EMR Guide for the Patient's Medical Home

2023 Update

This document has not been updated since originally published. The principles remain valid, but some important changes are:

1) AMA Accelerating Change Transformation Team (ACTT) has replaced Toward Optimized Practice (TOP) and the website is: https://actt.albertadoctors.org/ . The Patient's Medical Home (PMH) web page is: https://actt.albertadoctors.org/PMH and information on the PMH and Health Neighbourhood change packages is found at: https://actt.albertadoctors.org/pmh/capacity-for-improvement/change-packages-for-primary-care-clinics/

   The PMH Practice Assessments are located here: https://actt.albertadoctors.org/PMH/capacity-for-improvement/PMH-Assessments/Pages/default.aspx

2) Panel identification and panel maintenance processes are key for participating in both screening (ASaP) and the Central Patient Attachment Registry (CPAR). These are key documents:
   - Panel Process Change Package: https://actt.albertadoctors.org/file/panel-process-change-package.pdf
   - STEP Checklist: https://actt.albertadoctors.org/file/step-checklist.pdf
   - CPAR Panel Readiness Checklist: https://actt.albertadoctors.org/file/CII-CPAR_Panel_Readiness_Checklist.pdf

3) The Alberta Screening and Prevention (ASaP) maneuvers, intervals and ages are updated when the evidence changes. Please refer to the latest documentation for the most recent update for the maneuver, interval and age population before developing or editing a preventive screening EMR search/notification/alert at: https://actt.albertadoctors.org/PMH/organized-evidence-based-care/asap, NOT the intervals and ages in the following document.

4) The EMR Supports page at ACTT is: https://actt.albertadoctors.org/EMR/Pages/default.aspx

Updated March 2023

Accuro EMR Guide for Patient's Medical Home

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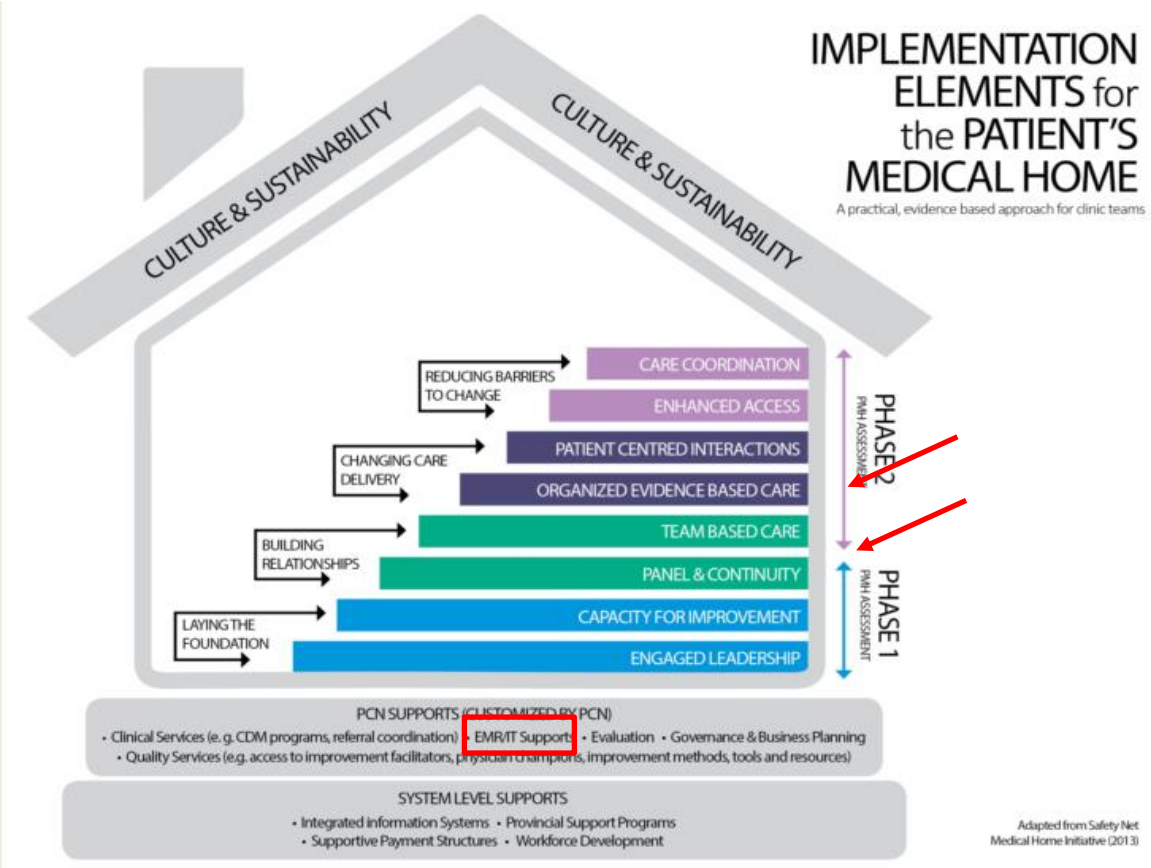
Introduction

Patient's Medical Home



When an EMR is used in a meaningful way within the Patient's Medical Home (PHM) model it supports effective patient panel identification, panel maintenance, panel management and will enable proactive panel-based care for patients in a practice.

Meaningful use of the EMR for 'Panel & Continuity' involves knowing which patients are actively attached to each provider and using this information for scheduling purposes and to monitor supply, demand and continuity with the provider. This work is **foundational for success**, and must be discussed with the entire practice, arriving at agreed upon policies and procedures on **what, why** and **how** data is to be captured and maintained with the EMR.

'Organized Evidence Based Care' for preventive screening is a logical place to start to learn how to use the EMR for panel management, or in other words, proactive panel-based care. Once EMR processes have been successfully implemented for preventive screening, they can be adapted for disease management and care of patients with complex health needs. Finally, 'Care Coordination' processes will leverage those developed for panel, continuity and organized evidence based care.

Foundation for Success - Commitment to Standardization in the EMR

Successful **standardization of data entry** for improvement or change, apart from leveraging the inherent functionality of the EMR, relies heavily on three "people and process" principles in conjunction with the use EMR functionality.

These are:

1. Team

   - Includes having 'engaged leadership' and inclusive team representation within each clinic or organization; a clinic champion for EMR standardization can be named
   - EMR improvements or changes do not happen in isolation, and require commitment of time and resources for improvement to happen
   - Combining EMR improvement with enhanced use of team, process improvement with a clinical goal in mind and practice facilitation is the ideal strategy in working toward adoption of the PMH
   - Leverage PCN supports where they exist (i.e. Improvement Facilitators, Panel Managers/Coordinators, etc.)
   - Team sets aside time to meet to agree on processes that enable proactive panel-based care and documents them to keep everyone on the same page (e.g., job aid and/or standard operating procedure manual)

2. Data Quality

   - Data Standardization – for the main areas of data input, the entire clinic team should discuss and agree upon:
     - use of fields in a standardized way, create structured exam forms or templates for the consistent capture of patient information; if the team wants to find it later or be able to search a population for the information, it helps to know where it was entered and if the EMR search/query tool can search it
     - utilizing standardized text or macros (common repeated text) whenever possible instead of free text
     - verification processes to ensure over time that data recording is reliable (e.g., BP is always in the BP field and not in a text box)
     - job aids for staff to assist with consistent patient data chart entry (e.g.,. scanning and attaching documents to patient charts)
     - processes to record patient problems with the appropriate ICD9 identifier (highly recommended) See Sample Problem List
   - Roles and responsibilities for charting (e.g., does the person who rooms the patient always chart BP, height and weight). When making changes to information outside of chart notes (e.g.to patient demographics or when making bulk /batch changes) it is recommended that the individual making the change enter their initials in an appropriate area."
   - It is advised that one person or a small group provide direction for patient data entry to ensure high quality in the clinic and minimize data inconsistency. Creating 'Good in, Good out' processes at the practice
   - Documentation of Standard Operating Procedures (Policies, Procedures and Processes) assists a clinic team in having a common understanding of workflow; these should be reviewed periodically

- Communicate with the practice team the linkage between data entry and the ability for a point-of-care reminder (e.g. Notifications , Rules, Alerts, etc.) to function and inform reporting

3. Incremental Change

- A key recommendation is to take baby steps in EMR changes, especially when it concerns practice-wide point-of-care reminders. These can be managed to make the changes small and sustainable for the practice team
- Use the simple but effective 'Model for Improvement' method including applying plan-do-study-act (PDSA) cycles to identify and test small incremental changes toward the desired and clearly identified improvement goal
- When a new point-of-care reminder is put in place an associated, documented 'people process' needs to be developed and implemented; thus making the change effective and sustainable, by embedding it into the work process and clinic culture

Help Files

Along with this EMR Guide and Videos made available on the TOP website, the embedded EMR Help Files from the vendor can be a great untapped resource with detailed instructions on how to optimize EMR functionality.

Additional opportunities exist with many EMRs through the vendor external (community) portals or websites to get technical support or provide ideas to promote future functionality.

PMH Resources

Patient's Medical Home

http://www.topalbertadoctors.org/change-concepts/introduction/patientsmedicalhomeinalberta

Patient's Medical Home Implementation Field Kit

http://www.topalbertadoctors.org/patients-medical-home-implementation-field-kit/

Patient's Medical Home Assessments:

Readiness

http://www.topalbertadoctors.org/file/pmh-assessment-for-practices--readiness.pdf

Phase 1

http://www.topalbertadoctors.org/file/pmh-assessment-for-practices--phase-1.pdf

Phase 2

http://www.topalbertadoctors.org/file/pmh-assessment-for-practices--phase-2.pdf

TOP Accuro EMR Videos

http://www.topalbertadoctors.org/tools--resources/emrsupports/#6

Searchable Data:

https://youtu.be/Q6RrSze_jlw?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Panel Identification

Patient Panel Definition

A patient panel is a set of patients that have established relationships with a primary provider. There is an implicit agreement that the identified physician or nurse practitioner and team will provide comprehensive, longitudinal primary care. Relational continuity, or an ongoing relationship between a primary provider and a patient, is enabled by a patient identification process.

Panel vs. Caseload

A **panel** is the set of patients attached to a specific primary provider. A primary provider is a physician or nurse practitioner mainly responsible for providing comprehensive primary health care longitudinally over time to a panel of patients.

A **case load** is a group of patients under the care of a provider for a limited scope of care. A specialist will have a case load as will some family physicians, general practitioners or nurse practitioners working in the areas of maternity care, women's health and other areas. For example, a PCN has a maternity clinic where family doctors who specialize in obstetrics offer care to low-risk patients during their pregnancy. In this case each family doctor will have a case load of patients not a panel of patients. In another example, a pediatrician is a member of a PCN. The pediatrician may have a handful of patients for whom she provides their comprehensive, primary care but for most of her patients she is a consultant and these patients have a family doctor to provide primary care. In this case the pediatrician has a small panel and a large case load of patients.

Panel Resources

Panel Guide
http://www.topalbertadoctors.org/file/guide-to-panel-identification.pdf

Supportive Tools for Every Panel (STEP) Documents
Developed and shared by the Calgary EQuIP (Elevating Quality Improvement in Practice) Team, these documents outline the activities and outputs for panel identification and panel management screening for use at both the practice and PCN levels.

STEP Checklist: a summary of the activities and outputs for panel identification and panel management screening in a checklist format.
STEP Toolkit: the activities and outputs of panel identification and panel management screening with suggested tools and related links
STEP Workbook: for use at the practice level to guide clinic teams through the activities and provide a means to record outputs for future reference
STEP Reference Page on the TOP website contains webinars that support the documents.

Demographics

Basic Demographic Information

In the demographic area of the patient chart the basic information that is needed for patient panel identification is:

- Full Name
- Date of Birth
- Gender
- Complete address
- Phone number(s)
- Primary provider
- Patient status (Active or Inactive)
    - Status Date
- Confirmation[1] date
- Alberta Patient Healthcare Number (PHN)

Other demographic/attachment fields exist by individual EMR. These other fields may also support patient panel identification and maintenance processes.

TOP Website Video:

Basic Patient Demographics

https://youtu.be/ZHAtYn2ebDE?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Confirmation

Most EMRs have a designated field for patient demographic data confirmation (also commonly called **verification or validation**). Marking this field/box indicates that the primary provider attachment, address, phone, and patient status are confirmed and up to date. The field also applies a date stamp so that all team members know when it was last done.

Confirmation is a crucial process for patient care. When a critical result arrives at a clinic, it is essential that the patient's contact information is up-to-date so that they may be contacted in a timely way.

Calculating the **confirmation rate** which may also commonly be called verification rate is an important process check that indicates how often patient data and attachment is verified by the team. The confirmation rate calculated over a longer period of time, such as year, should be higher for clinics with established processes than a confirmation rate calculated over a shorter period of time such as three months. A team may choose to calculate a confirmation rate over an appropriate timeframe that will give them feedback on their process improvements. See Confirmation Rate

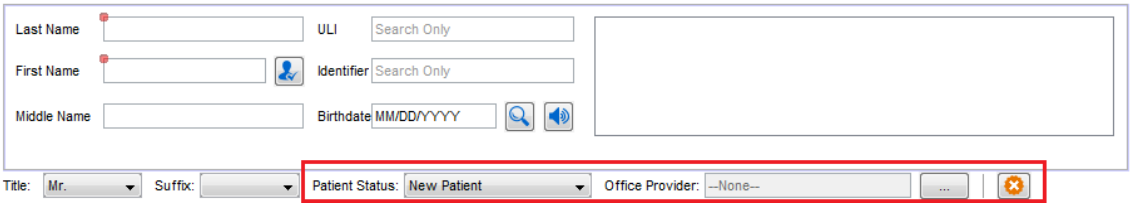
Process to capture patient attachment and confirmation

Patients are managed in the Patients area of the EMR. The **Patient Status, Office Provider** and **Verified** icon are the three key fields. A yellow X in the verified icon indicates that the patient has not been confirmed.

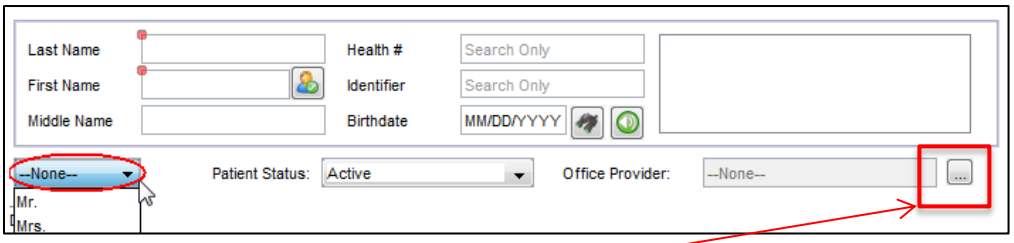
[1] Team members mark a field in the EMR to indicate the basic demographic information and attachment to a primary provider is correct. The name of this field varies by EMR.

A clinic must have consistent practices with all these fields as it is an important field in the Query Builder (Alerts) in running reports for patient attachment and confirmation.

Patient Demographics (attachment and confirmation)



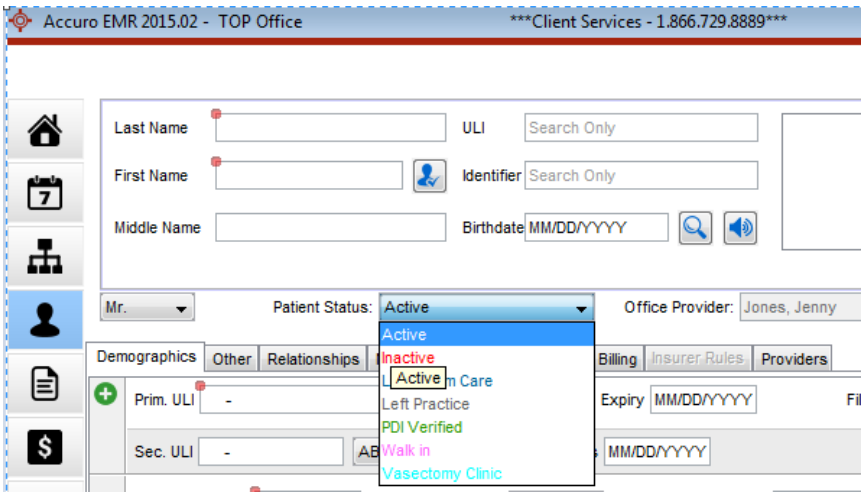
To set the **Office Provider**



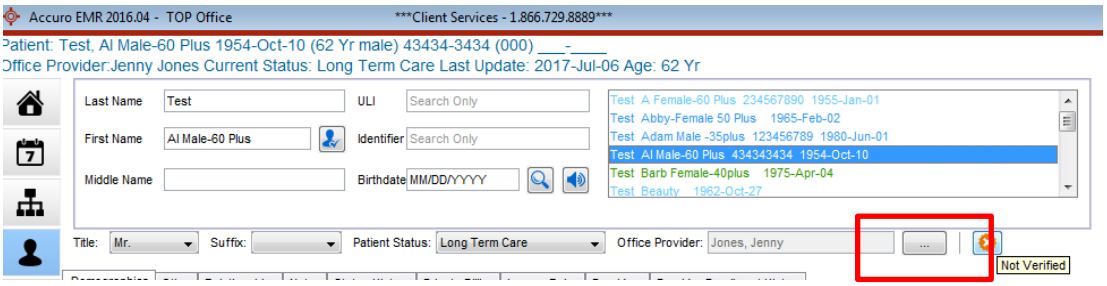
1. Click the **Patients** button on the side bar.
2. Click the **Ellipses** button to the right of the **Office Provider** text box.
3. Providers that exist in your clinic are displayed in the search results by default. To select one, click the provider's name to select and click **Select**.
4. Click **Update Patient**.

To set **Patient Status**

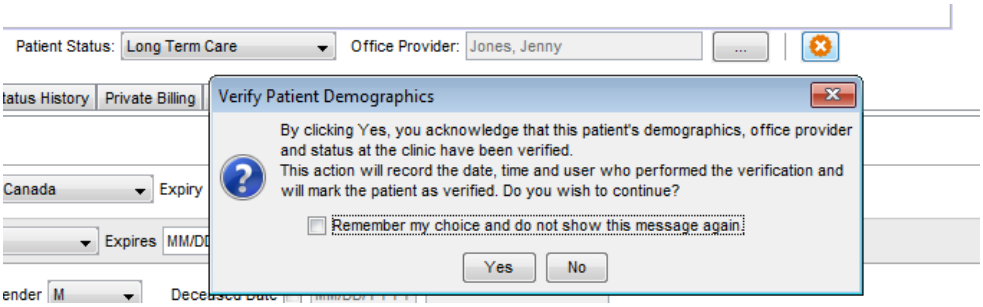
1. Click the **Patients** button on the Side bar.
2. Click and select the **Patient Status** from the list displayed.



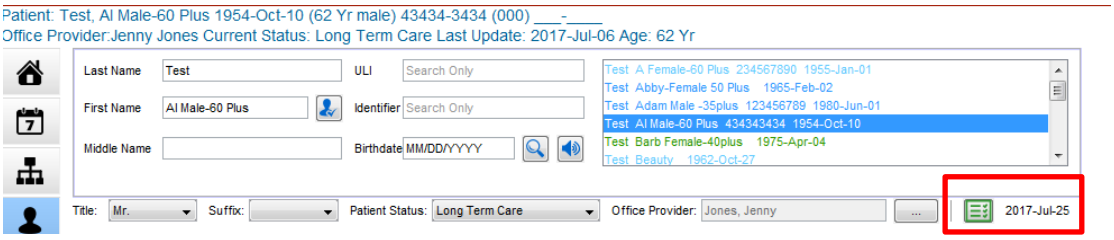
To set **Patient Verified Date (Confirmation)**



Once the button has be clicked this message with appear until check box is selected

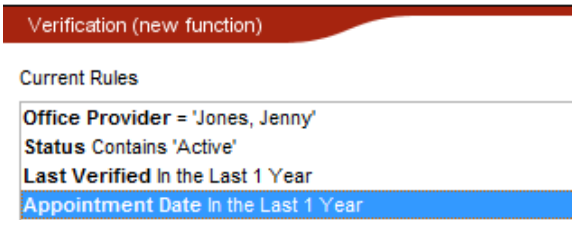


Once 'Yes' is selected the patient has been verified, the 'green' verified icon and date of last confirmation appear.



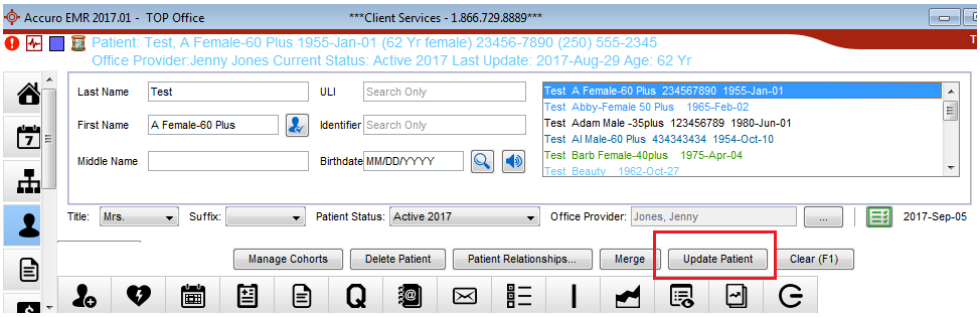
Query to display/report for confirmed patient attachment

Below is a sample query to produce a report for all of Dr. Jenny Jones active and attached patients that have been in the clinic in the last year.



Confirmation that the 'last verified' date of this attached patients has also been in the clinic in the last year is a manual step than must be done to compare 'last appointment date' with the 'verified date' to ensure an effective confirmation process is being adhered to by the clinic support staff.

Finally, click the **Update Patient** button at the bottom of the demographics page.



Central Patient Attachment Registry (CPAR)

CPAR is a centralized database that captures the attachment of Primary Care Physician or Nurse Practitioner and their patients. CPAR is a joint project between The Alberta Medical Association, Alberta Health (AH), and Alberta Health Services (AHS). The registry will enable improved relational and informational continuity in primary care across Alberta. Participating providers will have their panel lists submitted through a secure electronic portal to the registry that will look to see if other primary providers are paneling the same patients. Participating providers will receive 'conflict reports' listing names of their patients who also appear on the confirmed panel lists of other providers. Another report will identify when a patient on a provider's confirmed panel has information that does not match the patient client registry, including if the patient is deceased.

Teams will confirm at the practice that a patient is attached to a provider and record this in the EMR. What CPAR can do is verify that patients are not attached to other providers. When a patient appears on a provider's conflict report, it signifies that the patient has been attached to another provider's panel outside the practice and it will need to be addressed with the patient to confirm which provider (of those they are paneled to) they wish to consider their primary provider.

Five Key Changes in Behaviors at the Practice

1. At every interaction ask who the patient identifies as their primary provider
2. Record it in the EMR & Date Stamp It
3. Maintain & Review the panel List
4. Utilize the panel list to plan care delivery
5. Submit the Panel List to CPAR

TOP Website CPAR Link:

http://www.topalbertadoctors.org/CPAR/

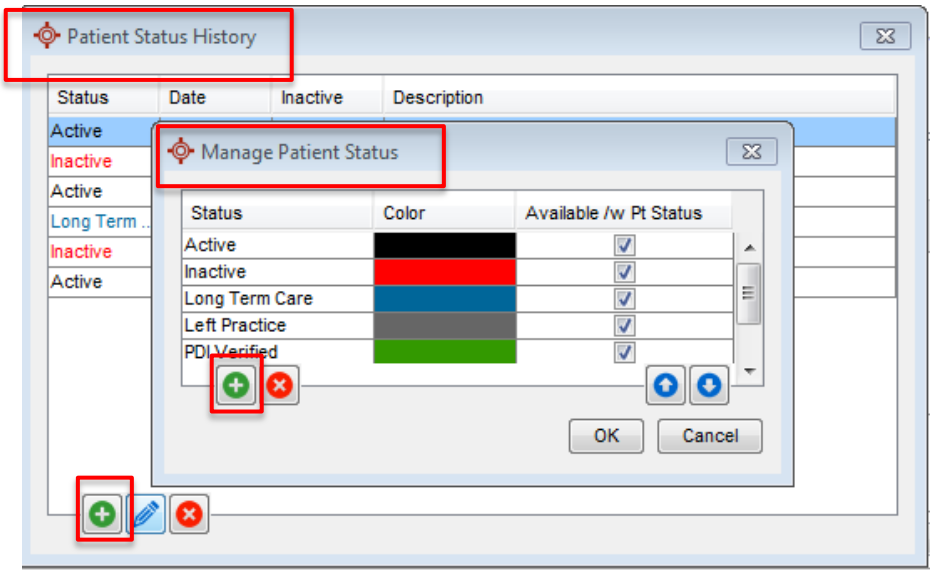
Configuring Status

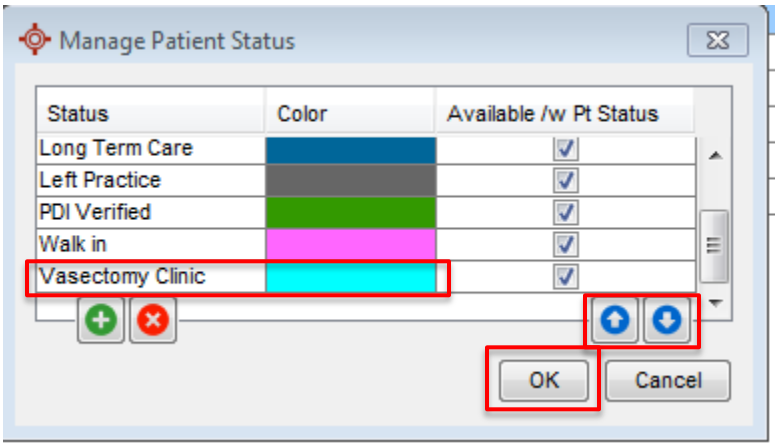
Many EMRs have the ability for a system administrator or user to customize patient statuses for the practice in addition to what is available in the EMR at 'Go Live'. This will allow the practice to specify various types of active and inactive patients in patient lists, reports or for setting up population-wide point-of care reminders.

Creating New Statuses

Steps to *Add* a new Status

1. Select a Test Patient.
2. Press **F8** to open the **Patient Status History** window.
3. Click on the pencil  icon to open the **Manage Patient Status** window.
4. Click on the **green plus**  icon, which will add a row to the end of the status list.





5. Double clicking in the **Status** column allows naming the status.
6. Clicking on the **Color** column allows selection of a colour unique to that status.

7. Use the Up and Down arrow icons to order the status list as desired.
8. Finally, click on the **OK** button to save changes.

Accuro has a **Patient Status** dropdown to capture the patient's current status information (demographics page): this also includes validating which physician is responsible *(***Office Provider***)* for the patient's care. The chart is date stamped (*Verified Last)* and this date appears in reports when a patient list report is generated from a built-in report (not recommended) or a custom reporting (created with the **Query Builder**) and/or when opened in a spreadsheet, which can then be formatted as required and saved.

Examples of Patient Status Used in Primary Care		
Status	**Status Name**	**Additional Information**
Active	Office Patient	Active office patient attached to a provider in the practice
	Specialty Service	This patient may be active in the practice but only for a given service (e.g., vasectomy, aesthetic, maternity care, aviation medical, circumcision, IUD). Some clinics give a status to each type of specialty service.
	Temporary	Applied to a patient seeking walk-in care. These patients are not considered part of the provider's panel.
	New	When a practice is still accepting new patients, a patient may not be confirmed as an office patient until after a first or second appointment.
	Orphaned/unassigned	When a provider leaves a practice resulting in an unassigned panel, these patients may be identified.
	Emergency Department	Mainly in rural centres, where a patient record exists for a visit that occurred in ER of a non-clinic patient.
	Long term care	For a group of patients seen in a long term care site but not in the practice.
	Lapsed or Dormant	Some clinics prefer to use this term for patients that are inactive, with no clinic visit in a period of time (e.g., 3 years). They will be given this term during panel clean up or maintenance, until confirmation of attachment can be ascertained.
Inactive	Inactive	Includes formerly active patients with no clinic visits in a period of time defined by the practice, (e.g., 3 years.)
	Deceased	Patient is deceased.
	Non-clinic patient / Not Our Patient	When a patient chart is created but the patient was never actually seen at the practice (e.g. may apply if a new patient made an appointment but never attended or a chart may have been created for lab work received for a non-clinic patient, etc.)
	Duplicate or Archive	When a patient has accidentally been registered more than once and the EMR does not have the ability to merge duplicate records the archived record has this unique status.

TOP Accuro Video

Accuro Use, Configuration and Verification of Patient Status

https://www.youtube.com/watch?v=P52Abv3tH1c&index=29&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Producing a Provider's Panel List

During the panel identification process the first step is to produce a list of all active patients attached to a provider using the report/search functionality of the clinic EMR. It is useful if the panel list includes the following columns of information:

- Name (first, last)
- Gender
- Date of birth (or age)
- Last visit date
- Last verification date (last date the primary provider and attachment were confirmed)
- PHN or ULI (this will be useful for CPAR[2] purposes)

Sorting by the column headers in the panel list in the EMR or a spreadsheet is a quick way to get an impression of:

- Older patients that may be deceased
- Patients with no visits to the clinic within the last 3 to 5 years
- Patients that have never had their attachment or primary provider confirmed
- ULIs that indicate out of province patient

Last Visit Date may assist to identify active patients:

- Patients with a visit in clinic during an agreed-upon, predetermined period (e.g., last 3 years)

These lists usually create awareness for initial panel clean up. Confirmation of the data produced on the lists with the primary provider and team will help to determine validity of the information. Further panel clean-up is assisted by additional searches in the EMR.

> **TIP**: Many EMRs will produce the list with the EMR report/search functionality but also offer exporting the list for further sorting and analysis in Microsoft Excel or Open Office Calc. **Basic spreadsheet training is recommended.**

TOP Website videos

Active Patient Panel
https://youtu.be/eapIk7T1vys?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Active Patient Panel in Last 3 Years
https://youtu.be/Qn5CyN0rDFQ?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Accuro Patient Panel Not in Last 3 Years or Future Appt
https://www.youtube.com/watch?v=ZQKlYuOw8oo&index=24&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Initial Panel Clean-Up

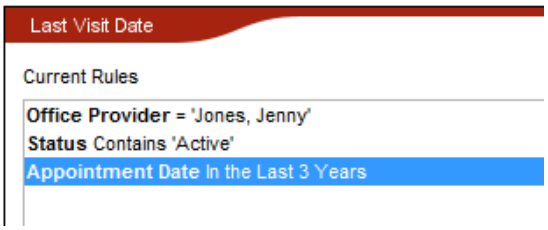
Searches/reports that assist initial panel clean up include producing a list of active patients attached to a provider, with the additional search parameters of:

Recommended Accuro Help files:

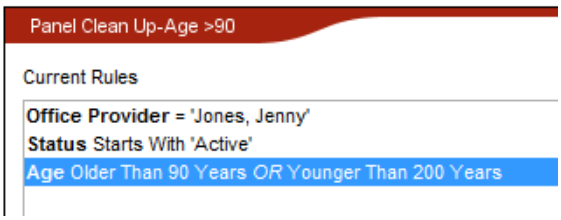
- Query Builder(Alerts)
- Query Definitions
- Query Builder Example: Total Count of Patients
- Query Builder Example: Diabetic Patients Not Had an Appointment in the Last 3 Months

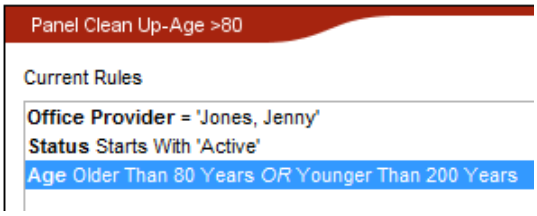
Using Query Builder

- Last visit date (e.g. last 10, 5 or 3 years and no future appointments)

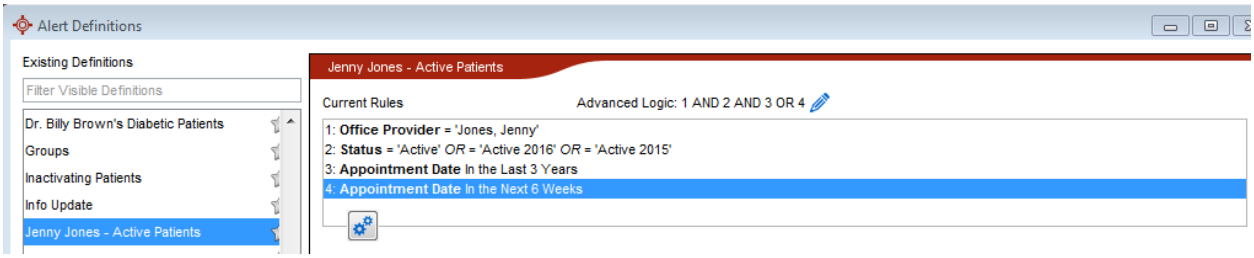


- Age: Sorting the list of active patients by age is valuable. In viewing the list of active patients from oldest to youngest or over the age of 90 years, a provider is usually able to indicate if there are patients on the list who should be marked as deceased

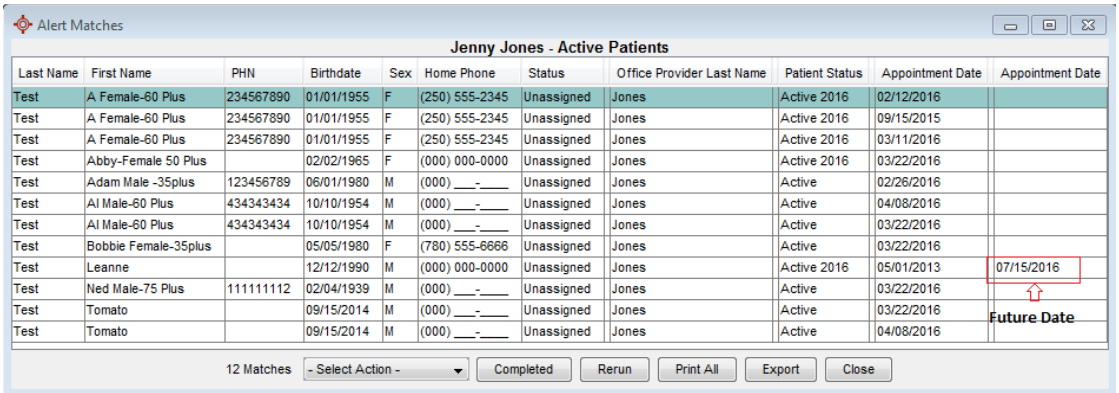




- No visits to the practice (and no future appointments) – producing a list of patients that are attached to a provider will identify patients that registered but may have never shown up to the practice. This search may identify patient charts created but the patient was never actually seen at the practice (e.g. may apply if a new patient made an appointment but never attended or a chart created for lab work received for a non-clinic patient, etc.)

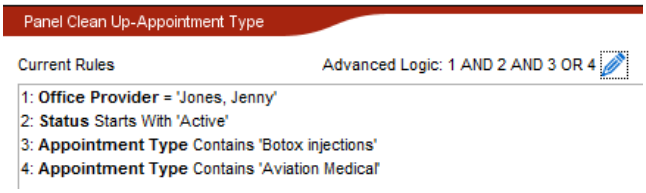


Sample Report: Dr. Jenny Jones active patients with appointment date for past 3 years (includes future appointments 6 weeks in future)

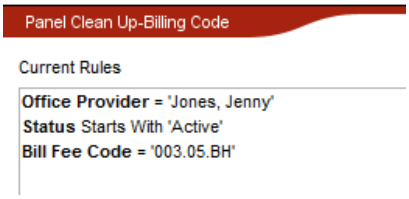


Last Name	First Name	PHN	Birthdate	Sex	Home Phone	Status	Office Provider Last Name	Patient Status	Appointment Date	Appointment Date
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Active 2016	02/12/2016	
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Active 2016	09/15/2015	
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Active 2016	03/11/2016	
Test	Abby-Female 50 Plus		02/02/1965	F	(000) 000-0000	Unassigned	Jones	Active 2016	03/22/2016	
Test	Adam Male -35plus	123456789	06/01/1980	M	(000) ___-____	Unassigned	Jones	Active	02/26/2016	
Test	Al Male-60 Plus	434343434	10/10/1954	M	(000) ___-____	Unassigned	Jones	Active	04/08/2016	
Test	Al Male-60 Plus	434343434	10/10/1954	M	(000) ___-____	Unassigned	Jones	Active	03/22/2016	
Test	Bobbie Female-35plus		05/05/1980	F	(780) 555-6666	Unassigned	Jones	Active	03/22/2016	
Test	Leanne		12/12/1990	M	(000) 000-0000	Unassigned	Jones	Active 2016	05/01/2013	07/15/2016
Test	Ned Male-75 Plus	111111112	02/04/1939	M	(000) ___-____	Unassigned	Jones	Active	03/22/2016	
Test	Tomato		09/15/2014	M	(000) ___-____	Unassigned	Jones	Active	03/22/2016	
Test	Tomato		09/15/2014	M	(000) ___-____	Unassigned	Jones	Active	04/08/2016	

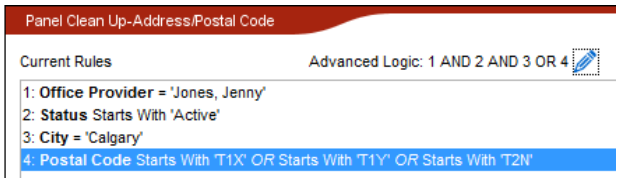
- Appointment Type/Reason – If the practice uses the appointment type or reason when scheduling visits, searching by this information my produce lists of patients that are not family practice panel patients such as 'aviation medical' or 'Botox injection'



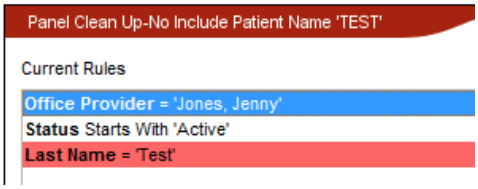
- Billing code - If the clinic offers specialty services to patients that are not members of the physician's family practice, they may be identifiable by billing code from the Schedule of Medical Benefits
    - Ask the physicians if there are any billing codes that they routinely use for patients that are not members of their family practice panel



- Address or postal code - Sorting of active patients by the address/city or postal code searches can be valuable in identifying individuals that may not be part of the family practice panel due to their place of residence; temporary workers to an area may be identified this way



- Test Patients – each clinic has test patients that were created for training or practice purposes, for reporting and analysis; they should not be included in the family practice panels. A common practice for test patients is to use the last name "Test". Be sure there are no real patients with the last name Test.



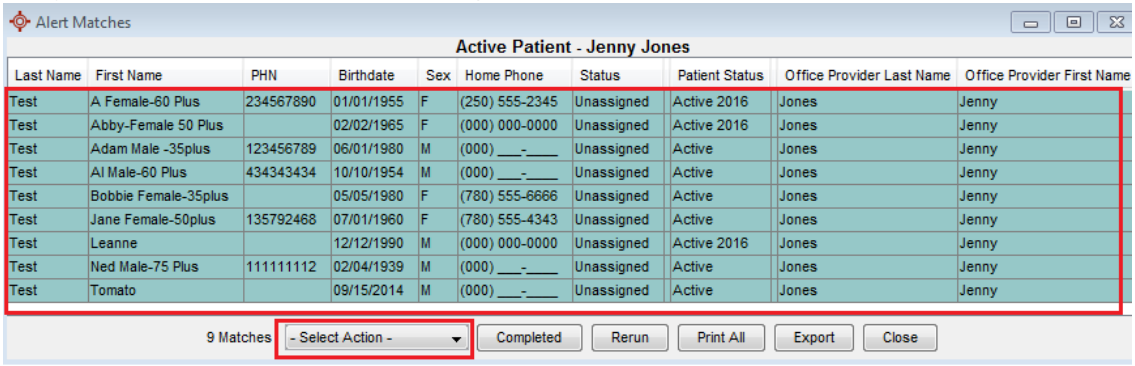
'Does match' or 'Not' in criteria in Accuro shows up in red in when building a query.

IMPORTANT: The primary provider and/or the practice team need to review the data from reports to ensure that the correct information is being pulled into them. Due to unique protocol at a practice, fields may be used in a specific way and this may impact the accuracy of reports.

Bulk/Batch Actions

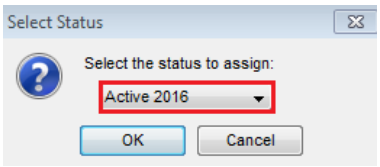
Once a list is produced and sorted, most EMRs are capable of applying a bulk change to the entire list or a group within the list. Making bulk changes makes the process of initial clean-up and ongoing panel maintenance faster and easier. For some EMRs the clinic needs to produce the list and then contact the vendor to support the bulk change.

Sample: Patient selection for Bulk Change



Depending on clinic workflow possible bulk actions from the **Select Action** dropdown list that could assist in *panel work* would be: **Set Patient Status, Create Patient Cohort, Assign to Patient Cohort** or **Assign Flag.**

Example: Once a report is produced, hold down left mouse key and drag the mouse down or hold *alt* key and click on each patient row to select. From the **Select Action** dropdown list select '**Set Patient Status'** which opens a **Select Status** pop up window.



Choose the appropriate status from the dropdown and then click 'OK' to make the bulk change.

TIP: Carefully verify data with the primary provider and/or care team before making a bulk change.

TOP Accuro Videos

Accuro Bulk Changes

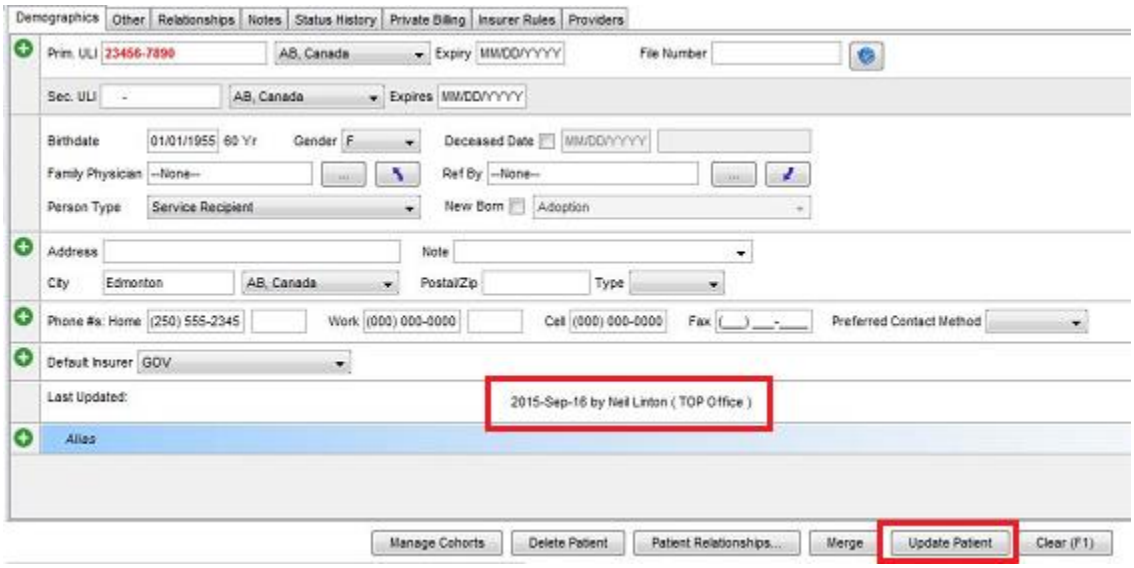
https://www.youtube.com/watch?v=RPqWU_gNAuc&index=17&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Panel Maintenance

Once an initial clean-up is complete there are several processes that support maintaining a clean confirmed patient panel list for each primary provider. Those processes include:

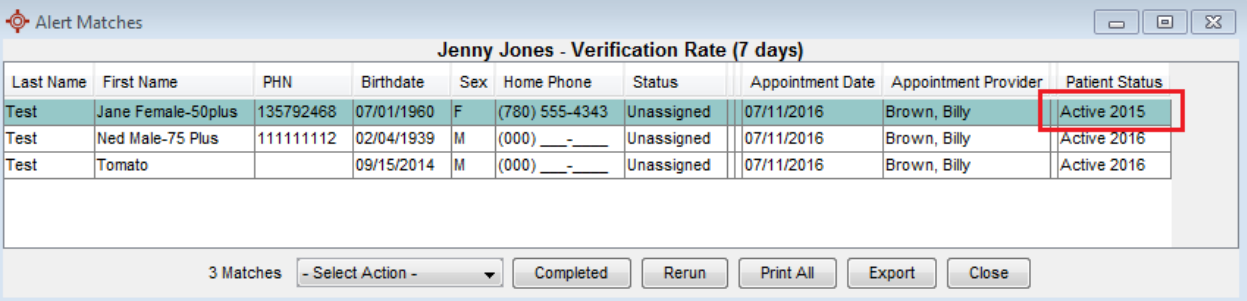
1. Ongoing phone/address data, primary provider attachment and status confirmation at patient check-in. Developing and monitoring a process for all front desk staff with expectations for data confirmation is recommended.

Tip: When checking patient demographics, even if no changes are made, front staff should click on the **Update Patient** button, as this will date stamp the demographic page with the last date the demographics were validated with the patient.



- This process can be checked using the EMR reporting (Query Builder). Run a search to produce a list of Active patients with visits in a given period of time (i.e. last 7 days) and determine what percentage of patients was verified during that time frame

Example: 3 appointments, 1 not verified, 2 verified – 67 % verification rate for the week)



- Standard operating procedures should be in place for front desk staff for:
    - Patients no longer part of the clinic
    - Patients not seen in the clinic (e.g., records created for patients where lab work was received or seen at another facility like the local ER)
    - Patients seen at your clinic but not your family practice patients (e.g., walk-in or temporary patients)
    - Patients scheduled for a "meet and greet" appointment

2. Conducting searches at regular intervals and applying bulk actions to patients that are no longer active at the practice. The regularity of the intervals varies by practice. It may be monthly for the first year and then every six months thereafter. Reports that assist identifying these patients include searches by:

    - Last visit date (and no future appointments)
    - Age
    - No visits to the practice (and no future appointments)
    - Appointment Type/Reason
    - Billing code
    - Address/city or postal code
    - Last Name is Test (first be sure there are no actual practice patients with the surname Test)

3. Patient outreach. Some practices identify active patients with no visits in the past 3 years (and no future appointments), prioritizing those overdue for preventive screening care, then reaching out proactively to determine if they are still members of the practice. The outcomes of the outreach involve updating the patient demographics, physician attachment and offers of preventive screening care.

    See Using Query Builder

TOP Accuro Videos

Accuro Search Using Billing Code

https://www.youtube.com/watch?v=PeRZhdy_lWw&index=27&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Panel Management

Panel management, also known as population management is a proactive approach to health care. Population means the panel of patients associated with a provider or care team. Population-based care (or panel-based care) *means that the practice team is concerned with the health of the entire active population of attached patients at the practice, not just those who come in for visits*.[3]

The Patient's Medical Home implementation element of 'Organized Evidence Based Care' involves embedding evidence-based guidelines into daily clinical practice where each encounter is designed to meet the patient's preventive and chronic illness needs. Setting up population-wide point-of-care reminders supports these planned interactions and EMR functionality supports appropriate follow-up care.

Approaches to Panel Management

Opportunistic

When approaching panel management opportunistically, it means catching a patient while they are in the practice or calling on the phone with a team member, to offer care.

> For example, a 52 year old female is in the practice for an appointment to inquire about the vaccine for shingles. While in the office her blood pressure is taken and she is offered requisitions for a FIT test, plasma lipid profile, fasting glucose and mammogram because they are all overdue.

Methods to identify patients that are overdue for clinical services may involve:

- Setting up population wide point-of care reminders that alert a team member that a patient is due for a clinical service
- Setting follow-up or another type of alert at the individual patient chart to proactively set up for the next intervention
- A team member that combs through the charts of patients meeting certain criteria, who have an appointment, to identify clinical services that are due and marking the chart to indicate this

Outreach

An outreach method to panel management involves identifying active and confirmed paneled patients overdue for clinical services that do not have appointments and '*reaching out*' to offer care. This process involves using the search/reporting tool in the EMR to produce lists of patients.

> For example, a 58 year old male was last in the clinic 2.5 years ago for a knee injury. The panel care coordinator (PCC) at the practice has run a report that shows this patient is overdue for a plasma lipid profile, a FIT test and a fasting glucose. The PCC phones the patient and confirms that he is still a patient of the practice attached to his paneled physician. ***** As per clinic protocol, the PCC makes an offer that the patient can come by the clinic and just pick up the lab requisition to get the overdue screening done and the clinic will follow-up as necessary. The patient agrees.

[3] Module 20. Facilitating Panel Management. May 2013. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod20.html

*Note: such protocols vary from practice to practice. It is an important process that must have provider agreement before implementation.

> **TIP**: It is recommended that a practice initiating outreach complete panel identification and maintenance processes first then begin with patients that have been confirmed as attached, active patients. This will prevent the experience of contacting patients that are deceased or no longer active at the practice.

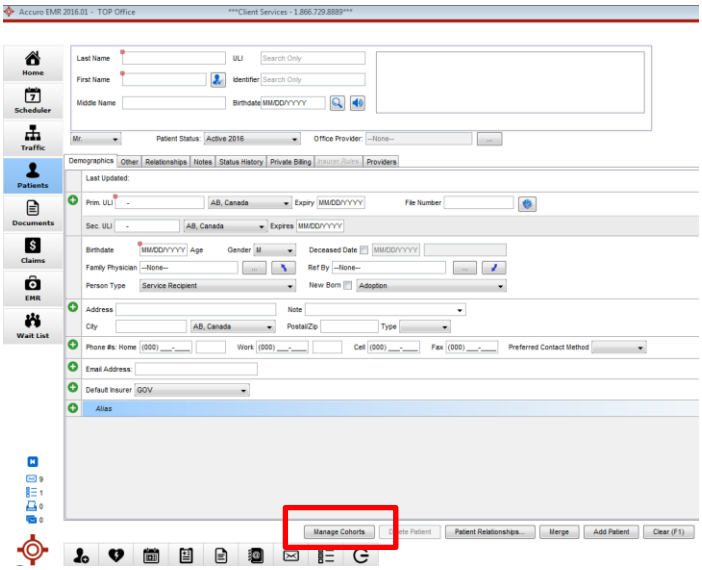
Prioritizing Patients for Outreach

For practices that are beginning outreach for the first time, identifying where to start can be a challenge. Consider using searchable criteria in your EMR that can guide you to reaching out to patients that may have the most to gain by offers of care. Consider the following criteria:

- Last visit date close to 3 (or more) years ago
- Age (older patients are at higher health risk than younger patients)
- Number of screening maneuvers due, e.g., consider starting with patients over 60 years of age with no colorectal cancer, diabetes or lipid panel screening due
- Patients with chronic conditions

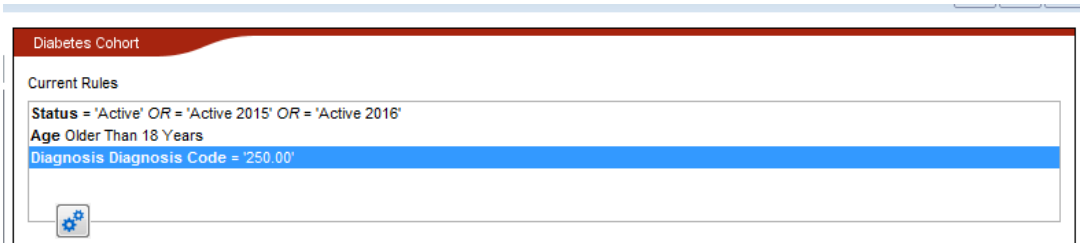
Registries (Cohorts)

A disease registry identifying patients with a coded disease condition is the first step in preparing for panel management of patients of a given condition. The formation of coding of patients with a condition is called a 'patient registry'. Ideally, all patients with a condition will have the condition noted in their 'Problem List' in a consistent way. For example, Diabetes is always called 'Diabetes Mellitus' and will likely have the '250' ICD-9 code attached to it. It is important that an entire practice agree on terms for the conditions to create registries. In this example Diabetes is not named with other inconsistent terms such as 'Diabetes', 'DMII', 'DM2', 'Diabet M', etc.

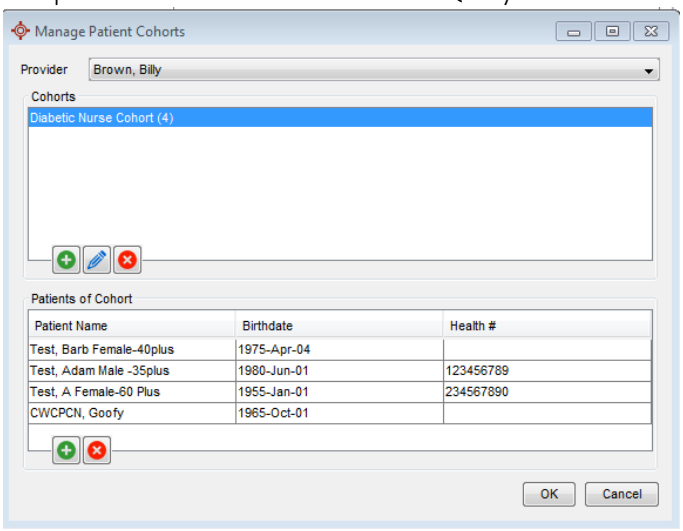


TIP: Free typing in the problem list is NOT recommended. Physicians should use the drop down list when coding problems. In some cases a "clean-up" of the list may be needed to enable consistent coding moving forward.

While the Service Codes used in claims or billing is a very useful search to inform the practice when forming registries, it is not in itself accurate enough to be used when creating point of care reminders. An accurate problem list should be the trigger for the point of care reminders. See Problem Lists



Sample of Diabetic Cohort built from Query Builder lists



There are useful searches that will support creation of disease registries. By looking in other areas of the EMR patients without the problem in their 'Problem List' can be identified.

Feature of EMR	Example 1 Data that would inform Diabetes Mellitus Registry	Example 2 Data that would inform Hypertension registry
Billing	Diagnostic code 250	Diagnostic code 401
Medications	Currently taking metformin or insulin	Currently taking an antihypertensive
Lab	HbA1c over 7 %	BP > value specified by clinic MDs

The bulk action feature from reporting area of the EMR is a useful tool when producing a list of verified patients with a given condition to add it to the patient problem list in bulk.

Important Note: Once a patient cohort has be created, should new patients match a particular cohorts criteria they **will not** be automatically added to an existing cohort. This action must be manual to ensure all those matching are included.

Recommended Accuro Help files:

- Cohorts (Tech Tuesday # 97)
- Manage Patient Cohorts

Deceased patients

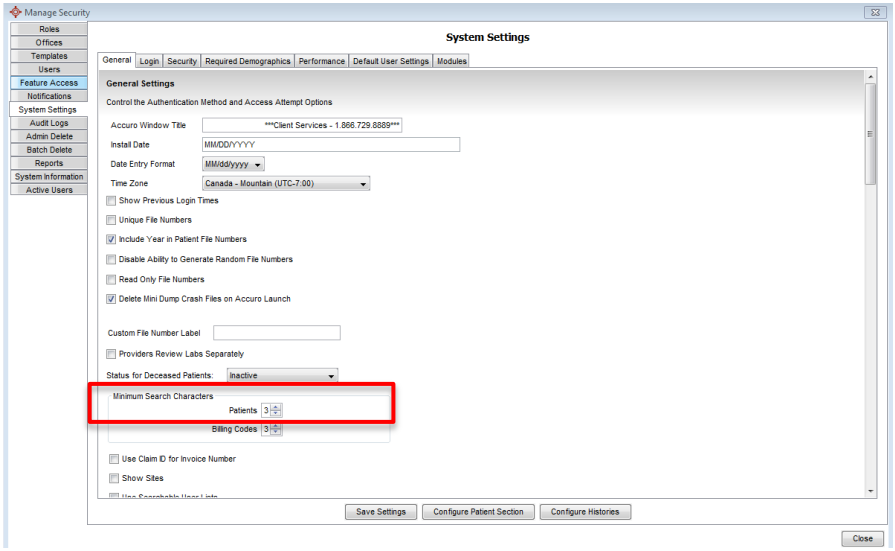
If a clinic is going to engage in outreach screening, managing the status of deceased patients is critical to ensure that a deceased patient's name does not appear on a list for outreach. Screening processes apply to active patients of a provider.

Clinics have the option to configure their system settings to add a default status when a patient is marked as deceased. It is sensible that deceased patients are all marked as inactive automatically when marked as deceased.

Check your **General Settings** in **System Settings**. The default Status for Deceased Patients is **None**. This can be managed in General Settings. Ideally, set the status for deceased patients to **Deceased** or, some clinics may choose, Inactive.

1. Click **Users** in the Menu bar.
2. Click **Manage Security**.
3. Click **the Systems Settings** tab.
4. The General tab appears.
5. Choose your **Status for Deceased Patients**.
6. **Save Settings**.

Auto-configuration of 'Deceased' patients as Status of 'Inactive'

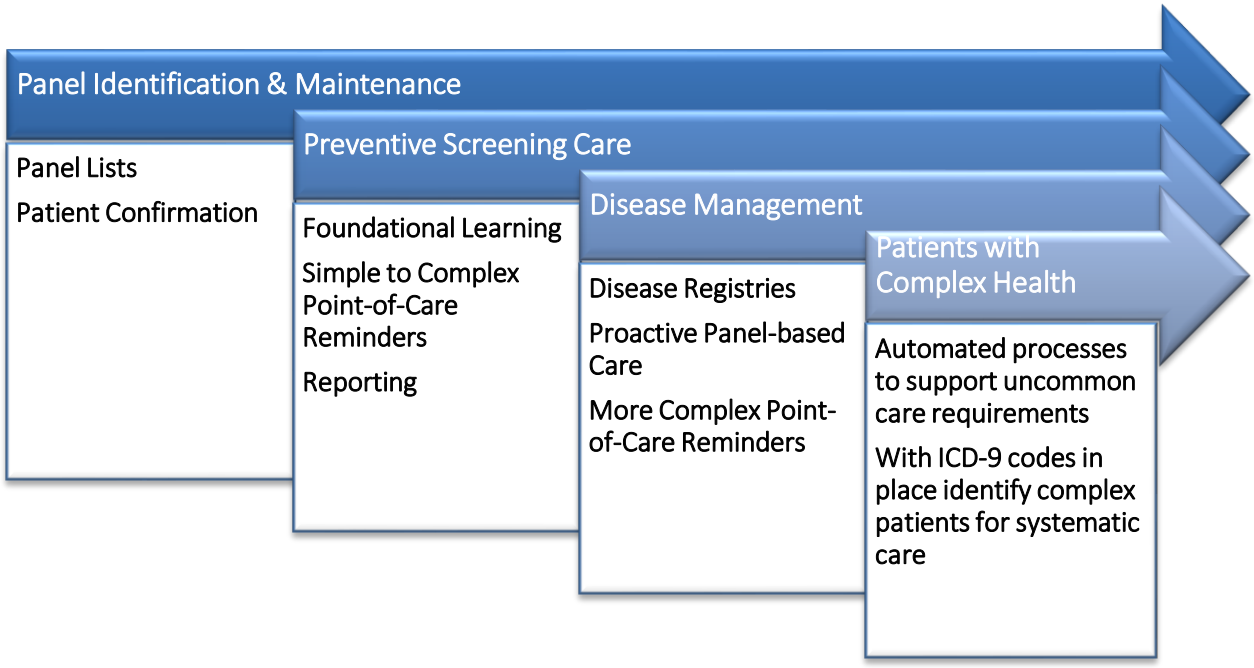


Recommended Accuro Help files:

- Patient Status History (Tech Tuesday # 14)
- Manage a Status

Panel Management: How to Get Started

Once patient panel identification and maintenance processes are in place, it is recommended to begin proactive panel-based care with the following approach:



Preventive Screening Care

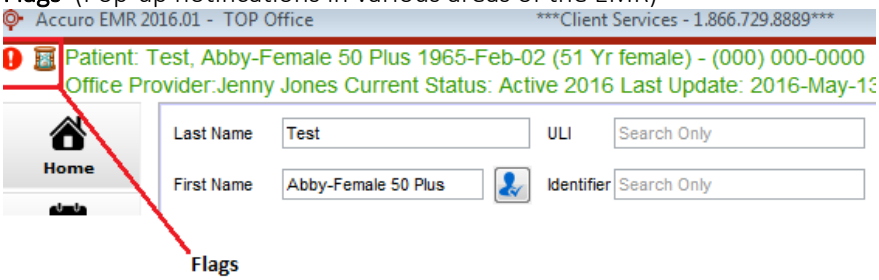
- Preventive screening care involves a small number of data elements compared to disease management
- There is benefit to starting with some clean sources of data like electronic lab feeds compared to information that maybe inconsistently charted in the clinic
- Clinic team will learn:
    - the importance of and begin standardization of naming protocols for scanned documents (e.g., mammograms and colonoscopy reports)
    - from this experience about patterns in their data entry and can make correction for future meaningful use of EMR
    - practice standard operating procedures that enable proactive panel-based care
- The searches and population-wide point of care reminders should start simple and can build to the more complex
- Practices can build on:
    - the number of screening maneuvers they are addressing and/or
    - the population of patients at the practice that point-of-care reminders are set for (e.g., gender and age)
- Provides a foundational experience for process improvement

Disease Management

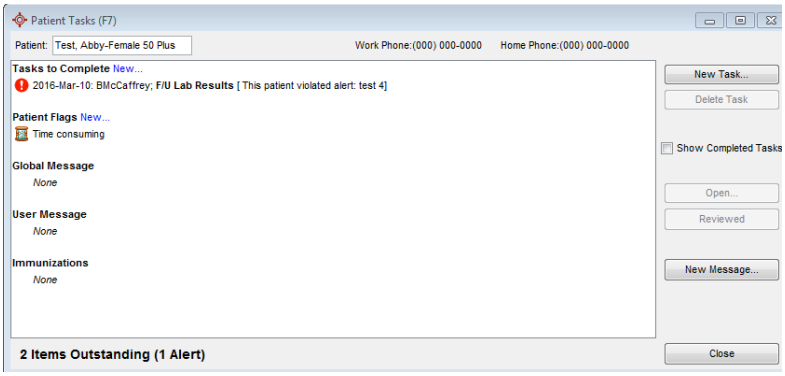
- Clinic team take lessons learned from less complex preventive screening care processes that can then be applied to disease management
- Involves more complex searches with more data elements than screening
- A dependency exists on reliable registries of patients with a given disease
    - Providers will learn the importance of consistent coding in the Problem List of the EMR
- Clinic team will build on the benefits of standardized data entry
- Building of more complex point-of-care reminders with increased reliability of planned, prioritized care

Proactive panel-based care of a registries or cohort (see registry/cohorts) of patients with a given condition (e.g., Diabetes or hypertension) and is enabled by key EMR features:

- Problem list
- Flags (Pop-up notifications in various areas of the EMR)



- Patient Tasks (Follow-ups, worklists)



- Billing information (can be less reliable)
- Alerts (created in the Query Builder for specified problems)

Recommended Accuro Help files:

- Patient Flags (Tech Tuesday #74)
- Customized Patient Flags
- Patient Tasks (F7)

Management of Patients with Complex Health Needs

With a solid foundation in preventive screening care and disease management, patients with complexities and multiple co-existing conditions will have visits that address many predictable health issues by using available EMR resources to more efficiently and reliably meet patient's important needs

Use of Care Planning Template

Each clinical team should put some thought around creating, updating and saving the care planning template (See Appendix A).

Consideration around conventions for saving and using keywords to identify Care Planning Template if the clinic is using the methodology of scanning and attaching this document to a patient's chart (See Appendix C). The consistent use of 'Type', 'Sub-Type' and 'Description' (if use precisely everytime) can all be searched in the Accuro Query Builder for reporting and measurement.

However if using the Care Planning Template as a custom 'Form' in Accuro, the PMH team should plan for what and how the various sections within the Care Plan template could be auto-populated. Some of the important areas for auto-population could include field like: patient demographics, primary provider, allergies, medications etc. Other information may be less important to auto-populate such as the problem list as it can change over time.

The Care Planning Template should also consider tracking any new additions to the plan in some way that is apparent; what is the addition, when identified and who entered the information (e.g. new allergy identified in recent hospitalization and entered by the nurse at the patient's request).

Tools for Panel Management

For the following areas it is recommended that when a team agrees on the processes that they are documented as standard operating procedures so that when a staff member leaves and a new staff member starts there is documentation.

Charting for Team-Based Patient-Centered Care

For a team to provide care that is patient-centric and takes care of the whole patient, a single provider in the practice can no longer document in an ad hoc manner. The team needs to know where to find pertinent information and know that the information can inform proactive, panel-based processes (such as searches or reminders) that can act as a safety-net around the individual patient care.

EMR users need to be aware of the search capabilities of their EMR. **Where information is entered matters!** In general, fields that can inform a search or report include:

- Drop down lists
- Radio buttons
- Boxes only designed to record specific information like blood pressure or weight
- Templated fields in an exam template

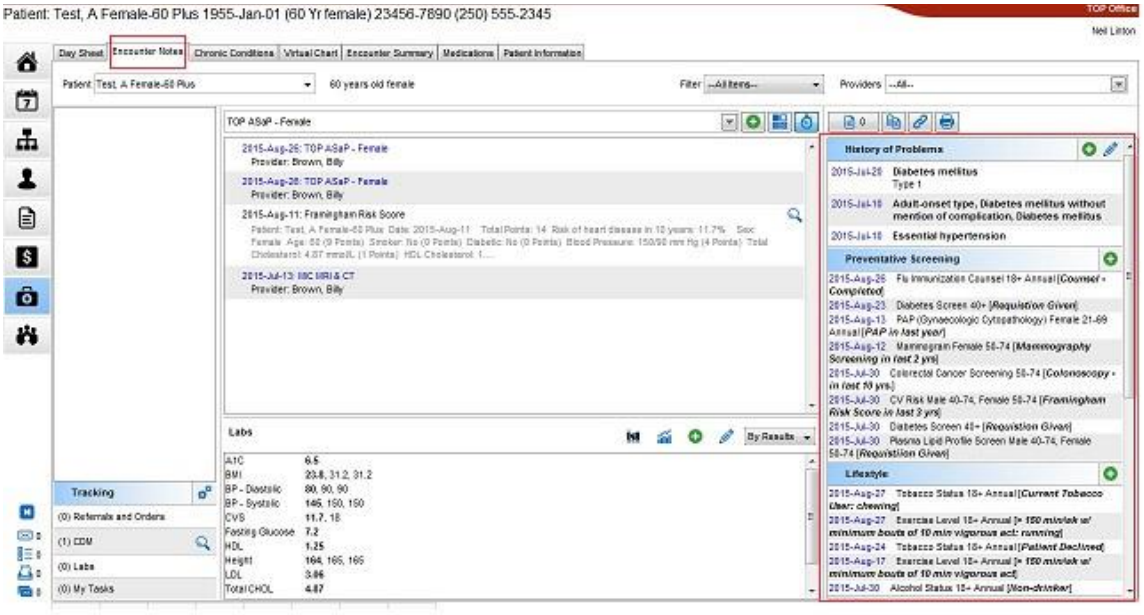
Even in an area where free text can be entered, if certain information is entered with a consistent term, it may be searched. Where common repeated text (macros or auto-replace) is used, it may be uniquely searched.

Chart in a way that the team can help care for the patient:

- Care team members know where to find information
- The patient's data may be included in population-wide reminders that helps to prevent patients "falling through the cracks"
- Monitoring and management can be done systematically

Medical History View (Encounter Notes)

The medical history view in the EMR section (Encounter Notes Tab) is a great summary of clinical information that is prominent in the patient record. For example once configured by the clinic it can be utilized to capture some or all of the ASaP Maneuvers in the existing or custom created Medical History bands.



Note: Depending on how much information is in the medical history band and the size of the computer monitor, it is possible the user needs to scroll down to see all content.

Medical History Bands

Medical history bands (MHB) can be enabled, reordered or disabled (hide) to suit office requirements. Bands that can be enabled or disabled are:

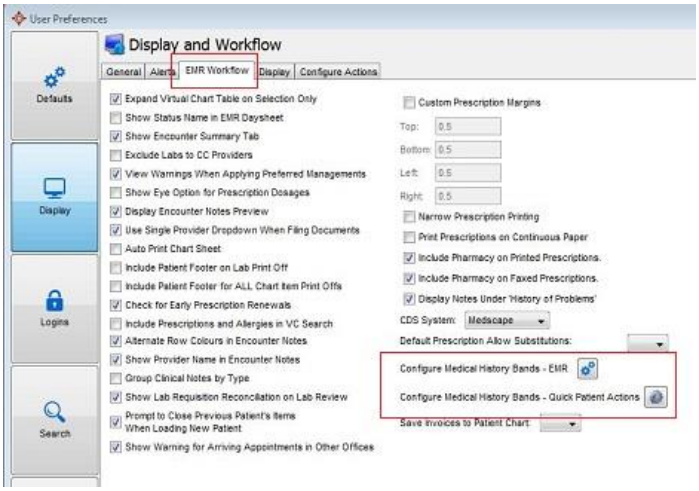
- History of Problems
- Active Medications
- External Medications Surgical history
- Allergies
- Immunization Schedule

- Immunization Summary
- Lifestyle
- Family History
- Risk Factors

Note: Customized bands may be added to suit the needs of a practice.

Steps to Adjust Medical History Display (Alt key)

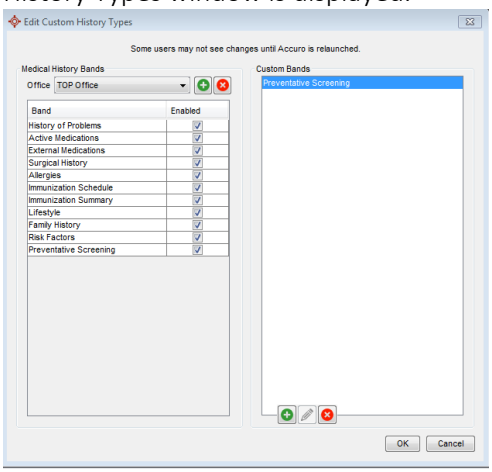
1. Click on the **File** menu item, then **User Preferences**
2. Click the **Display** section button
3. Click the **EMR Workflow** Tab
4. Click on the **Configure Medical History Bands gear icon** button



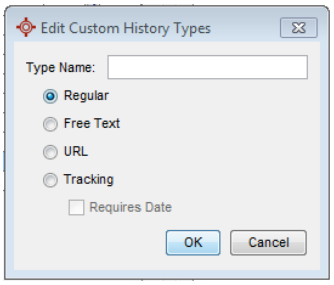
5. Drag the bands using left mouse button held down to the order you want them in Click **Save**

Steps to Add Custom Medical History Bands

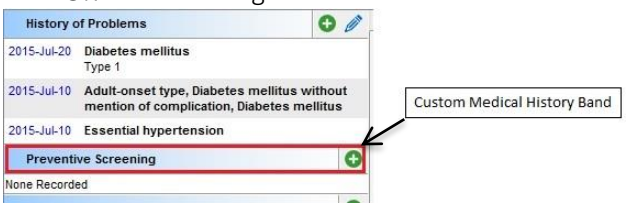
1. Press and release the Alt button on the keyboard click **Users** and select **Manage Security** from the list displayed.
2. Click the **System Settings** on the left-hand side of the window.
3. Click the **Configure Histories** button at the bottom right of the General Tab. The Edit Custom History Types window is displayed.



4. Click the **Add** button. The Edit Custom History Types window is displayed.



5. Type in the name of the custom history type. (**Careful, this cannot be edited later!**)
6. Select the history type from **Regular, Free Text, URL** or **Tracking.** Regular is recommended.
   Note: If you select Tracking you can also select the 'requires date' checkbox.
7. Click **OK** to save changes



Important Note: Go to a different screen and back to **Encounter Notes** to see the change. Take care in initial naming of a custom **Medical History Band**. There is no ability to rename or change after the initial creation. The custom Medical History Band cannot be deleted but it can be hidden if the users do not want it to appear.

Recommended Accuro Help files:

- **Configure Medical History View in Encounter Notes**

Important Note: In order refresh the **Encounter Notes** screen by going to a different tab and back to the **Encounter Notes**

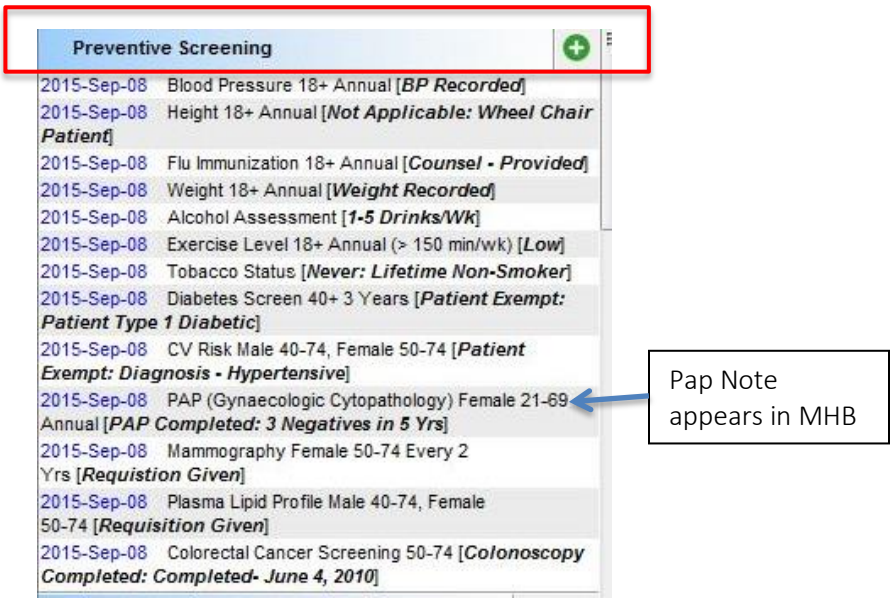
Options in setting up the Medical History Bands for preventive screening:

1. Simple Approach – record all 12 maneuvers in one Preventive Screening band. (Option 1)
2. Use existing Lifestyle and Immunization bands and record all others in a Preventive Screening Band and combined with CDM worksheets mapped to patient collected information, procedures and lab results (Includes addition of all 5 ASaP+ maneuvers). (Option 2)

Option 1: Set up/capture all 12 maneuvers in a custom Preventive Screening MHB. This table will assist in building the MHB

Maneuver	*Maneuver Label*	*Details List (Managed)*	*Notes (field) Suggested Text*
Blood Pressure	Blood Pressure 18+ Annual	BP Recorded Patient Declined Patient Deferred Not Applicable	Standardized N/A Reason
Weight	Weight 18+, 3 Yr	Weight Recorded Patient Declined Patient Deferred Not Applicable	Standardized N/A Reason
Height	Height 18+ Annual	Height Recorded Patient Declined Patient Deferred Not Applicable	Standardized N/A Reason
Exercise Assessment	Exercise Level 18+ Annual (>150 min/wk)	Sedentary Low Moderate High	Capture Min/Week Value
Tobacco Assessment	Tobacco Use Status 18+ Annual	Never Current Past Patient Declined Patient Deferred	Capture No. of Packs/Week (if applicable)
Influenza Vaccination/Screen	Flu Immunization 18+ Annual	Counsel Provided Counsel Deferred	Notes as required
Pap Test	PAP Test Female 25-69, 3 Yr	PAP Completed Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Plasma Lipid Profile	Plasma Lipid Profile Male 40-74 Female 50-74, 5 Yr	Plasma Lipid Completed Requisition Given Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
CV Risk Calculation	CV Risk Male 40-74 Female 50-74, 5 Yr	Framingham Score Recorded Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Diabetes Screen	Diabetes Screen 40+, 5 Yr	Fasting Glucose-Last 5 Yrs HgbA1c-Last 5Yrs Requisition Given Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Colorectal Cancer Screen	Colorectal Cancer Screen 50-74	FIT Result-Last 2Yrs Requisition Given Flex Sig-Last 5Yrs Colonoscopy-Last 10Yrs Referral Initiated Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Mammography	Mammogram Female 50-74, 2 Yr	Mammogram Completed Requisition Completed Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason

Example: Medical History Band with ASaP screening maneuvers (single MHB - simple)



The **Notes** field for each of the specific ASaP or other Modifiable/Lifestyle Maneuvers can be used to add additional information as applicable to individual patient. It will display in the MHB (i.e. PAP entry-above). This field is searchable in the Query Builder if standardized text is used.

Note: The MHB information collected for each patient will grow over time, this may require scroll of the MHB to review all historical information. The most recently captured maneuvers appear at the top of each band.

Option 2: Setup up the Lifestyle MHB to capture screening for exercise, tobacco use, alcohol, fruit and vegetable consumption (ASaP+)

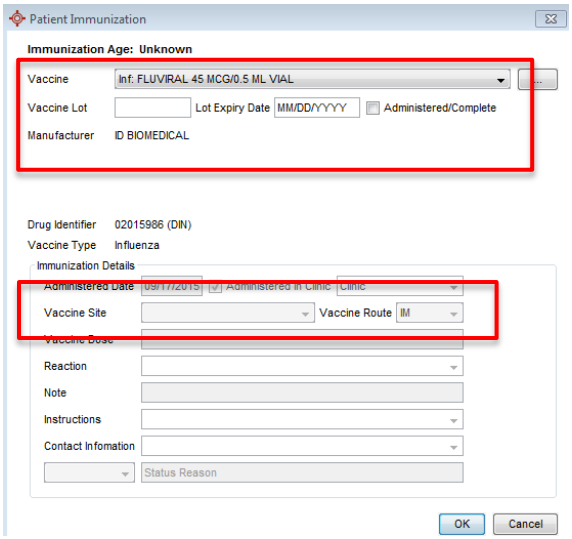
Record flu vaccinations in the immunization band. The remaining ASaP and ASaP+ maneuvers can be recorded in the custom Preventive Screening MHB. Three (3) maneuvers (Blood Pressure, Height and Weight) are captured directly in the **Physical History (Optimed)** test in the **Lab** area of **Encounter Notes** for each patient.

Lifestyle MHB - *Default* (Exercise, Tobacco Use, Alcohol, Fruit and Vegetable Consumption)

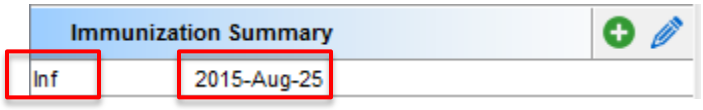
Maneuver	*Maneuver Label*	*Details List (Managed)*	*Notes (field) Suggested Text*
Exercise Assessment	Exercise Level 18+ Annual	Sedentary <150 Min/ week >150 min/wk, w/ minimum bouts of 10 min vigorous act	Notes as required
Tobacco Assessment	Tobacco Use Status 18+ Annual	Never Tobacco Smoker Ex Tobacco User Current Tobacco User Over 30, Lifetime Non Tobacco Patient Declined Patient Deferred	Capture No. of Packs/Week (if applicable)
Alcohol Consumption	Alcohol Use	Non-drinker 1-5 drinks per week 6-9 drinks per week 10-14 drinks per week >15 drinks per week Patient declined	Notes as required
Fruits and Vegetable Consumption	Fruits and Vegetables	No Consumption Below Recommended Amounts Recommended Amounts Above Recommended Amounts	Notes as required

Immunization Schedule MHB – *Default*

The Medical History Band is used to setup and capture the Vaccine and Lot information to facilitate capture of the administration of various vaccines given to the patient. This must be set up prior to being able to capture a date of inoculation for the flu vaccinations.



Immunization Summary MHB – *Default* (Influenza Vaccination/Screen)
This Medical History Band captures the patient immunization summary (flu vaccination) displaying a 'date stamp' of when last completed when captured in the Immunization Schedule MHB.

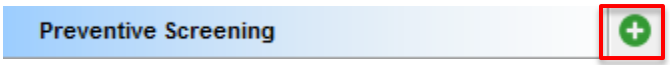


Preventive Screening MHB – *Custom* (Influenza Vaccination Counsel, Pap Test, Plasma Lipid Profile, CV Risk Calculation, Diabetes Screen, Colorectal Cancer Screen and Mammography)

Maneuver	*Maneuver Label*	*Details List (Managed)*	*Notes (field) Suggested Text*
Influenza Vaccination/Screen	Flu Immunization 18+ Annual	Counsel Provided Counsel Deferred	Notes as required
Pap Test	PAP Test Female 25-69, 3 Yr	PAP in last year PAP Completed- 5 Yr Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Plasma Lipid Profile	Plasma Lipid Profile Male 40-74 Female 50-74, 5 Yr	Plasma Lipid Profile in last 5 Yr Requisition Given Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
CV Risk Calculation	CV Risk Male 40-74 Female 50-74, 5 Yr	Framingham Score-last 5 Yr Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Diabetes Screen	Diabetes Screen 40+, 5 Yr	Fasting Glucose-last 5 Yr HgbA1c-Last 5 Yr Requisition Given Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Colorectal Cancer Screen	Colorectal Cancer Screen 50-74	FIT Result-Last 2Yrs Requisition Given Flex Sig-Last 5Yrs Colonoscopy-Last 10Yrs Referral Initiated Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason
Mammography	Mammogram Female 50-74, 2 Yr	Mammogram Screen-Last 2Yr Screening Complete >74 Yr Requisition Given Patient Declined Patient Deferred Patient Exempt	Standardized Exempt Reason

Steps to Add Screening Maneuvers to Medical History Bands (MHB)

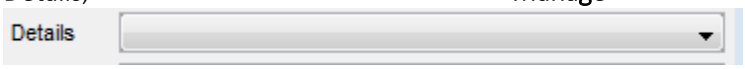
1. Click on the **Green Plus sign** in the 'custom' MHB



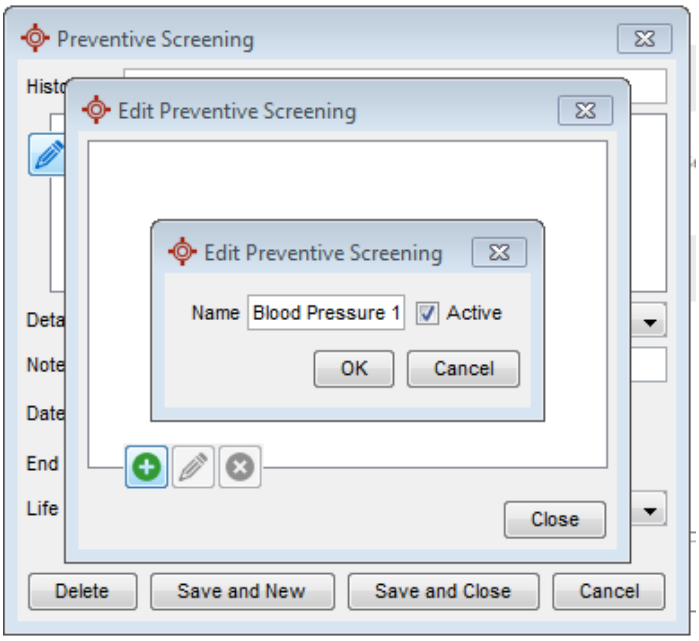
This will open the **Preventive Screening** configuration window

2. Select the **Pencil** icon to open and then the icon in the **Edit Preventive Screening** window
3. Add a meaningful 'Name' (E.g., Blood Pressure 18+) for the ASaP Maneuver to record and click **OK**, then **CLOSE**
4. Continue to add Maneuvers until your list is complete

5. The next step from the **Preventive Screening** window, is to select each maneuver and add the **Details**, select the down arrow and click on **Manage**



6. Using the , begin adding your menu response for the maneuver and order using the blue up and down arrows , then select **OK**

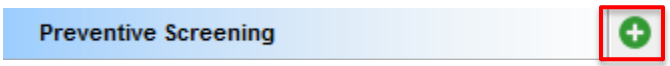


7. Finally select **Cancel** in the **Preventive Screening** Window, after adding the appropriate list of maneuvers to this **Medical History Band**

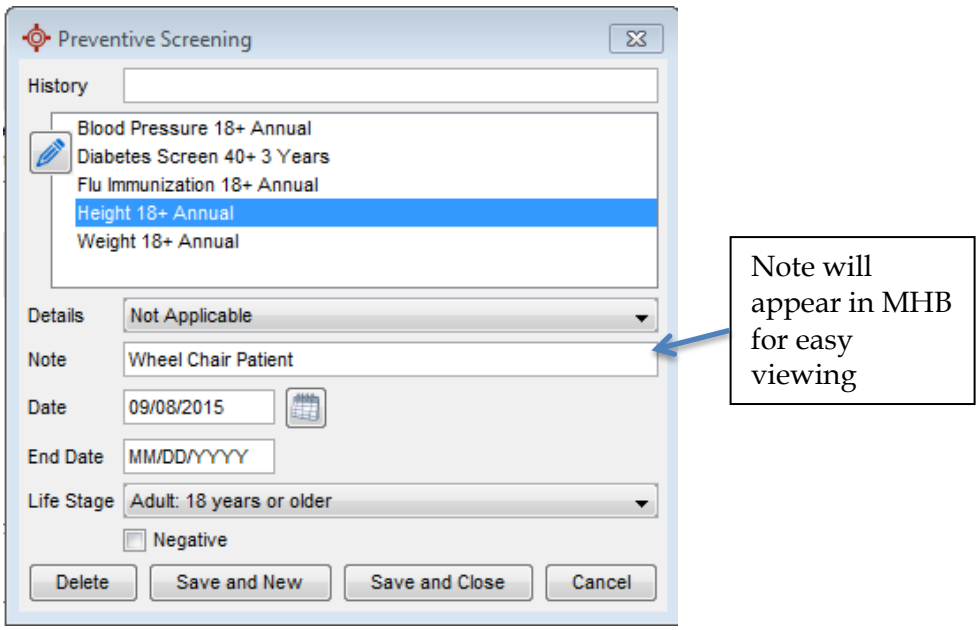
Steps to Capture 'Screening Maneuvers' to Medical History Bands (MHB)

Once the ASaP maneuvers are configured in the MHB, patient responses to the screening offers may be recorded.

1. Click on the Green Plus sign in the 'custom' MHB (i.e. Preventive Screening)



2. Select the desired maneuver to be captured, and from the **Details** dropdown list select the appropriate selection based on information collected or response provided by patient
3. Any additional information can be added to the **Note** and will be displayed (i.e. Wheel Chair Patient for Height)
4. Next add or select a date using the Calendar icon, by default the **Life Stage** of 'Adult: 18 years or older' is pre-populated. Note: the most recent entry for this item will appear at the top of the MHB window



5. Select **Save and Close** to add to the information to the MHB

Note: ASaP Maneuvers Capture Options - The Notes field is a searchable field in the Query Builder if the text is standardized (it is written the same way every time).

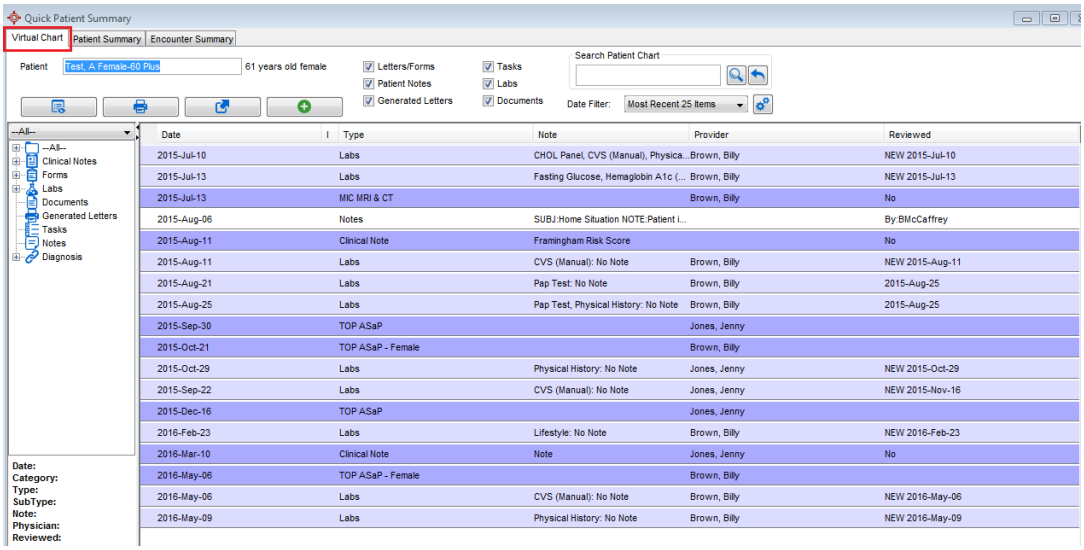
Option 3: Setup up Screening Maneuvers in 'Labs' (manual)

Depending on how the clinic's agreed upon workflow some screening maneuvers can be capture in the 'Labs' area on the patient's **EMR-Encounter Notes** tab in manual labs. See Manual Entry of Lab Data These manual labs can be created new or edit existing lab entry tests. See Appendix G – Set up and Use

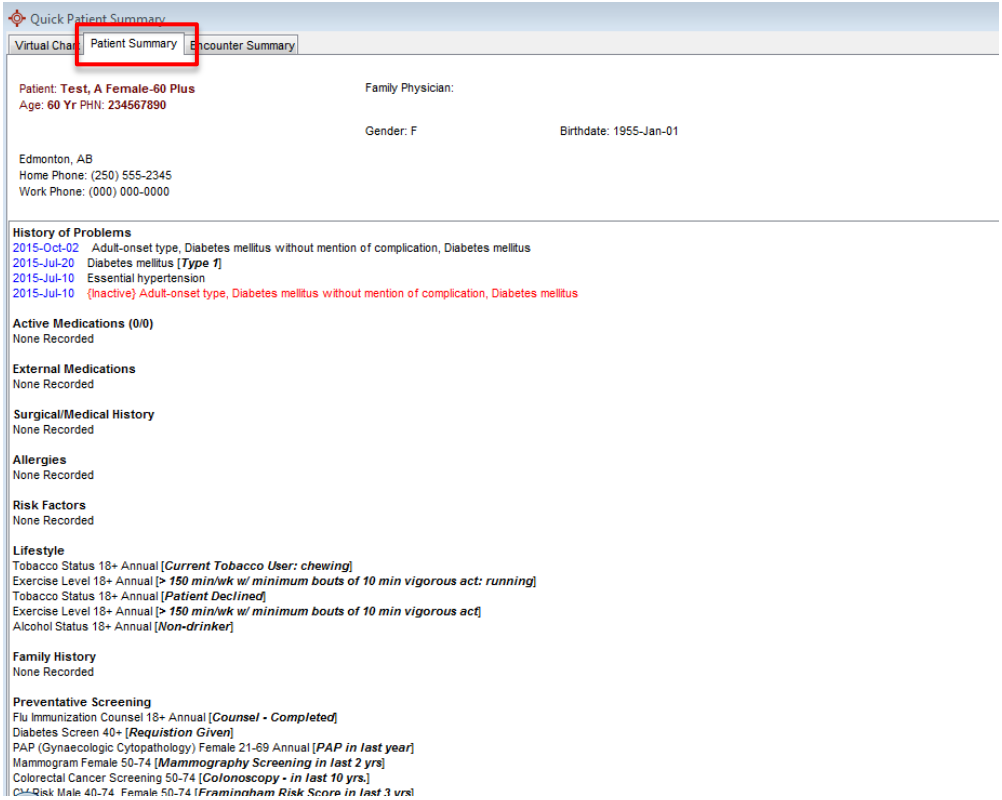
Quick Patient Summary

To access the **Quick Patient Summary** for the currently selected patient select **F3**.This provides access to three tabs: Virtual Chart, Patient and Encounter Summary.

Virtual Chart

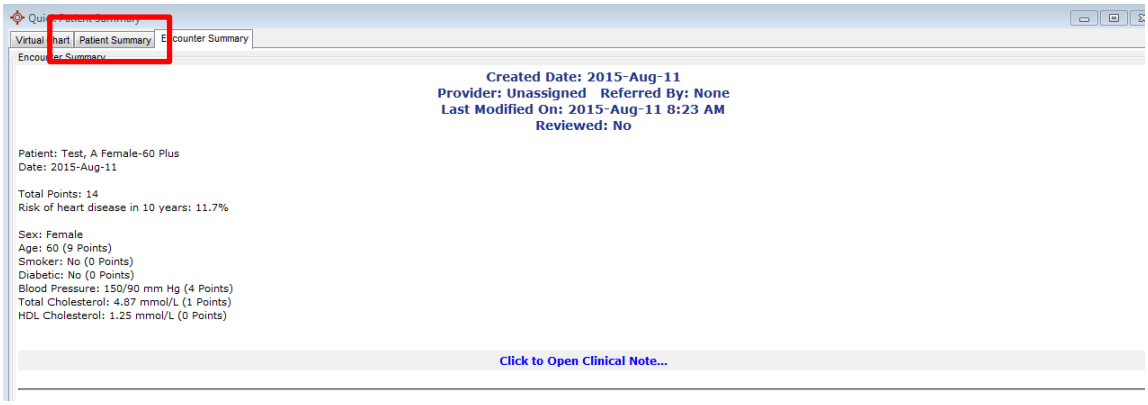


Patient Summary



Encounter Summary

In Accuro, if the **Encounter Summary** tab is not displayed in the clinic, it can be enabled. This is a tab that settles in between the Virtual Chart and the Medications tab. It is designed to take all of the clinical notes/letters, expand them, and stack them on top of each other in one big scrollable view. The notes are in reverse chronological order so the most recent one is at the top. This is useful view to get an idea of the content of previous visits easily. It is also in the **F3 (Quick Patient Summary)** window.



Steps to turn on **Encounter Summary**

1. Click on **File**, **User Preferences**
2. Click on the **Display** category
3. Click on the **EMR Workflow** tab
4. Enable the third checkbox called "**Show Encounter Summary Tab**"
5. Press **Apply**, then **OK**

Note: There is a link on each note in the Encounter Summary tab that opens the full note in edit mode. This is also useful for seeing what medical history items were added on the day of the note, like blood pressure, height and weight.

Recommended Accuro Help files:

- **Quick Patient Summary**
- **Virtual Chart**
- **Patient Summary**
- **Encounter Summary**
- **Encounter Summary (Tech Tuesday # 62)**

Scanned Documents

Every clinic receives electronic faxed documents which get linked to individual patient records. The naming or indexing of these documents as they are attached must enable two processes:

1) When a provider is viewing the patient chart they should easily identify the information and be able to find it quickly. Some EMRs have the ability to search for a document name at the individual patient level.
2) In the EMR search /query tool it is possible to produce a list of patients that have a type of linked document within a period of time. These same document names can be used to create a population-wide point-of-care reminder or a flowsheet.

Recommended Accuro Help files:

- Document Scanning (Tech Tuesday #10)
- Document Sub Types (Tech Tuesday #108)

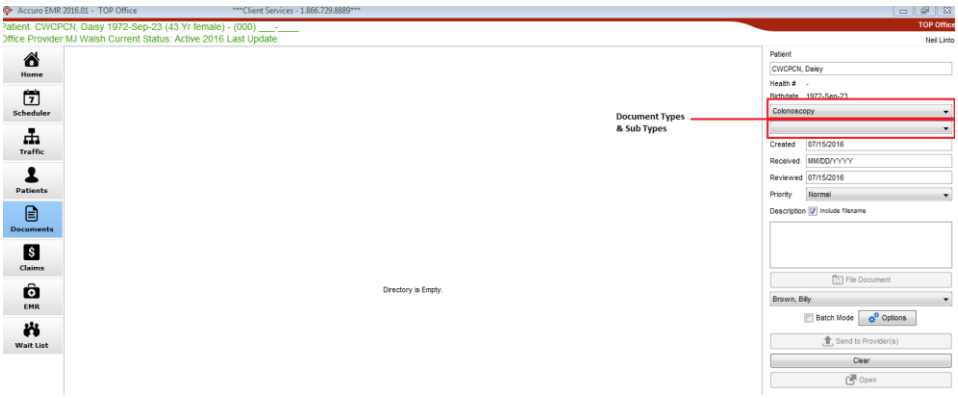
TOP Accuro Video

Data Quality Document Labelling in Accuro:

https://youtu.be/-B-Bs569n-E?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Key principles for linking scanned documents

- Create a list of acceptable document words that can be used at the practice that is agreed upon by the clinic team (clinicians and team members). See Appendix C for examples
- Use the drop down list in the EMR; avoid free typing
- Certain clinical reports need to be distinguished to enable panel management
    - Distinguish mammogram results from all diagnostic imaging
    - Some consult reports need consistent naming:
        - Colonoscopy reports
        - Flex sigmoidoscopy report
        - Colposcopy report
- Provide training to staff and place a printed list of acceptable keywords with indexing tips at every workstation where documents get linked to patient charts
- Name based on type of consultation rather than the name of the consultant
    - E.g., If a referral is for gastroenterologist consult, name the letter "Gastroenterology consult" not "Dr. Black consult"
- Only central clinic EMR administrator(s) should be allowed to add, delete or modify the main list



Tip: Two sample lists of keywords are available in the appendix of this document – See Appendix C

Manual Entry of Lab Data

Most EMRs have the ability to manually enter lab data that may be received by fax or completed within the clinic. Data may be received this way due to the lab originating from a source outside the region. If this lab data is entered as a "Manual Result" rather than a scanned document it can usually be trended and searched. Manual labs completed in clinic such as a random glucose test should be entered in manual labs. Some clinics use Manual Labs to enter singular results that are from Alberta NetCare that the provider wants to see in the lab results sections and so that the results can be graphed with other investigations received electronically.

Example 1:

A provider is opening a new practice. After the first appointment and the patient is accepted into the practice, on the visit for the first comprehensive medical, the provider wants the last three pap results entered in the patient's chart. A team member looks up the results and dates from NetCare in the chart with the manual labs feature careful to note the dates, results and that the source is Alberta NetCare.

Example 2:

A patient with diabetes is also under the care of an internal medicine specialist at a diabetes clinic outside of the area where the primary care practice is. The clinic gets copied on the patient's lab results ordered by the other clinic and they are received as a fax. So that the lab values can be trended with the lab results ordered at the primary care office, the faxed results are entered as manual lab results and appear in the patient's lab investigation section of the EMR not just as a document stored in their chart.

Useful Applications of Manual Lab Entry

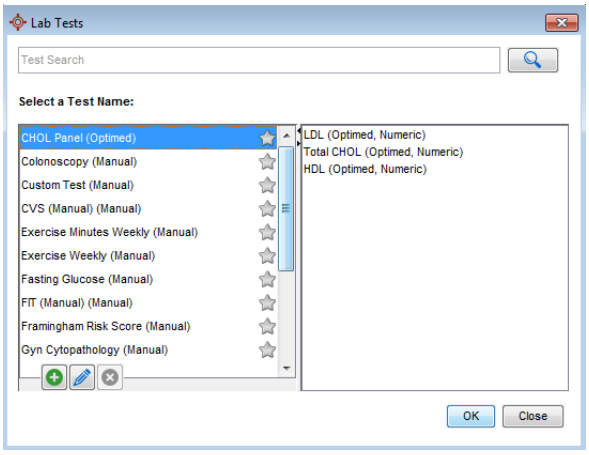
The manual lab result feature of EMRs offers a clinic flexibility to store results or information in a way that they can be trended and searched. Some ways in which clinics are using this feature:

- Preventive screening care offers are all documented as manual lab results – they are searchable and assist the clinic team in monitoring offers and measuring screening care. This requires some set-up and is very effective where it is the team that does preventive screening care work

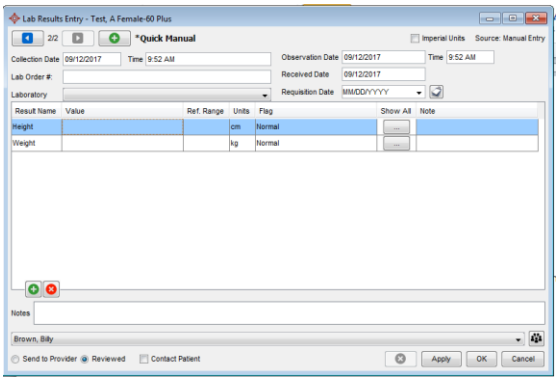
- Pain Disability Index is a score that is tabulated at the clinic that documents the level of pain a patient has. For practices that have a chronic pain clinic, manual lab entry allows them to record the score and trend against medications over time. It can also assist in quality improvement measurement.
- A clinic is tabulating frailty scores of their older patients. Recoding the scores in manual labs allows them to trend these scores over time, determine which patients in the practice have or have not had a frailty assessment and allows population based measures.

Create a manual lab

1. Press CTRL-ATL-L to open the **Lab Tests** window inside the 'Encounter Notes' Tab of a patient's record.



2. Click the green plus sign  to create a new manual lab or select from an pre-existing created 'Manual' lab.



3. Enter the values in the appropriate field and click OK to save the manual lab.

Recommended Accuro Help files:

- Lab results (Create a Manual Lab Result Form)
- Enter a Lab Result, Anywhere (Tech Tuesday #57)

TOP Accuro Videos

Custom Lab Data Entry Creation in Accuro:

https://youtu.be/mlLZDNjMne0?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Manual Lab Entry in Accuro:

https://youtu.be/PuF9CnEQzX0?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Searches/Queries – Getting Started

When learning to create searches the following tips will assist in obtaining accurate data:

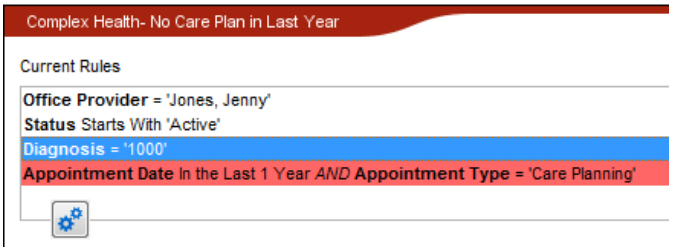
- Be informed on how data is recorded at the clinic; this will provide direction on which fields to search
- Build the search one parameter at a time
- Validate, as each line of the search is created, that the results are correct before adding another parameter to the search
- Search for the positive first then search for the negative
    - E.g., if you are searching for female patients 50 – 74 y that have not had a mammogram in the past 2 years first identify all patients that have HAD a mammogram in the past 2 years. Once you have validated that your search criteria are correct it is easy to search for patients that have NOT had a mammogram.
- Verify that your results are correct

Beneficial Searches for Care Planning

When patients have been documented as having complex health needs (e.g., Problem List includes "Complex Health" as an active problem, monitoring frequency of care planning as well as follow-up is key. Useful searches are:

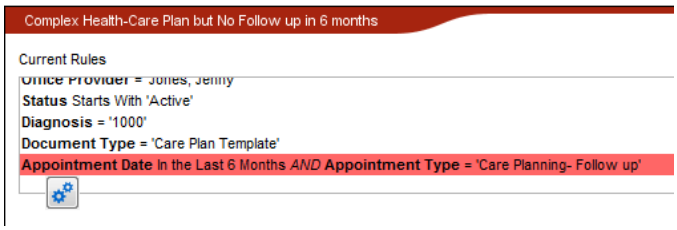
Sample Queries

- Patients with complex health needs with no care plan in the last year



Note: Diagnosis =1000 in this case is a 'custom' code create for Complex Health Needs

- Patients with complex health needs with a care plan but no specific appointment type designating a care plan follow-up in the last 6 months



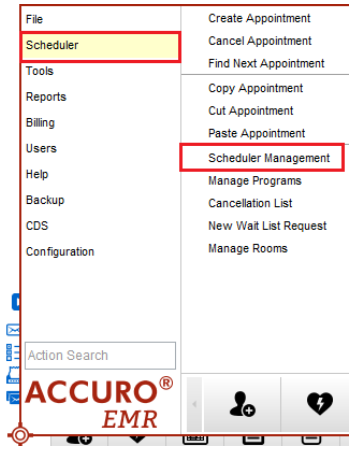
Office Provider = Jones, Jenny
Status Starts with 'Active'

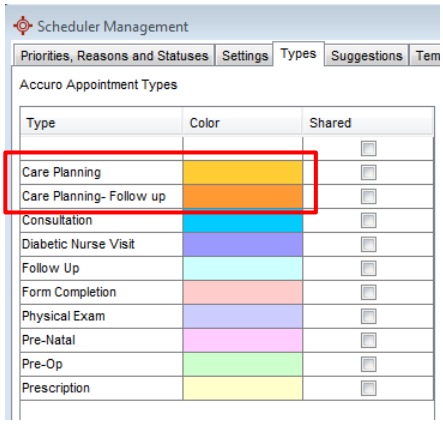
Diagnosis = '1000'
Document Type = 'Care Plan Template'
Appointment Date in the Last 6 Months AND **Appointment Type** = 'Care Planning Follow up' (Doesn't Match)

- This search depends on the practice having a unique appointment type designated as a care plan follow-up.
- Alternatively, a panel manager could create a search that identifies the patients with a care plan completed within a given time (e.g., 1 year) and then looks for specific types of appointments since then to identify patients that may need follow-up

Setting up Appointment Types

1. Click on the Accuro Icon to access the menu choices and click on **scheduler** which presents the user with a dropdown menu.





2. Click on the **Scheduler Management** to open this window, then selecting the 'Types' tab.
3. Using the green plus sign icon you can then add, modify or delete any appointment type (e.g. Care Planning or Care Planning – Follow up, etc.)

Recommended Accuro Help files:

- **Scheduler Preferences**
- **Types and Reasons**

Follow-up

EMRs have features for individual patient follow-up where a task is created to remind a team member to follow-up with a patient at a specific time for a specific reason. This feature is indispensable for chronic disease management and care of patients with complex health needs. Importantly, this task can be future dated so that the person who needs to action the follow-up need only see it when it is timely. It is also important to document when a follow-up is closed. Follow-ups remain documented in a patient's chart for record. In comparison, messaging is more immediate and is usually acted on in a short time frame, often while the patient is in the clinic. Messaging is often used for many non-patient purposes.

Clinical Decision Support: Population-wide point-of-care reminders

Most EMRs have a tool that will search the database for specific criteria to identify patients due for clinical service. Population-wide point-of-care reminders may be called 'rules', 'triggers', 'alert', 'notification' etc., and these are really just searches that run in the background of the EMR and provide notifications when a patient meets the criteria.

These can be created based on internal clinic information such as charting, scanned documents, billing or external information such as incoming lab or imaging data. These point-of-care reminders will automatically go away when the search criteria are met. Population-wide reminders are key enablers of proactive panel-based care. The higher the data quality in a practice, the more reminders a practice team are able to create and use reliably.

Recognizing that individual patient care will be tailored and that there are exceptions to the rules, reminders generally have the ability to be individualized for patients and modes of documenting exemptions may exist.

Important Note: Accuro currently requires that 'Alerts' built in the Query Builder are run when required. Currently Accuro doesn't have a 'Live' Alert mining in the background. **Example:** A diabetic cohort was created 6 months ago, since then 5 new diabetic patients were identified at the clinic. Re-running the original query would include the new patients that would need to be added to the diabetic cohort group.

Individual Patient Alerts

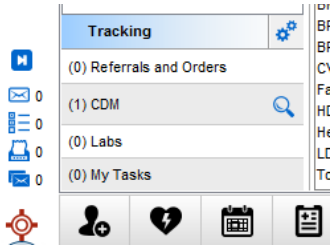
At the individual patient level, EMRs have the ability to create a note or alert for an individual patient. Individual patient alerts can vary from critical pop-ups to notes that appear in certain areas of the EMR such as scheduling, appointments or in charting.

Recommended Accuro Help files:

- Patient Flags (Tech Tuesday #74)
- Patient Tasks
- Rerun an Alert

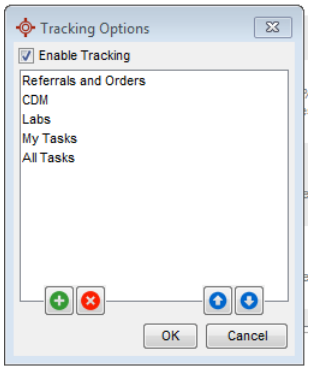
Tracking

Tracking is a newer feature of Accuro EMR (EMR, Encounter notes) that displays the count of outstanding tasks, un-reviewed labs and outstanding orders. With Tracking, a physician or preventive care outreach coordinator can be aware of any preventive investigations, such as a fasting glucose or a fecal immunochemical test (FIT), that have not been reconciled to the order.

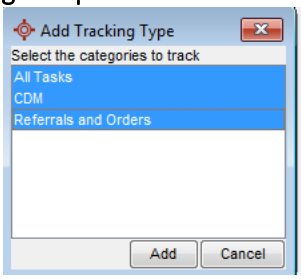


Each user has to turn tracking on. To enable Tracking:

1. Go to the **EMR** > **Encounter notes**
2. In the lower left corner, click the **gear icon** next to the word "Tracking"



3. Turn on the **Enable Tracking** checkbox.
4. Click the **green plus** to add the items you want to show in tracking.



- Choices are:
  - Tasks – show outstanding tasks
  - Unreviewed Labs – shows any labs sitting in a physician inbox not reviewed yet
  - Outstanding Orders – show any requisitions done without results linked back (requires the use of requisition forms set up for lab orders).
  - CDM shows conditions the patient has CDM form on (requires CDM to be turned on and worksheets used)
  - Preventative Care (Ontario only)

5. Highlight the desired choices, click **Add** and then click **OK**.

Recommended Accuro Help files:

- Tracking in Encounter Notes
- Enable Tracking in Encounter Notes
- Tasks
- Patient Tasks
- Add attachments to Existing Tasks
- Search for Incomplete Tasks

Panel Management Processes

Preventive Screening

As per the Alberta Screening and Prevention (ASaP) Program:

Revised Screening Maneuvers Menu for Adults 2017

Alberta Screening and Prevention Program (ASaP)

Maneuver	Age (Years)	Interval General Population
Blood Pressure	**18+**	**Annual**
Height	**18+**	**At least once**
Weight	**18+**	**3 years**
Exercise Assessment	**18+**	**Annual**
Tobacco Use Assessment	**18+**	**Annual**
Influenza Vaccination	**18+**	**Annual**
Mammography	**50-74**	**2 years**
Colorectal Cancer Screen One of: • FIT • Flex Sigmoidoscopy • Colonoscopy	50-74	2 years 5 years 10 years
Pap Test		
Do Pap test	25-69	3 years
Optional Pap test	21-24	
DO NOT DO Pap test	<21	
Plasma Lipid Profile Non-Fasting	**40-74**	**5 years**
Cardiovascular Risk Calculation	40-74	**5 years**
Diabetes Screen One of: • Fasting Glucose • Hgb A1c • Diabetes Risk Calculator	40+	5 years

The age and interval of given information is suitable for the general population. The need of individual patients will vary. For each maneuver, the physician/provider should offer testing as appropriate. See evidence-based practice points on reverse.

Documenting for ASaP

It is important that all ASaP maneuvers are documented in a consistent manner, ideally in a searchable field in the EMR.

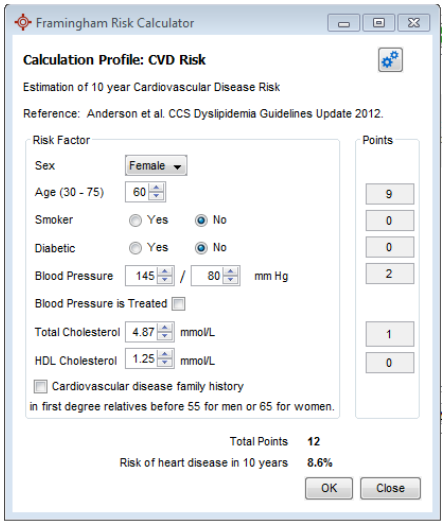
- BP, Height and Weight are recorded as vitals
- Lifestyle/modifiable risk factors are often recorded in an exam template or designated area – see more about this in the Lifestyle/Modifiable Risk Factors section
- Influenza screening includes:
    - Administering a vaccine
    - Recording of vaccination administered elsewhere
    - Record of offer to vaccinate or counsel
- The following are documented as investigations/lab results:
    - Mammography
    - Colorectal cancer screening – FIT
    - Pap test
    - Plasma Lipid Profile
    - Diabetes screening (HbA1c or fasting glucose)
- Colonoscopy and sigmoidoscopy are usually documented as a report. When received it is important that these are named/indexed appropriately and in a standardized way, (e.g., "Colonoscopy Report")

CV Risk Calculation

- This is a highly valuable tool to assess risk in patients with no previous cardiovascular disease (e.g., NOT taking a 'statin' class of medication)
- Conduct on average risk patients age 40 – 74 every 5 years
- Requires other data held in the EMR: gender, tobacco use, BP, non-fasting lipid data and diabetes diagnosis (for some CV Risk calculators)
- May use an internal EMR CV Risk Calculator or an external calculator such as: http://chd.bestsciencemedicine.com/calc2html#basic
    - Dependency on where the provider records the result or if it is auto created from the internal calculator in the EMR
- The preventive care screening search is to identify patients 40 – 74 y, not taking a 'statin', that have not had a CV Risk calculation in the past 5 years
    - Patients already at risk, such as those taking a statin, do not need to be assessed

The 2012 Canadian Cardiovascular Society standard Framingham Risk Calculator has been adopted as the new default in Accuro. This calculator is called "CVD Risk". This is an "Estimation of 10 year Cardiovascular Disease Risk". Reference: Anderson et al. CCS Dyslipidemia Guidelines Update 2012
To access the CVD Risk Calculator:

- Click **Tools** on the Menu bar and select **Framingham Risk Calculator**.
- Enter the patient information
- Click OK and Close. The results are saved to the patient's **Encounter Notes** section.



Note: Two alternate Framingham Calculator available

1. **'HCHD Risk' Framingham Calculator:** Estimation of10 year risk nonfatal myocardial infarction or coronary death
2. **'CHD Risk' Framingham Calculator:** Estimation of 10 year Coronary Heart Disease Risk

Warning: If you switch the profile for the Framingham Risk Calculator all users are switched to the new profile.

Lifestyle/Modifiable Risk Factors (ASaP+)

Modifiable risk factors should be recorded in a consistent fashion to enable preventive screening care as well as to monitor and manage patients who screen positive. All members of the clinic team should know where modifiable risk factors are recorded in the EMR and who is responsible for entering them. It is recommended to enter modifiable risk factors in an area of the EMR that is searchable and can enable a population-wide reminder.

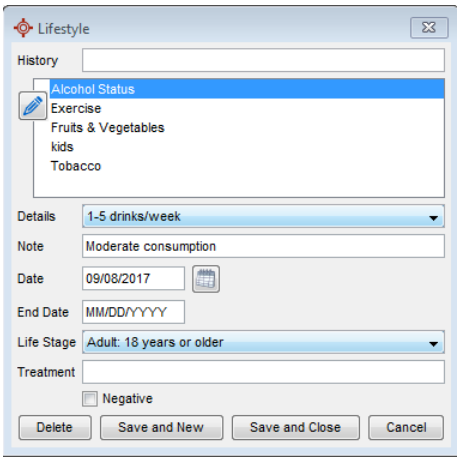
- Height and weight (to calculate BMI and weight changes)
  See ASaP Height & Weight Queries
- Physical Activity (Exercise Assessment)
- Tobacco Use Assessment
- Alcohol Use
  Potential data capture methodology for above (4) Lifestyle/Modifiable Risk Factors
  See ASaP Maneuvers Data Entry Tips
- Diet – Fruit and Vegetable Consumption

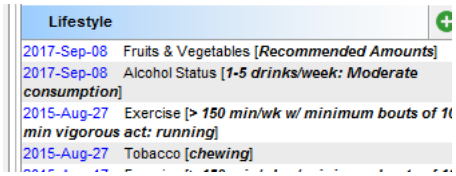
ASaP+ - Videos demonstrating patient/provider engaged using motivational interviewing:

https://www.youtube.com/watch?v=dm-rJJPCuTE
https://www.youtube.com/watch?v=bTRRNWrwRCo

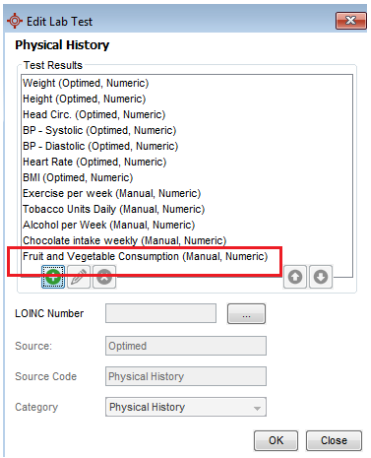
Capturing Fruit and Vegetable Consumption

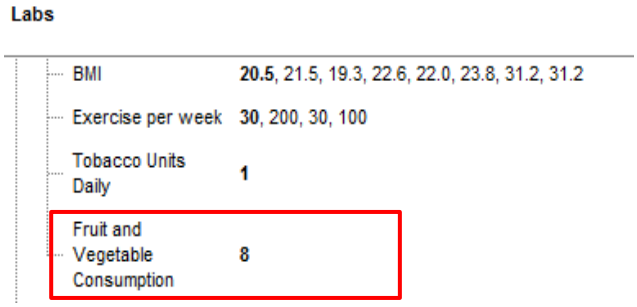
Two different methods could potential used in order to capture patient's fruit and vegetable consumption. The first would be creating a custom capture within the pre-existing (See Lifestyle MHB) or custom MHB. See Medical History Bands



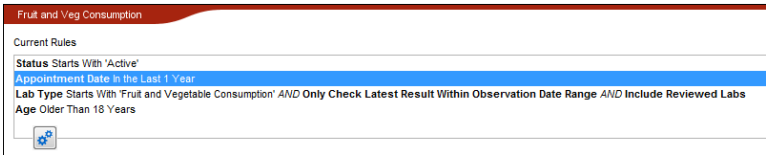


Alternatively one could also capture this information in Lab (manual) lab entry. The process to add this would be similar to adding exercise, tobacco use and alcohol consumption described in the ASaP Forms template instructions. See Setup and Use





Example of ASaP+ Query



Status = Active
Bill Date In the last 1 years
Lab Type = Height AND Only Check Latest Result AND Include Reviewed Labs
Age Older than 18 years

ASaP Program Participation

Providers registered in the ASaP Program with TOP will use chart review methodology to look for results of completed screens as well as offers, declines or exemptions. Consistency of recording assists in the chart review.

ASaP EMR Extraction Methodology for Schedule B

Practices and PCNs measuring ASaP results for Schedule B purposes using EMR extraction methodology need only focus on the record of results (**have a screen completed**) which, in general, is easier to search in the EMRs than offers, declines and exemptions.

Exclusions/Exemptions

Some patients are excluded from general adult preventive screening for clinical reasons. Developing consistent processes to document the exclusions assists the team in collaborating on preventive screening care.

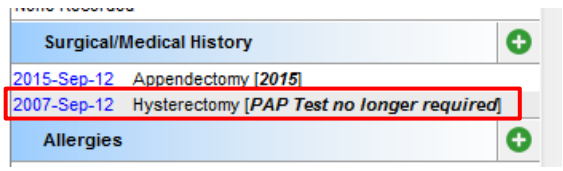
Some exclusions/exemptions are:

- Females with a complete bilateral mastectomy are excluded from mammograms
- Females with a total hysterectomy (no longer have a cervix) are excluded from pap smears
- Patients with documented cardiovascular risk and treatment no longer are screened for CV risk and may have different intervals for lipid profiles
- Patients diagnosed with diabetes are not screened for diabetes
- When diagnosed and undergoing interventions for colorectal, breast or cervical cancers, the routine screening intervals no longer apply and patients will follow their recommended care

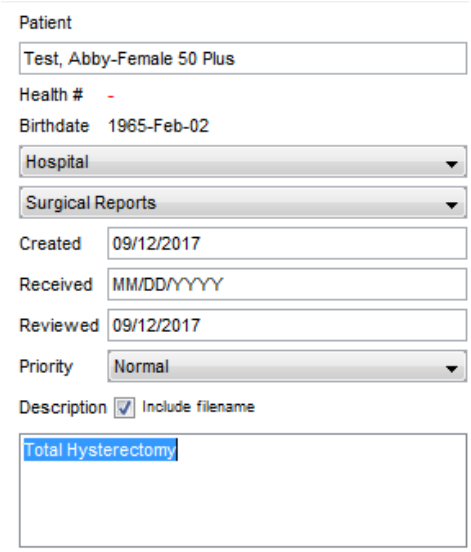
A team should consider how documentation of the exemption criteria impacts team-based screening care.

Example:
A female patient is offered a pap but remarks that she has had a total hysterectomy 10 years ago and asks if she needs one. The clinic team member indicates no. The team notes that the reason they didn't know was because the evidence of the hysterectomy was in a document called "surgical report". The team wants to ensure this doesn't happen again and agrees that possible actions they can take are that:

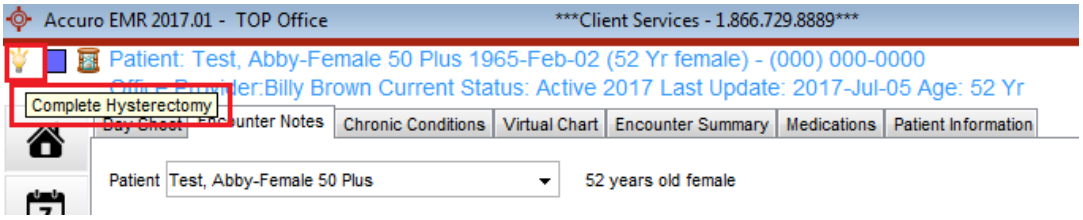
- The total hysterectomy needs to be added to the Past Surgeries area of the chart (In Accuro this can be captured in the Medical History Band – Surgical/Medical History



- The surgical report is coded with the additional term “Total Hysterectomy”



- The patient is exempted from the population-wide reminder for pap smears in the clinic (E.g. One possible solution could be to create a ‘custom’ patient flag for staff to know this patient is except from further PAP screening) See Disease Management



ASaP Searches - Examples

There are 2 general approaches for completing the ASaP specific searches:

1. Searching for patients due for an ASaP maneuver. We use this approach to build lists for opportunistic and outreach screening processes.
2. Searching for patients who have had the maneuver completed. We generally use this approach for quality improvement purposes to track how we are doing.

Searches for ASaP Maneuvers

Age and/or Gender Criteria	Maneuver/Timeframe
Patients in a specific age range and gender	have not been screened (seen) in the appropriate interval (e.g. 3 years)
Identify patients 18 + with no	Height recorded on the chart Weight recorded on the chart in the past 3 years Blood Pressure recorded in the last year Tobacco assessment in the last year Exercise assessed in the last year Influenza vaccination nor counsel in the last year
Identify females 25-69	have not had a Pap test in the past 3 years
Identify females 50 – 74 y	have not had a mammogram in the past 2 years (a mammogram may be a scanned document and/or an electronic result depending on the region)
Identify patients 40 +	have not had a fasting glucose OR a HbA1c test in the last 5 years
Identify patients 40 – 74	have not had a plasma lipid profile test in the past 5 year
Identify patients 50 – 74	have not had a fecal immunochemical test in the past 2 years OR a flex sigmoidoscopy in the past 5 years OR a colonoscopy in the last 10 years (where a FIT test is a lab result and a flex sig or colonoscopy can usually be identified by a scanned report)

In this section we will show an approach for each of the ASaP screening maneuvers. There may be more than one way to search and it will also depend on your clinic's documentation. Other approaches will work but we suggest you validate your search results, whatever approach you take.

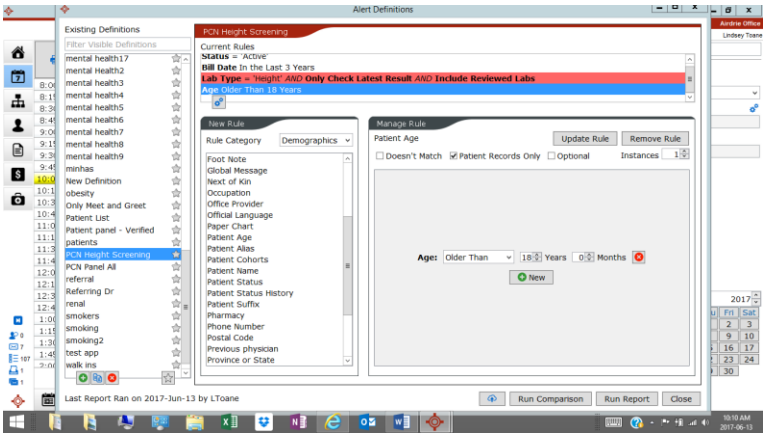
Offers of Screening in the Patient Chart (Location)

Screening Maneuver		Interval	Potential Location in EMR (noting that clinicians may have unique patterns of use)
Blood Pressure (18 +)		Annual	Clinical Notes or Physical History or custom Medical History Band (MHB*)
Height (18 +)		At Least Once	Clinical Notes or Physical History or custom MHB
Weight (18 +)		3 years	Clinical Notes or Physical History or custom MHB
Tobacco Use Assessment (18 +)		Annual	Encounter Notes > Lifestyle or Risk Factors MHB
Exercise Assessment (18+)		Annual	Encounter Notes > Lifestyle or Risk Factors MHB
Flu Vaccination Screen (18+)		Annual	Immunization Summary MHB
PAP Test (women 25-69)		3 years	Encounter Notes > Labs
Mammography (women 50-74)		2 years	Encounter Notes > Letters (Consult Report) or Documents
CV Risk Calculation (40 – 74)		5 years	CVD Risk (Framingham 10 Year CVD Risk) Calculator – Encounter Note, Manual CVS lab result
Plasma Lipid Profile (40 – 74) Non-Fasting		5 years	Encounter Notes > Labs
One of: [all patients 40 +_)	Fasting Glucose	5 years	Encounter Notes > Labs
	Hgb A1c		Encounter Notes > Labs
	Diabetes Risk Calculator		Encounter Notes> Manual or Custom MHB
One of: [all patients 50 – 74)	FIT	2 years	Encounter Notes > Labs
	Sigmoidoscopy	5 years	Encounter Notes > Letters or Documents
	Colonoscopy	10 years	Encounter Notes > Letters or Documents

* Medical History Band

Examples of ASaP Queries (based on completed screens)

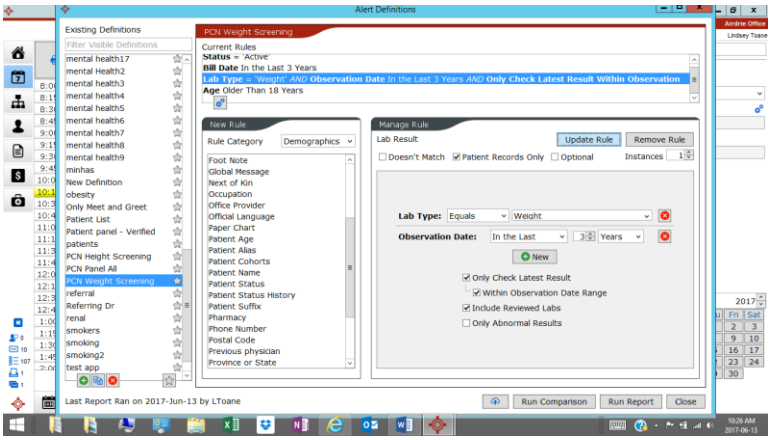
Height screen



Status = Active
Bill Date In the last 3 years
Lab Type = Height AND Only Check Latest Result AND Include Reviewed Labs
Age Older than 18 years

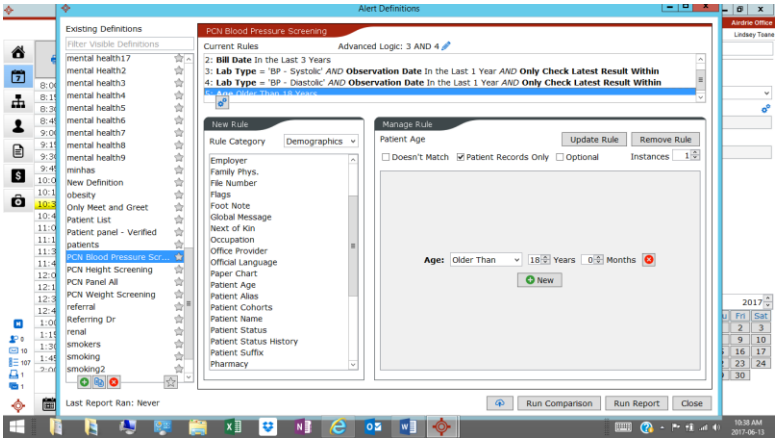
The above screen shot is done in the 'negative' meaning it is looking for those who have NEVER had a height recorded. Minus this count from your denominator to get the numerator.

Weight Screen



Status = Active
Bill Date In The Last 3 Years
Lab Type = Weight and Observation Date in the last 3 years AND only check latest within observation date
Age = Older than 18 Years

Blood Pressure

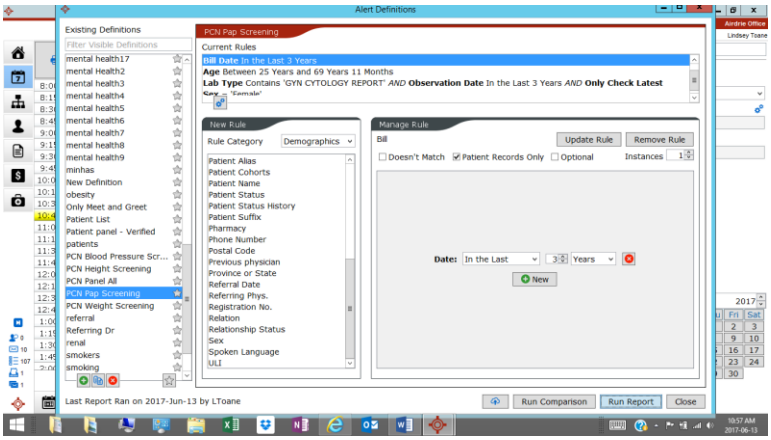


Status = Active
Bill Date In the last 3 years
Lab Type = 'BP-Systolic' AND Observation date in the last 1 year AND Only check latest Result within observation date.
Lab Type = 'BP-Systolic' AND Observation date in the last 1 year AND Only check latest Result within observation date.
Age = Older than 18 years

This uses advanced logic for this one, (see screen shot). It specifies needing both Systolic and Diastolic values (Line 3 and 4) to meet the criteria.

Any Blood pressures captured in the encounter notes will not be reported using this query.

Pap Screen



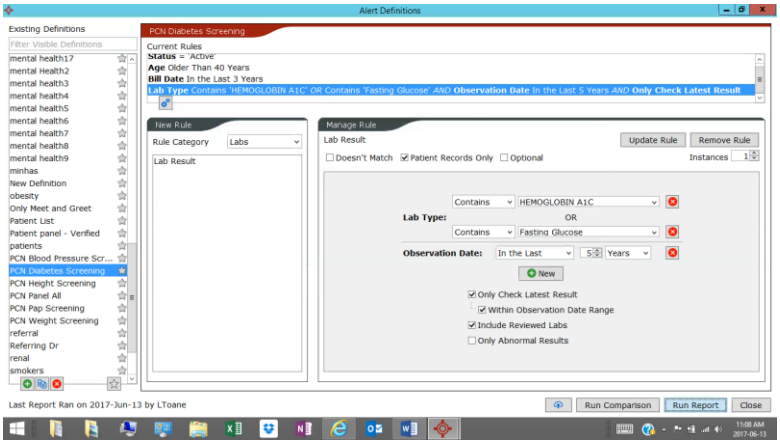
Status = Active
Bill Date In the last 3 years
Age Between 25 years and 69 years 11 months
Lab Type Contains "Gyn Cytology Report' AND Observation Date in the last 3 years AND only check latest result.

Sex (Gender) = Female

This is how you would choose lab type if it comes from Calgary Lab Services. If your labs comes from multiple labs you may need to build the query so that it looks for all the variations in which it comes in.

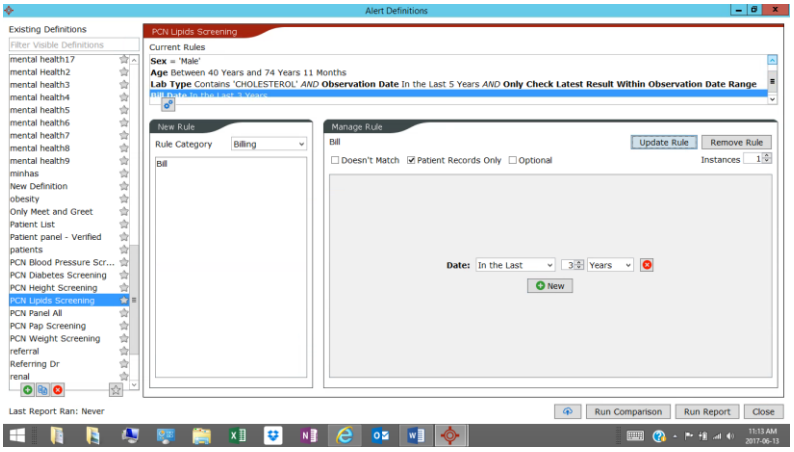
Some clinics try to account for the scanned paps (i.e. NetCare paps). This is especially useful for new patients when you are building on your history for patients. If your clinic is doing this, build your query to reflect how you are capturing this, (i.e. Medical History Band) and account for both the lab pap and scanned pap. It can make a difference to your screening rates.

Diabetes Screen



Status = Active
Age Older than 40 year
Bill Date In the last 3 years
Lab Type Contains 'HEMOGLOCBIN A1C' *OR* Contains "Fasting Glucose' AND Observation Date IN the last 5 years AND Only check latest result.
To add "OR" statements: Under Rule Category 'Labs', select 'Lab Result' .
Add the first lab then click the green plus sign and add another Lab Type.

Lipids Screening

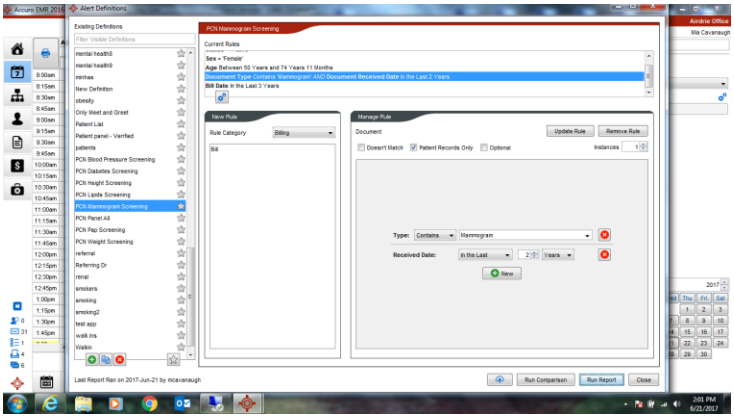


Status = Active
Age Between 40 years and 74 years 11 months

Lab Type Contains ‘Cholesterol’ AND Observation Date IN the last 5 years AND Only check latest result.
Bill Date In the last 3 years

Special Note on Lipid Screening
I have found that trying to account for all four elements of the lipid panel does not work well in most Accuro EMR’s. There can be times where LDL do not calculate because of a very high Triglyceride level. In speaking with a physician, the Cholesterol is ALWAYS reported by the lab. Some labs report a LIPID PANEL, some report out as individual labs (CHOL, HDL, LDL, TRIG). So you may need to look closely at how your lab report and choose your lab types appropriately.

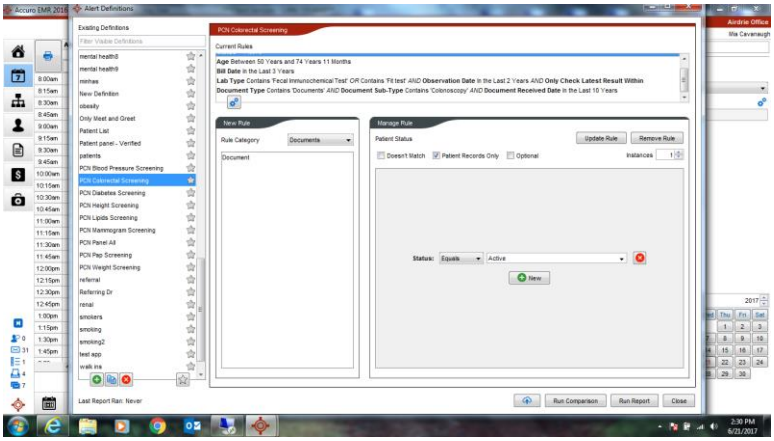
Mammogram Screening



Status = Active
Sex (Gender) = Female
Age Between 50 years and 74 Years 11 months
Document Type Contains ‘Mammogram’ AND Document Received date in the last 2 years.
Bill Date In the last 3 years.

Important Note: This query assumes that all staff is scanning Mammograms under this Document Type. In this case this query uses the ‘Received Date’ field that reflects the date the Mammogram was performed.

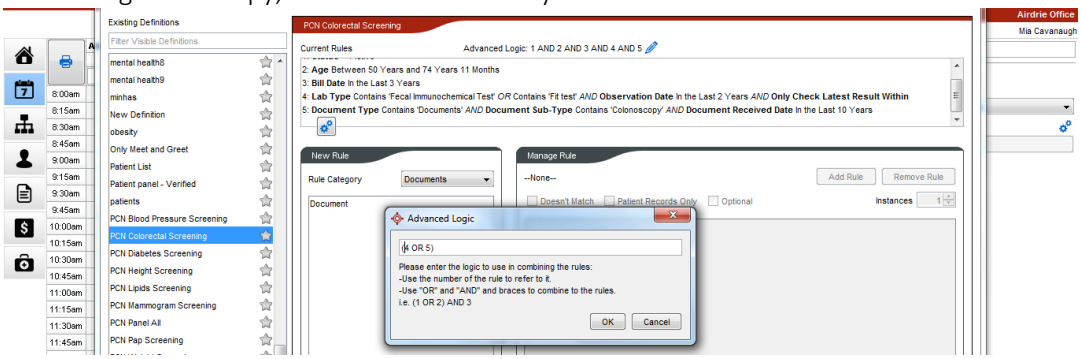
Colorectal Screening



Status = Active
Age Between 50 and 74 Years 11 months
Bill Date In the Last 3 years
Lab Type contains ‘Fecal Immunochemical Test’ OR Contains ‘Fit test’ AND Oberservation Date In the Last 2 years AND Only check latest result.
Document Type Contains ‘Document’ AND Document ‘ Sub Type’ Contains ‘Colonoscopy’ AND Documents received In the Last 10 years.
Advanced Logic: (4 OR 5). See next screen shot.

Notes

- This clinic has two ways (names) the lab populates the FIT test into the EMR so we need to account for both.
- This assumes that the clinic names their Colonoscopies in a standardized way with this specific name. If there are variations you may need to account for all.
- This clinic does not have even one Sigmoidoscopy in the EMR, but if there were, you need to account for this document as well. Add a third line of Document Type/ Document Sub Type/ Enter Sigmoidoscopy, received in the last 5 years.



TOP Accuro Videos

Accuro Preventative Screening Search for Missing Vitals

https://www.youtube.com/watch?v=m4wmq-Yu0mU&index=26&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Identify All Tobacco Users (Part1) in Accuro

https://youtu.be/7SlccxvWmiQ?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Identify All Patients not Assessed for Tobacco Use (Part 2) in Accuro

https://youtu.be/1hmRn27Tm7E?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Accuro ASaP Cardiovascular Risk Screening

https://youtu.be/bOIPllD50DI?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Accuro Preventative Screening PAP for ASaP

https://www.youtube.com/watch?v=6Wz10B34yP0&index=25&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Disease Management

Beneficial Searches for Disease Management

- Patients with a given diagnosis with:
    - No clinic visits in a period of time
    - A monitoring test not completed in a period of time
    - Monitoring tests that have values above a threshold

Chronic Disease Management

Proactive panel-based care of a cohort of patients with a given condition (e.g., diabetes or hypertension) is enabled by certain EMR features:

- **Problem list** – See Appendix B – Sample Lists
- **Flags, Tasks** - Point-of-care reminders set for a population of patients
- Pop-up notifications in various areas of the EMR
- **Tracking** Follow-ups, worklists

While patients with chronic conditions are treated and managed as individuals, processes for proactive panel-based care act as an extra "safety-net" to identify patients that may be due for care.

Example:

Peter is a chronic disease nurse that works for a PCN and a clinic. Peter has collaborated with the panel manager, who is very savvy at EMR searches, to build a number of saved searches that he runs weekly that support his work for chronic disease management. Peter has access to the clinic EMR remotely so he can run these searches and contact patients on days when he is not embedded in the clinic. The diabetes searches that the panel manager built for Peter are:

- List of patients with a diagnosis of diabetes and no clinic visit in the last 6 months and no future visits booked in the next month
- List of patients with a diagnosis of diabetes that have not had an HbA1c result in the last 6 months
- List of patients with a diagnosis of diabetes, whose last HbA1c result was over 7.0

Peter reviews the lists as part of his regular work as a chronic disease management nurse and calls the patients appropriately for follow-up or he may task another team member to call the patient to book an appointment.

Example 1:
A panel manager at a clinic does a search that produces a list on a monthly basis for patients with chronic conditions such as diabetes or chronic kidney disease that have had NO VISITS (and no future visits booked) in a period of time (e.g., 6 months or a year, depending on the condition). This allows the panel manager to reach out to these patients, confirm that they are still patients of their primary provider at the clinic, and offer a management appointment.

Example 2:
A panel manager uses lab data to run a monthly search in the EMR to identify patients that have lapsed in getting lab tests done that support management of their condition. For example, a

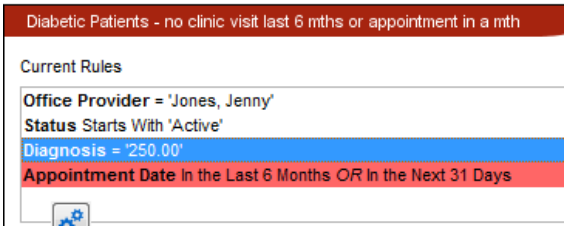
monthly search identifies any patient with a diagnosis of diabetes with no HbA1c result on file in a period of time, such as 6 or 7 months. The clinic may set protocol for the panel manager to act on this list or the list may be provided to the CDM nurse for action.

Example 3:
A panel manager has created a search in the EMR for the CDM nurse that produces a list of all patients with a diagnosis of diabetes that displays the patient's last lab values for HbA1c, fasting glucose, blood pressure and last visit date. The CDM nurse runs the search on a weekly basis and can sort columns in the report to identify patients that may need follow-up. By running the search live in the EMR the CDM nurse can easily click on the patient's name to be directed to their chart to get more information for next steps.

These examples identify ways that clinics can set up processes that act as a "safety-net" and be proactive in identifying patients early for interventions.

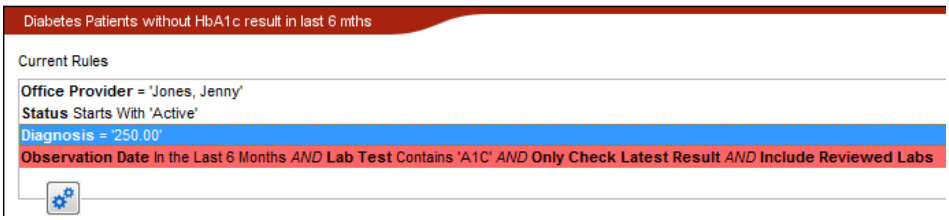
Chronic Disease Management Searches – Examples

List of patients with a diagnosis of diabetes and no clinic visit in the last 6 months and no future visits booked in the next month (31 days by provider)



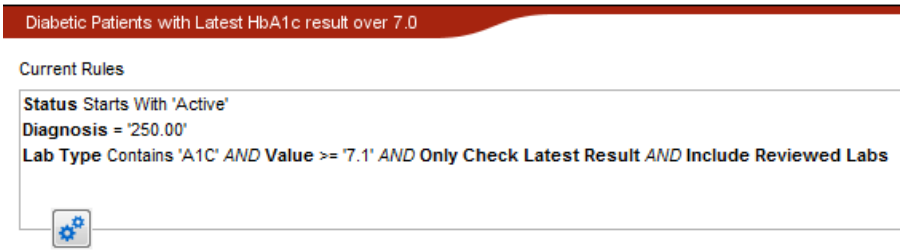
Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis = '250.00' (this includes all codes associated with ICD code 250 assuming they are being used)
Appointment Date in the Last 6 Months OR in the Next 31 Days

List of patients with a diagnosis of diabetes that have not had an HbA1c result in the last 6 months (by provider)



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis = '250.00'
Observation Date in the last 6 Months and Lab Test Contains 'A1C' AND Only Check Lastest Result AND Include Reviewed Labs

List of patients with a diagnosis of diabetes, whose last HbA1c result was over 7.0 (entire clinic's active patients)



Status Starts With 'Active'
Diagnosis = '250.00'
Lab Type Contains'A1C' AND Value >= '7.1' AND Only Check Latest Result AND Include Reviewed Labs

Problem Lists

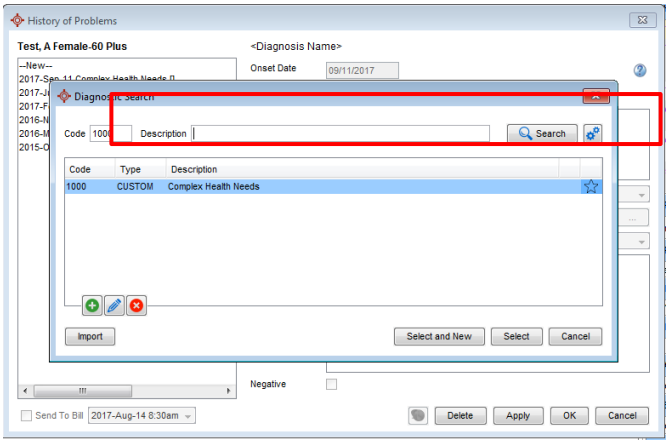
EMRs have at least one designated area to enter confirmed diagnoses in the problem list. Agreeing as a team to have consistent entry into one area in a consistent way is critical to enable team-based care of patients with chronic conditions.
There are useful searches that will support creation of disease registries. By looking in other areas of the EMR, patients without the problem in their 'Problem List' can be identified. See Appendix B – Sample Lists

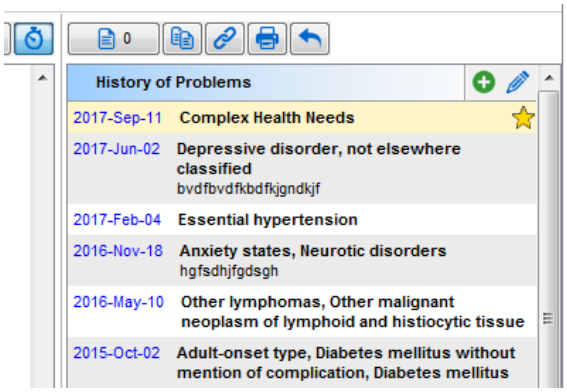
Feature of EMR	Example 1 Data that would inform Diabetes Mellitus Registry	Example 2 Data that would inform Hypertension registry
Billing	Diagnostic code 250	Diagnostic code 401
Medications	Currently taking metformin or insulin	Currently taking an antihypertensive
Lab	HbA1c over 7 %	BP > value specified by clinic MDs

The bulk action feature from reporting area of the EMR is a useful tool when producing a list of verified patients with a given condition to add it to the patient problem list in bulk.

In Accuro there are two possible places to add a patient's problem to their chart. The recommended method is to add a problem in the **History of Problems** in the Accuro Medical History Band on the 'Encounters Notes' tab.

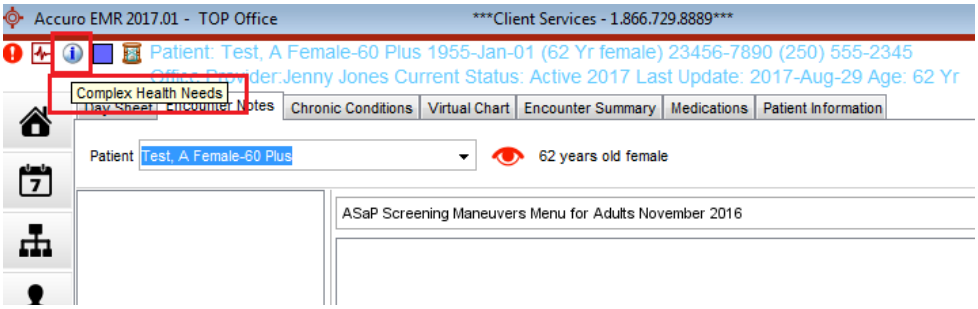
Example in 'History of Problems' (Medical History Band)





As a secondary identifier in a patient's chart one can create unique customizable **Patient Flags** (icon) for problem or conditions that displays in the patients Demographic Bar. The description of the icon appears when you hover over it.

Example of a 'Customized Patient Problem Flag'



Recommended Accuro Help files:

- Encounter Notes (Add a History of Problem in Encounter Notes)
- List of Patients with a Diagnosis (Tech Tuesday #118)
- Re-order the History of Problems (Tech Tuesday #72)
- Customized Patient Flags
- Patient Flags (Tech Tuesday #74)

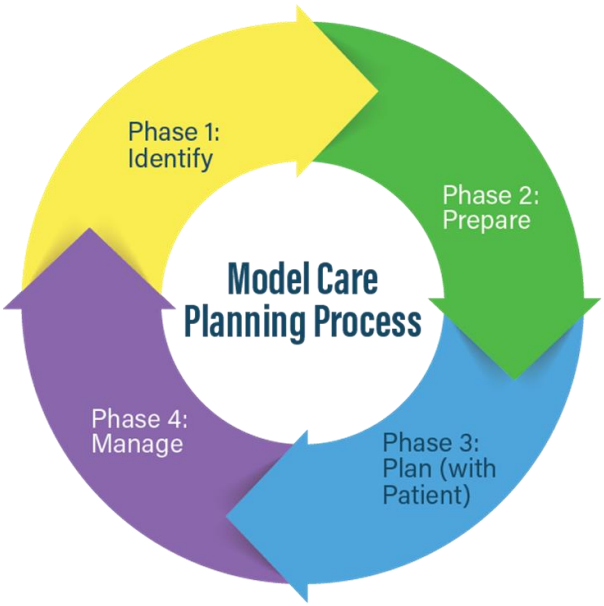
Care of Patient with Complex Health Needs

Patients Collaborating with Teams (PaCT)

PaCT is a next step in the Patients Medical Home journey. The next opportunity to positively impact care for those with the most complex health needs, including those at risk for or having multiple chronic diseases.

Care Planning

"The process by which healthcare professionals and patients discuss, agree upon, and review an action plan to achieve the goals or behavior change of most relevance and concern to the patient."



PaCT Care Planning Process

http://www.topalbertadoctors.org/pact/

PaCT Resources

http://www.topalbertadoctors.org/pact/toolsresources/

PaCT Processes

Clinics participating in PaCT will need to have well-established processes for panel identification and maintenance to ensure that they are offering care planning to their confirmed patients. Once the Central Patient Attachment Registry (CPAR) is available, it is recommended that clinics participate to ensure that they are offering care planning to their CPAR verified patients.

This section of the EMR guide focusing on PaCT is intended to be used by teams alongside the PaCT How-To Guide. The sections below follow the "Potentially Better Practices" as they relate to the "Optimize EMR" focus of each phase.

PaCT Prework

- Uploading the Care Planning Template into your EMR
  See Appendix A- Care Planning Template
- Discuss and agree upon standard charting procedures for team-based care

PaCT Identify Phase:

- Identifying patients with complex health needs
- Marking the patient's chart with "Complex Health"
  See Problem Lists

PaCT Prepare Phase:

- Appending relevant patient assessment information to the record.
- Pre-populating the care planning template
- Generating requisitions

PaCT Plan Phase:

- Care Planning Template Use:
  - Standardizing documentation to enhance pre-population
  - Optimizing documentation during the appointment
- Creating reminders for follow up appointments

PaCT Manage Phase:

- Maintaining the care planning document over time
- Creating reminders for planned care interventions
- Standardizing processes for referral tracking

PaCT Pre-work

Uploading the Care Planning Template into your EMR

A new care planning template has been created for the PaCT initiative that is patient-centered and relies on evidence-based care planning principles. For processes on how to make the template available in your clinic EMR, use the template at the care planning visit, save and use for follow-up visits, see your EMR specific tip sheet.

Discuss and agree upon standard charting procedures for team based care

Care planning is a team activity. For this to occur there should be general protocol on where information is stored in the chart so that all team members can both contribute to the chart, find information in the chart and contribute to the care plan appropriately. This would impact team members of diverse roles across the practice: scanners, medical office assistants, nurses, pharmacists, physicians, etc. In summary, chart in a way that team members can help care for the patient. Some benefits include:

- Care team members know where to find the information.
- The patient's data can inform population-wide reminders to alert when care services are due
- Monitoring and management can be done systematically

Important Note: It cannot be overstated how important this people process step is to the successful adoption of any information collection and capture in the clinic's EMR. Changes in workflow or process need to be discussed as a group.

Identify Phase

Identify patients with Complex Health Needs

The first step in the care planning process is to identify patients for care planning. Your PaCT team will have reviewed the suggested menu for selecting a patient population (see menu below). In the EMR-specific Guides you will see suggested approaches to searching each of the menu items.

Part of the improvement process for you team may be improving how your selected population is identified by your EMR. For instance, if you select 'frail patient's' as your focus, you may have to work on how frailty is documented to make it reliably searchable.

Menu

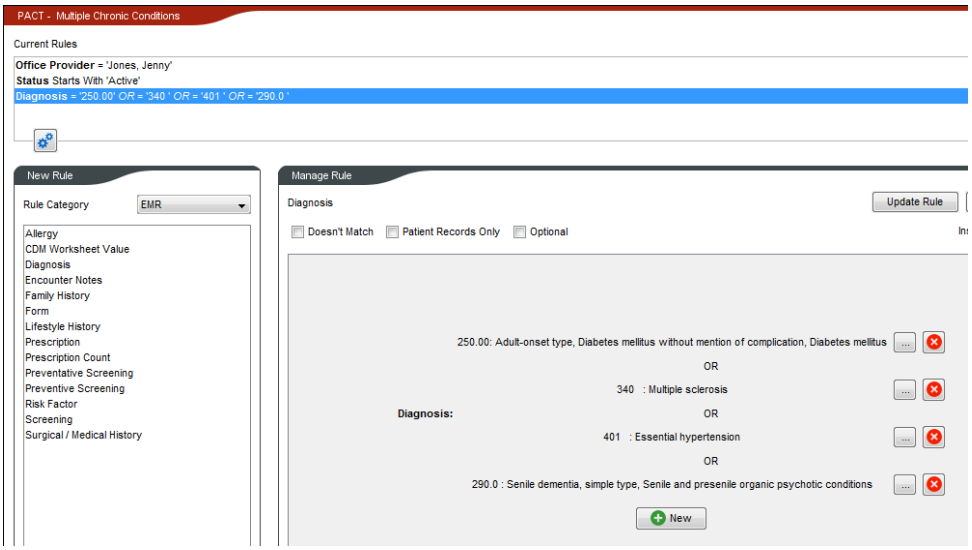
Clinical Criteria	*Risk Factors*	*Utilization Parameters*
☐ People with advanced illness ☐ Complex Conditions: (Multiple Sclerosis, Parkinson's Disease or Lupus) ☐ Dementia ☐ Multiple Chronic Conditions (e.g., 3 or more) ☐ Patient eligible for a Complex Care Plan ☐ Multiple medications ☐ Functional impairment ☐ Adults under 65 with disabilities	☐ Age (e.g., > 85, or > 75) ☐ Frailty ☐ LifeStyle/Modifiable risk factors ☐ *Social risk factors* ☐ High risk (using predictive risk assessment tool)	☐ Many visits (e.g., > 10) in the last year ☐ Hospitalizations (2 or more within the past year) ☐ ER visits (3 or more) in the past year ☐ Had a care plan in the past but not in the last year ☐ Receiving home health services ☐ No visits to the clinic in the last year (with risk factors or a chronic condition)

*Note – these are some main considerations – not an exhaustive list

Examples of 'Complex Health Needs' Queries

Clinical Criteria

Patients with Multiple Chronic Conditions (3 or More)



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis = '250' OR = '340' OR = '401' OR = '290'

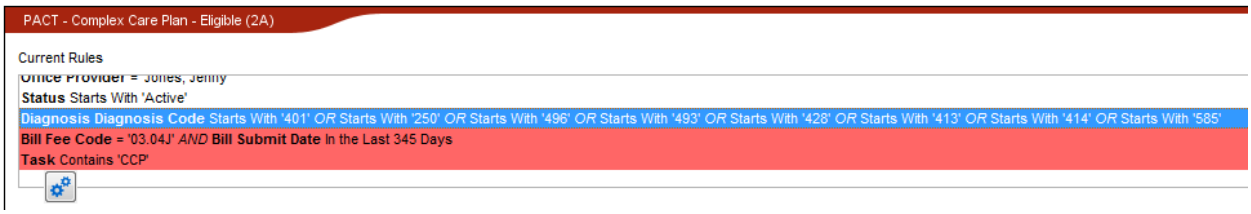
> **Important Note**: This query is only an example of potential combination that could be created. A clinical discussion should precede building and auctioning of the results based on the needs of the clinic patient population.

Patients Eligible for Complex Care Plan

Given the complexity of the Complex Care Plan eligibility it will require building and thoroughly testing all queries to capture all patients that are eligible. The rules for claiming the 03.04J are the patient must have two or more qualifying conditions, one from **Group A** and one from **Group B**, or two from **Group A**.

Group A	Group B
Hypertensive Disease (401) Diabetes Mellitus (250) Chronic Obstructive Pulmonary Disease (496) Asthma (493) Heart Failure (428) Ischemic Heart Disease (413 or 414) Chronic Renal Failure (585)	Mental Health Issues (290 thru 319) Obesity (278) Adult = BMI 40 or greater Child = 97 percentile Addictions (303-304) Tobacco (305.1)

CCP Eligible (2 Conditions Group A)



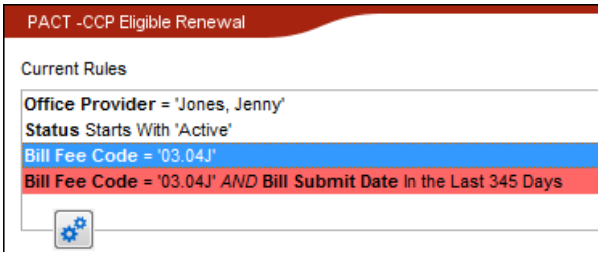
Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis Code Starts With '401 OR Starts With '250' OR Starts With '496' OR Starts With '493'…etc.
('Doesn't Match') Bill Fee Code = '03.04J' AND Submit Date in the Last 345 Days
('Doesn't Match') Task contains 'CCP'

Important Note: If Diagnostic codes are not in problem list, this query will fail. Patients may come up multiple times if more than 2 conditions and/or all the variations of 2 conditions. This applies to the query above and below

CCP Eligible (1 Condition from Group A and 1 Condition from Group B)

Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis Code Starts With '401 OR Starts With '250' OR Starts With '496' OR Starts With '493'…etc.
Diagnosis Code Starts With '29' OR Starts With '30' OR Starts '31' OR Starts With '278'…etc.
('Doesn't Match') Bill Fee Code = '03.04J' AND Submit Date in the Last 345 Days
('Doesn't Match') Task contains 'CCP'

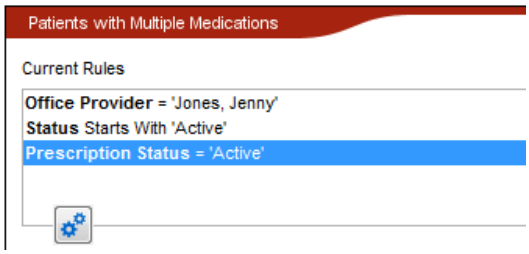
CCP Eligible – Annual Review/Renewals



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Bill fee code = 03.04J
('Doesn't Match') Bill Fee Code = '03.04J' AND Submit Date in the Last 345 Days

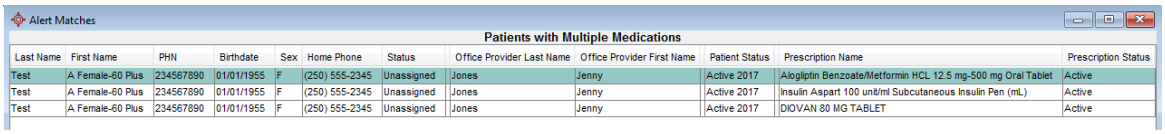
Patients with Multiple Medications

In order to target specific treatment condition the query example following could be further refined to specify which medications are of clinical focus.



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Prescription Status = 'Active'

Reporting output will show multiple line entries for active medication for each patient.



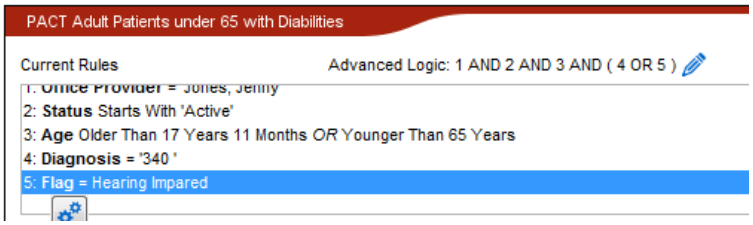
Last Name	First Name	PHN	Birthdate	Sex	Home Phone	Status	Office Provider Last Name	Office Provider First Name	Patient Status	Prescription Name	Prescription Status
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Jenny	Active 2017	Alogliptin Benzoate/Metformin HCL 12.5 mg-500 mg Oral Tablet	Active
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Jenny	Active 2017	Insulin Aspart 100 unit/ml Subcutaneous Insulin Pen (mL)	Active
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Jones	Jenny	Active 2017	DIOVAN 80 MG TABLET	Active

By exporting to a .csv (Excel, Calc) file further grouping and refining can be accomplished to produce a list of patient on multiple medication of interest. Should a clinic desire to put an indicator (e.g. Flag) on these patients, this can be accomplished individually by patient or selecting those with the 'Alert Matches'.

See Bulk/Batch Actions

Adult Patients under 65 with Disabilities

Any combination of disabilities could be built into a Query. In the example below advance logic is used to look for adult patients (18 – 64) that have either 'multiple sclerosis' or 'hearing impaired'.

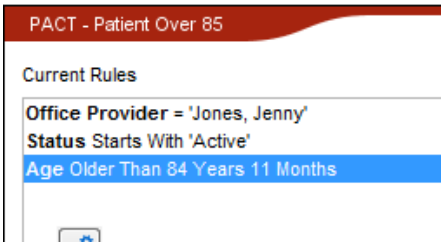


Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Age Older Than 17 Years 11 Months OR Younger Than 65 Years
Diagnosis = '340' OR
Flag = Hearing Impaired

With the query builder, the use of any combination or permutations from the patient's documented problem list, flag or both can be constructed.

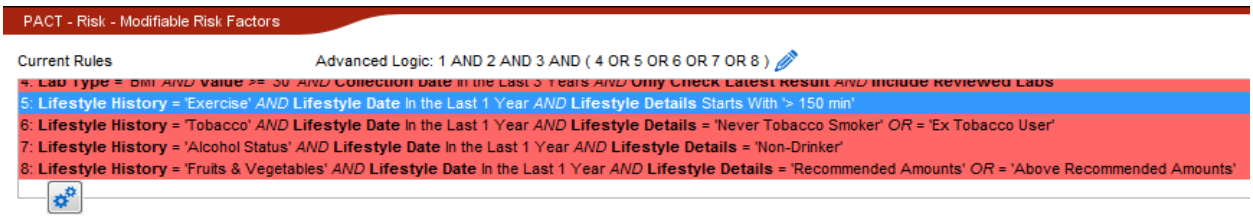
Risk Factors

Age > 85 or 90



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Age Older Than 84 Years 11 Months

Lifestyle/Modifiable Risk Factors



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Age Older Than 17 Years 11 Months
('Doesn't Match') Lab Type = 'BMI' AND Value >= '30' AND Collection Date in the Last 3 years AND Only Check Latest Result AND Include Reviewed Labs OR
('Doesn't Match') Lifestyle History = 'Exercise' AND Lifestyle Date in the Last 1 year AND Lifestyle Details Starts With '>150 min' OR
('Doesn't Match') Lifestyle History = 'Tobacco' AND Lifestyle Date in the Last 1 year AND Lifestyle Details = 'Never Tobacco Smoker' OR = 'Ex Tobacco User' OR
('Doesn't Match') Lifestyle History = 'Alcohol Status' AND Lifestyle Date in the Last 1 year AND Lifestyle Details = 'Non-Drinker' OR
('Doesn't Match') Lifestyle History = 'Fruits & Vegetables' AND Lifestyle Date in the Last 1 year AND Lifestyle Details = 'Recommended Amounts' OR = 'Above Recommended Amounts'

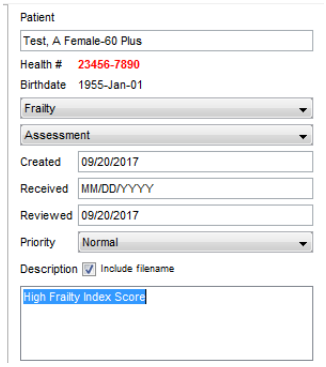
> **Important Note**: Query uses 'Advanced Logic' while assuming the use of custom Labs and standard Lifestyle History Band as previously explained . See MHB Option 2

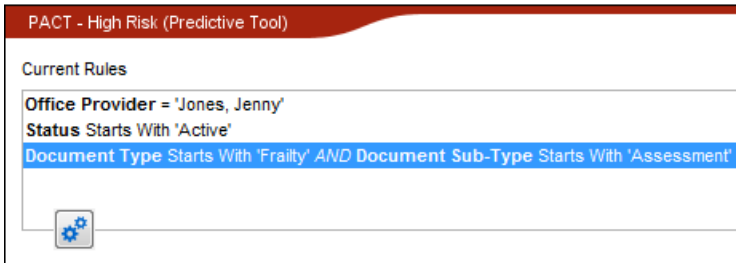
Social Risk Factors

A query to capture a patient's Social Risk Factors would depend on the method of information capture (E.g. homeless, no transportation, etc.). A scanned consistently named document, a custom 'History of Problem' (see Recording Complex Health Need) similar to 'Complex Health Needs' could potentially be captured (see Medical History Bands) or alternatively it could be captured in a custom 'Flag' (see Disease Management).

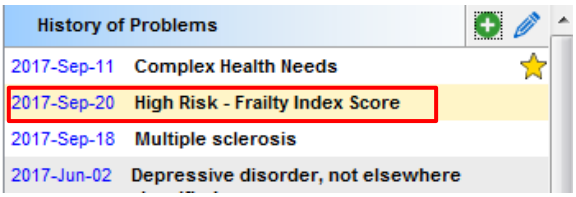
High Risk (using predictive risk assessment tool)

The presence of an assessment document (Type and Sub-Type) associated to the patient's medical record would be a good place to start looking for patient that might meet the 'high risk' criteria so they can be proactively identified and tracked effectively.





Based on a patient's assessment using a predictive risk assessment tool (e.g. frailty assessment) a custom Problem in a Medical History Band or Flag can be created and managed to indicate frailty.

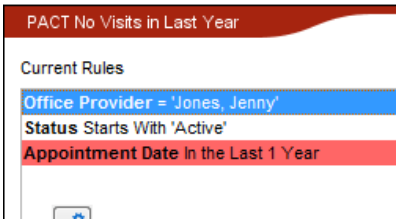


Utilization Parameters

Other patient data will be used to inform a team if a patient is appropriate for or due for care planning. Data that a team may use for this purpose includes:

- Visits:
    - Date since last visit. Searching for patients with chronic conditions or risk factors that have had a lapse since their last visit (e.g., one year) may represent patients due for care planning

No Visits to the Clinic in the Last Year



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
('Doesn't Match') Appointment Date in the Last 1 Year

Had a Care Plan in Past but Not in the Last Year

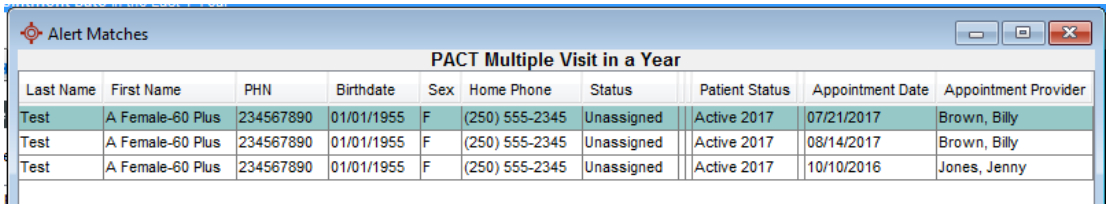
See query in previous section – CCP Eligible

- Number of patient visits to the clinic. This is searched from the number of appointments or visits. Some patients with many visits to the clinic (e.g., > 10/year) may assist the clinic in identifying patients with complex health needs

Many Visits (e.g. >10) in the Last Year

Accuro doesn't have a direct method to query count number of appointments that a patient has had in a year. However an exported file of each clinician's active patient with appointment dates can be exported to a CSV file and then utilizing functionality patient number of visits can be tabulated.

Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Appointment Date in the Last 1 Year



Last Name	First Name	PHN	Birthdate	Sex	Home Phone	Status	Patient Status	Appointment Date	Appointment Provider
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Active 2017	07/21/2017	Brown, Billy
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Active 2017	08/14/2017	Brown, Billy
Test	A Female-60 Plus	234567890	01/01/1955	F	(250) 555-2345	Unassigned	Active 2017	10/10/2016	Jones, Jenny

- Hospitalization and/or ER reports. These are external documents received at the clinic, usually as a fax/e-fax. In this case how these are indexed/named and attached to the chart matters. With consistent naming protocol, the number of hospital and/or ER reports can be found for a patient.

Hospitalization/ER visits (within the past year)

A similar approach as Social Risk Factors could be developed to capture this information. Another option could be if this information is captured by the clinic consistently and in a standardized manner as a 'document' this can be queried to identify these patients.

- Scanned documents: (See Scanned Documents)
  - Past care plans. If care plans are consistently named and linked in the patient's chart, past care plans can be found and as the date they are indexed can be determined, these can inform follow-up visits or follow-up care plans. The billing of the care plan can also be used to inform follow-up
  - Reports and referrals

- Home health services. Documenting in a consistent way which patients receive home health services would assist in identifying all these patients; some of which will represent patients with complex health needs.

Receiving Home Health Services

A similar approach as Social Risk Factors could be developed to capture this information.

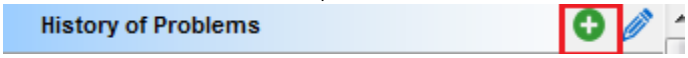
Recording "Complex Health Needs" in the EMR (Critical Step)

A critical step to monitor and follow-up with patients with complex health needs is to have one place in the EMR where the term "complex health needs" is recorded and is searchable; it is also beneficial if it is searchable for your quality improvement measures. As a clinic, determine and agree on **one place** it will be recorded. It is recommended that this be in the:

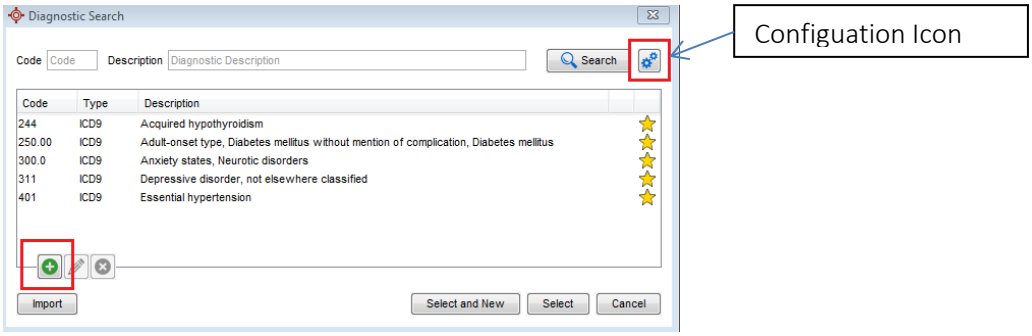
- Problem List (The term "Complex Health" may need to be added to the Problem List master list of terms by the clinic's EMR administrator.) See Sample Problem Lists
- Profile/Medical History

How to create a custom 'Problem' for Complex Health Needs

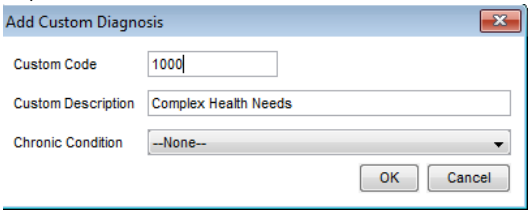
1. Click on the Green Plus sign on the ribbon of the 'History of Problems' Medical History Band in the Encounter Note tab of a patient record.



2. A 'Diagnotic Search' window opens clicking on the second green plus icon (bottom left)

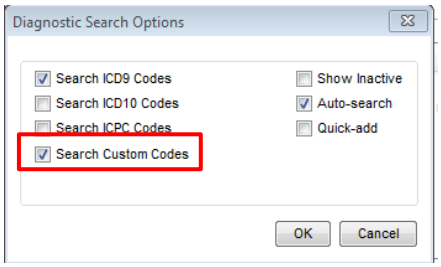


3. This opens a 'Add Custom Diagnosis Window. Type in the desired 'Custom Code' and 'Custom Description' and click OK



4. Finally back on the 'Diagnostic Search' Window click on the 'gears' configuration icon (see step two above).

5. This opens the 'Diagnostic Search Option' window. Ensure the 'Search Custom Codes' checkbox is checked and click OK.



The 'Complex Health Needs' patient problem is now available to add to patient **History of Problems** search by the custom code or description. Similarly a custom patient **Flag** could be created for display in the patient's demographic bar. This addition might be helpful for staff to see that do not have the EMR access rights to look at the Encounter Note in the patient's chart. See Problem Lists

Prepare Phase

Append patient assessment information to the record

Some patients identified for care planning may have seen other providers and had various diagnostic, lab or other tests completed that may be relevant to the care planning process. Some of this information might be available on NetCare. This potentially better practice suggests that someone from the care team looks at NetCare for relevant information and adds it to the EMR in a standardized way.

See Foundation for Success - Commitment to Standardization in the EMR

Populate care plan template with known information in advance of the encounter

Some EMR data can be entered once in the patient's chart and then flow to the care plan (mapped). By charting this way team members will save time when looking for information and it will take less time to create the care plan and there will be less chance of data discrepancies and errors. Data that can be mapped in most EMR's includes:

- Emergency Contact Info
- Current Problems
- Medications – Current (OTC & Rx) & Failed
- Allergies
- Family Medical History
- Significant Historical Medical Events
- Test & Treatments
- Labs
- Diagnostic Imaging
- Modifiable Risk Factors including Tobacco, Alcohol, Exercise, Obesity (BMI), Diet of Fruit & Vegetables

Other data that is less likely to be mapped in most EMRs should be charted in a consistent way so that the team knows where to enter it and where to find it in the record when working on the care plan with the patient. Such data includes:

- Care Team Members
- Medical Team Members
- Social History (Risk Factors)
- Frailty Identifier
- Medical and Assistive device
- Personal Care Directives
- Goals of Care
- Follow ups

NOTE: How and where you capture information in the EMR will determine the amount of information that can be mapped/linked to the Care Planning Template (see appendices).

Please refer to individual EMR Guide for details on pre-populating the template

http://www.topalbertadoctors.org/tools--resources/emrsupports/#vendor

Generate lab and/or diagnostic imaging requisitions in advance of the encounter

EMRs have requisitions for laboratory and diagnostic imaging that are generated from the system. If your team is not using this feature, this is an opportunity to begin using this feature to proactively generate and provide requisitions to patients in advance of appointments.

Some EMRs have built in capabilities to e-fax directly from the system to the lab or imaging centre of the patient's choice. There are also a number of third party software options that allow for secure electronic transmission of requisitions.

Plan Phase

Documenting in the care planning template

In the prepare phase, the care plan template activities focused on populating the template before the patient arrives for their appointment. In this section, the change is the population of the template during the appointment. These sections include:

- Medical goals and targets
- Patient goals (health and life)
- Medical action plan
- Patient self-management action plan

- Potential barriers and coping plan
- Follow-up plan (who, when what, next visit)
- other identified care team members outside of the clinic or PCN involved in the patient's care See Appendix A

Some teams will already be used to charting during the appointment. The goal is to have the information in the template by the end of the appointment with the patient so that you can print a copy for the patient.

It is suggested that you check settings on your EMR to see if/how you can print in a font size appropriate for the patient.

Set a reminder in your EMR for follow up appointments

Most EMRs have a function to set a reminder to the appropriate staff member to call a patient in for follow up. The patient should be aware of the follow up date based on their care planning follow up plan but many will still want or need a follow up call.

Many clinics already use this function in some capacity but there may be additional considerations for care planning that could be discussed.

Manage Phase

Maintaining the care planning document over time

As patients come in for follow up appointments there will be a need to add, delete and change information in the care planning template. Each EMR will handle this task in a slightly different way and you will need to become familiar with how your EMR handles this and what is optimal for you and your team. Over time, you may wish to start a new template which may be based on time or the volume of change over time for each patient.

Creating reminders for planned care interventions

Most EMRs have a reminder system where you can be reminded during the appointment that a care intervention is due or where you can create searches for certain interventions overdue/coming due.

Standardizing processes for referral tracking

Most clinics have processes for tracking referrals to specialists, programs and services. Participation in PaCT may be an opportunity to review processes and examine some of the features in your EMR for more effective referral tracking.

Measurement

While implementing the Patient's Medical Home, a practice or team will not know how they are doing unless they measure for improvement. Process measures reflect the things that are done in the practice and how the systems are operating. Example measures are:

Confirmation/Validation Rate[4]

It is useful is to measure how often the team is confirming the patient demographic information (address and phone) and physician attachment. When a clinic is new to the process of patient confirmation it can be measured in the search tool.

Process Measure(s)

For example a team that wants to measure how they did in a week:

patients confirmed this week / # patient visits this week x 100 = confirmation rate (%)

A clinic may also have an expectation over a period of time and can determine if the validation goals are being met. For example if a practice has an expectation that their validation rate over a 3 month period should be 95% the formula would be:

patients confirmed in the last 3 months / # patient visits in the last 3 months x 100 = confirmed rate (%)

Outcomes Measure (3 years)

Overtime a clinic can use an agreed upon timeframe (e.g. 3 yrs.) to determine that the confirmation of attachment percentage to their most responsible primary provider and team has been sustained.

patients confirmed in the 3 years / # patient visits in the 3 months x 100 = confirmed rate (%)

For all the above calculation by adding all the individual primary provider percentages a comprehensive clinic's percentage for confirmation can also be determined.

Appendix D: Calculating Panel and Clinic Confirmation Rates Worksheet

[4] When patient demographics and primary provider relationship are checked at the clinic that is called confirmation even though the box in the EMR may be called "verified" or "validated". A confirmed patient panel is produced at the clinic through this process. The Central Patient Attachment Registry will **verify** the patients on the confirmed panel to identify only those patients attached uniquely to that primary provider.

Screening Rate Based on Completed Screens

A practice will also find that they are able to measure rates for preventive screening care. Measuring completed screens looks for completed results. The generic equation is:

patients in eligible population with a
result during the screening interval [+] x 100 = screening rate (%)
patients in the eligible population*

[+] The screening interval is the time frame during which the screening maneuver should be done

* The eligible population would include all the active, paneled patients for a provider whether they came into the clinic or not as all rates are calculated over the paneled population.

Example 1: Dr. Brown wishes to calculate the completed blood pressure screening rate for her active paneled adult patients. Blood pressure should be measured annually (ASaP)

active adult patients* (18 +) with a BP result in the last year x 100 = BP screening rate (%)
active adult patients* (18 +)
* Attached to Dr. Brown in the EMR

Example 2: Dr. Brown wishes to calculate the completed diabetes screening rate for her active adult paneled patients. Diabetes screening is:

- appropriate for adults 40 +
- recommended once every 5 years
- completed with a fasting glucose, hemoglobin A1c result or a diabetes risk calculator score

active adult* patients (40 +) with a fasting glucose
OR HbA1c OR diabetes risk score in the last 5 years x 100 = Diabetes Screening Rate (%)
active adult patients* (40+)

* Attached to Dr. Brown in the EMR

Calculating a Screening Rate Based on Offers of Screening Care

Practitioners participating in the Alberta Screening and Prevention improvement project will include both completed screens and offers of the screen. In this case, to measure with the EMR there must be a place that **declined**, **deferred** and **exemptions** for screening are reliably recorded. In this case the generic equation is:

active adult patients with an offer of screen
or completed screen during screening interval x 100 = screening rate (%)
active adult patients

Appendix D: Calculating Panel and Clinic Confirmation Rates Worksheet

It is recommended to use the chart audit methodology[5] instead of EMR measures if the offers of screening care are unable to be searched in the EMR.

Disease Management Rate

EMRs are capable of measuring around disease management parameters provided the information is entered in a place where it can be searched.

Example:

Dr. Brown wishes to measure how many of her active paneled patients with diabetes have an HbA1c result below 7% in the last year.

Generic equation:

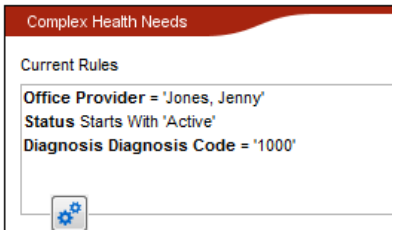
active patients* with diabetes[+] with an HbA1c result below 7% in the last year x 100 = rate (%)
active patients* with diabetes[+]

[+] Patients identified as having diabetes when Diabetes is listed as an active problem in their Problem List

Care Planning

For clinics participating in PaCT, progress on identification and care plans completed may wish to collect supporting measures. In this case the clinic may wish to measure how many patients have been identified as having a complex health needs and, of those patients, how many were offered care plans with the new process on a monthly basis. To do this the two monthly searches would be:

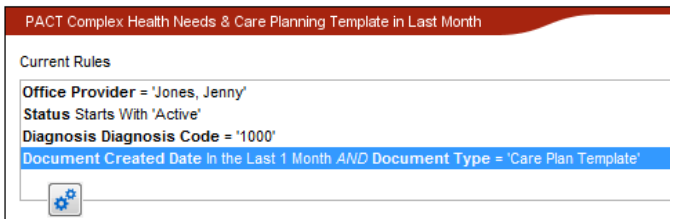
1. number of patients with complex health needs



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis Diagnosis Code = '1000'

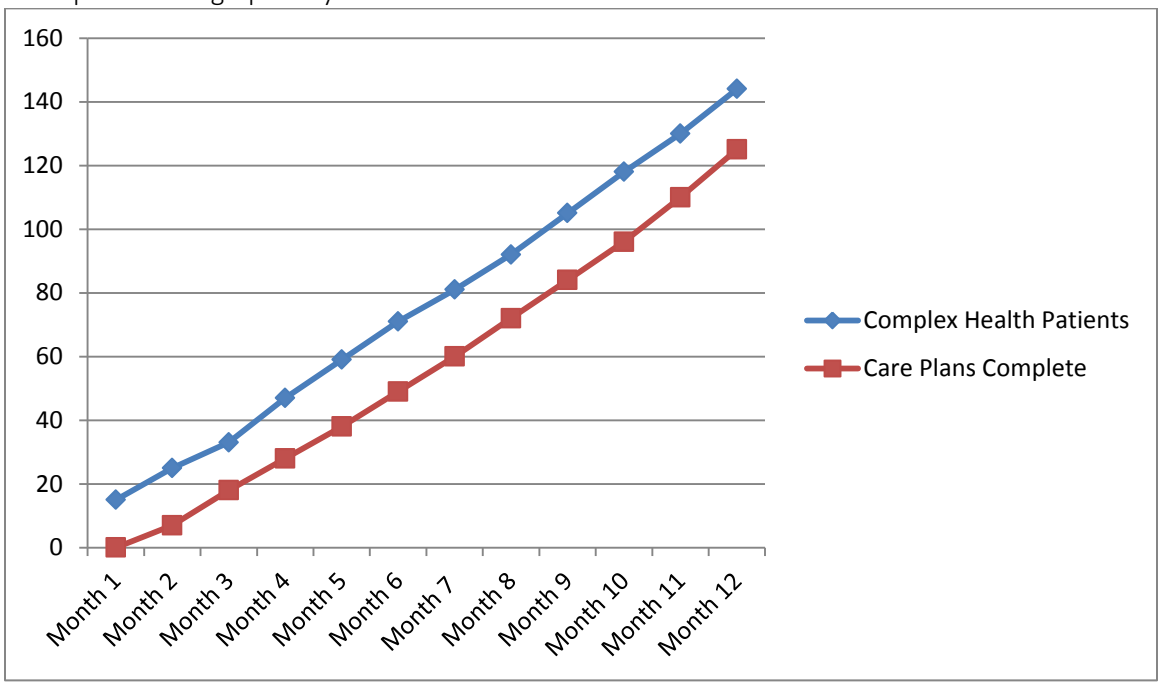
2. number of patients with complex health needs with a care planning template

[5] See ASaP EMR Chart Review Instructions: http://www.topalbertadoctors.org/file/asap-chart-review-instructions-emr.pdf



Office Provider = 'Jones, Jenny'
Status Starts With 'Active'
Diagnosis Diagnosis Code = '1000'
Document Created Date in the Last 1 Month AND Document Type = 'Care Plan Template'

An improvement graph may look like this:



Appendix A: Care Planning Template(with prompts)

Download the most up to date template at:
http://www.topalbertadoctors.org/pact/pactcommunicationtoolkit/

Patient Name:	Preferred Name:
AB Health Card No.:	Date of Birth:
Primary Care Provider:	Primary Provider Contact No.:
Emergency Contact:	Contact No.:

This document was created on: <INSERT DATE> and last updated on: <UPDATE DATE>

Introduction to Your Care Plan and Care Planning Visit

During the course of this visit, this document (called a care plan) will be filled out by you and your health care team. A care plan is useful when you have several people involved in your care or you have ongoing health conditions. It helps keep everyone on the 'same page' as to what matters to you (your goals, values and preferences). It also helps keep track of what you and your healthcare team have planned or are working on for the next 12 months to improve your health and wellbeing.

It is designed to help everyone involved in your health to know:


What is important to you


Your goals for the next 12 months


About your health conditions


The healthcare and support you need

PART A: Medical Summary

In order to better understand your health conditions and how you are currently managing them, questions about your health, medications, medical history, and treatments, etc. are discussed in the section below.

Current Health Conditions

Please name your current health conditions. What do you know about them? What more would you like to know about them?

Impact of Health Conditions

How do your health conditions impact you, your daily life and the things that are important to you (e.g., medication cost, personal and work obligations, transportation)?

Health Target(s)

Specific tests are used to help understand whether a health condition is well managed. Understanding where your numbers are now and what you can work towards will help ensure you can achieve what is important to you.

Test Results	My Current Number	Where I Need to be
BMI (height and weight calculation)		
Blood Pressure (BP)		
<add new test results>		

Current Medications

Please name the medications you are currently taking. How and why do you take them?

Medication	Dosage	When I Take It	What I Take it For

Past Medications

Are there any medications that you have taken in the past that you want your doctor to be aware of (e.g., failed medications or cases where one medication was replaced with another medication)?

Patient Name: _____ *Preferred Name:* _____

Alberta Health Care No.: _____ *Date of Birth:* _____

Allergies and Intolerances

Your records show that the following are your allergies and intolerances. Is there anything that should be added?

No Known Allergies ☐	Reaction	Severity
		Choose an item.
		Choose an item.
		Choose an item.

Family Medical History

In previous appointments you have shared the following family medical history. Is there anything that should be added?

Condition(s)	Relation

Significant Historical Medical Events

Your records show the following history of medical events. Is there anything that should be added? Include surgical history, hospitalizations or emergency visits in the last 2 years.

Medical Event	Date

Other Team Members Seen for Tests and / or Treatments

What other tests or treatments do you receive from health team members outside of this clinic? Include all tests and treatments and the corresponding health care team member information e.g., specialists, chiropractor, physiotherapist, etc.

Name of Test or Treatment	Frequency and/or Date	Health Team Member Name	Contact Number

Modifiable Lifestyle or Risk Factors

Specific lifestyle or risk factors, such as tobacco use, regular physical activity and diet can impact a person's health. Is there anything that you would like to share with me about what you are doing well in these areas or what you would like to improve?

Areas where doing well:	Areas for improvement:

What is your smoking status?

Non-smoker ☐ Ex-smoker ☐ Smoker with desire to quit ☐ Smoker actively quitting ☐
Smoker with no plans to quit at this time ☐ Other ☐ Specify:

Comments: *(e.g., if ex-smoker, length of time since quitting, type of product smoked)*

Medical and Assistive Devices

Are you currently using any medical or assistive devices?

None ☐ Wheelchair ☐ Oxygen ☐ Other ☐ Specify:

Advance Care Planning

Have you thought about, talked about with family and friends and written down wishes for your health care in the event that you are incapable of consenting to or refusing treatment or other care? Would you be interested to have guidance or assistance to prepare a personal care directive?

I have a personal care directive Yes ☐ No ☐	I have a Power of Attorney Yes ☐ No ☐
Do you have your goals of care documented? Yes ☐ No ☐	

Patient Name: _____ *Preferred Name:* _____

Alberta Health Care No.: _____ *Date of Birth:* _____

Comments:

Insert relevant information such as goals of the care designation, power of attorney contact information, etc.

PART B: Social History

Now that you have provided your medical history, this section captures other aspects of your life that may impact your ability to manage your health such as your finances, housing, and support systems. Is there anything in those areas that are impacting your health?

Do you ever have difficulty making ends meet (paying your bills) at the end of the month? Is there anything about your current employment situation or finances that would impact your health and wellbeing? Who covers the cost of medications and other services?

Is there anything you would like your care team to know about your housing situation? Do you feel safe where you live?

Do you feel you have enough support at this time to manage your health? Can you tell me more about your supports? Are there any community resources or services that you use (e.g., transportation services, food services, group support meetings, etc.)?

PART C: Goals and Action Plan

The section below builds on the information you've provided above by capturing some potential goals and actions that can be taken to better manage your health and improve your quality of life.

What you want to achieve and why it is important to you

Please share what matters to you personally and what you want to achieve so you have the best quality of life and health outcomes.

e.g., I want to have my diabetes managed (A1C below 8) so I can travel to Ottawa in the fall for my daughter's wedding.

Where you need to start

There are a number of areas you can work on to achieve your goal(s) listed above. The list below helps to determine what area is the highest priority for you.

Priority (1=lowest priority; 5=highest priority. The same number can be assigned more than once.)

1. Monitor and manage symptoms (e.g., pain, dizziness, weakness, blood sugars)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A
2. Engage in specific treatment activities (e.g., physiotherapy, foot care, mental health, wounds)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A
3. Attend services and appointments (e.g., lab work, specialist, education sessions)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A
4. Monitor and manage triggers and risk factors (e.g., alcohol, tobacco, recreational drugs, stress)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A
5. Monitor and manage healthy lifestyle factors (e.g., physical activity, nutrition, mood, social support)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A
6. Manage medications (e.g., right dose, side effects, medication review)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A

Action Plan

What specific actions you need to take to achieve your goal(s)
(SMART Goal – Specific, Measurable, Attainable, Realistic, Timely):

e.g., I will work on monitoring and managing my symptoms. I will do this by checking my blood sugar every morning before breakfast. I write down my result in my log book so I can work towards my A1C coming down and be able to go to my daughter's wedding.

Patient Name: _____ *Preferred Name:* _____

Alberta Health Care No.: _____ *Date of Birth:* _____

	Is there anything you think of that might get in your way? How could you work around these things?
	e.g., I will need to set a regular reminder on my cell phone to remember to check my blood sugar each morning before breakfast and I will put my log book beside my glucometer so I remember to write my numbers down.
	How confident are you that you can achieve the above goal and action plan?

1	2	3	4	5	6	7	8	9	10
C	C	C	C	C	C	C	C	C	C
Low				Medium					High

We (the physician and patient/agent) have discussed this care plan and the patient/patient agent has received a written copy of it. A similar document has not been completed with another physician in the past twelve months.

Date (yyyy/mm/dd)	Patient and/or Agent Name	Patient or Agent Signature
Date (yyyy/mm/dd)	Physician Name	Physician Signature

Appendix B: Sample Common Problem Lists/ Diagnostic Codes Lists for Primary Care for standardized EMR data capture

These examples were from real clinics or PCNs

Example 1: TOP 32 CODES

SYSTEM	CODE	DIAGNOSIS
Endocrine	250	Diabetes
	244	Thyroid (hypo)
	279	Obesity
	272	⬆ Lipids
Neurological	340	M.S
	345	Epilepsy
	346	Migraines
	434	Stroke
	780.5	Sleep Disturbance
MSK	723	Cervical Disorder
	715	OsteoArthritis
	714	Other Inflammatory Polyarthropathy (Rheumatoid Arthritis)
	729	Fibromyalgia
	724	Back
	781	Chronic Pain
Psycho	311	Depression
	300.0	Anxiety
	290	Dementia
Respiratory	496	COPD
	493	Asthma
CVS	428	Health Failure
	427	Arrythmia
	414	Coronary Artery
	401	Hypertension
	443	Peripheral Vascular Disease
GI	564	Functional GI Disorders
Renal	585	Chronic Renal Failure
OB/GYN	628	Infertility
	626	Menstrual Disorders
	627	Menopausal Disorders
ADDICTIONS	305.1	Smoking Dependency Syndrome
	303	Alcohol Dependency Syndrome

Created by the Red Deer PCN

Example 2:

Sample Standardized Problem List (simplified without using ICD9 codes)		
Addiction	Depression	Obesity
ADHD	Diabetes	Obstructive Sleep Apnea
Alcoholism	Down's Syndrome	OCD
Alzheimer's Disease	Eating Disorder	ODD
Amputation	Epilepsy	Other
Anemia	Erectile Dysfunction	Panic Disorder
Aneurysm	GERD	Paralyzed
Angina	Glucose Intolerance	Paraplegia
Anxiety	Gluten Intolerance	Parkinson's Disease
Asthma	Grave's Disease	Personality Disorder
Autism	Hemophilia	Phobia
Bell's Palsy	Hepatitis	PMDD
Bipolar Disorder	Hepatitis B	PMS
Blindness	Hepatitis C	Psychosis
Borderline Personality Disorder	High Blood Pressure	PTSD
Cancer	High Cholesterol	Reactive Attachment Disorder
Celiac Disease	HIV	Schizoaffective
Cerebral Palsy	HPV	Schizophrenia
Chronic Pain	Insomnia	Seasonal Affective Disorder
Cluster B Personality Disorder	Learning Difficulties	Seizure Disorder
COPD	Learning Disability	Sensory Processing Disorder
Crohn's Disease	Major Depressive Disorder	Tourette Syndrome
Dementia	Mood Disorder	

Created by Edmonton Oliver PCN

Appendix C: Lists of scanned document index words/keywords

These examples are from real clinics.

Example 1:

- ALLERGIST
- Appointment
- Appt Confirmation
- CARDIOLOGY
- Care Plan
- Care Plan - Signed
- Chart
- Colonoscopy Report
- Colposcopy Report
- Consult Letter
- CT Scan
- DERMATOLOGY
- Discharge Summary
- Driver's Medical
- ECG Graph
- ECG Report
- ENDOCRINOLOGY
- ENT
- Forms
- GASTRO
- GEN SURGERY
- Total Hysterectomy
- INTERNAL MED
- Lab
- Lab – Provincial
- Mammogram
- MRI
- Neurology
- Neurosurgery
- Notice of Admission
- Notice of Discharge
- OBGYN
- OPD Sheet
- Ophthalmology
- OR Report
- ORTHO
- Pap Report
- Parking Placard
- PEDIATRICS
- PLASTICS
- Pre-op Medical
- Referral
- Report
- Requisition
- RHEUMATOLOGY
- Rx Adaptation
- Rx Refill
- Ultrasound
- UROLOGY
- Vascular
- WCB
- Xray

Example 2:

- Admit
- Air Contrast
- ALT
- Anti-HIV
- Anti-Nuclear (ANA)
- Appointment Notice
- Attending physical statement
- Audiology Report
- Beta HCG
- Biopsy
- Blood Culture
- Blood Type
- Blue Cross Authorization
- Breast Ultrasound
- Body Fluid Culture
- Bone Density
- Bonnyville Cancer Centre
- Bubble Pack Authorization
- C-reactive Protein
- Care Plan
- Care Plan - Signed
- Cat Scan
- CEA
- Cervical Culture
- Chart Notes
- Chart Request Acknowledgement
- Chemistry
- Child Welfare Medical
- Chlamydia
- Claims Management Program
- Colonoscopy Report
- Colposcopy Report
- Consult
- Creatinine
- Critical Care Line
- Cross Cancer
- Cytology Report
- Diabetic Consult
- Discharge Instructions
- Discharge Summary
- Double Contrast
- Driver's Medical
- ECG
- Echocardiogram
- EA screen
- Endoscopy
- Ferritin
- Free testosterone
- Gastroscopy
- GC Probe
- Gynecological Cytology Report
- HBA1C
- Hematology
- Hepatitis
- Home Care
- Total Hysterectomy
- Imaging
- Influenza
- INR
- Iron and TIBC
- Lipid Testing
- Mammogram
- Medical release and report
- Medications
- Mental Health
- Microbiology
- Millard Health WCB
- MRI
- MRSA
- Newborn Metabolic Screen
- NIHB Drug Exception
- No Show
- Occult Blood
- Oncology Imaging
- OPD
- Operative Report
- Ova & Parasite
- Pap
- Pathologist Comment
- Patient Photo
- Perinatal
- Phenytoin
- Physician Admit Advice
- Pre-op medical
- Prenatal
- PSA
- Psychogeriatric Consult
- RAAPID North Patient Summary
- RAH
- Rapid Plasma Reagin Test
- Release of information
- Rx adaptation
- Rx request
- Serum Protein Elect.
- Slick
- Sputum Culture
- Stool Culture
- Superficial Culture
- Surgical Pathology Report
- Syphilis
- TB Update
- Throat culture
- Tom Baker Cancer Centre
- Troponin
- TSH
- UAH
- Ultra Sound
- Urethral Culture
- Urine Microalbumin
- Vaginosis Screen
- Vital Aire
- VRE
- WCB
- Wound Culture
- X-ray

Appendix D: Calculating Panel and Clinic Confirmation Rates Worksheet

Calculating Panel and Clinic Confirmation Rates Worksheet

Confirmation Rates for Dr. ______________________

3 Month Confirmation

Number of patients confirmed in last 3 months / Number of Patients seen in last 3 months ________ X 100 = %

Panel Confirmation

Number of patients confirmed in last 3 years / Number of Patients seen in last 3 years ________ X 100 = %

Confirmation Rates for Dr. ______________________

3 Month Confirmation

Number of patients confirmed in last 3 months / Number of Patients seen in last 3 months ________ X 100 = %

Panel Confirmation

Number of patients confirmed in last 3 years / Number of Patients seen in last 3 years ________ X 100 = %

Confirmation Rates for Dr. ______________________

3 Month Confirmation

Number of patients confirmed in last 3 months / Number of Patients seen in last 3 months ________ X 100 = %

Panel Confirmation

Number of patients confirmed in last 3 years / Number of Patients seen in last 3 years ________ X 100 = %

Confirmation Rates for Dr. ______________________

3 Month Confirmation

Number of patients confirmed in last 3 months / Number of Patients seen in last 3 months ________ X 100 = %

Panel Confirmation

Number of patients confirmed in last 3 years / Number of Patients seen in last 3 years ________ X 100 = %

Clinic Confirmation Rate (All Physicians)

3 Month Clinic Confirmation

Number of patients verified in last 3 months by all physicians in the clinic / Number of Patients seen in last 3 months by all physicians in the clinic _____ X 100 = %

Clinic Panel Confirmation

Number of patients verified in last 3 years by all physicians in the clinic / Number of Patients seen in last 3 years by all physicians in the clinic _____ X 100 = %

Date: ______________________________

* For Panel Confirmation Rates, use 3 years or date since practice opened if less than 3 years)*

If validating every visit you can pull this weekly or monthly. If validating every 6 months or yearly, then change the 3 month interval to what your interval is.

January 2017

Created by Highlands PCN

Appendix E - Accuro Hot Keys List

Keyboard Key	Function
F1	Patient Search
F2	Provider Management
F3	Quick Patient Summary (can also use Ctrl+F3)
F4	Quick Patient Appointments View
F5	Documents Previewer
F6	New Patient
F7	Patient Tasks
F8	Patient Status History
F9	Chart Sheet
F10	N/A
F11	Referral Letter
F12	Generate date/time stamp in EMR Letters/Clinical Notes
ALT+F2	Address Book
ALT+F4	Close/Exit
ALT+F12	Hide Screen
ALT+Home icon	Opens Home in separate window
ALT+Scheduler icon	Opens Scheduler in a separate window
ALT+Traffic icon	Open Traffic in a separate window
ALT+Documents icon	Opens Documents in a separate window
ALT+Claims icon	Opens Claims in a separate window
ALT+EMR icon	Opens EMR in a separate window
CTRL+F1	Open User Guide
CTRL+F3	New Patient Summary
CTRL+F10	Quick Patient Action Window
CTRL+F11	Adv. Letter
CTRL+A	Select All
CTRL+B	New Bill
CTRL+D	Cancel Appointment
CTRL+I	Find Invoice
CTRL+K	Find Claim ID
CTRL+L	Book on Waitlist
CTRL+P	New Procedure
CTRL+Q	Quit
CTRL+R	Reporting
CTRL+S	Create Appointment
CTRL+1	Home
CTRL+2	Scheduler
CTRL+3	Patient
CTRL+4	Documents
CTRL+5	Claims
CTRL+6	EMR
CTRL+7	Letters
CTRL+8	Waitlist
CTRL+9	-
CTRL+ALT+C	Calculator
CTRL+  (in Scheduler)	CSV Export of the Day Sheet

Appendix F - High Value Efficiency Tips

1. Clinic engaged conversation on Workflow (agreed upon and documented)
2. Non-electronic Documents – Develop Keyword List
    - clinic discussion and agreement – standardization
    - agreed upon but can be managed for ease by user ID
3. Customized Demographics Bar
    - Add additional information
    - Add colours
    - Add Flags (staff versus physician)
4. Clickable Words (template editor)

Recommended Accuro Help files:

- Clickable Words
- Clickable Words in EMR Notes (Tech Tuesday #25)

5. Effective use of Quick Action Buttons (bottom of desktop)-customize to user needs
    - Frequently used items
    - Examples: i.e Framingham calc, e-Forms/Templates, Template Editor

• Bottom - Standard

Recommended Accuro Help files:

- Set up the Action Bar

6. Use of Macros (don't work everywhere – i.e. MHB or Lab Order #)
    - Booking Appointments, Templates, Tasks, Notes, Messages, etc.
    - Macros available for Office or Individuals

Recommended Accuro Help files:

- Macros

7. Use of Footnotes as non-urgent alerts
8. Explore User preferences/settings (customize based on individual needs)

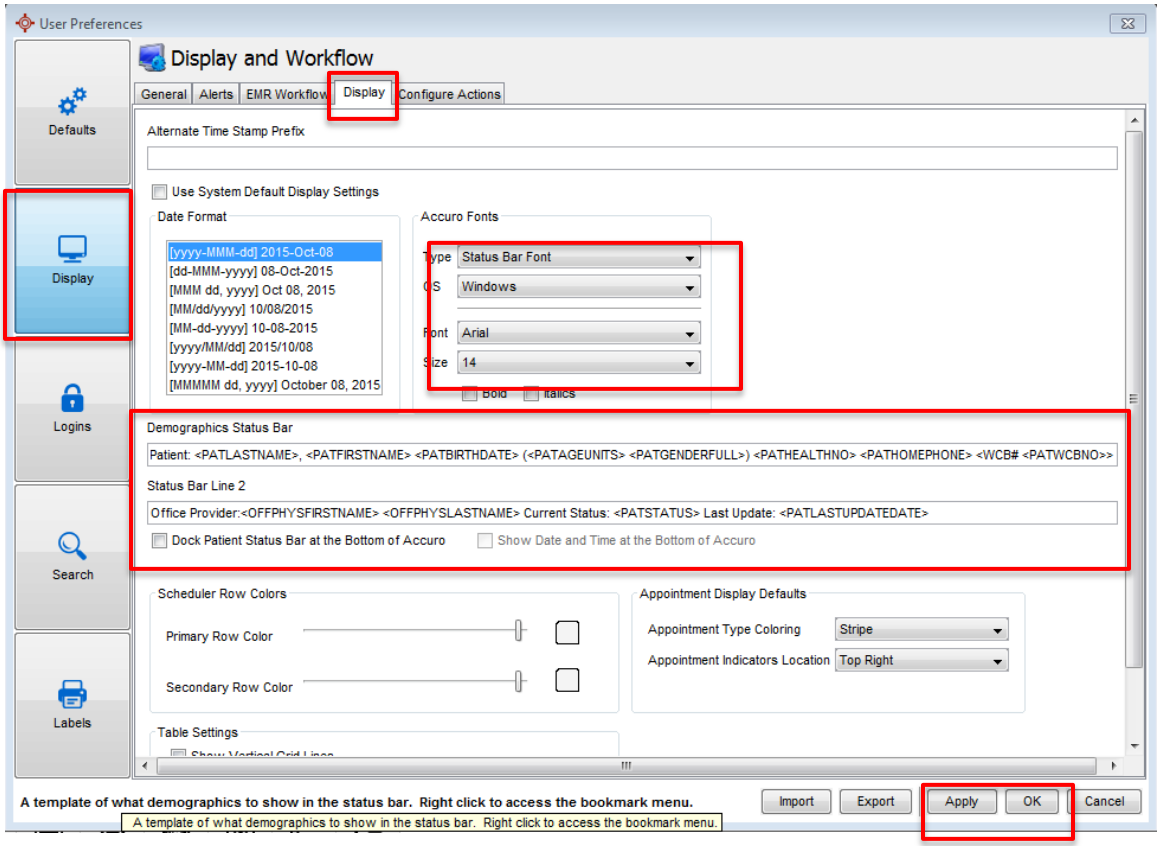
Demographic Status Bar – Customization

Patient demographics are critical baseline pieces of data required for billing, identifying patients, filling out forms, and contacting patients. This information is used every day. It is advisable for front staff performing patient check-in to customize the Demographic Status Bar to include the date the patient information was last updated.

Steps:

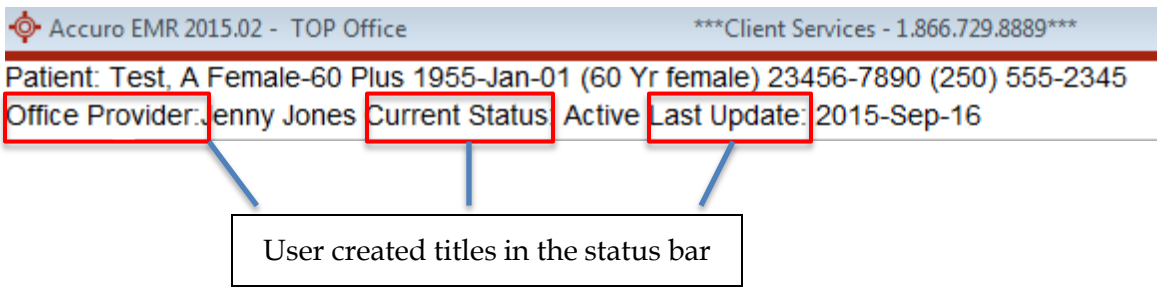
1. Click File, User Preferences
2. Go to the Display Area (tile on left).

3. Click on the tab labeled **Display**. In the middle of the screen is a **Demographic Status Bar** with tags like <OFFPHYSFIRSTNAME> listed. Each of these tags represents a field that will show in your patient bar. Labels can also be added.



4. In the 2 long text fields, delete any tags (the <…> words) the user does not want displayed.
5. Any available tags can be added in by Right Clicking the text field, revealing a selection list of all of the patient demographic fields. Click on the desired field, and it inserts the tag in to the line where the cursor is currently active.
6. Next change the font size and font to your preference – Change the Type to **Status Bar** (this does not allow font size adjustment in the rest of the application, just the font in the patient bar).
7. To ensure new additions are saved: click **Apply** and **OK** to save your changes.

Example: Demographic Status Bar

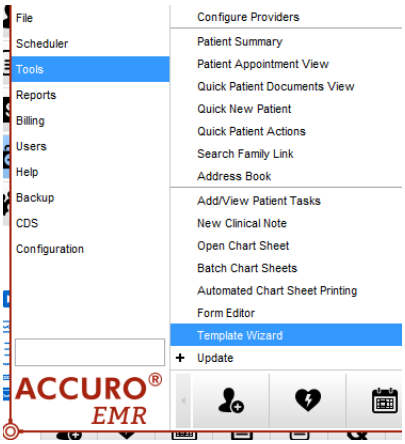


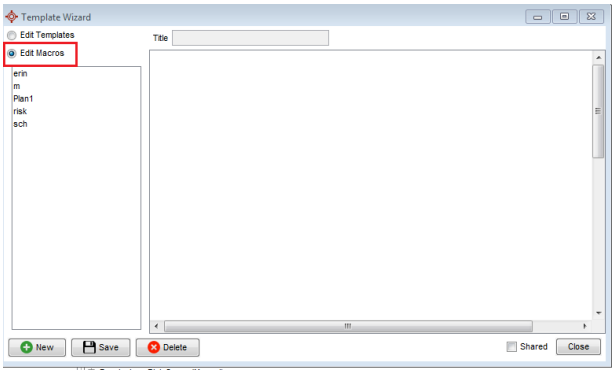
Macros

Use the Macros feature in Accuro to create shortcuts for repetitive text. Macros enable the user to save text and phrases they use regularly under a name. When you select macros and then the name all the text is automatically inserted into your note or letter.

This is an excellent time saving device for all those phrases and notes that you use regularly and would rather not have to type out time after time.

In order to add, modify or delete **Macros**, they are accessed through the **Tools** menu.





Recommended Accuro Help files:

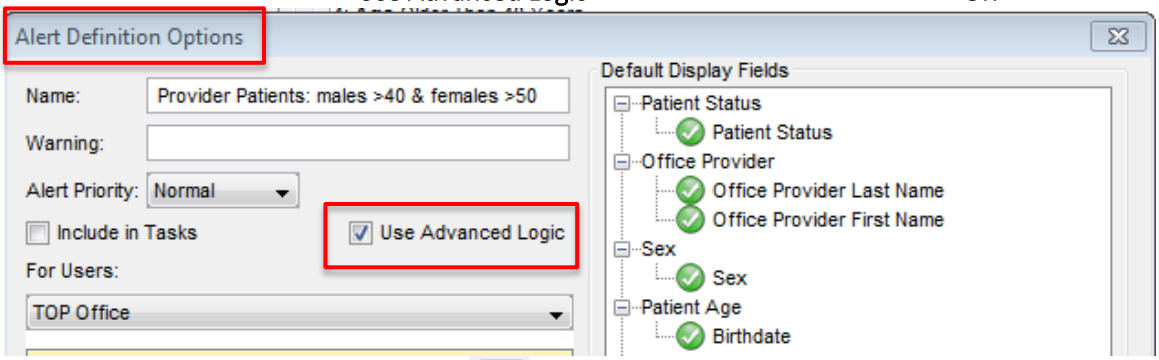
- Macros
- Macros within Macros (Tech Tuesday #26)
- Save Typing with Macros (Tech Tuesday #91)
- Using Macros in Forms

Query Builder (Alerts)-Example of Advance Logic

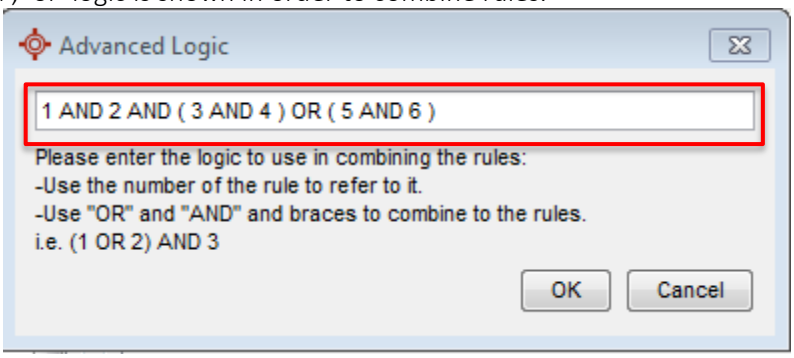
The Query Builder (Alerts) reporting tool in Accuro is capable of creating queries that are as complex as required. This requires a clear understanding of 'and', 'or' and 'not' (in Accuro – 'Doesn't Match') logic.

In order to access this advanced logic functionality when inside the Query Builder, click on the **Options** button, which opens the **Alerts Definition Options** window.

In this window make sure the **Use Advanced Logic** box is checked and click on the **OK** button.

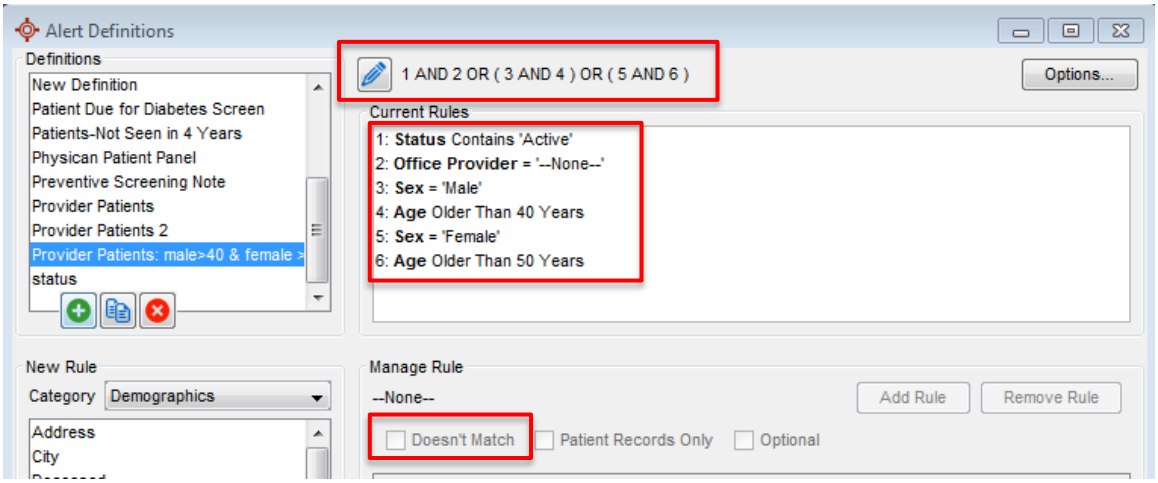


In the **Alert Definitions** window a pencil  icon appears at the top of the page. Clicking on this icon opens the **Advanced Logic** window show the current query as build. Instruction on how to format and use the 'and', 'or' logic is shown in order to combine rules.



The example below shows the logic for: 'All Active Patients' with 'Office Provider = None' for 'Males over 40' and 'Females over 50' years of age. This report would be a good process check to indicate those patients eligible for the Diabetes Screen that do not have an **Office Provider** attached.

Notice the use of 'Ands', 'Ors' and brackets ( ) to join and separate the conditions correctly.



Tip: Although there is no negative logic in this statement, any **Current Rule** could be checked **Doesn't Match** for the opposite condition for validation that the query is working correctly.

Custom Reports:

New to the Alert/Query Builder? The following are recommended Accuro help files:

- Query Definitions
- Create an Alert Definition
- Add Rules to an Alert Definition
- Run a Report on an Alert Definition
- Query Builder Example: Total Count of Patients
- Export Alert Matches
- Save Appointment List to csv File to be Used for a Mail Merge

To produce a list of **active** patients attached to each **provider**, use the **Query Builder (Alerts)** to identify the patients with a **Patient Status** as **Active** for each **Office Provider** participating in ASaP.

Overview: The workflow for creating an Alert (query/ report) is as follows:

1. A **Definition** is created (this is the name of the query/report)
2. Add the **Rules** (criteria/filter/constraint).
3. **Run** the report on the query (all the rules in the definition run concurrently).
4. The results of the query are displayed as **Alert Matches**

Optional next steps

1. Actions may be selected for the patient listed such as:
    - Create task
    - Set Patient Status
    - Assign Flag
    - Create Forms (these can be outreach letters)

2. The list/report may be **Exported –** note: save the list as a **csv file** to open in Open Office Calculator or a Microsoft Excel spreadsheet.

    Note: An exported list would be required for:
    - Panel list
    - Chart review process
    - Creating a list for patient outreach

1. Create the **Alert Definition**
    a) Click **Reports** in the Accuro Menu.
    b) Select **Query Builder (Alerts)** from the list displayed. The **Alert Definitions** window is now displayed.
    c) Click the **Add** button (green plus) in the top-left corner under **Definitions.**
    d) Type in the name of the definition (title of your report) and click **OK**.

The next set of steps involves selecting the criteria or **New Rule** for your Alert Definition (Report).

2. Adding the **New Rule** to the Alert Definition
    a) Select a Category to add into the New Rule by clicking on the downward pointing triangle.
    b) Select the appropriate item from the list.
    c) Complete the fields in the Manage Rule area
    d) Click the New button to add more criteria
    e) Click Add Rule to add the criteria to the Alert Definition.

3. Select **Run Report**
4. The **Check for Alert Matches** window opens:
    a) By default Apply Against: All Patients appears or you choose Selected Providers' Patients

b) Also by default: Match Types to View is set to Unassigned with options for Assigned or Completed. This relates to assigned Tasks related to individual clinic workflow.

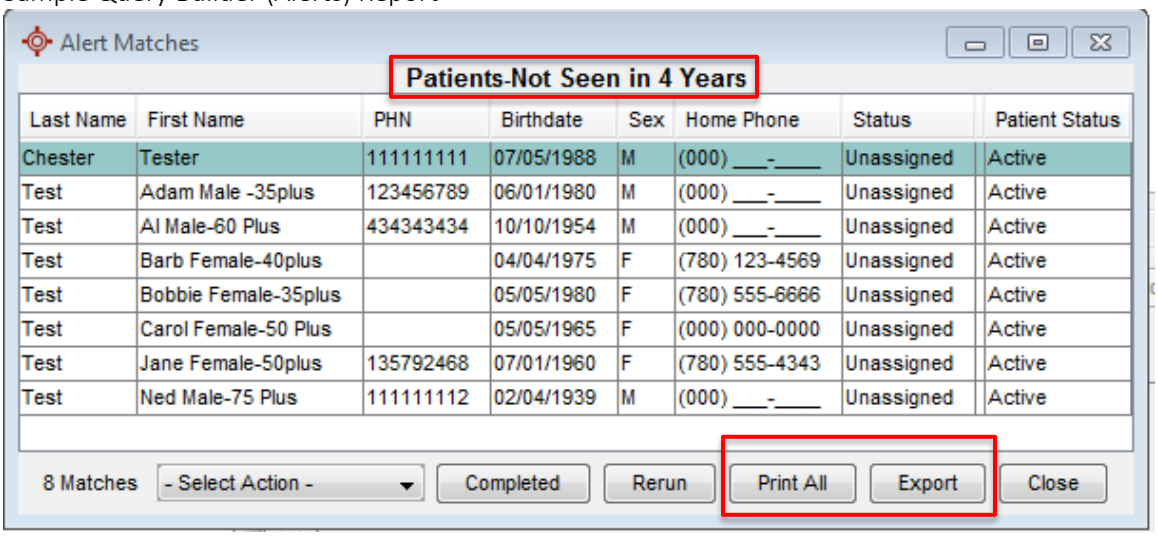
5. Select **Fields to Display** by clicking plus (+) or double clicking on X/Check mark as required.

6. Select Run to displayed **Alert Matches .**

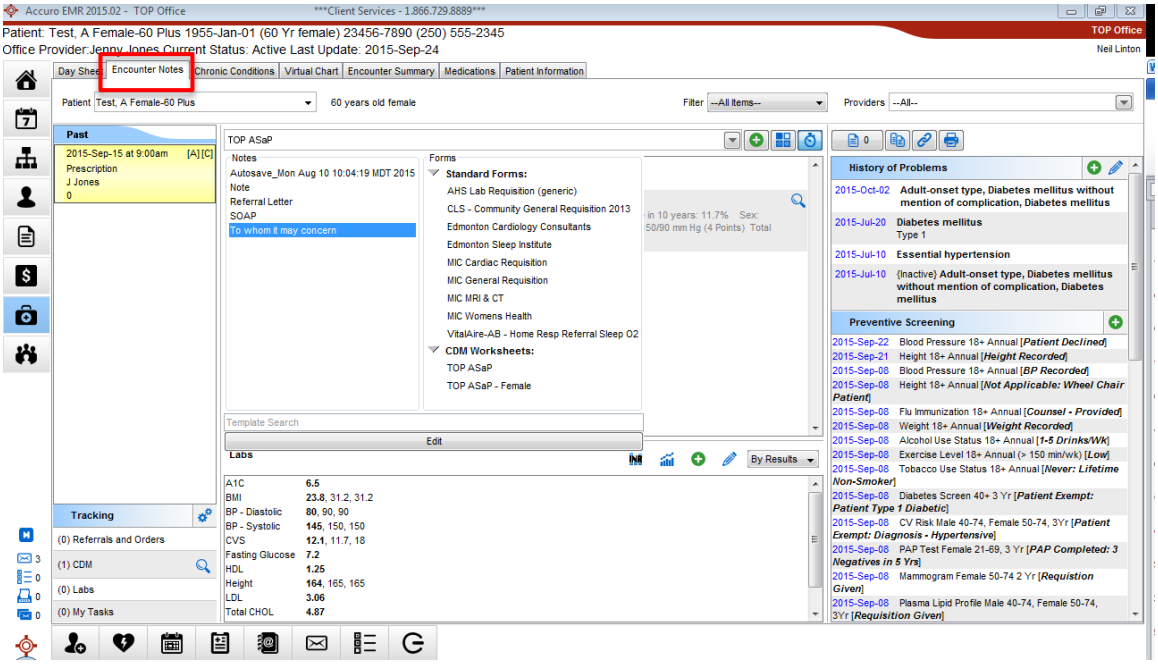
7. Using the **Select Action** dropdown a selection of patient can have a specific action assigned (i.e. Create Task, Apply Vaccine, Create Note, etc.).

8. The report can then be printed or exported (Select **Export)** as csv file.

Sample Query Builder (Alerts) Report



The Clinical Notes area of the EMR provides an overview of the notes for a patient and should be reviewed for screening offers.


Accuro EMR 2015.02 - TOP Office
Client Services - 1.866.729.8889
Patient: Test, A Female-60 Plus 1955-Jan-01 (60 Yr female) 23456-7890 (250) 555-2345
Office Provider:Jenny, Jones Current Status: Active Last Update: 2015-Sep-24
TOP Office
Neil Linton
Day Sheet
Encounter Notes
Chronic Conditions
Virtual Chart
Encounter Summary
Medications
Patient Information
Patient
Test, A Female-60 Plus
60 years old female
Filter
--All Items--
Providers
--All--
Past
2015-Sep-15 at 9:00am [A] [C]
Prescription
J Jones
0
TOP ASaP
Notes
Autosave_Mon Aug 10 10:04:19 MDT 2015
Note
Referral Letter
SOAP
To whom it may concern
Forms
Standard Forms:
AHS Lab Requisition (generic)
CLS - Community General Requisition 2013
Edmonton Cardiology Consultants
Edmonton Sleep Institute
MIC Cardiac Requisition
MIC General Requisition
MIC MRI & CT
MIC Womens Health
VitalAire-AB - Home Resp Referral Sleep O2
CDM Worksheets:
TOP ASaP
TOP ASaP - Female
in 10 years: 11.7% Sex:
50/90 mm Hg (4 Points) Total
Template Search
Edit
Labs
By Results
A1C 6.5
BMI 23.8, 31.2, 31.2
BP - Diastolic 80, 90, 90
BP - Systolic 145, 150, 150
CVS 12.1, 11.7, 18
Fasting Glucose 7.2
HDL 1.25
Height 164, 165, 165
LDL 3.06
Total CHOL 4.87
Tracking
(0) Referrals and Orders
(1) CDM
(0) Labs
(0) My Tasks
History of Problems
2015-Oct-02 Adult-onset type, Diabetes mellitus without mention of complication, Diabetes mellitus
2015-Jul-20 Diabetes mellitus Type 1
2015-Jul-10 Essential hypertension
2015-Jul-10 {Inactive} Adult-onset type, Diabetes mellitus without mention of complication, Diabetes mellitus
Preventive Screening
2015-Sep-22 Blood Pressure 18+ Annual [Patient Declined]
2015-Sep-21 Height 18+ Annual [Height Recorded]
2015-Sep-08 Blood Pressure 18+ Annual [BP Recorded]
2015-Sep-08 Height 18+ Annual [Not Applicable: Wheel Chair Patient]
2015-Sep-08 Flu Immunization 18+ Annual [Counsel - Provided]
2015-Sep-08 Weight 18+ Annual [Weight Recorded]
2015-Sep-08 Alcohol Use Status 18+ Annual [1-5 Drinks/Wk]
2015-Sep-08 Exercise Level 18+ Annual (> 150 min/wk) [Low]
2015-Sep-08 Tobacco Use Status 18+ Annual [Never: Lifetime Non-Smoker]
2015-Sep-08 Diabetes Screen 40+ 3 Yr [Patient Exempt: Patient Type 1 Diabetic]
2015-Sep-08 CV Risk Male 40-74, Female 50-74, 3Yr [Patient Exempt: Diagnosis - Hypertensive]
2015-Sep-08 PAP Test Female 21-69, 3 Yr [PAP Completed: 3 Negatives in 5 Yrs]
2015-Sep-08 Mammogram Female 50-74 2 Yr [Requistion Given]
2015-Sep-08 Plasma Lipid Profile Male 40-74, Female 50-74, 3Yr [Requisition Given]

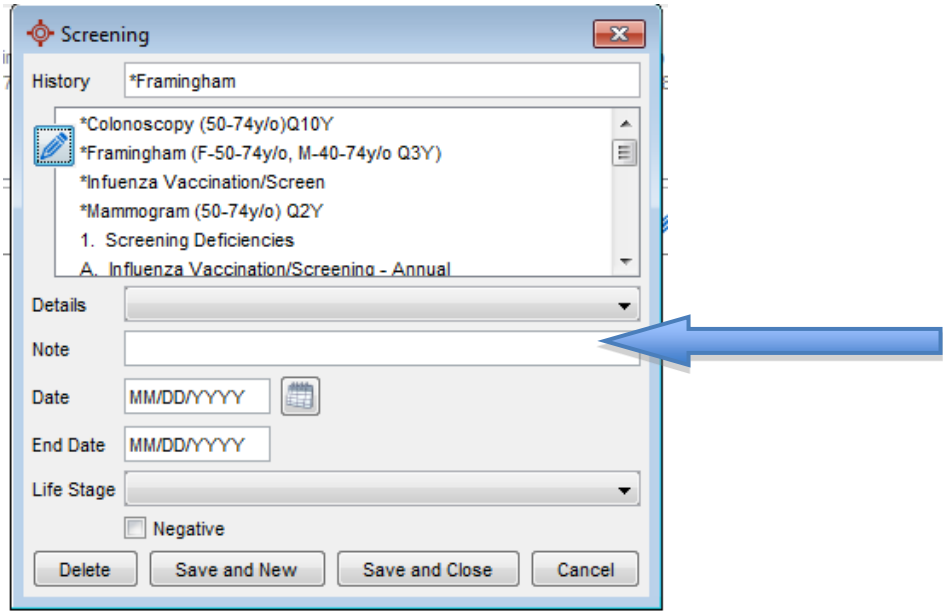
Appendix G - ASaP 2017 Form

Note: Some screen shots have NOT been updated from the 2016 form. Please refer to the 2017 intervals.

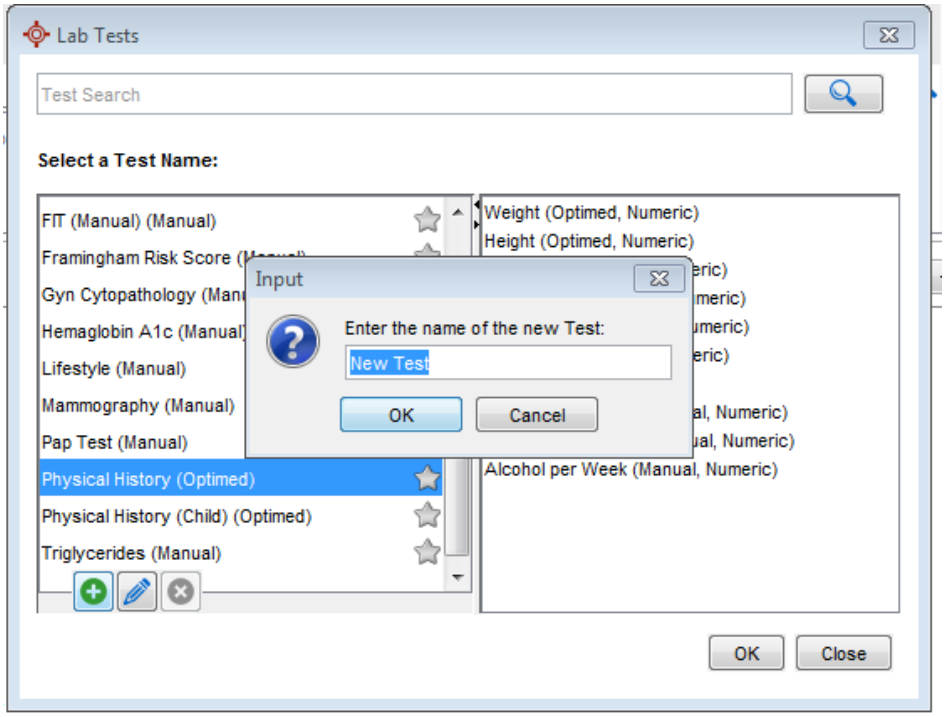
Instruction for setup and use

Please set up EMR prior to downloading ASaP Screening Maneuvers Form this will avoid preset linking disconnection. It is safe to "Preview" the form in Form Editor before set up.

1. Create a Custom Medical History Band entitled "Screening".
2. Entering Information into the Screening Band
    a. The following needs to be added to the screening band:
        i. Mammogram
        ii. Colonoscopy
        iii. Influenza Vaccination/Screening
        iv. Framingham Risk Score
    b. Mammogram and Colonoscopy Results
        i. Docufiler: As Staff sort documents within the Docufiler they should be instructed to add the date of both Mammograms and Colonoscopy within this Screening Band.
            1. NOTE: The date of the test MUST be placed in the Note field – Currently, using the "calendar" to record the date does not transfer onto the ASap Maneuvers Form



    c. Influenza Vaccination
        i. Staff should be instructed to ask patients whenever they are performing vitals when the patient last received Influenza vaccination and add the date to the Screening Band

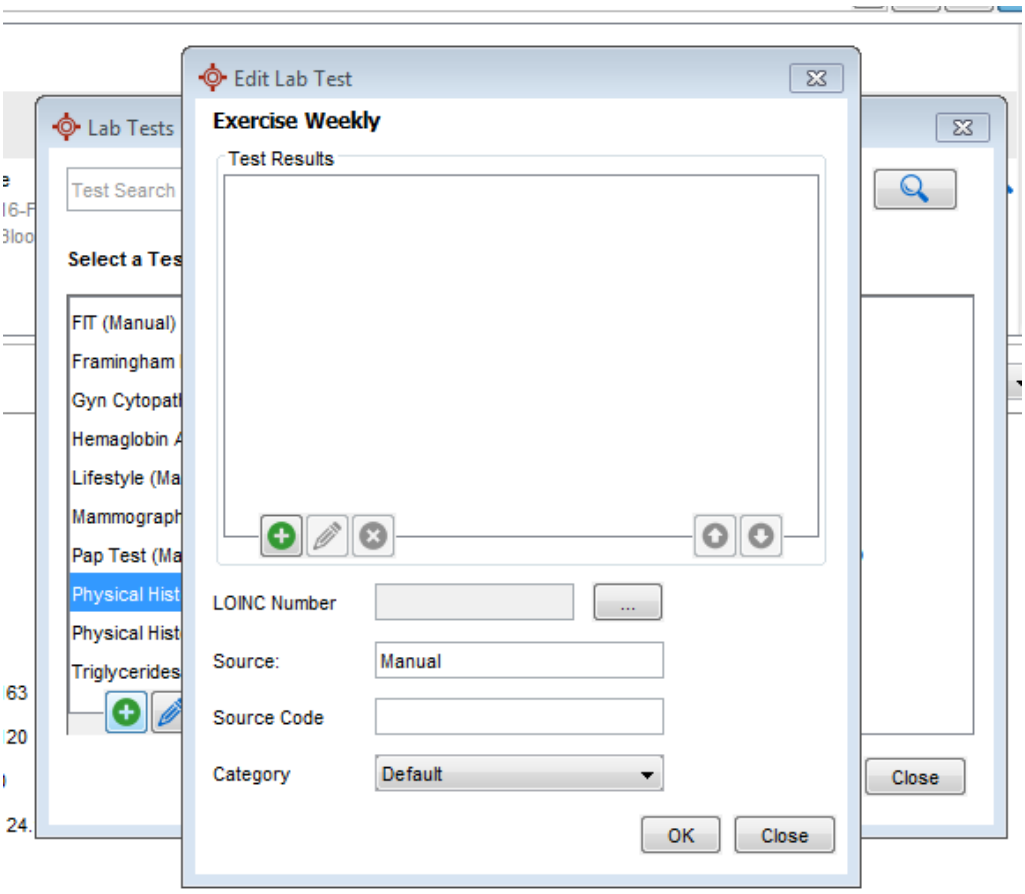


1. NOTE: The date of the test MUST be placed in the Note field – Currently, using the "calendar" to record the date does not transfer onto the ASap Maneuvers Form

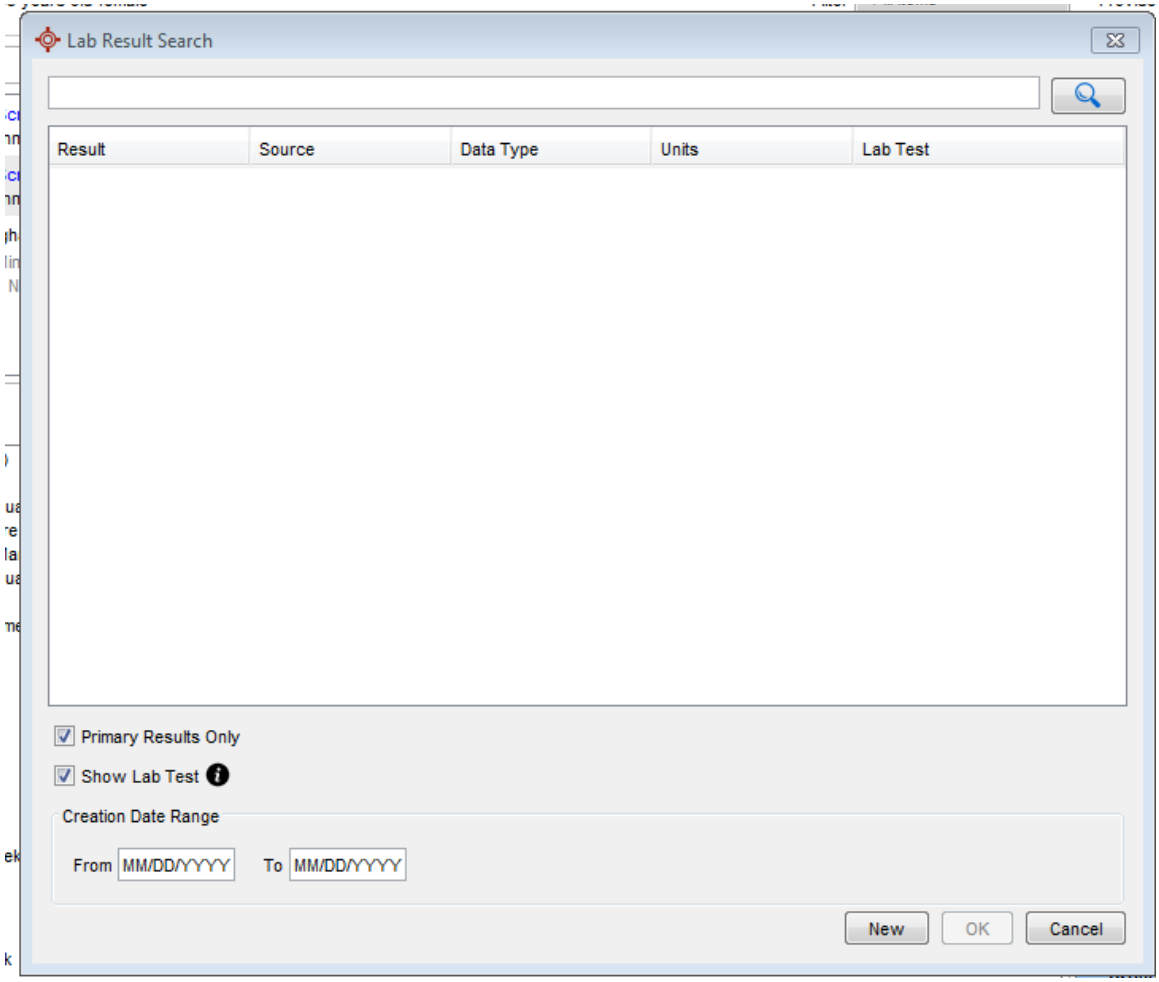
d. Framingham Risk Score
   i. When performed, both the date and the result should be added to the Screening Band by the physician.
      1. NOTE: The date of the test MUST be placed in the Note field – Currently, using the "calendar" to record the date does not transfer onto the ASap Maneuvers Form

3. Vitals
   a. Create a custom manual lab within the current "Physical History" that contains the following Exercise Weekly, Tobacco Daily, Alcohol Weekly
      i. Click on the green "+" as if to add a manual lab.
      ii. Choose "Physical History" and then "Edit" Pencil. An Input Screen will pop up and ask you to Enter the name of the new Test. Enter "Exercise Weekly"

iii. An Edit Lab Test Screen will pop up. Select the green "+".

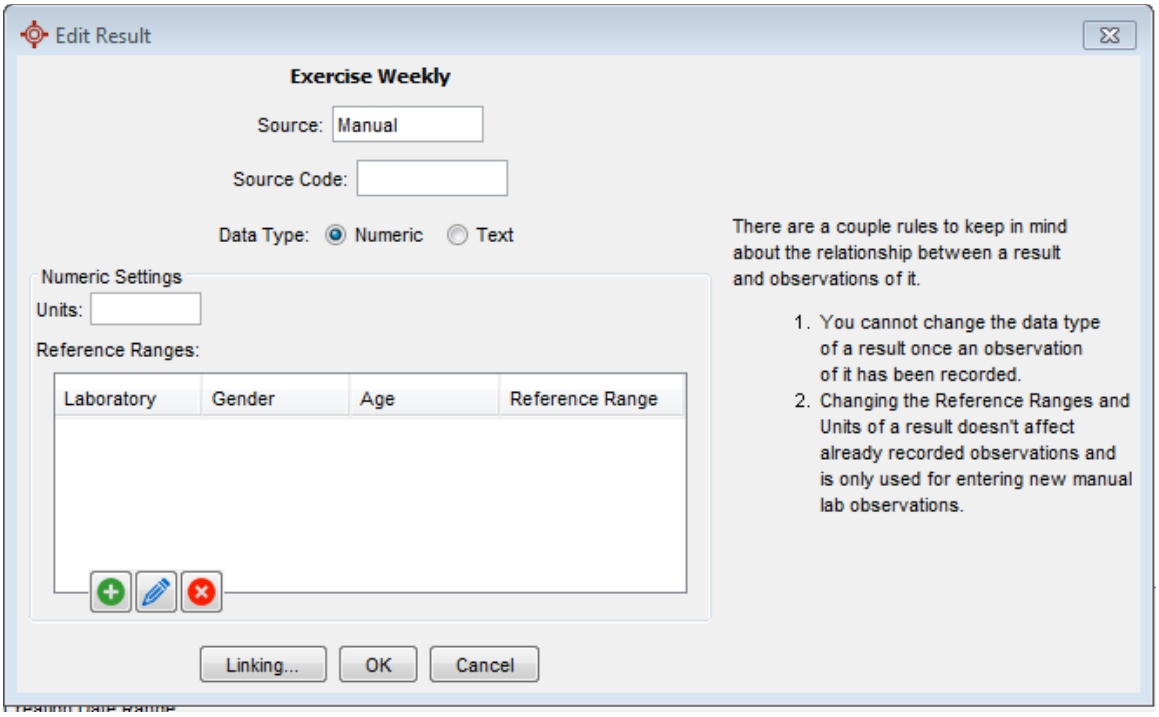


iv. A Lab Result Search Screen will pop up. Select the “New” button on the lower right.

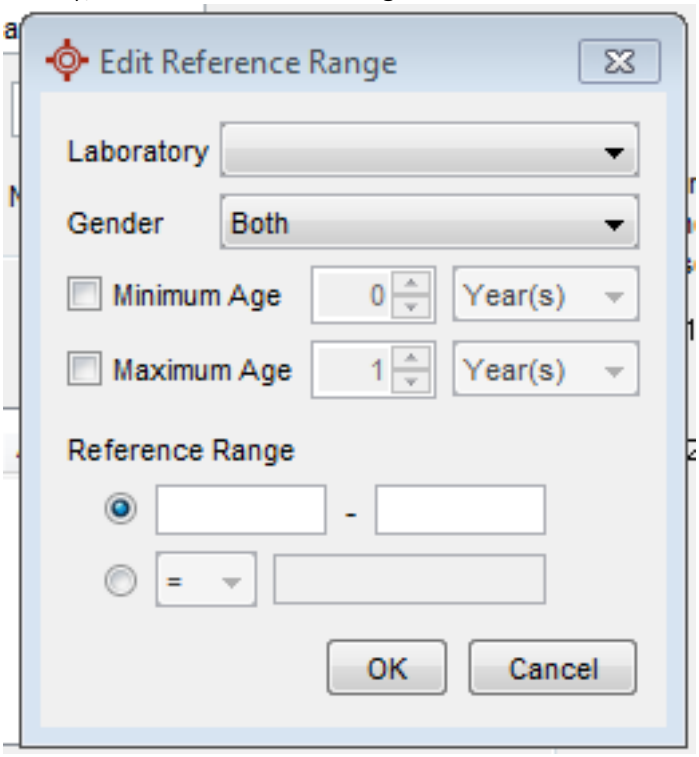


v. An Enter the name of the new result screen will pop up. Enter “Exercise Weekly” then OK.

vi. An Edit Result Screen will pop up, enter “Minutes” into Units. Click on the green “+”, then click on the “drop down” arrow by Laboratory and then click on “manage”.



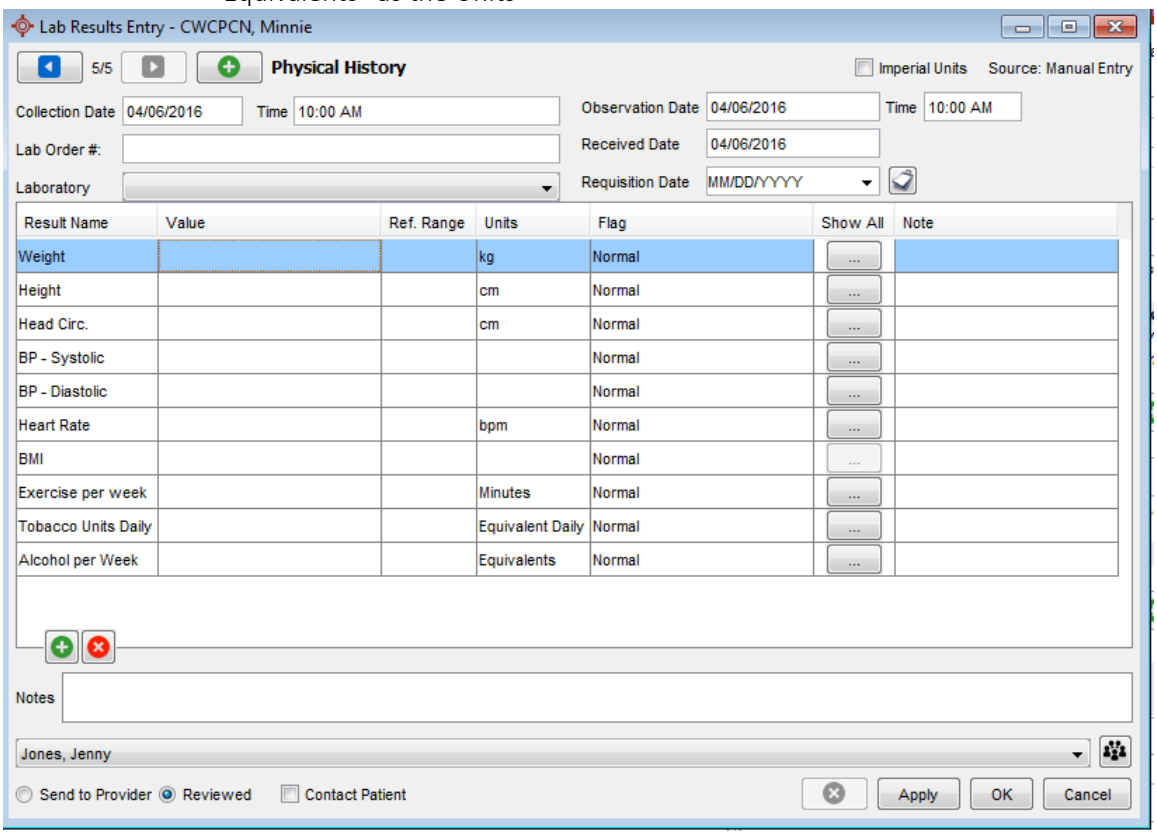
vii. A new screen will pop open, click on the green "+" and add "Exercise Minutes Weekly, and add a reference range of 0 to 2000. Then click on OK.



viii. Back to the "Lab Result Search" Screen. Search for "Exercise Weekly". Select. Click OK.

ix. Exercise Weekly will now show up in the Vitals Menu.

x. Follow the same process for Tobacco Daily and Alcohol Weekly but use "Equivalents" as the Units



b. Each time a patient has vitals recorded they should also be asked about there Exercise Weekly in minutes, Tobacco Equivalents consumption Daily, and Alcohol Equivalents

4. Download "ASaP Maneuvers" Form in Form Editor via the Tools Tab Left upper Corner and choose "Publish/Download". Search for ASaP and Download. Back in Form Editor "Unclick" "Under Construction" and Save.
5. The following is a "Preview" Shot prior to Downloading the form.

John Smith Age: 0 Day

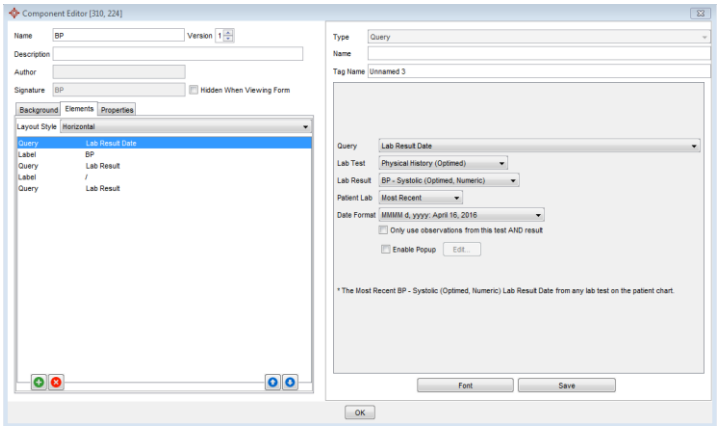
2016-Jun-28 Dr. John Smith

ASaP Alberta Screening and Prevention

Screening Maneuvers Menu for Adults **2016** Alberta Screening & Prevention Program (ASaP)	
Maneuver	**Result**
Blood Pressure 18+, Annual	BP /
Weight 18+, Every 3 Years	WT
Height 18+, At least once	HT
Exercise Assessment 18+, Annual	Weekly
Tobacco Use Assessment 18+, Annual	
Influenza Vaccination Recommendation 18+, Annual	**See below**
Pap Test - Females 25-69, Every 3 years	PAP
Plasma Lipid Profile Every 5 years Males: (40-74) Females: (50-74)	LDL Chol Trig HDL
CV Risk Calculation Every 5 years Males: (40-74) Females: (50-74)	**See below**
Diabetes Screen 40+, Every 5 years One of:	Fasting Glucose HbA1c Risk Calculator:
Colorectal Cancer Screening (50-74) One of:	FIT (Every 2 years) Flex Sigmoidoscopy (Every 5 years) **See below** Colonoscopy (Every 10 years) **See below**
Mammography - Females (25-74, Every 3 years)	**See below**

Screening
None Recorded

6. After Downloading the form, verify linkages between the form and the EMR in Form Editor.
    a. In Form Editor, Right Click on each Element starting with "BP" – Click thru each elements components in the left hand part of the screen and verify that it is correctly linked by reviewing information on Right hand of screen. If not correctly linked, use the drop downs on the Right to find the correct link and save.
    b. Continue to verify each element's mapping, especially those items that you have created. Those clinics utilizing this form who are not in the Calgary Health Region will need to map to the correct labs within their health region.
7. Finally, when saved, and then selected within a patient's chart, the form will autofill. The Entire Screening Band will insert. Items not done in the patient chart will not load into the Form.



Mickey CWCPCN Age: 53 Yr

2016-Jun-28 Dr. Jenny Jones

ASaP Alberta Screening and Prevention

Screening Maneuvers Menu for Adults **2016**
Alberta Screening & Prevention Program (ASaP)

Maneuver	Result
Blood Pressure 18+, Annual	2016-Feb-24 BP **140 / 91**
Weight 18+, Every 3 Years	2016-Feb-24 WT **75 kg**
Height 18+, At least once	2016-Feb-24 HT **170 cm**
Exercise Assessment 18+, Annual	2016-Feb-24 **250 Minutes** Weekly
Tobacco Use Assessment 18+, Annual	
Influenza Vaccination Recommendation 18+, Annual	**See below**
Pap Test - Females 25-69, Every 3 years	PAP
Plasma Lipid Profile Every 5 years Males: (40-74) Females: (50-74)	2016-Feb-24 LDL **2.2 mmol/L** 2016-Feb-24 Chol **5 mmol/L** 2016-Feb-24 Trig **1.5 mmol/L** 2016-Feb-24 HDL **2.1 mmol/L**
CV Risk Calculation Every 5 years Males: (40-74) Females: (50-74)	**See below**
Diabetes Screen 40+, Every 5 years One of:	2016-Feb-24 Fasting Glucose **5 mmol/L** 2016-Feb-24 HbA1c **5 %** Risk Calculator:
Colorectal Cancer Screening (50-74) One of:	FIT (Every 2 years) Flex Sigmoidoscopy (Every 5 years) **See below** Colonoscopy (Every 10 years) **See below**
Mammography - Females (25-74, Every 3 years)	**See below**

Screening
X. Framingham Risk Score Female (50-74y/o)Q3Y [***High***]
X. Flexible Sigmoidoscopy (50-74y/o)Q5Y [***Negative***]
X. FIT (50-74y/o)Q2Y [***Positive***]

TOP Accuro Videos

Accuro ASAP Form Download for Use

https://youtu.be/vZVQdel46lc?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

ASaP Screening Form for Use in Accuro

https://youtu.be/kw3tOefJB04?list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-

Accuro ASAP Recording Screening

https://www.youtube.com/watch?v=9dUf-vvbv2E&list=PLf486cdx9WgKkIcmlCToVMIn-4swktsv-&index=20

Appendix H - ASaP Maneuver Data Entry Tips

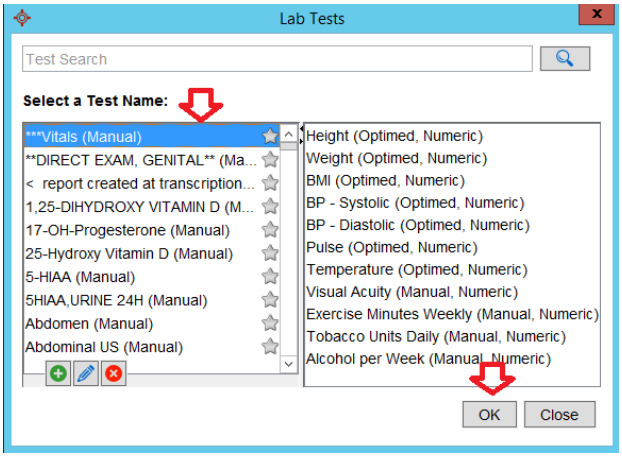
Acknowledgement: The content for this Appendix was created by the team at Kalyna Country PCN.

<u>Blood Pressure</u>

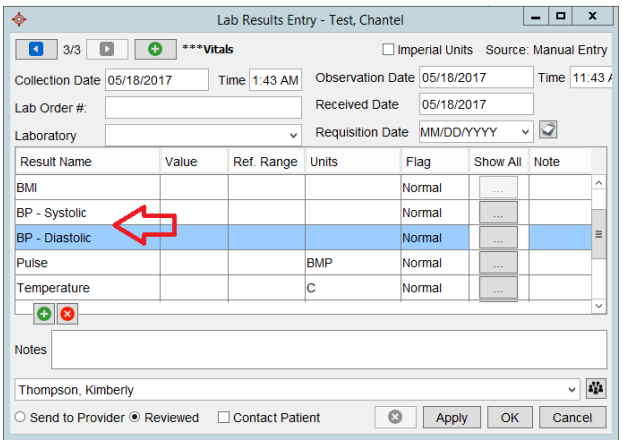
1. After logging into Accuro, locate the "Patient" button  on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name

3. **Click** "EMR" button  .
4. Go to Encounter Notes.
5. **Scroll** down to Labs, near right corner of the section there is a green plus button. Double **Click**.

6. A new window will open called; "Lab Tests".
7. Highlight the Test Name called "***Vitals (Manual)", and **Click** "*OK*".



8. A new window will open called "Lab Results Entry".
9. If needed **Scroll** to find "BP – Systolic" and "BP – Diastolic".



10. Enter the results of "BP – Systolic" and "BP – Diastolic" under the "Value" column. Make sure you enter the proper value for each test.
    a. If you want to add a note regarding the lab test result, this is where you would be able to add. The note can be added under the "Note" column on the proper test row.
11. Check the bottom of the page is the proper provider is selected below the notes section of the "Lab Results Entry" page.
12. **Click** "Apply" and then **Click** "*OK*" to save the entry. The window will close itself once you **Click** *OK*

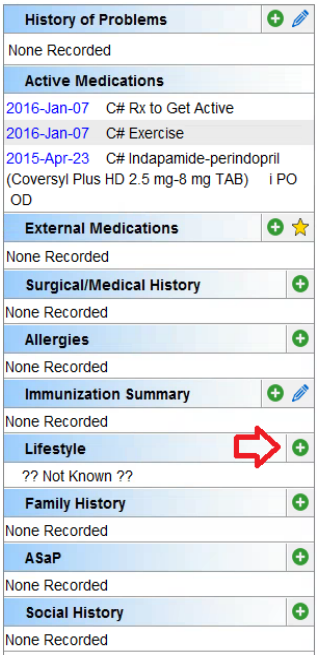
Note: The same process can be carried over for **Height** and **Weight** screening. Only steps 7 and 8 will differ during the data entry phase.

Tobacco Use, Exercise & Alcohol Assessments

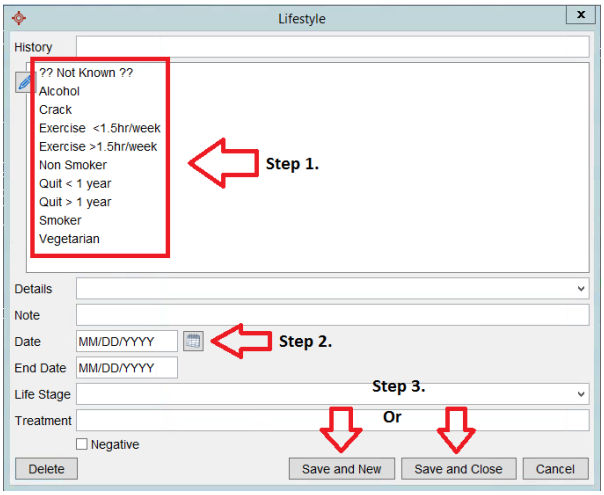
1. After logging into Accuro, locate the Patient button  on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name

3. **Click** EMR button  .
4. Go to Encounter Notes
5. Refer to the right side of the page, and look at appropriate Medical History Band (e.g. Lifestyle)

6. Once there look for the “Lifestyle” category. **Click** the green plus button .

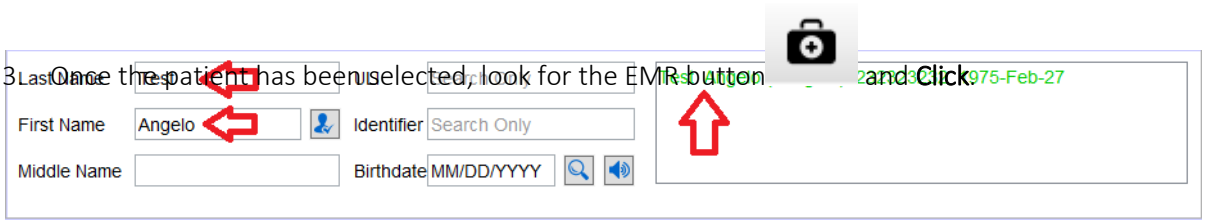


7. A new window will open called “Lifestyle”.
8. Here you can now add the data.
9. Steps to add data are as follows:
    1. Select the type of screening you are about to enter.
    2. Add the date when the data was collected. (Must be done for entry to be valid)
        a. If you want to add a note regarding screening, this is where it is possible to do so. The note can be added under the “Note” row.
    3. Once finished, **Click** “Save and Close” button. To enter more data about a different type of screening, **Click** “Save and New”.

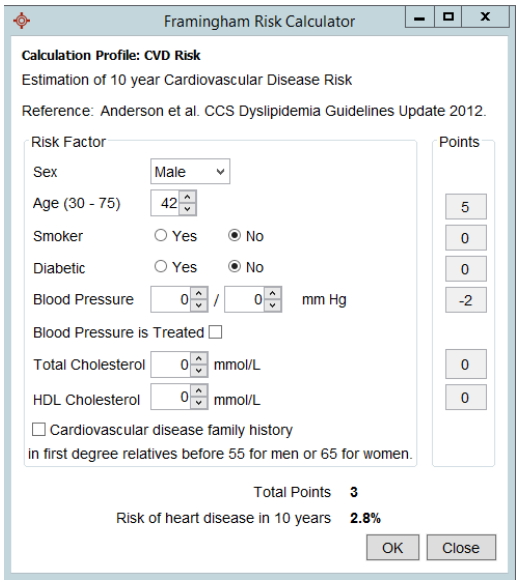


Cardiovascular Risk Assessment

1. After logging into Accuro, locate the Patient button  on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. Be sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name



3. Once the patient has been selected, look for the EMR button and **Click**.
4. Find the Accuro button  and **Click**.
5. In the Accuro search bar type in "Framingham". The "Framingham Risk Calculator" will show up on the results page. Double **Click**.
   ** Alternatively you can use the Framingham calculator available on your bottom dashboard of your screen
6. A new window will open called "Framingham Risk Calculator".



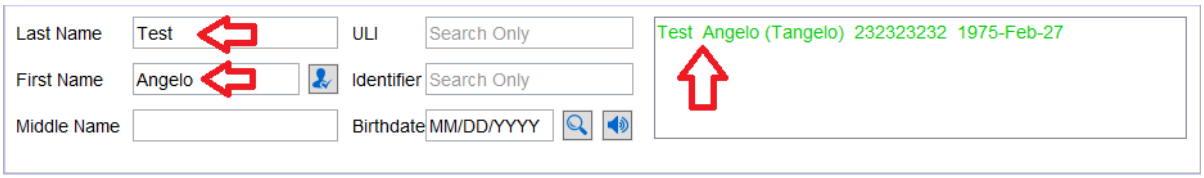
7. Enter the necessary data elements (Sex, Age, Diabetic, Blood Pressure, Total Cholesterol, HDL Cholesterol) needed for the EMR to compute the patients risk score. Note, some of the data elements will auto populate, please make sure that these are correct. Once you have entered the correct information, **Click** "*OK*".

8. The result will automatically be saved into the "Notes" section of the main page. Double **Click** on the result to view the whole page for review.
9. Once the value of "Heart Disease Risk in 10 Years" is known, enter the value into the labs area immediately after calculating the score.
10. At the bottom of the page you will see a section called "Labs".
11. 

In the Labs look for the green button, and **Click**.
12. A new screen called "Lab Tests" will pop up.
13. To find the lab tests:
    a. Use the search tab to begin typing the name of the tests (Cardiac Risk).
    b. Highlight the name of the test. **Click** "*OK*".
14. A new screen called "Lab Test Entry – 'Patient Name'" will pop up. Here, make sure you are entering the right information for the right patient.
    a. If you want to add a note regarding the lab test result, this is where it is possible to do so. The note can be added under the "Note" column on the proper test row.
15. Check the bottom of the page that the proper provider is selected below the notes section of the "Lab Results Entry" page.
16. Add the value to the correct field. **Click** "Apply" to save the entry, then **Click** "*OK*" to close the window.

Diabetes (Screen)

1. After logging into Accuro, locate the Patient button  on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name. 
3. Once the patient has been selected, look for the EMR button and **Click**.



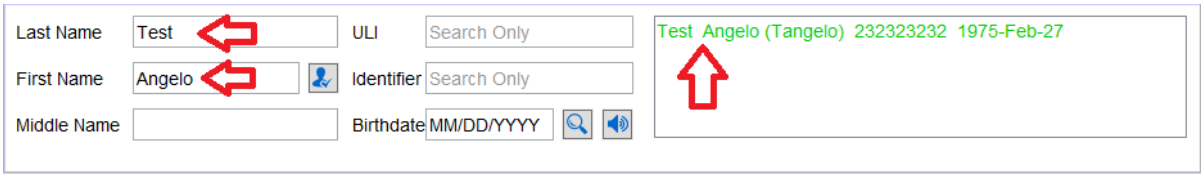
4. Go to Encounter Notes.
5. At the bottom of the page you will see a section called "Labs".
6. 

In the Labs look for the green button, and **Click**.

7. A new screen called “Lab Tests” will pop up.
8. To find the lab tests:
    a. Use the search tab to begin typing the name of the tests (Glucose Fasting or Hemoglobin A1C).
    b. Highlight the name of the test. **Click** “*OK*”.
9. A new screen called “Lab Test Entry – ‘Patient Name’” will pop up. Here make sure you are entering the right information for the right patient.
10. Check the bottom of the page is the proper provider is selected below the notes section of the “Lab Results Entry” page.
    a. If you want to add a note regarding the lab test result, this is where it is possible to do so. The note can be added under the “Note” column on the proper test row.
11. Add the value to the correct field. **Click** “Apply” to save the entry, then **Click** “*OK*” to close the window
12. Repeat steps 8-10 until you have captured all the necessary lab test results.

Plasma Lipid Profile

1. After logging into Accuro, locate the Patient button  on the left side of the screen and double **Click** it.
2. Fill in the “First Name” and “Last Name” of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name.
3. Once the patient has been selected, look for the EMR button and **Click**. 



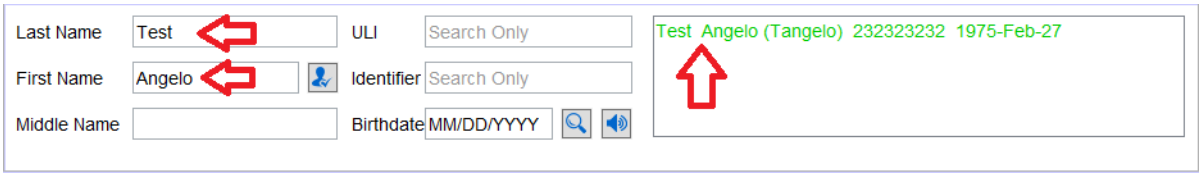
4. Go to Encounter Notes.
5. At the bottom of the page you will see a section called “Labs”.
6. 

In the Labs look for the green button, and **Click**.
7. A new screen called “Lab Tests” will pop up.
8. To find the lab tests:
    a. Use the search tab to begin typing the name of the tests (HDL, LDL, Cholesterol, and Triglycerides)
    b. Highlight the name of the test. **Click** “*OK*”.
9. A new screen called “Lab Test Entry – ‘Patient Name’” will pop up. Here make sure you are entering the right information for the right patient.

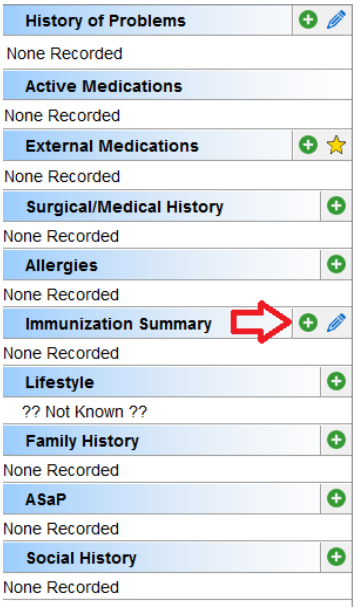
10. Check the bottom of the page is the proper provider is selected below the notes section of the "Lab Results Entry" page.
11. Add the value to the correct field.
    a. If you want to add a note regarding the lab test result, this is where it is possible to do so. The note can be added under the "Note" column on the proper test row.
12. Check the bottom of the page is the proper provider is selected below the notes section of the "Lab Results Entry" page.
13. **Click** "Apply" to save the entry, then **Click** "*OK*" to close the window
14. Repeat steps 6-10 until you have captured all the necessary lab test results.

Influenza Vaccination

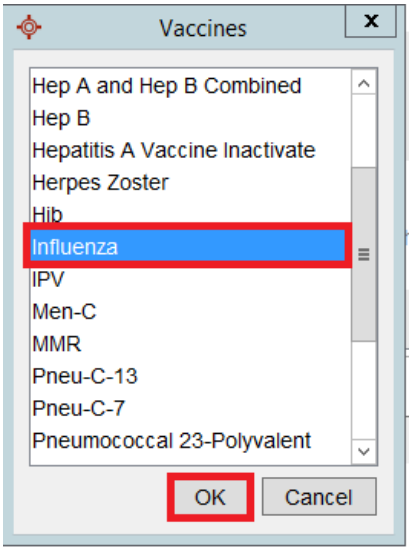
1. After logging into Accuro, locate the "Patient" button  on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name



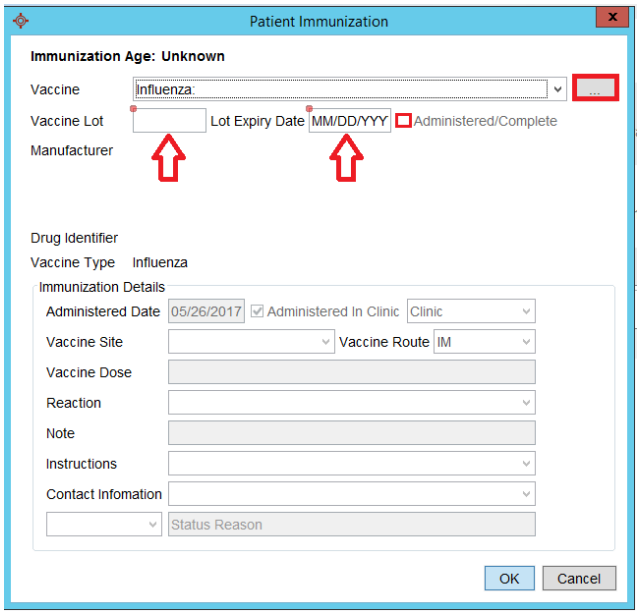
3. Once the patient has been selected, look for the EMR button  and **Click**.
4. **Click** EMR.
5. Go to Encounter Notes.
6. Refer to the right side of the page, and look for the blue banners.
7. Once there look for the "Immunization Summary" category. **Click** the green plus button.



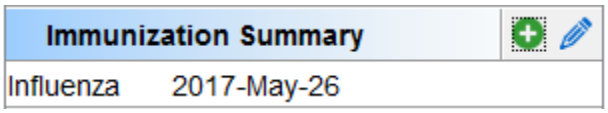
8. A new window will open called “Vaccines”.
9. Here you will be able to pick the type of vaccine to be administered. To administer the Flu Shot **Click** on Influenza and press *OK*.



10. A select vaccine pop up window will appear; **Click** *OK*
11. **Click** on the ellipsis to the right of the vaccine column and select the specific type of vaccine being administered. Make sure that the Vaccine Lot and Lot Expiry Date columns are filled in with the appropriate and the administered complete box is checked off. For lot number you can input a standard number of 0000. Once you have checked off and filled in the appropriate fields **Click** *OK*.



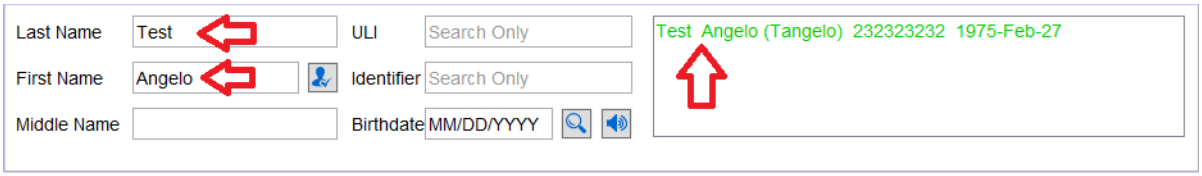
12. Once you complete these steps the Immunization section of the banner should update and the influenza vaccine along with the date should appear.



Pap Test

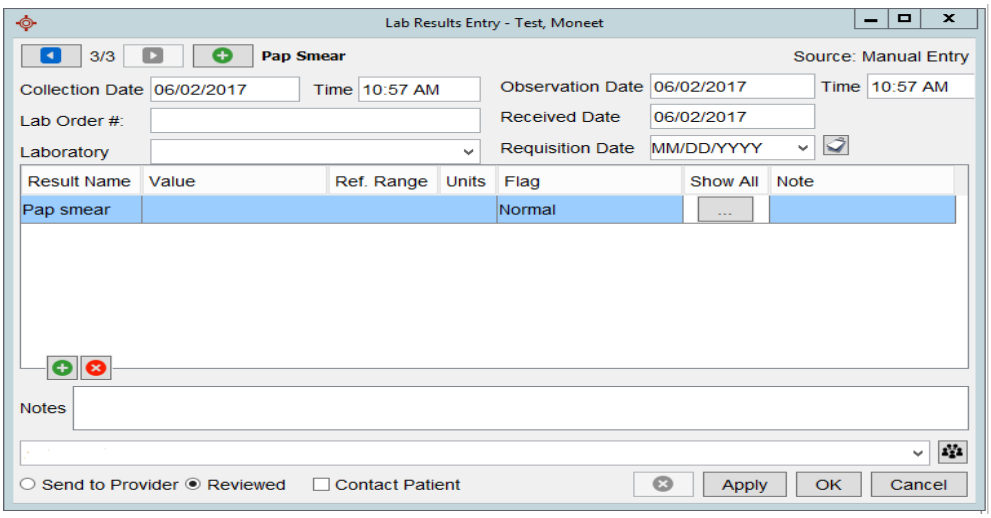
1. After logging into Accuro, locate the "Patient" button  on the left side of the screen and double **Click** it.

2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name



3. Once the patient has been selected, look for the EMR button  and **Click**.
4. Go to Encounter Notes.
5. **Scroll** down to Labs, near right corner of the section there is a green plus button. Double **Click**.
6. 

A new window will open called "Lab Tests".
7. To find the lab tests:
    1. Use the search tab to begin typing the name of the tests (Pap Smear)
    2. Highlight the name of the test. **Click** "*OK*".
8. A new screen called "Lab Test Entry – 'Patient Name' will pop up. Here make sure you are entering the right information for the right patient.



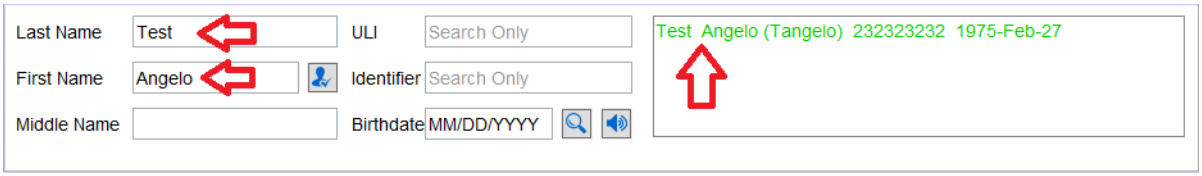
9. Add the value to the correct field.
    1. If you want to add a note regarding the lab test result, this is where it is possible to do so. The note can be added under the "Note" column on the proper test row.

Click "Apply" to save the entry, then **Click** "*OK*" to close the window

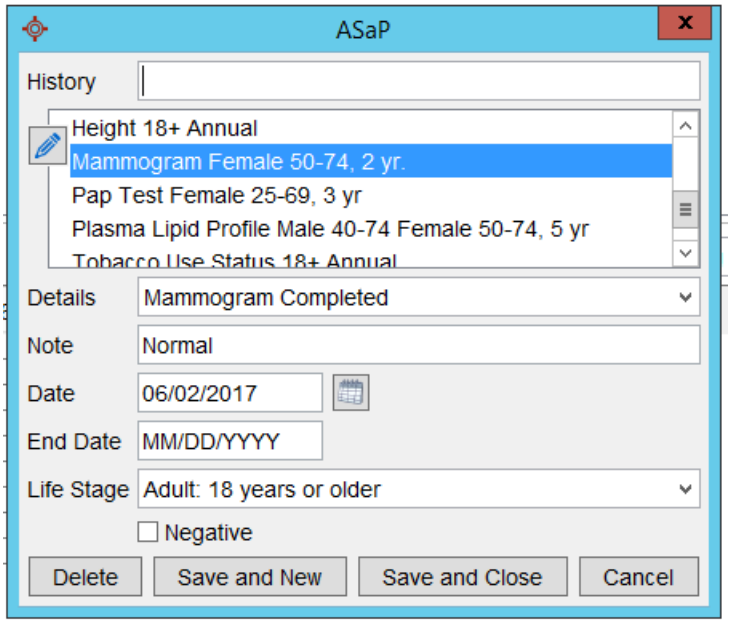
Mammography

1. After logging into Accuro, locate the "Patient" button  on the left side of the screen and double **Click** it.

2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name



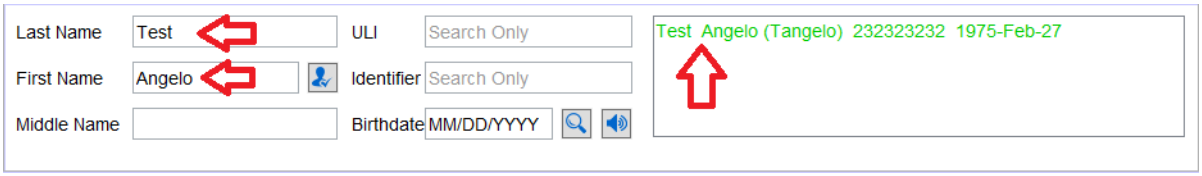
3. Once the patient has been selected, look for the EMR button  and **Click**.
4. **Click** EMR.
5. Go to Encounter Notes.
6. Refer to the right side of the page, and look for the blue banners.
7. Once there look for the "ASaP" category. **Click** the green plus button.



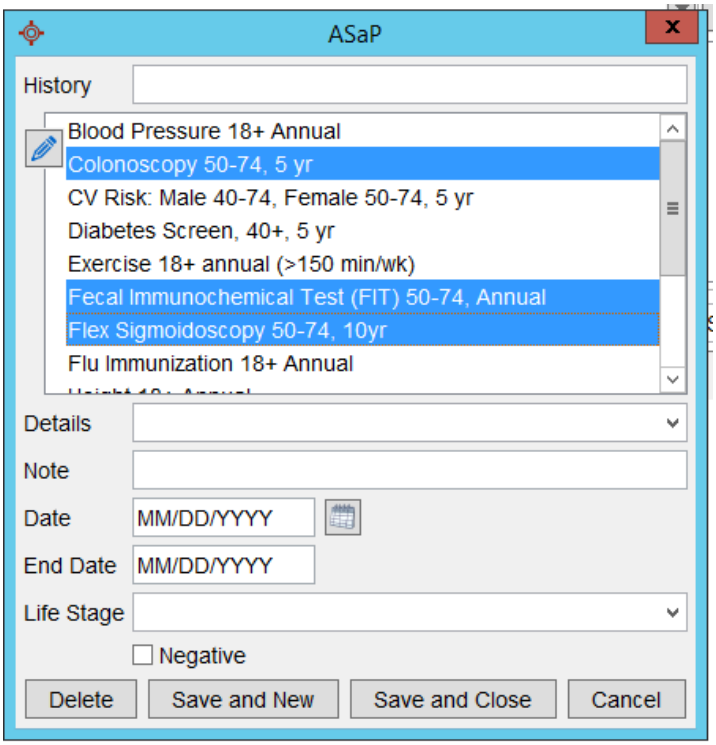
8. Select the appropriate test "Mammogram Female 50-74, 2 yr"
9. Enter a Detail about whether the Mammogram was completed, deferred, declined, exempt or the requisition was given. Also add a Note if the patient wasn't in the age
10. It is important to add a Note if the patient is not within the age range. You can also add notes about any other concerns you have.

Colorectal Cancer Screen

1. After logging into Accuro, locate the "Patient" button on the left side of the screen and double **Click** it.
2. Fill in the "First Name" and "Last Name" of the patient at the top of the page. (While typing, the EMR will automatically narrow down to the right patient you are looking for. To make sure make sure to check the patients DOB to the one in the EMR.) Double **Click** the patient name



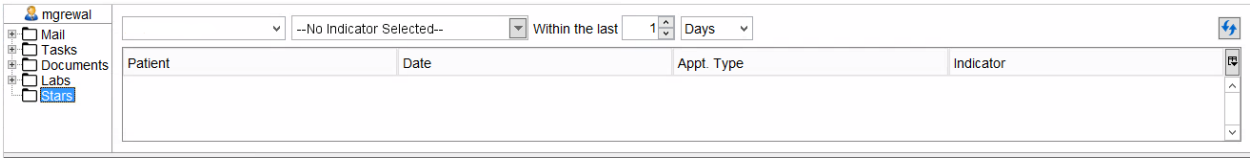
3. Once the patient has been selected, look for the EMR button and **Click**.
4. **Click** EMR.
5. Go to Encounter Notes.
6. Refer to the right side of the page, and look for the blue banners.
7. Once there look for the "ASaP" category. **Click** the green plus button.



8. Select the appropriate test “Colonoscopy 50-74, 5 yr” “Fecal Immunochemical Test FIT) 50-74, Annual” or “Flex Sigmoidoscopy"
9. Enter a Detail about whether the Test was completed, deferred, declined, exempt or the referral was initiated. Also add a Note if the patient wasn’t in the age
10. It is important to add a Note if the patient is not within the age range. You can also add notes about any other concerns you have.

Confirming Mammogram and Colon Cancer Received Results

1. Once you are logged onto Accuro, click the Home button 



2. At the top of the page there is a section for the physicians incoming received documents and labs. Mammograms will come in as documents and Colon reports will come in as labs.
3. Use this information to update the Lifestyle banner for the patients. The ‘How to’ documents for Mammograms and Colon Cancer will assist you on how to enter this information in.

Created by Kalyna Country PCN