PROACTIVE CARE COORDINATION ASSISTANT PROGRAM MANUAL

Edmonton Southside PCN

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Section 1: Introduction

An Overview - Edmonton Southside Primary Care Network (ESPCN) and Patient’s Medical Home (PMH)

What is ESPCN?

Primary Care Network doctors and health care professionals collaborate to provide integrated care for all patients' health care needs.

The Edmonton Southside Primary Care Network (PCN) was Alberta's first primary care network. The ESPCN has grown to become the largest PCN in Edmonton and consists of a team of medical professionals passionate about creating healthier communities. Each member of our team of healthcare providers plays a specific role in improving, coordinating, and delivering primary health services. Our team is composed of nurses, nurse practitioners, behavioural health consultants, social workers, registered dietitians, exercise specialists, respiratory therapists, occupational therapists, quality improvement and administrative staff.

Research shows that having an ongoing relationship with a family doctor and team helps you live longer, receive better care, make fewer visits to emergency rooms, and become hospitalized less. When you have a regular family doctor, your health history, ideas, and preferences are valued, and you are more actively involved in decision-making. Evidence shows that you will be more satisfied with your care.

Learn More by visiting the ESPCN website.

Our Mission	Our Vision	Our Values
To provide team-based primary care and work with our community to achieve the best health for all.	To be the trusted cornerstone of a healthy community.	Respect • Passion • Collaboration • Dedication • Innovation

Patient’s Medical Home

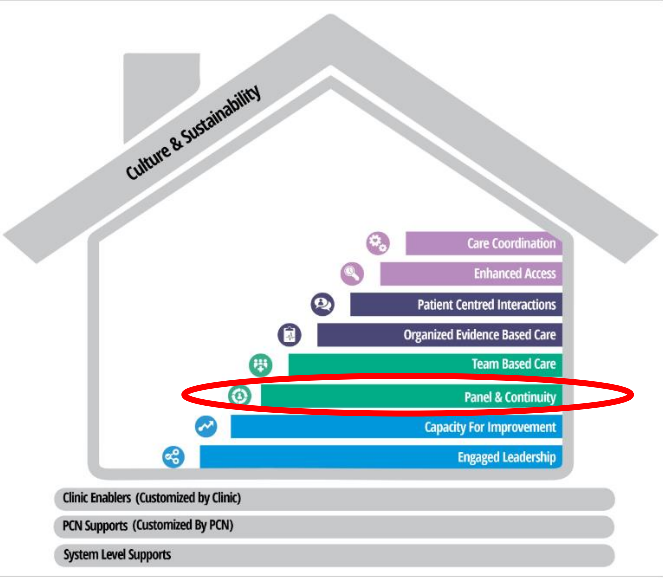
The PMH is a family practice defined by its patients as the place where they feel most comfortable to discuss their personal and family health concerns. It is the family practice that offers the medical care that the patient wants – readily assessable, centred on the patients’ needs, provided throughout every stage of life, and seamlessly integrated with other services in the health care system and the community. The goal is to have the patient’s family physician, the most responsible provider of their medical care, work collaboratively with a team of health professionals, to coordinate comprehensive healthcare services and ensure continuity of patient care. These professionals can be in the same physical site as the family physician or

linked through different practice sites. The PMH enables the best possible outcomes for each person, the practice population, and the community being served.

In other words, it is the one-stop-shop for most of the patient's health needs and the centre where all their health care needs are coordinated.

https://www.albertadoctors.org/leaders-partners/innovation-in-primary-care/patients-medical-home

https://acfp.ca/advocacy/patients-medical-home/



An Overview of the PCCA Role

The PCCA supports the clinic's journey towards becoming a Patient's Medical Home. They are part of the quality improvement team and report to the Proactive Care Coordination Lead (PCC-Lead). PCCAs call patients on a panel who are due for care or screening. In the image above, Panel and Continuity (seeing the same family doctor most of the time) are fundamental components of the patient's medical home.

Basic Panel Concepts

What is a Panel?

A patient panel is a list of the doctor's active patients or patients who consider a particular physician to be their family doctor, and the doctor agrees. Evidence shows that patients who consistently see the same physician have better health outcomes.

An accurate panel is fundamental to knowing who is due for preventative screening and for supporting the management of patients who are at higher risk, ensuring they are seen in their medical home regularly.

Panel Identification

Anyone in the clinic who interacts with the patient can do this.

This refers to how someone 'gets on' to a physician's patient's panel. The relationship between the patient and the physician must be confirmed for this to happen.

- Patient attachment is captured by:
    1. Asking patients who their regular family doctor is that they see for most of their ongoing health care needs.
    2. Confirming demographic information such as address and phone number.
    3. Applying a verification date stamp in the EMR.
- Confirm continued attachment at every opportunity.
- Different patient statuses to distinguish active, inactive, or other patient groups.

Each team should have a reliable panel process in place where:

1. Each patient record indicates the most responsible physician.
2. A list of active patients can be generated for each physician.

EMRs play a significant role in identifying, maintaining, and managing a patient panel.

Each clinic will establish the definition of an active or inactive patient.

Active patients have confirmed ongoing attachment with a primary provider at the clinic, and the provider agrees.

Inactive or end-dated patients may be those previously paneled to a physician but have moved or changed physicians. These could also be patients who have had a chart created but have never had an appointment. Among other outreach efforts, PCCAs regularly contact those patients who have not had a visit within the past 3 years to confirm attachment and update patient statuses accordingly.

Other patient statuses in the EMR may include 'consult,' 'walk-in,' or 'deceased'. The definitions of these statuses must be agreed upon and documented so that the entire clinic team is aware. The IF will lead conversations around this.

Panel Maintenance

Panel maintenance refers to confirming the information about a physician's panel is accurate. This may involve physician confirmation at the front desk using this sample script:

> Hello 'Mary' I'd like to check our information before you go in for your appointment. Are you still at 123 Lane Road? Is your phone number 123-4567? I see your appointment is with Dr. Lee today. Is Dr. Lee your primary physician? (If not, who is your primary physician?)

What is Care Coordination?

Some patients do not come to their medical homes for regular appointments, and as a result, they might be due for care or preventative health screening. Outreach is the proactive approach of inviting these patients for an appointment with the appropriate team member at their medical home.

Standard Areas of Outreach

The PCCA role is heavily focused on standard areas of outreach. Across the ESPCN, a PCCA will phone and offer an appointment or lab requisition(s) to patients who:

- Are under 18 years of age and have not been seen in the last 2 years.
- Are 18-74 years of age and have not been seen in the last 3 years.
- Are over 75 years old and have not been seen in the last year.
- Have a chronic health condition (diabetes, hypertension, heart failure, heart disease, COPD, or kidney disease) and have not been seen in the last year.
- Are due for preventative screening (colorectal cancer screening, pap test, mammogram, lipids/diabetes bloodwork)
- Are listed on a physician's CPAR Conflict report as being on the panel of another CPAR physician.

This ensures that patients at increased risk receive appropriate care in their medical homes.

The PCCA will work closely with their improvement facilitator to optimize care coordination practices that are consistent with the areas of outreach listed above. Ensuring panel information is current for each patient in the EMR will also be completed at this time.

The PCCA will support maintaining the correct status for each patient while engaging in outreach calls. For example, a status may need to be changed for those patients who are deceased or after calling the patient if informed that they have moved away or are receiving their primary care elsewhere. The clinic will decide on the process for this with the support of the IF.

An ESPCN patient shared:

> *"I got my call last week as a reminder I hadn't seen my PCN Physician in over 3 years. The call was sure appreciated - as a mom, I'm up to date with all the kiddos visits but had forgotten about myself. What an awesome program. Thank you!"*

A PCCA at an ESPCN clinic shared:

> *"I do outreach for 14 doctors, and rarely do I find out the result of the endless phone calls, lists, queries, requisitions, and appointments. But that changed today! A lady I*

called in March for a mammogram has been diagnosed with early breast cancer, a type that is slow growing and easy to cure with hopefully minimal surgery, chemo etc. So, while it's unfortunate that she's got breast cancer, it's been caught early. So, pick up those phones, and encourage everyone you talk with to get screened!!"

PCN Quality Improvement Team Members

The PCCA is part of a larger quality improvement team at the ESPCN.

Improvement Facilitators are drivers for change, working collaboratively with PCCAs, EMR Consultants, Primary Care Managers, Family Physicians, and other clinic staff. They help to assess current readiness for change to align the goals of the Patient's Medical Home to those that are important and valuable at the clinical level. IFs will work closely with you as a PCCA to ensure that processes are in place to support proactive panel management, including outreach. The IF will be the point of contact for clinic teams to coordinate any improvement efforts. The IF will work with you to guide your work and share it with the clinic regularly.

Electronic Medical Record (EMR) Consultants work closely with IFs and PCCAs on improvement initiatives, supporting clinics in a technical capacity and advising on EMR usage and optimization. They may provide direct support in clinics to build EMR queries/reports, templates, and notifications/alerts.

The **Proactive Care Coordination Lead (PCC-Lead)** is responsible for leading and managing all PCCAs. The PCC-Lead will ensure that PCCAs follow established, standardized processes, complete their work efficiently, meet weekly targets, and demonstrate great attention to detail.

Primary Care Managers (PCMs) will always oversee all clinic and staff activities and are important partners in any QI work. They support PCN-level initiatives and coordinate ESPCN multidisciplinary (MDT) and QI team members to optimize a clinic's journey to become a better medical home.

The **Quality Improvement (QI) Manager** is responsible for leading and managing the IFs, EMR-Cs, and PCC-Lead and overseeing the overall ESPCN QI Program, which encompasses the PCCA program.

Soft Phones

Each PCCA will receive a softphone. This app can be added to your computer to have the Edmonton Southside PCN name appear on the call display. You can call patients through this app using a provided headset. This was enabled because patients are likelier to answer phone calls from a number that is not blocked.

As the Caller ID and phone number are for Edmonton Southside PCN, it is very important to leave clear voice messages with the clinic's name and clinic phone number and direct the patient to call back the clinic. Some patients will still attempt to "redial" the ESPCN number that shows on their phone. If this happens, the patients will be directed to an automated voicemail directing them to listen to their voice message. This automated voicemail will also offer patients the option to press "0" to speak to the PCC Lead if they have any questions. The PCC Lead can view all softphone calls using a central system and may reach out to you if a patient who was contacted through your extension has further questions.

Netcare

To support your role as a PCCA, you will be provided with an Alberta Netcare fob or soft token. This secures your access to patient information and tracks your use of Netcare. Your use and non-disclosure of patient information are of paramount importance, and you will take a Netcare privacy course prior to starting your role.

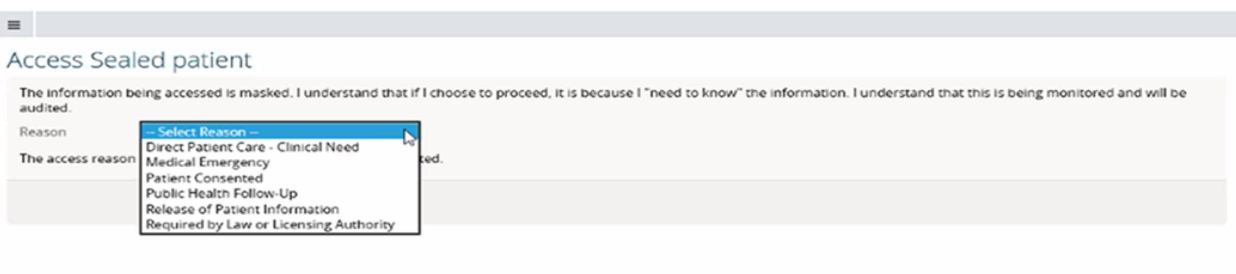
For PCCAs working in more than one clinic, you will have Netcare access for each one. Therefore, you must access the correct clinic drop-down in Netcare each time.

As described in the screening outreach section, prior to calling patients due for one of five preventative health screens (colorectal/breast/cervical cancer screening, plasma lipid profile, or diabetes screening), you will confirm that the screening information in the chart accurately reflects the most recent information available in Netcare. If the EMR chart information does not include the most recent information on Netcare, update the EMR chart according to the clinic process (i.e., Import results from Netcare or update the chart template with results). Only those patients who have no results in the EMR chart or Netcare will be called.

Prior to contacting patients with chronic disease or patients aged 75+ years, you may review Netcare to ensure the patient is not deceased, in the hospital, or in long term care. Note: a long-term care site has an attending physician managing care. This will be indicated in the Summary Reports section of Netcare as 'LTC' or 'Long Term Care'. Any other descriptors (e.g., Supportive Living, DSL, Congregate Living, etc.) do not necessarily indicate that the patient is being followed by another physician, and so those patients should still be contacted.

Sealed Charts

When looking into a patient's information on Netcare, you may occasionally encounter "Sealed Charts" – with a message like this:



If this occurs, refer to the following process:

1. Task or worklist the physician to request that the chart be unsealed, explain why you need to access the patient's Netcare profile and request that they respond to the task if they agree with you unsealing the chart.
2. If the physician agrees, select "Direct Patient Care – Clinical Need" as the reason on the list. Document and close the EMR task/worklist that you unsealed the Netcare profile with the doctor's permission.
3. If the physician provides verbal permission, create a task or worklist to document the reason the chart was accessed and that physician permission was received verbally.

Section 2: Introduction to Care Coordination, Outreach, Tracking your Work and Reporting

The most important part of the PCCA role is to support primary care providers and their teams by finding patients in the EMR who are due for care or preventative health screening who are not coming to the clinic and inviting them for an appointment with the appropriate team member.

The PCCA role is an outreach role, which means you will spend a great deal of time attempting to contact and speak with patients. You must always be friendly and professional because you are representing the physician, clinic, and ESPCN.

The components of any conversation with a patient should include:

- Confirming you are speaking to the patient.
- Introducing yourself and where you are calling from.
- Indicating the reason for the call
- Confirming patient attachment to the primary care provider
- Attempting to book an appointment.

The standard areas of outreach will now be reviewed regarding talking to patients on the phone and how to track this work. Instructions for reporting will also be reviewed.

The order of outreach should be Pediatric, Adults, 75+, Chronic Disease, and Screening. Your IF will advise you at what point and how often to call CPAR conflicts, as this may be a clinic-specific process.

As you can see, there are several tasks that you will be involved in while supporting your physicians and clinics. To help track your work in all these areas, you will update an Excel tracking sheet on your last day of work each week. A link to this tracking sheet will be shared with you on Teams (an ESPCN communication program) by your IF.

Your tracking sheet will help guide discussions/priorities regarding the ongoing work at the clinic and monitor/celebrate progress in different areas.

Standard Areas of Outreach

Pediatric

Instructions:

1. **Run Baseline.** At the start of this work, run your Pediatric (0-17 years with no visit in 2+ years) EMR report, and enter the clinic total baseline, for all doctors in the baseline section of the spreadsheet and the “Historical Data” section of this tab. Inform the clinic IF of the new baseline.

	A	B	C	D	E	F	G	H	I	J	K	L
1		**Pediatric: < 18 and no visit in 2 years**										
2	Doctor	**BASELINE**	Process: # of patients **called with confirmation of pediatrician, appointment offered, or inactivated**				Running Total		Historical data			
3		12-Nov-24	14-Nov-24	21-Nov-24	Date	Date			Date	Doctors' baseline total		
4	**Red**	32	32	DONE			32		01-Jul-24	82		
5	**Blue**	35	10	25	DONE		35		12-Nov-24	67		
6	**Total**	**67**	**42**	**25**	**0**	**0**	**67**					
7												
8	**Each quarter, ensure previous quarter's baseline total is entered in "Historical data" and erase previous data - use same table for new data. Baseline total should decrease over time.**											

2. **Check Chart.** Working through your list, go into each patient’s chart. Review the last worklist/task on the chart to determine if there is communication relating to the patient. If there is clear communication (e.g., a worklist that the patient’s family informed they have moved provinces, or have a new doctor), the patient may be moved from the panel without a phone call (proceed to Step #4).

3. **Call Patient’s Family.** We do not want to make assumptions about attachment for the remaining patients, so we will always call these patients to confirm who they consider to be their primary provider. Many will inform that they have moved or have new providers, and they can then be removed from the panel. Other patients may be followed by a pediatrician, and may not require a care appointment.

Suggested script:

“Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic.

May I speak with [guardians of patient Y] regarding Y?

Dr. Z asked me to follow up with you as s/he has not seen Y in over 2 years. We just wanted to update our patient lists. Is Dr. Z still Y's regular family doctor?

<If they need a better definition of what a family physician is:

> ***"A family physician would be someone you consider to be most responsible for your care and whom you could be comfortable coordinating complex health matters">***

[*If no longer a patient, inactivate patient as per clinic process*]
[If yes, click verification/date stamp in EMR and save and proceed to the next question]

> *Is Y also being followed by a pediatrician for their care?*
>
> [*If the patient is not followed by a pediatrician, proceed the next question.]*
> *[If patient is followed by a pediatrician, follow the steps below:*
>
> > -Confirm the pediatrician's name is entered in the EMR in the appropriate area of the chart as per the clinic's process.
> >
> > -Confirm if they have had a follow-up with their pediatrician in the past 2 years. Update EMR accordingly.
> >
> > -If they have not had an appointment with the pediatrician, follow the clinic's process to encourage them to book a follow-up with the pediatrician or offer an appointment following the steps below.
> >
> > *Since it's been over 2 years since Y last saw Dr. Z, I'd like to book Y an appt – our next available appt is ### does that work for you?"*

4. **Apply Task/Worklist**. **"Peds" outreach task/worklist** should be applied if:
    a. You reviewed the chart, and it clearly states that the patient's family has informed the clinic that they have ended their relationship with the provider.
    b. You contacted the patient (even if you did not reach them)
    c. You created a worklist for another clinic team member to contact the patient.
5. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run a report for the number of patients with the Pediatric worklist/tasks applied in the past week and enter that number in the appropriate date column. Once a physician's list has been thoroughly reviewed, the running total should equal the baseline, as all patients have some outreach action performed (either updating their patient status, receiving a phone call or having the process initiated for another team member to make the phone call).

Adults

Instructions:

1. **Run Baseline.** At the start of this work, run your Adults (18-74 not seen in 3 years) EMR report, and enter the clinic total baseline, for all doctors, in the baseline section of the spreadsheet and in the "Historical Data" section of this tab, and inform the clinic IF of the new baseline.

	Adults: 18-74 and no visit in 2 years								
Doctor	Baseline:	Process: # of patients reviewed + contacted				Running		Historical data	
	01-Mar-21	05-Mar-21	12-Mar-21	19-Mar-21	26-Mar-21	total		Date	doctors' baseline total
Red	25	25	0	0	0	25		01-Dec-20	250
Blue	24	0	24	0	0	24		01-Mar-21	114
Green	31	0	6	25	0	31		01-Jun-21	
Yellow	23	0	0	18	5	23		01-Sep-21	
Brown	11	0	0	0	11	11		02-Dec-21	
Total	114	25	30	43	16	114			

Each quarter, ensure previous quarter's baseline total is entered in "Historical data" and erase previous data - use same table for new data. Baseline total should decrease over time.

2. **Check Chart.** Working through your list, go into each patient's chart. If a patient has not been to the clinic in 3 years and has not updated their information, it is considered NOT a current care relationship. This means that a Netcare search is NOT appropriate. However, you may review the last worklist/task on the chart to determine if there is communication relating to the patient informing them they will not be returning to the clinic. If there is clear communication (e.g., a worklist that the patient informed they have moved provinces or have a new doctor), the patient may be removed from the panel without a phone call (proceed to Step #4).

3. **Call Patient.** We do not want to make assumptions about attachment for the remaining patients, so we will always call them to confirm who they consider to be their primary provider. Many will inform us that they have moved or have new providers, and they can then be removed from the panel.

Suggested script:

"Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic.

May I speak with Y?

Dr. Z asked me to follow up with you as s/he has not seen you in over 3 years. We just wanted to update our patient lists. Do you have a new family doctor, or is Dr. Z is still your regular family doctor?

OR It's been over 3 years since you were last in to see Dr. Z, and I'm wondering if you have a new family doctor?

<If patient is unsure or needs a better definition of what a family physician is:

> ***"A family physician would be someone you consider to be most responsible for your care and whom you could be comfortable coordinating complex health matters">***

[If yes, click verification/date stamp in EMR and save]

[*If no longer a patient, inactivate patient as per clinic process*]

Since it's been over 3 years since you last saw Dr. Z, I'd like to book you an appt at this time – our next available appt is ### does that work for you?"

If a patient confirms attachment to a primary provider, but chooses not to book follow-up, depending on a clinic's policies, they may be able to be verified in the EMR and remain on the panel. Some clinics may have specific policies around inactivating if they decline an appointment at this stage. Otherwise, these patients will continue to be called quarterly, until they present to the clinic.

4. **Apply Task/Worklist**. **"Time not in Clinic" outreach task/worklist** should be applied if:
    a. You reviewed the chart and there is clear communication that the patient has informed the clinic they have ended their relationship with the provider.
    b. You contacted the patient (even if you did not reach them)
    c. You created a worklist for another clinic team member to contact the patient.

Key Message:
Create, or update a worklist every time you are in a patient's chart. This is how you communicate with the clinic team, and how you document and track your work.

5. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run a report for the number of patients with the Adults worklist/tasks applied in the past week and enter that number in the appropriate date column. Once a physician's list has been completely reviewed, the running total should equal the baseline, as all patients have some outreach action performed (either updating their patient status, receiving a phone call, or having the process initiated for another team member to make the phone call).

Over 75 Years

Instructions:

1. **Run Baseline.** Enter the clinic total baseline, for all doctors, in the baseline section of the spreadsheet AND in the “Historical Data” section of this tab and inform the clinic IF of the new baseline.

	A	B	C	D	E	F	G	H	I	J	K	L
1			75+ and no visit in 1 year									
2	Doctor	Baseline:	Process: # of patients reviewed + contacted				Running		Historical data			
3		05-Apr-21	09-Apr-21	16-Apr-21	23-Apr-21	30-Apr-21	total		Date	PMA's doctors' baseline total		
4	Red	22	22	0	0	0	22		14-Dec-20	150		
5	Blue	12	0	12	0	0	12		01-Apr-21	56		
6	Green	7	0	7	0	0	7		01-Jul-21			
7	Yellow	2	0	2	0	0	2		01-Oct-21			
8	Brown	13	0	0	13	0	13		01-Jan-22			
9	Total	56	22	21	13	0	56					
10												
11	Each quarter, ensure previous quarter's baseline total is entered in "Historical data" and erase previous data - use same table for new data. Baseline total should decrease over time.											

2. **Check Netcare.** Prior to contacting patients aged 75+, you should review Netcare to ensure the patient is not deceased or in long term care. If your clinic is live on CPAR and you receive monthly demographic mismatch reports listing all deceased patients, you may skip this step. If the patient is deceased or in long term care, you can follow the clinic process to inform the physician and update the patient’s status in the EMR. Then, proceed to Step # 4.

   Netcare searches may be audited, and it is important for patient’s privacy that your search is limited to why you are in that patient’s chart. For this group, the Netcare areas you may search in include:

   Summary Reports: Care Plan Summary -Continuing Care

3. **Call Patient.** You will then contact these patients to confirm attachment and offer them an appointment. Screening results should not be reviewed unless the patient is reached, confirms attachment, and books an appointment. Many will have moved or have new providers and will be removed from the panel after being contacted.

Suggested script:

“Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic.

May I speak with Y?

Dr. Z asked me to follow up with you as s/he has not seen you in over a year. Can you confirm if Dr. Z is still your regular family doctor?

If yes, click verification/date stamp in EMR and save]

Dr. Z likes to see their patients every year, can I make you an appt at this time?"

[*If no, inactivate patient as per clinic process*]

4. **Apply Task/Worklist. "75+ Outreach" task/worklist** should be applied if:
    a. A Netcare review indicated that the patient is deceased or has moved to Long-Term Care, so they were removed from the panel.
    b. You contacted the patient (even if you did not reach them)
    c. You created a worklist for another clinic team member to contact the patient.
5. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run a report for the number of patients with the 75+ worklist/tasks applied in the past week and enter that number in the appropriate date column. Once a physician's list has been completed, the running total should equal the baseline, as all patients have some outreach action performed (either updating their patient status, receiving a phone call, or having the process initiated for another team member to make the phone call).

Chronic Disease

Instructions:

This tab tracks the care coordination of patients who have a diagnostic billing code for chronic disease (diabetes, hypertension, COPD, heart disease, or kidney disease) and have not presented to the clinic in one year or more. As clinics are already doing outreach for patients 75 years of age and over who have not presented to the clinic in one year or more, this chronic disease list can be limited to those under 75.

1. **Run Baseline.** Enter the clinic's total baseline for all doctors in the baseline section of the spreadsheet AND in the "Historical Data" section of this tab and inform the clinic IF of the new baseline.

	A	B	C	D	E	F	G	H	I	J
1		<75 + Chronic Disease* + No visit in 1 year							Historical data	
2	Doctor	Baseline:	Process: # of patients contacted				Running total		Date	PMA's doctors' baseline total
3		01-Feb-21	05-Feb-21	12-Feb-21	19-Feb-21	26-Feb-21			01-Nov-20	65
4	Red	5					0		01-Feb-21	30
5	Blue	6					0		01-May-21	
6	Green	4					0		01-Aug-21	
7	Yellow	3					0		01-Nov-21	
8	Brown	12					0			
9	Total	30	0	0	0	0	0			
10										
11	Each quarter, ensure previous quarter's baseline total is entered in "Historical data" and erase previous data - use same table for new data. Baseline total should decrease over time.									
12										

2. **Check Netcare.** These patients will benefit from a similar Netcare review as the 75+ group to update their charts if they are deceased or in long-term care. If your clinic is live on CPAR and you receive monthly demographic mismatch reports listing all deceased patients, you skip this step. If the patient is deceased or in long-term care, you can follow the clinic process to inform the physician and update the patient's status in the EMR. Then, proceed to Step # 4.

   Netcare searches may be audited, and it is important for patient's privacy that your search is limited to why you are in that patient's chart. For this group, the Netcare areas you may search in include:

   Summary Reports: Care Plan Summary -Continuing Care

3. **Call Patient.** You will then contact these patients to confirm attachment and offer them an appointment. Screening results should not be reviewed unless the patient is reached, confirms attachment, and books an appointment. Many will have moved or have new providers and will be removed from the panel after being contacted.

Please note that you are not booking a chronic disease management appointment. Although our EMR query identifies that the patient once received a diagnostic billing code associated with a chronic disease, the query is not specific enough to confirm that the patient currently has that chronic disease. You are just offering an annual check-up in your conversations with the patient.

Suggested Script:

"Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic.

May I speak with Y?

Dr. Z asked me to follow up with you as s/he has not seen you in over a year. Can you confirm if Dr. Z is still your regular family doctor?

[*If no, inactivate patient as per clinic process*]
[If yes, click verification/date stamp in EMR and save]

Dr. Z likes to see their patients every year, can I make you an appt at this time?"

4. **Apply Task/Worklist.** A **"Chronic Disease" task/worklist** should be applied if:
   a. A Netcare review indicated the patient is deceased or has moved to Long Term Care, and they were removed from the panel.
   b. You contacted the patient (even if you did not reach them)
   c. You created a worklist for another clinic team member to contact the patient.
5. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run a report for the number of patients with the Chronic Disease worklist/tasks applied in the past week and enter that number in the appropriate date column. Once a physician's list has been completed, the running total should equal the baseline, as all patients have some outreach action performed (either updating their patient status, receiving a phone call, or having the process initiated for another team member to make the phone call).

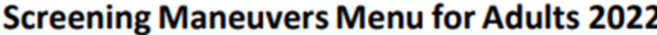
Screening Outreach

The Alberta Screening and Prevention Program (ASaP) is an evidence-based list of screens that males/females of certain ages should receive and at what time intervals (see figure on next page). These are guidelines for the general population. For example, every woman should receive a mammogram after the age of 45 years old, every 2 years until the age of 74. Different decisions may be made according to the physician's recommendations based on unique patient circumstances. For example, if a woman has a history of abnormal mammograms, the screening frequency may differ.

Regarding screening outreach, PCCAs will focus on preventative screening for the general population (ASaP guidelines below). This includes guidelines for three preventative cancer screens (cervical, breast, and colorectal screening) and two blood tests (lipids and diabetes). Your EMR-C will ensure that the outreach lists you work from are accurate.

asap-maneuvers-menu.pdf (albertadoctors.org)

To read more about the importance of preventative cancer screening, go to the Screening for Life website: Home - Screening For Life | Screening For Life



Screening Maneuvers Menu for Adults 2022

Alberta Screening and Prevention (ASaP)

Maneuver	Age (Years)	Interval General Population
Blood Pressure	18+	Annual
Height	18+	At least once
Weight	18+	3 years
Exercise Assessment	18+	Annual
Tobacco Use Assessment	18+	Annual
Influenza Vaccination	18+	Annual
Mammography*	45 -74	2 years
Colorectal Cancer Screen One of: FIT Flex Sigmoidoscopy Colonoscopy	 50-74 50-74 50-74	 2 years 5 years 10 years
Pap Test	25-69	3 years
Plasma Lipid Profile Non-Fasting	40-74	5 years
Cardiovascular Risk Calculation	40-74	5 years
Diabetes Screen One of: Fasting Glucose Hgb A1c Diabetes Risk Calculator	 40+ 40+ 40+	 5 years 5 years 5 years

Instructions:

1. **Run baseline.** The screening tab should include baselines for patients due for one of five preventative health screens: colorectal/breast/cervical cancer screening, plasma lipid profile, or diabetes screening. This baseline should only include unique patients – meaning that the 5 lists must be merged in the EMR (i.e., in Client List Manager for HealthQuest), or in a separate data program with duplicates removed (i.e., in Excel for Med Access).

   Some clinics with many patients due may add a time modifier to reduce the number of patients on this list (e.g., due for screening + has not had an appointment in 1 year, or due for screening + has not been billed for a complete medical exam in 1 year). As these lists become smaller, the time modifier will be decreased and then removed.

"Screening Reviewed" Column:

2. **Check Netcare.** Every time you are in a patient's chart for Screening Outreach purposes, confirm that preventative health screening information in the chart accurately reflects the most recent information available on Netcare. This includes results for patients who are eligible, according to the ASaP Maneuvers, for: mammogram, pap test, colorectal cancer screening, plasma lipid profile, and diabetes screening.

   If EMR chart information does not include the most recent information on Netcare, follow clinic process to update the EMR chart (i.e., importing results from Netcare, or updating chart template with results).

   Netcare searches may be audited, and it is important for patient's privacy that your search is limited to the reason you are in that patient's chart. For Screening, the Netcare areas you may search in include:

   Chemistry: For glucose fasting, HbA1c, Lipid panel, Fecal Immunochemical Test

   Diagnostic Imaging: For mammogram, breast ultrasound

   Pathology: For pap smear, colonoscopy, or flexible sigmoidoscopy

   Operative/Procedure/Investigations: For colonoscopy, flexible sigmoidoscopy, or total hysterectomy (only if pap smear results are not found)

3. **Call Patient.** Patient does not require a call if their screening is up to date as per the Netcare review.
4. **Apply Task/Worklist.** "**Screening Reviewed by PCCA" task/date stamp** should be applied if Netcare was reviewed– ***even if you do not change anything*.**
5. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, run the report for the number of charts reviewed for screening for each physician, and enter that number in the "Screening Reviewed" column of the excel sheet in the appropriate date column.

   - In the example below, on the week of February 13, 2023, the PCCA reviewed 10 charts on the Screening Outreach list for Dr. A (see the red box). The PCCA's "Screening Reviewed by PCCA" report at the end of the week showed 10 patients, and this was entered in the tracking sheet.

Preventative Screening (due for 1 of 5 screens) + no visit in 1 year						
Baseline	42		43		7	
Running Totals	Screening Reviewed	Outreach Calls	Screening Reviewed	Outreach Calls	Screening Reviewed	Outreach Calls
	42	20	43	20	7	2
Date	Enter # of patients contacted each week					
	Dr A		Dr B		Dr C	
	Screening Reviewed	Calls	Screening Reviewed	Calls	Screening Reviewed	Calls
13-Feb-23	10	5	0	0	7	2
20-Feb-23	12	5	43	8	done	
01-Apr-23	10	3	done			
08-Apr-23	10	7				
	done					

- Once a screening list has been completely reviewed, the "Screening Reviewed" Running Total should equal the Baseline of patients due for each physician. This is because all patients on this list have their charts reviewed for screening, even if nothing is updated. In Dr. A's example above, 42 patients were due for screening, and the PCCA reviewed 42 charts.

"Outreach Calls Column"

After reviewing each patient on the screening list (including a Netcare review), the PCCA will have determined if the patient is still due for screening and requires a phone call.

3. Call patient. In most cases, the PCCA will call patients who are due for screening and invite them for a screening appointment or offer a screening requisition. The PCCA will create a "Screening Outreach" task or worklist.

Suggested Script:

"Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic.

May I speak with Y?

Dr. Z asked me to follow up with you as s/he has not seen you in over a year. Can you confirm if Dr. Z is still your regular family doctor?

[If yes, click verification/date stamp in EMR and save]
I am reaching out to let you know that you are due for some routine preventative health screening (advise of test(s) due). Can I book you an appointment with the doctor and/or nurse to get your screening up to date? "

If yes, book an appointment as per the clinic process.

[*If no longer a patient, inactivate patient as per clinic process*]

4. Apply Task/Worklist. You can apply the **"Screening Outreach" task or worklist** even if you do not reach the patient but have left a voicemail.

The Screening Outreach task/worklist should only be applied once per patient, per rotation. If the patient returns the voicemail next week and this call is transferred to you, they will not be counted again. If you try to contact the same person again in 1 week, they will not be re-recorded. A recommended process is for PCCAs only to call patients once per rotation. Still, if the patient shows up again on your new outreach list at a subsequent rotation, they may be counted again by updating the previous task/worklist, as per the clinic's process.

5. Run Task/Worklist Report for Tracking Sheet. At the end of the week, run the report for the number of charts with the Screening Outreach task/worklist completed for each physician, and enter that number in the "Calls" in the appropriate date column of the Excel spreadsheet.

In the example below, on the week of February 13, 2023, although the PCCA reviewed 10 charts on the Screening Outreach list for Dr. A, only 5 patients required Screening Outreach calls (see the red box). The other 5 patients may have completed screening elsewhere (as identified by a Netcare check), and the PCCA would have updated their charts accordingly. The PCCA's "Screening Outreach" report at the end of the week showed the 5 patients who were called, and this was entered in the tracking sheet.

	Preventative Screening (due for 1 of 5 screens) + no visit in 1 year					
Baseline	42		43		7	
Running Totals	Screening Reviewed	Outreach Calls	Screening Reviewed	Outreach Calls	Screening Reviewed	Outreach Calls
	42	20	43	20	7	2
Date	Enter # of patients contacted each week					
	Dr A		Dr B		Dr C	
	Screening Reviewed	Calls	Screening Reviewed	Calls	Screening Reviewed	Calls
13-Feb-23	10	5	0	0	7	2
20-Feb-23	12	5	43	8	done	
01-Apr-23	10	3	done			
08-Apr-23	10	7				
	done					

Example:

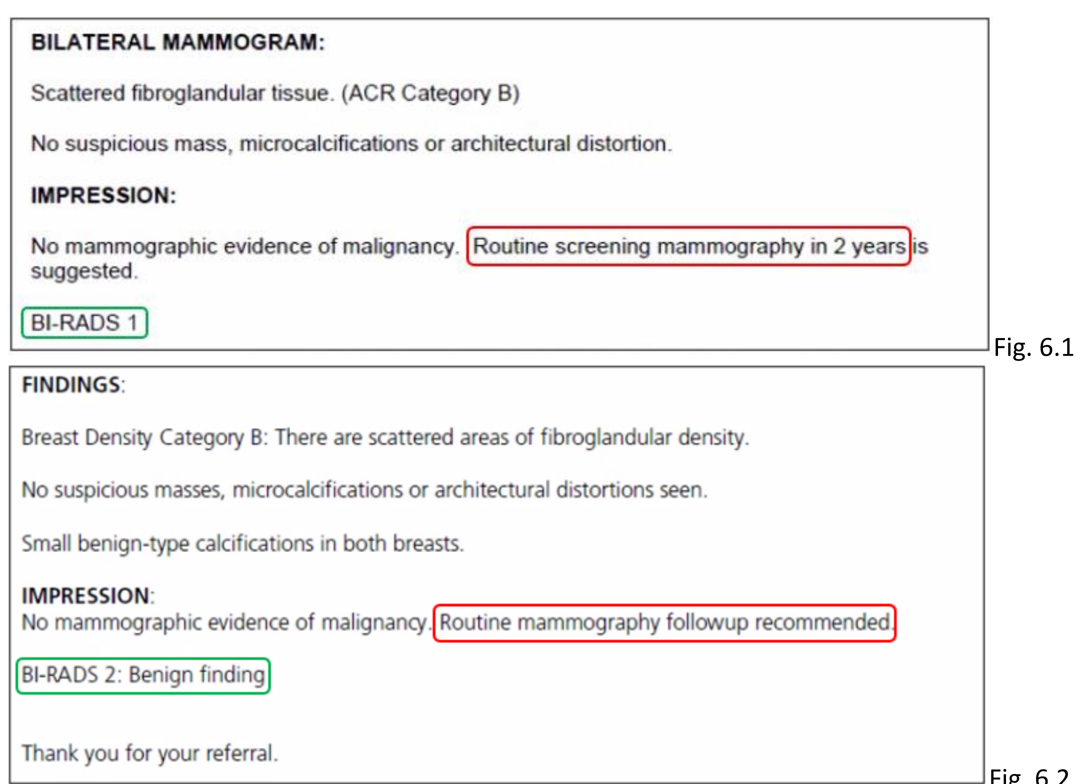
If a patient on your baseline list shows as due for a pap test, but you see in Netcare that a pap test was done within the past 3 years, with normal results, you will follow your clinic's process to update the EMR with those results. If the patient is not due for any additional screening/follow-up, they do not need to be contacted, and so will not be counted in the outreach "Calls" column. Your work reviewing their chart will still be counted in the "Screening Reviewed" column.

If, instead, you do not find external results and contact the patient to book an appointment, the patient will show up **both** in the "Screening Reviewed" column (because you have reviewed their chart and confirmed information matches what is on Netcare) and the "Calls" column (because you have contacted the patient and applied the Screening Outreach worklist/task).

Reviewing Screening Results

Most screening results are normal, meaning the patient's result falls within the recommended guidelines for the general population and they do not require any follow up or additional screening until they are due again. However, some patients would need further tests or urgent follow ups due to the nature of their results. This chapter enables the PCCA to make guided decisions based on the patient's test result.

Reviewing Mammogram Results



BILATERAL MAMMOGRAM:

Scattered fibroglandular tissue. (ACR Category B)

No suspicious mass, microcalcifications or architectural distortion.

IMPRESSION:

No mammographic evidence of malignancy. Routine screening mammography in 2 years is suggested.

BI-RADS 1

Fig. 6.1

FINDINGS:

Breast Density Category B: There are scattered areas of fibroglandular density.

No suspicious masses, microcalcifications or architectural distortions seen.

Small benign-type calcifications in both breasts.

IMPRESSION:
No mammographic evidence of malignancy. Routine mammography followup recommended.

BI-RADS 2: Benign finding

Thank you for your referral.

Fig. 6.2

- All mammogram reports should have recommendations (in a red box above) and ***Breast Imaging Reporting and Data System* (BI-RADS)** score (in a green box above). *See Figs. 6.1 and 6.2 above.*
- BI-RADS Scores range from 0 to 6. The higher the score, the more probable the finding is cancer. The BI-RADS scores are interpreted as follows:
    - **BI-RADS 0 –** Incomplete test: There is not enough information yet to complete the process. Usually, the radiologist would ask for a breast ultrasound (or another test in rare cases).
    - **BI-RADS 1** - Negative test – No follow-up needed. Routine screening is usually recommended.
    - **BI-RADS 2** - Non-cancer finding: Something was found but radiologist is 'certain' it is not cancer. No follow-up needed. Routine screening is usually recommended.
    - **BI-RADS 3** - Probably not cancer: There is up to **2% chance** of being cancer. 6-month follow-up mammogram is usually recommended.
    - **BI-RADS 4** - Suspicious abnormality – up to **30% chance** of being cancerous. Patient needs a biopsy.
    - **BI-RADS 5** - Highly suggestive of breast cancer. $\geq$ **95% chance** of being cancerous. Patient needs a biopsy. Most likely, physician would have already referred for specialist care alongside biopsy.
    - **BI-RADS 6** - Known biopsy with proven cancer: This is used for patients with known breast cancer confirmed with biopsy. Patient is most likely being followed by specialists.

Sources:

BIRADS 2 3 4 and 5: What does it mean? (breast-cancer.ca)

BI-RADS Score: Understanding Your Mammogram Results (healthline.com)

BI-RADS SCORE	RECOMMENDED ACTION FOR PCCAs
0	Check to see if patient has already had a breast ultrasound. If not, send task to physician.
1	No Action Needed – Continue with usual screening outreach process for patient. Call patient or send requisition depending on clinic process.
2	No action needed – Continue with usual screening outreach process for patient. Call patient or send requisition depending on clinic process.
3	If test ordered outside of clinic, send task to primary physician.
4	If test ordered outside of clinic, send task to primary physician.
5	If test ordered outside of clinic, send task to primary physician. Most likely, patient is being followed by specialist.
6	Most likely, patient is being followed by specialist. Send task to physician if mammogram was ordered outside of clinic.

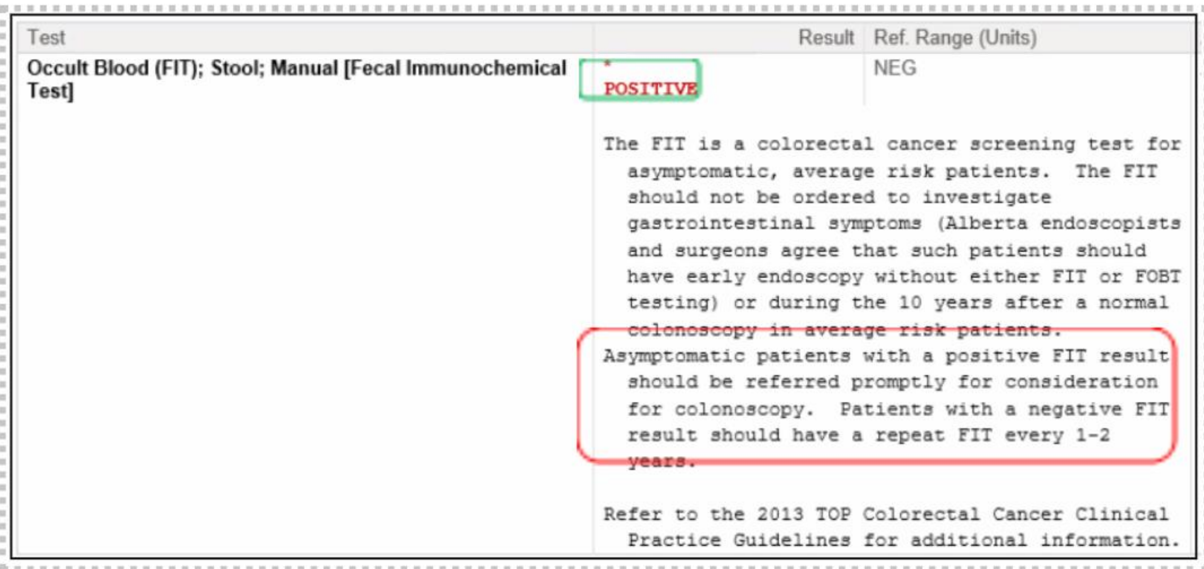
SOMETHING TO NOTE:

- In most cases the recommendations tally with the BI-RADS SCOREs. If this is not the case, please go with the recommendations. However, if the BI-RADS score suggests a higher cancer risk than the recommendation, action on the BI-RADS score.

Reviewing Fecal Immunochemical Test (FIT), Colonoscopy and Flexible Sigmoidoscopy Results

Fecal Immunochemical Test (FIT)

- Most patients are offered the FIT as the first colorectal cancer screening test.
- FIT results are reported as 'Negative' or 'Positive.' See Fig 6.3. A positive/abnormal result means there was blood identified in the stool. All positive FIT results require a follow-up colonoscopy investigation. 3% of positive FIT results in Alberta will lead to a diagnosis of colorectal cancer.[2]



Test	Result	Ref. Range (Units)
Occult Blood (FIT); Stool; Manual [Fecal Immunochemical Test]	* POSITIVE	NEG

The FIT is a colorectal cancer screening test for asymptomatic, average risk patients. The FIT should not be ordered to investigate gastrointestinal symptoms (Alberta endoscopists and surgeons agree that such patients should have early endoscopy without either FIT or FOBT testing) or during the 10 years after a normal colonoscopy in average risk patients.
Asymptomatic patients with a positive FIT result should be referred promptly for consideration for colonoscopy. Patients with a negative FIT result should have a repeat FIT every 1-2 years.

Refer to the 2013 TOP Colorectal Cancer Clinical Practice Guidelines for additional information.

Fig 6.3

Colonoscopy and **Flexible Sigmoidoscopy**

i. **Colonoscopy** is done,

a. As a follow-up to a positive FIT to rule out cancer.
b. As the screening test of choice for colorectal cancer if patient has an elevated risk for colorectal cancer, e.g. If a family member was diagnosed with colorectal cancer.
c. To diagnose other diseases of the large intestines which may or may not relate to cancer.

ii. **Flexible sigmoidoscopy** is like colonoscopy. The only difference is that sigmoidoscopy is used to evaluate only the lower part of the large intestine unlike colonoscopy which evaluates the entire large intestine.

When reviewing Colonoscopy results, look for recommendations (in the red box above) and findings (in the green box above) under the "<u>Impression and Plan</u>" OR "<u>Postoperative diagnosis</u>" section of the report. See examples: Figs. 6.4, 6.5 and 6.6

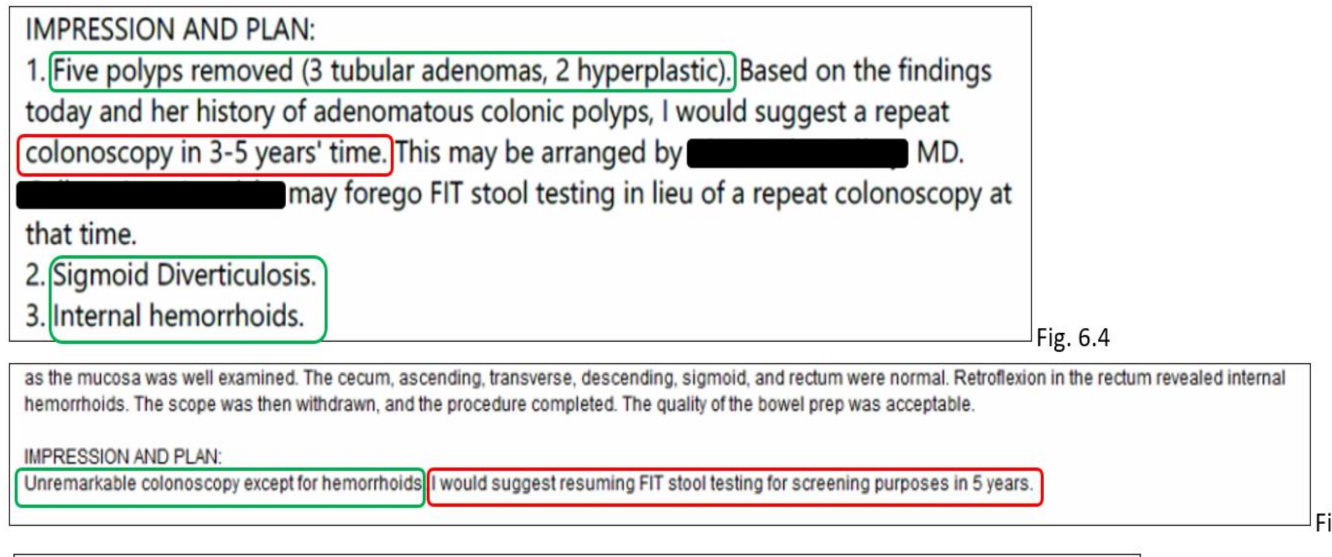

IMPRESSION AND PLAN:
1. Five polyps removed (3 tubular adenomas, 2 hyperplastic). Based on the findings today and her history of adenomatous colonic polyps, I would suggest a repeat colonoscopy in 3-5 years' time. This may be arranged by [redacted] MD. [redacted] may forego FIT stool testing in lieu of a repeat colonoscopy at that time.
2. Sigmoid Diverticulosis.
3. Internal hemorrhoids.

Fig. 6.4

as the mucosa was well examined. The cecum, ascending, transverse, descending, sigmoid, and rectum were normal. Retroflexion in the rectum revealed internal hemorrhoids. The scope was then withdrawn, and the procedure completed. The quality of the bowel prep was acceptable.

IMPRESSION AND PLAN:
Unremarkable colonoscopy except for hemorrhoids I would suggest resuming FIT stool testing for screening purposes in 5 years.

Fig 6.5

POSTOPERATIVE DIAGNOSIS:
1. Two polyps identified and removed. One was adenomatous. Based on the findings today, I suggest a repeat colonoscopy in 5 years' time. This maybe arranged by [redacted] through my office and I would be happy to see her again at that time. She may forego FIT stool testing in lieu of a repeat colonoscopy at that time.
2. Extensive colonic diverticulosis.
3. Internal hemorrhoids which explains the positive FIT stool test.

Fig. 6.6

Colonoscopy / Sigmoidoscopy: Results and usual recommendations

[1]The usual colonoscopy or sigmoidoscopy findings are interpreted as follows:

1. Normal/unremarkable/negative – This means that no abnormality was found. <u>Routine screening every 10 years (colonoscopy) or 5 years (sigmoidoscopy), ***or*** a resumption of FIT is recommended.</u>

2. Hemorrhoids*:* Up to 33% of all positive FIT results[3] are due to hemorrhoids. This is noncancerous. <u>Routine screening every 10 years (colonoscopy) or 5 years (sigmoidoscopy), ***or*** a resumption of FIT is recommended.</u>

3. Diverticula *(Singular: Diverticulum)* / Diverticulosis / Diverticulitis: This is noncancerous but will require treatment. <u>Recommendations vary, and usually depend on severity, patient symptoms, and other factors. In most cases, a 5-year repeat colonoscopy is recommended.</u>

4. Polyps: Polyps are abnormal growths that project into the large intestine from the wall of the intestine. When they are present, the surgeon would usually remove them for biopsy. Colonoscopy is usually repeated in 3-5years. There are two types of polyps:
   a. Hyperplastic / inflammatory polyps (pseudopolyps): These are benign (noncancerous) polyps.
   b. Adenoma: This type of polyp has about 5% chance[4] of becoming cancerous in the future.
5. Adenocarcinoma: This means the patient has cancer. The patient is most likely being treated and followed by a specialist.

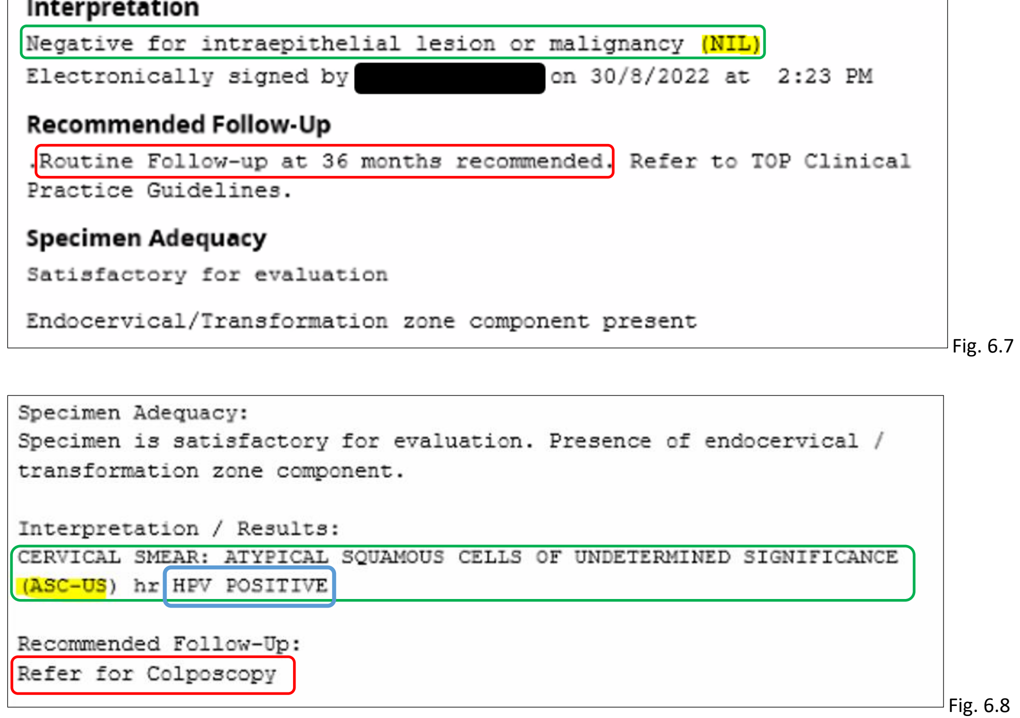
Recommended Actions for PCCAs, based on test results.

TEST	FINDING	Recommended Action for PCCA
FIT	Negative	Continue routine screening every 1-2 years depending on clinic process.
	Positive	If colonoscopy has not been done already, and test was ordered outside of clinic, send task to physician.
Colonoscopy OR Flex Sigmoidoscopy	Normal	Act on recommendation ***or*** continue routine screening every 10 years (if colonoscopy) or 5 years (if sigmoidoscopy).
	Hemorrhoids	Act on recommendation ***or*** continue routine screening every 10 years (if colonoscopy) or 5 years (if sigmoidoscopy).
	Diverticular Disease	If test was ordered outside of clinic, send task to physician.
	Polyps	If test was ordered outside of clinic, send task to physician.
	Adenocarcinoma	If test was ordered outside of clinic, send task to physician.

Sources:
[1]Understanding the results of your colonoscopy - Harvard Health
[2]AHS Yet-to-be-published study.
[3]Are Hemorrhoids Associated with False-Positive Fecal Immunochemical Test Results? - PubMed (nih.gov)
[4]They found colon polyps: Now what? - Harvard Health

Reviewing Pap Test Results

- The Pap test is offered as the screening test of choice for cervical cancer in women. [1]It is done to look for changes in the cells of the cervix, which may suggest early signs of cancer or established cancer of the cervix.
- When reviewing a Pap test result, look for the result under '**Interpretation'** and the recommendations under **Recommended follow-up**. Some patients may also have an HPV done with Interpretation. See Figures 6.7 – 6.9



Interpretation
Negative for intraepithelial lesion or malignancy (NIL)
Electronically signed by [redacted] on 30/8/2022 at 2:23 PM

Recommended Follow-Up
.Routine Follow-up at 36 months recommended. Refer to TOP Clinical Practice Guidelines.

Specimen Adequacy
Satisfactory for evaluation

Endocervical/Transformation zone component present

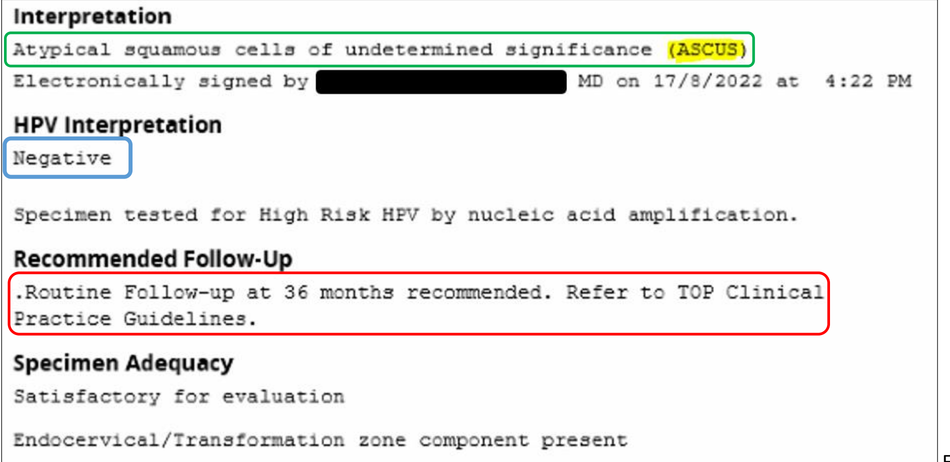
Fig. 6.7

Specimen Adequacy:
Specimen is satisfactory for evaluation. Presence of endocervical / transformation zone component.

Interpretation / Results:
CERVICAL SMEAR: ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE (ASC-US) hr HPV POSITIVE

Recommended Follow-Up:
Refer for Colposcopy

Fig. 6.8



Interpretation
Atypical squamous cells of undetermined significance (ASCUS)
Electronically signed by [redacted] MD on 17/8/2022 at 4:22 PM

HPV Interpretation
Negative

Specimen tested for High Risk HPV by nucleic acid amplification.

Recommended Follow-Up
.Routine Follow-up at 36 months recommended. Refer to TOP Clinical Practice Guidelines.

Specimen Adequacy
Satisfactory for evaluation

Endocervical/Transformation zone component present

Fig. 6.9

Pap Test: Results and usual recommendations

[2]Pap test results are reported with distinct descriptions based on the Bethesda reporting system. The most common findings and recommendations are as follows:

1. Negative for intraepithelial lesion or malignancy (NILM): This means the test was normal. Routine screening is usually recommended. If the patient had a previous abnormal test, a repeat testing every 6 months or 1 year may be recommended.
2. Atypical squamous cells of undetermined significance (ASC-US): [4]5-17% will have HSIL (see point #4). 0.1% to 0.2% of all ASC results will lead to a diagnosis of cancer. Depending on the age of

the patient and HPV results, a referral for colposcopy, a repeat Pap testing or routine screening may be recommended.

3. Atypical squamous cells; cannot rule out high-grade squamous intraepithelial lesion (ASC-H): [3]A referral for colposcopy is usually recommended. [4]24-94% of ASC-H results will have HSIL. 0.1% to 0.2% of all ASC results will lead to a diagnosis of cancer.
4. Atypical glandular cells (AGC): [3]A referral for colposcopy is usually recommended.
5. Low-grade squamous intraepithelial lesion (LSIL): [3]Depending on the age of the patient, and HPV results, a referral for colposcopy, a repeat Pap testing or routine screening may be recommended.
6. High-grade squamous intraepithelial lesion (HSIL): [3]A referral for colposcopy is usually recommended.
7. Cancers: When these are reported, it means the patient has cancer. The patient is most likely being treated and followed by a specialist. The common cancers are Squamous cell carcinoma and Adenocarcinoma in-situ. There may be other cancers as well.
8. Inadequate Sample: In a few cases, the result of a Pap Test may be reported as 'inadequate sample.' A repeat Pap test is usually recommended after 3 months[3] when the sample is inadequate for processing.

Pap tests after hysterectomy

Hysterectomy is the surgical removal of the uterus (womb). In most cases, the uterus is removed together with the cervix (total hysterectomy) or the cervix is left behind (partial hysterectomy). Patients who have had a total hysterectomy may no longer need Pap testing. This is true if the reason for the hysterectomy was benign (non-cancerous). If the uterus was removed due to cancer, the patient may need on-going 'Pap' testing, but the recommended interval will be specific to the patient. If the hysterectomy was partial, the patients would need ongoing pap testing just like a regular patient.

Sometimes physicians do not specify in the patient chart if a hysterectomy was partial or total. So, you may find a few patients on your list of patients due for hysterectomy who have 'Hysterectomy' documented in their chart.

1. If you find that a patient who is due for Pap has 'Hysterectomy' documented in their chart: Send a task (or worklist) to the RN - if there is one in the clinic - or to the physician to:
    a. Clarify if the hysterectomy was 'total.'
    b. Find out if the patient needs another Pap test.
2. If you find that a patient who is due for Pap has hysterectomy documented on Netcare:
    a. Document in approved area in chart.
    b. Send task to physician and wait for response before taking any action.

Recommended Actions for PCCAs, based on test results.[3]

PAP TEST RESULT (CODE)	RECOMMENDED ACTION FOR PCCA

NIL(M)	Act on recommendation ***or*** continue routine screening every 3 years.
ASC-US (ASCUS)	If test was ordered outside of clinic, send task to physician.
ASC-H	If test was ordered outside of clinic, send task to physician.
AGC	If test was ordered outside of clinic, send task to physician.
LSIL	If test was ordered outside of clinic, send task to physician.
HSIL	If test was ordered outside of clinic, send task to physician.
AIS, SCC, other cancers	If test was ordered outside of clinic, send task to physician.
Inadequate Sample	If test was ordered outside of clinic, send task to physician or RN depending on who requested the test.
Hysterectomy on chart	Send task to physician: Clarify if patient needs ongoing Pap testing.
Hysterectomy not on chart, but on Netcare:	- Document in approved section in the patient chart as determined by QI team and approved by physician. - Send task to physician.

Sources:

[1]Pap Test (alberta.ca), [2]How to read your Pap test report | MyPathologyReport.ca, [3]cervical-cancer-screening-cpg.pdf, (albertadoctors.org), [4]ASCUS (jhmi.edu)

Brief Preventative Screening Descriptions

A patient may ask for more information about what screening they are due for. It is important not to go into clinical details beyond the scope of your role, however the below simple screening descriptions can be used. If the patient has more specific questions, please ask them if it would be OK for the registered nurse to call them back to explain.

Screening Mammogram: is recommended every 2 years for women between 45-74 years of age, and is the best way to find breast cancer when there are no noticeable breast problems or symptoms.

Fecal Immunochemical Test (FIT): is a home stool (poop) test that looks for blood in the stool. There can be many reasons that blood may be found in the stool, including colorectal cancer.

Pap test: is the main screening test for cervical cancer. It checks the cells of your cervix to make sure there are no abnormal cells – abnormal cells can change over time and become cancerous without pain or symptoms. It completed in the clinic.

Diabetes Screening: is recommended every 5 years for people over 40 years of age and involves a blood sample at the lab.

Plasma Lipid Profile: is bloodwork that examines your cholesterol levels and is recommended every 5 years as part of preventative cardiovascular disease screening.

Screening Requisition Protocol

At select clinics, you may be able to provide preventative screening requisitions (mammogram, FIT, lipids, and/or diabetes) to the patient on behalf of the physician. The IF will present and discuss this option, and interested physicians will sign the protocol sheet, permitting you to order specific requisitions in their name. This sheet must be signed before you proceed with providing requisitions.

ESPCN PCCA REQUISITION PROTOCOL

Proactive Care Coordination Assistants (PCCAs) at the Edmonton Southside Primary Care Network (ESPCN) can identify patients who require health screening and prepare and offer routine requisitions, at the discretion of physician members by following evidence-based guidelines and an ESPCN-established process:

- PCCAs determine the test is appropriate by reviewing eligibility criteria outlined in the Alberta Screening and Prevention guidelines.
- PCCAs only offer screening requisitions to patients who have had at least one result in the past and the most recent result was normal. This is done by reviewing the patient's clinic chart and the provincial electronic health record (Netcare).
- PCCAs adhere to a follow-up procedure, to confirm patients provided requisitions have completed the test, and results have been received in the EMR.

PCCAs ask an additional health screening question for the FIT and Mammogram tests (see below). If the patient responds "yes" or is unsure, the PCCA will book an appointment with the physician. If the patient replies "no", the PCCA will provide the requisition.

FIT: *Do you have any new or unusual changes to your bowel habits?*

Mammogram: *Do you have any new or unusual changes to your breasts?*

Authorization:

I ____________________ (physician name) authorize the following requisitions to be prepared by my ESPCN PCCA. This will remain in effect until revoked.

✓	Requisition:	Restrictions (if any):
	Fecal Immunochemical Test (FIT)	
	Screening Mammogram	
	Diabetes screening (specify FBG or HBGA1C)	
	Plasma Lipid Profile Non-fasting	

Signed: ________________________ Date: ________________________

There are a few key points to consider when reviewing the requisition protocol:

- The **first time** a patient requires mammogram, FIT, lipids, or diabetes screening, they are booked with a physician or RN.
- PCCAs can only provide requisitions to patients who have completed a mammogram, FIT, lipids and/or diabetes screening **at least once** and whose **last result was normal**. Any patient whose most recent result was outside of the 'normal' parameters cannot be provided a requisition by the PCCA and requires an appointment to see the RN or physician.
- If you're using a time modifier while generating these lists, a requisition tracking process will be developed and used in the clinic to ensure that all requisitions provided are followed up on. This tracking will be included in the weekly tracking sheet.
- If you are not using a time modifier while generating these lists, the requisition process will be part of your regular screening outreach tracking.

Prior to offering the patient a mammogram or FIT requisition, health screening questions must be asked, and the answer must be documented in the worklist.

Mammogram Requisition Protocol - script

"A screening mammogram is recommended every 2 years for women between 45-74 years of age, and it is the best way to find breast cancer in those who do not have any noticeable breast problems or symptoms. I may be able to provide you with a requisition for you to get this done, but first, I need to confirm that you do not have any new or unusual changes in your breasts.

If the patient is unsure what this means, you can expand to include examples:

“a new lump in the breast or armpit; a nipple that is pointed inward; crusting, bleeding or a rash on the nipple; fluid coming out of the nipple; dimpling or thickening of the skin in one area of the breast?”

If the patient answers ‘YES there are changes’, book an appointment with the physician (state the reason in notes)

or

If the patient answers ‘NO, there are no changes,’ then according to the clinic process, the PCCA can either fax the requisition(s) to the facility of the patient’s choice or have the patient pick it up at the clinic.

“Dr. X would like you to complete this screen within the next month (adjust time as needed). You can find further information on health screening on the screeningforlife.ca website.”

If the patient declines, inform the patient we will call them again in 3 months.

FIT Requisition Protocol - script

“A FIT is used to screen for colorectal cancer by checking for traces of blood in your stool. I may be able to provide you with a lab requisition, but first, I need to confirm that you are eligible for this health screen. I may be able to provide you with a requisition to get your FIT test done but first, need to ask you two screening questions.

Have you had any new or unusual changes to your bowel habits?”

If the patient is unsure what this means, you can expand to include examples:

“bowel symptoms can include rectal bleeding or blood in your stool, new or worsening pain in your abdomen, losing weight and you don’t know why or a change in bowel habits (narrow or ribbon-like stools, frequent diarrhea or constipation).”

“Have you had a colonoscopy in the past 10 years?”

If the patient is unsure what this means, you can explain:

“A colonoscopy is a procedure where a doctor uses a flexible tube with a camera to look inside your colon”

If the patient answers “YES” to either question, book an appointment with the physician (state the reason in notes)

or

If patient answers “NO” to both questions, then according to the clinic process, the PCCA can either fax the requisition(s) to the facility of the patient’s choice, or the patient can pick up the requisition at the clinic.

“You will pick up the FIT kit at the lab and then complete the test at home. Dr. X would like you to complete this test within the next month (adjust time as needed). You can find further information on health screening on the screeningforlife.ca website.”

If the patient declines, inform the patient we will call them again in 3 months.

Leaving the patient a phone message- script

“Hello, this message is for [patient’s name]. I’m calling from Dr. (Dr name)’s office at (Clinic’s name). This is **not** an urgent message, just a routine reminder call. Please call the clinic back when you have time at (phone number). Again, nothing urgent, and we look forward to hearing from you.”

Update EMR with notes, e.g., left message/date and reason (e.g., patient due for (Mammo, etc), book for screening appointment).

CPAR Conflicts

Instructions:

Many ESPCN doctors are enrolled in CII/CPAR. CPAR is a central registry where patient lists of all enrolled physicians are automatically uploaded from EMRs every month. In many of these clinics, the PCCA is registered as a Panel Administrator, allowing access to a database outside the EMR. The PCCA can then download Conflict Lists, which are patients on their provider’s EMR panel, who are also listed on the panel of another CPAR provider.

In most cases, PCCAs will contact Conflict Patients, confirm attachment, and either inactivate them in the EMR if they confirm attachment to the other provider, or verify them and send a letter to the conflict provider. Individual clinic processes on how to manage these lists, and which patients to initially call, will differ for each clinic and the IF will advise accordingly.

Once the PCCA is registered as a Panel Administrator, before starting work on Conflict Reports, the PCCA will complete **CII CPAR: Go-Live and Beyond** training modules. This can be coordinated with the PCCA Lead and the IF.

1. **Enter Baseline.** Enter the clinic total baseline, for all doctors, in the baseline section of the spreadsheet AND in the "Historical Data" section of this tab and inform the clinic IF of the new baseline.

	A	B	C	D	E	F	G	H
1	**CPAR - Conflict reports**							
2	**Doctor**	**Baseline**	Process: # of patients reviewed + **contacted**		Running total		Historical Data	
3		02-Mar-24	05-Mar-24	12-Mar-24				**Total on list**
4							**2023-09-01**	**269**
5	Dr. Green	112	80	32	112		**2023-12-02**	**200**
6	Dr. Yellow	8	0	8	8		**2024-03-02**	**150**
7	Dr. Red	30	0	30	30			
8	**Total**	150	80	70	150			

2. **Call Patient.** You will then contact these patients to confirm attachment.

Suggested Script:

"Good morning/afternoon, my name is X, and I am calling from the Edmonton Southside Primary Care Network on behalf of Dr. Z from A Medical Clinic."

"May I speak with Y?"

"I am reaching out to you because you have two doctors listed as your primary providers: Dr. Z, here at A Medical Clinic, and [Conflict Doctor] at [Conflict Clinic]. Can I confirm which doctor you consider to be your main family doctor?"

- If the patient confirms the conflict doctor is their primary provider, inactivate them as per clinic process. Then continue:

  "I have updated our records so you are no longer listed as a patient of Dr. Z's. No further action is required on your part. Thank you for your time and have a good day!"

- If the patient confirms it is the doctor at the clinic you are calling from, click verification/date stamp in EMR and save. Then continue:

  "Thank you. I have confirmed you consider Dr. Z to be your family doctor. I will be reaching out to [conflict doctor] at [conflict clinic] to let them know your decision, so you can be removed from their list. Is that okay with you?

- If the patient confirms this is okay, follow your clinic process to send a saved EMR letter template to the conflict provider, informing them that the patient is attached to your clinic's provider, and asking them to inactivate the patient on their end.

In some cases, the patient may want to keep both providers. Your IF will review this scenario with you and any clinic/physician-specific processes.

3. **Apply Task/Worklist.** A **"CPAR Conflict" task/worklist** should be applied if:
    a. You contacted the patient (even if you did not reach them)
    b. You created a worklist for another clinic team member to contact the patient.
4. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run a report for the number of patients with the CPAR Conflict task/worklists applied in the past week and enter that number in the appropriate date column. Once a physician's list has been completed, the running total should equal the baseline, as all patients have some outreach action performed. In some clinics, additional data may be collected, such as tallying the number of patients who confirmed attachment, or the number of letters faxed to the conflict providers. Your IF will advise accordingly.

Suggested Script for Leaving a Message for all outreach:

*"Hello, this message is for [patient's name]. This is Dr. Z's office calling. This is **NOT** an urgent message, just a routine reminder call. Please call the clinic back when you have time at (phone number), again the telephone number is (phone number). Again, nothing urgent, and we look forward to hearing from you."*

**Leave task/worklist open with instructions for front staff

Macros/Auto Completes for Worklist/Tasks

If you cannot reach a patient and/or leave a message for the patient, they may call the clinic back. The front staff must have enough information in the chart to help the patient. This is why always using a task/worklist when working on a patient's chart is essential.

One option is to connect with your IF about building macros or auto-completes within your EMR for standardized messages. Below are some examples.

Macro	Replace Text
NA	No answer/no voicemail. If patient calls back, please confirm that Dr. X is still their family doctor, confirm contact information, click the verification box, and book an appointment.
LM	Left message (first attempt). If patient calls back, please confirm that Dr. X is still their family doctor, confirm contact information, click the verification box, and book an appointment.
NIU	Number not in use. If patient calls back, please confirm that Dr. X is still their family doctor, confirm contact information, click the verification box, and book an appointment.

WN	Wrong number. If patient calls back, please confirm that Dr. X is still their family doctor, confirm contact information, click the verification box, and book an appointment.
BA	Booked appointment

In most clinics, the worklist/task should not be completed until the patient is reached. By staying open, the front reception has some information on how to proceed when the patient calls back.

At each rotation, filter your tasks/worklists so you can respond to any communication from clinic team members. You are not required to otherwise review your own tasks/worklists. It is the responsibility of the clinic team to close your worklists if the patient calls back, and not part of your role to close worklists left open.

Access

In your work, you will find that some physicians have more timely appointments than others. A clinic has good access when patients can get in to see their doctor when they need to. When patients cannot access their doctor, they may go to a walk-in clinic or Emergency Department. Seeing someone other than their family physician causes a break in the continuity of care. It is always best when a patient can seek care from their medical home where their physician and team know their whole story and can direct care accordingly.

We know that being able to see your family doctor in a timely manner is important for patient health outcomes. To support this, the IF can recommend certain strategies that could improve patients' access to their physicians. If you notice that it is difficult to book appointments for patients because there are a limited number of appointments available or the appointments are so far into the future, please let your IF know. There may be some improvements that can be made.

Third Next Available (TNA)

One measure of access that you will be responsible for collecting is the Third Next Available appointment (TNA). The ESPCN Evaluation Manager will review how to calculate the TNA and the steps involved in inputting this information into Perform PCN, our reporting database.

Reporting Third Next Available Q & A:

What is Third Next Available (TNA)?

TNA is "the number of calendar days between the day a patient makes a request for an appointment with a physician and the third open appointment in the schedule for a physical, routine or return visit exam." TNA is used, rather than the first or second, because it is a better reflection of availability; the first or second next available appointment may be available due to a cancellation or some other unpredictable event.

Why is TNA important to measure?

Delay for appointments has a negative impact on continuity of care between physician and patient. When a patient cannot receive timely access to care from his/her own doctor and is forced to seek care elsewhere, their family doctor may not receive all the information to manage their care. If the patient instead decides to wait for care, their health could get worse.

Knowing the delay for patients to see the provider is the critical first step to improving access.

Which providers do we collect TNA?

PCCAs collect TNA weekly for all physicians during their rotations at a clinic. This is collected each week of each rotation, even if it is not the quarter that TNA reports are generated in.

How do I calculate TNA?

Open schedule.
Determine the length of your shortest appointment slot offered. Longer appointments are comprised of multiples of these building blocks- for example, an annual physical exam may be booked for 30 minutes or 3 10-minute blocks.

Pretend you just received a call from a patient to book an appointment with a provider. Look at when the third next available empty building block in the schedule is (it does not matter who is calling or for what kind of appointment).

To find the TNA count the number of calendar days from a selected data collection day to the day when the third next appointment (building block) is available.

This includes Saturdays and Sundays even if the clinic is not open.

What day should I use?

Collect data on the same day at the same time each week. Consistency is important; however, this is only a target. The more consistent = better data.

Do I collect every week during my rotation?

Yes, TNA is collected regardless of circumstances at the clinic- for example, events, holidays, etc. Patient perspective is critical, as we must see the delay as it is experienced from the patient point of view. Therefore, when counting TNA, we count all calendar days including those that the clinic is closed due to weekends or holidays.

Can I see an example?

Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon

	05-Nov-18	06-Nov-18	07-Nov-18	08-Nov-18	09-Nov-18	10-Nov-18	11-Nov-18	12-Nov-18
9-930	BP	Physical	Diabetes	Diabetes	Diabetes			Asthma
930-10	Prenatal	Asthma	Diabetes	Prenatal	**NOT BOOKED**			Prenatal
10-1030	Well baby	**NOT BOOKED**	Prenatal	**NOT BOOKED**	Prenatal			**NOT BOOKED**
1030-1100	Toe	Dressing	Short of breath	Physical	Dressing			Well baby
1100-1130	Nursing Home	Physical	Well baby	Dressing	Diabetes	**CLOSED**	**CLOSED**	Dressing
1130-1200	Dressing	Prenatal	Prenatal	Prenatal	Prenatal			Prenatal
1200-1230	Back pain	Diabetes	Physical	Asthma	Well baby			Physical
1230-100	F/U	F/U	F/U	F/U	F/U			F/U
100-130	Diabetes	Asthma	Diabetes		Diabetes			Well baby
130-200	F/U	F/U	F/U	F/U	F/U			F/U
200-230	Prenatal	Prenatal	Prenatal	Prenatal	Prenatal			Prenatal

Jane does the count on Tuesday (Nov 6) at 10:30

- 1st Next Available appointment- Thursday Nov 8 (10-1030)
- 2nd Next Available appointment- Friday Nov 9 (930-100)
- 3rd Next Available appointment- Mon Nov 12 (10-1030)

The 3rd next available appointment= 12 (Nov 12) minus 6 (Nov 6) = 6 days

Always record the time to the third next available appointment. If the third next available appointment is on the same day 0 days is recorded.

What if the clinic has ‘carve out’ appointment slots?

Some providers may “carve out” (hold) chunks of time in their calendar. Carve outs are appointments held for specific kinds of patients or clinical needs. For purposes of TNA reporting these holds are not counted as they are in essence being held for specific circumstances and can only be filled for and by the identified specific need. Examples of carve outs: procedures, physicals, paediatric patients, and for urgent concerns or for walk in patients.

What if the provider is part-time?

TNA can be collected for part time physicians with the understanding that values will typically be larger (longer delay) due to the very nature of them only being present in the clinic on predesignated days. However, improvements to access can be made no matter what the physician full time equivalent may be based on appropriate panel size and other principles of

access improvement. If two or more part-time physicians share a calendar for a common panel of patients the measurement reported should be of that shared calendar.

What if the clinic offers walk-in appointments?

Unfortunately, for those physicians and clinics who do not pre-schedule any appointments and who only open schedules daily **TNA cannot be measured**. By the very nature of this type of system it is impossible to measure delay. This is not to say that delay does not exist, it is simply not visible. The delay for appointments exists outside of the visibility of the clinic. Patients queue up each day to get one of the appointments made available daily and if they are not lucky enough to obtain one of the openings, they must again join the virtual queue in hopes of getting an appointment the next day and so on.

Some clinics may have a combination of scheduled and unscheduled appointments. In this environment, it is possible to measure TNA for the scheduled appointments using the steps noted above.

What if a provider is away?

TNA is always tracked regardless of if the provider is away. The only exception is if a locum is fully "replacing" the doctor who is away- you can count their availability in the TNA count.

How is TNA reported?

PCCAs track TNA weekly at the clinic for all physicians and PCN providers. The data is entered into the Perform PCN database weekly. You will generate graphs displaying these reports twice a year on Perform PCN, and the IF will share these with the physician.

The PCN aggregates data from all clinics in our reporting to Alberta Health. Individual provider results are not reported.

Screening, Panel, TNA Reporting and Running Graphs

The PCCA is also responsible to enter data for panel demographics, verification rates, TNA, and screening rates in to Perform PCN at different time intervals. Additionally, some data will be entered into separate Excel sheets. In your EMR, queries and reports set up by your EMR Consultant will be available to you to generate the necessary data that you need to enter in to Perform PCN or Excel.

The data that the PCN collects is a reporting requirement required by our funder, Alberta Health. Once the PCN receives the data, it is aggregated (lumped together) so no physician or clinic is identified before it is sent to Alberta Health.

For instructions on how to enter data in to Perform PCN, please refer to the manual provided to you. You will receive your Perform PCN login information via e-mail. The ESPCN Evaluation Manager will review this with you as part of your orientation.

Summary of what PCCA will report each quarter:

PCCAs generate different reports each quarter. These reports have been staggered at intervals to optimize your time in clinic to engage in patient outreach, while also at a sufficient frequency to assess impact of clinic improvement efforts. All data is entered into Perform PCN, unless specified as "Entered in Excel" on the schedule below:

Date	Focus of Data	Reports
Jan 1 – Mar 31st (Winter)	General Population Screening	ASaP reports – percentage of eligible patients screened for: - Breast cancer - Colorectal cancer - Cervical cancer - Diabetes screening - Plasma lipid profile - CV Risk calculation - Height & Weight - Blood pressure (BP) - Exercise assessment - Tobacco use assessment
Apr 1 – Jun 30th (Spring)	Panel and Access	- Total patients on panel - Ages and sex of patients - Percentage of patients verified for attachment in past 6 months/3 years
		Vulnerable groups – **Entered in Excel**: - Total patients on panel seen in past 3 years. - Patients age 75+ seen in past 1 year. - Patients with a chronic disease (diabetes, hypertension, COPD, heart failure, heart disease, kidney disease) seen in past 1 year
		- Access: Days to third next available appointment

Jul 1 – Sep 30th (Summer)	General population screening	Repeat of 5 ASaP reports: - Breast cancer - Colorectal cancer - Cervical cancer - Diabetes screening - Plasma lipid profile
	Clinical Outcomes	Percentage of patients with diabetes with: - A completed foot exam in the past year - A completed HBA1C test in the past 6 months
Oct 1 – Dec 31st (Fall)	Panel and Access	Repeat of Spring reports from Apr 1 – Jun 30th.

PCCAs will enter the appropriate data on the first day of their clinic rotation, each quarter. For example, if a PCCA has two rotations at a single clinic during Winter reporting, they will only enter the "General Population Screening" data once. An exception is TNA, which will be entered weekly during all weeks at a clinic, preferably on a Tuesday, except the first rotation of Winter and Fall reporting, when it will be entered on a Monday, to be reflected in the current graphs.

If a PCCA does not have a rotation in a clinic during a reporting quarter (e.g., the PCCA takes a two-week vacation from June 14-June 30th, and their single scheduled Spring reporting rotation at a clinic is bumped into July, making it Summer reporting), the PCCA will enter both the previous and current quarter's data at their next rotation (e.g., the PCCA will enter both Spring's "Panel and Access" data, and Summer's "General screening and clinical management" data, during their July rotation, which falls in Summer reporting.

Greater than 10% changes from one quarter to the next

Once the reports are run and the graphs are generated, the PCCA must check to see if there is a change greater than 10% from the previous to the current time period. Often, large changes indicate a data-entry error. If the change is greater than 10%, the PCCA will re-run the query to verify that it is correct. If the change is still greater than 10%, the PCCA will make the IF aware, prior to saving and sending graphs to the IF. If there is no change greater than 10%, the PCCA must also indicate this has been confirmed, when sending reports to the IF.

After confirming the accuracy of individual physician data, PCCAs will also generate a clinic level graph and report.

Sharing the Reports

Each time data is entered in to Perform PCN, the PCCA will generate a graph, save as a PDF, and share it back with their IF through Teams. THREE types of graphs (Panel, Screening, and Access) are generated in Perform PCN. Below are specific instructions on how to generate these graphs.

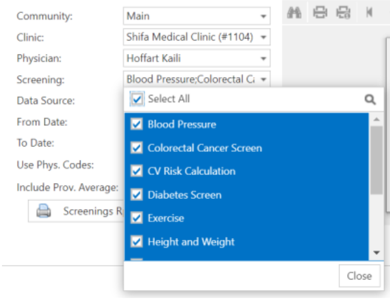
IFs will share the physician-specific graphs/reports directly with each PCN member physician and the clinic-level graphs/reports in the Teams-Medical Home channel as a way to inform the ESPCN MDT and PCM of the important care coordination work happening behind the scenes.

Screening Graphs

Steps for running Screening Graphs:

1. Run screening graph individually for each PCN member physician at the clinic.
2. In Perform PCN, select the **Panel Management** tab on top, then scroll down to **Physician Reports**
3. Under *Community* select *Main*
4. Under *Clinic* select *Clinic Name* on the dropdown list
5. Under *Physician* select the *individual physician's name* on the dropdown list
6. Select Screening maneuvers depending on when your rotation is:
    a. In the first quarter of the year (rotation between January and March) – under *Screening* check off *Select All*

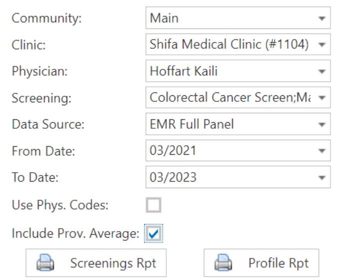
Screening/Panel-Physician Report



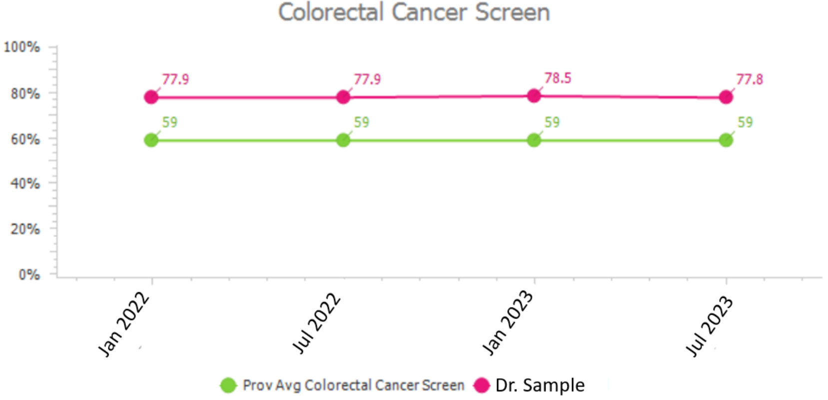
    b. In the third reporting quarter (rotation between July and September), only check off: Colorectal Cancer Screening, Diabetes, Mammogram, Pap Test, Plasma Lipid Profile – unless requested by IF to run data for additional maneuvers.

7. Under *Data Source* select *EMR Full Panel*
8. Under "*From Date*", select a date *two years prior to today*. Under "*To Date*" select *today's date*.
9. Check box labeled *Include Prov. Average*
10. Select *Screening Rpt* button on bottom of screen.

Screening/Panel-Physician Report

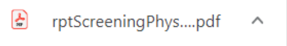


11. Example of what the physician Screening Graph should look like



12. Select the ***Save (disk) Icon*** to save report as a PDF file.

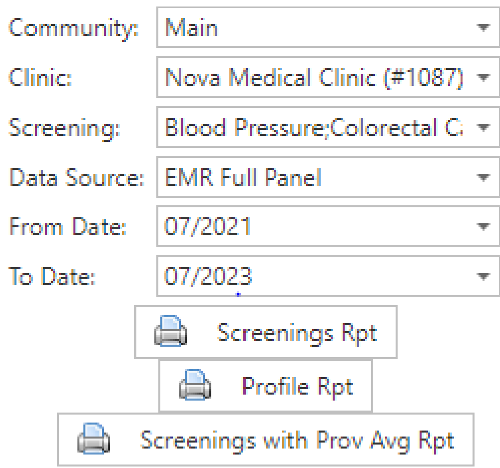
13. The report will be generated on the bottom left-hand side of the screen.



14. Open the file to save report to your computer (use a private/secure location)
15. Save the screening reports using the following standard format:
    Screening-Physician Last Name-MMM DD YYYY
    i.e. ***Screening-Shute-Jul 10 2023.pdf***
16. Once all report files are saved, open each report to double check the file name matches the physician data.

To run the clinic level graph, follow the instructions below:

1. In Perform PCN, select the **Panel Management** tab on top, then scroll down to **Clinic Reports**
2. Under *Community* select *Main*
3. Under *Clinic* select *Clinic Name* on the dropdown list
4. Select Screening maneuvers depending on when your rotation is:
    a. In the first quarter of the year (rotation between January and March) – under *Screening* check off *Select All*
    b. In the third reporting quarter (rotation between July and September), only check off: Colorectal Cancer Screening, Diabetes, Mammogram, Pap Test, Plasma Lipid Profile – unless requested by IF to run data for additional maneuvers.
5. Under *Data Source* select *EMR Full Panel*
6. Under "*From Date*", select a date *two years prior to today*. Under *"To Date"* select *today's date*.
7. Select *Screening with Prov Avg Report* button on bottom of screen.



1. These reports should appear similar to the physician reports for Winter and Summer, with each screen separated into different boxes, and the provincial average line below. See the example below.

Colorectal Cancer Screen

100%
80%
60%
40%
20%
0%

45.4
44.1
51.3
51.7

Jan 2022
July 2022
Jan 2023
July 2023

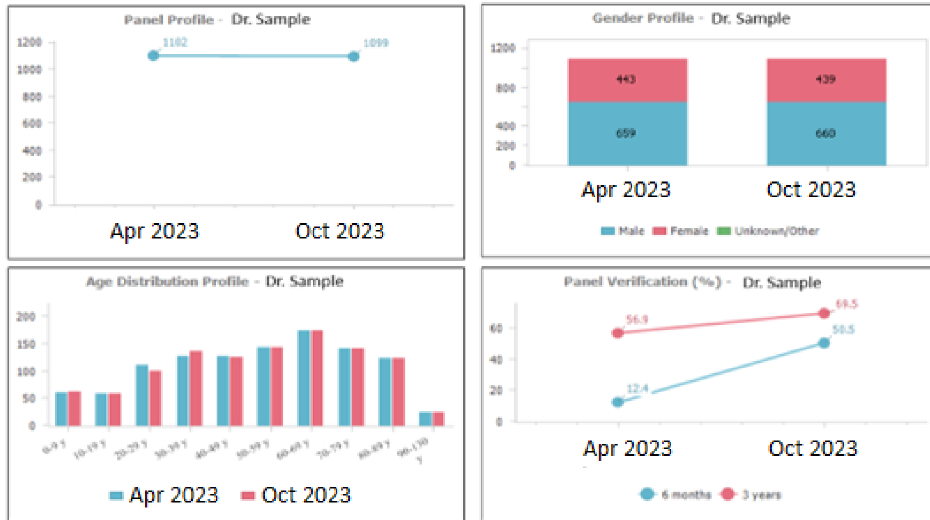
Prov Avg Colorectal Cancer Screen
Medical Clinic

2. Select the ***Save (disk) Icon*** to save report as a PDF file.
3. The report will be generated on the bottom left-hand side of the screen.
4. Open the file to save report to your computer (use a private/secure location)
5. Save the screening report using the following standard format: Screening-Clinic Name-MMM DD YYYY
6. Month Year i.e. ***Screening-A1-Jul 13 2024.pdf***

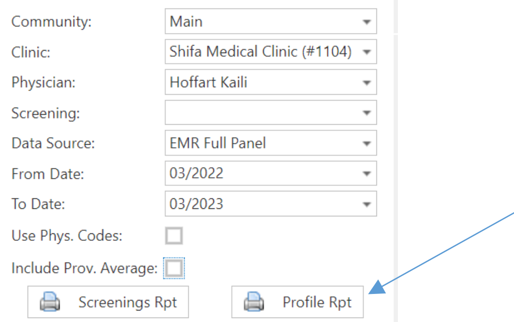
Panel Graphs

Steps for running Panel graphs:

1. Run panel graph individually for each PCN member physician at the clinic.
2. In Perform PCN, select the **Panel Management** tab then scroll down to **Physician Reports**
3. Under *Community* select *Main*
4. Under *Clinic* select *Clinic Name* on the dropdown list
5. Under *Physician* select the *individual physician's name* on the dropdown list
6. Under *Screening* leave blank
7. Under *Data Source* select *EMR Full Panel*
8. In *"From Date"* select a date *1 year prior to today*, in *"To Date"* select *today's date*.
9. The panel graph should show 2 data points, spaced 6 months apart. If needed, adjust your timeline to ensure 2 data points are visible. Here is an example of what the Panel Graph should look like:



10. Select *Profile Rpt* Button on bottom of screen.

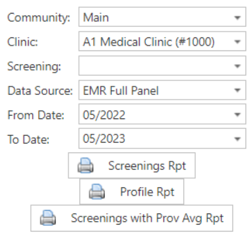


11. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
12. The report will be generated on the bottom left-hand side of the screen.
13. Open the file to save report to your computer (use a private/secure location)
14. Save all panel reports using the following standard format:
    Panel-Physician Last Name-MMM DD YYY
    i.e. ***Panel-Shute-Apr 13 2024.pdf***
15. Once all report files are saved, open each report to double check the file name matches the physician data.

Steps for running the clinic-level panel graphs:

1. In Perform PCN, select the **Panel Management** tab then scroll down to **Clinic Reports**
16. Under *Community* select *Main*
17. Under *Clinic* select *Clinic Name* on the dropdown list
18. Under *Screening* leave blank

19. Under *Data Source* select *EMR Full Panel*
20. In *"From Date"* select a date *1 year prior to today*, in *"To Date"* select *today's date*.
21. The panel graph should show 2 data points, spaced 6 months apart. If needed, adjust your timeline to ensure 2 data points are visible.
22. Select *Profile Rpt* Button on bottom of screen.



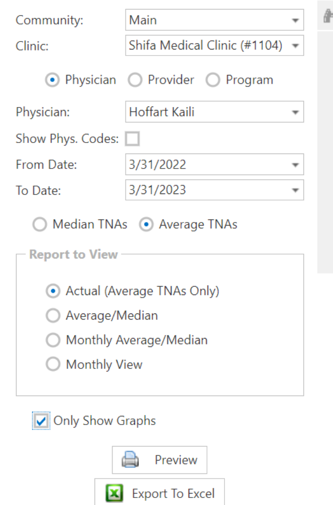
23. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
24. The report will be generated on the bottom left-hand side of the screen.
25. Open the file to save report to your computer (use a private/secure location)
26. Save the panel report using the following standard format:
    Panel-Clinic Name-MMM DD YYYY
    i.e. ***Panel-A1-Apr 13 2024.pdf***
27. Once all report files are saved, open each report to double check the file name matches the physician data.

Access (TNA) Graphs

Steps for running TNA graphs:

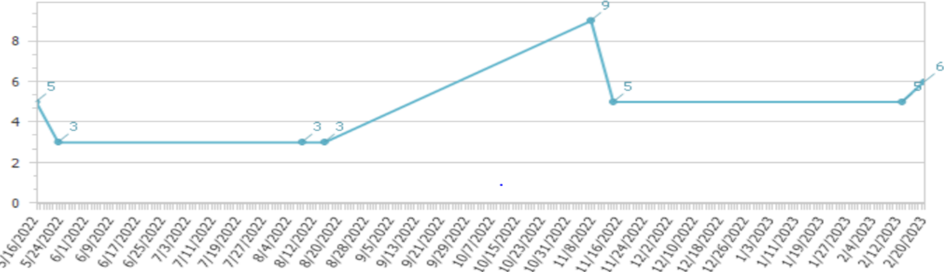
1. Although TNA is typically entered into Perform PCN on a Tuesday, on the first Monday of a clinic rotation in Spring (Apr-Jun) and Fall (Oct-Dec) reporting, enter current TNA, so that it will be captured in the most recent report.
2. Run TNA graph individually for each PCN member physician at the clinic.
3. In Perform PCN, select the **Third Next** tab then scroll down to the **Third Next Available Apt Report**
4. Under *Community* select *Main*
5. Under *Clinic* select *Clinic Name* on the dropdown list
6. Select *Physician* radio button.
7. Under *Physician* select the *individual physician's name* on the dropdown list
8. In "*From Date"* select *1 year prior to today's date* (always select Monday of the week) and in "*To Date"* select *today's date* (always select Monday of the week)
9. Select *Average TNA* radio button.
10. Select *Actual (Average TNAs Only)* radio button.
11. Check off box *Only show graphs.*

Third Next Available App. Report



12. Select the ***Preview*** Button on the bottom of the screen.
13. Example of what the Third Next Available Appointment graph should look like

The graph above shows a clinic that has 5 PCCA rotations, so has TNA entered 10 out of 12 weeks each quarter. The graph below shows a clinic that has one PCCA rotation, so has TNA entered 2 out of 12 weeks each quarter. Both clinics have TNA entered weekly during weeks the PCCA supports their clinic. Both graphs show 1 year of available TNA data.



14. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
15. The report will be generated on the bottom left-hand side of the screen.
16. Open the file to save report to your computer (use a private/secure location)
17. Save all TNA reports using the following standard format:
    Access-Physician Last Name-MMM DD YYYY
    i.e. ***Access-Physician Last Name-Apr 13 2024.pdf***
18. Once all report files are saved, open each report to double check the file name matches the physician data.

Verification Rate Formula

Verification rates measure how often patient attachment to the physician is confirmed – see below:

 # Of Patients with an appointment (in a particular time period) who were verified

/ Total # of patients with an appointment (in a particular time period)

This should be calculated for the 6-month and 3-year time periods each quarter.

Reports will be built into a query within the EMR for you to use, however it can be helpful to understand the elements that go into the calculation.

PCCA Rotation Checklist

This rotation checklist can help you ensure you have completed all the right steps in order and are communicating regularly with your IF during each of your rotations.

First Rotation of Quarter:

Week 1	

Monday (or 1st day of rotation):	☐ If it is Apr-Jun or Oct-Dec, enter your TNA into Perform PCN so that it will show up on your Access report.
	☐ Enter quarterly data. Run Perform PCN physician and clinic graphs, review, and send to IF.
	☐ Run baseline for the Pediatric outreach group.
	    ☐ Enter baseline into PCCA Weekly Tracking Sheet
	    ☐ Send IF a Teams Message “Baseline for Pediatric outreach is ##. I am starting this outreach now!”
	    ☐ Complete outreach on Pediatric until list is complete

Tuesday:	☐ If it is Jan-Mar or Jul-Sep, enter TNA into Perform PCN.

Friday:	☐ Run weekly tracking reports and enter information into PCCA Weekly Tracking Sheet. ☐ Complete weekly PCCA form on hours worked/activity totals.
Week 2 (Full-time PCCAs), Week 2-4 (Part-time PCCAs)	
Tuesday:	☐ Enter TNA into Perform PCN.
Friday:	☐ Run weekly tracking reports and enter information into PCCA Weekly Tracking Sheet. ☐ Complete weekly PCCA form on hours worked/activity totals.
Throughout Rotation	
☐ When Pediatric outreach is complete, run baseline for Adults Outreach, and follow the same steps above. ☐ When Adults outreach is complete, run baseline for 75+ Outreach, and follow the same steps above. ☐ When 75+ outreach is complete, run baseline for Chronic Disease Outreach, and follow the same steps above. ☐ When Chronic Disease outreach is complete, run baseline for Screening Outreach, and follow the same steps above ☐ Work on CPAR Conflicts at the time decided by your IF and team (this may be prior to the other outreach groups, at the end, or on a certain day each week).	

Subsequent Rotations of Quarter:

Some clinics have multiple rotations each quarter. If a clinic has more than one rotation, follow the instructions below after the first rotation:

Week 1	
Monday (or 1st day of rotation):	☐ Continue working on last outreach group from previous rotation, until list is complete. ☐ When list is complete, move onto next outreach group, informing IF of baseline, in order: Pediatric, Adults, 75+, Chronic Disease, Screening, Conflicts.
Tuesday:	☐ Enter TNA into Perform PCN.
Friday:	☐ Run weekly tracking reports and enter information into PCCA Weekly Tracking Sheet.
Week 2 (Full-time PCCAs), Week 2-4 (Part-time PCCAs)	
Tuesday:	☐ Enter TNA into Perform PCN.
Friday:	☐ Run weekly tracking reports and enter information into PCCA Weekly Tracking Sheet.

Regardless of where you leave off, for your first rotation of the next quarter you will always start back at the Pediatric group. Eventually these lists will become small and manageable, and it will be possible to complete all within a single quarter.

Manage, Identify, and Showcase

To support your success in the predominantly remote PCCA role, we have established systems to help you manage and showcase your work efficiently. These systems are designed to provide clarity and assist in addressing any questions from clinics about your progress. Here's how we track and support your activities:

Minimum Activity Targets: We aim for you to connect with at least 150 patients each week during a 40-hour work week, which translates to about 30-35 patients per day. This target helps ensure we're meeting our goals and provides a clear benchmark for your activities.

Soft Phone Application: You'll use the ESPCN softphone application while working remotely. This tool helps us keep track of call activity, including timing and duration, so we can support your work effectively. Your PCC-Lead will be able to view this data to stay informed about your progress.

PCCA Tracking sheet: As outlined in this manual, you'll regularly update the PCCA Tracking Sheet with your task baselines and weekly totals. This helps us monitor your progress and plan for future quality improvement efforts. Your PCC-Lead will review this information to stay updated and provide support.

Weekly reporting form: At the end of each week, you'll complete a brief Microsoft Forms document summarizing your weekly activities, hours spent on different tasks, and any time spent on clinic phones versus softphones. This form helps us adjust your weekly minimum target as needed. For instance, if you spend time in meetings or education, your minimum target will be adjusted accordingly. Our goal is to ensure that any challenges you face are addressed promptly, with your PCC-Lead available to support you in overcoming any obstacles, whether they're related to technology, EMR reports, or clinic processes.

Section 3: Further Background Information

Communication

Prior to changing any processes at a clinic, always consult with the IF. The IF is aware of the larger picture and must be involved in all improvement efforts.

Since you will be involved in working closely within a clinic, you will develop relationships with that clinic team and have interactions and conversations about different processes such as patient verification, booking patients, follow up tasks, etc. You may be asked to support several different activities. Some may be within the scope of your PCCA role, and some may not. It may be challenging to manage this, and that is a key reason why communication in your role is highly important. This chapter will help you to know who to communicate around a variety of topics. But if in doubt, always connect with your Improvement Facilitator via Teams or phone.

Guidelines about who to contact when issues arise. When in doubt, ask your clinic IF.

Issue	Examples	Action
Attendance: Last minute changes to clinic access	1. Clinic is unexpectedly closed or closes early 2. Clinic has technology or space issues, and PCCA cannot work there	1. Call or Teams message the PCC Lead right away. 2. Teams message Clinic IF.
Attendance: Last minute changes to PCCA availability	PCCA is sick or requires a personal day, or needs to leave work early	1. Follow PCN protocol: ▪ Call or Teams message PCC Lead ▪ Call or EMR message clinic ▪ Request time off on ADP. 2. If possible, also Teams message Clinic IF.
Attendance: Expected absences	PCCA is planning time off for vacation, professional development, etc.	1. Follow PCN protocol to request time off on ADP. 2. Once time off is approved, Teams message dates to Clinic IF and Clinic PCN manager (if PCCA is aware of a clinic scheduled during that time).
New requests for support from clinic team directly to PCCA	Clinic team reaches out to PCCA for assistance with a new request i.e. generating patient lists, EMR support.	Prior to starting new requests, Teams message IF to review and determine next steps.
Clinic Process Changes	1. PCCA has questions about role or clinic work	Teams message Clinic IF.

	2. Physician has asked for process change related to PCCA role. 3. Physician has asked for support in areas outside of PCCA role	
EMR issues	Issues with EMR queries, CDS alerts, or any other EMR related questions	Teams message Clinic EMR-C and Clinic IF
Equipment and Supplies	1. PCN laptop or phone need to be ordered, are not working, or are missing necessary programs. 2. Clinic computer is missing necessary programs. 3. You need supplies, such as folders.	If related to PCN supplies, Teams message PCC Lead and current Clinic PCN manager/Clinic IF if issue causes disruption to clinic work. If related to clinic computer/ phone/ access, discuss with office manager, and Teams message Clinic PCN manager and Clinic IF.

Amount of PCCA Support by Clinic

Any ESPCN clinic that has a panel, and an EMR that can generate reports, is eligible to receive PCCA support. The lesser of the clinic's panel EMR and Alberta Health panel size will determine the maximum amount of time that the PCCA is able to support. The IF, in discussions with the clinic, will determine if a clinic requires the maximum number of rotations for which they are eligible.

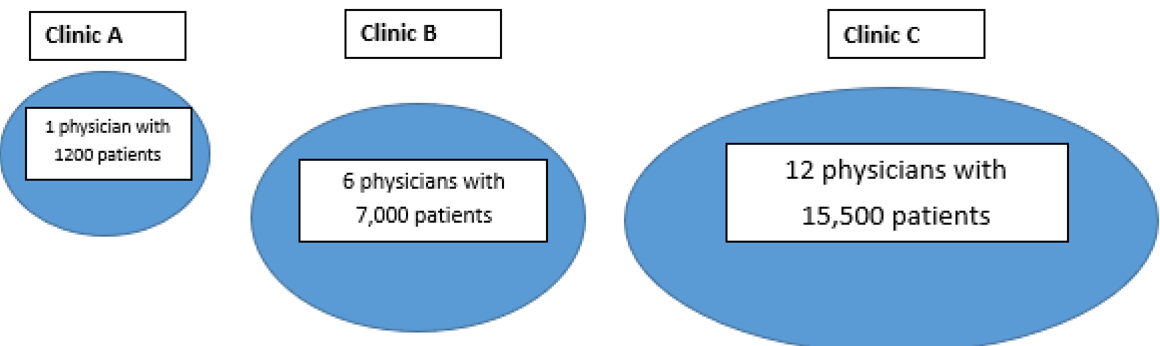
Lesser of EMR/AH Panel Size	Maximum amount of PCCA rotations (6 rotations =1.0 FTE)
Panel 0-1599:	1 for 1st year, then 0.5 after
Panel 1600-3199:	1
Panel 3200-6399:	2
Panel 6400-9599:	3
Panel 9600-12,799	4
Panel 12,800-15,999:	5
Panel: 16,000-19,199	6

Clinics with more patients are eligible for more PCCA support so that care can be coordinated equitably across the ESPCN. The idea is to spread the support around to reach as many patients as possible. In the example below:

Clinic A would be eligible to receive PCCA support for 2 weeks every 12 weeks for one year (1 Rotation), then 1 week every 12 weeks after that (0.5 rotations).

Clinic B would be eligible to receive PCCA support for 6 weeks every 12 weeks (3 rotations).

Clinic C would be eligible to receive PCCA support for 10 weeks every 12 weeks (5 rotations).



This means that most PCCAs will have two to six different clinics that they rotate through once per quarter (four times per year). PCCAs will all work partially from clinic and partially from home.

Occasionally, a PCCA will have completed their work before the end of their rotation, or will experience a technical issue, such as problems with their EMR login or Alberta Netcare access being removed. In these cases, the PCCA should consult with the clinic IF and PCM, to ensure they are aware and have attempted to problem solve at the clinic level. If the PCCA is unable to work at their assigned clinic, they should choose another clinic in their portfolio to support until their next rotation begins. Typically, this will be a clinic with significant care coordination needs, that can benefit from any additional support beyond their scheduled rotation. The PCCA should inform the PCC Lead and clinic's IF when this occurs.

Privacy

Health Information Act (HIA) Guiding Principles

Patient information is considered confidential, and any information collected or gathered is governed by the Health Information Act (HIA), which sets out rules governing the collection, use and disclosure of health information for anyone in Canada. ESPCN has developed working guidelines for how to comply with the HIA, which can be used as a reference when handling patient information. If you have any questions about HIA or patient information confidentiality, contact the ESPCN Privacy Officer.

Confidentiality Forms at your Clinic

All PCCAs will sign a confidentiality form at their clinics. PCMs will arrange this for you.

Saving patient lists

Generating lists of patients for outreach and reporting is a key function of the PCCA role. The most secure way to interact with patient information is keeping the information within the EMR, using a dashboard or Client List Manager. In certain cases, it may be required for the PCCA to download a patient list. When doing so, ensure you follow these steps:

1. Save the list to your OneDrive folder.
2. Delete the list from your downloads folder and empty your Recycling Bin.
3. Keep the list for only the amount of time you are actively using it. Once you no longer need that list, delete it from your OneDrive folder, and empty your Recycling Bin. Most PCCA lists should not be required for longer than 6 months.

Important Notes to Consider:

1. PCCAs should never leave the clinic with patient information, including encrypted USBs or printed lists.
2. Patient-identifiable information should never be shared using the Teams meetings or messaging platforms due to potential security issues.

Alberta Medical Association (AMA) Resources

The ACTT (Accelerating Change Transformation Team) is a branch of the Alberta Medical Association that supports all physicians in Alberta, especially primary care physicians, with changes needed to build the best medical homes for Albertans.

One example of a training tool that ACTT has developed is Learn@AMA, an online learning platform. As part of your orientation, you will complete the Panel in Action courses, the Primary Care Explained module, and the CII/CPAR Panel Administrator overview.

The ACTT website can be found here: Accelerating Change Transformation Team

ACTT also offers information on how EMRs can support physician practices with active panel management. Their website offers resources on EMR guides and facilitates EMR Networks that meet monthly. PCCAs interested in advancing your EMR knowledge are encouraged to use your Professional Development hours to attend these free webinars. More information can be found here: Electronic Medical Record Supports (albertadoctors.org)