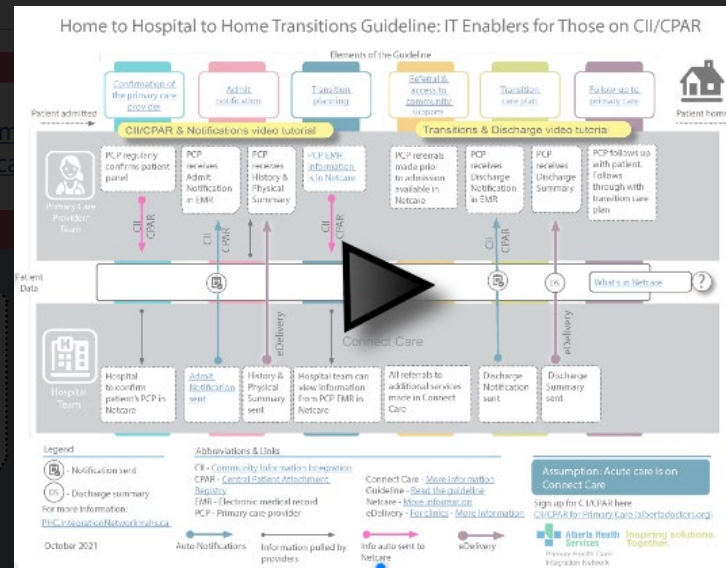


Home to Hospital to Home Transitions Guideline: IT Enablers for Those on CII/CPAR

IT Enabler Map Intro



Play the Intro Video

Purpose of map

- The IT enabler map shows how CII/CPAR, Connect Care, eDelivery and Netcare ensure patients' information follows them through their healthcare journey.

Navigating the map

- Across the top are the six elements of the Home to Hospital to Home Transitions Guideline. Click for more detail.

- Below the elements are two yellow bars. Click to view explainer videos.

- The two grey bars in the center of the map show the activities of the primary care team and the hospital team.
- The arrows on the map show how information travels between the hospital team and the patient's medical home.

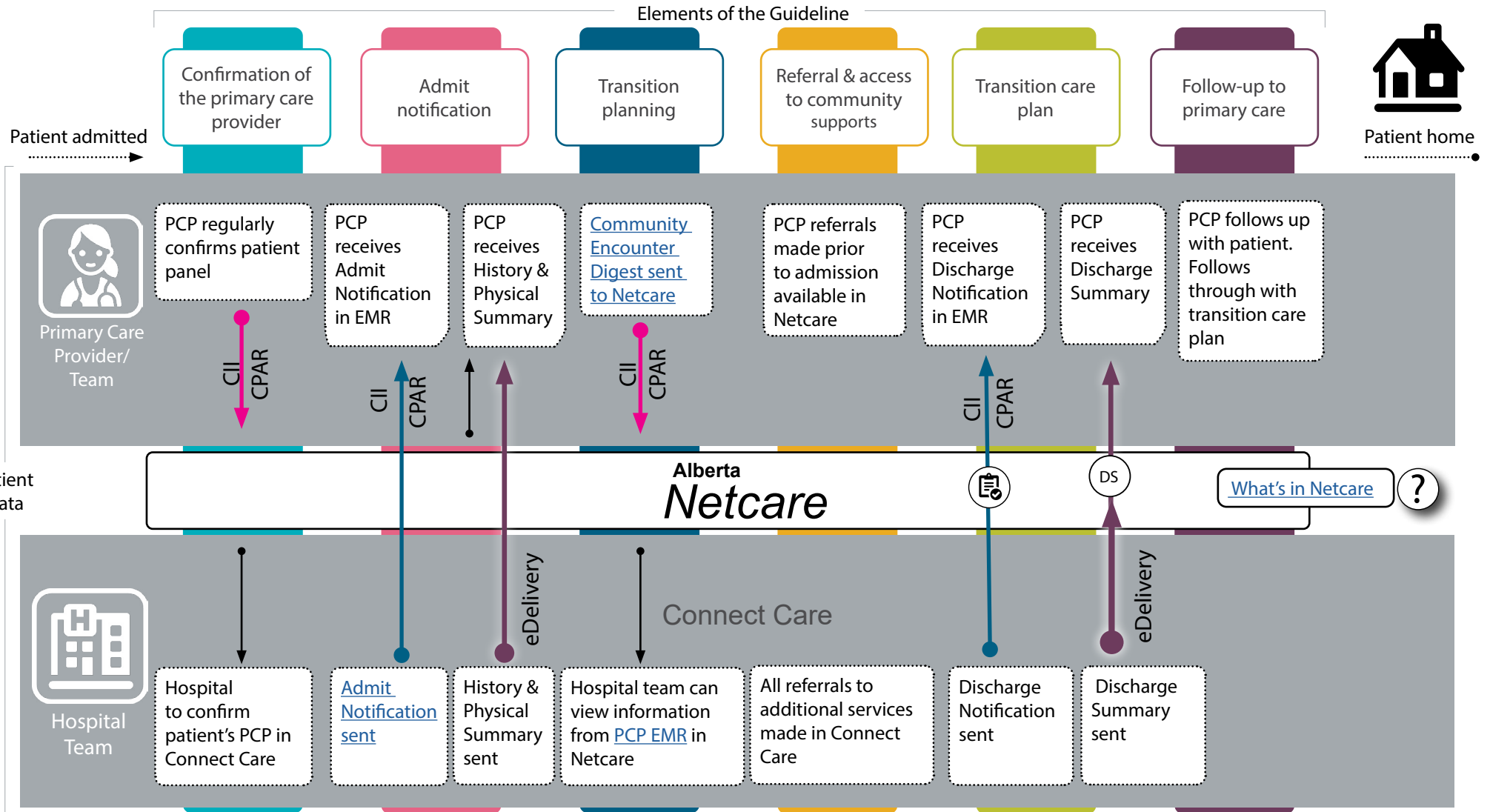
Auto Notifications Information pulled by providers Info auto sent to Netcare eDelivery

Assumption: Acute care is on Connect Care
 Sign up for CII/CPAR here
[CII/CPAR for Primary Care \(albertadoctors.org\)](#)

Alberta Health Services
 Inspiring solutions. Together.

Primary Health Care Integration Network

Home to Hospital to Home Transitions Guideline: IT Enablers for Those on CII/CPAR



Legend

- Notification sent
- Discharge summary

For more information:

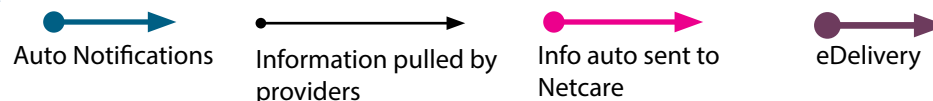
PHC.IntegrationNetwork@ahs.ca

February 2023

Abbreviations & Links

CII - [Community Information Integration](#)
 CPAR - [Central Patient Attachment Registry](#)
 EMR - Electronic medical record
 PCP - Primary care provider

Connect Care - [More information](#)
 Guideline - [Read the guideline](#)
 Netcare - [More information](#)
 eDelivery - [For clinics](#) - [More Information](#)



Appendix



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INTRODUCTION

Community Information Integration/Central Patient Attachment Registry (CII/CPAR) is a provincial program that connects community physician EMRs to the health system through Alberta Netcare. CII/CPAR is improving continuity of care for Albertans.

COMMUNITY ENCOUNTER DIGEST (CED)

The CED report is created in Alberta Netcare by CII and summarizes care the patient has received over the past 12 months from all community-based clinics in Alberta that participate in the CII program. Information is not pulled from subjective or notes fields, it includes information from these defined areas of the EMR:

- Service providers and delivery location
- Encounter: patient reason and provider assessment
- Health concerns (problems/profile items)
- Possible allergies
- Observations: BP, Ht, Wt
- Immunizations
- Referral requests (these remain on the CED for 36 months)

The CED is meant to be a ‘rolling snapshot’ of care that an Albertan has received to provide an at-a-glance view for other providers.

Information is added to the CED if it is recorded during a patient visit. For example, if a provider records a new problem/profile item during a visit, it gets added as a line in the Health Concern History area of the CED. If no new problem/profile item is recorded during that visit, a new line will not be added to the Health Concern History area. In the Measured Observations area, if a BP is recorded, it will be added, but if there is no height, weight or waist circumference recorded during that visit, those boxes will be blank.

CII does not ‘mine’ the chart of a patient and transfer or collect information from visits before the clinic was live on CII. Information appears on the CED only for encounters that happen after go live.

Participating providers are provided a ‘map’ for their EMR so that they can understand how some of the information they enter into the EMR informs the CED. A provider can choose to use features of their EMR to keep information from flowing to the CED. After 12 months information drops off the CED.

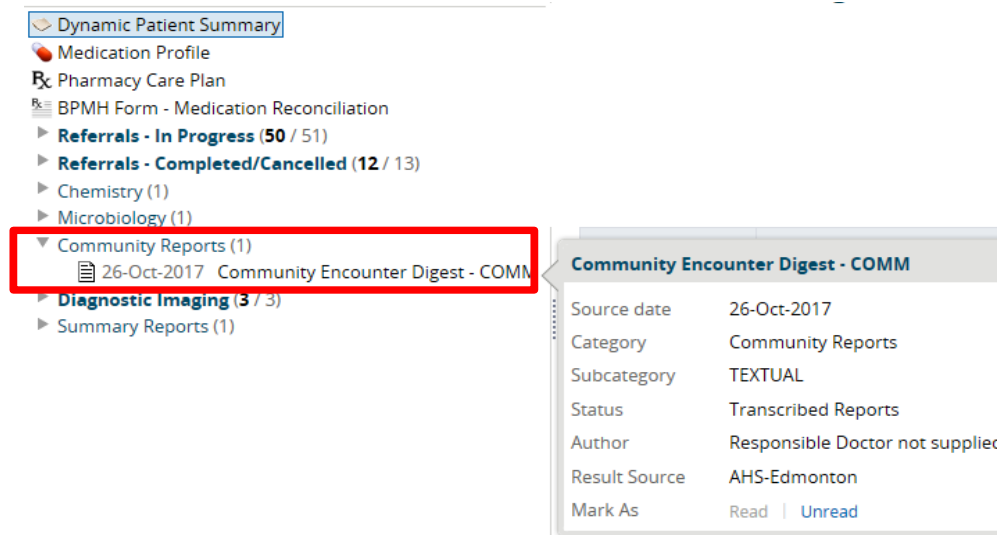
The CED is proving to be very valuable for providers in emergency departments and hospitals. They can now see if the concern for which the patient is presenting is new or has previously been a reason for an encounter in the community. There have already been a number of cases where urgent care providers have reached out to community providers for additional information that has significantly improved patient outcomes, and, in some instances, saving lives.

The disclosure statement at the bottom of the CED is in line with the terms and use of other information in Alberta Netcare. The information is ‘as is’ and does not represent a medical history or summary.



WHERE IS THE CED FOUND IN ALBERTA NETCARE?

A new folder was added to the Clinical Document Viewer tree in Alberta Netcare called “Community Reports”.



Community Encounter Digest - COMM	
Source date	26-Oct-2017
Category	Community Reports
Subcategory	TEXTUAL
Status	Transcribed Reports
Author	Responsible Doctor not supplied
Result Source	AHS-Edmonton
Mark As	Read Unread

Every Albertan who has visited a CII enabled provider in the past 12 months has a CED in their Alberta Netcare record. Newer versions of the CED will replace any prior versions in Alberta Netcare. An updated version will show as bolded (unread) for Alberta Netcare users.

OTHER DOCUMENTS COMPLEMENT THE CED

The CED is not meant to be a comprehensive record or a patient summary. The Patient Summary is under development and it is meant to be the comprehensive summary of the patient curated by the patient’s primary care provider.

Specialty care providers using CII are already able to share select consult reports to Alberta Netcare. These are found in the Consultations folder in Alberta Netcare.

CAN INFORMATION ON THE CED BE CORRECTED?


If a participating provider wishes to modify past entered information, they will need to re-open the encounter/visit where it was entered, modify the entry and then sign it off again. That evening the change will go to the CED in Alberta Netcare. If any previously submitted information is later removed from the patient’s chart at the clinic (due to a correction or data entry error, for example), that information will be updated on the CED with strikethrough font to show that it no longer applies for this patient.

The CED disclosure statement indicates that the information is ‘as is’, as a reminder to all providers viewing the report that its contents should always be confirmed with the patient or family members.

For more information about CII/CPAR visit: <https://actt.albertadoctors.org/PMH/panel-continuity/CII-CPAR/Pages/default.aspx>



Sample Community Encounter Digest



Community Encounter Digest

Listing Encounters Submitted between 2017-May-18 and 2018-May-18

Person: Public, John Q PHN/ULI: 20001716 Alberta DOB: 1943-Jan-16 Gender: M

COMMUNITY ENCOUNTERS

Encounter Date	Service Delivery Location	Provider Name	Provider Role, Expertise	Patient Reason for Encounter	Clinician Encounter Clinical Assessment
2018-May-18	Calgary Medical Clinic	James King	Physician, General Practice		Pulmonary embolism [415.19AD]
2018-Mar-12	Westmont Medical Clinic	Adam Douglas	Physician, General Practice	Review Results – review recent	Recurrent pulmonary embolism [415.19AD]
2018-Jan-09	Westmont Medical Clinic	Zack Wade	Physician, General Practice	Gout	
2017-Dec-05	Westmont Medical Clinic	Adam Douglas	Physician, General Practice	Asthma – Follow-up – F/C spec	Obstructive sleep apnea [327.23D]
2017-Sep-26	Calgary Medical Clinic	James King	Physician, General Practice	Wheezing – cough, chest congestion	Gout [274.9H]
2017-Aug-29	Calgary Medical Clinic	James King	Physician, General Practice	Medication Management	Drug [786.09EC]
2017-Jul-15	Westmont Medical Clinic	Adam Douglas	Physician, General Practice	Review results – lab results	
2017-Jun-08	Westmont Medical Clinic	Adam Douglas	Physician, General Practice	Medication Management	Pedal edema [782.3BN]

* Encounters collected from participating clinics over the past 12 months; it may not represent all encounters for the patient.

HEALTH CONCERN HISTORY

Encounter Date	Health Concern	Provider Name	Source
2018-Jan-09	Gout	Zack Wade	South Calgary Medical Clinic
2017-Dec-05	Obstructive sleep apnea	Adam Douglas	Westmont Medical Clinic
2017-Jul-15	Pulmonary Embolism (Resolved)	Adam Douglas	Dr. Douglas, Adam
2017-Jun-08	Anticoagulation Monitoring, INR Range 2-3 (Resolved)	Adam Douglas	Westmont Medical Clinic

* Health concerns collected from participating clinics; it may not represent all health concerns for the patient.

POSSIBLE ALLERGY

Encounter Date	Possible Allergy / Intolerance Agent	Provider Name	Source
2017-Jun-08	Celebrex	Adam Douglas	Westmont Medical Clinic

* Allergy information collected from participating clinics; it may not represent all allergies for the patient.

MEASURED OBSERVATIONS

Encounter Date	Systolic BP	Diastolic BP	Height	Weight	Waist Circumference	Source
2018-Jan-09	110	64				Westmont Medical Clinic
2017-Dec-05	110	64	1.81 m	142.8 kg	41 inches	Westmont Medical Clinic
2017-Sep-26	125	84				Calgary Medical Clinic
2017-Aug-29	113	73	181 cm	315 lb		Calgary Medical Clinic

* Measured observations collected from participating clinics; it may not represent all measurement observations for the patient.

IMMUNIZATIONS – No community data sent

REFERRALS

Referral	Referral Request Date	Referral Occurrence Date	Source
Urology	2017-Sep-27	2018-Feb-11	Calgary Medical Clinic
	2017-Sep-27		Westmont Medical Clinic



What's in Netcare – acute care patient information

Notification	Description	Netcare Folder
Anesthesia Post-procedure Evaluation	Post-op notes for anesthesia	Operative/Procedure/Investig'n
Consults	Multidisciplinary – note completed when a consult has been requested/completed on a patient	Consultations
Deceased Note	Note completed by prescriber after patient is deceased	Discharge/Transfer Summaries
Discharge Summary	Prescriber-focused discharge summary	Discharge/Transfer Summaries
ED Procedure Note	Carves out bedside procedures in Emergency Department	Emergency Records
ED Provider Notes	Note completed by an Emergency Department physician (may not include discharge instructions)	Emergency Records
History & Physical	Prescriber history and physical	History
Interval History & Physical Note	Used to update History & Physicals	History
Labour & Delivery Note	Required for delivery summary	Operative/Procedure/Investig'n
Op Note	Operative Report completed post-surgery by surgeon	Operative/Procedure/Investig'n
Procedures	Multidisciplinary – documentation around a procedure being completed	Operative/Procedure/Investig'n
Radiation Completion Note	Replaces the "Radiation Treatment Summary;" contains the care path for treatment booking rather than the summary documentation	Progress Notes
Teleconsult	Telephone encounter, used for Telehealth. Created when you do documentation in a telephone encounter (Patient Care > Telephone call). This is a specific type of encounter to represent a telephone call with the patient and is only used in that encounter type.	Consultations
Transfer Note	Prescriber-focused note that will be completed when a patient is transferred between units/services	Discharge/Transfer Summaries
Transition Note	Transfer	Discharge/Transfer Summaries
Trauma Tertiary Assessment	Requested by Trauma Acute Care – required documentation for trauma (similar to a history/physical)	History



After Visit Summary: an overview

What is the After Visit Summary?

- It's a document specifically for patients, summing up their healthcare visit and any instructions from care providers on how the patient should manage the next steps of their care plan.
- It's given to patients by care providers after a medical appointment.
- It does not replace the discharge summary report—the After Visit Summary is a patient-friendly version of the discharge summary report.

What does the After Visit Summary offer to patients?

- Important follow-up information after an Emergency Department or outpatient visit, or an inpatient stay
- Instructions from care providers and details on medications, diet and follow-up tasks
- Information patients need from a multidisciplinary provider team

What are the benefits of the After Visit Summary?

- Increases the consistency of patient follow-up documentation
- Improves continuity of care
- Empowers patients by giving them the information they need



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Discharge Summary: an overview

What is the Discharge Summary?

- It's a document sent from the hospital team to care providers who will be looking after a patient after they are discharged.
- It serves as a health record of the patient's hospital stay.
- It's the primary document communicating a patient's transition care plan to primary care and community providers.
- It's often the only form of communication that accompanies the patient to the next care setting.
- It's available to care providers on Netcare.

Why is the Discharge Summary important?

- It's an essential part of promoting patient safety during transitions between care settings, particularly during the time immediately following discharge.
- It gives primary care and community teams important information on their patients' hospitalization, so the providers may offer the best possible follow-up care.

What's in the Discharge Summary?

- Diagnosis and discharge medications
- Results of procedures
- Follow-up needs and pending test results
- Admission and discharge dates; attending physician's name
- Goals of care
- Summary of the patient's presentation and relevant medical history notes
- Most responsible diagnosis; follow-up instructions
- Details on hospital problems
- Assessment and plan
- Discharge medications and medication reconciliation
- Recommended interventions



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