EMR Certification

Primary Care Quality Indicator Reminders and Data Extract Assessment Guide

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Version 5.1

Shared health Soins communs Manitoba

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1 Overview

1.1 Document Purpose

This document contains details of the demonstration component of the assessment required in order for an Electronic Medical Record (EMR) Product to be certified for Manitoba's Primary Care Quality Indicator (PCQI) Reminders and Data Extract.

1.2 Acronyms

EMR Electronic Medical Record

PCQI Primary Care Quality Indicators

1.3 Related Documents

Table 1: Related Documents

DOCUMENT
Primary Care Quality Indicator Reminders and Data Extract Specification
eHealth hub – Home Clinic Enrolment Service Interface Specification

2 Patient Profiles

This section describes the test patient data required to certify against this specification. When setting up these patients in your EMR Product, the following guidelines should be adhered to:

1. If the EMR Product requires additional demographic data to create a patient record, Vendors should populate those fields as they see fit.
2. Patient records must only contain the clinical data specified in the “Clinical” column. If there is more or less clinical data provided for that patient, that record would not pass verification. Patient records must reflect age and timeframes outlined below at the time of demonstration.
3. Vendors will be required to create three providers as outlined below andVendors must ensure that only patients outlined in section 2 are assigned to these providers.
    a. Provider Identifier “1001” assigned to a Provider Type “Family Physician”.
    b. Provider Identifier “1002” assigned to a Provider Type “Nurse Practitioner”.
    c. Provider Identifier “1003” assigned to a Provider Type “Family Physician”.
4. Enrolment Start Date and End Date fields do not need to be populated if already certified to eHealth_hub – Home Clinic Enrolment Service Specification.

Table 2: Patient Data

PATIENT	DEMOGRAPHICS	CLINICAL
Patient First and Last Name: Mary Verification-One **Description of Test:** Tests that only patients with a visit in the last five years are included in the extract.	Administrative Sex: Female Date of birth: 01-Jan-1966 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000001 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1001 Date of Last Visit: more than 60 months ago	

PATIENT	DEMOGRAPHICS	CLINICAL
Patient First and Last Name: Dana Verification-Two **Description of Test:** Tests appropriate extract of prevention data including chronic obstructive pulmonary disease (COPD) diagnosis, and data from the diabetes cluster.	Administrative Sex: Female Date of birth: 01-Jan-1964 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000002 Patient Identifier Type: JHNMB Manitoba Health Registration Number: 100100 Postal Code: R3P 1G6 Patient Assigned to Provider: 1001 Enrolment Start Date*: 01-Mar-2005 Enrolment End Date*: 01-Jun-2015 Date of last visit: 01-Mar any year, less than 60 months ago	Date of last lipid test: 01-Sep-2014 Date dyslipidemia screening advice last provided: 01-Oct-2014 Date of last fasting blood sugar test: 01-Nov-2014 Date cervical cancer screening advice last provided: 01-Jun-2014 Date breast cancer screening advice last provided: 23-Dec-2011 Date blood pressure screening advice last provided: 01-Mar-2015 Date of last physical activity advice: 01-Mar-2014 Date smoking cessation counselling last provided: 01-Jan-2015 Date of last obesity / overweight screening: 01-Mar-2015 Smoking/vaping status: Current smoker COPD diagnosis: Yes Date of COPD diagnosis: 01-Mar-2015 Date of last A1c screening: 01-Jan-2015 Patient has diabetes: Yes Date of last nephropathy test: 01-Oct-2014 Patient has documented nephropathy: Yes Date of last fundoscopic exam: 01-Jan-2015 Date of last foot exam: 01-Feb-2015 Patient has documented peripheral neuropathy: No Date of last fundoscopic exam referral: 01-Jan-2014 Date of last statin prescription: 31-Dec-2016
Patient First and Last Name: Ruth Verification-Three	Administrative Sex: Female Date of birth: 01-Jan-1981	Date of MMR immunization: 01-Oct-1988 Date of last blood pressure measurement: 01-Feb-2015

PATIENT	DEMOGRAPHICS	CLINICAL
Description of Test: Tests appropriate extract of prevention data including Canadian Thoracic Society (CTS) questionnaire responses, and data from the congestive heart failure (CHF) and coronary artery disease (CAD) clusters. Also confirms ability to capture patient identifiers assigned to patients by jurisdictions other than Manitoba.	EMR Patient Identifier: Vendor to determine Patient Identifier: 1000000XY Patient Identifier Type: Other Zip Code: 60601 Patient Assigned to Provider: 1001 Enrolment Start Date*: 01-May-2007 Date of last visit: 01-Sep any year, less than 60 months ago	Date of last cervical cancer screening: 01-Jan-2014 Exemption from cervical cancer screening: No Date of last FOBT test: 01-Jan-2014 Exemption from breast cancer screening: No Date of last breast cancer screening: 01-Jan-2012 Smoking Status: Former smoker Date of last cigarette / tobacco product: 01-Mar-2010 Character response to the CTS questions: Do you cough regularly? No response Do you cough up phlegm? Yes Short of breath with simple chores? Yes Wheeze with exertion or at night? No Frequent colds that persist? No Patient has CHF: Yes Date of last ACE inhibitor or ARB prescription: 01-Jul-2015 Patient has CAD: Yes Exemption from ACE inhibitor or ARB prescription: LVEF>=40% Date of last exemption from ACE inhibitor or ARB prescription: 30-Nov-2016
Patient First and Last Name: Ana Verification-Four **Description of Test:** Tests appropriate extract of prevention data including	Administrative Sex: Female Date of birth: 01-Jan-1948 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000004 Patient Identifier Type: JHNAB	Date of childhood immunizations counselling: 01-Mar-1955 Date of last influenza vaccination counselling: 01-Apr-2015 Exemption from cervical cancer screening: Yes Exemption from breast cancer screening: Yes Date of last pneumococcal vaccination counselling: 01-Oct-2014 Date of last colonoscopy: 01-Dec-2011

PATIENT	DEMOGRAPHICS	CLINICAL
COPD cluster and CTS questionnaire responses, as well as data from the asthma, osteoporosis, CAD and hypertension clusters. Also confirms ability to capture patient identifiers assigned to patients by jurisdictions other than Manitoba.	Patient Assigned to Provider: 1001 Date of last visit: 01-Apr any year, less than 60 months ago	Smoking Status: Never a smoker Date of last smoker screening: 01-Apr-2015 Character response to the CTS questions Do you cough regularly? No Do you cough up phlegm? No response Short of breath with simple chores? Yes Wheeze with exertion or at night? No Frequent colds that persist? No Date of last COPD at risk screening: 01-Apr-2015 COPD diagnosis: No Date of last Spirometry: 01-Jun-2014 Patient has asthma: Yes Patient has an asthma action plan: Yes Date of most recent asthma action plan or care review: 01-Oct-2014 Date of bone density post-fracture notification letter: 01-Apr-2015 Date of last bone mineral density test: 01-Jul-2015 Osteoporosis diagnosis date: 01-Jul-2015 Osteoporosis diagnosis: Yes Date of last osteoporosis medication prescription: 01-Aug-2015 Patient has an osteoporosis action plan: Yes Date of most recent osteoporosis action plan review: 01-Aug-2015 Patient has CAD: Yes Date of last lipid lowering medication prescription: 01-Jul-2015

PATIENT	DEMOGRAPHICS	CLINICAL
		Patient has hypertension: Yes Date of last test to detect renal dysfunction: 01-Aug-2015 Exemption from dyslipidemia screening: Yes, Framingham Risk Score <10% Date of last exemption from dyslipidemia screening: 01-Sep-2015
Patient First and Last Name: Bob Verification-Five **Description of Test:** Tests appropriate extract of prevention care data including COPD diagnosis, and data from the hypertension, asthma and osteoporosis clusters.	Administrative Sex: Male Date of birth: 01-Jan-1974 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000005 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1001 Date of last visit: 01-Jul any year, less than 60 months ago	Date colon cancer screening advice last provided: 01-Jan-2014 Date dyslipidemia screening advice last provided: 01-Oct-2014 COPD diagnosis: Yes Date of COPD diagnosis: 01-Jul-2015 Patient has hypertension: Yes Exemption from dyslipidemia screening: Yes, disease stable Date of last exemption from dyslipidemia screening: 01-Sep-2015 Patient has asthma: Yes Patient has an asthma action plan: No Date of bone density post-fracture notification letter: 01-Apr-2015 Osteoporosis diagnosis: No Date of last osteoporosis medication prescription: 01-Jun-2015

PATIENT	DEMOGRAPHICS	CLINICAL
Patient First and Last Name: Ryan Verification-Six **Description of Test**: Tests appropriate extract of prevention care data, and data from the diabetes and CHF clusters. Also confirms that Nurse Practitioner data is included in the extract.	Administrative Sex: Male Date of birth: 01-Jan-1950 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000006 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1002 Date of last visit: 01-Dec any year, less than 60 months ago	Date of last influenza vaccination: 01-Apr-2013 Date of pneumococcal vaccination: 01-Oct-2014 Patient has diabetes: Yes Patient has documented nephropathy: No Patient has documented peripheral neuropathy: Yes Patient has CHF: Yes
Patient First and Last Name: Tasha Verification-Seven **Description of Test**: Tests appropriate extract of Mental Health and Addictions (MHA) data and data from CAD cluster.	Administrative Sex: Female Date of birth: 01-Jan-1951 EMR Patient Identifier: Vendor to determine Patient Identifier: 100000007 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1002 Date of last visit: 01-Jul any year, less than 60 months ago	Date of last flexible sigmoidoscopy: 01-Sep-2019 Patient has CAD: Yes Date of last LDL level > 2.0: 01-Oct-2019 Date of last Non-HDL level > 2.8: 01-Nov-2019 Patient has GAD: Yes GAD-7 Test Date: Dec 1, 2019 GAD-7 Score: 10 Date of last anxiety medication prescription: Dec 26, 2019 Date of last anxiety counselling: Dec 27, 2019 Date of last anxiety referral: Dec 28, 2019 Patient has MDD: Yes PHQ-9 Test Date: Jan 1, 2020 PHQ-9 Score: 2 Date of last depression medication prescription: Jan 26, 2020 Date of last depression counselling: Jan 27, 2020 Date of last depression referral: Jan 28, 2020

PATIENT	DEMOGRAPHICS	CLINICAL
		Primary Substance: Cannabis dependence Substance usage inquiry: Feb 1, 2020 Date of last significant substance usage: Dec 31, 2019 Date of last SUD medication prescription: Feb 26, 2020 Date of last SUD counselling: Feb 27, 2020 Date of last SUD referral: Feb 28, 2020
Patient First and Last Name: Sloan Verification-Eight **Description of Test**: Tests appropriate extract of Prevention, Mental Health and Addictions (MHA), and STBBI data.	EMR Patient Identifier: Vendor to determine Patient Identifier: 100000008 Patient Identifier Type: JHNMB Manitoba Health Registration Number: 10A10B Patient Assigned to Provider: 1002 Date of last visit: 01-Aug any year, less than 60 months ago	Date of last FIT: Jan 13, 2024 Date of last screening for sexual activity: Jan 14, 2024 Sexual Activity: Not sexually active Date of last Substance usage inquiry: Jan 15, 2024 Injectable Substance Use: Using injectable substances Date of last STBBI screening/prevention counselling: Jan 16, 2024 Date of last immunization status review: Jan 17, 2024 Date of last Patient Request for STBBI Screen: Jan 18, 2024 Patient has STBBI: Yes Patient has ADHD: Yes Date of last ADHD care plan review: Jan 19, 2024 Date of last ADHD symptom screen: Jan 20, 2024 Patient has Bipolar disorder: Yes Date of last Bipolar Disorder care plan coordination/review: Jan 21, 2024 Date of last Bipolar Disorder referral: Jan 22, 2024 Patient has Schizophrenia: Yes Date of last Schizophrenia care plan review: Jan 23, 2024

PATIENT	DEMOGRAPHICS	CLINICAL
		Patient has Borderline Personality Disorder: Yes Date of last Borderline Personality Disorder Psychiatry/Psychology referral: Jan 24, 2024 Date of last Borderline Personality Disorder care plan coordination/review: Jan 25, 2024 Patient is on PrEP: Yes Date of last PrEP medication prescription: Jan 26, 2024 Date of last HIV test: Jan 27, 2024 Date of last Creatinine test: Jan 28, 2024 Patient has HIV: Yes Date of last HIV referral: Mar 14, 2024 Date of last HIV care plan coordination/review: Mar 15, 2024 Date of last HIV viral load test: Jan 29, 2024 Date of last CD4 count: Jan 30, 2024 Date of last Pregnancy screening: Jan 31, 2024 Pregnancy screening exemption: No Date of last Contraceptive needs counselling: Feb 13, 2024 Date of last Cervical cancer screening: Feb 14, 2024 Exemption from cervical cancer screening: No Patient has syphilis: Yes Date of last syphilis diagnosis: Mar 16, 2024 Syphilis staging/appropriate treatment: Feb 15, 2024 Date of last Syphilis serology screening: Feb 16, 2024 Patient has chronic Hepatitis B: Yes Date of last Hepatitis B referral: Feb 17, 2024

PATIENT	DEMOGRAPHICS	CLINICAL
		Date of last Hepatitis B care plan coordination/review: Feb 18, 2024 Patient has Hepatitis B (not confirmed as chronic): Yes Date of last Hepatitis B (not confirmed as chronic) diagnosis: Feb 19, 2024 Date of last Treatment initiation for Hepatitis B: Feb 20, 2024 Date of last Hepatitis B screen: Feb 21, 2024 Date of last CBC: Feb 22, 2024 Date of last Liver test: Feb 23, 2024 Date of last Hepatocellular carcinoma screen: Feb 24, 2024 Patient has chronic Hepatitis C: Yes Date of last Hepatitis C referral: Feb 25, 2024 Date of last Hepatitis C care plan coordination/review: Feb 26, 2024 Patient has Hepatitis C (not confirmed as chronic): Yes Date of last Hepatitis C (not confirmed as chronic) diagnosis: Feb 27, 2024 Date of last Treatment initiation for Hepatitis C: Feb 28, 2024 Date of last Hepatitis C screen: Mar 13, 2024 Patient has Cirrhosis: Yes
Patient First and Last Name: Megan Demonstration-One **Description of Test:** Tests clinical reminder functions.	Administrative Sex: Female 65 years old Patient Identifier: 100000011 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003	Patient has Asthma: Yes Patient has Hypertension: Yes

PATIENT	DEMOGRAPHICS	CLINICAL
	Date of last visit: 01-Oct any year, less than 60 months ago	
Patient First and Last Name: Kim Demonstration-Two **Description of Test:** Tests clinical reminder functions.	Administrative Sex: Female 67 years old Patient Identifier: 100000012 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003 Date of last visit: 01-Oct any year, less than 60 months ago	Mammogram test within last 24 months Pneumococcal vaccination within last 12 months A1c test within last 36 months Patient has asthma: Yes Patient has asthma action plan: Yes Asthma action plan or care reviewed within last 12 months Bisphosphonate medication prescribed 36 months ago
Patient First and Last Name: Thomas Demonstration-Three **Description of Test:** Tests clinical reminder functions.	Administrative Sex: Male 45 years old Patient Identifier: 100000013 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003 Date of last visit: 01-Oct any year, less than 60 months ago	Smoker: Current Patient has diabetes: Yes Patient has congestive heart failure: Yes CTS questions completed with minimum one “Yes” response Smoking cessation counselling provided within last 24 months Spirometry test within last 24 months
Patient First and Last Name: John Demonstration-Four **Description of Test:** Tests clinical reminder functions.	Administrative Sex: Male 40 years old Patient Identifier: 100000014 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003 Date of last visit: 01-Nov any year, less than 60 months ago	Patient has diabetes: Yes Patient has congestive heart failure: Yes Lipid test within last 12 months Fundoscopic exam referral made within last 12 months ACE inhibitor or ARB prescribed within last 12 months
Patient First and Last Name: Joseph Demonstration-Five	Administrative Sex: Male 36 years old	Patient has hypertension: Yes Patient has coronary artery disease: Yes

PATIENT	DEMOGRAPHICS	CLINICAL
Description of Test: Tests clinical reminder functions.	Patient Identifier: 100000015 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003 Date of last visit: 01-Nov any year, less than 60 months ago	Renal dysfunction test within last 12 months
Patient First and Last Name: Aiden Demonstration-Six **Description of Test:** Tests clinical reminder functions.	Administrative Sex: Male 40 years old Patient Identifier: 100000016 Patient Identifier Type: JHNMB Patient Assigned to Provider: 1003 Date of last visit: 01-Aug any year, less than 60 months ago	Patient has coronary artery disease: Yes Date of last Non-HDL Level >2.8 within last 12 months Patient has GAD: Yes Patient has MDD: Yes
* Enrolment Start Date and End Date fields do not need to be populated if already certified to eHealth_hub - Home Clinic Enrolment Service Specification.		

3 Clinical Reminder Assessment

In all demonstration scenarios Vendors are expected to:

- Complete all test patient data (section 2) and actions listed in the Pre-requisite column (section 3) in their EMR Product prior to the demonstration session
- Perform all actions listed in the Demonstration Step column during the demonstration session facilitated by the EMR Certification team
- Confirm the Expected Results with EMR Certification team through demonstration of their EMR Product. All Expected Results must be achieved to pass the demonstration component of the assessment.

3.1 General

The following table describes the demonstration Vendors must complete for the Clinical Reminders – General requirements. The patients and providers used to support these demonstration activities must be different from the test patients in Section 2.

The original requirement identifier (ID), requirement statement and associated guidelines are included for the reviewer's convenience.

Table 3: General Reminder Assessment Scenarios

ID	Requirement	Pre-requisites	Demonstration Step	Expected Results
PCG-01	Ability to generate clinical decision support reminders.	A patient, 12 years old or greater, was provided an obesity / overweight screening 22 months ago.		Soon to be overdue reminder for obesity /overweight screening displays in the patient's record. Provider is able to update other aspects of the patient's record while the clinical reminder is displayed.
		A patient with an active health concern of hypertension last received a test to detect renal dysfunction 15 months ago.		Overdue reminder for test to detect renal dysfunction displays in the patient's record.
			Remove or de-activate the hypertension health concern for the above patient.	Overdue reminder for renal dysfunction screening no longer displays in the patient's record.
PCG-02	Ability to disable reminder function.	Clinical reminders are enabled for Provider 1 and Provider 2. A patient, 18 years of age or greater, with no blood pressure measurement.		Provider 1 and Provider 2 user settings indicate clinical reminders are enabled. Overdue reminder blood pressure measurement displays in the patient's record.
			Disable clinical reminders for Provider 1.	Provider 1 user settings indicate clinical reminders are disabled. Provider 2 user settings indicate clinical reminders are not disabled.
			View patient record as Provider 1.	No clinical reminders display in the patient's record.
			View patient record as Provider 2.	Clinical reminders (e.g. blood pressure measurement) display in the patient's record.

ID	REQUIREMENT	PRE-REQUISITES	DEMONSTRATION STEP	EXPECTED RESULTS
PCG-03	Provides integration between components such that data does not require re-entry to support primary care quality indicators.	Patient, 65 years old, has PHIN, postal code, MHRN, date of birth, administrative sex, relationship with a provider, and has had an appointment in the past. The following are mapped to appropriate reminders: • Influenza vaccination • Blood pressure measurement • Fasting blood sugar • Congestive heart failure • ACE inhibitor medications		Clinical reminders appear in the patient's record for: • Influenza vaccination • Blood pressure measurement • Fasting blood sugar
			Record influenza vaccination for the patient in immunizations area of EMR.	Influenza vaccination appears in all applicable areas. Reminder for influenza disappears.
			Record blood pressure measurement for the patient in the general care data area of the EMR.	Blood pressure measurement appears in all applicable areas. Reminder for blood pressure measurement disappears.
			Record fasting blood sugar for the patient in lab results area of EMR.	Fasting blood sugar appears in all applicable areas. Reminder for fasting blood sugar disappears.
			Record patient as having congestive heart failure in health concerns area of EMR.	Congestive heart failure appears in all applicable areas. Reminder for ACE inhibitor appears.
			Prescribe ACE inhibitor for the patient in medications area of EMR.	ACE inhibitor prescription appears in all applicable areas. Reminder for ACE inhibitor disappears.

ID	REQUIREMENT	PRE-REQUISITES	DEMONSTRATION STEP	EXPECTED RESULTS
			Review PCDE	PCDE contains relevant data from patient demographic data elements (e.g. EMR patient identifier, patient identifier, patient identifier type, MHRN, date of birth, administrative sex, postal code) PCDE contains relevant data from provider demographic data elements (e.g. provider identifier) PCDE contains relevant appointment data from appointment data elements (date of last visit)

3.2 Data Capture

The original requirement identifier (ID), requirement statement and associated guidelines are included for the reviewer's convenience.

Table 4: Data Capture Requirements

ID	REQUIREMENT	PRE-REQUISITES	DEMONSTRATION STEP	EXPECTED RESULTS
PCDC-03	COPD at risk screening CTS questions	Within a patient record for a patient: • Without an active health concern of COPD • Over 40 years of age • Former smoker		
			Demonstrate collection of the following responses: Question 1: Yes Question 2: No Question 3: No Question 4: No response Question 5: No	Patient record will reflect entered responses, along with the date responses were elicited.

ID	REQUIREMENT	PRE-REQUISITES	DEMONSTRATION STEP	EXPECTED RESULTS
			Enter an administered date for the CTS questionnaire.	
PCDC-17	PrEP Status	None	1. Indicate that the patient is currently on PrEP (not by way of medication).	1. Patient is identified as being on PrEP.

3.3 Reminder Guidelines

The following table articulates the required demonstration scenarios for the PCQI Clinical Reminders. Note that the Expected Results column contains a reference to the original requirement identifier. All other clinical reminder functions will be assessed through Verification, as defined in the Primary Care Quality Indicator Reminders and Data Extract Specification.

Table 5: Reminder Guideline Scenarios

PATIENT	DEMONSTRATION STEP	EXPECTED RESULTS
Patient: Megan Demonstration-One		Reminder active for: • Cervical cancer screening (PRV001) • Breast cancer screening (PRV003) • Diabetes screening (PRV006) • Pneumococcal immunization 65+(PRV009) • Asthma action plan or care (AST001) • Renal dysfunction screening (HYP003) • Blood pressure measurement (HYP004)
	Add to patient file: • Current smoker • Complete CTS questions with minimum one "yes" question response • Exemption from pap test exam • Blood pressure measurement	Reminder active for: • Smoking cessation counselling (PRV012) • COPD screening using spirometry (PRV015) No reminder for: • Cervical cancer screening (PRV001) • Blood pressure measurement (HYP004)

PATIENT	DEMONSTRATION STEP	EXPECTED RESULTS
Patient: Kim Demonstration-Two		Reminder active for: • Osteoporosis on-going care (OST002) • Obesity/overweight screening (PRV013) No reminder for: • Breast cancer screening (PRV003) • Diabetes screening (PRV006) • Pneumococcal immunization 65-70 (PRV009) • Asthma action plan or care (AST001)
	Add to patient file: • Pap test within last 36 months • Osteoporosis medication (e.g. paricalcitol) within last 12 months • Obesity/overweight screening within last 12 months	No reminder for: • Cervical cancer screening (PRV001) • Osteoporosis on-going care (OST002) • Obesity/overweight screening (PRV013)
Patient: Thomas Demonstration-Three		Reminder active for: • Fundoscopic exam (DIA003) • Dyslipidemia screening (DIA005) • ACE inhibitor (CHF002) No reminder for: • Smoking cessation counselling (PRV012) • COPD screening using spirometry (PRV015)
Patient: John Demonstration-Four		No reminder for: • ACE inhibitor (CHF002) • Dyslipidemia screening (DIA005) • Fundoscopic exams (DIA003)
Patient: Joseph Demonstration-Five		Reminder active for: • Lipid reduction counselling (CAD005) No reminder for: • Renal dysfunction screening (HYP003)
	Add to patient file: • Lipid reduction counselling within last 12 months • Asthma diagnosis	No reminder for: • Lipid reduction counselling (CAD005)
	Add to patient file:	No reminder for:

PATIENT	DEMONSTRATION STEP	EXPECTED RESULTS
Patient: Aiden Demonstration-Six	• GAD-7 < 10, performed 20 months ago	• GAD Ongoing assessment (MHA001) • GAD Management Services (MHA002)
	Add to patient file: • GAD-7 = 10, performed 20 months ago	Reminder active for: • GAD Ongoing assessment (MHA001) • GAD Management Services (MHA002)
	Add to patient file: • GAD-7 < 10, performed 11 months ago	Soon to be overdue reminder for: GAD Ongoing assessment (MHA001) Reminder active for: • GAD Management Services (MHA002)
	Add to patient file: • In-office brief intervention 11 months ago	Soon to be overdue reminder for: • GAD Ongoing assessment (MHA001) • GAD Management Services (MHA002)
	Add to patient file: • Significant substance use 25 months ago, asked 20 months ago	No reminder for: • SUD Ongoing assessment (MHA005) • SUD Management Services (MHA006)
	Add to patient file: • Significant substance use 23 months ago, asked 20 months ago	Reminder active for: • SUD Ongoing assessment (MHA005) • SUD Management Services (MHA006)
	Add to patient file: • Significant substance use 23 months ago, asked 11 months ago	Soon to be overdue reminder for: • SUD Ongoing assessment (MHA005) Reminder active for: • SUD Management Services (MHA006)
	Add to patient file: • SUD referral 11 months ago	Soon to be overdue reminder for: • SUD Ongoing assessment (MHA005) • SUD Management Services (MHA006)

The following table articulates the required demonstration scenarios specific to version 5.x of the PCQI Clinical Reminders.

Table 6: Additional Reminder Guideline Scenarios

ID	DESCRIPTION	PRECONDITION	SCRIPT	EXPECTED RESULTS
PRV017	Sexual Activity and Substance Use Screening	Patient is 11 years of age	1. View reminders 2. Set patient age to 12 3. Record screening for sexual activity and substance use	1. No reminder 2. Overdue reminder 3. No reminder
PRV018	STBBI Screening, Prevention Counselling and Immunization Status Review	Patient is 70 years of age	1. View reminders 2. Record STBBI screening, prevention counselling and immunization status review from 35 months ago 3. Set patient age to 30 4. Record patient as sexually active 5. Record patient as injecting drugs 6. Record patient as not injecting drugs but sexually active (new or multiple sex partners) 7. Record STBBI screening, prevention counselling and immunization status review from 11 months ago 8. Change patient age to 29 9. Record patient as sexually active 10. Record patient as not sexually active 11. Record patient as requesting STBBI screening one month ago 12. Remove patient requesting STBBI screening and record patient as having syphilis	1. Overdue reminder 2. No reminder 3. Soon to be overdue reminder 4. Soon to be overdue reminder 5. Overdue reminder 6. Overdue reminder 7. Soon to be overdue reminder 8. Soon to be overdue reminder 9. Soon to be overdue reminder 10. No reminder 11. Overdue reminder 12. Soon to be overdue reminder
MHA007	ADHD Management	Patient with ADHD, no other related data	1. View reminders 2. Populate ADHD care plan with date from 11 months ago 3. Add ADHD symptom screen with today's date	1. Overdue reminder 2. Soon to be overdue reminder 3. No reminder
MHA008	Bipolar Disorder Management	Patient with Bipolar Disorder, no other related data	1. View reminders 2. Populate Bipolar Disorder care plan with date from 11 months ago 3. Add referral to community health service with today's date	1. Overdue reminder 2. Soon to be overdue reminder 3. No reminder

ID	DESCRIPTION	PRECONDITION	SCRIPT	EXPECTED RESULTS
MHA009	Schizophrenia Management	Patient with Schizophrenia, no other related data	1. View reminders 2. Populate Schizophrenia care plan with date from 11 months ago	1. Overdue reminder 2. Soon to be overdue reminder
MHA010	Borderline Personality Disorder Management	Patient with Borderline Personality Disorder, no other related data	1. View reminders 2. Populate Borderline Personality Disorder care plan with date from 11 months ago 3. Add referral to Psychiatry/Psychology with today's date	1. Overdue reminder 2. Soon to be overdue reminder 3. No reminder
STB001	PrEP – Follow-up HIV/STBBI Screening	Patient with no related data	1. Record patient as being on PrEP 2. Record patient as not on PrEP 3. Give patient PrEP qualifying prescription from 4 months ago 4. Give patient PrEP prescription from 2 months ago 5. Record patient as having HIV 6. Remove HIV from patient record and give patient HIV test with today's date	1. Overdue reminder 2. No reminder 3. No reminder 4. Overdue reminder 5. No reminder 6. Soon to be overdue reminder or no reminder
STB003	HIV – Referral / Care Plan	Patient with HIV, no other related data	1. Add referral to HIV Program or Pediatric Infectious Disease Program from 11 months ago 2. Remove referral 3. Add coordination/review of care plan related to HIV with today's date	1. Soon to be overdue reminder 2. Overdue reminder 3. No reminder
STB006	HIV – Pregnancy Screening	Female patient with HIV, had visit yesterday	1. View reminders 2. Add pregnancy screening exemption 3. Remove pregnancy screening exemption and record offer of pregnancy screen and contraceptive needs counselling with yesterday's date 4. Add visit for today 5. Change patient to male	1. Overdue reminder 2. No reminder 3. No reminder 4. Overdue reminder 5. No reminder

ID	DESCRIPTION	PRECONDITION	SCRIPT	EXPECTED RESULTS
STB008	Syphilis – Staging and Treatment	Patient with Syphilis, no other related data	1. View reminders 2. Record patient as having syphilis staging and treatment that started prior to last syphilis diagnosis date 3. Record patient as having syphilis staging and treatment that started after last syphilis diagnosis date	1. Overdue reminder 2. Overdue reminder 3. No reminder
STB011	Hepatitis B - Rescreen	Patient with no related data	1. Record Hepatitis B (not confirmed as chronic) with date from 5 months ago 2. Record Hepatitis B (not confirmed as chronic) with date from 7 months ago 3. Record Hepatitis B treatment initiated with date from 8 months ago 4. Record Hepatitis B treatment initiated with date from 5 months ago 5. Remove Hepatitis B treatment initiated. Record Hepatitis B re-screening with today's date	1. No reminder 2. Overdue reminder 3. Overdue reminder 4. No reminder 5. No reminder
STB017	Hepatitis C – Hepatocellular Carcinoma Screening	Patient with Chronic Hepatitis C, no other related data	1. View reminders 2. Record Cirrhosis 3. Record hepatocellular carcinoma screening by ultrasound from 5 months ago	1. No reminder 2. Overdue reminder 3. Soon to be overdue reminder

4 Primary Care Data Extract

4.1 General Extract Requirements

The original requirement identifier (ID), requirement statement and associated guidelines are included for the reviewer's convenience.

Table 7: Data Extract Scenarios

ID	REQUIREMENT	PRE-REQUISITES	DEMONSTRATION STEP	EXPECTED RESULTS
PCDE-01	Ability to generate the Primary Care Data Extract files	If applicable, more than one clinic must be set up within the EMR instance. Logged in as EMR user with data extract privileges.		
			Generate the data extract with the following parameters: • EDTR Clinic ID: to be provided by Manitoba prior to demonstration • Providers: 1001, 1002, 1003 • Include patients not currently assigned to a provider: No Vendor to choose any destination folder.	Extract file names and formats and data match is expected based on requirements and the given test data.

4.2 Data Extract Assessment

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

1. Generate and submit a complete Primary Care Data Extract prior to completing the demonstrations described above (i.e. data capture, clinical reminders).
2. Generate and submit a complete Primary Care Data Extract after completing the demonstrations.

Submissions must be sent to EMR@sharedhealthmb.ca. Each submission will be verified in terms of content and format by Manitoba Health.

EMR vendors should note that Manitoba may choose to generate and verify additional data extracts during verification activities.

5 Release Notes

VERSION 1.1 AUGUST 29, 2016

- List of tables updated to align with original Assessment Guide
- In Section 4.2, bullet 1, changed wording from “described below” to “described above”

VERSION 1.2 MARCH 21, 2017

- Patient Profiles: Ruth Verification-Three – Removed “Patient prescribed ACE inhibitors or ARB medication in the last 12 months: Yes”
- Patient Profiles: Ryan Verification-Six – Removed “Patient prescribed ACE inhibitors or ARB medication in the last 12 months: No”
- Patient Profiles: Kim Demonstration-Two – Updated Pneumococcal vaccination
- Patient Profiles: Joseph Demonstration-Five – Changed “Patient has asthma” to “No”
- Reminder Guideline Scenarios: Joseph Demonstration-Five – Removed beta blocker prescription and added asthma diagnosis
- PCDE-01 – Modified pre-requisite

VERSION 1.3 APRIL 28, 2017

- Section 3.2 Data Capture – Re-numbered PCDC-01 to PCDC-03 to match spec
- Section 2 Patient Profiles – Added patient identifiers and patient identifier types to all demonstration patients
- Patient Profiles: Joseph Demonstration-Five – Removed line “Patient has asthma: No“

VERSION 1.5 SEPTEMBER 1, 2017

- Skipped Version 1.4 to align version number with the Specification
- Removed all references to beta blockers, as this has been removed from the Specification
  - Patient Profiles: Ruth Verification-Three, Ana Verification-Four
  - Reminder Guidelines: Joseph Demonstration-Five
- Changed all references of “full fasting lipid test” to “lipid test”
- Changed “Smoking Cessation Advice” to “Smoking Cessation Counselling”
- Patient Profiles: Dana Verification-Two – Added date of last statin prescription
- Patient Profiles: Ruth Verification-Three – Added Exemption from ACE inhibitor or ARB prescription and date of last exemption from ACE inhibitor or ARB prescription

VERSION 1.6 AUGUST 2, 2018

- Related Documents – added “eHealth_hub – Home Clinic Enrolment Service Interface Specification”
- Removed references to myocardial infarction, as this has been retired in the Specification
- Patient Data table – Added note that “Enrolment Start Date and End Date fields do not need to be populated if already certified to eHealth_hub - Home Clinic Enrolment Service Specification.
- PCDE-01 – Added provider 1003 to generation of data extract to include demonstration patients

VERSION 4.0 MAY 1, 2020

- Updated format to Shared Health template
- Skipped to version 4.0 to align with Manitoba Primary Care Quality Indicators Guide v4.0
- Removed *Intended Audience* section
- Updated all patient *Date of last* visit to relative date
- Removed references to *sedentary patient*
- Replaced *colon cancer screening* with *FOBT test*
- Removed references to *LDL Level >2.0 within last 12 months*
- Removed references to *Date fasting blood sugar screening advice last provided*
- Added Tasha Verification-Seven
- Added Aiden Demonstration-Six and corresponding reminder scenario

VERSION 4.1 JUNE 16, 2020

- Updated version number to align with specification

VERSION 4.2 NOVEMBER 17, 2020

- Patient Profiles: Tasha Verification-Seven – added *Patient has CAD: Yes*
- Reminder Guideline Scenarios: Aiden Demonstration-Six
    - Updated expected result for when adding a *GAD-7 < 10, performed 11 months ago*
    - Updated fourth row to *In-office brief intervention 11 months ago* and changed expected result
    - Updated expected result for when adding a *significant substance use 23 months ago, asked 11 months ago*
    - Updated last row to *SUD referral 11 months ago* and changed expected result

VERSION 5.0 OCTOBER 1, 2024

- Removed guideline and status columns from tables, as these are already in the specification document
- Patient Data table – added Sloan Verification-Eight
- PCG-03 – updated to reflect updates to corresponding requirement
- PCDC-17 - new
- Added Table 5: Additional Reminder Guideline Scenarios
- PCDE-01 – Added prerequisite - *Logged in as EMR user with data extract priviliges*

VERSION 5.1 DECEMBER 16, 2024

- Table 2: Patient data - Dana Verification-Two
    - Changed Smoking/vaping status: “Current Smoker/Vaper” to “Current smoker”