PROACTIVE CARE COORDINATION ASSISTANT PROGRAM MANUAL

Primary Care Network
EDMONTON SOUTHSIDE

Contents

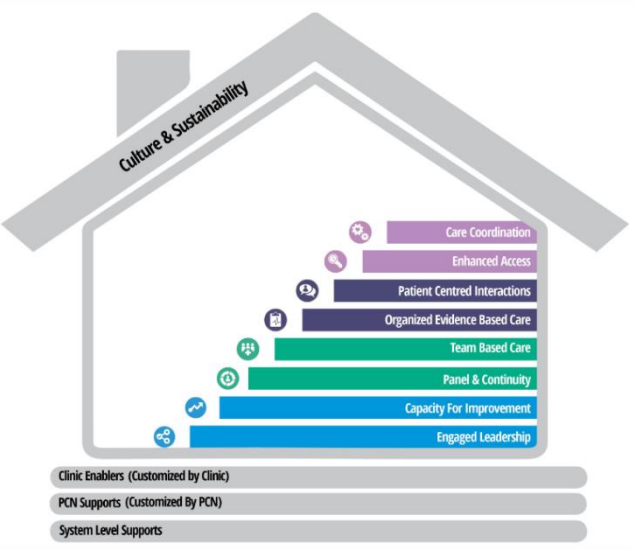
Section 1: Introduction

An Overview - The Patient's Medical Home

Research shows that having an ongoing relationship with a physician or nurse practitioner primary care provider (PCP) 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.

Patient's Medical Home

The Patient's Medical Home (PMH) is a family practice that offers 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.

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

An Overview of the PCCA Role

Proactive Care Coordination Assistants (PCCAs) support clinics towards becoming Patient's Medical Homes. 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. **PCCAs reach out to patients due for care or preventative health screening, and act as a safety net to prevent at-risk patients from falling through the cracks in the health system, by connecting them to their 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.

<u>Each clinic will establish the definition of an active or inactive patient.</u>

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. 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 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 today. 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? "

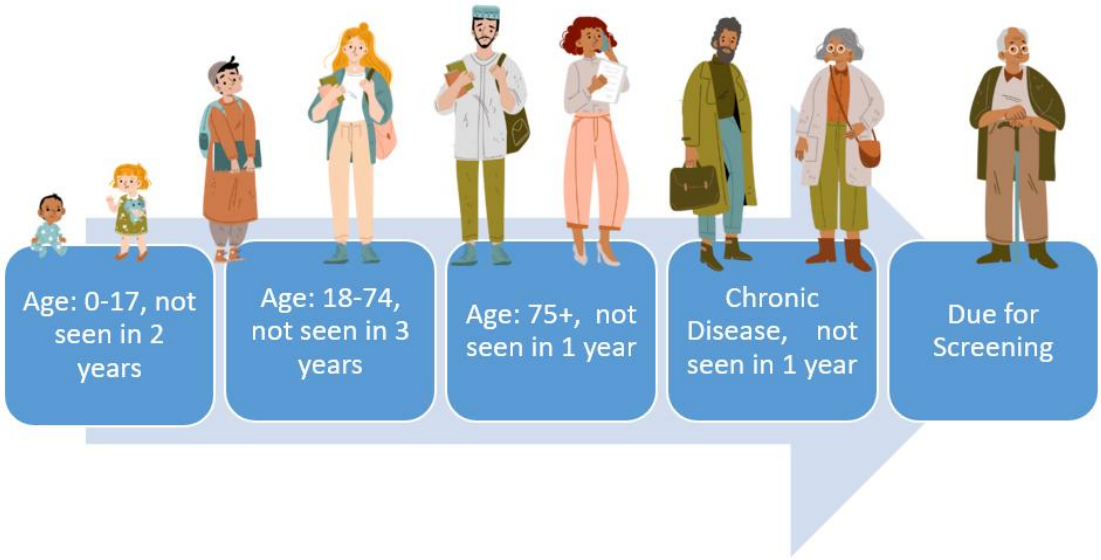
What is Care Coordination?

Some patients may be due for care or preventative health screening. Care coordination is the proactive approach of identifying these patients, outreaching to them, and inviting them for an appointment with the appropriate team member at their medical home or connecting them directly to preventative health screening.

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 outreach. 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 app. You will "phone" patients through the app on your computer, which shows "Primary Care Network" on the call display of the patients you call.

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.

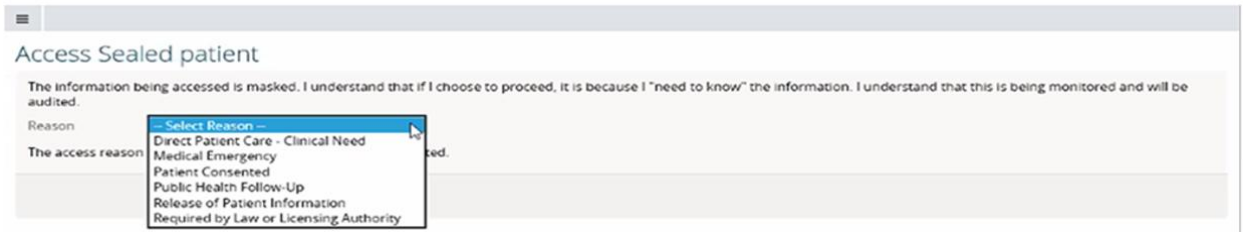
Netcare

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.

You will have Netcare access at each clinic, and must access the correct clinic clinic-dropdown each time.

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: Care Coordination and Outreach

The PCCA role involves finding patients in the EMR who are due for care or preventative health screening, calling them, and booking them appointments or offering 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, or providing a reminder to complete screening, or offering a screening requisition.

The standard order of outreach will 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.

Pediatric Outreach

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.

	Pediatric: < 18 and no visit in 2 years Work on after Conflicts					Historical Data	
Doctor	Baseline:	Process: # of patients reviewed and/or called		Running Total		Date	Total
Date	2-Mar-26	02-Mar-26				01-Jan-26	102
Dr. Red	**62**	62		62		02-Mar-26	62
Total	**62**	62	0	62			

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.

PCCA 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).

Adult Outreach

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.

Adults: Age 18-74 Years & No Done Appt in 3 Years work on this list after peds					Historical Data	
Doctor	Baseline:	Process: # of patients reviewed and/or called	Running Total		Date	Total
Date	2-Mar-26	08-Mar-26			01-Jan-26	291
Dr. Red	**105**	105	105		02-Mar-26	105
Total	**105**	105	105			

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 of the maximum number of outreach calls this group should receive before being 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.

PCCA 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. "Adult" outreach task/worklist** should be applied if:

    a. You reviewed the chart and there is clear communication that the patient has informed the clinic they have ended their relationship with the provider.

    b. You contacted the patient (even if you did not reach them)

    c. You created a worklist for another clinic team member to contact the patient.

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

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 Year Outreach

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.

75+ and no visit in 1 year work on this list after Adults				Historical Data	
Doctor	**Baseline:**	Process: # of patients reviewed and/or called	**Running Total**	**Date**	**Total**
Date	**05-Mar-26**	08-Mar-26		06-Jan-26	54
Dr. Red	21	21	21	05-Mar-26	21
Total	**21**	21	21		

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. 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, you can follow the clinic process to inform the PCP and update the patient's status in the EMR. Then, proceed to Step # 4.
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.

PCCA 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 Outreach

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.

<75 + Chronic Disease + No visit in 1 year work on this list after 75+					Historical Data	
Doctor	**Baseline:**	Process: # of patients reviewed and/or called	**Running Total**		**Date**	**Total**
Date	**05-Mar-26**	08-Mar-26			06-Jan-26	92
Dr. Red	45	45	45		05-Mar-26	45
Total	**45**	45	45			

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. 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, you can follow the clinic process to inform the PCP and update the patient's status in the EMR. Then, proceed to Step # 4.
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.***

PCCA 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, 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.

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.

Cervical Cancer Screening: includes the pap test and HPV Screen. Pap test is the main screening test for cervical cancer for females age 25-49. 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.

For patients age 50-69, an HPV Screen is completed, which tests for the presence of human papillomavirus (HPV), which can lead to cervical cancer. Both tests are 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 cholesterol levels. It is recommended every 5 years for people age 40-74 as part of preventative cardiovascular disease screening.

Screening Outreach Instructions:

- **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.
  Please note: At most clinics, your query will exclude patients you have already called as part of your "Adults" outreach.
- **Organize list by last visit date.** Start with the patients who have not been in the clinic for the longest time.
- **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. Next, check whether a requisition or FIT kit was 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.
- **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.
  Note: If using HealthQuest EMR, you will update the ASaP template after your Netcare review. If, prior to your Netcare review, you come across a patient who should be inactivated (for example, has a worklist that they have moved), you should still update the ASaP template, and then create a general chart worklist to inform when they were inactivated. This ensures your activity is counted for that patient.

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, HPV Screen, 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 outreach according your clinic's process. .

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

All mammogram reports should have recommendations and a Breast Imaging Reporting and Data System (BI-RADS) score. 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 SCORE	DESCRIPTION	RECOMMENDED ACTION FOR PCCAs
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).	Check to see if patient has already had a breast ultrasound. If not, send task to PCP.

1	Negative test – No follow-up needed. Routine screening is usually recommended.	No Action Needed – Continue with usual screening outreach process for patient. Call patient or send requisition depending on clinic process.
2	Non-cancer finding: Something was found but radiologist is 'certain' it is not cancer. No follow-up needed. Routine screening is usually recommended.	No action needed – Continue with usual screening outreach process for patient. Call patient or send requisition depending on clinic process.
3	Probably not cancer: There is up to **2% chance** of being cancer. 6-month follow-up mammogram is usually recommended.	If test ordered outside of clinic, send task to PCP.
4	Suspicious abnormality – up to **30% chance** of being cancerous. Patient needs a biopsy.	If test ordered outside of clinic, send task to PCP.
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.	If test ordered outside of clinic, send task to PCP. Most likely, patient is being followed by specialist.
6	Known biopsy with proven cancer: This is used for patients with known breast cancer confirmed with biopsy. Patient is most likely being followed by specialists.	Most likely, patient is being followed by specialist. Send task to PCP if mammogram was ordered outside of clinic.

Source: *BIRADS 2 3 4 and 5: What does it mean? (breast-cancer.ca)*; *BI-RADS Score: Understanding Your Mammogram Results (healthline.com)*

In most cases the recommendations align with the BI-RADS scores. If this is not the case, send a task to the PCP.

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.' A positive or abnormal result means there was blood identified in the stool. All positive FIT results require a follow-up colonoscopy investigation.

Colonoscopy: 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.

Flexible Sigmoidoscopy: is like colonoscopy, but only evaluates the lower part of the large intestine, unlike colonoscopy which evaluates the entire large intestine.

When reviewing Colonoscopy results, look for recommendations and findings under the "Impression and Plan" OR "Postoperative diagnosis" section of the report.

Recommended Actions for PCCAs, based on test results.

TEST	FINDING	DESCRIPTION	Recommended Action for PCCA
FIT	Negative	A negative result means there was no blood identified in the stool.	Continue routine screening every 1-2 years depending on clinic process.
	Positive	A positive or abnormal result means there was blood identified in the stool. All positive FIT results require a follow-up colonoscopy investigation.	Confirm colonoscopy has not been ordered/done already, then book follow-up with PCP to discuss screening options.
Colonoscopy or Flex Sigmoidoscopy	Normal	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.	Book follow-up with PCP to discuss next screening options.
	Hemorrhoids	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.	Book follow-up with PCP to discuss next screening options.
	Diverticular Disease	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.	If test was ordered outside of clinic, send task to PCP.
	Polyps	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.	If test was ordered outside of clinic, send task to PCP.

	Adenocarcinoma	Adenocarcinoma: This means the patient has cancer. The patient is most likely being treated and followed by a specialist.	If test was ordered outside of clinic, send task to PCP.

Source: [1]Understanding the results of your colonoscopy - Harvard Health; [3]Are Hemorrhoids Associated with False-Positive Fecal Immunochemical Test Results? - PubMed (nih.gov); [4]They found colon polyps: Now what? - Harvard Health

Reviewing Cervical Cancer Screening Test Results

Cervical cancer screening includes the pap test and the HPV Screen. For the general population, the Pap test is offered as the screening test for cervical cancer in women age 25-49, while the HPV test is offered for women age 50-74. The pap test looks 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.

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.

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

PAP TEST RESULT (CODE)	DESCRIPTION	RECOMMENDED ACTION FOR PCCA
NIL(M)	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.	Offer routine screening every three years for patients age 25-59.
ASC-US (ASCUS)	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.	If test was ordered outside of clinic, send task to PCP.

	Depending on the age of the patient and HPV results, a referral for colposcopy, a repeat Pap testing or routine screening may be recommended.	
ASC-H	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.	If test was ordered outside of clinic, send task to PCP.
AGC	Atypical glandular cells (AGC): [3]A referral for colposcopy is usually recommended.	If test was ordered outside of clinic, send task to PCP.
LSIL	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.	If test was ordered outside of clinic, send task to PCP.
HSIL	High-grade squamous intraepithelial lesion (HSIL): [3]A referral for colposcopy is usually recommended.	If test was ordered outside of clinic, send task to PCP.
AIS, SCC, other cancers	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.	If test was ordered outside of clinic, send task to PCP.
Inadequate Sample	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.	If test was ordered outside of clinic, send task to PCP or RN depending on who requested the test.
Hysterectomy on chart	Patients with a "Total Hysterectomy" should not show in the EMR as due for cervical cancer screening, as they are excluded in our EMR queries. However, you may find a patient who has 'Hysterectomy' documented in their chart, but not indicated if it is "total" or "partial".	Send task to RN or PCP: Clarify if hysterectomy was total or partial, and whether patient requires ongoing cervical cancer screening. If "total", request chart be updated so patient can be removed from future screening lists.

Hysterectomy not on chart, but on Netcare:	If you find that a patient who is due for Pap has hysterectomy documented on Netcare, the chart needs to be updated in order for the patient to be removed from future screening lists.	Download result into EMR and send task to RN or PCP to update in chart.

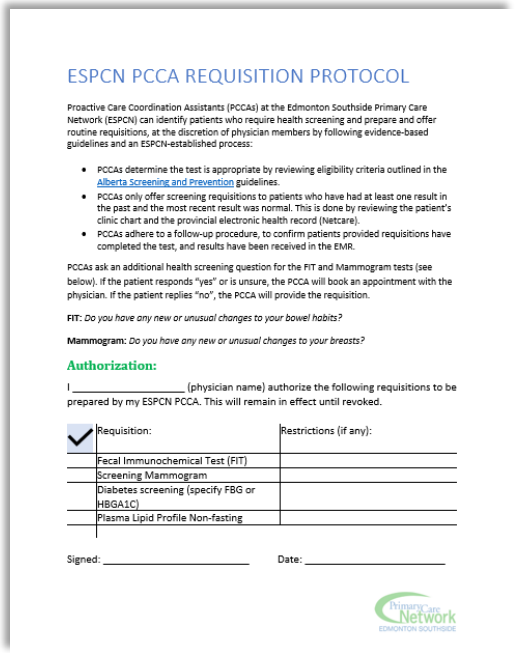
Source: [1]Pap Test (alberta.ca), [2]How to read your Pap test report | MyPathologyReport.ca, [3]cervical-cancer-screening-cpg.pdf, (albertaPCPs.org), [4]ASCUS (jhmi.edu)

After reviewing Netcare and actioning on any external results, you will resume your outreach process:

- **Outreach to Patient.** When outreaching to patients for screening outreach, your approach will depend on what you have found during your chart review, and any clinic-specific processes. For example:
  - You may find a **patient was recently provided a requisition**, 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 a lab or imaging centre. Typically, requisitions are valid for 1 year after being issued.
  - Your may find your **patient had a requisition faxed** to lab or imaging centre, but there are no results available. If the requisition for FIT, diabetes, or plasma lipid profile was sent to a lab in the past 2 months, the lab will still have it on file. If a requisition for mammogram was sent to an imaging centre in the past 3 years, the centre will still have it on file. In your call, you may ask if this is still the centre of their choice to attend and encourage them to book their appointment.
  - 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 previously, but that there are no available results. In your call, you may ask the patient if they still have the FIT kit, ensure that the expiry date listed on the kit has not passed, and then remind them to complete the kit and bring it to a nearby lab.
  - If your clinic has an RN who completes cervical cancer screening, you may follow a clinic process to **book a separate Women's Health Visit**, where the RN can assess the patient and complete the cervical cancer screening required.
  - Finally, your will also be able to directly **provide screening requisitions** (mammogram, FIT, lipids, and/or diabetes) to the patient on behalf of many PCPs. 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 process is described in detail below.

Screening Requisition Protocol

For a PCCA to provide screening requisitions, a PCP must sign the PCCA Requisition Protocol, selecting which requisitions they approve the PCCA to provide on their behalf.



ESPCN PCCA REQUISITION PROTOCOL

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

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

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

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

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

Authorization:

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

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

Signed: _____ Date: _____

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

- The **first time** a patient requires mammogram, FIT, lipids, or diabetes screening, they are booked with 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. This includes patients whose most recent test was a colonoscopy, even if they appear to be eligible for FIT screening again.

There are two streams of requisition protocol: Direct and Phone call.

Direct: Involves the PCCA sending the requisitions directly to the patient through the clinic's EMR patient portal. If this is the option selected by the PCP, the PCCA must also include an informational letter or handout, along with the requisition. Your IF will share this information with you.

Phone call: If this is the option selected, the PCCA can offer a variety of ways to provide the patient the requisition, including faxing it to the lab, emailing it to them through an EMR email, or arranging for them to pick it up at the clinic. PCCAs also need to follow a script to ask screening questions before providing the requisitions, when offering mammogram or FIT requisitions.

- **Faxing requisitions:** When offering to fax a requisition, ask the patient if they have a preferred location. See the options for lab and imaging centres below, and be aware if the centre will keep a requisition on file.

Type of test	Centre	General Fax?	How long they keep requisition on file	Does patient need to call?
FIT, Diabetes, and Plasma Lipid Profile	APL (Alberta Precision Laboratories)	No – must fax to individual lab location	2 months	Yes
Mammogram:	Insight	Yes	3-5 years	No: they will call.

ask patient if they have a location preference	MIC (Medical Imaging Consultants)	Yes	Forever	No: If the patient is <70 and has a file with them, they will text to book online or call. If the patient is >70 or does not have a file, they will call to book.
	CDC (Canada Diagnostic Centre)	Yes	Forever	No: they will call with 3 days, but patient can call if they want to book sooner.

- **EMR email:** Some clinics allow PCCAs to use an EMR feature to send the patient an email to the email address listed on their patient chart. Please note – PCCAs are never allowed to send patients emails through their ESPCN email address – an EMR email has a higher level of encryption to protect patient information. If sending through EMR email, the PCCA must:
  - Confirm the email address in the EMR is correct
  - Document: "Received verbal consent to email requisition to email address on file.". This consent is valid for the purpose of this particular outreach only. It can carry over to related follow-ups, such as emailing reminders to complete the same requisition at a future rotation.
- **Pick up at clinic:** If a patient chooses to come into the clinic to pick up their requisition, prepare the templated requisition, and leave a clear worklist, so the front team will understand what to do when the patient arrives.

PCCA 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, if no longer a patient, inactivate patient as per clinic process]

I am reaching out to let you know that you are due for some routine preventative health screening (advise of test(s) due).

- If offering a **screening reminder:**
  [PCP] provided you with a [name requisition type] on [date requisition was provided]. Have you had a chance to book an appointment for this screening yet?;
  [If not]. Do you still have the requisition or would you like us to share it again?
  Note: even if your PCP is not participating in requisition protocol, you should have a clinic process to re-share a previously ordered screening requisition with patients.
- If offering a **FIT kit completion reminder:**

[PCP] provided you with a [FIT kit] on [date FIT kit was provided]. Have you had a complete this test yet?
[If not]. Do you still have the FIT kit available? Can you check the expiry date to ensure it is not expired?
Note: If the FIT kit has expired, follow a clinic process for patient to be provided a new kit. If the FIT kit has not expired, remind them to complete the test.

- If offering a **requisition for mammogram:**
  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 provide a requisition.

- If offering a **requisition for FIT:**
  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 surgeon 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 provide a FIT requisition.

- If offering an **appointment:**
  Can I book you an appointment with the PCP and/or Registered Nurse to get your screening up to date?
  If yes, book an appointment as per the clinic process.

- If the patient **declines a screening requisition or appointment:** If the patient declines any offer of screening, offer to book them a telephone call with the clinic Registered Nurse, for more information. If the clinic declines the RN phone, thank the patient for their time, and inform them that we will try calling them again in three months.

- If **leaving a message:**
  *Hello, this message is for [patient's name]. I'm calling on behalf of (PCP's name) 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). We look forward to hearing from you.*

– *If your clinic is not open during your PCCA working hours, you may also add onto your reminder message "Please call the clinic back during clinic hours."*

- **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.

- **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 March 8, 2026, the PCCA reviewed 105 charts on the Screening Outreach list for Dr. Red.. The PCCA's "Screening Reviewed by PCCA" report at the end of the week showed 105 patients, and this was entered in the tracking sheet.

Preventative Screening (Due for 1 of 5 screens) ***Work on this list after completing 'chronic disease'***

					Historical Data	
Baseline	**381**				**Date**	**Total**
2025-04-24	**Screening Reviewed**	**Outreach Calls**	**Total Screening Reviewed**	**Total Remaining**	01-Nov-25	789
Running Totals	**381**	**344**	**381**	**0**	13-Jan-26	601
	Enter # of patients reviewed and contacted each week				08-Mar-26	381
	Dr. Red					
Req protocol?	None					
Paps?	RN					
Date	Screening Reviewed	Outreach Calls	Weekly Activity Totals			
2026-03-08	105	90	195			
2026-03-15	276	254	530			

- 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.

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 above, on the week of March 8, 2026, although the PCCA reviewed 105 charts on the Screening Outreach list for Dr. Red, only 90 patients required Screening Outreach calls. The 15 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 90 patients who were called, and this was entered in the tracking sheet.

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

PCCA Macros

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. When patients come in for their scheduled visits, providers also need to understand why the patient was called. This is why always using a task/worklist when working on a patient's chart is essential.

You will also be provided a list of standard macros to use within your clinic, which helps standardize the content entered into each task/worklist.

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.

Defer PCCA Outreach Macros: PCCAs run the same outreach lists each quarter and will often contact the same patients multiple times. In most cases, this is appropriate. Some patients require repeated reminders before they book an appointment or complete screening.

In some situations, however, patients on the list are not appropriate for outreach or are unavailable for an extended period. In these cases, use the **"Defer PCCA Outreach"** EMR macros to temporarily remove them from outreach lists.

Required Macros (HealthQuest and Med Access EMRs)

PCCAs should create two macros:

1. **Defer PCCA outreach for 6 months**
2. **Defer PCCA outreach for 12 months**

These macros should be applied to the outreach worklist/task template, along with:

- The reason for outreach (macro), and
- A manually entered note explaining why outreach is being deferred

How Deferral Works

- Patients with a **6-month defer** will not appear on outreach lists for 6 months
- Patients with a **12-month defer** will not appear on outreach lists for 12 months

These macros apply only to PCCA outreach lists and do not affect EMR alerts, reports, or other clinical workflows. Use them only when appropriate.

Area	Defer PCCA outreach for 6 months	Defer PCCA outreach for 12 months	When to not apply a defer macro, and alternate process
Patient is out of province or country	Time away is expected to be 6-12 months.	Time away is expected to be greater than 12 months, but	1. Time away is less than 6 months – *leave on list for future outreach.* 2. Patient has moved away permanently – *inactivate in EMR.*

		patient is expected to return.	
Patient is medically inappropriate for screening (e.g., palliative, advanced dementia, homebound)	Do not apply.	1. There is clear documentation from the PCP that the patient is not appropriate or not eligible. 2. Patient has never been sexually active and is due for Cervical Cancer Screening.	1. Do not assume. *Confirm with PCP if unsure.* 2. If the query is incorrect (e.g., wrong age), *inform EMR-C.* 3. If chart is incomplete (e.g., hysterectomy not recorded as "total"), ask PCP to update.
Patient has refused screening or visit.	Patient requests reminder in 6 to 12 months	Patient declines RN telephone follow-up and requests no further PCCA calls.	Patient declines screening or visit: *offer RN phone call and attempt outreach again next quarter*
Patient is not part of primary care panel (e.g., PCP sees patient in facility setting)	Do not apply.	Do not apply.	*Follow clinic process to update patient status, or inform IF if process is not in place*
Patient owes clinic money.	Do not apply.	Do not apply.	Work with IF and clinic to determine process, such as: – asking patient to call the clinic to book – informing patient they are due for care while noting balance – assigning follow-up to clinic manager
Pediatric Patient has seen pediatrician within 2 years	Last appointment with pediatrician was between 18 months-2 years	Last appointment with pediatricians was within past 18 months.	Patient has not seen either PCP or pediatrician in the past 2 years, even if they confirm attachment to a PCP. Instead, ask them to book follow-up at either PCP or pediatrician, and leave patient on list.

If you come across situations outside of this list that may require patient to be deferred from PCCA outreach, ask your PCC Lead for direction.

CPAR Conflict Outreach

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.

	CPAR - Conflict reports work on first						Historical Data	
Doctor	BASELINE	Process: # of patients called or fax resent to clinic or inactivated			Running Total		Date	Total
	2026-03-02	02-Mar-26	08-Mar-26				01-Jan-26	389
Dr. Red	247	188	59		247		02-Mar-26	247
Total	247	188	59	0	247			

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

PCCA 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.

PCCA Script for Leaving a Message for all outreach:

*"Hello, this message is for [patient's name]. I am calling on behalf of (PCP's name) at (clinic name) 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."*

- *If your clinic is not open during your PCCA working hours, you may also add onto your reminder message "Please call the clinic back during clinic hours."*

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

Section 3: Reporting

Time to Third Next Available Appointment

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.

One measure of access that you will be responsible for collecting is the Third Next Available appointment (TNA), and entering it into Perform PCN. 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. 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.

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

Can I see an example?

Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon
	05-Nov-18	06-Nov-18	07-Nov-18	08-Nov-18	09-Nov-18	10-Nov-18	11-Nov-18	12-Nov-18
9-930	BP	Physical	Diabetes	Diabetes	Diabetes	**CLOSED**	**CLOSED**	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			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. 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. The data is entered into the Perform PCN database weekly.

Annual Reporting of Clinic EMR Data

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.

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 year: This section outlines the reports that PCCAs run once per year during their January to March rotation. The list below reflects the required reports only, without additional assumptions or interpretation.

Purpose: Annual reporting provides clinics with a snapshot of their performance in preventive care, access, continuity, and key chronic disease indicators. IFs use these reports to:

- Identify gaps in screening and monitoring.

- Support clinic teams in planning QI activities for the year.
- Provide standardized, comparable data across the PCN.

Reporting Schedule:

PCCAs will complete the following reports:

1. **General Population Screening:** Perform PCN reports

Run and record the **percentage of eligible patients screened** for the following measures:

- Breast cancer
- Colorectal cancer
- Cervical cancer
- Diabetes screening
- Plasma lipid profile
- Cardiovascular (CV) risk calculation
- Height and weight
- Blood pressure (BP)
- Exercise assessment *(do not include on graph)*
- Tobacco use assessment *(do not include on graph)*

2. **Panel:** Perform PCN Reports

Generate the following panel-level data:

- Total patients on panel
- Ages and sex distribution of patients
- Percentage of patients verified for attachment in the past:
    - 6 months
    - 3 years

3. **Continuity of Care:** Excel-based Continuity of Care Reports

Generate and record the:

- Number of patients on panel seen in the past 3 years
- Number of patients age 75+ seen in the past year
- Number of patients with a chronic disease seen in the past year (diabetes, hypertension, COPD, heart failure, heart disease, kidney disease)

4. **Access:** Perform PCN Reports

Generate graph for the

- Days to **Third Next Available appointment**

5. Clinical Outcomes

Routine Monitoring for Chronic Disease Care: Excel-based Continuity of Care Reports

Record the **number of patients**:

- With diabetes
- With diabetes, who had a completed foot exam in the past year
- With diabetes, who had an HbA1c test in the past 6 months

- With hypertension
- With hypertension, who had a blood pressure measurement recorded in the past 6 months

Patients Outside of Target Ranges: Excel-based Continuity of Care Reports

Record the **number of patients**:

- With diabetes who had an a1c in the past 12 months
- With diabetes who had an a1c in the past 12 months and had an A1C >8.5% in the last 12 months
- With hypertension who had a blood pressure recording in the past 12 months
- With hypertension who had a blood pressure recording in the past 12 months, who had an elevated systolic blood pressure >130 in the past 12 months

Notes for PCCAs

- Ensure all reports are filed in the designated shared folder for your clinic group.
- When graphing results, exclude Exercise Assessment and Tobacco Use Assessment.
- Review all reports for data anomalies. As a general rule, look for changes greater than 15% in the past 12 months. If you observe these changes, follow these steps:
    - First, re-run the data, to ensure there was not an entry error
    - Then, when sharing the data with the clinic's IF, inform that you have observed a significant change in the data, and that you have re-run your reports to ensure it was not an entry error.
- PCCAs will enter the appropriate data on the first day of their clinic rotation between January and March.
- TNA will be entered weekly during all weeks at a clinic, preferably on a Tuesday.
- After confirming the accuracy of individual PCP data, PCCAs will also generate a clinic level graph and report.

Sharing the Reports

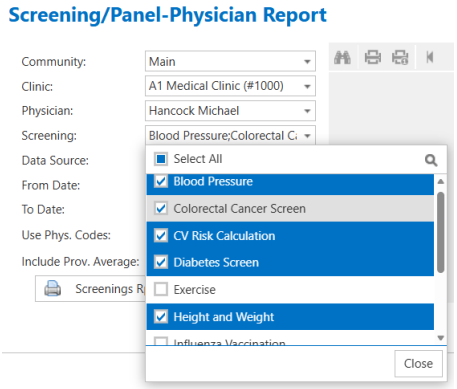
Each time data is entered in to Perform PCN, the PCCA will generate a graph, save as a PDF, and share it back with their IF through Teams. Three types of graphs (Panel, Screening, and Access) are generated in Perform PCN. Below are specific instructions on how to generate these graphs.

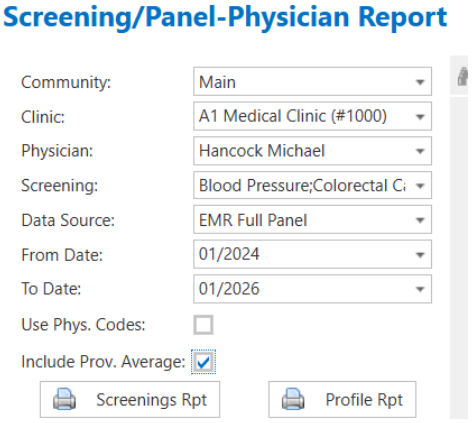
IFs will share the PCP-specific graphs/reports directly with each PCN member PCP and the clinic-level graphs/reports in the Teams-Medical Home channel as a way to inform the ESPCN MDT and PCM of the important care coordination work happening behind the scenes.

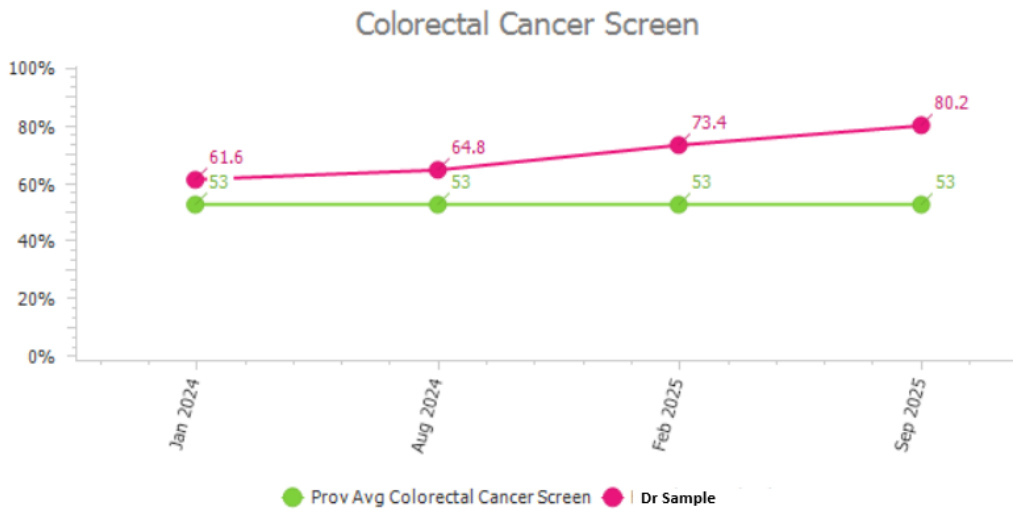
Screening Graphs

Steps for running Screening Graphs:

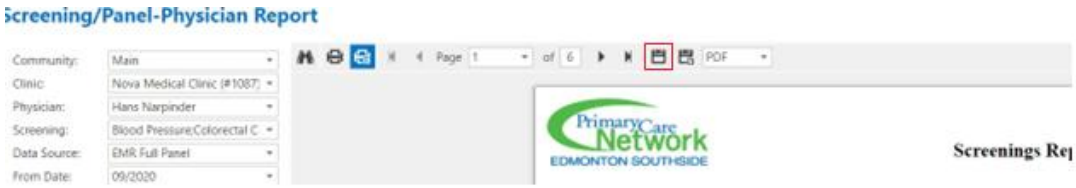
1. Run screening graph individually for each PCN member PCP at the clinic.
2. In Perform PCN, select the **Panel Management** tab on top, then scroll down to **PCP Reports**
3. Under *Community* select *Main*
4. Under *Clinic* select *Clinic Name* on the dropdown list
5. Under *PCP* select the *individual PCP's name* on the dropdown list
6. Select Screening maneuvers: under *Screening* check off *Select All,* then unselect "tobacco", "influenza", and "exercise".
7. Under *Data Source* select *EMR Full Panel*
8. Under "*From Date*", select a date *two years prior to today*. Under "*To Date*" select *today's date*.
9. Check box labeled *Include Prov. Average*
10. Select *Screening Rpt* button on bottom of screen.
11. Example of what the PCP Screening Graph should look like



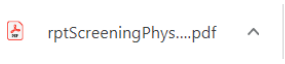




12. Select the *Save (disk) Icon* to save report as a PDF file.



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

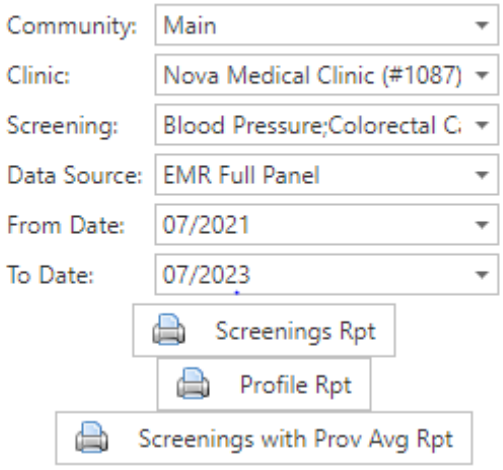


14. Open the file to save report to your computer (use a private/secure location)
15. Save the screening reports using the following standard format: Screening-PCP Last Name-MMM DD YYYY
    i.e. ***Screening-Shute-Jan 10 2026.pdf***
16. Once all report files are saved, open each report to double check the file name matches the PCP data.

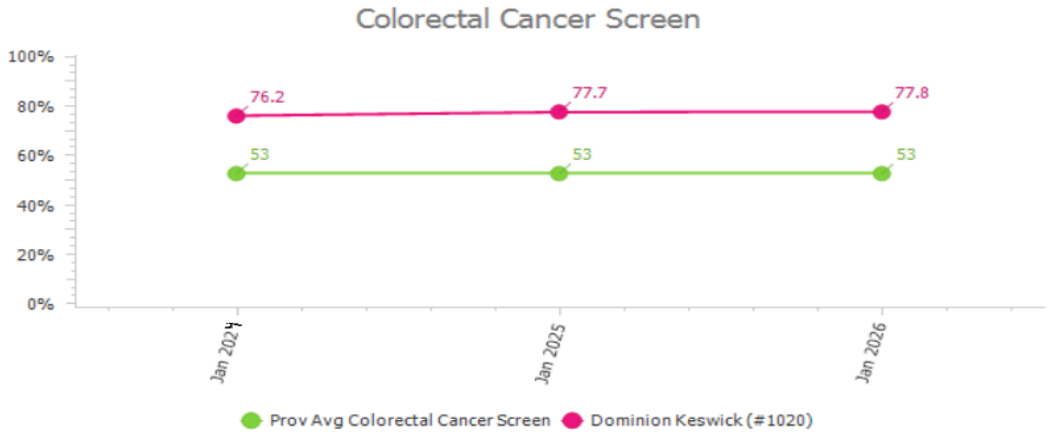
To run the clinic level graph, follow the instructions below:

1. In Perform PCN, select the **Panel Management** tab on top, then scroll down to **Clinic Reports**
2. Follow the same instructions as above.
3. Select *Screening with Prov Avg Report* button on bottom of screen.

Screening/Panel-Clinic Report



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



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-Dominion-Jan 13 2026.pdf***

Panel Graphs

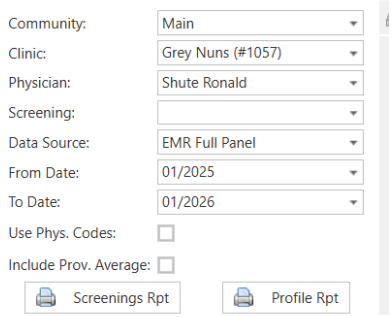
Steps for running Panel graphs:

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 at least 2 data points. It is okay if there are more than 2 data points as long as the timeframe is one year. 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.

Screening/Panel-Physician Report

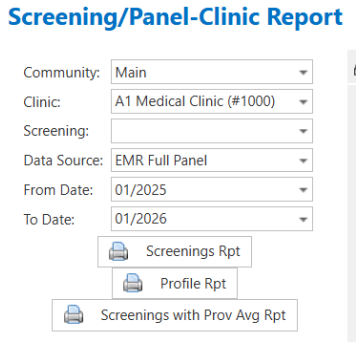


11. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
12. The report will be generated on the bottom left-hand side of the screen.
13. Open the file to save report to your computer (use a private/secure location)
14. Save all panel reports using the following standard format: Panel-PCP Last Name-MMM DD YYY
    i.e. ***Panel-Shute-Jan 13 2026.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**
2. Under *Community* select *Main*
3. Under *Clinic* select *Clinic Name* on the dropdown list
4. Under *Screening* leave blank
5. Under *Data Source* select *EMR Full Panel*
6. In "*From Date*" select a date *1 year prior to today*, in "*To Date*" select *today's date*.
7. The panel graph should show at least 2 data points. If needed, adjust your timeline to ensure 2 data points are visible. It is okay if there are more than 2 data points as long as the timeframe is one year.
8. Select *Profile Rpt* Button on bottom of screen.

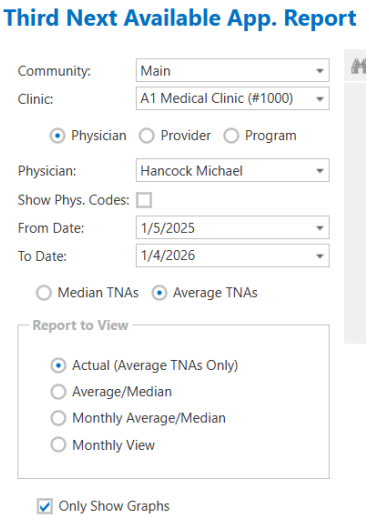


9. Once the report generates select the *Save (disk) Icon* to save report as a PDF file
10. The report will be generated on the bottom left-hand side of the screen.
11. Open the file to save report to your computer (use a private/secure location)
12. Save the panel report using the following standard format: Panel-Clinic Name-MMM DD YYYY
    i.e. ***Panel-A1-Jan 13 2026.pdf***
13. Once all report files are saved, open each report to double check the file name matches the PCP data.

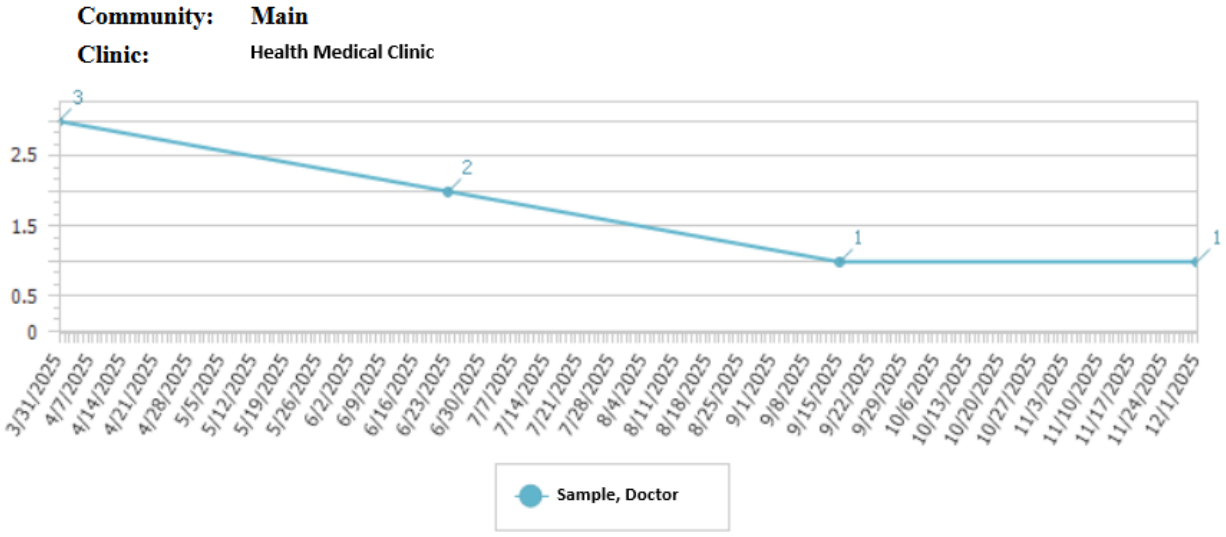
Access (TNA) Graphs

Steps for running TNA graphs:

1. TNA is typically entered into Perform PCN on a Tuesday.
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 0.5 PCCA rotations, so has TNA entered 1 out of 12 weeks each quarter. A clinic with 1 PCCA rotation would have 2 entries every 12 weeks.

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.
17. Save all TNA reports using the following standard format: Access-PCP Last Name-MMM DD YYYY, i.e. ***Access-PCP Last Name-Jan 13 2026.pdf***

Section 4: Weekly Tasks

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 a rotation between January and March: enter your annual data. Generate Perform PCN PCP and clinic graphs, review, send to IF. ☐ Run baseline for the Pediatric outreach group. ☐ Enter baseline into PCCA Weekly Tracking Sheet ☐ 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 Adult outreach, 75+, Chronic Disease, and Screening Outreach, until lists are complete. Complete outreach for CPAR conflicts as directed.	

Regardless of where you leave off, for your first rotation of the next quarter you will 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. If your clinic is addressing CPAR conflicts, this may also be the first group you address.

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

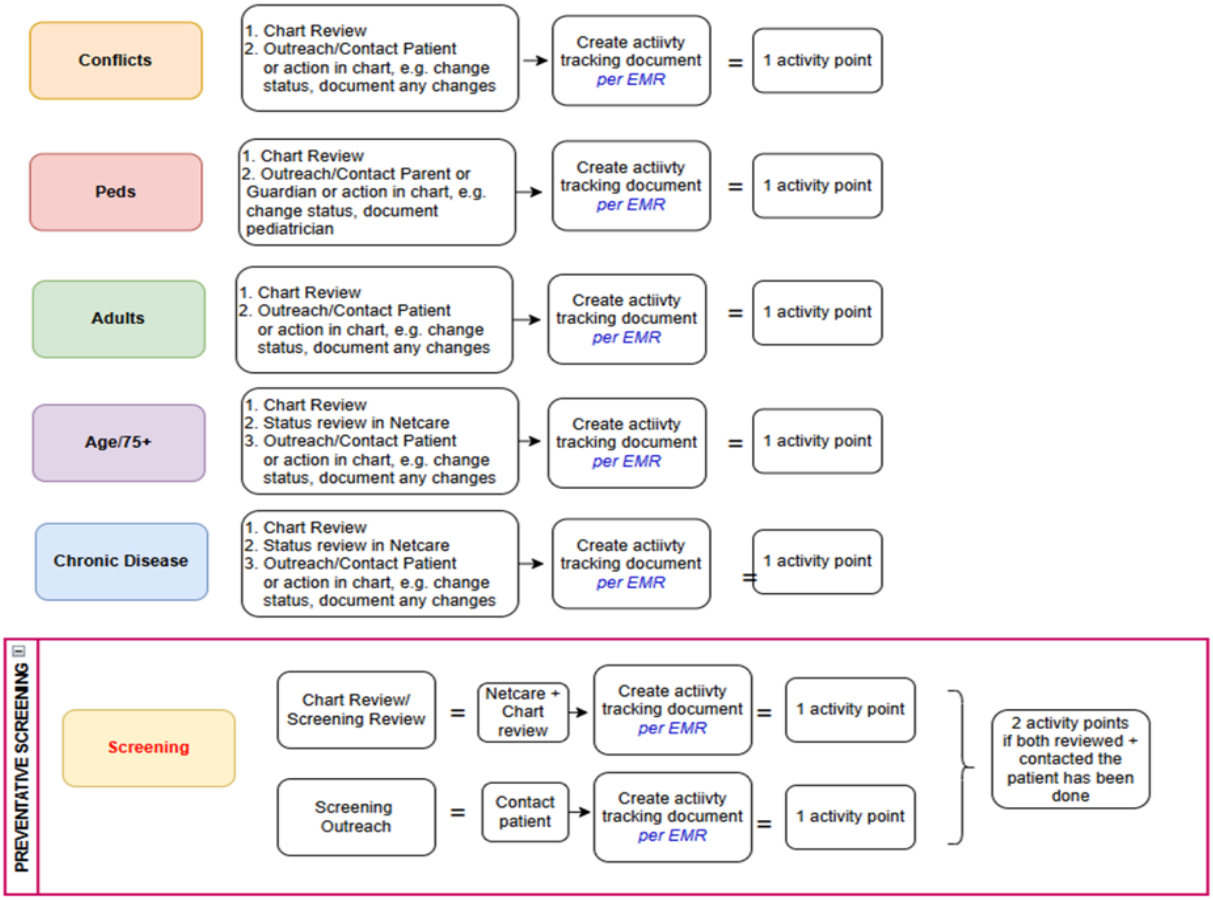
Additionally, the minimum target also considers that Screening Outreach may take additional time to coordinate, particularly when requisition protocol, FIT kit distribution, and RN Women's Health Visits are being offered, and allows up to **22 minutes per patient** (2 Activity Points) for:

- 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 a screening template to be 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 take 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.

This graphic provides a snapshot of how activity points align with areas of outreach:



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 annual 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 annual 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 5: Further Information

Communication Expectations

Because you are in a largely remote position, PCCAs must communicate clearly and early, when issues arise. Before starting new requests or changing any clinic processes, contact your **Clinic IF**.

PCCAs are expected to **email the clinic one week before a new rotation** to confirm dates and in-clinic days.

Who to Contact

Sick time:

- Phone **PCC Lead.**
- Submit ADP request.
- Review Outlook schedule and decline any meeting requests for that day, and inform sender (e.g., MDT Huddles organized by PCM, meeting with IF or EMR-C).
- Inform clinic of absence via EMR message, email, or phone.

Delays to work (clinic closures, technology or space issues):

- **Inform the PCC Lead right away**, contact F12 if necessary, send a joint message to the clinic and **Clinic PCM**.
- If waiting for a response to delay, move to short-term back-up clinic.

New clinic requests or process questions (requests for patient lists, EMR support, workflow changes, tasks outside role):

- Contact the **Clinic IF** before adjusting workflow.

EMR issues (queries, CDS alerts):

- Send a joint message to the **Clinic EMR-C and Clinic IF**.

Equipment or supplies (PCN devices, programs, clinic access, folders):

- Inform the **PCC Lead**.

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 QI Manager, IF, and PCM, will determine the amount of PCCA support needed. Overtime, as panels and charts become more accurate, rotation time will be decreased to reflect the reduced needs of a clinic. Over 85% of ESPCN clinics receive 0.5-1 PCCA rotations each quarter, with a few larger clinics receiving more support. 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. If the PCCA is unable to work at their assigned clinic, they will work at their short-term back-up clinic, which is listed on the PCCA Rotation Schedule. 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.