HQCA Health Quality Council of Alberta

Primary Care Networks

Alberta Health Services

Guide
for Data Sharing Standards in Primary Health Care

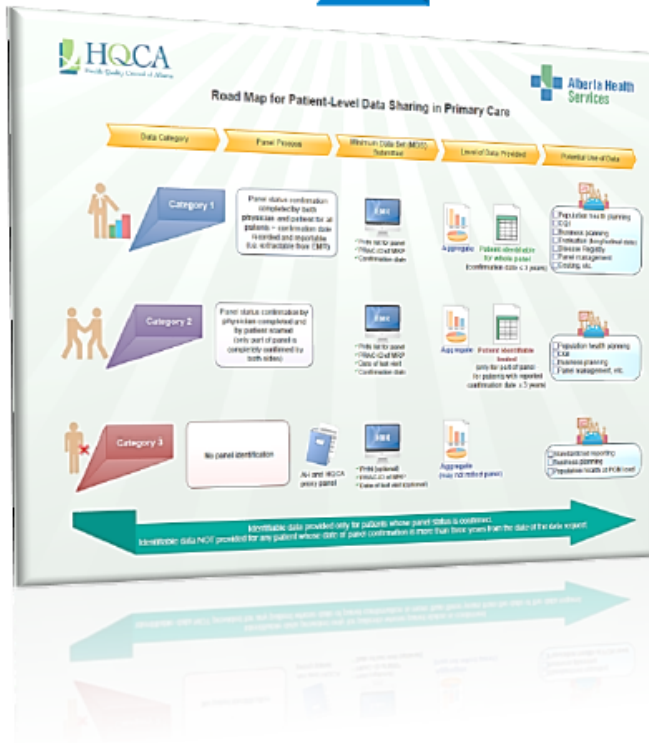Road Map for Patient-Level Data Sharing in Primary Care

Alberta Health Services (AHS), Alberta Health (AH) and the Health Quality Council of Alberta (HQCA) hold a wide range of valuable data on how your patients use and experience the healthcare system. In combination with data from your clinic EMR, this can be used to improve the services you provide to patients. AHS and the HQCA have developed common standards and processes for sharing this data with you.

The Guide for Patient Level Data Sharing Standards in Primary Care describes:

☑ What level of data (aggregate or patient identifiable) you can access based on the degree to which you have confirmed your patient panel

☑ What information you need to provide when you request data

☑ What privacy agreements and related processes need to be in place when patient identifiable data is shared

☑ What support is available to you to improve your paneling activities and the accuracy of your confirmed patient panel list

The Overall Aim of the Guide is to:

01 Support a culture of data driven continuous improvement

02 Provide a framework that supports an incremental process towards patient attachment and continuity of care

03 Help you access aggregate and patient identifiable data

If you want more information on the Guide or would like to discuss how you might use the Guide, please see contact information on page 11.

WHY DO WE SHARE DATA?

High quality data are essential for effective patient care and the Patients' Medical Home. High quality data can help you make clinical decisions; coordinate the care of your patients; evaluate and improve services; and also help your PCN design services around the needs of the population.

As a physician, you have direct access to data from your clinic EMR. However, this is only part of the full picture of the patient journey. AH, AHS and the HCQA hold a wide range of valuable data on how patients use and experience the healthcare system that can enhance and enrich what you have in your clinic EMR. We want to share this data with you.

> **Other sources of patient-identifiable and aggregate data:**
> ❖ **AHS** data (administrative data)
> ❖ **AH** claims / billing data (public health; billing data)
> ❖ **HQCA** reports (e.g., physician, clinic and PCN panel reports and patient experience survey reports)

HOW DO WE SHARE DATA?

With an enhanced data set, you will be able to better understand the care that your patients have received within Alberta's healthcare system. However, we all have to ensure that patient data are shared appropriately, safely and securely.

> **Definition of a confirmed patient panel:**
> The relationship between the physician and the patient has been confirmed by a conversation between the physician or clinic staff member and the patient where both agree that the physician is the patient's primary care provider.

We can only share patient-identifiable data with you if: 1) you have confirmed with your patients that you are their most responsible physician; 2) you have communicated this to AH, AHS and the HQCA when you request data; 3) we have the authority to release the data to you.

If you have not confirmed the relationship with your patients, AH, AHS and the HQCA can provide only aggregated data for your patients. All paneling activity will help you improve the amount and type of data you receive and support your journey towards receiving an enhanced data set which includes patient-identifiable information.

The Data Sharing Standards guide outlines the privacy **principle** of data sharing (correct information to the correct provider) for secondary purposes (evaluation, quality improvement, etc.) to enable primary care providers to access or match patient-identifiable data from other organizations for their confirmed patient panel (or access aggregate data if panel is not confirmed) to address a specific question that primary care providers want to study about their patient populations.
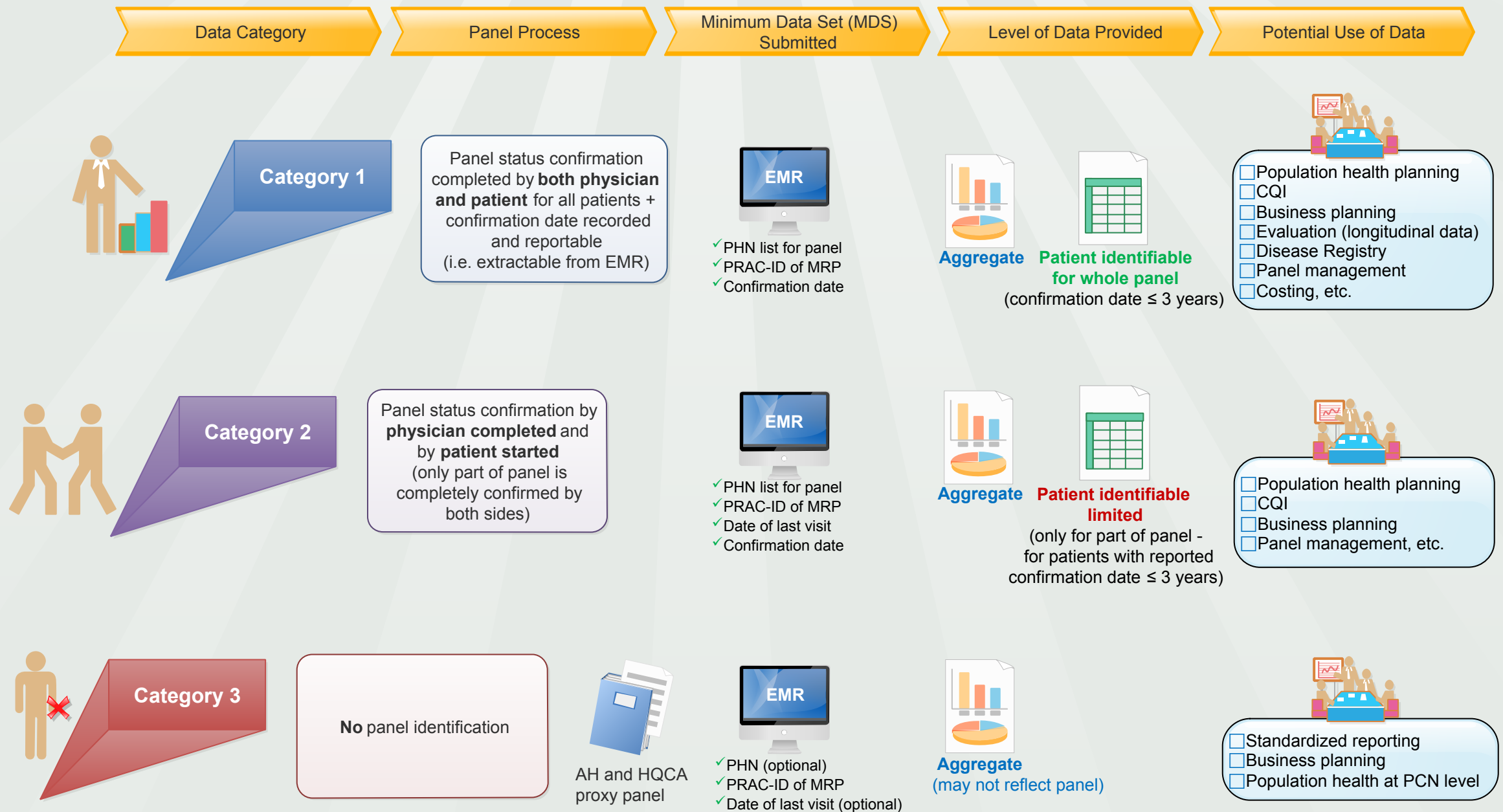
DATA SHARING STANDARDS IN PRIMARY CARE

This guide presents a road map to receiving data (i.e., three categories and the levels of data you can expect to receive depending on the degree to which you have confirmed the relationship with your patients); data privacy requirements for sharing patient-identifiable health information; and the support you can access to help you progress between categories and receive the most detailed patient-identifiable data.

KEY MESSAGES FOR ROADMAP FOR PATIENT-LEVEL DATA SHARING IN PRIMARY CARE

➢ We will provide different levels of aggregated and patient-identifiable data depending on the extent to which you have confirmed the relationship with your patients.

➢ The date on which you confirmed the relationship with each patient needs to be provided to receive patient-identifiable data. The confirmation date needs to be within 3 years of the date of request.

➢ If you have not done any paneling activity, you can still receive aggregated data based on your patient list. This list can be derived from your proxy panel (i.e., the HQCA algorithm or AH four-cut method) or from your clinic EMR. This will help you better understand your patient population and how your patients use the healthcare system *(category 3)*. Note: a proxy panel may be a better representation of your panel than the list generated from your EMR.

➢ Once you have started confirming the relationship with your patients you can receive aggregated data for the whole panel, and some patient-identifiable data about patients with whom the relationship has been confirmed. This is an interim step in developing a robust, confirmed panel *(category 2)*.

➢ Patient-identifiable data is available to physicians who have confirmed with patients that they are the patient's most responsible physician *(category 1)*. Patient-identifiable data can only be shared for a specific purpose, and only the minimum amount of data required for the purpose will be shared.

➢ The **recommended practice** for paneling in Alberta is to confirm the relationship with your patients at every clinic visit.

Road Map for Sharing Patient-Identifiable Health Information in Primary Health Care

Data Category	Panel Process	Minimum Data Set (MDS) Submitted	Level of Data Provided	Potential Use of Data
Category 1	Panel status confirmation completed by **both physician and patient** for all patients + confirmation date recorded and reportable (i.e. extractable from EMR)	EMR ✓ PHN list for panel ✓ PRAC-ID of MRP ✓ Confirmation date	Aggregate **Patient identifiable for whole panel** (confirmation date ≤ 3 years)	☐ Population health planning ☐ CQI ☐ Business planning ☐ Evaluation (longitudinal data) ☐ Disease Registry ☐ Panel management ☐ Costing, etc.
Category 2	Panel status confirmation by **physician completed** and by **patient started** (only part of panel is completely confirmed by both sides)	EMR ✓ PHN list for panel ✓ PRAC-ID of MRP ✓ Date of last visit ✓ Confirmation date	Aggregate **Patient identifiable limited** (only for part of panel - for patients with reported confirmation date ≤ 3 years)	☐ Population health planning ☐ CQI ☐ Business planning ☐ Panel management, etc.
Category 3	**No** panel identification	AH and HQCA proxy panel — EMR ✓ PHN (optional) ✓ PRAC-ID of MRP ✓ Date of last visit (optional)	Aggregate (may not reflect panel)	☐ Standardized reporting ☐ Business planning ☐ Population health at PCN level

Identifiable data provided only for patients whose panel status is confirmed.
Identifiable data NOT provided for any patient whose date of panel confirmation is more than three years from the date of the data request.

Category	Paneling Status	Source of PHN List	Minimum Data Set Requirements to Receive Data[1]	Level of Data Provided[2]	Potential Use of Data
3	• No panel identification activity has occurred	Any of: • Physician – EMR list, billing software, scheduling software, program or disease registry (depending on the physician's practice pattern, the proxy panel may be a better representation of the physician's actual panel) • AH – proxy panel created using the 4 cut method • HQCA – proxy panel created using the HQCA algorithm	• PRAC-ID • PHN list *(optional)* • Date of last visit for each patient *(optional)*	• Aggregate only	• Standardized-reporting *(e.g., HQCA physician, clinic or PCN panel reports)* • Business planning • Understand proxy panel characteristics at the physician, clinic or PCN level • Population health planning at the PCN level • Evaluation for small identified groups of patients for different programs *(i.e., chronic disease program)*
2	• Confirmation of panel status with patients may have started but not all patients have been confirmed.	Any of: • Physician – EMR list, billing software, scheduling software, program or disease registry • AH – proxy panel created using the 4 cut method • HQCA – proxy panel created using the HQCA algorithm	• PRAC-ID • PHN list • Date of last visit for each patient *(to receive aggregate data)* • Confirmation date for each patient *(to receive patient-identifiable data)*	• Aggregate • Patient-identifiable data could be released for patients with reported confirmation date no more than 3 years from the date of the data request.	• Standardized reporting *(e.g., HQCA physician, clinic or PCN panel reports)* • Business planning • Panel management • Population health planning at the PCN and clinic level • Quality improvement *(aggregate data)* e.g., process improvement to improve screening rates • Program improvement

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[1] Describes the minimum data that physicians will share with AHS and the HQCA to access AHS data and the HQCA reports.

[2] AHS and the HQCA, along with other provincial programs who support paneling and data sharing, are committed to working with you to help you evaluate and advance your paneling process and data sharing practices.

| Category	Paneling Status	Source of PHN List	Minimum Data Set Requirements to Receive Data[1]	Level of Data Provided[2]	Potential Use of Data
1	• Physician or office staff have a process to confirm with patient that the physician is the most responsible primary care physician for that patient. • When the patient chooses to be paneled to a clinic, or a patient receives care by a shared practice, the clinic physicians will agree on a process to assign one provider to act as the custodian or most responsible provider for that patient to enable data sharing. • The date on which panel status was last confirmed with the patient must be documented *(e.g., in the EMR, paper chart or other electronic format)* and be reportable by submitting the confirmation date value. • Date of confirmation with the patient should be no more than three years from the date of the data request.	• Physician – patient panel generated from the EMR or billing software • Clinic or PCN – patient panel generated from the EMR(s)	• PRAC-ID • PHN list for panel • Confirmation date for each patient *(to receive patient -identifiable data)*	• Aggregate • Identifiable data provided only for patients whose panel status is confirmed, documented and reported • Identifiable data not provided for any patient whose date of panel confirmation is more than three years from the date of the data request.	• Population health planning *(aggregate)* • Quality improvement *(aggregate data)* e.g., process improvement to improve screening rates • Program improvement • Panel maintenance/ clean-up • Management of targeted groups of patients on the panel *(e.g,. patients with diabetes who are high users of ED services)* • Longitudinal data for evaluation purposes • Registry • Enhancing EMR with additional patient-level data • Costing

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[1] Describes the minimum data that physicians will share with AHS and the HQCA to access AHS data and the HQCA reports.

[2] AHS and the HQCA, along with other provincial programs who support paneling and data sharing, are committed to working with you to help you evaluate and advance your paneling process and data sharing practices.

KEY MESSAGES FOR MINIMUM DATA SET REQUIREMENTS TO RECEIVE DATA

➢ The panel list including required data elements must be submitted in an electronic format by a custodian or delegated affiliate when requesting patient-identifiable data. Acceptable formats include:
  > Delimited text file e.g., CSV file
  > Excel file with discrete fields for each data element
  > Access data base file

➢ All data shared between physician, clinic, PCN, HQCA, AHS and AH should be transferred securely as described in the relevant Privacy Impact Assessment (PIA), agreement that permits information sharing (Information Sharing Agreement (ISA), Information Management Agreement (IMA), or Contractual Agreement) and organizational policies (e.g., encrypted, secure exchange protocol).
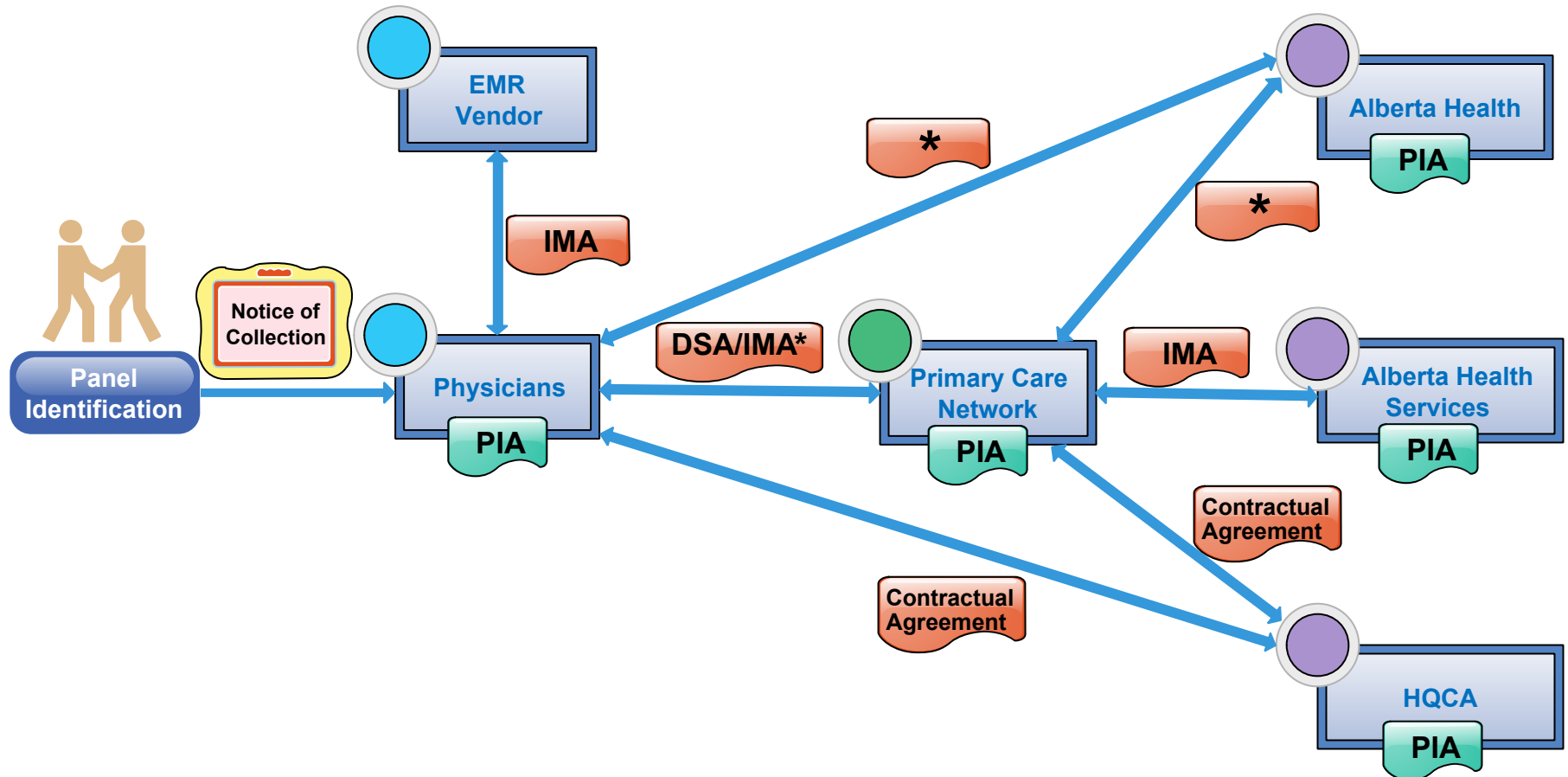
Notice of Collection - **Notice of Collection** of patient health information must be posted in the waiting areas of physician clinics.

PIA - **Privacy Impact Assessment.**

DSA/IMA* - **Data Sharing Agreement,** and/or **Information Management Agreement** (should include a clause or mechanism that authorizes a PCN to exchange patient-identifiable data provided by physicians on their behalf with AH, AHS & HQCA).

CA - **Contractual Agreement** (can contain elements of Information Sharing or Information Management Agreements).

* - To be determined by AH.

KEY MESSAGES FOR REQUIREMENTS TO MEET LEGAL STANDARDS FOR HEALTH INFORMATION SHARING

The legal, ethical and professional requirements that guide the collection, use and disclosure of health information are governed by the HIA (Health Information Act), FOIP (Freedom of Information and Protection of Privacy Act), Personal Information Protection Act (PIPA) and Standards of Practice (College of Physicians and Surgeons of Alberta). To meet the legal standards for health information sharing under sections 57 and 58 of the HIA: custodians should collect, use and disclose the least amount of information in the most anonymous manner possible to meet an authorized purpose.

Required documentation and conditions to be met for secure exchange of health information:

1. **Signed Agreement** between those who will be sharing information that specifies the conditions under which information will be shared and used. One or more of the following agreements suitable to the situation and meeting the requirements of the HIA and its regulations is required:

   - ✓ **Data Sharing Agreement** (between PCNs and member physicians)
   - ✓ **Information Sharing Agreement** (between custodians within clinics per CPSA Standards of Practice)
   - ✓ **Information Management Agreement** (Health Information Regulation AR 70/2001)
   - ✓ **Contractual Agreement** (should contain ISA and/or IMA elements to enable data sharing)

   Minimally the agreement(s) should include two main conditions:
   1. Statement about how patient-identifiable information will be shared and managed, and
   2. When health information is to be shared with an individual who is receiving the information on behalf of a clinic or practice group or program, statement that all custodians have an agreement in place with that individual that allows the information sharing to occur.

   The *AMA Privacy Agreement Matrix* may be helpful to determine whether an IMA or ISA is appropriate for your project or ongoing activities, but might not cover all situations (e.g., when a Contractual Agreement may be more appropriate):
   https://www.albertadoctors.org/leaders-partners/clinic-patient-privacy/agreements-and-data-sharing
   https://www.albertadoctors.org/emr_resources/companion-data-sharing-standards.pdf

2. **Privacy Impact Assessment (PIA)** submitted to the OIPC (Office of the Information and Privacy Commissioner of Alberta) when individually identifying information is to be shared or data matching perfomed:

a) when implementing a new or changing an existing administrative practice or information system:

HIA 64(1) "Subject to subsection (3), each custodian must prepare a privacy impact assessment that describes how proposed administrative practices and information systems relating to the collection, use and disclosure of individually identifying health information may affect the privacy of the individual who is the subject of the information."

b) when data matching performed:

HIA 70(2)"Before performing data matching under this section, the custodian or health information repository in whose custody and control the information that is created through data matching will be stored must prepare a privacy impact assessment and submit the assessment to the Commissioner for review and comment."

Note: If you are implementing changes to your data sharing practices, you must review your existing PIA to determine if amendments are required.

3. **Notice of Collection**

When collecting health information directly from a patient notification must be provided by means of a sign or verbally (from the custodian) as appropriate.

HIA 22(3) A custodian "when collecting individually identifying health information about an individual directly from the individual must take reasonable steps to inform the individual (a) of the purpose for which the information is collected, (b) of the specific legal authority for the collection, and (c) of the title, business address and business telephone number of an affiliate of the custodian who can answer the individual's questions about the collection."

4. **Data Governance Structure** to oversee the information sharing and management processes and establish required policies, procedures and guidelines to protect privacy, confidentiality and security of health information.

5. **Privacy and Security training** regarding managing patient-identifiable data and HIA awareness – for the custodian's staff and affiliates who are involved in health information collection, use and disclosure.

(Health Information Act: Guidelines and practices manual. (2011). Edmonton: Alberta Health & Wellness.)

RESOURCES, TEMPLATES AND GUIDES FOR PRIVACY REQUIREMENTS FOR PATIENT-LEVEL DATA SHARING IN PRIMARY CARE

Please contact the relevant organization with whom you wish to share data (i.e., AH, AHS, HQCA) for specific templates and practical help / support to develop your Privacy Impact Assessment (PIA), Information Sharing Agreement (ISA), Information Management Agreements (IMA), or Contractual Agreement. Below are some generic guidance and templates which you may also find helpful to develop your knowledge.

- ❑ **Privacy Agreement Matrix** (AMA resources)
   https://www.albertadoctors.org/emr_resources/privacy-agreement-matrix.pdf

- ❑ **Information Management Agreement and Information Sharing Agreement Templates**(AMA resources)
   https://www.albertadoctors.org/leaders-partners/clinic-patient-privacy/tools-and-resources
   https://www.albertadoctors.org/leaders-partners/clinic-patient-privacy/agreements-and-data-sharing

- ❑ **Disclosure Agreement Template** (AMA resources)
   https://www.albertadoctors.org/EMRs/Lead_DisclosureAgreement_Nov_5_2013.pdf

- ❑ **Privacy Impact Assessment Requirements** (OIPC resources)
   https://www.oipc.ab.ca/action-items/privacy-impact-assessments.aspx
   https://www.oipc.ab.ca/media/117453/guide_pia_requirements_2010.pdf

- ❑ **Health Information Act**
   http://www.qp.alberta.ca/documents/Acts/H05.pdf

SUPPORT FOR DATA SHARING IN PRIMARY CARE

If you are just embarking on developing your data sharing practices, want help in shaping your thinking, but do not know who to turn to first, please contact:

Stakeholder Organizations	Contact
AHS Primary Health Care (PHC)	Daniel Marchand, Executive Director, Strategic Coordination, Primary Health Care, AHS Daniel.Marchand@albertahealthservices.ca
AHS Primary Health Care (PHC)	Judith Krajnak, Director Evaluation and Analytics, Primary Health Care, AHS Judith.Krajnak@albertahealthservices.ca
Accelerating Change Transformation Team (ACTT)	Arvelle Balon-Lyon, Program Director for Accelerating Change Transformation Team, arvelle.balon-lyon@albertadoctors.org
Health Quality Council of Alberta (HQCA)	Markus Lahtinen, Director, Health System Analytics , HQCA Markus.Lahtinen@hqca.ca

Support is available to you to help with paneling and to understand and make the best use of the data you receive.

Support	AHS ARES	AMA ACTT	HQCA
To access data to improve your paneling activity: aggregate, and at more advanced levels patient identifiable data, to help you identify and confirm your panel	✓		✓
To improve your paneling processes: practical "how-to" strategies to help you build and maintain your panels		✓	
To provide you with privacy requirements resources and tools : to meet the necessary legal, ethical and professional requirements that guide collection, use (i.e., data matching) and disclosure of health information. It includes required documentation and conditions to be met for secure exchange of health information. These requirements are governed by HIA (Health Information Act), FOIP (Freedom of Information and Protection of Privacy Act) and Standards of Practice (CPSA)	✓	✓	
To ensure appropriate information sharing agreements are in place	✓	✓	✓
To access data on your panel: the partners who may have the authority to share information and data based on your request.	✓		✓
To improve your data literacy and make best use of your data: the ability to create meaningful information from your data.	✓	✓	✓

GLOSSARY OF TERMS

Administrative Data	Administrative data refers to information collected primarily for administrative purposes (not the clinical record or for research). This type of data is collected by AH and AHS and other organizations for the purposes of analyzing the use, outcome, experience and cost of health care services (Wiki, 2016)

Affiliate	An "affiliate" (HIA section 1(1)(a)) includes:
	  i. "an individual employed by a custodian;
	  ii. a person who performs a service for the custodian as an appointee, volunteer or student of under a contact or agency relationship with the custodian."
	The duty of an affiliate is to collect, use or disclose health information in a manner that is in accordance with the affiliate's responsibilities as determined by their custodian ('need to know' basis).

Aggregated Data	Aggregate meaning non-identifiable data in groups with similar characteristics (ARES, 2016)
AH Four-Cut Method	AH's 4-cut method for determining a proxy panel (TOP, 2014): 1. Single provider – if an individual has only seen one provider, they are assigned to that provider. 2. Majority provider – if an individual has seen more than one provider, but one was seen for the majority of visits, they are assigned to that provider. 3. Last physical – if an individual has seen multiple providers the same number of times, they are assigned to the one who did the last physical. 4. If an individual has seen multiple providers the same number of times and not had a physical, they are assigned to the provider they saw last.
Billing Data	Billing data is used by Alberta Health as a record of all insurable services that physicians have provided to patients. Alternate Relationship Plan (ARP) shadow billing data is also used by AH as the primary clinical accountability metric to help determine funding allocations and re-negotiation of the ARP master agreement (UoA, 2016)
Confirmed Panel	The relationship between the physician and the patient has been confirmed by a conversation between the physician or clinic staff member and the patient where both agree that the physician is the patient's primary care provider.
Continuous Quality Improvement (CQI)	CQI is an approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems: it focuses on "process" rather than the individual; it recognizes both internal and external "customers"; it promotes the need for objective data to analyze and improve processes.
Contractual Agreement	An agreement between a custodian and another party (custodian or non-custodian) that describes services provided and may state the obligations and conditions for sharing of health information . It may contain elements of an ISA or IMA and be used to appoint an affiliate or authorized representative with regards to health information in the custody of that organization.
Custodian	"Custodians" of health information are health services providers or organizations that are in the health sector (defined in section 1(1)(f) of the Health Information Act), who have "health information" in their custody or under their control. Custodians are designated in the Health Information Regulation, which includes members of listed regulated health professions (e.g., regulated members of the College of Physicians and Surgeons of Alberta).

Data Governance Structure	"Data Governance Structure/Committee" means the body or individual appointed or elected by the custodians (i.e., Participating Physicians, HQCA, AHS) to manage and oversee the ongoing compliance with the terms and conditions of the IMA. and/or ISA, and/or Contractual Agreement (that should contain ISA and/or IMA elements).
Data Sharing Agreement (DSA)	Data sharing includes data matching, joint access to repositories of data, file duplication, and any method of data access that enables more than one agency or organization to use personal data. Data sharing results in personal data moving out of traditional data silos and being used in new ways, by different agencies, or for new or different purposes. For example: in some practices, a DSA is in place between PCN and its member physicians, when that PCN is collecting data from its member physicians and facilitating data matching with AHS, AH or HQCA to evaluate PCN programs or overall PCN panel management.
Disease Registry	A database of individuals on a physician's panel who have a specific diagnosis or condition, and therefore, have similar care needs.
Electronic Medical Record (EMR)	A computer-based medical record specific to one clinician's (e.g., physician) practice or organization. It is the record clinicians maintain on their own patients, and which detail demographics, medical and drug history, and diagnostic information such as laboratory results and findings from diagnostic imaging. It is often integrated with other software that manages activities such as billing and scheduling (Canada Health Infoway, 2016)
Encrypted	Data that is encrypted using an algorithm and can only be read by the intended recipient who has the correct algorithm to decrypt and read the data.
Freedom of Information And Protection Of Privacy Act (FOIP)	The Act came into force on October 1, 1995 and provides individuals with the right to request access to information in the custody or control of public bodies while providing public bodies with a framework for conducting the collection, use and disclosure of personal information.
Health Information	Health Information means one or both of the following (ARES, 2016): (i) diagnostic, treatment and care information (including health service provider information); (ii) registration information
Health Information Act (HIA)	The HIA came into effect on April 25, 2001 and applies to all health care organizations in Alberta. The HIA covers: – The rights of the individual to request and receive accurate data about themselves. – The duty of the custodian to ensure affiliates operate within the Act. – The appropriate collection, use and disclosing of health information. (AHS, 2016)
Health Information Regulation AR 70/2001	Specific regulations pertaining to the Health Information Act (HIA).
HQCA Algorithm	The HQCA's algorithm for determining a proxy panel (TOP, 2014) 1. Single provider - if an individual only saw one physician, they are assigned to that provider. Remaining patients are assigned to a clinical risk grouper for the next steps. 2. Frequency of procedures codes – looks at 11 common procedure codes. 3. Frequency of diagnostic codes – looks at 10 diagnostic codes.

	4. Frequency of visits, excluding certain codes that are not strong predictors of primary physician. 5. Looks at frequency of all visits, including the codes excluded in step 4. 6. This looks at the most recent physician visited by an individual.
Information Management Agreement (IMA)	The agreement between a custodian of health information and information manager (i.e., AHS, PCN, EMR vendor)entered into pursuant to section 66 of the HIA, that governs the terms under which the Information Manager, among other responsibilities prescribed by the HIA, processes, stores, retrieves or disposes of health information; strips, encodes or otherwise transforms individually identifying health information, or provides information management or information technology services.
Information Sharing Agreement (ISA)	The agreement entered into between custodians of health information, which is intended to provide the terms upon which they can share the health Information in their custody with one another for the purpose of providing clinical care through a shared EMR System, and to define and manage the permitted uses and disclosure of that EMR information.
Notice of Collection	A custodian when collecting individually identifying health information about an individual directly from the individual must take reasonable steps to inform the individual (a) of the purpose for which the information is collected, (b) of the specific legal authority for the collection, and (c) of the title, business address and business telephone number of an affiliate of the custodian who can answer the individual's questions about the collection.
Physician – EMR List	A panel report or practice search generated from the EMR
Minimum Data Set (MDS)	A minimum list of names, definitions and sources of data items needed to support a specific purpose – e.g., public health surveillance or monitoring for appropriate care using a registry
Most Responsible Primary Care Physician	The physician who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time. With expanding scopes of practice of other regulated health professionals, it is possible in some circumstances that a non-physician might also be considered the most responsible practitioner (CMPA, 2016)
Panel Management	Panel management, also known as population management, is a proactive approach to health care. Panel management means the care team is concerned with the health of the entire panel / population of its patients, not just those who come in for visits. Examples of panel management activities include screening, specific care pathways for those on disease registries (AHRQ, 2016)
Patient-Identifiable Data	Individually identifying data meaning a person who is the subject of the data can be readily identified from the data (ARES, 2016)
Patient Panel	A patient panel, or roster, lists the unique patients that have an established relationship with a physician. There is an implicit or explicit agreement that the identified physician will provide primary care services (TOP, 2014)
PHN List for Panel	Personal Health Number – a unique identifier for each patient required for billing
PRAC-ID of MRP	Practice Identifier for Most Responsible Physicians – a unique identifier for each physician required for billing.
Primary Use of Data	The health information is collected and used to support clinical decision-making in the care of individual patients. "Primary use of health data is the use of personal health information by the organization or entity (health facility or health provider) that produced or acquired the data in the process of providing real-time, direct care of an individual... information is being used for the purposes for which it was initially collected. "

	(Abrams, K., & Gibson, C. J. (2013). Fundamentals of Health Information Management. Canadian Health Information Management Association (CHIMA). Ottawa, ON: Canadian Healthcare Association
Privacy Impact Assessment (PIA)	Legislative requirement to assess privacy impact on individually identifying information when implementing a new or changing an existing administrative practice or information system.
Proxy Panel	Individuals are assigned to a physician using a set of steps that determines which physician the individual has had most contact with. The approximated / proxy panel is based on the past three years of visits based on all health services provided in all health facilities. Proxy panel reports generated using 4-cut method (AH) or HQCA algorithm.
Secure Exchange Protocol	An agreed common language, and an agreed series of steps, designed to enable data to be shared securely over the network (Wiki, 2016)
Secondary Use of Data	"Secondary use of heath data refers to the use of personal health information for purposes other than direct care. That includes its use for quality or safety measurement; outcome analysis; clinical and health services research or epidemiological studies; costing and funding of health services; public health surveillance; policy development; provider or institution certification and/or accreditation; and marketing or other business or commercial activities." "Secondary uses of the information are necessary to support the effectiveness, efficiency, and sustainability of the health system." (Abrams, K., & Gibson, C. J. (2013). Fundamentals of Health Information Management. Canadian Health Information Management Association (CHIMA). Ottawa, ON: Canadian Healthcare Association.)
Standards of Practice	Along with the CPSA Code of Conduct and the Code of Ethics, the CPSA Standards of Practice outline the minimum standards of professional behavior and ethical conduct expected of all physicians registered in Alberta. Specific standards are supplemented with Advice to the Profession, which supports physicians in implementing the standards in their practice. Standards of practice are enforceable under the Health Professions Act and are referenced in complaints resolution and discipline hearings (CPSA, 2016).

REVISION HISTORY

Document Status (Version)	Date of Revision	Changes or Additions
Version 1.0	January 2017	The first version was reviewed and approved by all stakeholders and published.
Version 2.0	May 2021	The following updates were made for the second version: the goal of the guide clarified on p.2, privacy requirements diagram and links updated on pp.8-11, new contact information for stakeholders provided on p.12, and glossary of terms updated.