MANITOBA HEALTH, HEALTHY LIVING AND SENIORS

Manitoba EMR Data Extract Specifications

Version 2

Updated: September 11, 2015

1 Introduction

The purpose of this document is to describe the data to be included in the Manitoba EMR Data Extract, including the format and order of each element within the extract. The Manitoba EMR Data Extract is used to provide patient care data to Manitoba Health, Health Living and Seniors (MHHLS) through its agent Manitoba eHealth. The information will be collected, complied and analysed; it will be used to support a number of provincial programs, including the Physician Integrated Network (PIN) initiative, the EMR Adoption Program and the validation of the Manitoba's annual management of chronic disease tariffs, as well as being a source to provide feedback to participating clinics, supporting quality of care in clinical practice.

Please note that the content of Manitoba's EMR Data Extract specifications are expected to evolve as the EMR Content Standards, developed by the Canadian Institute for Health Information (CIHI) are implemented in Manitoba. As those standards are implemented this guide may be revised or replaced.

1.1 Demographic Data

The following table represents the basic demographic data elements included in the Manitoba EMR Data Extract. The demographic file will include one record per patient containing the most up-to-date information for that patient as of the date the extract is run. The demographic file is to be entitled "demographic.csv" and it should contain a record for each patient that has visited the clinic in the last 60 months.

For clinics participating in the PIN Program, patient records that are assigned to physicians who have explicitly stated they do not want to participate in the program should be excluded from the extract prior the data being transmitted to MHHLS. For data extracts provided by all other clinics, data will need to exclude any patient records that are assigned to a physician who has not signed the EMR Adoption Program Information Sharing Agreement (ISA).

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership[1]		
				EMR Adoption	PIN	CDM
1	Clinic Identifier	Clinic Identifier assigned by MHHLS	Type = Character Format = #####	√*	√*	√*
2	Manitoba Health Physician Billing Number	Billing ID to uniquely identify the provider of service providing health care to an individual.	Type = Character Format = #####	√	√*	

[1] Initiative Membership identifies which programs/initiatives utilize the different data elements collected. Fields that contain a checkmark are used in the calculations relevant to the initiative and fields that are also marked with an asterisk are those that must contain valid data elements for the entire patient record to be included in any calculation.

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership[1]		
				EMR Adoption	PIN	CDM
3	EMR Patient Identifier	The unique identifier assigned by the EMR for the patient record in the EMR	Type = Character Format = #########	√*	√*	√*
4	Manitoba Health Personal Health Identification Number (PHIN)	Used to uniquely identify the individual for health care purposes. Will be used to track quality indicators by patient.	Type = Character Format = ######### (must be 9 numeric characters)	√*	√*	√*
5	Manitoba Health Registration Number	The identifier assigned to Manitoba individuals or families. Used, in the absence of a valid Patient Identifier, to identify Manitoba patients or families using primary care services.	Type = Character Format = ###### (Must be 6 numeric characters	√	√	√
6	Date of Birth	Used to determine age, which is necessary for several indicators.	Type = Date Format = MMDDYYYY	√*	√*	√*
7	Gender	Used to determine eligibility for several indicators.	Type = Character Format = 'M' or 'F' or "U"	√*	√*	√*
8	Postal Code	Used to determine the general geographical location of a client's residence.	Type = Character Format = A#A #A#	√	√	
9	Core Patient	A patient who has received the majority of care within the physician clinic.	Type = NUMERIC Flag Format = 1 for true or yes or 0 for false or no	√	√*	
10	Date of last visit	The date of the patient's most recent visit to the clinic or group practice.	Type = Date Format = MMDDYYYY	√*	√*	√
11	Active Indicator	Indicates whether the patient is marked as "Active" in the EMR. Active Patients are those patients who the clinic believes to be actively seeking care from the site. Patients do not need to have a defined relationship	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership[1]		
				EMR Adoption	PIN	CDM
		between the site such as "Enrolled" or "Core" to be considered active.				
12	Client Enrolled Start Date	Represents the date the Client was included on the roster. A patient should be identified as "enrolled" if he/she has confirmed his/her affiliation to the clinic and has been provided with all information and notices respecting enrolment that may be required under provincial policy or guidelines.	Type = Date Format = MMDDYYYY		√	
13	Client Enrolled End Date	Represents the date the client was removed from the roster.	Type = Date Format = MMDDYYYY		√	
14	Patient Identifier	Represents the health number assigned to the patient by a recognized issuing authority (provincial, territorial or federal).	Type = Variable length String (Max 30 characters) • A valid Health Card Number for the issuing province, territory or federal authority • UNK (unknown) • NA (not applicable)	√	√	

15	Patient Identifier Type	Represents the type of patient identifier. The element is constrained to provincial, territorial or federal identifier types.	Type = Character Format = ##### Field must contain one of the following values (JHN=Jurisdictional Health Number): **Value** **Description** JHNAB Alberta JHNBC British Columbia JHNMB Manitoba JHNNB New Brunswick JHNNL Newfoundland JHNNS Nova Scotia JHNNT Northwest Territories JHNNU Nunavut JHNON Ontario JHNPE Prince Edward Island JHNQC Quebec JHNSK Saskatchewan JHNYT Yukon JHNAF Armed Forces JHNVA Veterans Affairs JHNFN First Nations JHNCO Correctional Institution JHNRC RCMP JHNCI Immigration Other Other	√	√	

1.2 Prevention

The following represents the data elements that need to be collected and extracted in the Prevention file. The Prevention file will include one record per patient listed in the Demographic file extract and it will contain the patient's most up to date information. I.e. the Prevention file should have the same number of patients as the Demographic file. The prevention file is to be entitled "prevention.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
1	Clinic Identifier	Clinic Identifier assigned by MHHLS.	Type = Character Format = #####	√*	√*	
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	
3	Date of last cervical cancer screening	The date of the last PAP test.	Type = Date Format = MMDDYYYY	√	√	
4	Exemption from cervical cancer screening	This is a true/false value. For example, if the patient has had a hysterectomy, or has not been sexually active, they would be exempt from cervical cancer screening.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	
5	Date cervical cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of cervical cancer screening.	Type: Date Format: MMDDYYYY	√	√	
6	Date of last colon cancer screening	The date of the last FOBT test	Type: Date Format: MMDDYYYY	√	√	
7	Date colon cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of colon cancer screening.	Type: Date Format: MMDDYYYY	√	√	
8	Date of last breast cancer screening	The date of the last mammography test.	Type: Date Format: MMDDYYYY	√	√	
9	Exemption from breast cancer screening	This is a true/false value. For example, if the patient has had a radical mastectomy she would be exempt from breast cancer screening.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
10	Date breast cancer screening advice was last provided	The date that the patient was most recently given advice about the benefits of breast cancer screening.	Type: Date Format: MMDDYYYY	√	√	
11	Date of last lipid test	For dyslipidemia screening. Date of the last lipid to be taken back due to clinical evidence.	Type: Date Format: MMDDYYYY	√	√	
12	Date dyslipidemia screening advice was last provided	The date that the patient was most recently given advice about the benefits of dyslipidemia screening.	Type: Date Format: MMDDYYYY	√	√	
13	Date of last fasting blood sugar screening	Collected for all patients.	Type: Date Format: MMDDYYYY	√	√	
14	Date fasting blood sugar screening advice was last provided	The date that the patient was most recently given advice about the benefits of fasting blood sugar screening.	Type: Date Format: MMDDYYYY	√	√	
15	Date of Childhood immunizations counselling	The date on which all immunizations recommended by age seven have been confirmed or the date on which parents or guardians have been counselled on the recommended immunizations.	Type: Date Format: MMDDYYYY	√	√	
16	Date of last influenza vaccination counselling	The date of the patient's last influenza vaccination counselling.	Type: Date Format: MMDDYYYY	√	√	
17	Date of Pneumococcal vaccination	The date the patient's pneumococcal vaccination was given.	Type: Date Format: MMDDYYYY	√	√	
18	Date of most recent live birth	Used to determine eligibility for breast feeding education indicator.	Type: Date Format: MMDDYYYY			

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
19	Date of most recent breast feeding support/counselling	Collected for female patients who have had a live birth within the last 12 months.	Type: Date Format: MMDDYYYY			
20	Date of last blood pressure measurement	Collected for all patients	Type: Date Format: MMDDYYYY	√	√	
21	Date blood pressure screening advice was last provided	The date that the patient was most recently given advice about the benefits of blood pressure screening.	Type: Date Format: MMDDYYYY	√	√	
22	Sedentary patient	True/false value to indicate if the patient undertakes regular physical activity, more specifically, whether a patient performs at least 20 minutes of light exercise three times per week. Used to determine eligibility for Physical Activity Advice indicator.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	
23	Date of last physical activity advice	Collected for all patients 12 of age and over who are sedentary (as defined above).	Type: Date Format: MMDDYYYY	√	√	
24	Smoker	True/false value to indicate if the patient is a smoker.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	
25	Date smoking cessation advice was last provided	The date that the patient was most recently given advice about the benefits of quitting smoking.	Type: Date Format: MMDDYYYY	√	√	
26	Date of last influenza vaccination	The date of the patient's last influenza vaccination.	Type: Date Format: MMDDYYYY	√	√	
27	Date of last pneumococcal vaccination counselling	The date of the patient's last pneumococcal vaccination counselling.	Type: Date Format: MMDDYYYY	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
28	Date of last obesity / overweight screening	Collected for all patients.	Type: Date Format: MMDDYYYY	√	√	
29	Date of last colonoscopy	The date of the last colonoscopy.	Type: Date Format: MMDDYYYY	√	√	
30	Date of MMR immunization	The date on which all MMR immunizations recommended by age seven have been confirmed.	Type: Date Format: MMDDYYYY	√	√	
31	Date of last PHQ-2 administration	The date PHQ-2 (Patient Health Questionnaire-2) most recently verbally administered by a physician/other health care provider or self-administered on paper.	Type: Date Format: MMDDYYYY	√	√	
32	The character response to the PHQ-2 questions	Response to the PHQ-2 questions according to the following matrix: Q1 Yes & Q2 Yes – 1, Q1 Yes & Q2 No – 2, Q1 No & Q2 Yes – 3, Q1 No & Q2 No – 4.	Type = Character Format = #	√	√	
33	The date a depression screening follow-up assessment occurred	The date one or more outcomes were selected by a physician or other health care provider during the follow-up assessment.	Type: Date Format: MMDDYYYY	√	√	
34	The depression screening follow-up outcome selected	Character to be exported a selected - 1 b selected - 2 c selected - 3 d selected - 4 b AND c selected - 5	Type = Character Format = #	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
35	Date of active depression diagnosis	The date patient had been diagnosed with depression. This field refers to the date diagnosis was entered, not the onset date.	Type: Date Format: MMDDYYYY	√	√	
36	Smoking Status	Used to determine eligibility for indicator.	Type = numeric Values: 1 – Current smoker 2 – Former smoker 3 – Never a smoker	√	√	
37	Date of last cigarette/tobacco product	Used to determine if a "former smoker".	Type = Date Format : MMDDYYYY	√	√	
38	Date of last Smoker screening	This is the last time a patient's smoking status was visited.	Type = Date Format : MMDDYYYY	√	√	
39	Character response to the CTS questions	Response to the 5 screening questions endorsed by the Canadian Thoracic Society. # Question 1 Do you cough regularly? 2 Cough up phlegm? 3 Short of breath with simple chores? 4 Wheeze with exertion or at night? 5 Frequent colds that persist?	Type = Binary Format = 5 character value 0=No 1=Yes Example value: 01101 How this translates to responses: # Answer 1 No 2 Yes 3 Yes 4 No 5 Yes	√	√	
40	Date of last COPD At risk screening	The last time this patient was assessed if they were at risk for COPD.	Type = Date Format : MMDDYYYY	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM
41	Date of last Spirometry	The date of the patient's last Spirometry testing	Type = Date Format : MMDDYYYY	√	√	
42	COPD diagnosis	Indication that the patient has an active diagnosis of COPD.	Type: Numeric Values: 1 – Diagnoses with COPD 0 – Not Diagnosed with COPD (test came back negative	√	√	
43	Date of COPD diagnosis	The date the COPD Diagnosis was made	Type = Date Format : MMDDYYYY	√	√	
44	Date of last A1c screening	Preventative Diabetes Screening	Type = Date Format : MMDDYYYY	√	√	√

1.3 Diabetes Management

The following represents the data elements that need to be collected for Diabetes Management. The file will include one record per patient diagnosed with Diabetes. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic file. The diabetes file is to be entitled "diabetes.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8431
1	Clinic Identifier	Clinic Identifier assigned by MHHLS	Type = Character Format = #####	√*	√*	√*
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	√*
3	Patient has Diabetes	Indication that the patient has an active diagnosis of diabetes, type 1 or type 2.	Type: Binary Format: 1 for true or yes or 0 for false or no	√*	√*	√*

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8431
4	Date of last A1c	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
5	Date of last nephropathy test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
6	Patient has documented nephropathy	Collected for all diabetic patients.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
7	Date of last fundoscopic exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
8	Date of last foot exam	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
9	Patient has documented peripheral neuropathy	Collected for all diabetic patients.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
10	Date of last full fasting lipid test	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
11	Date of last blood pressure measurement	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
12	Date of last obesity / overweight screening	Collected for all diabetic patients.	Type: Date Format: MMDDYYYY	√	√	√
13	Date of last fundoscopic exam referral	Collected for all diabetic patients. This is the date of the fundoscopic referral, and not the date of the exam itself.	Type: Date Format: MMDDYYYY	√	√	√

1.4 Asthma Management

The following represents the data elements that need to be collected for Asthma Management. The file will include one record per patient diagnosed with Asthma. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic file. The Asthma file is to be entitled "Asthma.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8432
1	Clinic Identifier	Clinic Identifier assigned by MHHLS	Type = Character Format = #####	√*	√*	√*
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	√*
3	Patient has Asthma	Indication that the patient has an active diagnosis of asthma.	Type: Binary Format: 1 for true or yes or 0 for false or no	√*	√*	√*
4	Number of canisters of SABA prescribed within past 12 months	Collected for all asthma patients.	Type = Numeric Format = ###			
5	Patient has received preventer / controller medicine within past 12 months	True/false value. Collected for all asthma patients.	Type: Binary Format: 1 for true or yes or 0 for false or no			
6	Date patient last visited emergency department for asthma	Collected for all asthma patients.	Type: Date Format: MMDDYYYY			
7	Patient has an Asthma Action Plan	Collected for all asthma patients.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8432
8	The date of the most recent Asthma Action Plan review	The date of the last Asthma Action Plan Review or the date Asthma Action Plan was developed (if no subsequent review was made). Collected for all asthma patients.	Type: Date Format: MMDDYYYY	√	√	

1.5 Congestive Heart Failure Management

The following represents the data elements that need to be collected for Congestive Heart Failure Management. The file will include one record per patient diagnosed with Congestive Heart Failure. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic extract. The Congestive Heart Failure file is to be entitled "CHF.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8433
1	Clinic Identifier	Clinic Identifier assigned by MHHLS	Type = Character Format = #####	√*	√*	√*
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	√*
3	Patient has Congestive Heart Failure	Indication that the patient has an active diagnosis of congestive heart failure.	Type: Binary Format: 1 for true or yes or 0 for false or no	√*	√*	√*
4	Date patient last visited emergency department for congestive heart failure	Collected for all CHF patients.	Type: Date Format: MMDDYYYY			
5	Date of last obesity / overweight screening	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	√	√	√

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8433
6	Patient using ACE inhibitors or ARB	Collected for all CHF patients.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
7	Date of last full fasting lipid test	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	√	√	√
8	Date of last blood pressure measurement	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	√	√	√
9	Date of last fasting blood sugar test	Collected for all CHF patients.	Type: Date Format: MMDDYYYY	√	√	√
10	Date of Last A1c Screening	Preventative Diabetes Screening	Type = Date Format : MMDDYYYY	√	√	√

1.6 Hypertension Management

The following represents the data elements that need to be collected for Hypertension Management. The file will include one record per patient diagnosed with Hypertension. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic file. The Hypertension file is to be entitled "Hypertension.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8435
1	Clinic Identifier	Clinic Identifier assigned by MHHLS	Type = Character Format = #####	√*	√*	√*
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	√*
3	Patient has Hypertension	Indication that the patient has an active diagnosis of hypertension.	Type: Binary Format: 1 for true or yes or 0 for false or no	√*	√*	√*

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8435
4	Date of last fasting blood sugar test	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	√	√	√
5	Date of last full fasting lipid test	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	√	√	√
6	Date of last test to detect renal dysfunction (e.g. Serum, Creatinine)	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	√	√	√
7	Date of last blood pressure measurement	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	√	√	√
8	Date of last obesity / overweight screening	Collected for all hypertensive patients.	Type: Date Format: MMDDYYYY	√	√	√
9	Exemption from full fasting lipid screening	To allow an exemption for patients at low cardiovascular risk	Type = Numeric values 1= Framingham Risk Score<10% 2=disease stable	√	√	√
10	Date of last exemption from full fasting lipid screening	This is the last date the patient was assessed for being at low cardiovascular risk	Type: Date Format: MMDDYYYY	√	√	√
11	Date of last A1c screening	Preventative Diabetes Screening	Type = Date Format : MMDDYYYY	√	√	√

1.7 Coronary Artery Disease Management

The following represents the data elements that need to be collected for Coronary Artery Disease Management. The file will include one record per patient diagnosed with Coronary Artery Disease. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic file. The Coronary Artery Disease file is to be entitled "CAD.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8434
1	Clinic Identifier	Clinic Identifier assigned by MHHLS.	Type = Character Format = #####	√*	√*	√*
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	√*
3	Patient has Coronary Artery Disease	Indication that the patient has a diagnosis of coronary artery disease.	Type: Binary Format: 1 for true or yes or 0 for false or no	√*	√*	√*
4	Date of last fasting blood sugar test	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	√	√	√
5	Date of last full fasting lipid test	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	√	√	√
6	Date of last blood pressure measurement	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	√	√	√
7	Date of last obesity / overweight screening	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	√	√	√
8	LDL Level >2.0 in last 12 months	Collected for all CAD patients.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
9	Date of last lipid reduction counselling	Collected for all CAD patients. Note: medications listed under ATC code C10 can be used for this item.	Type: Date Format: MMDDYYYY	√	√	√

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	CDM 8434
10	Date of last lipid lowering medication prescription	Collected for all CAD patients.	Type: Date Format: MMDDYYYY	√	√	√
11	Patient has had acute myocardial infarction	True/false value to determine eligibility for indicator 7.06, Beta Blockers.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
12	Patient has a current prescription for a beta blocking drug	True/false value collected for all CAD patients up to 74 years of age (inclusive) who have had an AMI and are currently prescribed beta blocking drugs.	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	√
13	Date of Last A1c Screening	Preventative Diabetes Screening	Type = Date Format : MMDDYYYY	√	√	√

1.8 Osteoporosis Management

The following represents the data elements that need to be collected for Osteoporosis Management. The file will include one record per patient diagnosed with Osteoporosis. Each record should contain the patient's most up to date information and the patient should have a corresponding record in the Demographic file. The Osteoporosis Management file is to be entitled "Osteoporosis.csv".

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	
1	Clinic Identifier	Clinic Identifier assigned by MHHLS.	Type = Character Format = #####	√*	√*	
2	EMR Patient Identifier	This is the unique number assigned to the patient by the clinic for identification within the clinic's EMR.	Type = Character Format = #########	√*	√*	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	
3	Date of Manitoba bone density post-fracture notification letter	The date of the letter sent out to primary care physicians by MHHLS to identify patients as having a possible fracture.	Type: Date Format: MMDDYYYY	√	√	
4	Date of last bone mineral density test	Identification of the date of Last Bone Mineral Density Test	Type: Date Format: MMDDYYYY	√	√	
5	Osteoporosis diagnosis date	The date that the current osteoporosis diagnosis was made.	Type: Date Format: MMDDYYYY	√	√	
6	Osteoporosis diagnosis	Indication that the patient has an active diagnosis of osteoporosis	Type: Numeric Values: 1 – Diagnoses with Osteoporosis 0 – Not Diagnosed with Osteoporosis (test came back negative	√	√	
7	Date of last osteoporosis medication prescription	The most recent date a qualifying medication was prescribed to the patient. Collected for all osteoporotic patients	Type: Date Format : MMDDYYYY	√	√	
8	Last prescribed bisphosphonate	The most recent date that a biophosphate was prescribed to this patient. Collected for all osteoporotic patients	Type: Date Format : MMDDYYYY	√	√	
9	Patient has an osteoporosis action plan	True/False value to determine eligibility for indicator. Collected for all osteoporotic patients	Type: Binary Format: 1 for true or yes or 0 for false or no	√	√	

Order in Extract	Data Element Description	Purpose / Patient Population	Type and Format	Initiative Membership		
				EMR Adoption	PIN	
10	Date the most recent osteoporosis action plan review	The date of the last Osteoporosis Action Plan Review or the date the Osteoporosis Action Plan was developed (if no subsequent review was made). Collected for all osteoporotic patients	Type: Date Format : MMDDYYYY	√	√	

1.9 Revision Log

Version No.	Description of revision	Date of revision
3	1. All reference to the Manitoba Health Division changed to Manitoba Health, Healthy Living and Seniors 2. Fields that were previously Described as "Patient Identifier" as now defined as "EMR Patient Identifier". 3. Inserted demographic field 14 (Patient Identifier). 4. Inserted demographic field 15 (Patient Identifier Type). 5. Fields that were previously defined as "HGB A1C" or some variation have been relabeled as "A1c" 6. Elements were added to support COPD: a) Inserted Prevention Field 36 (Smoking Status). b) Inserted Prevention Field 37 (Date of last cigarette/tobacco product). c) Inserted Prevention Field 38 (Date of last Smoker screening). d) Inserted Prevention Field 39 (Character response to the CTS questions). e) Inserted Prevention Field 40 (Date of last COPD At risk screening). f) Inserted Prevention Field 41 (Date of last Spirometry). g) Inserted Prevention Field 42 (COPD diagnosis). h) Inserted Prevention Field 43 (Date of COPD diagnosis). i) Inserted Prevention Field 44 (Date of Last A1c screening). 7. Inserted CHF Field 10 (Date of Last A1c screening). 8. Inserted Hypertension Field 9 (Exemption from full fasting lipid screening). 9. Inserted Hypertension Field 10 (Date of last exemption from full fasting lipid screening). 10. Inserted Hypertension Field 11 (Date of last A1c screening). 11. Inserted CAD Field 13 (Date of last A1c screening). 12. Section 1.8 was added to support Osteoporosis Management. This section defines a new file labeled as "Osteoporosis.csv" and this file will collect information that is relevant to Osteoporosis management a) The standard fields, Clinic Identifier and EMR Patient Identifier were added to this file definition. b) Inserted Osteoporosis Field 3 (Manitoba bone density post fracture notification letter). c) Inserted Osteoporosis Field 4 (Date of last bone mineral density test). d) Inserted Osteoporosis Field 5 (Osteoporosis diagnosis date). e) Inserted Osteoporosis Field 6 (Osteoporosis diagnosis). f) Inserted Osteoporosis Field 7 (Date of osteoporosis medication prescription). g) Inserted Osteoporosis Field 8 (Date of last bisphosphonate). h) Inserted Osteoporosis Field 9 (Patient has an osteoporosis action plan). i) Inserted Osteoporosis Field 10 (Date the most recent osteoporosis action plan review).	Feb 2015

2	1.1 – Change in filtration criteria • Modification of the initial criteria that a patient must have visited the clinic in the last 36 months. This has now been increased to 60 months. Remove the Criteria that all patients need to be a core patient • Implement the filtration criteria that all patient records identifying a physician who has not signed an ISA cannot be present in the data extract that is submitted to MHHLS. 1.2 – Initiative Membership Identification • Three new columns were added to reflect membership of each data element. The columns identify if a data element is a member of EMR adoption, PIN and CDM initiative respectively..	Dec 2012
1	1.1 – Document Changes • The Manitoba Health Information Management Guide v1.5 was separated into 2 documents o Manitoba Health Information Management Guide v1.6 o Manitoba EMR Data Extract Specifications v1 1.2 – Demographic Data • Three new demographic data elements: active indicator, client enrolled start and end date have been introduced in this section. • Age contrarians from all indicators have been removed. • The column titled as "Required in Data Extract" has been included in demographic data elements and the values for that corresponding record has been updated accordingly. 1.3 – Prevention • Data Element #30 has been redefined as MMR immunization. • Five new data elements for depression screening have been introduced in this section.	Feb 2012