Best Practice:

Your primary care panel report

McTesterson, Sample
Reporting Period: April 2018
PRIVATE AND CONFIDENTIAL

UNIVERSITY OF SASKATCHEWAN
College of Medicine
DEPARTMENT OF ACADEMIC FAMILY MEDICINE
MEDICINE.USASK.CA

THE SASKATCHEWAN COLLEGE OF FAMILY PHYSICIANS
LE COLLÈGE DES MÉDECINS DE FAMILLE DE LA SASKATCHEWAN
A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
UNE SECTION DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

SMA SASKATCHEWAN MEDICAL ASSOCIATION

SASKATCHEWAN HEALTH QUALITY COUNCIL

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Established by government legislation in 2002, the Health Quality Council (HQC) is a provincial organization with a mandate to accelerate improvement in the quality of health care in Saskatchewan. HQC works with patients and families, clinicians, administrators, researchers, and quality improvement specialists to make health care better and safer for everyone in Saskatchewan.

Acknowledgements

The production of these reports is made possible by financial support from the Saskatchewan Medical Association and the College of Medicine, Department of Academic Family Medicine (University of Saskatchewan). We wish to thank eHealth Saskatchewan for providing their resources, technology, and infrastructure supports in the development and delivery of these reports. Saskatchewan's panel reports are the product of collaboration involving several organizations in this province, and build on the experiences of our sister agencies, Health Quality Ontario and the Health Quality Council of Alberta. These reports are created with physicians for physicians.

HQC would like to thank the Physician Expert Panel for their guidance in this work:

- Dr. Sarah Bates
- Dr. Jessica Harris, Family Medicine Resident
- Dr. Marty Heroux
- Dr. Mark Lees
- Dr. Stan Oleksinski
- Dr. Janet Reynolds
- Dr. Ginger Ruddy
- Dr. Michael Stoll
- Mark Ceasar, Director, Saskatchewan Medical Association

HQC also wishes to acknowledge the following for their contributions:

- Scott Wells, Director, Information and Analytic Services, eHealth Saskatchewan
- Jessica Jeannot, Manager, Information Services, eHealth Saskatchewan
- Shawn McCann, Information Analyst, eHealth Saskatchewan
- Julia Bareham, Pharmacist Manager, College of Physicians and Surgeons of Saskatchewan
- Saskatchewan Ministry of Health, Data Trustee and supportive partner

Data for these reports were extracted from administrative health databases at the Ministry of Health and eHealth Saskatchewan under a data-sharing agreement.

Please note that only you have access to this report. Privacy of your data is being protected under the Health Information Protection Act. No other physician, government agency, and/or third party has access to this report unless you decide to share it. Your panel data will be used in an aggregated level as the provincial level comparison in other individual physician reports.

Report overview

The Physician Panel Report is a standardized report developed specifically for use by Saskatchewan family physicians. It was created using administrative health databases to provide you with selected information about your patient panel. As a family physician, better understanding your patient panel can be key to optimizing continuity of care, understanding the clinical needs of your patients, maintaining appropriate access for patients, and supporting clinic-level business planning.

Patients have been assigned to your panel based on your billing claims between April 1, 2015 and March 31, 2018, and an algorithm developed by Alberta Health Services that is 78%-85% accurate when compared to confirmed panels.This panel report includes information about your patients' characteristics, health system utilization, and a selection of important prescribing information.

A critical strategy for improving the health of Saskatchewan residents is providing family physicians with measurement and feedback, to stimulate improvement and innovation in how care is delivered in the community. This report has been developed to provide you with actionable and timely data that can support decision making, quality improvement, and in turn better clinical outcomes. Reports such as this can be used to inform panel management in your clinic, better understand your panel's characteristics (e.g., panel size), and increase your understanding of how family practice care fits within the broader health system. Furthermore, this report can also be leveraged to support you in adopting the Patient's Medical Home model developed by the College of Family Physicians of Canada. (https://patientsmedicalhome.ca/).

This report will enable you to analyze your patient panel's characteristics, emergency department utilization, hospital admissions, and prescription drug use for selected medications. Inside you'll also find helpful resources and external links to better your practice. These reports are dynamic documents that will continue to evolve based on expert advice and feedback from you. Please share your thoughts, comments, and improvement ideas with us: bestpracticesask@hqc.sk.ca

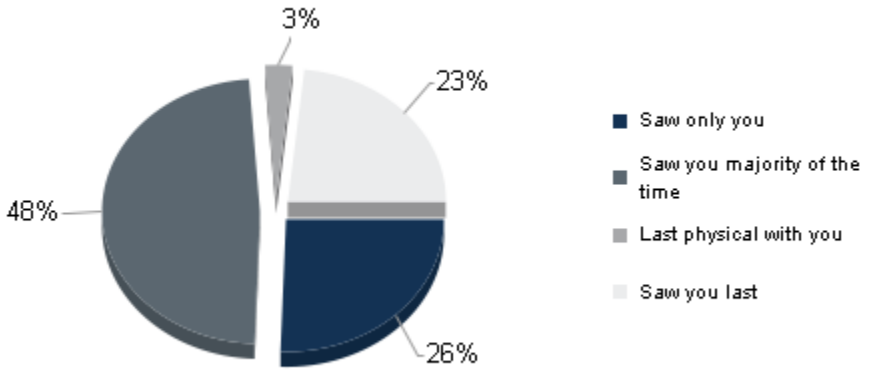
Quality improvement work that you initiate in response to your panel report may be eligible for Continuing Professional Development credits. For more information, contact bestpracticesask@hqc.sk.ca

1 How are patients assigned to my panel?

We used an approach developed by Alberta Health Services (called the 4-cut methodology) to assign patients to your panel, based on billing claims you provided between April 1, 2015 and March 31, 2018. Patients who were not seen within this period or new patients seen after this time are not included. To ensure the report is focused on your active patients, individuals who did not have Saskatchewan Health coverage on March 31, 2018 are also excluded from your panel. In Alberta, the 4-cut method is 78%-85% accurate when compared to confirmed patient panels.

Your total panel size = 1,706

Figure 1: Patient assignment distribution



Assignment Group	Patients
Saw only you	438
Saw you majority of the time	823
Last physical with you	45
Saw you last	400

The algorithm aims to predict the 'main family physician' – amongst all family physicians – that each patient saw during the three-year period. Alberta's 4-cut approach is a step-wise methodology involving the following four criteria:

1. **Saw only you**: If an individual only saw you during the three years, he or she is assigned to your panel.
2. **Saw you majority of the time**: If an individual saw you and other family physicians, but visited you the majority of the time, he or she is assigned to your panel.
3. **Had last physical examination with you**: If an individual saw you and other family physicians the same number of times, he or she is assigned to you if you did the last physical exam.
4. **Saw you last**: If an individual saw you and other providers the same number of times and has not had a physical, he or she is assigned to you if he or she saw you last.

Possible actions

Although the 4-cut methodology estimates your patients with good accuracy, you may gain additional insights from your panel report by comparing it to your confirmed panel of patients. For more information on this process, please contact bestpracticesask@hqc.sk.ca.

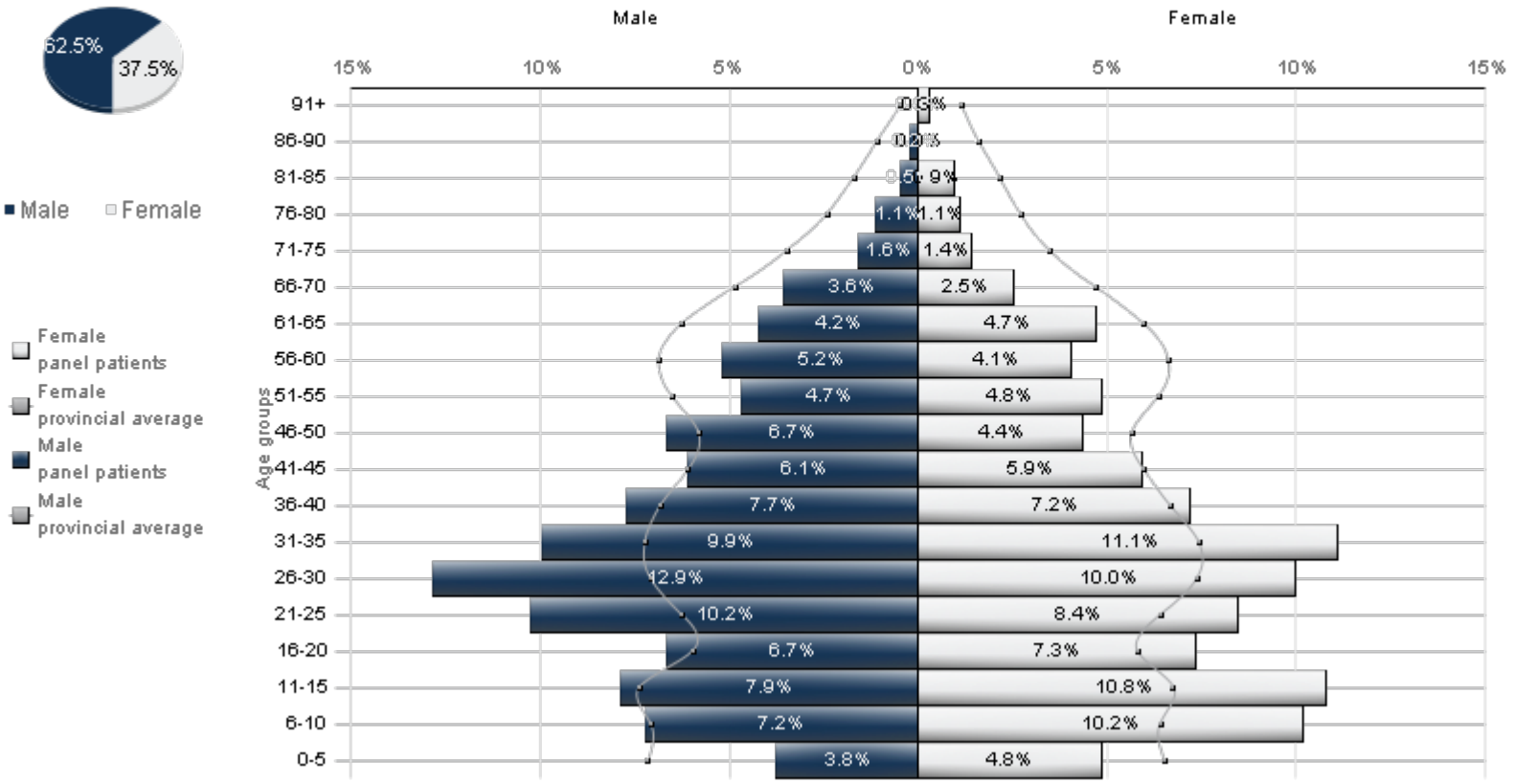
2 My panel characteristics

2.1 Who are the patients on my panel and how often do I see them?

Age (calculated as of March 31, 2018) and sex are important factors influencing how and why people interact with the health care system. Understanding these characteristics of your panel, as well as knowing which cohorts of patient sees you more often, can help you better understand your workload and lead to improved planning and outcomes.

Your panel includes 1,706 patients

Figure 2: Your panel's age/sex distribution



Possible actions

Based on this information, are there any patient groups you have seen more than others? Compared to the overall Saskatchewan population, are you caring for older or younger individuals? Is there a quality improvement initiative that might improve services to a particular age group on your panel?

2.2 Who am I seeing?

Your understanding of the age and sex distribution of your patient panel is augmented by information about the proportion of your visits from each demographic. Identifying more intensive users allows supports to be tailored to meet their needs.

Figure 3: Percentage of males in your panel and their visits to you

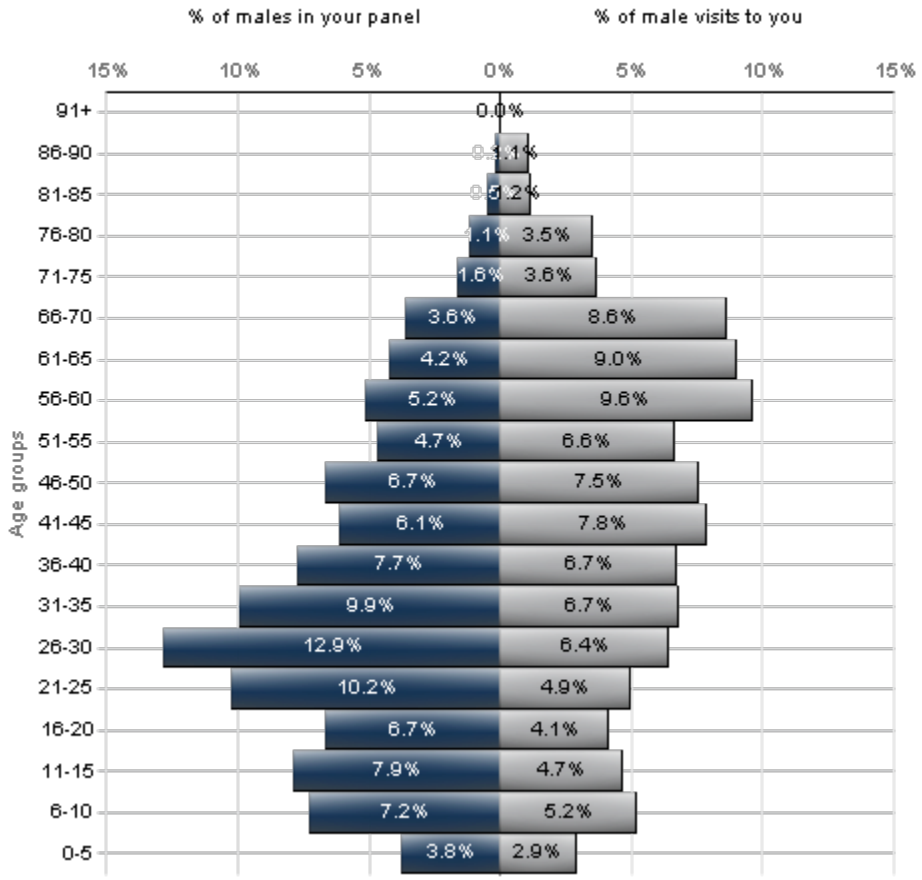
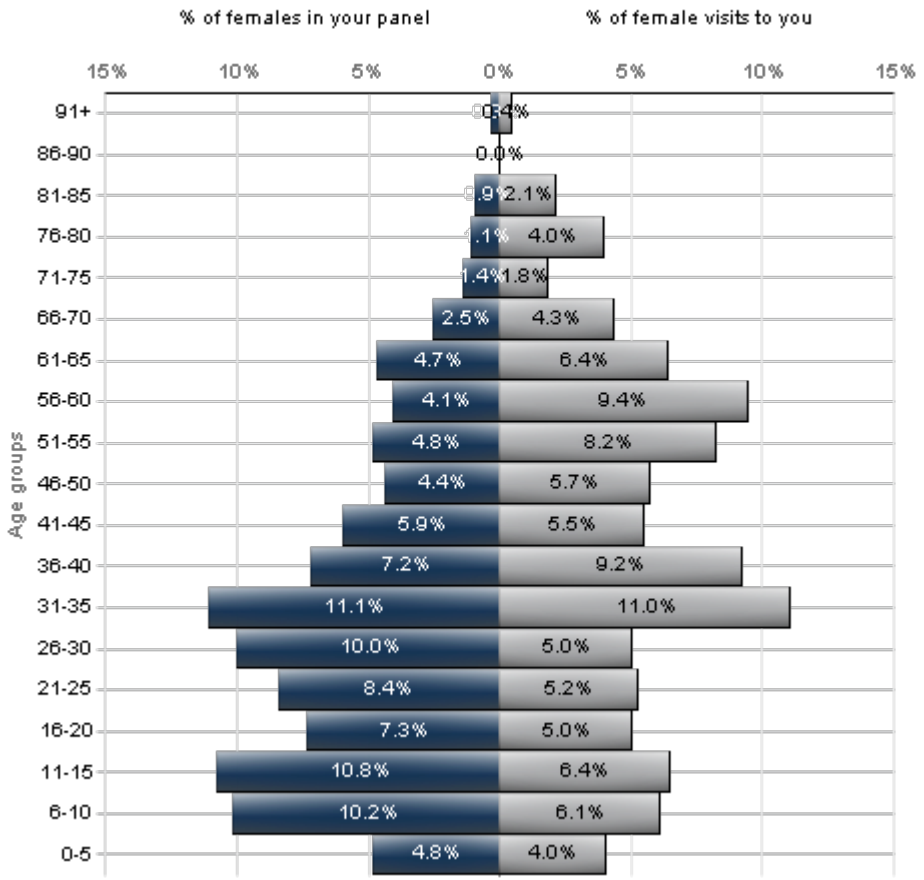


Figure 4: Percentage of females in your panel and their visits to you



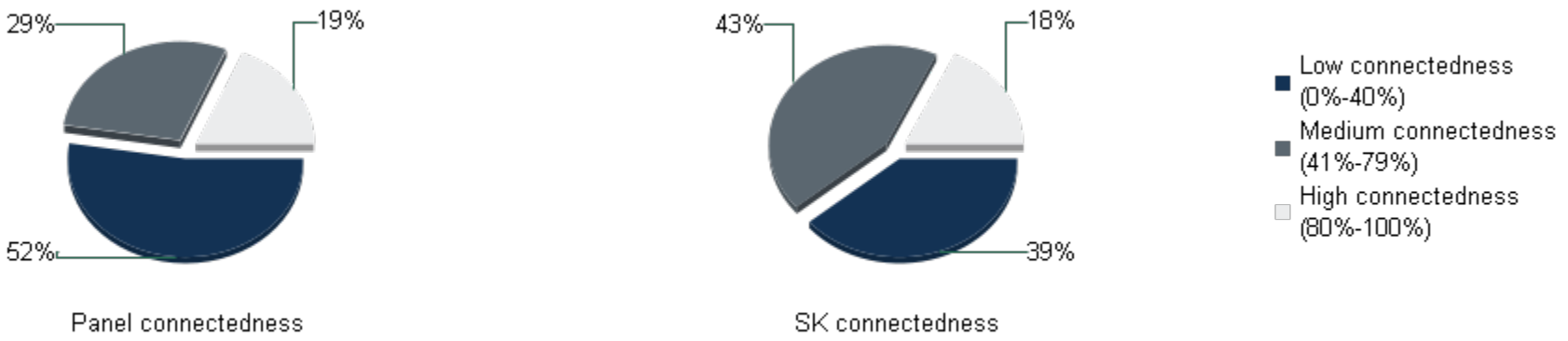
Possible actions

Is there a quality improvement intervention that might enable you to address groups that are more intensive users of services? Examples might include educational interventions aimed at reducing injuries in young boys, group prenatal visits, or group visits around managing chronic diseases.

2.3 What is my panel's continuity?

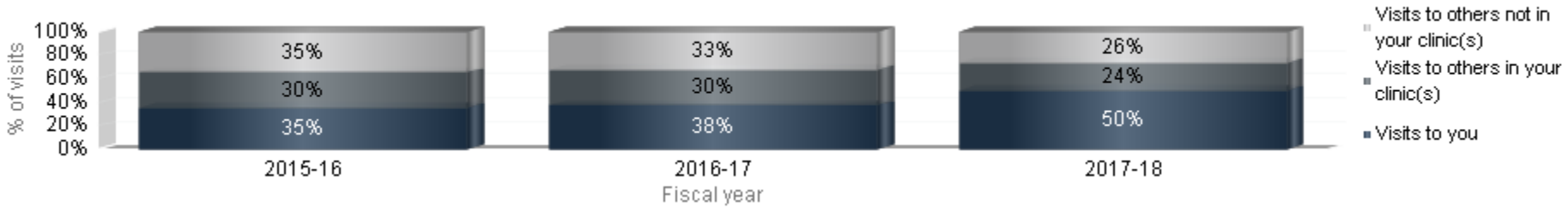
Patients will rarely receive all of their health care from a single family physician. Patients in your panel may also see other family physicians in addition to you. Continuity of care refers to the proportion of all visits that patients on your panel made to a family physician that were to you. Below is a summary of how your patients are connected to you. The higher the continuity, the greater the likelihood the patient was yours during the data period. The degree of connectedness is measured by Usual Provider of Care (UPC) Index and is broken into 3 categories: low, medium and high.

Figure 5: Your panel's connectedness



Having a stable relationship with your patients and involving them in clinical decision making not only increases their satisfaction with their care but also improves clinical outcomes and decreases unnecessary tests and can reduce use of acute services. The figure below shows how many times patients in your panel have seen you and other family physicians both inside and outside of your clinic.

Figure 6: Who is seeing your patients?



Possible actions

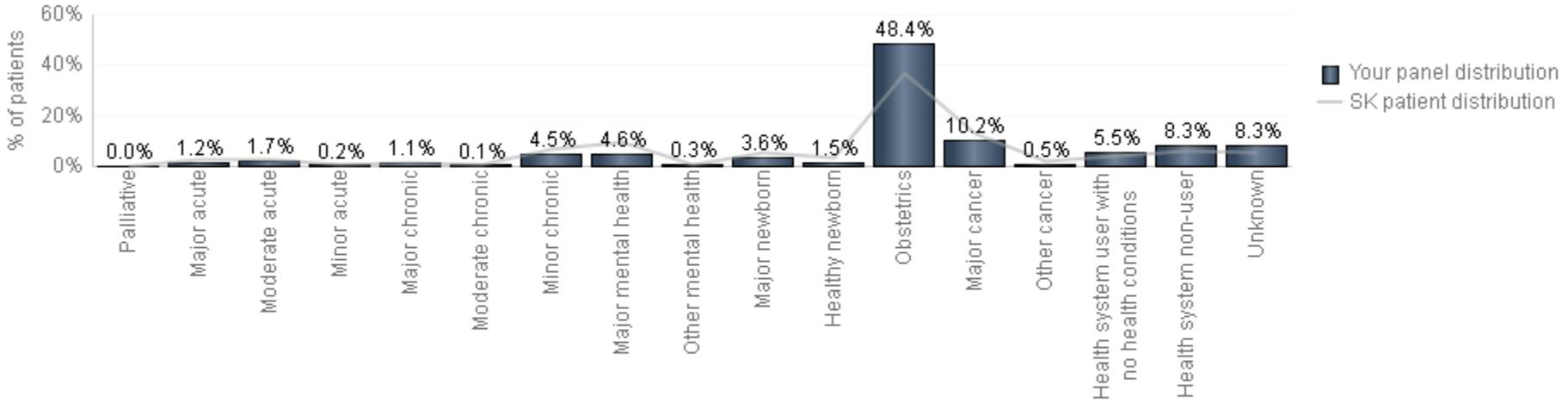
How does your panel continuity compare to the provincial average? It may be higher if you've been in a stable practice for a long time, without any extended leaves. Your panel continuity may be low if you are new to practice, your panel size is very large, or you see a lot of patients from outside of your clinic.

- Saskatchewan Medical Association http://www.sma.sk.ca/programs/44/physician-health-program.html
- Canadian Patient Safety Institute http://www.cps.sk.ca/imis/CPSS/News___Events/Continuing_Medical_Education.aspx

2.4 What is my panel's burden of illness?

Each patient in your panel has been uniquely assigned to a health profile group based on his/her interactions with the health care system (during the last two years: April 1, 2016 - March 31, 2018). Patients are assigned to one profile group based on the condition that is responsible for most of their health service utilization. For example, an individual with dementia, diabetes, and cardiovascular disease would be assigned to the "Major Mental Health" profile group if dementia is the condition driving most of his/her health service use.

Figure 7: Your panel's burden of illness



Possible actions

Does your panel include patients with chronic conditions, mental health problems, or other illnesses? There are best practice guidelines available that can support you in caring for patients with these needs:

• Canadian Task Force https://canadiantaskforce.ca/guidelines/published-guidelines/

Team-based care is also an effective approach to meeting the needs of patients with chronic disease, mental health issues, or both. Please consider available programs in your area:

• Saskatchewan Medical Association: http://www.sma.sk.ca/resources/21/chronic-disease-management.html

• eHealth Saskatchewan https://www.ehealthsask.ca/services/CDM

• Saskatchewan Ministry of Health https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/mental-health-and-addictions-action-plan

3 Acute care utilization

3.1 What percentage of my patients visited an emergency department (ED)?

Emergency departments are designed to serve patients with immediate care needs. The figure below shows your panel's emergency visits, divided by triage levels.

12% of your patients have visited emergency departments last year (total of 385 visits). In Saskatchewan, 13% of residents have visited the emergency departments during the same year.

Figure 8: Your panel's frequency of ED visits

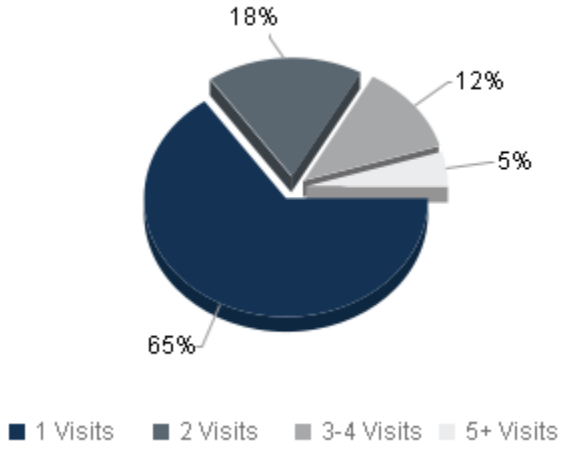
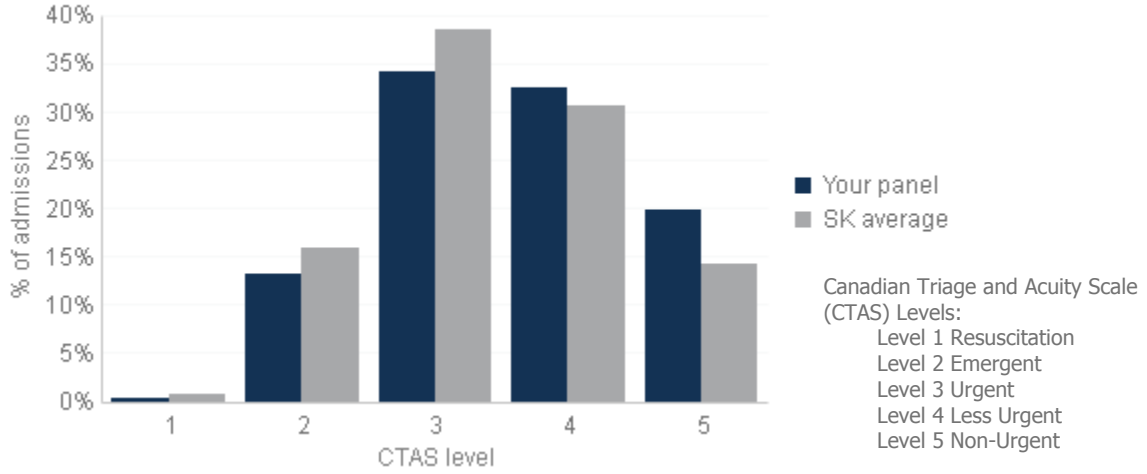


Figure 9: Your panel's ED visits by triage score



Research shows that a small number of patients are responsible for a large proportion of health care use. Do you see this pattern in your panel? For instance, did a lot of your patients visit an Emergency Department three or more times last year?

Possible Actions

Can you identify those patients who are frequent users of the ED? What can you and your colleagues do to reduce inappropriate ED visits?

Large numbers of "less urgent" visits (i.e., CTAS 4 and 5) may be a sign that patients are having trouble accessing primary health care. Does this appear to be a problem for patients in your practice? There are steps you can take to help your patients access your services:

• Transform My Practice http://transformmypractice.ca/

Health care providers should talk to their patients about appropriate use of emergency departments. There are resources available to support you in having these conversations:

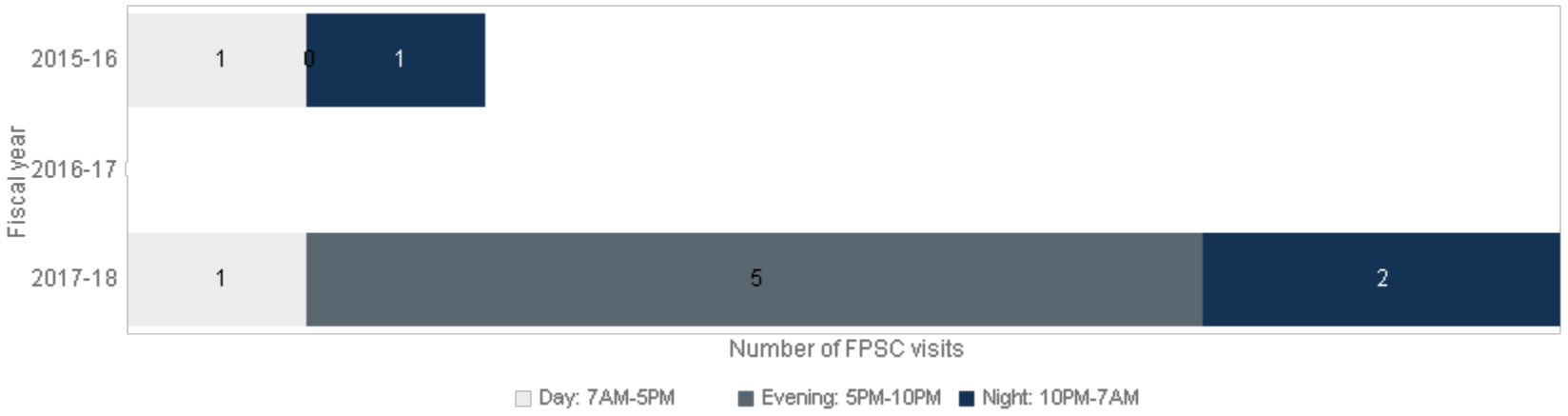
• Choosing Wisely Canada https://choosingwiselycanada.ornnecessary-treatments-ed/

3.2 What are my patients' avoidable ED visits by time of day?

Avoidable visits to Emergency Departments not only delay treatment for other patients who require urgent care, but also can lead to longer wait times, unnecessary treatments, and put patient safety at risk.

The figure below shows ED visits for Family Practice Sensitive Conditions (FPSC), by time of day, for patients in your panel. The visits were for conditions that could have been effectively treated in a family physician's office. These conditions include but are not limited to viral warts, conjunctivitis, sinusitis, sunburns, and migraines. See the technical appendix for a full list of conditions.

Figure 10: Your panel's ED visits for FPSC by time of day



Possible actions

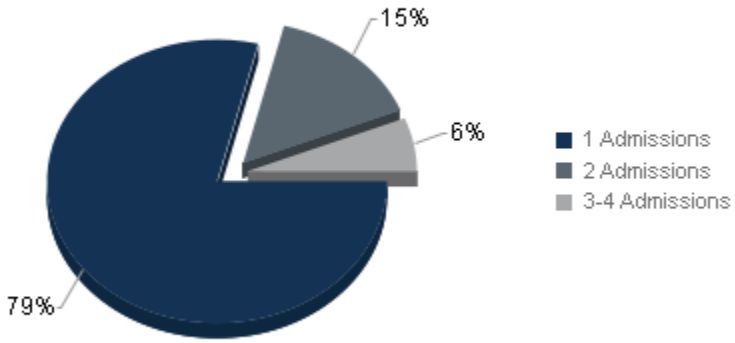
High rates of avoidable ED visits during business hours may indicate your patients are having trouble getting an appointment to see you. Tracking measures related to supply, demand, activity, third next available appointments, no-show rates, and continuity of care can help you optimize your practice. Enrolling in Transform my Practice : http://transformmypractice.ca/ help you get started.

3.3 What percentage of my patients were admitted to a hospital?

The figure below shows the percentage of your patients who were admitted to hospitals during the last fiscal year. Were your patients admitted to hospital more frequently than the provincial average?

5% of your patients were admitted to a hospital (inpatient) last year (total of 103 admissions). In Saskatchewan, 7% of residents were admitted during the same period. On average your panel stayed in hospitals for 27 days. While 26 days were related to their acute care, the other 1 days were alternate level of care (ALC) days. Last year, SK patients spent 23 days in hospitals, where 20 days were acute and 2 days were ALC.

Figure 11: Your panel's hospital admission frequency



Hospital Visit Group	Patients
1 Admissions	64
2 Admissions	12
3-4 Admissions	5

Possible actions

To identify patients who had recent hospitalizations, search "discharge summaries" in your EMR. Could some of those hospitalizations have been avoided? Should you connect with these patients?

Do you have an improvement idea that you'd like to pursue? HQC's Clinical Quality Improvement Project (CQIP) is a QI training program designed specifically for physicians:

• CQIP https://hqc.sk.ca/education-learning/cqip.

3.4 Why were my patients admitted to hospital during last fiscal year?

Here are the most common reasons for your patients' hospital admissions during the last fiscal year. Please note that day surgeries are not included.

Figure 12: Your panel's top 10 reasons for admission

Top 10 hospitalization reasons	# of patients	# of admissions	% of all admissions	Avg LOS (panel)	Avg LOS (SK)
Factors influencing health status and contact with health services	13	13	12.6%	5.7 days	5.8 days
Diseases of the circulatory system	10	12	11.7%	6.2 days	8.3 days
Pregnancy, childbirth and the puerperium	10	10	9.7%	1.9 days	2.6 days
Diseases of the digestive system	8	12	11.7%	5.5 days	5.5 days
Diseases of the respiratory system	8	9	8.7%	12.1 days	7.5 days
Certain infectious and parasitic diseases	7	7	6.8%	9.9 days	8.1 days
Injury, poisoning and certain other consequences of external causes	7	7	6.8%	4.6 days	6.9 days
Mental and behavioural disorders	7	9	8.7%	23.3 days	13.8 days
Diseases of the genitourinary system	6	6	5.8%	13.2 days	5.0 days
Diseases of the musculoskeletal system and connective tissue	6	6	5.8%	5.3 days	6.3 days

The table below shows your patients' admissions, lengths of stay, and re-admissions, divided according to their level of continuity/connectedness with you (i.e., low, medium, and high connectedness). The research literature shows that continuity of care improves patient outcomes and decreases hospital admissions and re-admissions.

Figure 13: Your panels admission/readmission by Usual Provider of Care Category

Connectedness level	Low connectedness (0%-40%)	Medium connectedness (41%-79%)	High connectedness (80%-100%)
Admissions (panel)	53	29	1
Admissions (other similar size panels)	66	62	10
Avg LOS (panel)	10.7 days	9.7 days	1.0 days
Avg LOS (SK)	7.8 days	8.1 days	8.8 days
Readmissions (panel)	6.0%	3.8%	0.0%
Readmissions (SK)	12.5%	11.4%	11.3%

Possible actions

Continuity of care – an ongoing relationship between a provider and a patient – should be a key objective of primary care. Evidence shows that patients who consistently see the same primary care physician have better outcomes and lower costs.

What does the data tell you about continuity in your relationships with patients? Given the characteristics of your panel, are you surprised by the reasons for admission? Are there differences in LOS between your panel and the provincial average? Admissions for patients with chronic conditions can sometimes be avoided with evidence-based chronic disease management. Consider enrolling in the SMA CDM-QIP program:

• Saskatchewan Medical Association http://www.sma.sk.ca/resources/21/chronic-disease-management.html.

4 Prescribing indicators

4.1 What percentage of my senior patients (65+) filled prescriptions for antipsychotic medications?

According to CIHI (2016), antipsychotics are commonly prescribed to individuals with Alzheimer's disease and related dementias who experience behavioural and psychological symptoms, including delusions, aggression, and agitation. Studies have found that antipsychotics may be over used in long term care facilities.

Figure 14 shows your prescription rates, over time, for seniors. Do you see any trends? Are your rates higher or lower than the rest of the province? Figure 15 shows the proportion of antipsychotics prescribed by you, as well as the proportion prescribed for your patients by other providers (including specialists).

Figure 14: The proportion of your senior (65+) patients prescribed antipsychotics

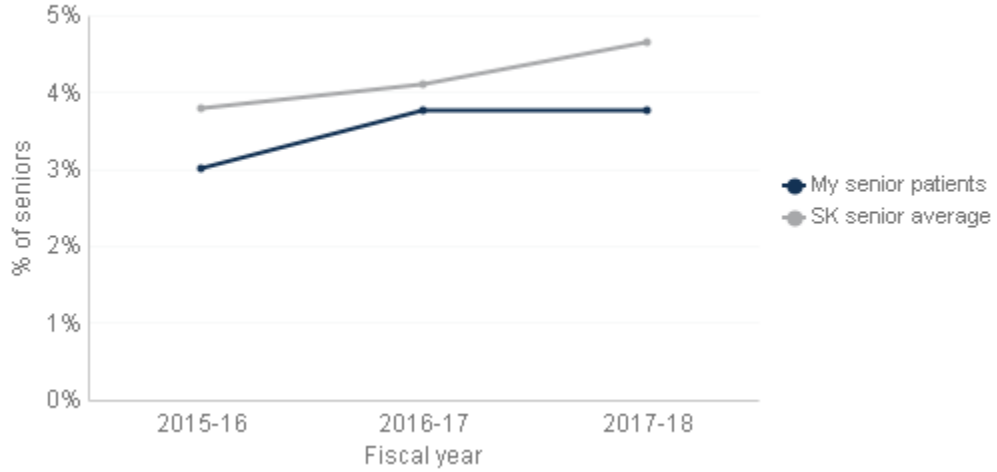
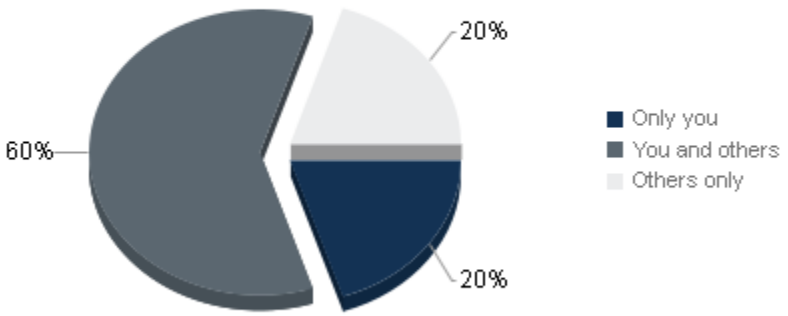


Figure 15: Your panel's prescribing source for antipsychotics



Possible actions

To better understand your prescribing patterns, it may be helpful to search your EMR to identify diagnoses being treated and location of seniors (i.e., community vs long-term care). RxFiles is a great provincial resource through which pharmacists provide academic detailing to clinicians:

• RxFiles: http://www.rxfiles.ca/rxfiles/home.aspx

• Health Canada: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2015/43797a-eng.php

A toolkit called "When Psychosis isn't the Diagnosis" is available to support interventions to reduce excessive use of antipsychotic medications in long-term care facilities. Its content is derived from the Appropriate Use of Antipsychotics (AUA) Toolkit developed by Alberta Health Services:

• Choosing Wisely Canada https://choosingwiselycanada.org/perspective/antipsychotics-toolkit/

4.2 What percentage of my patients filled prescriptions for opioid medications?

The College of Family Physicians of Canada has published guidelines for family physicians regarding opioid prescribing:

- **Don't continue opioid analgesia beyond the immediate postoperative period or other episode of acute, severe pain.**
- **Don't initiate opioids long-term for chronic pain until there has been a trial of available non-pharmacological treatments and adequate trials of non-opioid medications.**

The figures below shows opioid dispensing rates for your panel, for opioids, by prescribing source.

Figure 16: Your panel's prescriptions for opioids

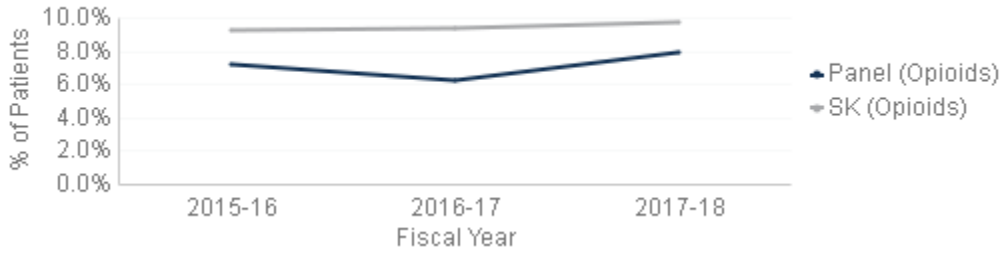


Figure 17: Your panel's prescribing source for opioids

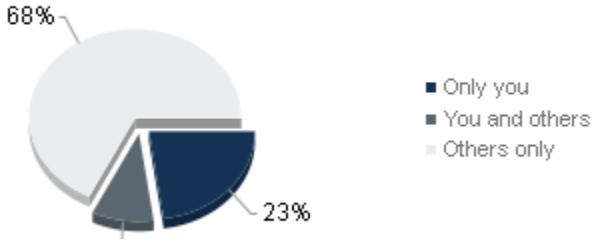


Figure 18: Percentage of your panel with 2+ dispensations in the time frame given

Possible actions

Better understand the patients for whom you are currently prescribing opioids. Run a search/report in the EMR to verify a list of patients being prescribed opioids. Perform a chart review and reflect on the reasons why these patients were prescribed opioids.

How many of your patients are being prescribed opioids for short-term vs. long-term use?

How many of your patients with chronic non-cancer pain are being prescribed opioids outside the recommended use guidelines? Are any patients at risk for or experiencing an opioid use disorder?

• Chronic Non-Cancer Pain Management and Opioid Resources (CFPC): https://www.cfpc.ca/chronic-non-cancer-pain-management-opioid-resources/

• Canadian Guideline for Opioids for Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html

• Choosing Wisely Canada (CWC): https://choosingwiselycanada.org/campaign/opioid-wisely/

4.3 Benzodiazepines

Benzodiazepines may be of benefit for some patients experiencing Generalized Anxiety Disorder (GAD). They have been shown to reduce both somatic and emotional symptoms of GAD. There is significant concern over dependence and tolerance to these medications, as well as the potential for significant side effects such as impaired psychomotor function, impaired memory, dependence and withdrawal symptoms (depending on duration of treatment), rebound anxiety (after short-term use).

The figures below show dispensing rates for your panel, for benzodiazepines, by prescribing source.

Figure 19: Your panel's prescriptions for benzodiazepines

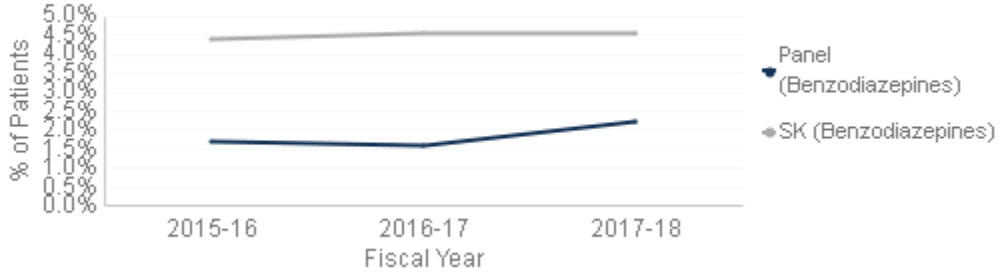


Figure 20: Your panel's prescribing source for benzodiazepines

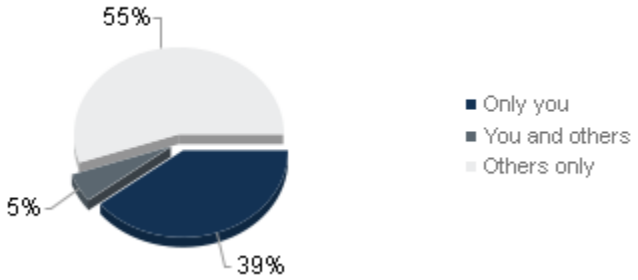


Figure 21: Percentage of your panel with 2+ dispensations in the time frame given

Possible actions

Better understand the patients for whom you are currently prescribing benzodiazepines. Run a search/report in the EMR to verify a list of patients being prescribed benzodiazepines. Consider using a risk-assessment tool. Perform a chart review and reflect on the reasons why these patients were prescribed benzodiazepines:

How many of your patients are being prescribed benzodiazepines for short-term vs. long-term use?

Are any patients at risk for or experiencing an opioid use disorder?

• Chronic Non-Cancer Pain Management and Opioid Resources (CFPC): https://www.cfpc.ca/chronic-non-cancer-pain-management-opioid-resources/

• Canadian Guideline for Opioids for Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html

• Choosing Wisely Canada (CWC): https://choosingwiselycanada.org/campaign/opioid-wisely/

4.4 Benzodiazepines and opioids

Combining benzodiazepines with opioids may increase the sedative effects and respiratory depression of the opioids. It may also result in poorer pain control and the need for higher doses of opiates and other pain-control medications.

The figures below show dispensing rates for your panel, for opioids and benzodiazepines individually and combined, along with the prescribing physician.

Figure 22: Your panel's prescriptions for opioids and benzodiazepines

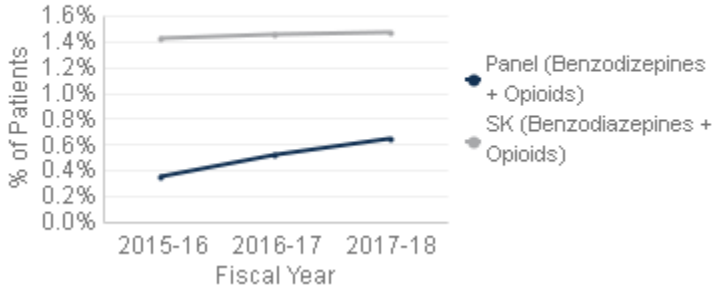


Figure 23: Your panel's prescribing source for opioids and benzodiazepines

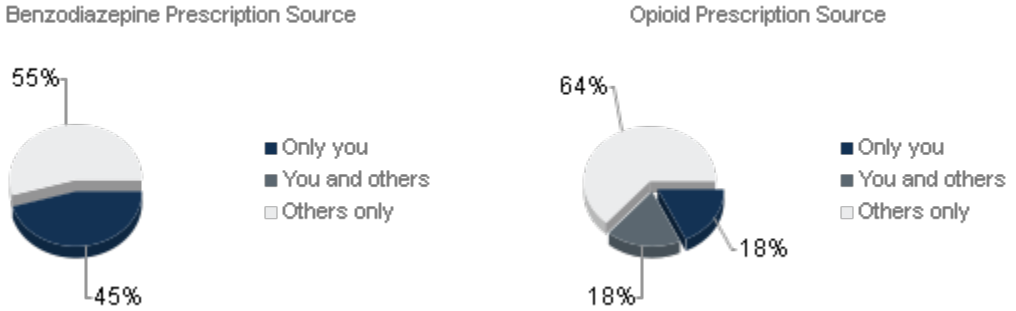


Figure 24: Percentage of your patients prescribed both opioids and benzodiazepines over time

Possible actions

Better understand the patients for whom you are currently prescribing benzodiazepines and opioids. Run a search/report in the EMR to verify a list of patients being prescribed both opioids and benzodiazepines. Perform a chart review and reflect on the reasons why these patients were prescribed these drugs in combination:

How many of your patients are being prescribed benzodiazepines and opioids for short-term vs. long-term use?

• Chronic Non-Cancer Pain Management and Opioid Resources: https://www.cfpc.ca/chronic-non-cancer-pain-management-opioid-resources/

• Canadian Guideline for Opioids for Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html

• Choosing Wisely Canada: https://choosingwiselycanada.org/campaign/opioid-wisely/

My Practice Report Checklist

Items to think about …

- ☐ Are there any patient groups you have seen more than others?
    - ☐ Is there a quality improvement initiative that might improve services to a particular age group on your panel?
- ☐ Is there a quality improvement intervention that might allow you do address groups which are more intensive users of services? (e.g. group visits for prenatal care or chronic disease management)
- ☐ How does your panel's continuity compare to the provincial average?
- ☐ Does your panel include patients with chronic conditions, mental health problems, or other illnesses?
    - ☐ Are there team-based care programs available in your area?
- ☐ Are some of your patients frequent users of the Emergency Department?
    - ☐ Is there anything you and/or your clinic can do to reduce inappropriate Emergency Department visits?
- ☐ [any to add based on new content on page 10?]
- ☐ Identify patients who had recent hospitalizations by searching "discharge summaries" in your EMR.
    - ☐ Could some of those hospitalizations have been avoided?
    - ☐ Should you connect with these patients?
    - ☐ Are you surprised by the reasons for hospitalizations among your patients?
    - ☐ Are there differences between your panel and the provincial average LOS?
- ☐ Search your EMR to identify diagnoses being treated and location of seniors (i.e.., community vs long-term care).
- ☐ Run a search/report in the EMR to verify a list of patients being prescribed opioids. Reflect on the reasons why patients are being prescribed opioids.
    - ☐ How many of your patients are being prescribed opioids for short-term vs. long-term use?
    - ☐ How many of your patients with chronic non-cancer pain are being prescribed opioids outside the recommended use guidelines?
    - ☐ Are any patients at risk for or experiencing an opioid use disorder?
- ☐ Run a search/report in the EMR to verify a list of patients being prescribed benzodiazepines. Reflect on the reasons why patients are being prescribed benzodiazepines
- ☐ How many of your patients are being prescribed benzodiazepines for short-term vs. long-term use?
    - ☐ Are any patients at risk for or experiencing a benzodiazepine use disorder?
- ☐ Have you enrolled in Transform My Practice?
- ☐ Have you considered pursuing a quality improvement though the Clinical Quality Improvement Project (CQIP) program?