Alberta Doctors' Digest

Community Information Integration and Central Patient Attachment Registry

Although Alberta physicians continue to face many challenges, we should take pride that we still have one of the most robust health care systems in Canada. Strong emphasis on Patient's Medical Home (PMH) pillars, including strengthened continued care in the community and emphasis on electronic medical records, has put us further ahead compared to other provinces in Canada.

This dedication has continued with the ongoing rollout of the Community Information Integration/Central Patient Attachment Registry (CII/CPAR). It is the direct result of a 2016 amending agreement between the AMA and Alberta Health to create a technological tool to better support primary care. As a joint project between the AMA, Alberta Health and Alberta Health Services, CII/CPAR works to facilitate standardized two-way data collection between a patient's medical care in the community and other care providers via Alberta Netcare. Data collected is governed by the Health Information Data Governance committee made of a multidisciplinary group of users such as physicians, nurses and pharmacists.

As of April 8, 2021, 1,208 physicians from 289 clinics have signed up for CII/CPAR. "Of those signed up, currently, 569 family medicine and 176 specialist care physicians in 163 clinics are fully live," states Barbra McCaffrey, CII/CPAR Project Lead.

If you feel confused about all the acronyms and various health information systems in Alberta, you are not alone! Community Information and Integration (CII) is the technology that collects standardized patient information from community EMRs and consolidates it into a central database with some of the information available on Alberta Netcare. The Central Patient Attachment Registry (CPAR) is a provincial database that recognizes an established relationship between a patient and their primary care provider. CII/CPAR are different from ConnectCare, which is a system designed to unify clinical care information within AHS facilities.

Practically speaking, CII/CPAR bridges missing information about patients who are treated in the community and serves as a natural extension to Alberta Netcare. This does not mean all information from community encounters are collected, rather only standardized and mapped data are uploaded and viewable by other providers. This includes basic demographics, provider name, vitals, chief complaints and diagnoses – just to name a few.

Community patient information is summarized on a Community Encounter Digest (CED) report, also found on Alberta Netcare. The purpose of this summary isn't meant to be an all-inclusive repository of patient data, but rather a snapshot into the patient's engagement history with community practitioners. For example, an obstetrician caring for a patient with gestational hypertension could at a glance have some insight into their blood pressure trends in previous months before prescribing medication. A family physician seeing a chronic pain patient for walk-in care could see a pending referral to a chronic pain specialist, eliminating the need for duplicate referrals.

Efficiency via automation

About 30% of Alberta patients admitted to hospitals and subsequently discharged back to the community experience a gap in care resulting in worsening of their illness, higher readmission rates and poorer quality care. Patients who are formally panelled to a primary care provider are automatically notified of an emergency room visit or a hospital discharge to ensure timely follow-up in the community. These reports are automatically received much like laboratory data, reducing administrative burden and opportunities for human error from manual scanning and referral tracking.

"Receiving e-notifications over the past year has been particularly helpful, because I now know when my patients have been discharged from emergency with COVID symptoms and can follow up on their COVID test results," says Dr. Janet Craig, family physician from Glenora Medical Clinic in Edmonton. "Also, if they have been discharged after an admission for COVID pneumonia, I can follow them using the COVID primary care pathway. Prior to signing up for CII/CPAR, I would not have known about these discharges unless the patient contacted me directly because I usually receive emergency reports and discharge summaries 7-10 days after patients leave the hospital."

There is also no direct financial cost in choosing to participate in CII/CPAR. After some administrative effort involved in initial set-up, predetermined data fields are automatically collected from a conformed EMR and collated onto the central database. Some of the information collected will also be available to patients via their MyHealth Records portal. Giving patients access to this information allows for better centralization and coordination of care while reducing unnecessary administrative follow-ups.

Strengthening primary care

CII/CPAR enhances the Patient's Medical Home by providing the backbone infrastructure required to support continuity of care, particularly with medically complex patients who may be seeing more than one practitioner.

Patients who are panelled to more than one primary care provider are flagged to community practitioners in monthly reports which allows practitioners to address outdated panel information. Examples of information included are patients who are deceased, moved away or have otherwise switched primary care providers. Patients can continue to seek episodic care from other providers such as walk-ins, however the reports will help clarify which providers are most responsible for ongoing longitudinal care.

CII/CPAR is also available to allied health professionals who work with participating physicians. This includes (but is not limited to) chronic disease nurses, pharmacists and dieticians – and allows them to submit information about their community encounters.

Future-oriented care

In general, a patient's primary provider is the one who knows them the best. On the horizon is the development of a patient summary report. This gives the option for the patient's primary provider to write a brief summary about the patient, highlighting any nuances that may impact clinical care, particularly when the patient is seen outside their medical home. This summary would also be available to the patient to access online via their Alberta MyHealth Records portal to ensure that both patient and providers are on the same page.

Currently, CII/CPAR is in the general rollout phase and supported by Accuro, Healthquest, Med Access, PS Suite and Wolf. Participation is available to both family physicians and specialists. Interested providers who are affiliated with a primary care network (PCN) can contact their physician liaison for more information on how to get started.

Physicians without PCN affiliation can contact the AMA's Accelerating Change Transformation Team (ACTT) directly at cii-specialty@albertadoctors.org.

Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.

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