EMR Certification

Primary Care Quality Indicator Reminders and Data Extract Specification

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1 Introduction

1.1 Purpose

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

1.2 Background

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

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

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

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

1.3 Related Documents

This document references the following companion documents:

Table 1: Related Documents

DOCUMENT
Primary Care Quality Indicators Guide
Primary Care Quality Indicator Reminders and Data Extract Assessment Guide
eHealth_hub – Home Clinic Enrolment Service Interface Specification

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1.4 Glossary

Table 1: Terms and Acronyms

Term or Acronym	Definition
CAD	Coronary Artery Disease
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
Enrolment	The process by which a Client is recognized to have the Home Clinic as their primary provider of care and the Home Clinic agrees to provide comprehensive continuous primary care and to coordinate care with other health-care providers. See Enrolment Methods Overview for additional information.
FOBT	Fecal Occult Blood Test
GAD	Generalized Anxiety Disorder
GAD-7	Generalized Anxiety Disorder Questionnaire (7-item)
MDD	Major Depressive Disorder
MHA	Mental Health and Addictions
PCDE	Primary Care Data Extract
PCQI	Primary Care Quality Indicators
PHQ-9	Patient Health Questionnaire (9-item)
SUD	Substance Use Disorder

2 Clinical Reminders

Introduction

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

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

Requirements Structure

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

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

  Note: data capture requirements vary slightly from the format described above.
- **Assessment** – the method of assessment specific to the requirement. Relevant assessment options include:
    - Verification – leveraging the Certification Environment, Manitoba will verify the product's ability to meet requirements. Clinical and administrative resources may be involved in the verification process.

- Demonstration – applicants will demonstrate key functions within their EMR product. Demonstrations may be conducted in person, by remote means (e.g. teleconference and Internet) or through recorded video.

Assessment

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

2.1 General

Table 2: General Clinical Reminders Requirements

ID	Requirement	Guidelines	Additional Notes	Status	Assessment
PCG-01	Ability to generate decision support reminders.	At a minimum, automatically alerts the clinician when an item or action: • Is overdue; or • Will become due in the next one to 90 days (soon to be overdue). All reminders must be visible within the EMR. Overdue and soon to be overdue reminders must be distinguishable from one another. Reminders must not appear in relation to a patient's inactive problems. Reminders represented as tasks in the provider's work queue are not an acceptable solution. Existing reminders must not prevent a user's interaction with the EMR.	e.g. overdue items in red and soon to be overdue in yellow e.g. clinician sets the patient's diabetes diagnosis to 'inactive'. Diabetes reminders would no longer appear for this patient. e.g. clinician will be able to enter chart data (e.g. labs, encounter notes, etc.) when a reminder exists within patient record	Previous	Demonstration
PCG-02	Ability to disable reminder function.	Must be able to turn off Primary Care Quality reminders at the individual provider level.	e.g. a dermatologist could turn off all primary care reminders	Previous	Demonstration
PCG-03	Provides integration between components such that data does not require re-entry to support primary care	At a minimum, integration is required for the following data element categories: • General Care • Health Concerns • Allergies	e.g. provider could choose which field to use for capture of blood pressure measurement and map it to the appropriate reminder	Previous	Demonstration

ID	Requirement	Guidelines	Additional Notes	Status	Assessment
	quality indicators.	• Lab Test • Medications • Risk Factors • Immunizations			

2.2 Data Capture

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

Table 3: Data Capture Requirements

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
PCDC-01	EMR Data Transport and Repository (EDTR) Clinic Identifier	Identifier assigned to clinic by MHSAL for use with data extract submissions.			Previous	Verification
PCDC-02	Cigarette / Tobacco Product	Date of the patient's last cigarette / tobacco product.	It would be acceptable if this were incorporated with other risk factor data elements. Must allow for: • Full date (dd/mm/yyyy) • Partial date (mm/yyyy or yyyy)		Previous	Verification
PCDC-03	Chronic Obstructive Pulmonary Disease (COPD) at risk screening questions from the Canadian Thoracic Society	Screening questions endorsed by the CTS. Used for COPD at risk screening.	Questions must include: 1. Do you cough regularly? 2. Cough up phlegm? 3. Short of breath with simple chores? 4. Wheeze with exertion or at night? 5. Frequent colds that persist?		Previous	Demonstration

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
	(CTS)		Must be able to save responses to each question, as well as the date it was administered. Provider must be able to save without entering a response for each question.			
PCDC-04	Information Type	Type of educational material / information reviewed with and/or provided to the patient.	Specific information may include: • Handouts • Counselling • Risks • Benefits	e.g. vaccination counselling, physical activity advice	Previous	Verification
PCDC-05	Information Provided / Reviewed Date / Time	The date/time that the information was reviewed with and/or provided to the patient.			Previous	Verification
PCDC-06	Exemption Type	Exemption from performing a specific screening activity.		e.g. breast cancer screening	Previous	Verification
PCDC-07	Exemption Reason	Reason for patient exemption from screening activity.		e.g. patient had double mastectomy	Previous	Verification
PCDC-08	Exemption Duration	The length of time the exemption is valid.		e.g. 12 months, 5 years	Previous	Verification
PCDC-09	Framingham Risk Score	Score resulting from the Framingham risk assessment.	It would be acceptable if this were incorporated with other risk factor data elements.	e.g. 18 points	Previous	Verification
PCDC-10	Framingham Risk Percent	Percent risk resulting from the Framingham risk assessment.	It would be acceptable if this were incorporated with other risk factor data elements.	e.g. 8%	Previous	Verification
PCDC-11	Enrolment Start	Represents the date the	Must allow capture of historical		Previous	Verification

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
	Date	patient was enrolled with the clinic.	dates, including 01/01/1899. Note: This requirement may alternatively be satisfied by Certification to the eHealth_hub – Home Clinic Enrolment Service Specification.			
PCDC-12	Enrolment End Date	Represents the date the patient enrolment was terminated.	Note: This requirement may alternatively be satisfied by Certification to the eHealth_hub – Home Clinic Enrolment Service Specification..		Previous	Verification
~~PCDC-13~~	~~Enrolment Termination Reason~~	~~The reason that the enrolment was terminated.~~	~~At a minimum, the list of values must include:~~ ~~• Patient deceased~~ ~~• Patient moved out of area~~ ~~• Patient left jurisdiction (province)~~ ~~• Patient added in error~~ ~~• Patient no longer in Primary Care~~ ~~• Provider initiated termination~~ ~~• Patient request~~ ~~• Other~~		Retired	Verification
PCDC-14	GAD-7 Score	Score resulting from administering the GAD-7 questionnaire.			New	Verification
PCDC-15	PHQ-9 Score	Score resulting from administering the PHQ-9 questionnaire.			New	Verification
PCDC-16	Last Significant Substance Use Incident	Patient's last substance use incident.	Must be able to capture substance used (from a list) and the date of substance use. At a minimum, substance list must include (note corresponding ICD-9		New	Verification

ID	Data Element	Description	Guidelines	Additional Notes	Status	Assessment
			codes in brackets): • Alcohol (303) • Opioid (304.0) • Sedative, hypnotic or anxiolytic (304.1) • Cocaine (304.2) • Amphetamine and other psychostimulant (304.4) • Hallucinogen (304.5) • Other specified drug (304.6) • Combinations of opioid type drug with any other (304.7) • Combinations of drug dependence excluding opioid type drug (304.8) • Unspecified drug (304.9)			

2.3 Reminder Guidelines

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

2.3.1 Prevention

Table 4: Prevention Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
PRV001	Cervical Cancer Screening	All the following conditions are true. Patient is: • Female; • At least 21 years of age but not older than 69; and • Not exempt from having a pap smear exam.	The date of last pap smear occurred within last 36 months	Previous	Demonstration

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ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
PRV002	Colon Cancer Screening	The patient is at least 50 years of age but not older than 74	One or more of the following conditions is true: • Date of last fecal occult blood test (FOBT) occurred within last 24 months; • Date of last colonoscopy occurred within last ten years; and/or • Date of last flexible sigmoidoscopy occurred within last ten years	Updated	Verification
PRV003	Breast Cancer Screening	All the following conditions are true. Patient is: • At least 50 years of age but not older than 74; • Female; and • Not exempt from mammograms.	The date of last mammogram test occurred within last 24 months	Previous	Demonstration
PRV004	Dyslipidemia Screening for Women	All the following conditions are true: • Patient is at least 50 years of age but not older than 69; • Patient is female; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months.	The date of last lipid test occurred within last 60 months	Previous	Verification
PRV005	Dyslipidemia Screening for Men	All the following conditions are true: • Patient is at least 40 years of age but not older than 69; • Patient is male; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months.	The date of last lipid test occurred within last 60 months	Previous	Verification
PRV006	Diabetes Screening	All the following conditions are true. Patient is: • At least 40 years of age but not older than 74; and	One or more of the following conditions is true: • Date of last fasting blood sugar screening occurred within last 36	Previous	Demonstration of condition in bold text

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
		• Not diagnosed with diabetes.	months; and/or • Date of last A1c test occurred within last 36 months.		Verification of remaining condition
PRV007	MMR Immunization	The patient is seven years of age	One or more of the following conditions is true: • Parents were provided childhood immunizations counselling; and/or • Patient received last MMR vaccination.	Previous	Verification
PRV008	Influenza Immunization 65+	The patient is 65 years of age or greater	One or more of the following conditions is true: • Patient was provided influenza immunization counselling within last 12 months; and/or • Patient received an influenza vaccination within the last 12 months.	Previous	Verification
PRV009	Pneumococcal Immunization 65-70	All the following conditions are true: • Patient is 65 years of age or greater but not older than 70; and • Patient did not receive a pneumococcal immunization.	One or more of the following conditions is true: • Patient was provided pneumococcal vaccination counselling within the last 12 months; and/or • Patient received a pneumococcal vaccination.	Previous	Demonstration of condition in bold text Verification of remaining condition
PRV010	Blood Pressure Measurement	The patient is 18 years of age or greater	The patient received a blood pressure measurement within last 24 months	Previous	Verification
PRV011	Advice on Physical Activity	The patient is 12 years of age or greater	The patient was provided exercise / activity advice within last 24 months	Previous	Verification
PRV012	Smoking Cessation Counselling	All the following conditions are true. Patient is: • 12 years of age or greater; and • A current smoker.	The patient was provided with smoking cessation counselling in last 24 months	Previous	Demonstration

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
PRV013	Obesity / Overweight Screening	The patient is 12 years of age or greater	The patient was provided an obesity / overweight screening within last 24 months	Previous	Demonstration
PRV014	Chronic Obstructive Pulmonary Disease (COPD) At Risk Screening	All the following conditions are true. Patient is: • Not diagnosed with COPD; • 40 years of age or greater; and • A current or a former smoker	All the following conditions are true. Patient was provided a: • COPD at risk screening within last 24 months; and • CTS questionnaire which they answered.	Previous	Verification
PRV015	COPD Screening Using Spirometry	All the following conditions are true: • Patient is 40 years of age or greater; • patient is not diagnosed with COPD; • Patient is a current or former smoker; and • Patient has responded yes to one or more of the questions on the CTS questionnaire.	The patient was provided a spirometry screening within last 24 months	Previous	Demonstration
PRV016	Smoking Status	The patient is 12 years of age or greater	The date of last smoker screening occurred within last 24 months	Previous	Verification

2.3.2 *Diabetes Management*

Table 5: Diabetes Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
DIA001	A1c	The patient is identified as diabetic	The patient was provided an A1c test within last six months	Previous	Verification
DIA002	Nephropathy Screening	All the following conditions are true. Patient is: • Identified as diabetic; and • 12 years of age or greater but less than 75.	One or more of the following conditions is true: • Patient has a documented nephropathy; and/or • Patient received a nephropathy test within the last 12 months.	Updated	Verification

ID	INDICATOR	REMINDER ACTIVE WHEN	FULFILLED WHEN	STATUS	ASSESSMENT
DIA003	Fundoscopic Exams	All the following conditions are true. Patient is: • Identified as diabetic; and • 15 years of age or greater.	One or more of the following conditions is true: • Patient received a fundoscopic referral in last 12 months; and/or • Patient received a fundoscopic exam within last 12 months.	Previous	Demonstration of condition in bold text Verification of remaining condition
DIA004	Foot Exam	The patient is identified as diabetic	The patient received a foot exam within last 12 months	Previous	Verification
DIA005	Dyslipidemia Screening	All the following conditions are true: • Patient is identified as diabetic; • Patient is less than 75 years of age; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months	The patient received a lipid test within last 60 months	Previous	Demonstration
DIA006	Blood Pressure Measurement	The patient is identified as diabetic	The patient received a blood pressure measurement within last 12 months	Previous	Verification
DIA007	Obesity / Overweight Screening	The patient is identified as diabetic	The patient received an obesity / overweight screening within last 12 months	Previous	Verification

2.3.3 Asthma Management

Table 6: Asthma Management Reminder Guidelines

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

2.3.4 Congestive Heart Failure (CHF) Management

Table 7: CHF Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
CHF001	Obesity / Overweight Screening	All the following conditions are true. Patient is: • Identified as having CHF; and • 18 years of age or greater.	The patient received an obesity / overweight screening within last 12 months	Previous	Verification
CHF002	ACE Inhibitor	All the following conditions are true. Patient is: • Identified as having CHF; and • 18 years of age or greater.	One or more of the following conditions is true: • Patient has been prescribed an ACE inhibitor or ARB medication (see Appendix A: Medication Codes) within last 12 months; and/or • Patient received exemption from ACE inhibitor or ARB medication within last 12 months.	Previous	Demonstration of reminder active Verification of remaining condition
CHF003	Dyslipidemia Screening	All the following conditions are true: • Patient is identified as having CHF; • Patient is 18 years of age or greater but less than 75; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months.	Patient received a lipid test within last 60 months	Previous	Verification
CHF004	Blood Pressure Measurement	All the following conditions are true. Patient is: • Identified as having CHF; and • 18 years of age or greater.	Patient received a blood pressure measurement within last 12 months	Previous	Verification
CHF005	Diabetes Screening	~~All the following conditions are true. Patient is:~~ • ~~Identified as having CHF;~~ • ~~Not identified as diabetic; and~~ • ~~18 years of age or greater.~~	~~One or more of the following conditions is true:~~ • ~~Patient received a full fasting blood sugar test within last 12 months; and/or~~	Retired	~~Verification~~

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
			• ~~Patient received an A1c test within last 12 months.~~		

2.3.5 Hypertension Management

Table 8: Hypertension Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
HYP001	Diabetes Screening	~~All the following conditions are true. Patient is:~~ • ~~Identified as having hypertension;~~ • ~~Not identified as diabetic; and~~ • ~~18 years of age or greater.~~	~~One or more of the following conditions is true. Patient received:~~ • ~~A full fasting blood sugar test within last 12 months; and/or~~ • ~~An A1c test within last 12 months.~~	Retired	~~Verification~~
HYP002	Dyslipidemia Screening	All the following conditions are true: • Patient is identified as having hypertension; • Patient is 18 years of age or older but less than 75; • Patient is not exempt from dyslipidemia screening; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months.	Patient received a lipid test within last 60 months	Previous	Verification
HYP003	Renal Dysfunction Screening	All the following conditions are true. Patient is: • Identified as having hypertension; and • 18 years of age or greater but less than 75.	Patient received a test to detect renal dysfunction within the last 12 months	Updated	Demonstration
HYP004	Blood Pressure Measurement	All the following conditions are true. Patient is: • Identified as having hypertension; and • 18 years of age or greater.	Patient received a blood pressure measurement within last 12 months	Previous	Demonstration
HYP005	Obesity / Overweight	All the following conditions are true. Patient is:	Patient received an obesity / overweight screening within last 12 months	Previous	Verification

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
	Screening	• Identified as having hypertension; and • 18 years of age or greater.			

2.3.6 Coronary Artery Disease (CAD) Management

Table 9: CAD Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
CAD001	Diabetes Screening	~~All the following conditions are true. Patient is:~~ • ~~Identified as having CAD;~~ • ~~Not identified as having diabetes; and~~ • ~~18 years of age or greater.~~	~~One or more of the following conditions is true. Patient received:~~ • ~~A full fasting blood sugar test within last 12 months; and/or~~ • ~~An A1c test within last 12 months.~~	Retired	~~Verification~~
CAD002	Dyslipidemia Screening	All the following conditions are true: • Patient is identified as having CAD; • Patient is 18 years of age or greater but less than 75; and • No statins (see Appendix A: Medication Codes) prescribed in last 12 months.	Patient received a lipid test within last 60 months	Previous	Verification
CAD003	Blood Pressure Measurement	All the following conditions are true. Patient is: • Identified as having CAD; and • 18 years of age or greater.	Patient received a blood pressure measurement within last 12 months	Previous	Verification
CAD004	Obesity / Overweight Screening	All the following conditions are true. Patient is: • Identified as having CAD; and • 18 years of age or greater.	Patient received an obesity / overweight screening within last 12 months	Previous	Verification
CAD005	Lipid Reduction Counselling	All the following conditions are true: • Patient is identified as having CAD; • Patient is 18 years of age or greater but not older than 74; and • One or more of the following	One or more of the following conditions is true. Patient received: • Lipid reduction counselling in last 12 months; and/or • A prescription for lipid lowering	Updated	Demonstration of condition in bold text Verification of remaining

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
		conditions are true: ▪ LDL level>2.0 mmol/L within the last 12 months; and/or ▪ Non-HDL level>2.8 mmol/L within the last 12 months.	medication (see Appendix A: Medication Codes) within last 12 months.		condition
CAD006	Beta Blockers	~~All the following conditions are true:~~ • ~~Patient is identified as having CAD;~~ • ~~Patient has had an acute myocardial infarction (AMI);~~ • ~~Patient must be less than 75; and~~ • ~~Patient is not identified as having asthma.~~	~~Patient is currently prescribed beta blockers~~	Retired	~~Verification~~

2.3.7 Osteoporosis Management

Table 10: Osteoporosis Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
OST001	Osteoporosis screening	All the following conditions are true: • Patient is 50 years of age or greater; and • Patient received a bone density post-fracture notification letter on or after their 50th birthday.	One or more of the following is true: • Patient received a bone mineral density test after the date of the post-fracture notification letter; • Patient had their osteoporosis action plan created or reviewed after the post-fracture notification letter; and/or • Patient received a prescription for an osteoporosis medication (see Appendix A: Medication Codes) after receiving the post-fracture notification letter.	Previous	Verification
OST002	Osteoporosis on-going care	All the following conditions are true: • Patient is 50 years of age or greater; and	One or more of the following is true: • Patient had their osteoporosis action plan reviewed within the last	Previous	Demonstration of conditions in bold text

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
		• One or more of the following conditions is true: ▪ Patient is identified as having osteoporosis; ▪ Patient has an osteoporosis action plan; and/or ▪ Patient received a prescription for an osteoporosis medication (see Appendix A: Medication Codes) within the last 60 months.	12 months; and/or • Patient received a prescription for an osteoporosis medication (see Appendix A: Medication Codes) within the last 12 months.		Verification of remaining condition

2.3.8 Chronic Obstructive Pulmonary Disease (COPD) Management

Table 11: COPD Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
COP001	Smoking Status Assessment	The patient is identified as having COPD	The date of last smoker screening occurred within last 12 months	Previous	Verification
COP002	Smoking Cessation Counselling	All the following conditions are true. Patient is: • Identified as having COPD; and • A current smoker.	The patient was provided with smoking cessation counselling in last 12 months	Updated	Verification
COP003	Influenza Immunization	Patient is identified as having COPD	One or more of the following conditions is true: • Patient was provided influenza immunization counselling within last 12 months; and/or • Patient received an influenza vaccination within the last 12 months.	Previous	Verification
COP004	Pneumococcal Immunization	Patient is identified as having COPD	One or more of the following conditions is true: • Patient was provided pneumococcal vaccination counselling within the last 12 months; and/or	Previous	Verification

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment
			• Patient received a pneumococcal vaccination.		

2.3.9 *Mental Health and Addictions Management*

Table 12: Mental Health and Addictions Management Reminder Guidelines

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment

MHA001	GAD Ongoing Assessment	All the following conditions are true:
		• Patient is 12 years of age or greater;
		• Patient is identified as having GAD; and
		• One or more of the following conditions is/are true:
		  • Patient scored >= 10 on any GAD-7 within the last 24 months; and/or
		  • Patient received a prescription for an anxiety medication (see Appendix A: Medication Codes) within the last 24 months.
			GAD-7 was administered within the last 12 months	New	Demonstration

MHA002	GAD Management Services	All the following conditions are true:
		• Patient is 12 years of age or greater;
		• Patient is identified as having GAD; and
		• One or more of the following conditions is/are true:
		  • Patient scored >= 10 on any GAD-7 within the last 24 months; and/or
		  • Patient received a prescription for an anxiety medication (see Appendix A: Medication Codes) within the last 24 months.
			One or more of the following conditions is/are true:
			• In-office brief intervention / management plan developed or reviewed related to anxiety within the last 12 months;
			• Patient was referred to anxiety related psychotherapy services within the last 12 months; and/or
			• Patient received a prescription for an anxiety medication (see Appendix A: Medication Codes) within the last 12 months.
				New	Demonstration

MHA003	MDD Ongoing Assessment	All the following conditions are true: • Patient is 12 years of age or greater;	PHQ-9 was administered within the last 12 months	New	Verification

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ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment

		• Patient is identified as having MDD; and
		• One or more of the following conditions is/are true:
		  • Patient scored >= 10 on any PHQ-9 within the last 24 months; and/or
		  • Patient received a prescription for a depression medication (see Appendix A: Medication Codes) within the last 24 months.			

MHA004	MDD Management Services	All the following conditions are true:
		• Patient is 12 years of age or greater;
		• Patient is identified as having MDD; and
		• One or more of the following conditions is/are true:
		  • Patient scored >= 10 on any PHQ-9 within the last 24 months; and/or
		  • Patient received a prescription for a depression medication (see Appendix A: Medication Codes) within the last 24 months.
			One or more of the following conditions is/are true:
			• In-office brief intervention / management plan developed or reviewed related to depression within the last 12 months;
			• Patient was referred to depression related psychotherapy services within the last 12 months; and/or
			• Patient received a prescription for a depression medication (see Appendix A: Medication Codes) within the last 12 months.
				New	Verification

MHA005	SUD Ongoing Assessment	All the following conditions are true:
		• Patient is 12 years of age or greater; and
		• One or more of the following conditions is/are true:
		  • Patient had a significant substance use incident within the last 24 months; and/or
		  • Patient received a prescription for a SUD medication (see Appendix A: Medication Codes) within the last 24 months.
			Patient was asked within the last 12 months about significant substance use	New	Demonstration

ID	Indicator	Reminder Active When	Fulfilled When	Status	Assessment

MHA006	SUD Management Services	All the following conditions are true:
		• Patient is 12 years of age or greater; and
		• One or more of the following conditions is/are true:
		  • Patient had a significant substance use incident within the last 24 months; and/or
		  • Patient received a prescription for a SUD medication (see Appendix A: Medication Codes) within the last 24 months.
			One or more of the following conditions is/are true:
			• In-office brief intervention / management plan developed or reviewed related to SUD within the last 12 months;
			• Patient was referred to addiction/harm reduction services within the last 12 months; and/or
			• Patient received a prescription for a SUD medication (see Appendix A: Medication Codes) within the last 12 months.
				New	Demonstration

3 Primary Care Data Extract

3.1 Introduction

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

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

3.2 General Extract Requirements

Table 13: General Data Extract Requirements

ID	Requirement	Guidelines	Additional Notes	Status	Assessment
PCDE-01	Ability to generate the Primary Care	At a minimum, must allow user to set parameters for: • Clinic/office/site to include in the data set • Providers to include in the data set		Previous	Demonstration

ID	Requirement	Guidelines	Additional Notes	Status	Assessment
	Data Extract files	• Include patients not currently assigned to a provider (yes/no) • Destination folder for the output Function must be able to be performed by a typical end user. It is not acceptable to require vendor intervention to complete this function.			

3.3 General Extract Rules

Table 14: General Extract Rules

ID	Rule	Additional Notes	Status	Assessment
GER-01	Extract file names generated by the EMR must be: • demographic.csv • asthma.csv • diabetes.csv • prevention.csv • CHF.csv • hypertension.csv • CAD.csv • osteoporosis.csv • MHA.csv All files must be in comma-separated values (.csv) format. All files must be UTF-8 encoded. Each row must be terminated with <CR><LF> line break types.		Updated	Verification
GER-02	The extract must conform to the exact Primary Care Data Extract structure defined in sections 3.4 to 3.11.		Previous	Verification
GER-03	The demographic file must only include one record per patient who visited the clinic in the last 60 months. Patients with only no show or cancelled appointments during this period must be excluded.	e.g. a patient cancels an appointment in January 15 and has had no other appointments in the last 60 months. If an extract is generated at the end of January, this patient's data would be excluded.	Previous	Verification

ID	RULE	ADDITIONAL NOTES	STATUS	ASSESSMENT
GER-04	All files must contain the most up-to-date information for that patient as of the date the extract is generated. All data in the extract must align with data in the EMR at the time of creation of the extract.		Previous	Verification
GER-05	The prevention file must only contain one record per patient listed in the demographic file extract.	i.e. the prevention file will have the same number of patient records as the demographic file.	Previous	Verification
GER-06	Only patients who visited the clinic in the last 60 months and have an active health concern for the relevant condition shall be included in the relevant file. Osteoporosis is the exception to this rule.	e.g. only patients with active diabetes diagnosis will be in the diabetes file. i.e. every patient in a file will also be in the demographic file as per GER-03.	Previous	Verification
GER-07	Patients must be included in the osteoporosis file when patient visited the clinic in the last 60 months and has at least one of the following: • Received a post fracture notification letter; • Prescription for osteoporosis medication within last 60 months; and/or • Osteoporosis action plan	i.e. every patient in the osteoporosis file will also be in the demographic file as per GER-03.	Previous	Verification
GER-08	Diagnosis dates must always be the original diagnosis date.	e.g. patient is originally diagnosed with COPD on January 1, 2010, and subsequently receives a second COPD-related diagnosis on March 1, 2013. The COPD diagnosis date submitted in the extract will remain January 1, 2010.	Previous	Verification
GER-09	It is not acceptable to force zeros (0) if data is not captured in applicable discrete data field.	e.g. if not all CTS questions are answered, extract must not contain a forced zero (0) value for that question. Values must be left blank.	Previous	Verification
GER-10	Patients must be included in the MHA file when a patient visited the clinic in the last 60 months and had at least one of the following:	i.e. every patient in the MHA file will also be in the demographic file as per GER-03.	New	Verification

ID	Rule	Additional Notes	Status	Assessment
	• Active health concern of GAD; • Active health concern of MDD; and/or • Any SUD related data elements are populated.			

3.4 Demographic Data

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

Table 15: Demographic Data

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

ID	Order in Extract	Data Element	Description	Type and Format	Status
DD-06	6	Date of Birth	Used to determine age, which is necessary for several indicators.	Type: Date Format: MMDDYYYY	Previous
DD-07	7	Administrative Sex	Used to determine eligibility for several indicators.	Type: Character Format: ‘M’ or ‘F’ or “U”	Previous
DD-08	8	Postal/Zip Code	Used to determine the general geographical location of a client’s residence.	Type: Character Formats: • Postal code: A#A #A# • Zip code: ##### • Zip code, extended: #####-####	Previous
DD-09	9	Core Patient	Retired	Blank	Previous
DD-10	10	Date of last visit	The date of the patient’s most recent visit to the clinic.	Type: Date Format: MMDDYYYY	Previous
DD-11	11	Active Indicator	Retired	Blank	Previous
DD-12	12	Enrolment Start Date	The date the client was included on the roster. Note: If already certified to and using Home Clinic Enrolment Service Specification, submission of this data is optional (may be left blank).	Type: Date Format: MMDDYYYY	Previous
DD-13	13	Enrolment End Date	The date the client was removed from the roster. Note: If already certified to and using Home Clinic Enrolment Service Specification, submission of this data is optional (may be left blank).	Type: Date Format: MMDDYYYY	Previous
DD-14	14	Patient Identifier	The health number assigned to the patient by a recognized issuing authority (provincial, territorial or federal).	Type: Variable length string (Max 30 characters) • A valid health card number for the issuing province, territory or	Previous

ID	ORDER IN EXTRACT	DATA ELEMENT	DESCRIPTION	TYPE AND FORMAT	STATUS
				federal authority • UNK (unknown) • NA (not applicable)	
DD-15	15	Patient Identifier Type	Represents the type of patient identifier. The element is constrained to provincial, territorial or federal identifier types.	Type: Character Format: AAAAA Field must contain one of the following values (JHN=Jurisdictional Health Number): **Value** **Description** JHNAB Alberta JHNBC British Columbia JHNMB Manitoba JHNNB New Brunswick JHNNL Newfoundland JHNNS Nova Scotia JHNNT Northwest Territories JHNNU Nunavut JHNON Ontario JHNPE Prince Edward Island JHNQC Quebec JHNSK Saskatchewan JHNYT Yukon JHNAF Armed Forces JHNVA Veterans Affairs JHNFN First Nations JHNCO Correctional Institution JHNRC RCMP JHNCI Immigration Other Other	Previous

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3.5 Prevention

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

Table 16: Prevention Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
PR-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
PR-03	3	Date of last cervical cancer screening	The date of the last pap test.	Type: Date Format: MMDDYYYY	Previous
PR-04	4	Exemption from cervical cancer screening	This is a true / false value.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-05	5	Date cervical cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of cervical cancer screening.	Type: Date Format: MMDDYYYY	Previous
PR-06	6	Date of last FOBT test	The date of the patient's last FOBT test. Part of colon cancer screening.	Type: Date Format: MMDDYYYY	Updated
PR-07	7	Date colon cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of colon cancer screening.	Type: Date Format: MMDDYYYY	Previous
PR-08	8	Date of last breast cancer screening	The date of the last mammography test.	Type: Date Format: MMDDYYYY	Previous
PR-09	9	Exemption from breast cancer screening	This is a true / false value.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-10	10	Date breast cancer	The date that the patient was most recently given	Type: Date	Previous

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ID	Order in Extract	Data Element	Description	Type and Format	Status
		screening advice was last provided	advice about the benefits of breast cancer screening.	Format: MMDDYYYY	
PR-11	11	Date of last lipid test	The date of the last lipid test. For dyslipidemia screening.	Type: Date Format: MMDDYYYY	Previous
PR-12	12	Date dyslipidemia screening advice was last provided	The date that the patient was most recently given advice about the benefits of dyslipidemia screening.	Type: Date Format: MMDDYYYY	Previous
PR-13	13	Date of last fasting blood sugar screening	Collected for all patients. The date of the last fasting blood sugar test.	Type: Date Format: MMDDYYYY	Previous
PR-14	14	Date fasting blood sugar screening advice was last provided	The date that the patient was most recently given advice about the benefits of fasting blood sugar screening.	Type: Date Format: MMDDYYYY	Previous
PR-15	15	Date of childhood immunizations counselling	The date on which all immunizations recommended by age seven have been confirmed or the date on which parents or guardians have been counselled on the recommended immunizations.	Type: Date Format: MMDDYYYY	Previous
PR-16	16	Date of last influenza vaccination counselling	The date of the patient's last influenza vaccination counselling.	Type: Date Format: MMDDYYYY	Previous
PR-17	17	Date of pneumococcal vaccination	The date the patient's pneumococcal vaccination was given.	Type: Date Format: MMDDYYYY	Previous
PR-18	18	Date of most recent live birth	Retired	Blank	Previous
PR-19	19	Date of most recent breastfeeding support / counselling	Retired	Blank	Previous
PR-20	20	Date of last blood pressure measurement	The date the patient received a blood pressure measurement. Collected for all patients.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-21	21	Date blood pressure screening advice was last provided	The date the patient was most recently given advice about the benefits of blood pressure screening.	Type: Date Format: MMDDYYYY	Previous
PR-22	22	Sedentary patient	True / false value to indicate if the patient undertakes regular physical activity, more specifically, whether a patient performs at least 20 minutes of light exercise three times per week.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
PR-23	23	Date of last physical activity advice	The date the patient was most recently given advice about the benefits of physical activity. Collected for all patients 12 of age and over who are sedentary (as defined above).	Type: Date Format: MMDDYYYY	Previous
PR-24	24	Smoker	Retired	Blank	Previous
PR-25	25	Date smoking cessation counselling was last provided	The date that the patient was most recently given counselling about the benefits of quitting smoking.	Type: Date Format: MMDDYYYY	Previous
PR-26	26	Date of last influenza vaccination	The date of the patient's last influenza vaccination.	Type: Date Format: MMDDYYYY	Previous
PR-27	27	Date of last pneumococcal vaccination counselling	The date of the patient's last pneumococcal vaccination counselling.	Type: Date Format: MMDDYYYY	Previous
PR-28	28	Date of last obesity / overweight screening	The date of the last obesity / overweight screening. Collected for all patients.	Type: Date Format: MMDDYYYY	Previous
PR-29	29	Date of last colonoscopy	The date of the patient's last colonoscopy.	Type: Date Format: MMDDYYYY	Previous
PR-30	30	Date of MMR immunization	The date on which all MMR immunizations recommended by age seven have been confirmed.	Type: Date Format: MMDDYYYY	Previous
PR-31	31	Date of last PHQ-2 administration	Date of last PHQ-2 administration is no longer an active data element. To ensure proper processing of	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			the extract file, this field must be maintained in the extract. Submission of this data is **optional**.		
PR-32	32	Character response to the PHQ-2 questions	The character response to the PHQ-2 questions is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Character Format: #	Previous
PR-33	33	Date a depression screening follow-up assessment occurred	Date a depression screening follow-up assessment occurred is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Date Format: MMDDYYYY	Previous
PR-34	34	Depression screening follow-up outcome selected	Depression screening follow-up outcome selected is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Character Format: # Character to be exported: a selected - 1 b selected - 2 c selected - 3 d selected - 4 b AND c selected - 5	Previous
PR-35	35	Date of active depression diagnosis	Date of active depression diagnosis is no longer an active data element. To ensure proper processing of the extract file, this field must be maintained in the extract. Submission of this data is **optional**.	Type: Date Format: MMDDYYYY	Previous
PR-36	36	Smoking status	Used to determine eligibility for indicator.	Type: Numeric Values: 1 – Current smoker 2 – Former smoker 3 – Never a smoker	Previous
PR-37	37	Date of last cigarette / tobacco product	The date of the last time the patient consumed a product containing tobacco. Used to determine if a	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			"former smoker".		
PR-38	38	Date of last smoker screening	The date of the last time the patient's smoking status was visited.	Type: Date Format: MMDDYYYY	Previous
PR-39	39	Character response to CTS questions	Response to the 5 screening questions endorsed by the CTS. # Question 1 Do you cough regularly? 2 Cough up phlegm? 3 Short of breath with simple chores? 4 Wheeze with exertion or at night? 5 Frequent colds that persist?	Type: Binary Format: 5 character value required 0 – No 1 – Yes Examples: 01 01 How this translates to responses: # Answer 1 No 2 Yes 3 (blank) 4 No 5 Yes	Previous
PR-40	40	Date of last COPD at risk screening	The date of the last time the patient was assessed for risk of COPD.	Type: Date Format: MMDDYYYY	Previous
PR-41	41	Date of last spirometry test	The date of the patient's last spirometry test.	Type: Date Format: MMDDYYYY	Previous
PR-42	42	COPD diagnosis	Indication that the patient has an active diagnosis of COPD.	Type: Numeric Values: 0 – Not diagnosed with COPD 1 – Diagnosed with COPD	Previous
PR-43	43	Date of COPD diagnosis	The date of the first COPD related diagnosis.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
PR-44	44	Date of last A1c test	Preventative diabetes screening.	Type: Date Format: MMDDYYYY	Previous
PR-45	45	Date of last statin prescription	The most recent date a qualifying medication was prescribed to the patient. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	Previous
PR-46	46	Date of last flexible sigmoidoscopy	The date of the patient's last flexible sigmoidoscopy.	Type: Date Format: MMDDYYYY	New

3.6 Diabetes Management

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

Table 17: Diabetes Management Data

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

ID	Order in Extract	Data Element	Description	Type and Format	Status
DI-07	7	Date of last fundoscopic exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-08	8	Date of last foot exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-09	9	Patient has documented peripheral neuropathy	Collected for all diabetic patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
DI-10	10	Date of last lipid test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-11	11	Date of last blood pressure measurement	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-12	12	Date of last obesity / overweight screening	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	Previous
DI-13	13	Date of last fundoscopic exam referral	Collected for all diabetic patients. This is the date of the fundoscopic referral, and not the date of the exam itself.	Type: Date Format: MMDDYYYY	Previous

3.7 Asthma Management

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

Table 18: Asthma Management Data

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

ID	Order in Extract	Data Element	Description	Type and Format	Status
			clinic for identification within the clinic's EMR.	Format: #########	
AS-03	3	Patient has asthma	Indication that the patient has an active diagnosis of asthma.	Type: Character Format: 1 – true or yes	Previous
AS-04	4	Number of canisters of SABA prescribed within past 12 months	Retired	Blank	Previous
AS-05	5	Patient has received preventer / controller medicine within past 12 months	Retired	Blank	Previous
AS-06	6	Date patient last visited emergency department for asthma	Retired	Blank	Previous
AS-07	7	Patient has an asthma action plan	Collected for all asthma patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
AS-08	8	The date of the most recent asthma action plan or care review	The date of the last asthma action plan or care review or the date asthma action plan was developed (if no subsequent review was made). Collected for all asthma patients.	Type: Date Format: MMDDYYYY	Updated

3.8 Congestive Heart Failure Management

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

Table 19: CHF Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status

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ID	Order in Extract	Data Element	Description	Type and Format	Status
CF-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
CF-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
CF-03	3	Patient has Congestive Heart Failure	Indication that the patient has an active diagnosis of congestive heart failure.	Type: Character Format: 1 – true or yes	Previous
CF-04	4	Date patient last visited emergency department for congestive heart failure	Retired	Blank	Previous
CF-05	5	Date of last obesity / overweight screening	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-06	6	Patient using ACE inhibitors or ARB	Retired	Blank	Previous
CF-07	7	Date of last lipid test	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-08	8	Date of last blood pressure measurement	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	Previous
CF-09	9	Date of last fasting blood sugar test	Retired	Blank	Updated
CF-10	10	Date of last A1c test	Retired	Blank	Updated
CF-11	11	Date of last ACE inhibitor or ARB prescription	Collected for all CHF patients. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	Previous
CF-12	12	Exemption from ACE inhibitor or ARB	To allow an exemption for patients who do not require ACE inhibitor or ARB prescription.	Type: Numeric values Format:	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		prescription		1 – LVEF>=40% 2 – Other	
CF-13	13	Date of last exemption from ACE inhibitor or ARB prescription	This is the last date the patient was assessed for being exempt from ACE inhibitor or ARB prescription.	Type: Date Format: MMDDYYYY	Previous

3.9 Hypertension Management

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

Table 20: Hypertension Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
HY-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
HY-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
HY-03	3	Patient has hypertension	Indication that the patient has an active diagnosis of hypertension.	Type: Character Format: 1 – true or yes	Previous
HY-04	4	Date of last fasting blood sugar test	Retired	Blank	Updated
HY-05	5	Date of last lipid test	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-06	6	Date of last test to detect renal dysfunction (e.g. serum, creatinine)	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-07	7	Date of last blood	Collected for all hypertensive patients.	Type: Date	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
		pressure measurement		Format: MMDDYYYY	
HY-08	8	Date of last obesity / overweight screening	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	Previous
HY-09	9	Exemption from dyslipidemia screening	To allow an exemption for patients at low cardiovascular risk.	Type: Numeric values Format: 1 – Framingham Risk Score<10% 2 – Disease stable	Previous
HY-10	10	Date of last exemption from dyslipidemia screening	This is the last date the patient was assessed for being at low cardiovascular risk.	Type: Date Format: MMDDYYYY	Previous
HY-11	11	Date of last A1c test	Retired	Blank	Updated

3.10 Coronary Artery Disease Management

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

Table 21: CAD Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
CA-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type: Character Format: #####	Previous
CA-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type: Character Format: #########	Previous
CA-03	3	Patient has Coronary Artery Disease	Indication that the patient has an active diagnosis of coronary artery disease.	Type: Character Format: 1 – true or yes	Previous
CA-04	4	Date of last fasting	Retired	Blank	Updated

ID	ORDER IN EXTRACT	DATA ELEMENT	DESCRIPTION	TYPE AND FORMAT	STATUS
		blood sugar test			
CA-05	5	Date of last lipid test	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-06	6	Date of last blood pressure measurement	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-07	7	Date of last obesity / overweight screening	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-08	8	LDL level > 2.0 mmol/L in last 12 months	Retired	Blank	Updated
CA-09	9	Date of last lipid reduction counselling	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	Previous
CA-10	10	Date of last lipid lowering medication prescription	Collected for all CAD patients. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	Previous
CA-11	11	Patient has had acute myocardial infarction	Retired	Blank	Previous
CA-12	12	Patient has a current prescription for a beta blocking medication	Retired	Blank	Previous
CA-13	13	Date of last A1c test	Retired	Blank	Updated
CA-14	14	Date of last LDL level > 2.0 mmol/L	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	New
CA-15	15	Date of last Non-HDL level > 2.8 mmol/L	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	New

3.11 Osteoporosis Management

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

Table 22: Osteoporosis Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
OS-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type = Character Format = #####	Previous
OS-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	Previous
OS-03	3	Date of Manitoba bone density post-fracture notification letter	The date of the letter sent out to primary care physicians by MHSAL to identify patients as having a possible fracture.	Type: Date Format: MMDDYYYY	Previous
OS-04	4	Date of last bone mineral density test	Identification of the date of last bone mineral density test.	Type: Date Format: MMDDYYYY	Previous
OS-05	5	Osteoporosis diagnosis date	The date that the current osteoporosis diagnosis was made.	Type: Date Format: MMDDYYYY	Previous
OS-06	6	Osteoporosis diagnosis	Indication that the patient has an active diagnosis of osteoporosis.	Type: Numeric Values: 0 – Not Diagnosed with Osteoporosis 1 – Diagnosed with Osteoporosis	Previous
OS-07	7	Date of last osteoporosis medication prescription	The most recent date a qualifying medication was prescribed to the patient. See Appendix A: Medication Codes. Collected for all osteoporotic patients.	Type: Date Format: MMDDYYYY	Previous
OS-08	8	Last prescribed bisphosphonate	The most recent date that a bisphosphonate was prescribed to this patient. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	Previous

ID	Order in Extract	Data Element	Description	Type and Format	Status
			Collected for all osteoporotic patients.		
OS-09	9	Patient has an osteoporosis action plan	True / false value to determine eligibility for osteoporosis on-going care indicator. Collected for all osteoporotic patients.	Type: Binary Format: 0 – false or no 1 – true or yes	Previous
OS-10	10	Date the most recent osteoporosis action plan review	The date of the last osteoporosis action plan review or the date the osteoporosis action plan was developed (if no subsequent review was made). Collected for all osteoporotic patients.	Type: Date Format: MMDDYYYY	Previous

3.12 Mental Health and Addictions Management

The following represents the data elements that need to be collected for Mental Health and Addictions Management.

Table 23: Mental Health and Addictions Management Data

ID	Order in Extract	Data Element	Description	Type and Format	Status
MH-01	1	EDTR Clinic Identifier	The clinic identifier assigned by MHSAL.	Type = Character Format = #####	New
MH-02	2	EMR Patient Identifier	The unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	New
MH-03	3	Patient has Generalized Anxiety Disorder	Indication that the patient has an active diagnosis of Generalized Anxiety Disorder.	Type: Character Format: 1 – true or yes	New
MH-04	4	GAD-7 Test Date	Date of the most recent GAD-7 administered to the patient.	Type: Date Format: MMDDYYYY	New
MH-05	5	GAD-7 Score	The patient’s most recent GAD-7 score.	Type: Numeric Values: 0-21	New

ID	Order in Extract	Data Element	Description	Type and Format	Status
MH-06	6	Date of last anxiety medication prescription	The most recent date that an anxiety medication prescribed to the patient. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	New
MH-07	7	Date of last anxiety counselling	Date of the last in-office counselling or action plan creation/review for anxiety.	Type: Date Format: MMDDYYYY	New
MH-08	8	Date of last anxiety referral	The most recent date of referral to an anxiety related resource	Type: Date Format: MMDDYYYY	New
MH-09	9	Patient has Major Depressive Disorder	Indication that the patient has an active diagnosis of Major Depressive Disorder.	Type: Character Format: 1 – true or yes	New
MH-10	10	PHQ-9 Test Date	Date of the most recent PHQ-9 administered to the patient.	Type: Date Format: MMDDYYYY	New
MH-11	11	PHQ-9 Score	The patient's most recent PHQ-9 score.	Type: Numeric Values: 0-27	New
MH-12	12	Date of last depression medication prescription	The most recent date of depression medication prescribed to the patient. See Appendix A: Medication Codes.	Type: Date Format : MMDDYYYY	New
MH-13	13	Date of last depression counselling	Date of the last in-office counselling or action plan creation/review for depression.	Type: Date Format: MMDDYYYY	New
MH-14	14	Date of last depression referral	The most recent date of referral to a depression related resource.	Type: Date Format: MMDDYYYY	New
MH-15	15	Primary Substance	Substance used in the last significant substance usage.	Type: ICD-9 code Format: 303 - Alcohol 304.0 - Opioid 304.1 - Sedative, hypnotic or anxiolytic	New

ID	Order in Extract	Data Element	Description	Type and Format	Status
				304.2 - Cocaine 304.4 - Amphetamine and other psychostimulant 304.5 – Hallucinogen 304.6 - Other specified drug 304.7 - Combinations of opioid type drug with any other 304.8 - Combinations of drug dependence excluding opioid type drug 304.9 - Unspecified drug	
MH-16	16	Substance usage inquiry	The last date the patient was asked about substance usage.	Type: Date Format: MMDDYYYY	New
MH-17	17	Date of last significant substance usage	The last date the patient identified a substance usage that would be deemed a significant usage.	Type: Date Format: MMDDYYYY	New
MH-18	18	Date of last SUD medication prescription	The most recent date of SUD medication prescribed to the patient. See Appendix A: Medication Codes.	Type: Date Format: MMDDYYYY	New
MH-19	19	Date of last SUD counselling	Date of the last in-office counselling or action plan creation/review for the SUD.	Type: Date Format: MMDDYYYY	New
MH-20	20	Date of last SUD referral	The most recent date of referral to SUD related resource.	Type: Date Format: MMDDYYYY	New

3.13 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 the Primary Care Data Extract as follows:

- At least two weeks before the scheduled product demonstration related to other requirements within this specification; and

- After performing all demonstration activities specified within this specification.

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

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

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4 Appendix A: Medication Codes

Table 24: Medication Codes

<table>
<tr><th colspan="2">MEDICATION CATEGORY</th><th>ATC CODE</th></tr>
<tr><td colspan="2">Lipid Lowering Medications</td><td>C10</td></tr>
<tr><td colspan="2">Statins</td><td>C10AA
C10B</td></tr>
<tr><td colspan="2">ACE/ARB</td><td>C09</td></tr>
<tr><td rowspan="2">Osteoporosis</td><td></td><td>G03XC
H05AA
H05BA
M05BX</td></tr>
<tr><td>Bisphosphonate</td><td>M05BA
M05BB</td></tr>
<tr><td colspan="2">Anxiety</td><td>N05B</td></tr>
<tr><td colspan="2">Depression</td><td>N06A</td></tr>
<tr><td colspan="2">SUD</td><td>N07B</td></tr>
</table>

5 Release Notes

Version 1.1 December 9, 2015

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

Version 1.2 August 31, 2016

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

Version 1.3 September 29, 2016

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

Version 1.4 April 28, 2017

- Replaced MHHLS with MHSAL
- Section 1.2 – Added glossary
- DD-01 – Clarified that this field may be 4 or 5 characters in length
- DD-02 – Updated description. Clarified that this field may be 4 or 5 characters in length.
- DD-03 – Clarified that the length shown is the max length but shorter lengths are acceptable
- DD-12 - Removed sentence "Submission of this data is optional. To ensure proper processing of the extract file, this field must be maintained in the extract."
- DD-13 – Removed sentence "Submission of this data is optional. To ensure proper processing of the extract file, this field must be maintained in the extract."
- CA-13 – Changed "Date of last A1c screening" to "Date of last A1c test"

Version 1.5 September 1, 2017

- Background – Added Chronic Obstructive Pulmonary Disease to list of indicators
- Related Documents – Added reference to Primary Care Data Indicator Guide
- PRV004, PRV005, DIA005, CHF003, HYP002, CAD002 – In *Reminder Active When*, added "no statins prescribed in last 12 months. In *Reminder Fulfilled When*, removed "full fasting" and changed 12 months to 60 months.
- PRV012 – Changed "Smoking Cessation Advice" to "Smoking Cessation Counselling"
- PRV016 – New reminder
- CHF002 – In *Reminder Fulfilled When*, added "patient received exemption from ACE inhibitor or ARB medication within last 12 months"
- CAD006 – Retired reminder. Reminder no longer required.

- PR-11, DI-10, CF-07, HY-05, CA-05 – Removed "full fasting". These data elements no longer require the test to be fasting.
- CA-12 – Changed this field to optional
- PR-25 - Changed "Smoking Cessation Advice" to "Smoking Cessation Counselling"
- PR-45, CF-12, CF-13 – New fields
- Section 2.3 – Added COPD Management section

Version 1.6 August 2, 2018

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

Version 4.0 May 1, 2020

- Updated format to Shared Health template
- Skipped version numbers to align with Manitoba Primary Care Quality Indicator Guide v4.0
- Background – Updated to include Mental Health and Addictions
- Related Documents – Removed Primary Care Quality Indicators Guide version
- Glossary – Added several acronyms
- PCDC-11, PCDC-12 – Modified wording in guideline notes.
- PCDC-14, PCDC-15, PCDC-16 – New
- PRV002 – In *Fulfilled When*, added "date of last flexible sigmoidoscopy occurred within last ten years"
- DIA002, HYP003 – Added upper age limit of 75
- AST001 – In *Fulfilled When*, added "or asthma care reviewed"
- CHF005, HYP001, CAD001 – Retired
- CAD005 – In *Reminder Active When*, added condition "Non-HDL level>2.8 mmol/L within the last 12 months"
- COP002 – In *Reminder Active When*, removed "former smoker"
- Mental Health and Addictions Management reminder guidelines - New
- GER-01 – Added MHA.csv filename. Added file encoding and row termination.
- GER-09 - New
- PR-06 – Updated wording to more accurately reflect what this field represents
- PR-22 – Removed sentence "Used to determine eligibility for Physical Activity Advice indicator"
- PR-46 – New

- AS-08 – Changed from “action plan review” to “action plan or care review”
- CF-09, CF-10, HY-04, HY-11, CA-04, CA-08, CA-13 – Retired
- CA-14, CA-15 – New
- Mental Health and Addictions Management data – New
- Appendix A – Medication Codes is new. Added references to this section anywhere that mentions medications.

VERSION 4.1 JUNE 16, 2020

- PCDC-16, MH-15 – Added 304.5 Hallucinogen

VERSION 4.2 NOVEMBER 17, 2020

- PCDC-16 – Changed “Alcohol (303.0)” to “Alcohol (303)”
- GER-09 – There were two GER-09 requirements. Renamed the second one to GER-10
- CA-11 – Updated Description and Type and Format fields to reflect retirement of this data element per the Version 1.6 updates on August 2, 2018.