Best Practice:

Your primary care panel report

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eHealth Saskatchewan

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

Contents

The panel report program...

The **BestPractices Primary Care Panel Reports** are developed by the Saskatchewan Health Quality Council, with involvement of the SMA, and guided by physicians. 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

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. 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. These reports are created *with* physicians *for* physicians.

For the 2020 edition, HQC would like to thank the **Physician Expert Panel** for their guidance in this work:

- Dr. Sarah Bates
- Dr. Kristin Bonkowski Foy
- Dr. Jessica Harris
- Dr. Emmett Harrison, Family Medicine Resident
- Dr. Mark Lees
- Dr. Christo Lotz
- Dr. Stan Oleksinski
- Dr. Ginger Ruddy
- Andrea MacKay, Sr. Analyst, Health Policy, SMA

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- Scott Wells, Director, Information and Analytic Services, eHealth Saskatchewan
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- Shawn McCann, Data Scientist, eHealth Saskatchewan
- Neil Klippenstein, Information Analyst, eHealth Saskatchewan
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- Saskatchewan Ministry of Health, Data Trustee and supportive partner

In particular, this work would not be possible without the involvement and support of eHealth Saskatchewan and their staff who produce and distribute the reports.

Please note that you are the only one receiving this report; the results are not shared with anyone else.

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.

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

Report Overview

The **BestPractices Primary Care 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, a strong understanding of 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.

For the 2020 version, patients have been assigned to your panel based on your billing claims between **January 1, 2017 and December 31, 2019,** using an algorithm developed by Alberta Health Services that is 78%-85% accurate when compared to confirmed panels.

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 the care you provide 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, various health indicators, 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

Thank-you for your feedback!

The 1st version of the report was released in 2019. We asked for your feedback and the key themes we heard were:

- The panel identification method was unclear
- The panel size was lower than expected
- Some data was difficult to interpret or lacked sufficient detail to be informative
- There is a desire for clinic level reports for shared and team-based practices
- Saskatchewan average was too broad to be a truly useful comparator

Please, continue to give us feedback!
We aim to keep improving this report and ensuring it is relevant and useful to you

What's new for 2021?

- ✓ The panel identification method is more clearly explained (page 5)
- ✓ A comparison of your panel to the number of "discrete" patients seen is provided (page 6)
- ✓ New metrics relating to prescription drugs and chronic disease management
- ✓ More granular categories or metrics used for others (e.g., disease burden)
- ✓ Your local Health Network is now used as the comparator
  - See www.bestpracticesask.ca/resources for details on how network was identified and applied

Plus…

- ✓ **A new education program is available to help you read and make use of your report, while also obtaining Mainpro+ credits.**
  - There are 4 new modules worth 10-15 credits each
  - For more details, see page 30 or www.bestpracticesask.ca/education

We're also assessing the feasibility of providing clinic-level reports and hope to have these available in the future.

1. PANEL ASSIGNMENT METHOD

a) What is a panel of patients

A physician's panel is the list of patients for whom you appear to be their main, or only, family physician. Note that this is determined from the patient's perspective

b) How are these patients identified and assigned to my panel?

- We used the "4-cut method" developed by Alberta Health Services to analyze all family physician billing records for the past 3 years (January 1, 2017 and December 31, 2019).
- First, we identify all people with Saskatchewan Health coverage as of December 31, 2019.
- Those that had no family physician (FP) visits within the 3-year period are labelled "unattached". Everyone who had at least 1 FP visit in the 3 years is proceeds to the 4-cut method:

cut #1 all patients who had all their FP visits with a **single** FP are assigned to that FP. The rest of the patients saw >1 FP and go to step 2.

cut #2 all patients who had an FP that they had **most** of their visits with are assigned to that FP. Any unassigned patients go to step 3.

cut #3 all patients without a "most common" FP but had a physical exam are assigned to the FP that billed for their **most recent physical**. All remaining patients go to step 4.

cut #4 all remaining patients are assigned to the FP they saw **most recently**.

In Alberta, the 4-cut method is 78%-85% accurate when compared to confirmed patient panels.

So, here's how we arrived at your panel of patients….

Saw only you:

If an individual only saw you during the three years, he or she is assigned to your panel.

Saw you the 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.

Had their last physical examination with you:

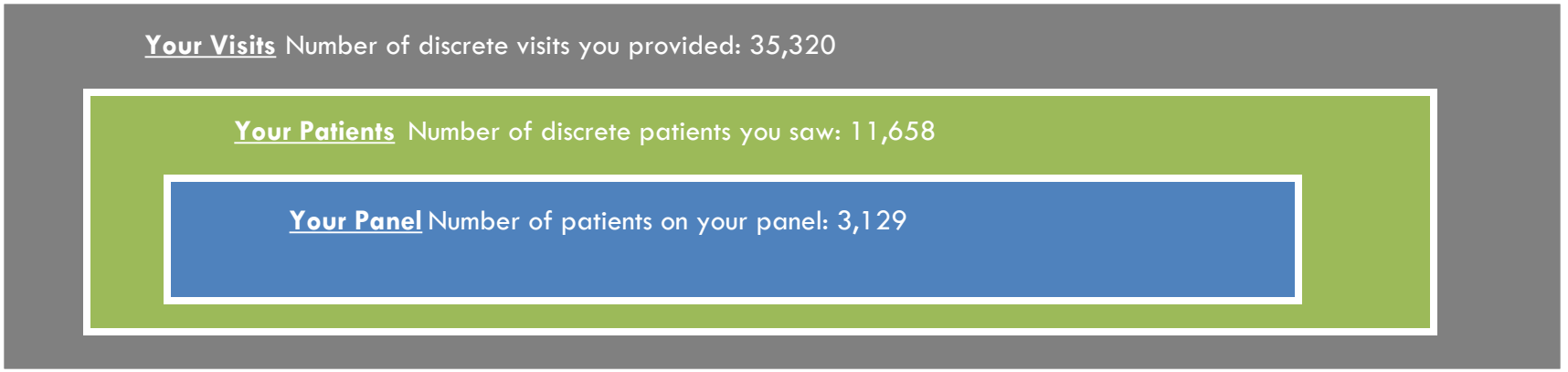
If an individual saw you and other family physicians the same number of times, he or she is assigned to you if you did the last physical exam.

Saw you last:

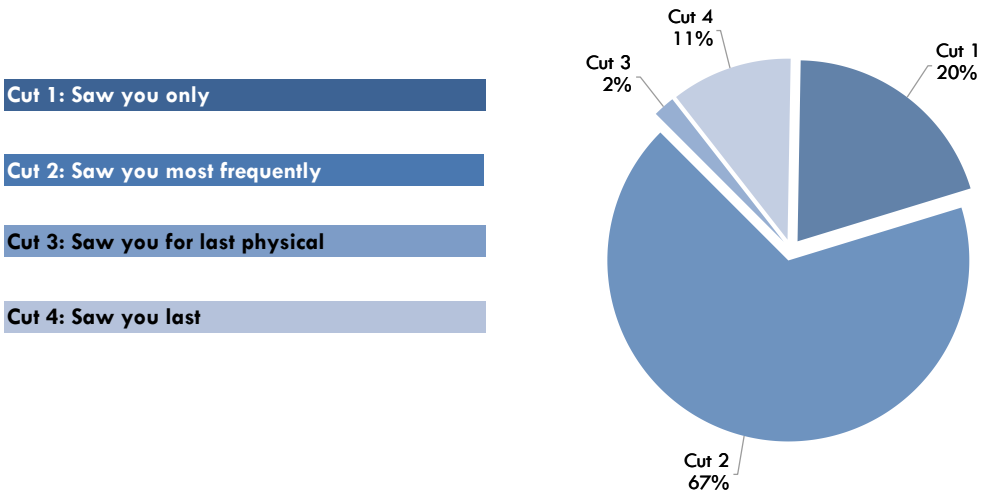
If an individual saw you and other providers the same number of times and has not had a physical, he or she is assigned to you if he or she saw you last.

1.1 How many patients are on my panel and how does this compare to the patients I've seen?

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 January 1, 2017 and December 31, 2019. Patients who were not seen within this period or new patients seen after this time are not included in a panel. To ensure the report is focused on your active patients, individuals who did not have Saskatchewan Health coverage on December 31, 2019 are also excluded. In Alberta, the 4-cut method is 78%-85% accurate when compared to confirmed patient panels.



Your Panel assignment by "cut"



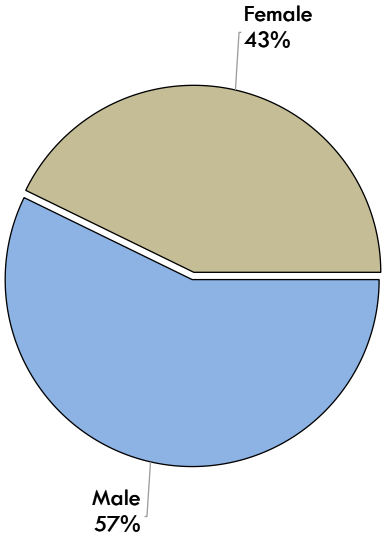
And there are 12,228 unattached patients in your network:
Regina 3
Total Patients in Network: 75,187

The rest of this report is based on the patients in **Your Panel**

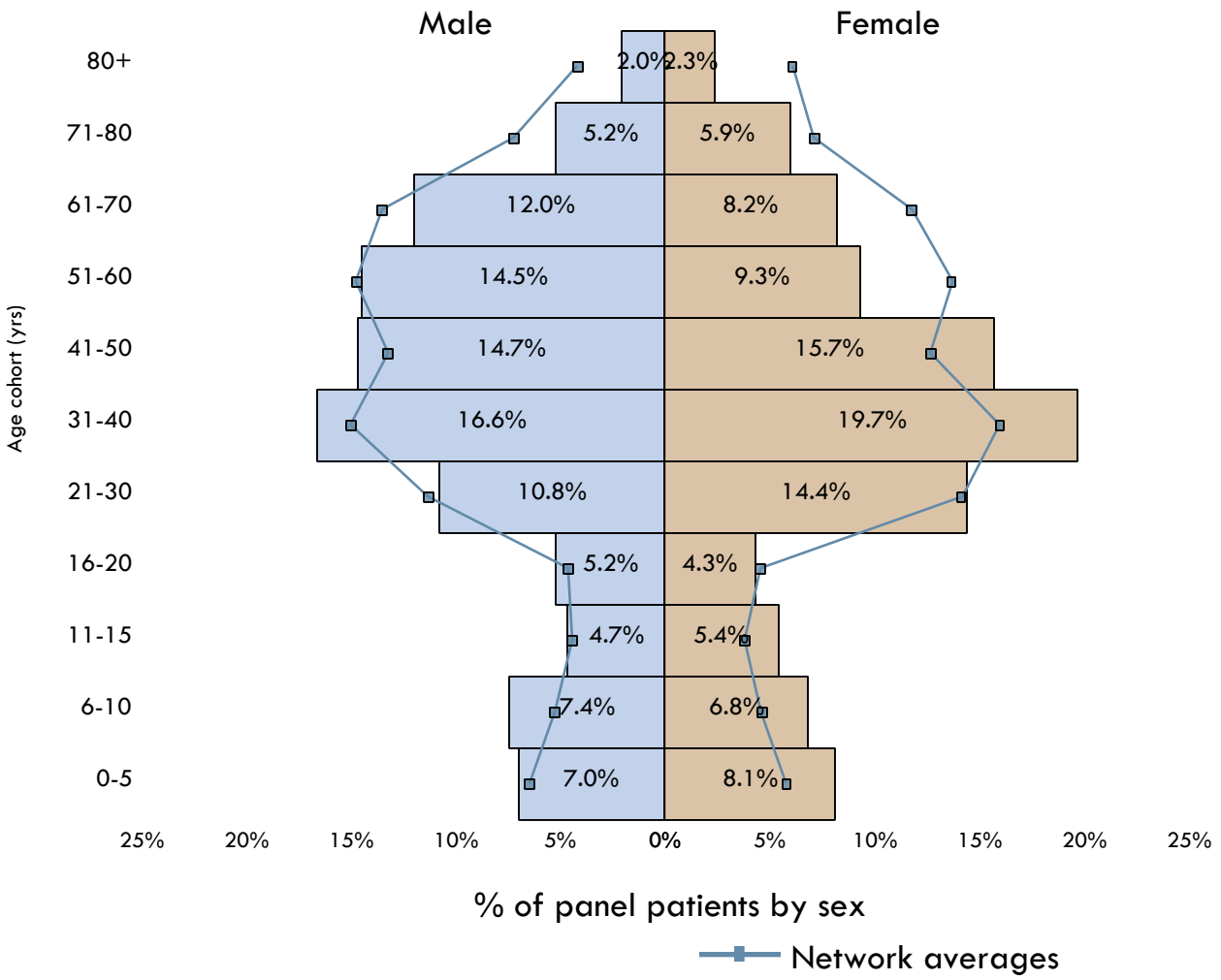
1.2 What is the age and sex profile of my panel patients?

How and why people interact with the health care system can vary by age and sex. The graphs below show your panel's profile based on these factors, which may help you understand your workload, patient behaviours and preferences, and lead to improved planning and outcomes.

Your panel by sex



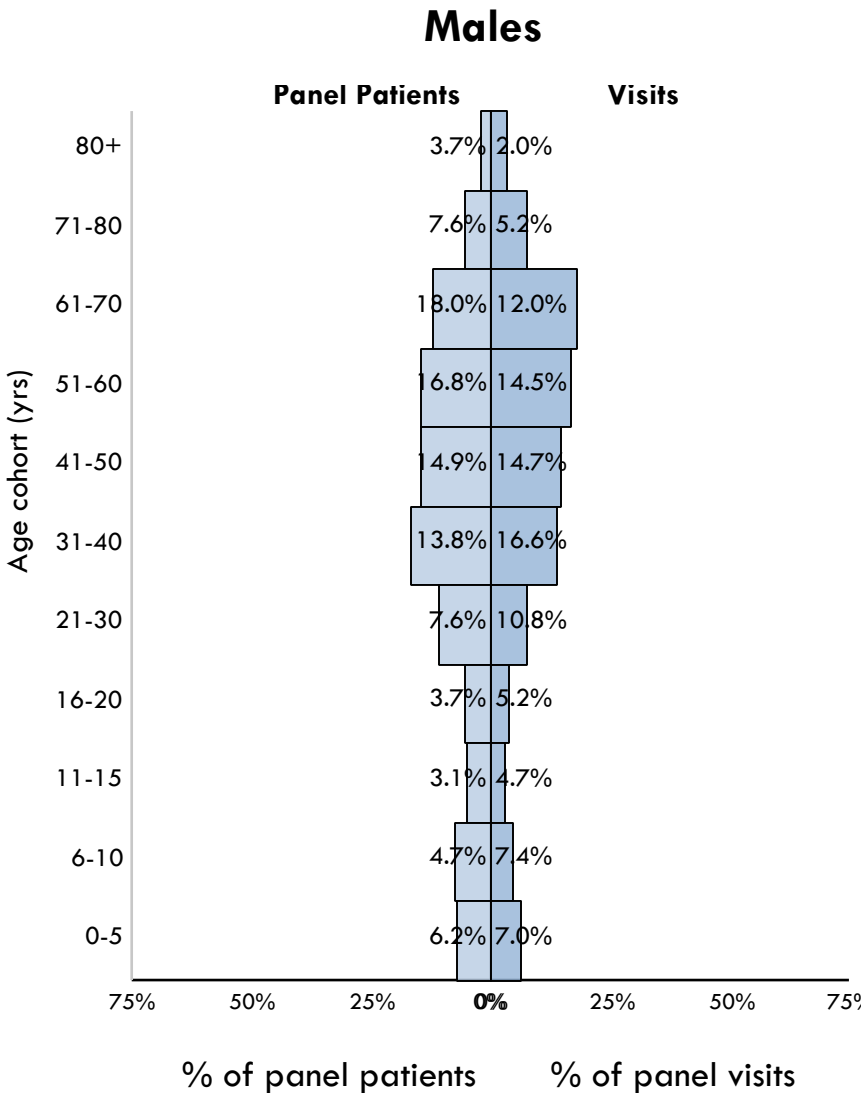
% of your panel by age, for each sex

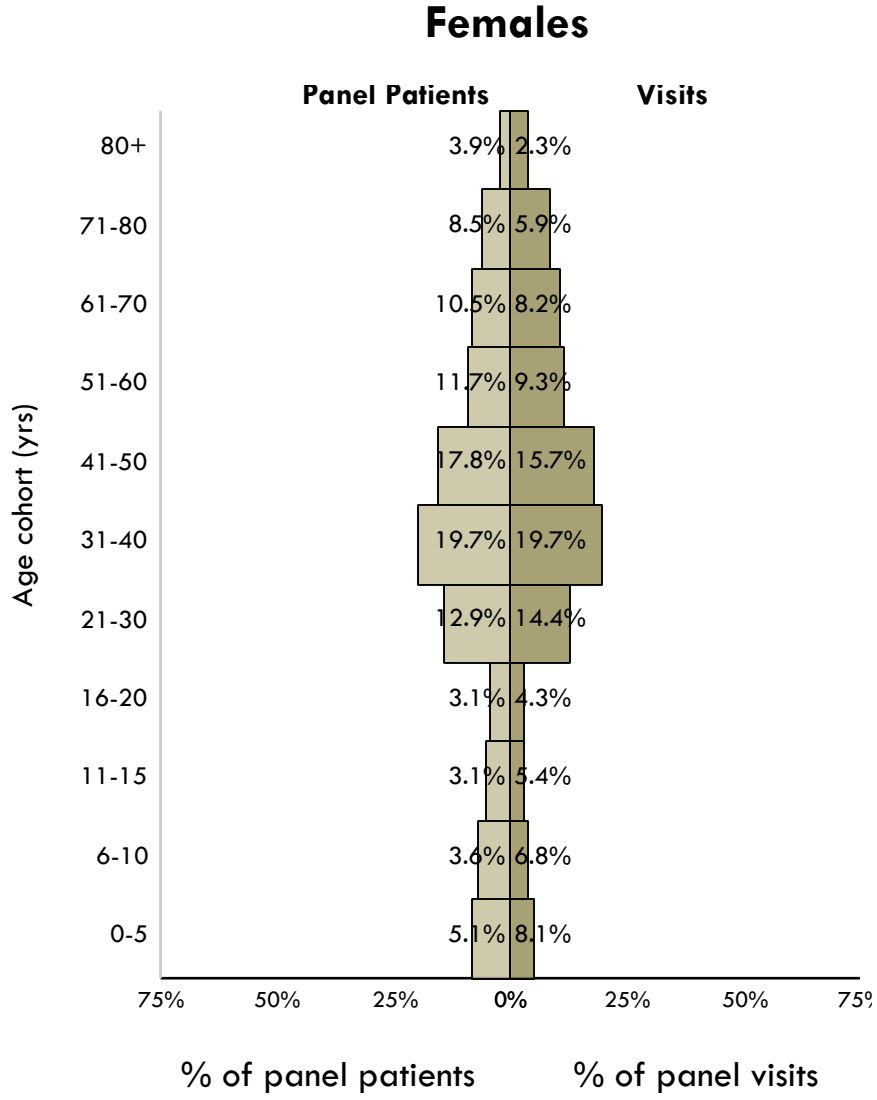


2. Primary Care

2.1 How are my visits distributed by patient age and sex? How does this compare to my panel?

These figures show the relationship between % of your panel, and % of your patient visits, by age and sex. Comparing these proportions may show that some patient cohorts have far more (or less) visits than others, and than their presence in your panel suggests.

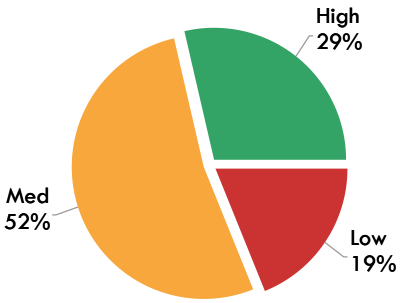




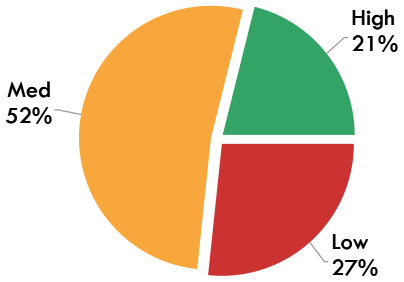
2.2 What is my panel's continuity of care?

During any 3-year period, many patients will see more than one family physician. As continuity of care (i.e. seeing the same provider) is associated with better patient outcomes, the pie charts show your panel's continuity. This is calculated as the *proportion of their FP visits that were with you **or** your clinic*, to reflect team-based care.

CONNECTEDNESS TO YOU

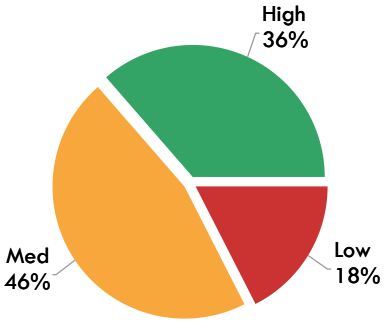


CONNECTEDNESS TO YOUR CLINIC



AVERAGE CONNECTEDNESS WITHIN YOUR NETWORK

Average across panels of physicians in your network



Levels of connectedness to you/clinic based on % of visits:

Low | **Medium** | **High**

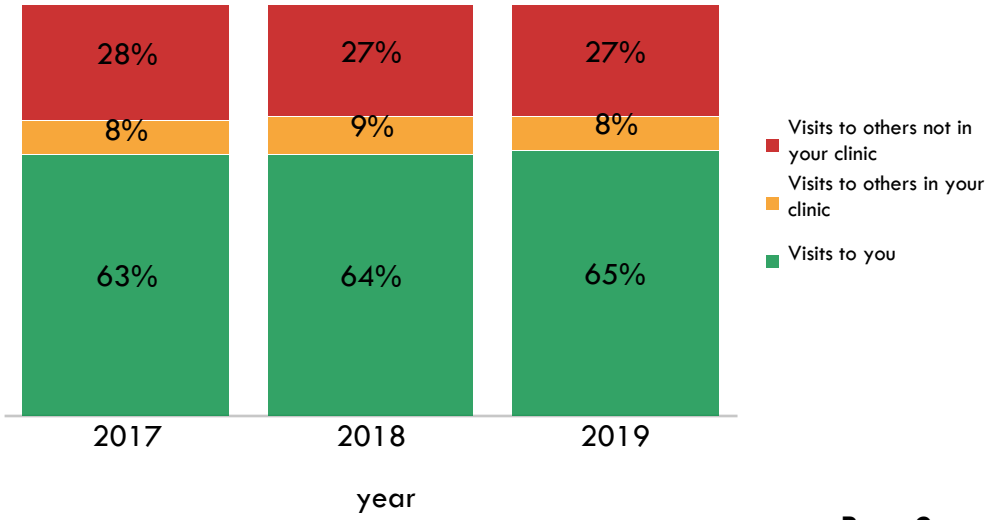
0% <------ 40% <-----> 80% ----> 100% of their FP visits

(Patients with only 1 visit are not included.)

Having a stable relationship with a family physician can…

- increase patients' satisfaction with their care
- improve patients' clinical outcomes
- decrease unnecessary tests
- reduce patients' use of acute services

% of your panel's FP visits by provider cohort



2.3 What are the most common conditions driving my patients' physician visits?

This page tells you the most common reasons why your patients see both family physicians and non-family physicians (specialists, Emergency Medicine physicians etc.). It is based on billing data and only reflects the first diagnostic code associated with the visit. Are there gaps? Are you caring for patients/cohorts where you believe there are not the appropriate supports available in the Network or within your practice? How could you advocate for your patients' needs?

The most common reason your patients saw a ***family physician*** was…

Diabetes mellitus

The most common reason your patients saw ***other physicians*** was…

Diabetes mellitus

Top 10 Reasons for visits to… Family Physicians

	Condition	% of panel visits	Network Avg
1	Diabetes mellitus	7.1%	4.0%
2	Essential hypertension	6.5%	6.4%
3	General symptoms	3.4%	4.3%
4	General medical examination	3.3%	4.3%
5	Disorders of lipoid metabolism	3.0%	1.7%
6	Acute upper respiratory infections of multiple or unspecified sites	2.3%	1.8%
7	Deficiency of B-complex components	2.1%	0.7%
8	Acute pharyngitis	2.0%	1.1%
9	Other and unspecified disorders of back	2.0%	1.8%
10	Other disorders of urethra and urinary tract	2.0%	1.5%

Other Physicians*

	Condition	% of panel visits	Network Avg
1	Diabetes mellitus	5.5%	3.6%
2	Essential hypertension	4.1%	4.5%
3	General symptoms	2.7%	3.3%
4	General medical examination	2.4%	3.1%
5	Normal pregnancy	2.2%	2.3%
6	Symptoms involving respiratory system and other chest symptoms	2.1%	1.8%
7	Neurotic disorders	1.9%	2.2%
8	Disorders of lipoid metabolism	1.9%	1.2%
9	Depressive disorder, not elsewhere classified	1.8%	2.1%
10	Acute upper respiratory infections of multiple or unspecified sites	1.7%	1.3%

* Other Physicians: Specialists, Emergency Medicine physicians, etc.

Note: Excludes radiological codes

3. Chronic Conditions

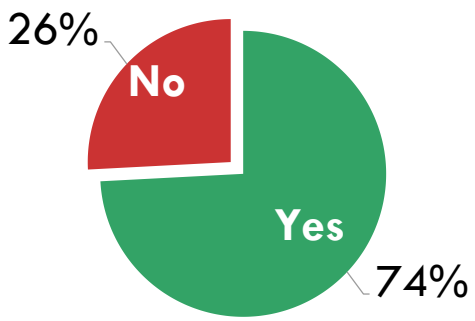
3.1 How well is diabetes being managed among the patients on my panel?

301 patients on your panel have diabetes

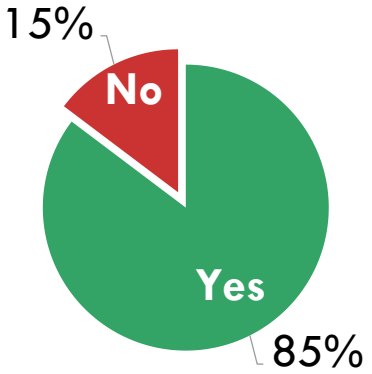
(10% of your panel vs 9% in Network)

The Saskatchewan Chronic Disease Management Quality Improvement Project (CDM-QIP) flow sheets are created utilizing evidence-based best-practice guidelines. Diabetes Canada recommends an A1C target of <=7.0% and a blood pressure of < 130/80 for most adults with type 1 or type 2. The figures below show how many patients on your panel have diabetes, how many of them had flow sheets in 2019, and the proportions of your patients who had blood pressure and A1C within target, based on their most recent flowsheet.

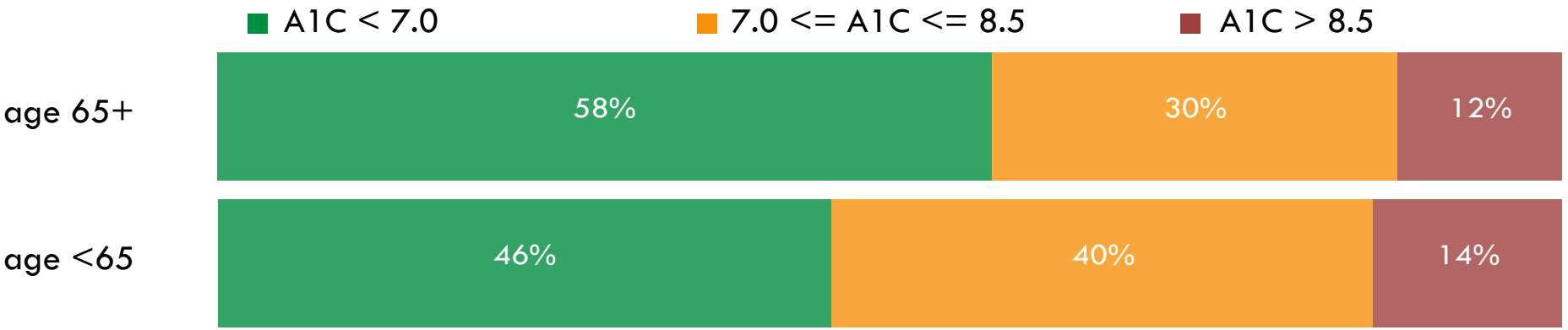
In 2019, did my patients have flow sheets?



Do my diabetic patients have blood pressure <130/80?



A1C profile by patient age



3.2 How well is coronary artery disease (CAD) being managed among the patients on my panel?

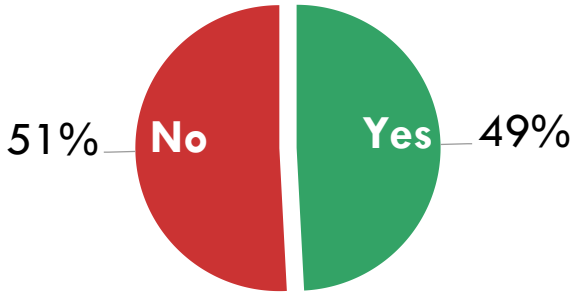
136 patients on your panel have CAD

(4% of your panel vs 6% in Network)

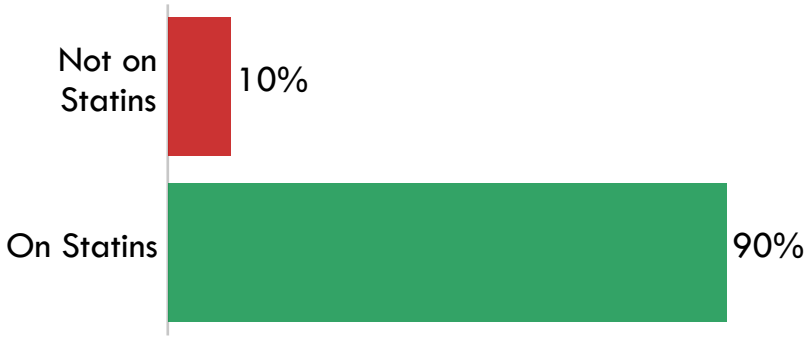
CAD is also targeted through the CDM-QIP program. CAD is an indication for statins and the Canadian Cardiovascular Society recommends an LDL < 2 mmol/L or > 50% reduction in LDL with statin therapy. Target blood pressure is < 140/90 per Hypertension Canada. The figures below show how many patients on your panel have CAD, how many of them had flow sheets in 2019, their statin usage, and the proportions of your patients who had blood pressure and LDL within target, based on their most recent flowsheet.

Among your panel patients with CAD...

What proportion had flow sheets in 2019?

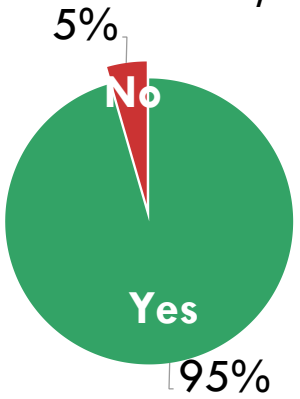


What proportion are on statins?

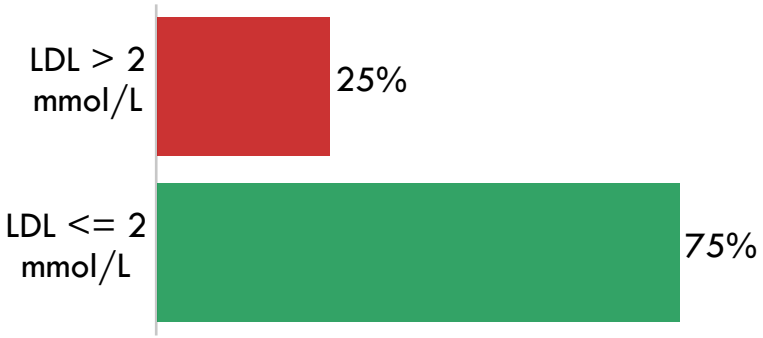


Among your panel patients with CAD flow sheets...

How many have blood pressure <140/90?



What proportion had LDL <=2 mmol/L?



4. Acute Care Utilization

4.1 How often did my panel patients visit 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. 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 ED three or more times last year?

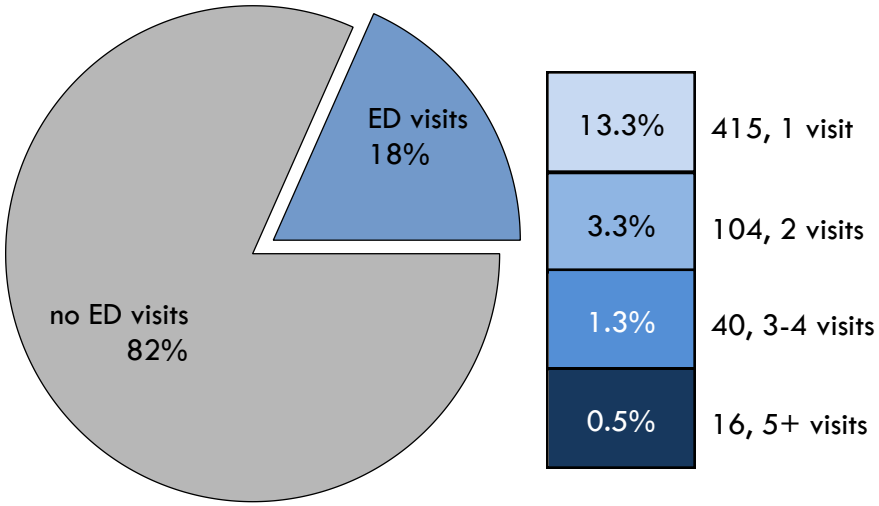
Panel patients that visited an ED in the past 3 years:

39% of your panel

Average in your network: 37%

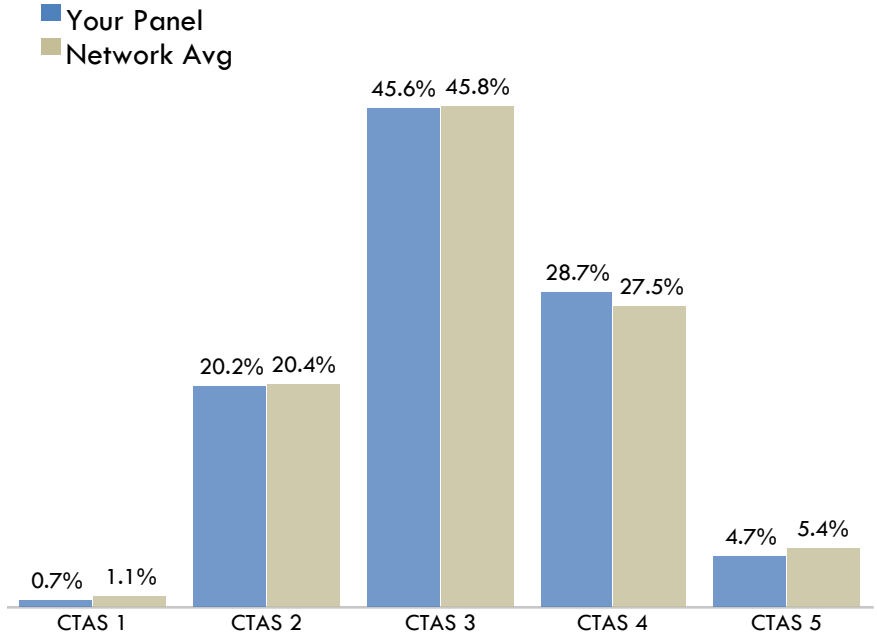
What was your panel's ED utilization in 2019?

% panel patients by number of ED visits



How acute were they?

% of ED visits in past 3 years by CTAS level



Does the proportion of your panel that visited an ED appear low? It may be that your local EDs don't submit records to the National Ambulatory Care Reporting Service.
See "Limitations" (pg 23) for more details.

Canadian Triage and Acuity Scale (CTAS) Levels

- Level 1 - Resuscitation
- Level 2 - Emergent
- Level 3 - Urgent
- Level 4 - Less Urgent
- Level 5 - Non-Urgent

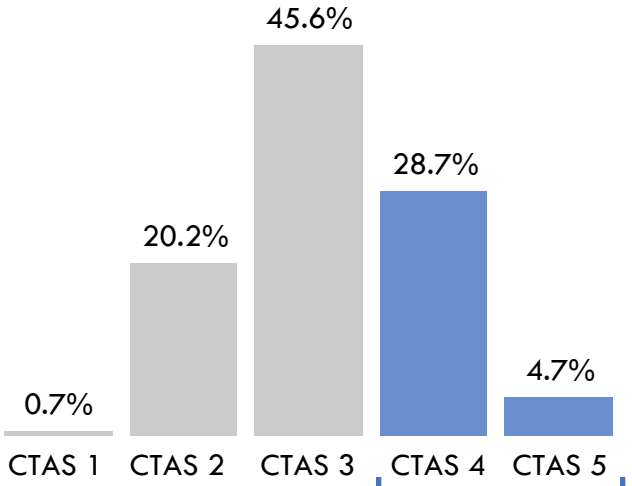
4.2 How often did my patients visit an emergency department (ED) for minor conditions?

This indicator shows ED visits for patients in your panel based on their CTAS level, further divided by the time of day they arrived at the ED.

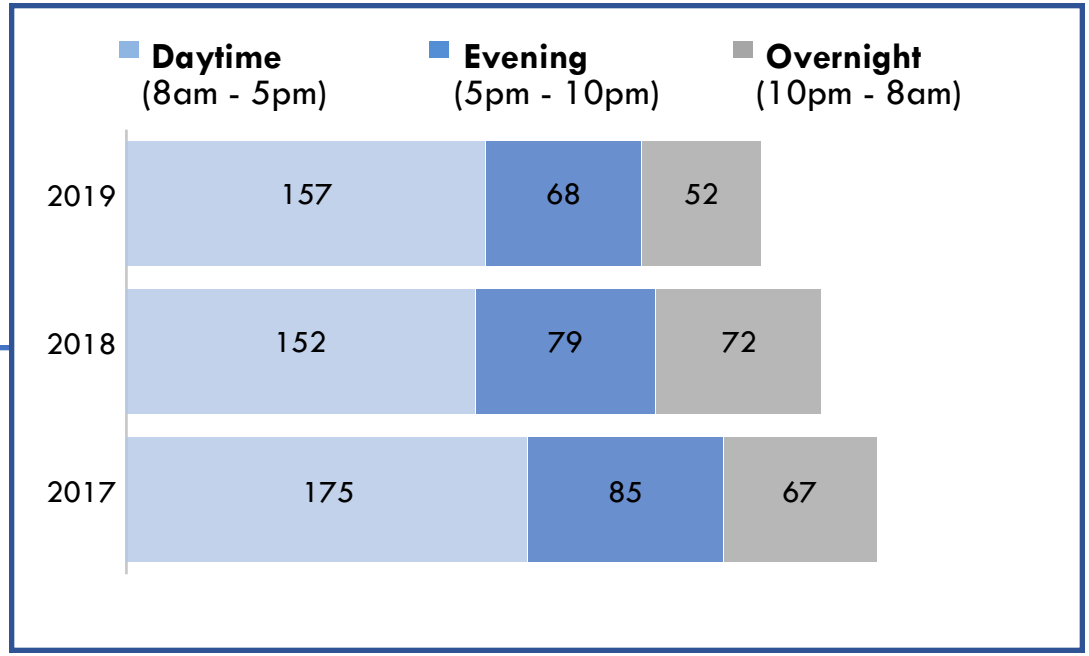
Avoidable ED visits:

- Delay treatment for more urgent patients
- Can lead to unnecessary treatments
- Increase care costs
- Can put patient safety at risk.

% of your panel's ED visits by CTAS level



Your panel's CTAS 4/5 ED visits by time of day and year



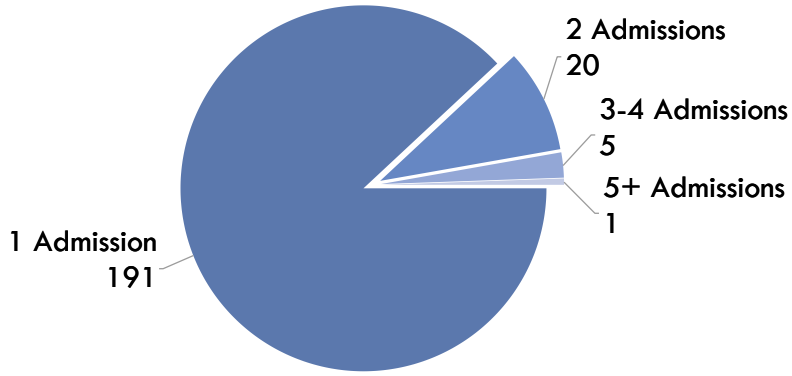
Interested in learning how CTAS 4/5 conditions differ from Ambulatory Care Sensitive Conditions (ACSCs)?
See: ***www.bestpracticesask.ca/resources***

4.3 How frequently were patients on my panel admitted to hospitals?

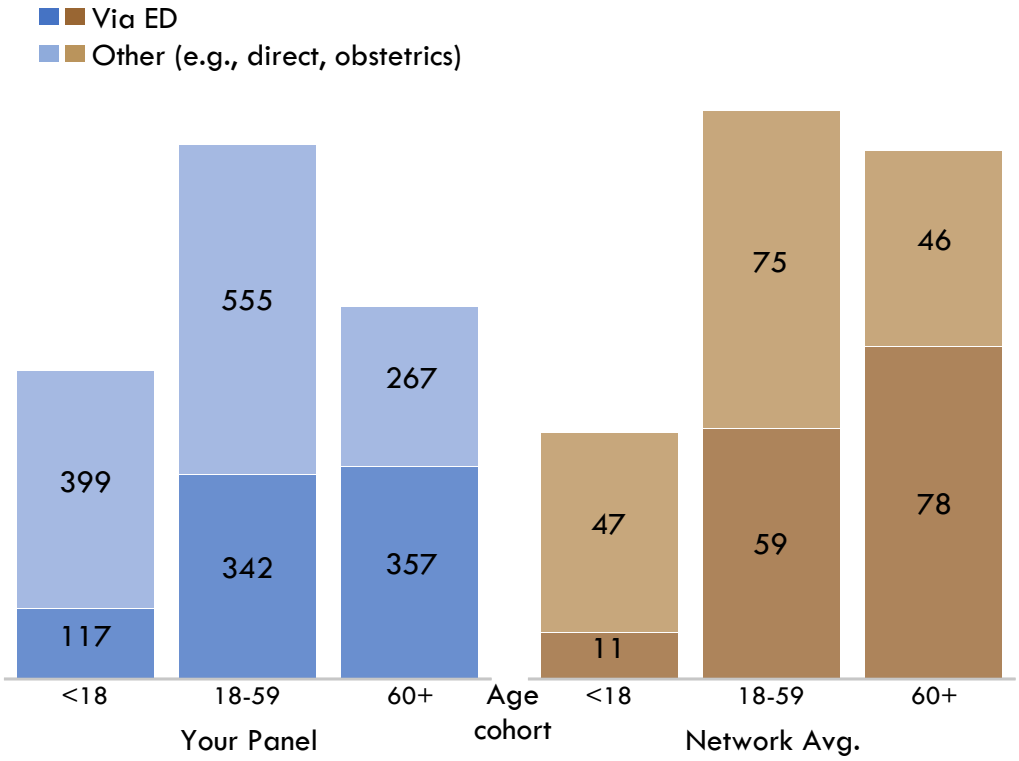
The data below show the percentage of your patients who were admitted to hospitals during the past year (2019) as well as their length of stay. The figures also show how many of your patients had multiple admissions and a breakdown of admissions by age.

	Your Panel	Network Average
% of patients admitted	7%	8%
# of hospital admissions	235	107
Average Length of Stay (LOS)	5 days	8 days

How many times were patients admitted?
of panel patients who had…



How many admissions were there by age?



4.4 Why were my patients admitted to hospitals last year and how long were they there?

Here are the most common reasons for your patients' hospital admissions during the past year (2019). Day surgeries are not included. The figure also includes the average length of stay (LOS) for your patients versus the network average.

The most common reason your patients were admitted to hospital was…

Z38 Liveborn infants according to place of birth

The longest average LOS among your patients was for…

I50 Heart failure

The number of patients, admissions and LOS for the top 10 conditions

		# of Patients		# of Admissions		Average LOS (days)	
	Hospital Diagnosis	Your Panel	Network Avg	Your Panel	Network Avg	Your Panel	Network Avg
1	Z38 Liveborn infants according to place of birth	27	13	27	13	2	2
2	K35 Acute appendicitis	9	3	9	3	3	2
3	O70 Perineal laceration during delivery	8	4	8	4	1	2
4	O68 Labour and delivery complicated by fetal stress [distress]	6	6	6	6	3	2
5	O34 Maternal care for known or suspected abnormality of pelvic organs	6	3	6	3	2	2
6	J18 Pneumonia, organism unspecified	5	4	5	4	5	9
7	I50 Heart failure	5	3	6	4	11	13
8	O75 Other complications of labour and delivery, not elsewhere classified	4	1	4	1	2	3
9	K80 Cholelithiasis	4	2	4	3	5	4
10	M17 Gonarthrosis [arthrosis of knee]	4	4	5	4	5	5

4.5 How does continuity of care relate to hospitalizations for conditions that are best cared for in primary care?

The table below shows your patients' admissions, lengths of stay, and re-admissions for Ambulatory Care Sensitive Conditions (ACSC), 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.

Which conditions are included?

- Asthma
- Congestive heart failure
- COPD
- Coronary artery disease
- Diabetes
- Mood Disorders

ACSC's only apply to patients under age 75

The number of admissions and LOS by connectedness level

Level of connectedness	# of Admissions		Average LOS (days)	
	Your Panel	Network Avg	Your Panel	Network Avg
High >80% of visits	3	2	7	7
Medium 40-80% of visits	18	6	5	8
Low <40% of visits	3	3	1	8
1 visit	0	0	0	3

Interested in learning more about Ambulatory Care Sensitive Conditions (ACSCs)?
See: ***www.bestpracticesask.ca/resources***

5 Prescribing indicators

It's not all on you...

The following section attempts to capture some data around your prescribing of certain medications – Beers List drugs, benzodiazepines, opioids, and antipsychotics. The point of reviewing this information is not to blame, criticize, or accuse.

The point is to inform and reflect.

There are a great many variables that need to be taken into consideration when it comes to who you prescribed medications to, and why - factors that this report is completely unable to recognize or identify.

All physicians are aware that most pharmaceutical options are double-edged swords.

But physicians are also highly sensitive to the limitations of the health system in which they work. Non-pharmaceutical options for mental health and pain are vastly limited, particularly among patients of lower socioeconomic status.

How many of us have said to ourselves "this patient really needs rehabilitation and physiotherapy, not drugs" as we have written their prescription for pain medication?

Or recognized the desperate need for supportive counselling or CBT in a patient to whom we prescribed clonazepam?

Sadly, such support is unavailable to many Saskatchewan patients.

Further, physicians are cognizant of the fact that some of our elderly patients in long-term care facilities exhibit behaviours that could be better managed through compassion and human-to-human contact, rather than drugs. However, the fiscal realities and limitations on human resources cannot always provide such intense individual care.

That stated, and with all these pieces and complexities in mind, there is still value in understanding our prescribing patterns - value in the mindfulness that is introduced by understanding "how much" and "how often".

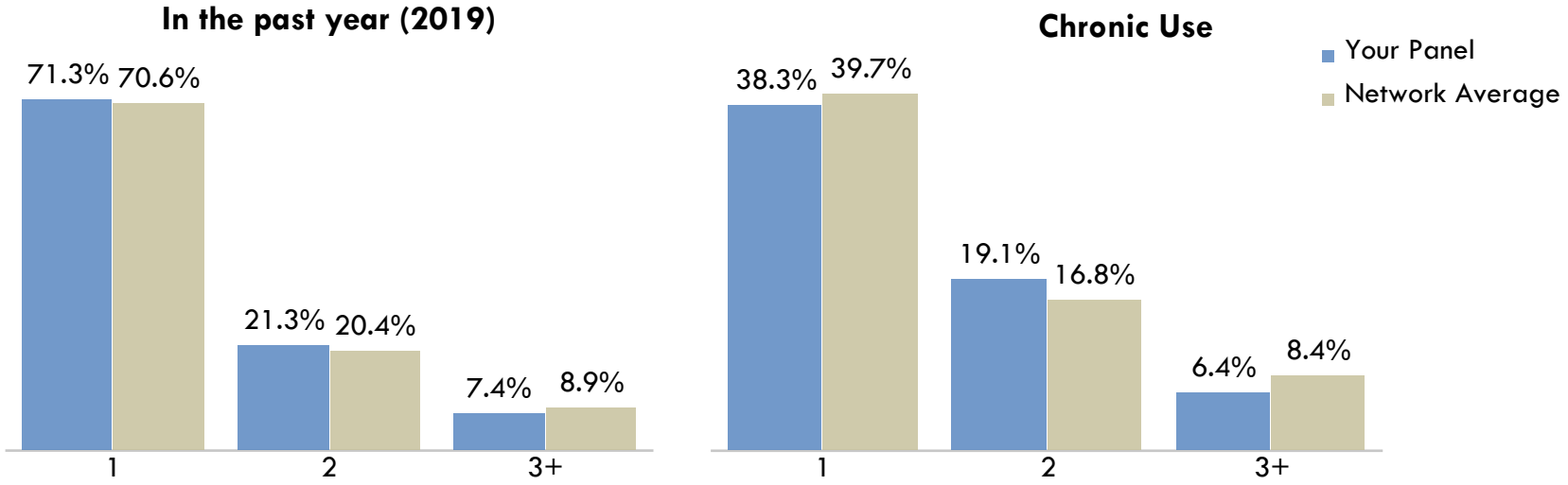
5.1 Prescribing for Senior Citizens: High Risk Medications

The Beers Criteria have helped inform clinical decision-making concerning the prescribing of medications for older adults in order to improve safety and quality of care since 1991.

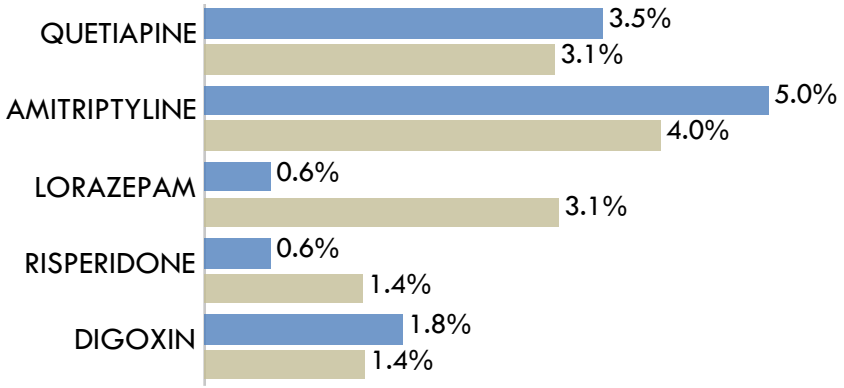
- Adverse drug events are more common in individuals taking more high risk medications. This list is not meant to supersede clinical judgment or an individual patient's values and needs (AGS, 2019).

Reducing polypharmacy is also recommended to reduce pill burden, risk of adverse drug events, and financial hardship.
(American Family Physician, 2019)

What percentage of your patients 65 and older took one or more medications listed in the Beers Criteria?



These are the 5 most frequently prescribed Beers drugs in Saskatchewan.
What percentage of your patients have received them versus network averages?



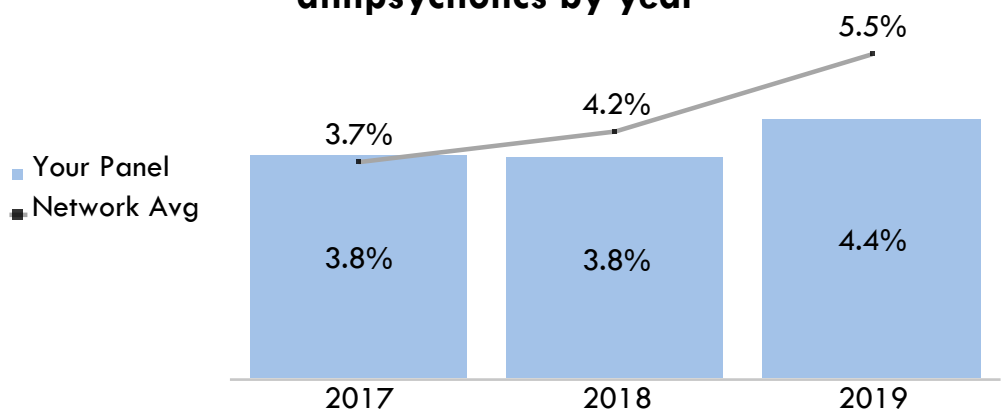
Interested in learning more about Beers Drugs?
Or curious how "chronic use" is defined?
See: ***www.bestpracticesask.ca/resources***

5.2 Prescribing for Senior Citizens: Antipsychotic Medications

Antipsychotics are commonly prescribed to seniors with dementia who experience behavioural and psychological symptoms, including delusions, aggression, and agitation (CIHI, 2016).

- The American Geriatric Society recommends avoiding their use unless non-pharmacologic options have failed, and patient is a threat to self or others (strong recommendation, moderate quality of evidence).
- Studies have found that antipsychotics may be overused in long term care facilities. These medications are associated with increased risk of stroke and mortality in persons with dementia. (AGS 2019)

% of your patients over age 65 receiving antipsychotics by year

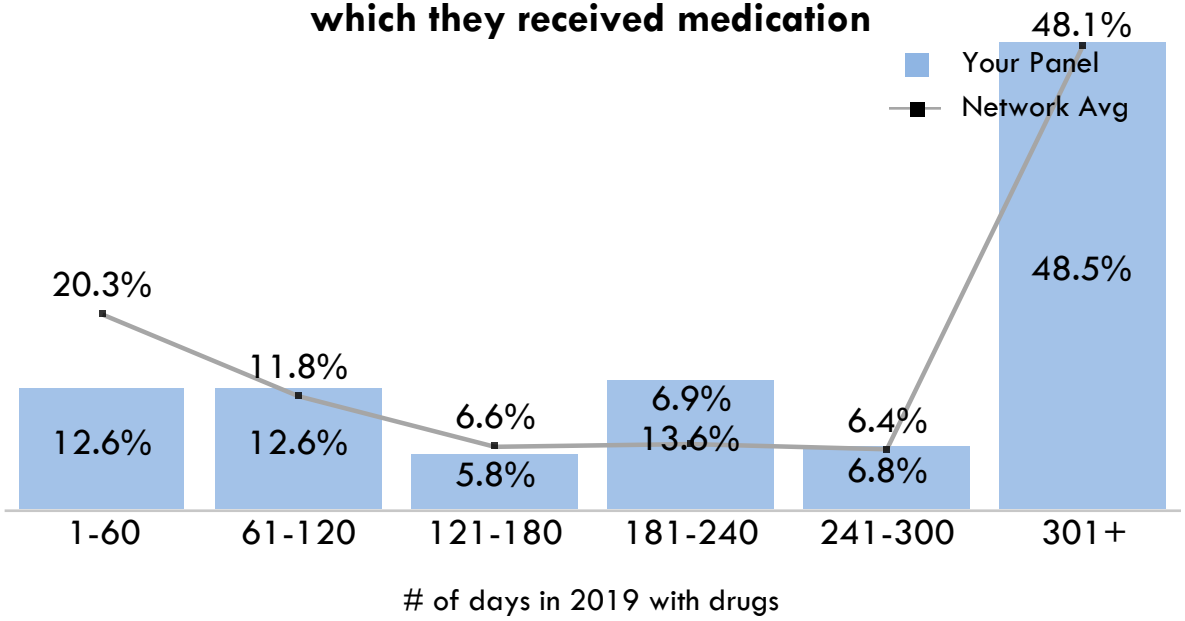


For seniors (age 65+) receiving antipsychotics:

Who prescribed them?
% by prescribing source

You only	18%
You & your clinic colleagues	35%
You & others	0%
You & clinic colleagues & others	12%
Clinic colleagues only	0%
Clinic colleagues & others	0%
Others only	35%

% of senior patients by # of days in past year (2019) for which they received medication



5.3 Prescribing of Opioid Medications

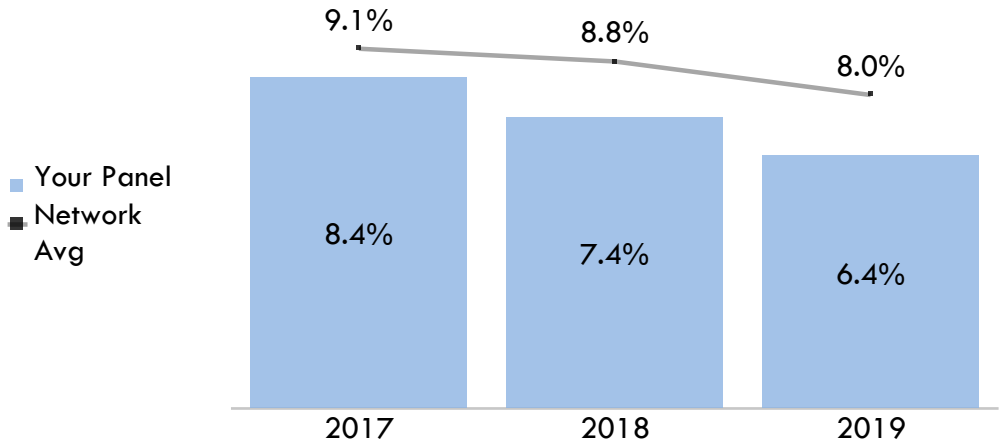
The College of Family Physicians of Canada has published guidelines regarding opioid prescribing:

- **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**

See recommendations at:

https://portal.cfpc.ca/resourcesdocs/uploadedFiles/CPD/Opioid%20poster_CFP_ENG.pdf

% of your panel patients receiving opioids by year

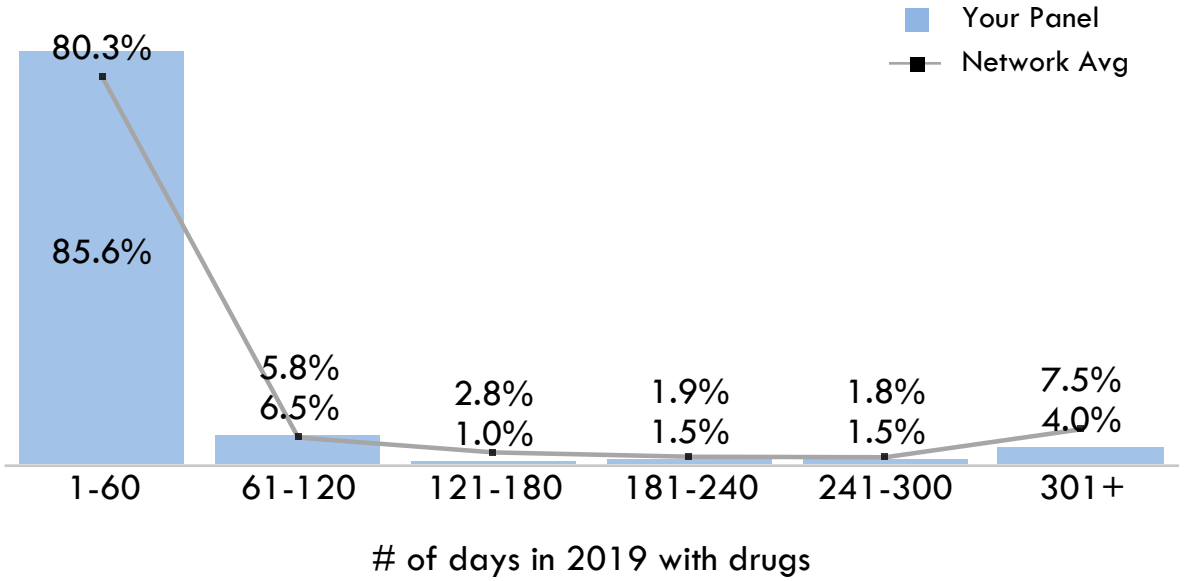


Among those receiving opioids:

Who prescribed them?
% by prescribing source

You only	10%
You & your clinic colleagues	9%
You & others	1%
You & clinic colleagues & others	1%
Clinic colleagues only	4%
Clinic colleagues & others	2%
Others only	74%

% of panel patients by # of days in 2019 for which they received medication

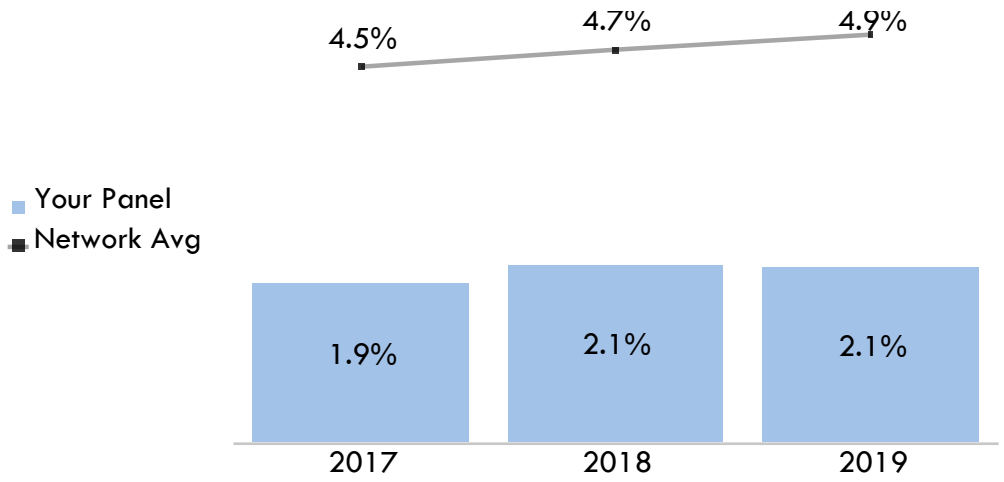


5.4 Prescribing of benzodiazepines

Benzodiazepines may be of benefit for some patients experiencing Generalized Anxiety Disorder (GAD). They can reduce both somatic and emotional symptoms of GAD. There is significant concern, however, regarding:

- **dependence and withdrawal (depending on duration of use)**
- **tolerance**
- **impaired psychomotor function and memory**
- **rebound anxiety (after short term use)**
- **increased risk of opioid toxicity and overdose**
- **use to treat insomnia**

% of your panel patients receiving benzodiazepines by year

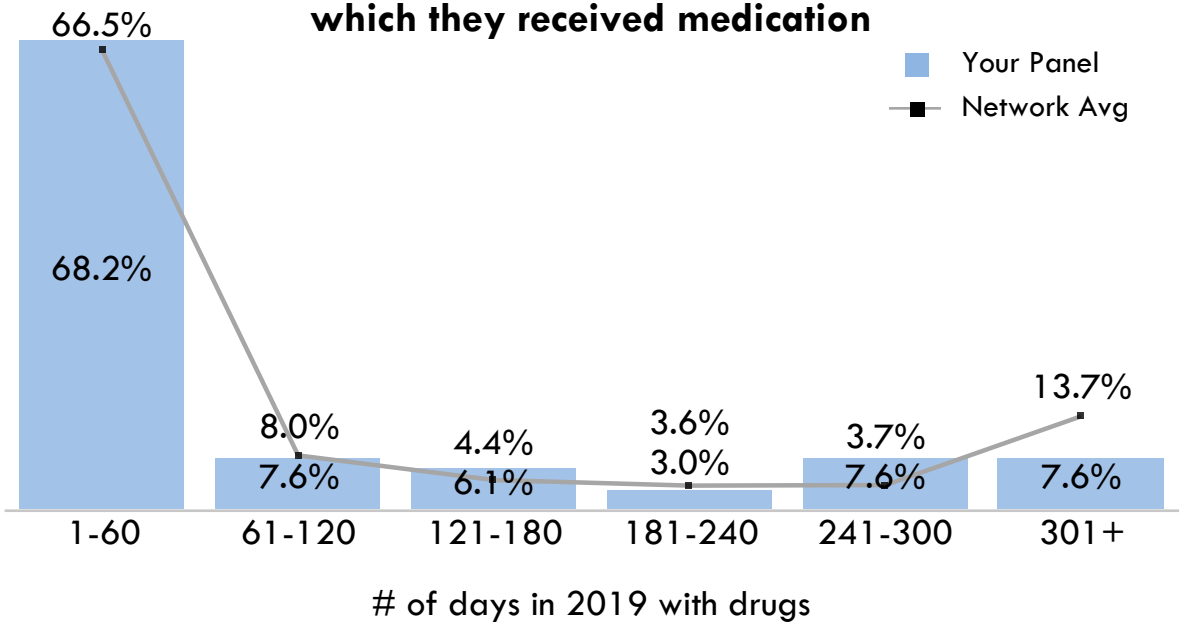


Among those receiving benzodiazepines:

Who prescribed them? % by prescribing source

You only	18%
You & your clinic colleagues	12%
You & others	2%
You & clinic colleagues & others	2%
Clinic colleagues only	4%
Clinic colleagues & others	0%
Others only	61%

% of panel patients by # of days in 2019 for which they received medication



Data Limitations

The data used to create these reports are obtained from various administrative health databases including the person health registry system, maintained by eHealth, as well as several clinical sources, such as the Discharge Abstract Database for hospitalizations, the National Ambulatory Care Reporting System, for emergency department visits, Medical Service Branch's physician billing data for physician visits, and the provincial drug data system for prescription drug dispensations. Each of these data sources has limitations. Some of the key considerations relevant to your report are outlined below.

Physician Billing data

- Physician billing data only include 1 diagnostic code per patient visit; this may affect the results shown on page 10 as the code on record may not be the most responsible diagnosis. The diagnostic codes exclude decimals which may also limit the level of detail available for the diagnosis
- Physician billing data may not be complete as records might not be complete for physicians who are not paid on a fee-for-service basis due to varying shadow billing practices.

Emergency Department data

- Emergency Department visits are not reported by all emergency departments in the province. Among those that do report, varying amounts of data are submitted, thus presenting complaint and/or diagnostic code may not be available for all records.
- See the FAQ at www.BestPracticeSask.ca/resources for details regarding included/excluded sites.

Provincial Drug Data

- The days supply data used to calculate the number of days in 2019 for which patients received anti-psychotics, opioids and benzodiazepines is not validated by the Ministry of Health. It is based on data provided by pharmacies. In particular, there may be uncertainty around the number of days for which opioid prescriptions that are provided via patch may supply.

Additional Resources

The following pages provide additional information and resources for each section of your report, to help you learn more about the topics that interest you, as well as questions to support your self-reflection.

- The links shown are also available on the BestPractice website: www.BestPracticeSask.ca/Resources.

Section 1.1 Panel Assignment

- Although the 4-cut methodology estimates your patient panel with good accuracy, you may gain additional insights from your panel report by comparing it to your "expected" panel of patients based on your EMRs Most Responsible Physician (MRP).
- For more information on the 4-cut method process, please email: *bestpracticesask@hqc.sk.ca*.

Section 1.2 & 2.1 Panel & Visits by Age/Sex

- Compared to the overall Saskatchewan population:
  - Are you caring for older or younger individuals?
  - Is your practice skewed towards men or women?
- Are there additional supports available in your practice and your community to provide primary care to your panel? If not, how could you advocate for these supports and services?
- Does understanding more about your intensive users influence the time and effort you commit to CME? For example, should you devote CME to prostate health, or managing menopause, or prenatal management?
- If you were able to provide group visits, would you consider them for managing chronic disease or prenatal care?
- Does understanding which cohorts visit most often influence your booking schedule? For example, are appointment times appropriate? Is same day availability appropriate?

Additional Resources continued...

Section 2.2 Continuity of Care

- 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.
- For further evidence regarding the value of continuity in primary care, see patientsmedicalhome.ca/vision/continuity-care/

Section 2.3 Most common conditions driving patient visits

- Could this information help you identify areas for CME focus or extra training? Can you use it to advocate for patient needs?
- 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:
  - canadiantaskforce.ca/guidelines/published-guidelines/
- Please consider available programs in your area:
  - www.sma.sk.ca/resources/21/chronic-disease-management.html
  - www.ehealthsask.ca/services/CDM
  - www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/mental-health-and-addictions-action-plan

Section 3.1 Chronic conditions: Diabetes

- Is there room for improvement in your use of the CDM-QIP program?
- Do you want to learn more about the CDM-QIP program and how it can be of benefit to you and your patients? See: www.sma.sk.ca/resources/21/chronic-disease-management.html
- Are you up to date with the most recent Diabetes Canada guidelines?
  - Diabetes Canada guidelines and tools: https://www.diabetes.ca/health-care-providers

Additional Resources continued...

Section 3.2 Chronic conditions: Coronary Artery Disease

- Do you have more questions about the CDM-QIP program? See: www.sma.sk.ca/resources/21/chronic-disease-management.html
- Do you need to read the latest guidelines for coronary artery disease or find resources for patients?
  - Canadian Cardiovascular Society guidelineswww.ccs.ca/en/guidelines
  - Hypertension Canada resources: guidelines.hypertension.ca

Section 4.1 Emergency department use

- Can you identify who among your patients are frequent users of EDs and why?
- 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?
- Health care providers should talk to their patients about appropriate ED use. Resources are available to help you have these conversations: choosingwiselycanada.org/unnecessary-treatments-ed

Section 4.2 ED visits for minor conditions

- 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.
- The Saskatchewan Health Quality Council (HQC) provides surveys that you may want to utilize to find out how your patients feel they could be better served by you and your clinic: https://www.hqc.sk.ca/health-system-performance/measuring-the-patient-experience
- Considering the COVID-19 pandemic, patients may not know that a physician's office is open, and the physician has same-day appointments. Does your practice website inform patients of your office hours?

Additional Resources continued...

Section 4.3 Hospital Admissions

- As primary providers, you are likely aware of the patients in your practice who have frequent hospital admissions. These patterns often reflect a high degree of multi-morbidity or advanced chronic disease. Sometimes, patients are at highest risk for re-admission in the acute post hospital discharge time period. This can reflect premature discharge, patient non-compliance, lack of community follow up or poor ongoing support in the community setting.
  - Do you have the resources in your practice and/or in your community to care for high needs patients post hospital discharge?
  - Do you feel appropriately informed and supported when your patients are discharged from hospital?
  - Are there better ways to coordinate hospital discharge in your Network that might reduce the chances of readmission?
- Do you have an improvement idea that you'd like to pursue? HQC's Clinical Quality Improvement Program (CQIP) is a QI training program designed specifically for physicians: www.hqc.sk.ca/education-learning/cqip

Section 4.4 Top 10 conditions for hospitalization

- This data only captures a single condition for each admission. If there were multiple medical conditions responsible for the hospital admission, that complexity is not reflected. However, it may be interesting to note whether or not your "most common reason for admission" varies from the Network's. Does the reason for hospital admission surprise you? Is that condition something that you need to address, either within your own practice, in your clinic or within your Network?
- "Length of stay" in hospital is a metric that reflects many variables. However, discharge planning often plays a large role. Are you aware of any obstacles for the discharge of your patients? Do they receive the care they require in the community? Alternatively, do you believe that your patients require a longer LOS? Are their medical conditions stable at discharge? Do you believe that there are appropriate links between acute care and community care in your Network?
- Should you have concerns, do you know who your Primary Care Network physician leads are?

Additional Resources continued...

Section 4.5 ACSC Admissions and Continuity of Care

- Continuity of care, or 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 of care.
- What does the data tell you about continuity in your relationships with patients?
  - Given the characteristics of your panel, are you surprised by the number of ACSC admissions?
  - 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: www.sma.sk.ca/resources/21/chronic-disease-management.html

Section 5.1 Beers Drugs

- A quick reference card for the Beers Criteria is available at www.elderconsult.com/wp-content/uploads/PrintableBeersPocketCard.pdf
- The STOPP/START Criteria, screening tools to help physicians select the appropriate treatment is available at www.farmaka.be/frontend/files/publications/files/liste-stopp-start-version-2.pdf
- If you'd like further understanding of a medication's appropriateness, see the Medication Appropriateness Index: https://globalrph.com/medcalcs/medication-appropriateness-index-calculator/
- Other resources that can support medication selection, prescribing and deprescribing are available at the following websites:
  - Polypharmacy Toolkit: www.rgptoronto.ca/wp-content/uploads/2018/11/SF7-Toolkit-Polypharmacy.pdf
  - Polypharmacy: Evaluating Risks and Deprescribing (AAFP, 2019): www.aafp.org/afp/2019/0701/p32.html
  - RxFiles Drug Considerations in the Elderly: www.rxfiles.ca/RxFiles/uploads/documents/members/CHT-LTC-Eldely-Pearls.pdf

Additional Resources continued...

Section 5.2 Anti-psychotics

- Search your EMR to identify the locations and diagnoses of senior patients being treated with anti-psychotics (i.e., community vs long-term care). Is there pattern?
- If you'd like support in understanding your prescribing patterns, RxFiles offers academic detailing to clinicians by pharmacists: www.rxfiles.ca/rxfiles/home.aspx.
  - If you'd like a one-on-one consultation, appointments can be made at: rxfilesyqrbooking.timetap.com/#/
- 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 Alberta Health Services' Appropriate Use of Antipsychotics (AUA) Toolkit: www.albertahealthservices.ca/scns/auatoolkit.aspx. (Also available at https://choosingwiselycanada.org/perspective/antipsychotics-toolkit/)
- Are you aware of Health Canada's alert regarding risperidone? See healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2015/43797a-eng.php
- For related case studies, see: www.cfp.ca/content/57/12/1420

Section 5.3 Opioids

- Run a search/report in your EMR of patients being prescribed opioids. Reflect on the reasons why these patients were prescribed opioids. Are the prescriptions appropriate?
- How many of your patients with chronic non-cancer pain are being prescribed opioids outside the recommended use guidelines? (See the guidelines at nationalpaincentre.mcmaster.ca/guidelines.html)
- Are any of your patients at risk for, or experiencing, an opioid use disorder? Consider tracking and assessing for aberrant drug behaviours: See nationalpaincentre.mcmaster.ca/documents/practicetoolkit.pdf (appendices B-10 & B-11)
- Other resources to support appropriate opioid prescribing include:
- Chronic Non-Cancer Pain Management and Opioid Resources: www.cfpc.ca/chronic-non-cancer-pain-management-opioid-resources/
- Choosing Wisely Canada: choosingwiselycanada.org/campaign/opioid-wisely/
- RxFiles offers academic detailing to clinicians by pharmacists: www.rxfiles.ca/rxfiles/home.aspx
  - If you'd like a one-on-one consultation, appointments can be made at: rxfilesyqrbooking.timetap.com/#/

Additional Resources continued...

Section 5.2 Benzodiazepines

- Run a search/report in the EMR to identify individuals being prescribed benzodiazepines. Are these prescriptions appropriate? Consider using a risk-assessment tool, such as that created by the Centers for Effective Practice in 2019, which can be applied to patients of all ages: cep.health/clinical-products/benzodiazepine-use-in-older-adults. It also contains a robust selection of alternatives that may benefit patients for whom you decide benzos are not the safest option.
- Are any patients at risk for or experiencing a benzodiazepine use disorder based on long term use and other risk factors? Consider tapering patients at highest risk off benzodiazepines in favour of alternative treatments. See: www.cpsa.ca/wp-content/uploads/2017/06/Benzodiazepine-Clinical-Toolkit-Use-and-Taper.pdf
- In older patients, consider applying the Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder: ccsmh.ca/wp-content/uploads/2019/11/Benzodiazepine_Receptor_Agonist_Use_Disorder_ENG.pdf

WANT TO LEARN MORE? ACCESS THE PANEL REPORT EDUCATION MODULES!

Select and complete any of the modules below, learn however you prefer – independently or in a group - and receive CPD credits.

Download Guides and register for Sessions at www.BestPracticeSask.ca/education

What's next?

What might next year bring? Here are some ideas we're exploring (no promises yet ☺)

Indicators related to:

- **Cancer screening programs**
  - What proportion of your patients are screened per program guidelines for Cervical, Breast and Prostate Cancer?
- **Childhood Vaccinations**
  - What proportion of your pediatric patients are fully immunized for common diseases by their 2nd and 7th birthdays?
- **Social Determinants of Health**
  - Do your patients face employment and/or food insecurity issues? Barriers to transportation or access to health services?

What conversations can we have with patients on these topics?

Plus…

- **New training modules**
  - More in-depth investigation into sections of the report (e.g., prescription indicators)
  - Information on how to generate your own custom reports in your EMR

These are just some of our thoughts; please, continue to give us feedback and your ideas!
We aim to keep improving this report and ensuring it is relevant and useful to you.