CA-12	12	(None)	Retired	Blank	Previous
CA-13	13	Date of last A1c test	Preventative diabetes screening	Type: Date Format: MMDDYYYY	Previous

3.11 Osteoporosis Management

The following represents the data elements that need to be collected for Osteoporosis Management.

Table 22: Osteoporosis Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
OS-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type = Character Format = #####	Previous
OS-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification	Type = Character Format = #########	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			within the clinic's EMR.		
OS-03	3	Date of Manitoba bone density post-fracture notification letter	The date of the letter sent out to primary care physicians by MHSAL to identify patients as having a possible fracture.	Type: Date Format: MMDDYYYY	Previous
OS-04	4	Date of last bone mineral density test	Identification of the date of last bone mineral density test.	Type: Date Format: MMDDYYYY	Previous
OS-05	5	Osteoporosis diagnosis date	The date that the current osteoporosis diagnosis was made.	Type: Date Format: MMDDYYYY	Previous
OS-06	6	Osteoporosis diagnosis	Indication that the patient has an active diagnosis of osteoporosis.	Type: Numeric Values: 0 – Not Diagnosed with Osteoporosis 1 – Diagnosed with Osteoporosis	Previous
OS-07	7	Date of last osteoporosis medication prescription	The most recent date a qualifying medication was prescribed to the patient. Collected for all osteoporotic patients.	Type: Date Format : MMDDYYYY	Previous
OS-08	8	Last prescribed bisphosphonate	The most recent date that a bisphosphonate was prescribed to this patient. Collected for all osteoporotic patients.	Type: Date Format : MMDDYYYY	Previous
OS-09	9	Patient has an osteoporosis action plan	True / false value to determine eligibility for osteoporosis on-going care	Type: Binary Format:	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			indicator. Collected for all osteoporotic patients.	0 – false or no 1 – true or yes	
OS-10	10	Date the most recent osteoporosis action plan review	The date of the last osteoporosis action plan review or the date the osteoporosis action plan was developed (if no subsequent review was made). Collected for all osteoporotic patients.	Type: Date Format : MMDDYYYY	Previous

3.12 Data Extract Assessment

EMR vendors should email EMR@manitoba-ehealth.ca to request your test EDTR Clinic Identifier. EMR vendors will be required to submit a complete set of files for the Primary Care Data Extract as follows:

1. At least two weeks before the scheduled product demonstration related to other requirements within this specification; and
2. After performing all demonstration activities specified within this specification.

Submissions should be submitted to EMR@manitoba-ehealth.ca. Manitoba will verify the content and format of the data within these files, and validate the structure of the files.

Manitoba may choose to generate and verify additional data extracts during verification activities.

4 Appendix A: Release Notes

VERSION 1.1 DECEMBER 9, 2015

- Added status for PR-40 to PR-44 in section 3.5 Prevention.

VERSION 1.2 AUGUST 31, 2016

- Removed the general statement that "…requirements will be assessed through Verification method, unless otherwise stated" and listed "Verification" assessment method for each applicable requirement.
- Added new guideline to PCDC-11 to align with provincial enrolment processes.
- Updated CHF002 reminder fulfilled condition to include "within the last 12 months".
- Changed "screening" to "test" in HYP001 reminder fulfilled condition.
- Changed "The Demographic file…" to "All files…" in GER-04 to align with previous PCDE file requirements.
- Removed "…and it will contain the patient's most up to date information." from GER-05. This requirement is included in GER-04.

VERSION 1.3 SEPTEMBER 29, 2016

- CHF002 assessment method updated to match the Assessment Guide. Assessment method was previously only Demonstration. CHF002 is now assessed through both Demonstration and Verification.

VERSION 1.4 APRIL 28, 2017

- Replaced MHHLS with MHSAL.
- Section 1.2 – Added glossary.
- DD-01 – Clarified that this field may be 4 or 5 characters in length.
- DD-02 – Updated description. Clarified that this field may be 4 or 5 characters in length.
- DD-03 – Clarified that the length shown is the max length but shorter lengths are acceptable.
- DD-12 - Removed sentence "Submission of this data is optional. To ensure proper processing of the extract file, this field must be maintained in the extract."
- DD-13 – Removed sentence "Submission of this data is optional. To ensure proper processing of the extract file, this field must be maintained in the extract."

- CA-13 – Changed "Date of last A1c screening" to "Date of last A1c test".

VERSION 1.5 SEPTEMBER 1, 2017

- Background – Added Chronic Obstructive Pulmonary Disease to list of indicators.
- Related Documents – Added reference to Primary Care Data Indicator Guide.
- PRV004, PRV005, DIA005, CHF003, HYP002, CAD002 – In *Reminder Active When*, added "no statins prescribed in last 12 months. In *Reminder Fulfilled When*, removed "full fasting" and changed 12 months to 60 months.
- PRV012 – Changed "Smoking Cessation Advice" to "Smoking Cessation Counselling".
- PRV016 – New reminder.
- CHF002 – In *Reminder Fulfilled When*, added "patient received exemption from ACE inhibitor or ARB medication within last 12 months".
- CAD006 – Retired reminder. Reminder no longer required.
- PR-11, DI-10, CF-07, HY-05, CA-05 – Removed "full fasting". These data elements no longer require the test to be fasting.
- CA-12 – Changed this field to optional.
- PR-25 - Changed "Smoking Cessation Advice" to "Smoking Cessation Counselling".
- PR-45, CF-12, CF-13 – New fields.
- Section 2.3 – Added COPD Management section.

VERSION 1.6 AUGUST 2, 2018

- Related Documents – added "eHealth_hub – Home Clinic Enrolment Service Interface Specification".
- PCDC-11, PCDC-12 – added "Note: If already certified to eHealth_hub - Home Clinic Enrolment Service Specification, this requirement is optional".
- PCDC-13 – retired.
- PRV009 – simplified wording by removing language regarding "65th birthday".
- GER-06, GER-07 – clarified to state that patients must have had a visit within the last 60 months and added additional notes that "every patient in a [chronic disease/osteoporosis] file will also be in the demographic file as per GER-03"
- DD-09, DD-11, PR-18, PR-19, PR-24, AS-04, AS-05, AS-06, CF-04, CF-06, CA-11, CA-12 – deleted Data element name, updated description to say field is no longer used and changed format to blank.
- DD-12, DD-13 – added "Note: If already certified to and using Home Clinic Enrolment Service Specification, submission of this data is optional (may be left blank)."