PROACTIVE CARE COORDINATION ASSISTANT PROGRAM MANUAL

Edmonton Southside PCN

Contents

Section 1: Introduction

An Overview - Edmonton Southside Primary Care Network and Patient's Medical Home

What is ESPCN?

Primary Care Networks (PCNs) are comprised of PCP and nurse practitioner members, who work as Primary Care Providers (PCPs). The Edmonton Southside Primary Care Network (ESPCN) was Alberta's first PCN and is the largest PCN in the Edmonton area. Each member of our team of healthcare providers plays a specific role in improving, coordinating, and delivering primary health services.

Research shows that having an ongoing relationship with a PCP and team helps you live longer, receive better care, make fewer visits to emergency rooms, and become hospitalized less. When you have a regular PCP, 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.

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

Learn More by visiting the ESPCN website.

Patient's Medical Home

The Patient's Medical Home (PMH) is a family practice that offers the medical care that is 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 PCP, 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 PCP or linked. The PMH enables the best possible outcomes for each person.

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://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 PCP 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 PCP's active patients or patients who consider a particular PCP to be their primary care provider, and the PCP agrees. Evidence shows that patients who consistently see the same PCP 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 PCP's patient's panel. The relationship between the patient and the PCP must be confirmed for this to happen.

- Patient attachment is captured by:
    1. Asking patients who their regular PCP 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 PCP.
2. A list of active patients can be generated for each PCP.

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 PCP but have moved or changed PCPs. 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 been seen in extended periods of time 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 PCP's panel is accurate. This may involve PCP 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 PCP? (If not, who is your primary PCP?)

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 primarily 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 PCP's CPAR Conflict report as being on the panel of another CPAR PCP.

The PCCA will work closely with their Improvement Facilitator to optimize care coordination practices that are consistent with the standard areas of outreache. 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 PCP 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 PCPs, 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, PCPs, 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)** leads and manages 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) 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** leads and manages the IFs, EMR-Cs, and PCC-Lead and oversees 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 phone number of 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 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 PCP 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 PCP, 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 PCP to explain why you need to access the patient's Netcare profile and request that they respond if they agree with you unsealing the chart.
2. If the PCP 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 PCP's permission.
3. If the PCP provides verbal permission, create a task or worklist to document the reason the chart was accessed and that PCP permission was received verbally.

Section 2: Introduction to Care Coordination, Outreach, and Reporting

The most important part of the PCCA role is to find patients in the EMR who are due for care or preventative health screening and book them appointments or offer screening requisitions.

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 PCP, 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 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 and any additional clinic-specific outreach groups.

To track your work in all these outreach areas, you will update an Excel tracking sheet each week on your last day of work. Your tracking sheet will also detail all clinic processes on the Process Manual tab.

Standard Areas of Outreach

<table>
<tr><td style="background-color:red">Pediatric</td></tr>
</table>

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 PCPs in the baseline section of the spreadsheet and the "Historical Data" section of this tab. Inform the clinic IF of the new baseline.

Doctor	BASELINE	Process: # of patients called with confirmation of pediatrician, appointment offered, or inactivated				Running Total
	12-Nov-24	14-Nov-24	21-Nov-24	Date	Date	
Red	32	32	DONE			32
Blue	35	10	25	DONE		35
Total	67	42	25	0	0	67

Pediatric: < 18 and no visit in 2 years

Historical data

Date	Doctors' baseline total
01-Jul-24	82
12-Nov-24	67

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. **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.

3. **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 PCP), the patient may be moved from the panel without a phone call (proceed to Step #4). You will also review your own previous worklists/tasks, as your clinic will have a rule of the maximum number of outreach calls this group should receive before being inactivated.

4. **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 Primary Care Provider?

<If they need a better definition of what a PCP is:

> *"A PCP 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 seen their pediatrician in the past 2 years. Update EMR task/worklist accordingly, including approximate date of last pediatrician visit.

-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?"

5. **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.

6. **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 PCP'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 PCPs, 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
1			**Adults: 18-74 and no visit in 2 years**								
2	Doctor	Baseline:	Process: # of patients reviewed + contacted				Running			Historical data	
3		01-Mar-21	05-Mar-21	12-Mar-21	19-Mar-21	26-Mar-21	total		Date	doctors' baseline total	
4	Red	25	25	0	0	0	25		01-Dec-20	250	
5	Blue	24	0	24	0	0	24		01-Mar-21	114	
6	Green	31	0	6	25	0	31		01-Jun-21		
7	Yellow	23	0	0	18	5	23		01-Sep-21		
8	Brown	11	0	0	0	11	11		02-Dec-21		
9	Total	114	25	30	43	16	114				
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. **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.

3. **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 to be a "current care relationship", so a Netcare search would be inappropriate. 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 PCP), the patient may be removed from the panel without a phone call (proceed to Step #4). You will also review your own previous worklists/tasks, as your clinic will have a rule that after 1-3 outreach calls, patients not seen in 3 years will be inactivated.

4. **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 PCP, or is Dr. Z is still your regular Primary Care Provider?

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 Primary Care Provider?

<If patient is unsure or needs a better definition of what a PCP is:
"A PCP 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.

5. **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.

   > *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.*

   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.

6. **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 PCP'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 PCPs, 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. **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.

3. **Check EMR Chart.** Working off your patient list, open each patient's EMR chart. Review the recent worklists to note if the patient was previously called, and whether they called back, and any other relevant information.

4. **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 PCP 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

5. **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 Primary Care Provider?

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*]

6. **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.

7. **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 PCP'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 PCPs 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. Note that at most clinics, your query will exclude patients you already called as part of your "Adults" outreach.

Doctor	Baseline: 01-Feb-21	05-Feb-21	12-Feb-21	19-Feb-21	26-Feb-21	Running total		Date	PMA's doctors' baseline total
			Process: # of patients contacted						Historical data
Red	5					0		01-Nov-20	65
Blue	6					0		01-Feb-21	30
Green	4					0		01-May-21	
Yellow	3					0		01-Aug-21	
Brown	12					0		01-Nov-21	
Total	30	0	0	0	0	0			

Title: <75 + Chronic Disease* + No visit in 1 year

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. **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.

3. **Check EMR Chart.** Working off your patient list, open each patient's EMR chart. Review the recent worklists to note if the patient was previously called, and whether they called back, and any other relevant information.

4. **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 PCP 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

5. **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 Primary Care Provider?

[*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?"

6. **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.

7. **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 PCP'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) are evidence-based guidelines of preventative health screening for the general population, including eligibility criteria and time intervals. 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 PCP's

recommendations based on unique patient circumstances. For example, if a woman has a history of abnormal mammograms, the screening frequency may differ.

For screening outreach, PCCAs will focus on the ASaP 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 (albertaPCPs.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.** You will run 5 different screening reports to find patients due for colorectal/breast/cervical cancer screening, plasma lipid profile, or diabetes screening.

You will either merge those 5 lists within the EMR or by using Excel. You will then remove the duplicate patients. This will leave you with a single list of patients due for screening for each PCP. Next, enter each PCP's total number of patients due for screening in the baseline section of the Screening tab on your Weekly Tracking Sheet. Finally, enter the total combined baseline for all PCPs in the "Historical Data" section of this tab and inform the clinic IF of the new total baseline.

Please note: At some clinics, your query may initially include a time modifier (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 your screening lists become smaller, the time modifier will be decreased and eventually removed. At most clinics, your query will also exclude patients you have already called as part of your "Adults" outreach.

2. **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.

3. **Check EMR Chart.** Working off your patient list, open each patient's EMR chart. Review the automated notifications and screening template, if applicable, e.g. ASaP template in Healthquest, to determine which screens the patient is due for according to the ASaP Maneuvers: mammogram, pap test, colorectal cancer screening, plasma lipid profile, and diabetes screening. Confirm screening results are not available in the EMR, and confirm a requisition was not given to the patient for that screen at another visit. Review recent worklists to note if the patient called back, and any other relevant patient information.

4. **Check Netcare.** After determining which screens the patient is due for in the EMR chart, you will check Netcare for any external screening results. These may be found on Netcare if a patient has had screening ordered by a provider outside of your clinic. If recent screening results are found in Netcare that are not shown in the EMR chart, follow the clinic process, detailed in your Clinic Process Manual section of your PCCA Weekly Tracking Sheet, to update the EMR chart. In most cases, this will mean simply updating the Preventative Health Screening template in the EMR, though some clinics may require the actual results to be imported from Netcare.

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, you may use the Netcare search function to search for the result. You may additionally search in the following areas:

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)

After you have updated the chart with external results, you may determine the patient is no longer due for screening. Those patients will not require a phone call and the next step can be skipped. All others should receive a call.

5. **Call Patient.** When calling patients for screening outreach, your conversation may depend on what you have found during your chart review, and any clinic-specific processes. For example:
   - If your clinic is offering FIT kits, you may find during your chart review that a patient due for colorectal cancer screening was provided a FIT kit two months ago, but that there are no available results. In your call, you may provide that patient a reminder to do their kit and bring it to a nearby lab.
   - You may find a patient was recently provided a requisition for a mammogram, but there are no results available. In your call, you may check that they still have a copy of that requisition and remind them to book their test at an imaging centre.
   - If your clinic has an RN who completes pap test, you may follow a clinic process to book a separate Women's Health Visit, where the RN can assess the patient and complete the pap test, if needed.

Suggested Script and Process:

"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. Can you confirm if Dr. Z is still your regular Primary Care Provider?

[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 PCP 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*]

6. **Apply Task/Worklist.** Depending on the work completed, you may apply one or two tasks/worklists for screening.

- For every patient's chart that you open, you will apply the: "**Screening Reviewed by PCCA" task/date stamp.** This is applied even if you do not change anything in the chart.
- If, after reviewing the chart, you determined that the patient did require an outreach phone call, you will also apply the "Screening Outreach" task or worklist. This is applied even if you did not actually speak to the patient on the phone. This worklist should detail why you called the patient, and have information for the front staff to support the patient if they call the clinic back.

Note: PCCAs should only call patients and apply the Screening Outreach task/worklist once per patient, per rotation. If the patient shows up again on your new outreach list at a subsequent rotation, they may be counted again by responding to the previous task/worklist, as per the clinic's process.

7. **Run Task/Worklist Report for Tracking Sheet.** At the end of the week, you will run two reports:

Screening Reviewed: The first is to find the number of charts reviewed for screening for each PCP. You will enter that number in the "Screening Reviewed" column of the weekly tracking 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 PCP. 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.

Screening Outreach: The second report finds the number of patients who received outreach phone calls, for each PCP. You will enter that number in the "Calls" column of the weekly tracking sheet in the appropriate date column.

- 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					

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 need further tests or urgent follow ups due to the nature of their results. While interpreting results is outside of the PCCA's scope, it is important to identify if a patient has abnormal external results or missed follow-up that the PCP should be made aware of, to prevent patients from falling through the cracks. This chapter enables the PCCA to make guided decisions based on the patient's test result.

Reviewing Mammogram Results

Fig. 6.1

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. > **95% chance** of being cancerous. Patient needs a biopsy. Most likely, PCP would have already referred for specialist care alongside biopsy.

o **BI-RADS 6** - <u>Known biopsy with proven cancer</u>: 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 PCP.
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 PCP.
4	If test ordered outside of clinic, send task to primary PCP.
5	If test ordered outside of clinic, send task to primary PCP. Most likely, patient is being followed by specialist.
6	Most likely, patient is being followed by specialist. Send task to PCP 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]

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.

Fig. 6.4

Fig 6.5

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

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 ▮▮▮▮▮ 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. Routine screening every 10 years (colonoscopy) or 5 years (sigmoidoscopy), *or* a resumption of FIT is recommended.

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

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

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 PCP.
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 PCP.
	Polyps	If test was ordered outside of clinic, send task to PCP.
	Adenocarcinoma	If test was ordered outside of clinic, send task to PCP.

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

Fig. 6.7

Fig. 6.8

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 PCPs 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 PCP 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 PCP 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 PCP.
ASC-H	If test was ordered outside of clinic, send task to PCP.
AGC	If test was ordered outside of clinic, send task to PCP.
LSIL	If test was ordered outside of clinic, send task to PCP.
HSIL	If test was ordered outside of clinic, send task to PCP.
AIS, SCC, other cancers	If test was ordered outside of clinic, send task to PCP.
Inadequate Sample	If test was ordered outside of clinic, send task to PCP or RN depending on who requested the test.
Hysterectomy on chart	Send task to PCP: 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 PCP. - Send task to PCP.

Sources: [1]Pap Test (alberta.ca), [2]How to read your Pap test report | MyPathologyReport.ca, [3]cervical-cancer-screening-cpg.pdf, (albertaPCPs.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 some clinics, you may be able to provide preventative screening requisitions (mammogram, FIT, lipids, and/or diabetes) to the patient on behalf of the PCP. The IF will present and discuss this option, and interested PCPs 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.

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 their PCP.
- 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 PCP.
- 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 PCP (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 PCP 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 PCP (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:

Most ESPCN PCPs are enrolled in CII/CPAR. CPAR is a central registry where patient lists of all enrolled PCPs 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.

1. **Enter Baseline.** Enter the clinic total baseline, for all PCPs, 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 Primary Care Providers listed as your primary providers: Dr. Z, here at A Medical Clinic, and [Conflict PCP] at [Conflict Clinic]. Dr. Z would like to confirm which one you consider to be your main Primary Care Provider?"

— If the patient confirms the conflict PCP 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 PCP 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 PCP. I will be reaching out to [conflict PCP] 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. Confirm the fax number of the conflicting clinic using the Alberta Find a Doctor "Doctor directory".

In some cases, the patient may want to keep both providers. Your IF will review this scenario with you and any clinic/PCP-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 PCP'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 [underline]patient's name[/underline]. 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 PCP, 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 PCP, 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 PCP, 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 is informed 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 PCPs have more timely appointments than others. A clinic has good access when patients can get in to see their PCP when they need to. When patients cannot access their PCP, they may go to a walk-in clinic or Emergency Department, which causes a break in the continuity of care. It is always best when a patient can seek care from their medical home where their PCP and team know their whole story and can direct care accordingly.

We know that being able to see your PCP in a timely manner is important for patient health outcomes. 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), and entering it into Perform PCN.

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 PCP 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 PCP and patient. When a patient cannot receive timely access to care from his/her own PCP and is forced to seek care elsewhere, their PCP 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 PCPs 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. PCN Multidisciplinary Team Members collect their own TNA.

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 on a Tuesday each week, except for the two times a year per clinic where you collecting Panel and Access data. On these days, collect on the Monday, so the recent data can be included in your reporting.

<u>Do I collect every week during my rotation?</u> 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 PCPs 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 PCP full time equivalent may be based on appropriate panel size and other principles of access improvement. If two or more part-time PCPs 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 PCPs 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 PCP 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 PCPs 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 PCP.

Screening, Panel, TNA Reporting and Running Graphs

The PCCA is responsible to enter data for panel demographics, verification rates, TNA, and screening rates into Perform PCN. 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 PCP 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 – Mar (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 (do not include on graph) - Tobacco use assessment (do not include on graph)
Apr – Jun (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 – Sep (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 - An A1C result above 8.5% in the past year Percentage of patients with hypertension with: - A blood pressure (BP) result in the past 6 months - An elevated BP in the past year
Oct – Dec (Fall)	Panel and Access	Repeat of Spring reports from Apr – Jun.

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.

	Mon	Tues	Wed	Thu	Fri
Winter reporting	March 24	March 25	March 26	March 27	March 28
	March 31	April 1	April 2	April 3	April 4
Start of Spring reporting	April 7	April 8	April 9	April 10	April 11

Reporting Period changes mid-rotation: In the example above, because April 1st falls mid-week, Spring reporting does not start until April 7th. So, if a PCCA had a single rotation, from March 24-April 4, they would only complete Spring reporting. However, if a PCCA had a rotation from March 31-April 11, they would complete Spring reporting on April 7. This may mean completing their Winter reporting the first week of their rotation, and their Spring reporting the 2nd week.

No Rotation in quarter: 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 PCP 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 PCP-specific graphs/reports directly with each PCN member PCP 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 PCP at the clinic.
2. In Perform PCN, select the **Panel Management** tab on top, then scroll down to **PCP Reports**
3. Under *Community* select *Main*
4. Under *Clinic* select *Clinic Name* on the dropdown list
5. Under *PCP* select the *individual PCP'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*
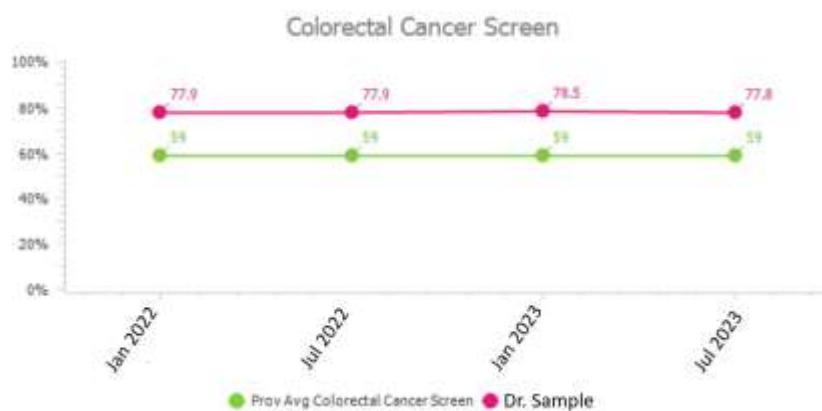
Screening/Panel-Physician Report

> 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. <u>Check box</u> labeled *Include Prov. Average*
10. Select *Screening Rpt* button on bottom of screen.

Screening/Panel-Physician Report

> 11. Example of what the PCP Screening Graph should look like

Colorectal Cancer Screen

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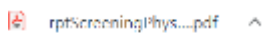
14. Open the file to save report to your computer (use a private/secure location)
15. Save the screening reports using the following standard format:
    Screening-PCP Last Name-MMM DD YYYY
    i.e. **_Screening-Shute-Jul 10 2023.pdf_**
16. Once all report files are saved, open each report to double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

Screening/Panel-Clinic Report

Community: Main
Clinic: Nova Medical Clinic (#1087)
Screening: Blood Pressure;Colorectal C
Data Source: EMR Full Panel
From Date: 07/2021
To Date: 07/2023

🖨 Screenings Rpt
🖨 Profile Rpt
🖨 Screenings with Prov Avg Rpt

1. These reports should appear similar to the PCP 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

Legend: Prov Avg Colorectal Cancer Screen · Medical Clinic
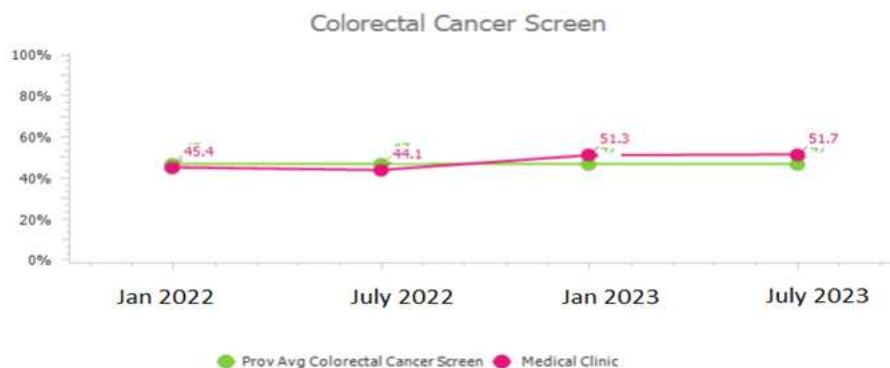
2. Select the *Save (disk) Icon* to save report as a PDF file.
3. The report will be generated on the bottom left-hand side of the screen.
4. Open the file to save report to your computer (use a private/secure location)
5. Save the screening report using the following standard format: Screening-Clinic 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 PCP at the clinic.
2. In Perform PCN, select the **Panel Management** tab then scroll down to **PCP Reports**
3. Under *Community* select *Main*

4. Under *Clinic* select *Clinic Name* on the dropdown list
5. Under *PCP* select the *individual PCP'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.
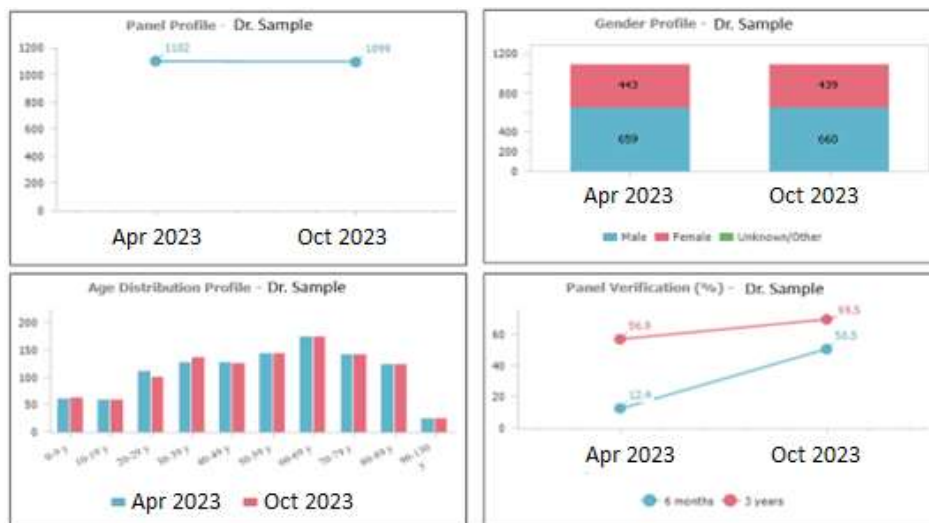

11. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
12. The report will be generated on the bottom left-hand side of the screen.
13. Open the file to save report to your computer (use a private/secure location)
14. Save all panel reports using the following standard format:
    Panel-PCP 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 PCP 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 PCP 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 PCP 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 *PCP* radio button.
7. Under *PCP* select the *individual PCP'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.*

12. Select the *Preview* Button on the bottom of the screen.
13. Example of what the Third Next Available Appointment graph should look like
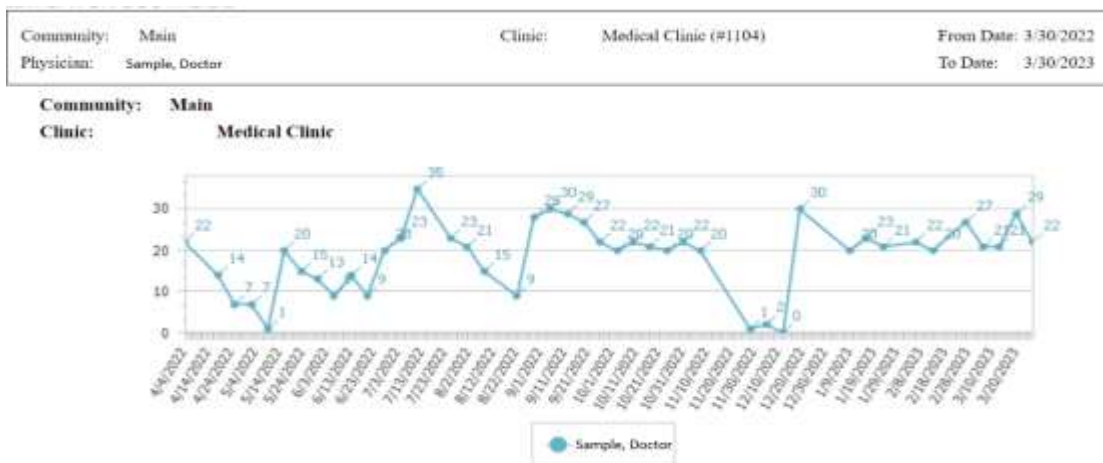
The graph above shows a clinic that has 5 PCCA rotations, so has TNA entered 10 out of 12 weeks each quarter. The graph below shows a clinic that has one PCCA rotation, so has TNA entered 2 out of 12 weeks each quarter. Both clinics have TNA entered weekly during weeks the PCCA supports their clinic.

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-PCP Last Name-MMM DD YYYY
    i.e. ***Access-PCP Last Name-Apr 13 2024.pdf***
18. Once all report files are saved, open each report to double check the file name matches the PCP data.

Verification Rate Formula

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

> **# Of paneled patients with an appointment (in a particular time) who were verified**
> **/ Total # of paneled patients with an appointment (in a particular time)**

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

Section 3: PCCA Rotation Checklist and Activity Tracking

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.

Week 1	

Monday (or 1st day of rotation):	☐ If it is the day you are running Spring or Fall reporting, enter TNA into Perform PCN so that it will show up on your Access report. Otherwise, this is run on Tuesdays.
	☐ Enter quarterly data. Run Perform PCN PCP and clinic graphs, review, send to IF.
	☐ Run baseline for the Pediatric outreach group.
	      ☐ Enter baseline into PCCA Weekly Tracking Sheet
	      ☐ Send IF a Teams Message with the Pediatric Outreach baseline
	      ☐ Complete outreach on Pediatric until list is complete

Tuesday:	☐ Enter TNA into Perform PCN.
Friday:	☐ Run weekly tracking reports and enter data 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 data into PCCA Weekly Tracking Sheet. ☐ Complete weekly PCCA form on hours worked/activity totals.
Throughout Rotation	
☐ When Pediatric outreach is complete, run Adults Outreach baseline. Follow same steps until list is complete, and continue with 75+, Chronic Disease, and Screening Outreach, until lists are complete. ☐ 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. Pick up where you left off at the last rotation, and continue following the checklist order until the end of the quarter.	

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.

Activity Tracking

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:

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.

Minimum Activity Targets: Activity is calculated from your tracking sheet and refers to the total number of worklists/tasks applied each week. The PCCA minimum Activity Target of 200 helps ensure we're meeting our goals and provides a clear benchmark for your activities.

This minimum target of 200 considers that some phone calls and chart reviews take longer than others, particularly at clinics new to PCCA work, so allows up to **11 minutes per patient** (1 Activity Point) on outreach lists:

- Pediatric
- Adult
- 75+
- Chronic Disease
- CPAR Conflicts
- Screening: when only a chart review is required

> While the minimum activity target is **200** per week, the PCCA activity average is **275** per week

Additionally, the minimum target also considers that Screening Outreach may take additional time to coordinate, particularly when requisition protocol, FIT kit distribution, and RN Women's Health Visits are being offered, and allows up to **22 minutes per patient** (2 Activity Points) for:

- Screening: when both a chart review and outreach phone call are required

Clinic factors related to panel and chart accuracy can also impact activity. For example, a PCCA doing Screening Outreach and PCCA Requisition Protocol for the first time at a new clinic may encounter several charts that require an ASaP template to be added and populated with external screening results, which can be time intensive, and then may also spend extra time preparing a requisition and faxing it to a lab. On the other hand, a PCCA working on Adult Outreach of patients not seen in 3 years may find most phone calls last less than 5 minutes. Your IF and PCC-Lead are aware of factors that can impact your weekly activity and will support you to make progress on your lists.

As progress calling patients on outreach lists is **directly related to improvement in outcomes** for continuity of care, preventative health screening, and CPAR conflicts, efficiency is an essential skill for PCCAs.

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.

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. If you were absent or spend time in meetings, education, or running quarterly reports, 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.

How Activity Targets are Measured: The total weekly activity score is calculated using your reported activity points and your actual time available for PCCA work. This ensures your target is fairly adjusted when time is spent on tasks outside of outreach, such as meetings or education. The formula is:

((Total Activity ÷ Total Available Hours for PCCA Work) × 40) ÷ 200
- Adjusts your activity to a standard 40-hour week, then compares it to the 200-point target.

Where:
- **Total Available Hours** = Total hours worked
  – hours on quarterly reporting
  – hours meeting with IF/EMR-C
  – hours in PCN-directed meetings or education

Score Interpretation:

Score	Interpretation
<1.0	Below target
1.0-1.5	Meeting target
>1.5	Above target

Examples:

Scenario	Calculation	Score	Interpretation
40-hr week, no time removed, 140 activity pts	((140 ÷ 40) × 40) ÷ 200	0.7	Below target
40-hr week, no time removed, 200 activity pts	((200 ÷ 40) × 40) ÷ 200	1.0	Meeting target
40-hr week, 10 hrs removed, 150 activity pts	((150 ÷ 30) × 40) ÷ 200	1.0	Meeting target
40-hr week, 5 hrs removed, 300 activity pts	((300 ÷ 35) × 40) ÷ 200	1.7	Above target
32-hr week, no time removed, 350 activity pts	((350 ÷ 32) × 40) ÷ 200	2.2	Above target

Section 4: 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	Clinic is unexpectedly closed or closes early, or has technology or space issues, and PCCA cannot work there	1. Call/message the PCC Lead right away. 2. Teams message Clinic IF. 3. Work on backup clinic
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/message PCC Lead • Call/message clinic • Request time off on ADP. 2. If possible, also inform 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, message dates to Clinic IF (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, message IF to review and determine next steps.
Clinic Process Changes	1. PCCA has questions about role or clinic work 2. PCP has asked for process change related to PCCA role.	Teams message Clinic IF.

	3. PCP has asked for support in areas outside of PCCA role	
EMR issues	Issues with EMR queries, CDS alerts, or any other EMR related questions	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.	Inform PCC-L.

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 <u>maximum</u> amount of time that the PCCA is able to support. The IF, in discussions with the clinic, will determine the <u>actual</u> number of rotations a clinic will receive.

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. Overtime, as panels and charts become more accurate, rotations will be decreased to reflect the reduced needs of a clinic.

This means that most PCCAs will have three 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. The PCM or IF 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 PCPs in Alberta. ACTT hosts an online learning platform, Learn@AMA. 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.

ACTT also offers information on how EMRs can support PCP 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. The ACTT website can be found here: Accelerating Change Transformation Team