Selecting the Right Data Transfer Method: A Comprehensive Guide

Overview

This form identifies the various options that are available to physicians looking to import data from their existing EMR to Profile. The document will also outline the data items included in each type of data transfer, enabling providers to make an informed decision. Please note that this is not a contract but rather an informational document designed to support your decision-making as you explore the option of transferring your data to Profile.

These guidelines serve as a high-level reference, providing an overview of what is included under each transfer type. Given the uniqueness of each EMR, we recognize that no two data transfers are the same. We encourage you to use this as a general guide while understanding that we are committed to providing tailored support to meet your specific needs. Our team will work closely with you on a case-by-case basis to facilitate the transfer of the data you wish to migrate, ensuring a smooth and efficient process.

Types of Data Transfers

MSVA Format

This is format includes only basic patient demographic data. Selecting this format is advisable where you want to transfer ONLY patient details (e.g., Name, PHN, Date of Birth etc.), but not clinical details.

CDS Format

This is format includes basic patient demographic data and some medical record data.

PDF Format

This format transfers a human readable PDF document of the Medical Record. The documents section, such as scanned documents, is transferred as separate files.

Rich Data Transfer

This format includes Clinical, Demographic Data, Financial and Organization Data. This format is delivered in Profile JFA Format with a data specification file (Jaffa Specification)

Which Data Transfer Type is Right for me?

Providers have the flexibility to choose the data transfer method that best suits their needs, as the optimal approach will ultimately depend on their specific circumstances. Key factors influencing this decision include the time available for the transfer, the level of detail or volume of data they wish to migrate, and the associated costs. Providers with tight deadlines may opt for a faster but more limited transfer, while those requiring comprehensive historical data might choose a more detailed, time-intensive method.

Comparison of Options

Data Item	MSVA	Ontario MD CDS	PDF	Rich Data
Short Codes	No	Partial[1]	No	Yes
Patient Basic Demographic Data	Yes	Yes	Yes	Yes
Users and Providers	No	Partial[1]	No	Yes
External Providers	No	Partial[1]	No	Yes
Services	No	No	No	Yes
Disease Codes	No	Partial[1]	No	Yes
Source Patients and Cards	No	No	No	Yes
Patient Photo	No	No	No	Yes
Organizations	No	No	No	Yes
Payers	No	No	No	Yes
Histories	No	Yes	Yes	Yes
Prior Approvals	No	No	No	Yes
Contacts (Encounters)	No	Yes	Yes	Yes
Memo Box	No	No	No	Yes

[1] Only Code/Description/Name for data related to patient record

Past Orders	No	No	In Contacts	Yes
Patient Problems (without Allergies and Pregnancies)	No	Yes	Yes	Yes
Patient Allergies	No	Yes	Yes	Yes
Patient Obstetrics and Pregnancies	No	No	No	Yes
Alerts	No	Yes	No	Yes

Data Item	MSVA	Ontario MD CDS	PDF	Rich Data
Care Plan Templates	No	No	No	Yes
Care Plans	No	Yes	Still Due Interventions only	Yes
Appointments	No	Yes	Historical (where contact exists)	Yes
Appointments with no Patients	No	No	No	Yes
Patient Tasks	No	No	Only Due	Yes
Typing Templates	No	No	No	Yes
Document Templates	No	No	No	Yes
Letters	No	Yes	Yes	Yes
Usual Medications	No	No	Yes	Yes
Prior Medications	No	Yes	No	Yes
Transcriptions	No	No	Yes	Yes
Lab Results	No	Yes	Yes	Yes
Measures	No	Yes	In Contacts	Yes
Mail	No	No	No	Yes
Opening Balances	No	No	No	Yes

Scan Documents	No	Yes	Yes	Yes
eForms (WCB BC only)	No	Data[2]	No	Yes
Approval Attachments (WCB BC only)	No	No	No	Yes
Roster History (NB only)	No	No	No	Yes
Referrals	No	No	Yes	Yes
Invoices (reconciled & non-reconciled)	No	No	No	Yes
Financial Journals	No	No	No	Yes

These questions are a guideline only, please carefully read this entire document and be sure to understand what you are selecting.

Note: the test import includes data for only one provider.

Contact Us

Please don't hesitate to reach out to the Intrahealth Data Migration Team if you have any questions or need further assistance. Each EMR is unique, and we are here to support you throughout the process to ensure a smooth and successful data migration. For additional support, you can contact:

Role	Named Resource	Contact Information
Data Migration Manager	Laili Qiyam	laili.qiyam@intrahealth.com
Technical Operations Manager	Mark Sawaf	mark.sawaf@intrahealth.com

[2] Clinical Metrics data imported without visual forms

Glossary

Short Codes

Predefined abbreviations or alphanumeric codes used to quickly enter standardized information in the system, such as diagnoses, procedures, or medications.

Patient Basic Demographic Data

Core patient details, including name, date of birth, gender, address, phone number, emergency contacts, and insurance information.

Users and Providers

Users: Individuals with access to the EMR system, such as administrative staff, nurses, and physicians.

Providers: Licensed healthcare professionals who deliver medical services, including doctors, specialists, and nurse practitioners.

External Providers

Healthcare professionals outside the organization (e.g., referring physicians, specialists, labs, or imaging centers) who may be involved in a patient's care.

Services

Medical procedures, treatments, or consultations offered by the healthcare facility (e.g., lab tests, imaging, physiotherapy, or specialist consultations).

Disease Codes

Standardized classification codes (e.g., ICD-10, SNOMED) used to document and categorize diagnoses for billing, reporting, and clinical decision-making.

Source Patients and Cards

- **Source Patients:** The original patient records from which data is migrated, merged, or linked.
- **Cards:** A representation of a patient's data within the system, possibly referring to health insurance or medical ID cards.

Patient Photo

A digital image of the patient stored in their EMR profile for identity verification and reducing misidentification errors.

Organizations

Healthcare entities such as hospitals, clinics, long-term care facilities, or any institution involved in patient care.

Payers

Insurance companies, government programs, or other third-party entities responsible for covering medical expenses.

Histories

A record of a patient's medical, surgical, family, and social history, including past illnesses, surgeries, medications, and lifestyle factors.

Prior Approvals

Authorization from payers (e.g., insurance providers) required before certain medical services, procedures, or medications are covered.

Contacts (Encounters)

- **Contacts:** Communication details of individuals involved in a patient's care, such as family members or referring doctors.
- **Encounters:** Logged interactions between a patient and a provider, including appointments, check-ups, and hospital visits.

Memo Box

A free-text section within the EMR where providers can add notes, reminders, or additional details about a patient's case.

Past Orders

A record of previous prescriptions, lab tests, imaging, and treatment orders issued for the patient.

Patient Problems (without Allergies and Pregnancies)

A list of active and past medical conditions excluding allergies and pregnancy-related issues (e.g., hypertension, diabetes, arthritis).

Patient Allergies

Documented allergic reactions to medications, foods, or environmental factors (e.g., penicillin allergy, latex sensitivity).

Patient Obstetrics and Pregnancies

Medical history related to pregnancy, childbirth, and reproductive health, including past pregnancies, miscarriages, and obstetric complications.

Alerts

System-generated or manual warnings about critical patient information (e.g., allergy warnings, drug interactions, fall risk, or flagged conditions).

Care Plan Templates

Predefined structured templates used to create customized care plans for patients based on specific conditions, treatment protocols, or guidelines.

Care Plans

Individualized patient treatment plans outlining goals, interventions, and follow-ups, designed to manage chronic diseases, post-surgical recovery, or rehabilitation.

Appointments

Scheduled medical visits between a patient and a healthcare provider, including consultations, follow-ups, procedures, or telehealth sessions.

Appointments with No Patients

Booked time slots without an assigned patient, often used for administrative tasks, provider breaks, training, or meetings.

Patient Tasks

To-do items assigned to a patient or related to their care (e.g., medication reminders, upcoming lab tests, self-monitoring tasks).

Typing Templates

Preformatted text snippets for quick data entry (e.g., standard patient instructions, common diagnoses, or progress notes).

Document Templates

Predefined formats for creating standardized documents, such as medical reports, referral letters, or discharge summaries.

Letters

Official written communication within the EMR, including referral letters, patient notices, insurance requests, and medical summaries.

Usual Medications

A list of frequently prescribed drugs for a patient based on their medical history or a provider's commonly used prescriptions.

Prior Medications

A history of previously prescribed medications, including those that have been discontinued or completed.

Transcriptions

Converted audio-to-text documentation of dictated medical notes, typically from physicians, specialists, or voice recognition software.

Lab Results

Patient laboratory test outcomes (e.g., blood tests, urinalysis, imaging reports), stored in the EMR for review and tracking.

Measures

Quantitative clinical metrics recorded over time, such as blood pressure, BMI, glucose levels, and cholesterol.

Mail

Internal or external messaging within the EMR for communication between providers, staff, or patients.

Opening Balances

The initial financial balance of a patient's account, including outstanding charges, credits, or prepaid amounts at the start of a billing period.

Scan Documents

Digitized copies of paper-based medical records, ID cards, insurance forms, or signed consent documents stored in the EMR.

Roster History (NB only)

A record of patient enrollment and assignment history for New Brunswick (NB) healthcare providers, tracking which physician or clinic the patient has been assigned to over time.

Referrals

Requests for specialist care or external medical services sent from a primary care provider to another physician, specialist, or healthcare facility. Can be internal (within the same organization) or external (outside facilities) and may include attachments such as lab results or imaging reports.

Invoices (Reconciled & Non-Reconciled)

- **Invoices:** Billing documents generated for medical services rendered, sent to patients, insurance companies, or government payers.
- **Reconciled Invoices:** Payments have been matched and accounted for, ensuring all billed amounts are settled.
- **Non-Reconciled Invoices:** Payments have not yet been matched or fully processed, meaning there are outstanding balances or pending claims.

Financial Journals

Detailed records of financial transactions related to patient billing, payments, and adjustments within the EMR. Includes entries for charges, refunds, adjustments, reconciliations, and write-offs, helping in financial tracking and reporting.