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Issued: September 2024



# Best Practice:

Your primary care panel report

**2024-2025 release**

*based on healthcare utilization data between Jan 1, 2021, and Dec 31, 2023*

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College of Medicine  
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## About the Primary Care Panel Reports

The **Primary Care Panel Reports (PCPR)** are developed by the Saskatchewan Health Quality Council (HQC), with the involvement of the Saskatchewan Medical Association (SMA) and guided by physicians.

Established by government legislation in 2002, the 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 PCPR 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 SMA and the College of Medicine of the University of Saskatchewan. We wish to thank the Saskatchewan Ministry of Health for being Data Trustee and supportive partner, and eHealth Saskatchewan (eHS) 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 2024 edition, we would like to acknowledge the Physician Expert Panel for their continuous guidance and support in this work:

- Dr. Emmett Harrison
- Dr. Christo Lotz
- Dr. Ginger Ruddy
- Dr. Mark Lees

And the following individuals for their support and contributions:

- Meric Osman, Research & Data Team Lead, SMA
- Shawn McCann, Data Scientist, eHS
- Moumita Shau, IT Information Analyst, eHS

### IMPORTANT



Privacy of your data is being protected under the Health Information Protection Act. No other physician, government agency, or third party has access to this report, and you may share to share it at your discretion. 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 of the Ministry of Health and eHealth Saskatchewan under a data-sharing agreement.

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## Report overview

The **BestPractice PCPR** is a standardized report developed specifically for use by Saskatchewan family physicians. The indicators included in this report were mainly derived from Administrative Databases to provide you with information and insights, that would otherwise not be available.

### WHY USE THIS REPORT

This report strives to help you, and any family physician in the province, gain a strong and better understanding of their patients' panel. This knowledge can be used to:

- Identify opportunities and areas for improvement.
- Understand the global clinical needs of your patients.
- Compare metrics with peers within your jurisdiction of practice.
- Support clinic level business planning.
- Establish baseline measurements for future improvement initiatives.

It is similarly important to understand how this report was created, its limitations, and other characteristics that make this report such a unique and potentially useful tool. Please visit the FAQ of our webpage to learn more.

### MINIMAL REQUIREMENTS

There are no requirements for a Panel Report to be generated. Even if you have not been in practice throughout the reference period, a report of your panel will be generated. However, physicians relatively new to the province or who have just started practicing are likely to have a small panel and some or most of the indicators might not be as informative. We suggest you wait until you have been practicing in Saskatchewan for at least 2-3 years before you request your Panel Report.

### TIME FRAME

All the indicators and summary information contained in this report, the 2024 version, are based on your estimate active patient panel as of December 31, 2023. Your patient panel was ascertained using a *proxy algorithm* that utilises physician billing claims data of all the patients you provided a service to between **January 1, 2021, and December 31, 2023**.

Any new requests received between **June 2024 and May 2025**, will be processed and a 2024 version of the report will be sent out during either the first two weeks of September 2024 OR within two weeks of the initial request; whichever is the latest.

### ONGOING UPDATES

You will continue to receive this report on a yearly basis until you decide to opt-out. Yearly updates of the report are scheduled to be sent out via email during the first half of September.

If you are a first-time subscriber, you will receive a PDF copy of your report via email. Please contact [bestpracticesask@hqc.sk.ca](mailto:bestpracticesask@hqc.sk.ca) if your contact information has changed to ensure that you continue to receive future communications and report updates.

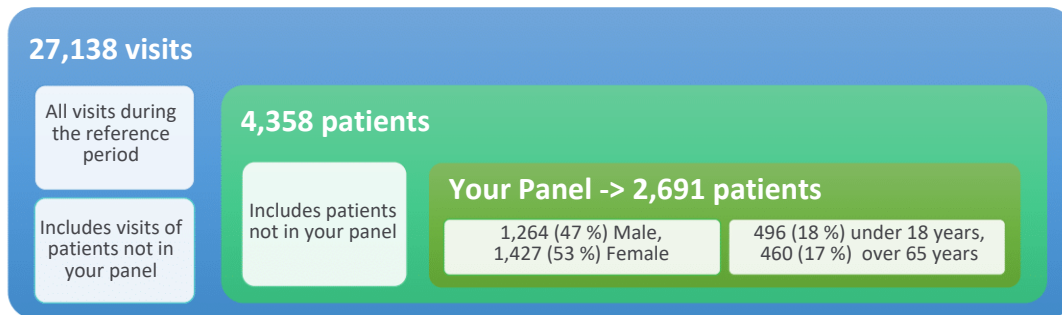
### DATA SOURCES

The measures and indicators in this report are derived from administrative data from Saskatchewan received from the Ministry of Health and eHealth Saskatchewan unless otherwise specified in the indicator. Your EMR is not accessed nor used to create these reports. For resources and detailed information on the methods and definitions used for each indicator please see Technical Appendix and additional links at [www.BestPracticeSask.ca](http://www.BestPracticeSask.ca). The **Reference Period** for this report is January 1, 2021, to December 31, 2023.

You have been assigned to the **Regina 3** Health Network.

## Your Panel

As of December 31, 2023, your patient panel is comprised of 2,691 individuals. During the reference period:

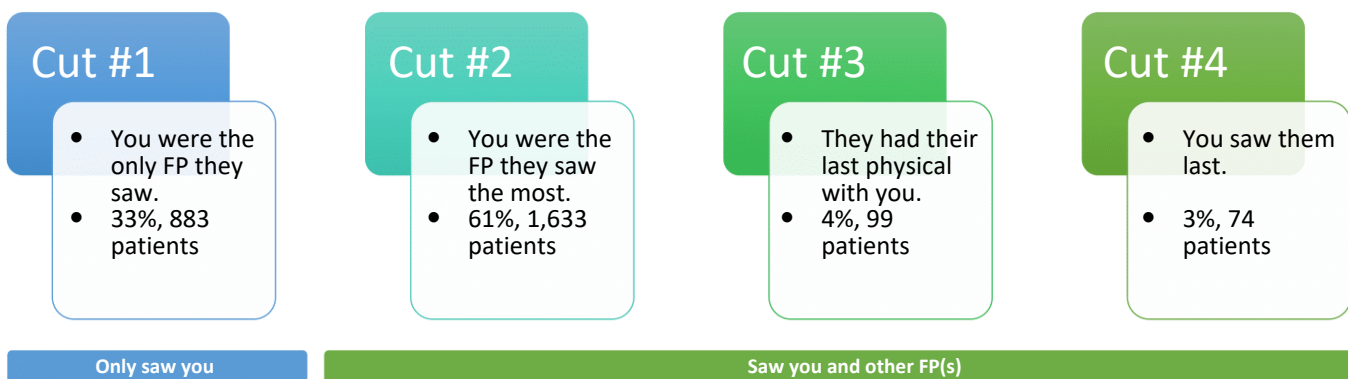


The 4-cut method uses family physician (FP) billing records submitted during the reference period. Using these records and for each person living in the province (provided they have seen a FP at least once), we determine the panel to which they belong (i.e. what physician they are assigned to).

People with no visits to FP during the reference period will be considered unassigned and will not be included in anyone's panel.

The **2,691** patients in your panel were assigned as follows:

There are 19,225 unassigned patients in your network:  
**Regina 3**



## A snapshot of your panel

The table below show selected measures about your panel and can help you assess how your panel compares to your Health Network.

Measure	Your Panel	Clinic	Network
<b>Number of patients (n)</b>	2,691	5,608	93,335
Female	1,427	2,853	47,161
0-17 years	246	541	8,639
18-64 years	919	1,828	29,360
65 and older	261	483	9,162
Male	1,264	2,755	46,174
0-17 years	250	550	8,918
18-64 years	815	1,798	28,761
65 and older	199	406	8,495
<b>Average age (years)</b>	42.6	43.1	41.3
Female	43.0	43.5	41.5
Male	41.7	42.3	41.0
<b>Average PHYSICIAN continuity (%)</b>	77%	78%	72%
Percentage with <b>high</b> continuity	54%	56%	45%
Percentage with <b>low</b> continuity	9%	8%	14%
<b>Average CLINIC continuity (%)</b>	79%	78%	75%
Percentage with <b>high</b> continuity	58%	58%	56%
Percentage with <b>low</b> continuity	6%	7%	11%
<b>Average visits to (per patient) any family physician</b>	10.567	11.306	12.037
Female	13.415	12.417	13.598
0-17 years	6.311	5.691	5.972
18-64 years	13.402	12.245	13.357
65 and older	19.148	18.008	21.562
Male	10.567	9.991	10.442
0-17 years	6.306	5.867	5.839
18-64 years	9.694	8.959	9.267
65 and older	17.617	16.872	19.253

**For the list of selected measures:**

**Your Panel** column summarizes the group of patients assigned to your panel.

The **Clinic** column represents the clinic to which you have been assigned. The algorithm assigns you to the clinic where most of your billing records submitted during the reference period came from.

The **Network** column represents the Health Network where the clinic you have been assigned to is located.

**Questions?** Do not hesitate to reach out to our team if you need any clarification on the methodology used.

[bestpracticesask@hqc.sk.ca](mailto:bestpracticesask@hqc.sk.ca)

Or visits our FAQ site and download our Technical Notes document for more details.

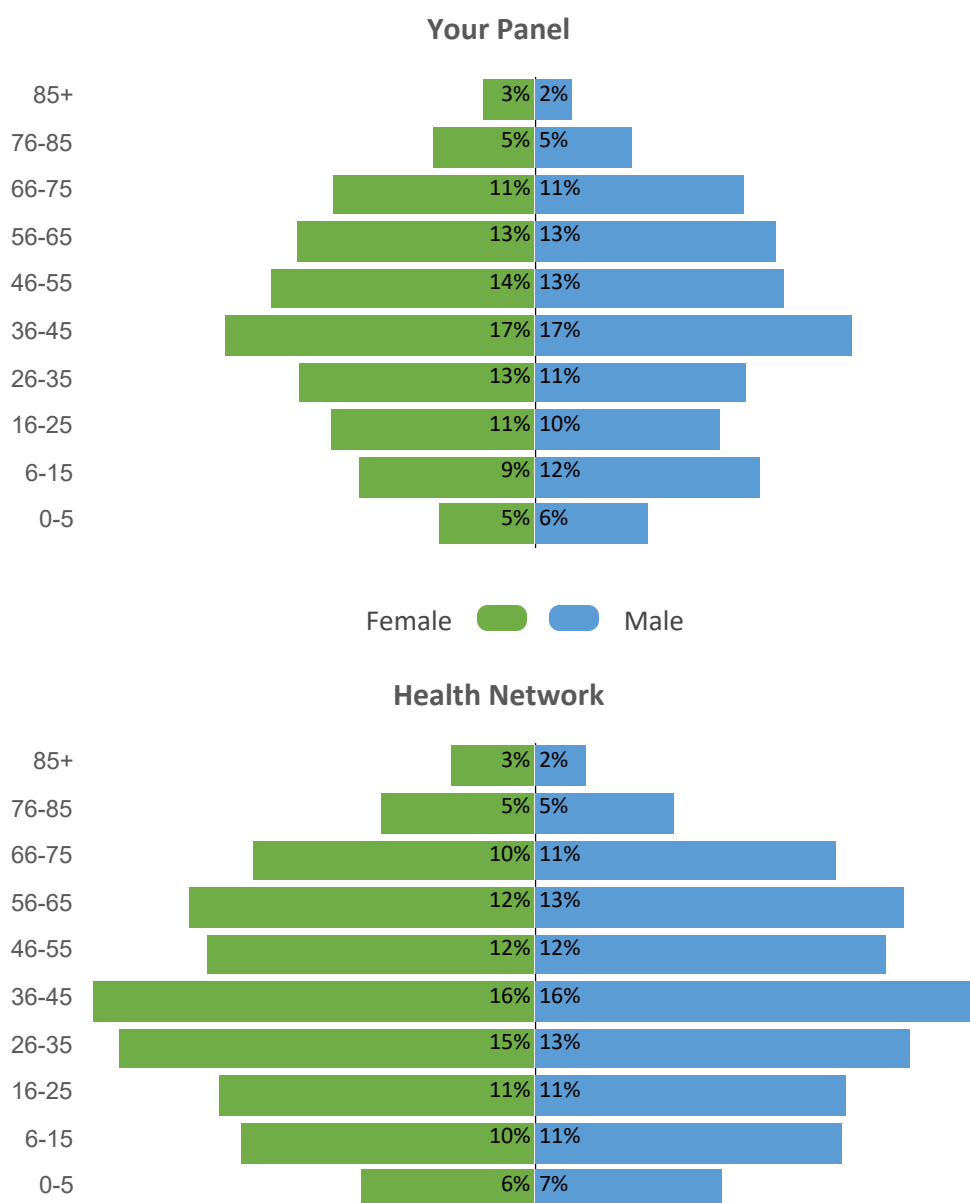
The following sections of your report contain more detailed information on the selected measure in the table above as well as other measures.

## Panel characteristics

The table below shows some selected measures of your panel characteristics.

Measure	Panel	Clinic	Network
Panel Size	2,691	5,608	93,335
Male	1,264	2,755 (49%)	46,174 (49%)
Female	1,427	2,853 (51%)	47,161 (51%)
Average age	43	43	41
Average physician continuity	77%	78%	72%
Average clinic continuity	79%	78%	75%

The age and sex composition of your Panel, as well as that of all patients in your corresponding Health Network can be seen below:

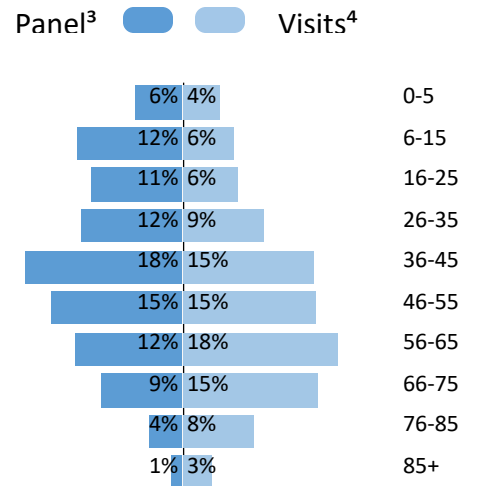


# Primary Care

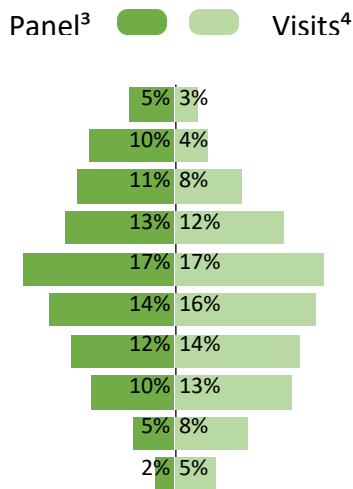
The following table shows the number and proportion of all your visits by calendar year:

## Male patients

Age Group	Your panel <sup>1</sup>	Your visits <sup>2</sup>					
		2021		2022		2023	
		#	%	#	%	#	%
0-5	71	115	3.4	195	4.9	143	4.4
6-15	152	180	4.6	253	6.5	197	5.8
16-25	133	273	6.8	254	5.9	151	4.6
26-35	148	387	8.9	392	8.1	228	8.1
36-45	226	553	13.6	604	13.8	450	14.4
46-55	189	542	13.8	584	13.9	509	14.2
56-65	155	659	18.0	636	17.0	624	18.6
66-75	117	582	17.1	554	16.6	517	16.7
76-85	50	301	9.5	300	9.4	278	9.3
85+	17	128	4.2	115	3.8	114	3.9
ALL	1264	3,722	100.0	3,891	100.0	3,214	100.0



## Female patients



Age Group	Your panel <sup>1</sup>	Your visits <sup>2</sup>					
		2021		2022		2023	
		#	%	#	%	#	%
0-5	76	98	1.8	185	3.2	127	2.9
6-15	141	177	3.2	238	4.2	174	3.5
16-25	160	441	8.2	420	7.2	295	6.9
26-35	179	668	11.7	746	11.7	484	12.0
36-45	248	857	15.5	938	16.1	774	17.1
46-55	206	869	16.8	839	15.6	748	15.8
56-65	171	769	15.2	730	14.6	682	14.8
66-75	136	715	14.0	664	13.8	635	13.9
76-85	70	443	8.5	423	8.8	407	8.6
85+	35	262	5.1	221	4.8	225	4.7
ALL	1427	5,302	100.0	5,407	100.0	4,552	100.0

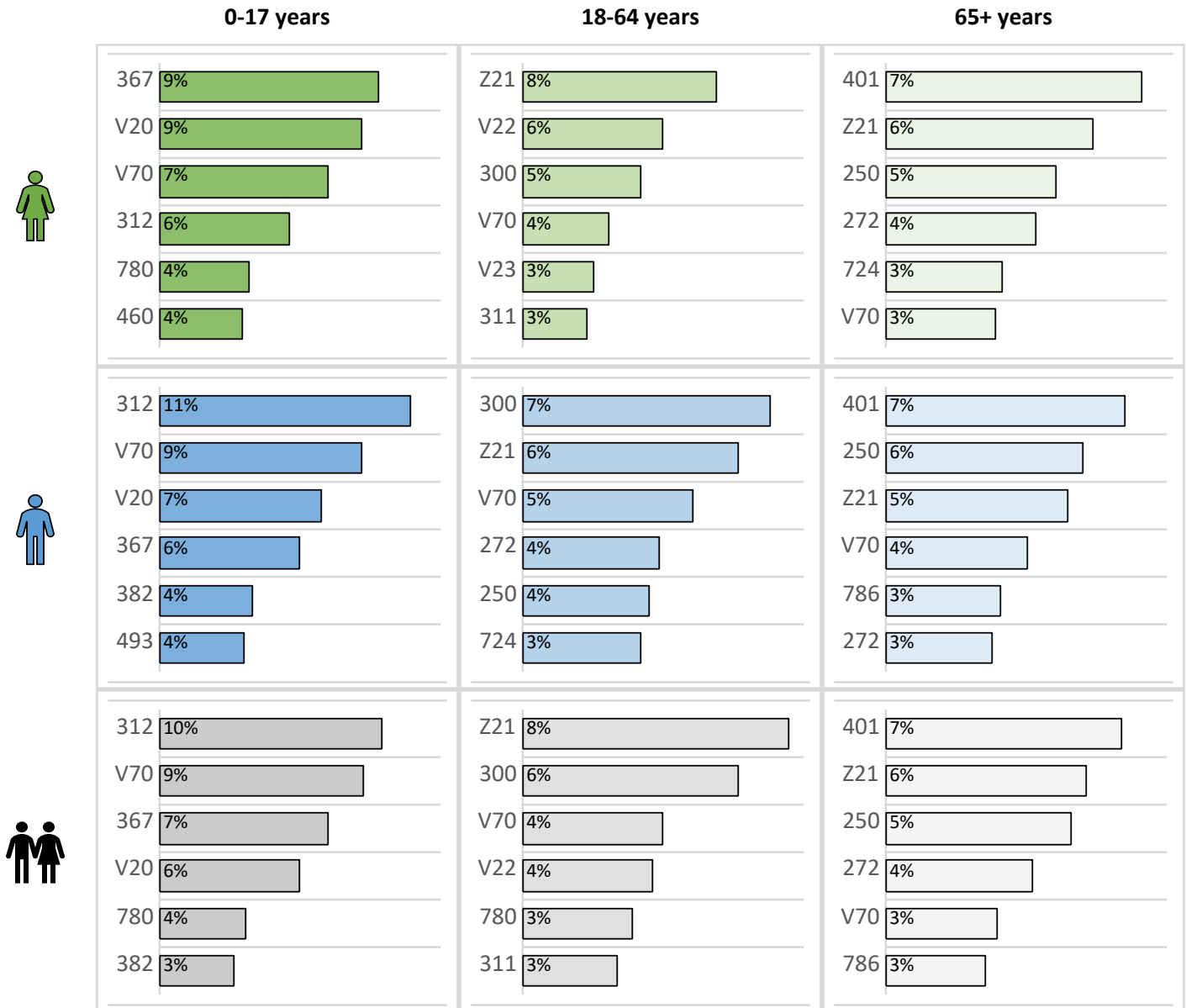
### Definitions

1. Includes all patients in your panel as of December 31, 2023.
2. Includes all your visits (MSB claims submitted by you) for each calendar year during the reference period. These visits include claims for patients in your panel and other patients NOT in your panel displayed.
3. Percentage of people in your panel.
4. Percentage of all your visits (all MSB claims submitted by you) of patients in your panel and not in your panel during the reference period.



## Diagnoses driving Family Physician visits

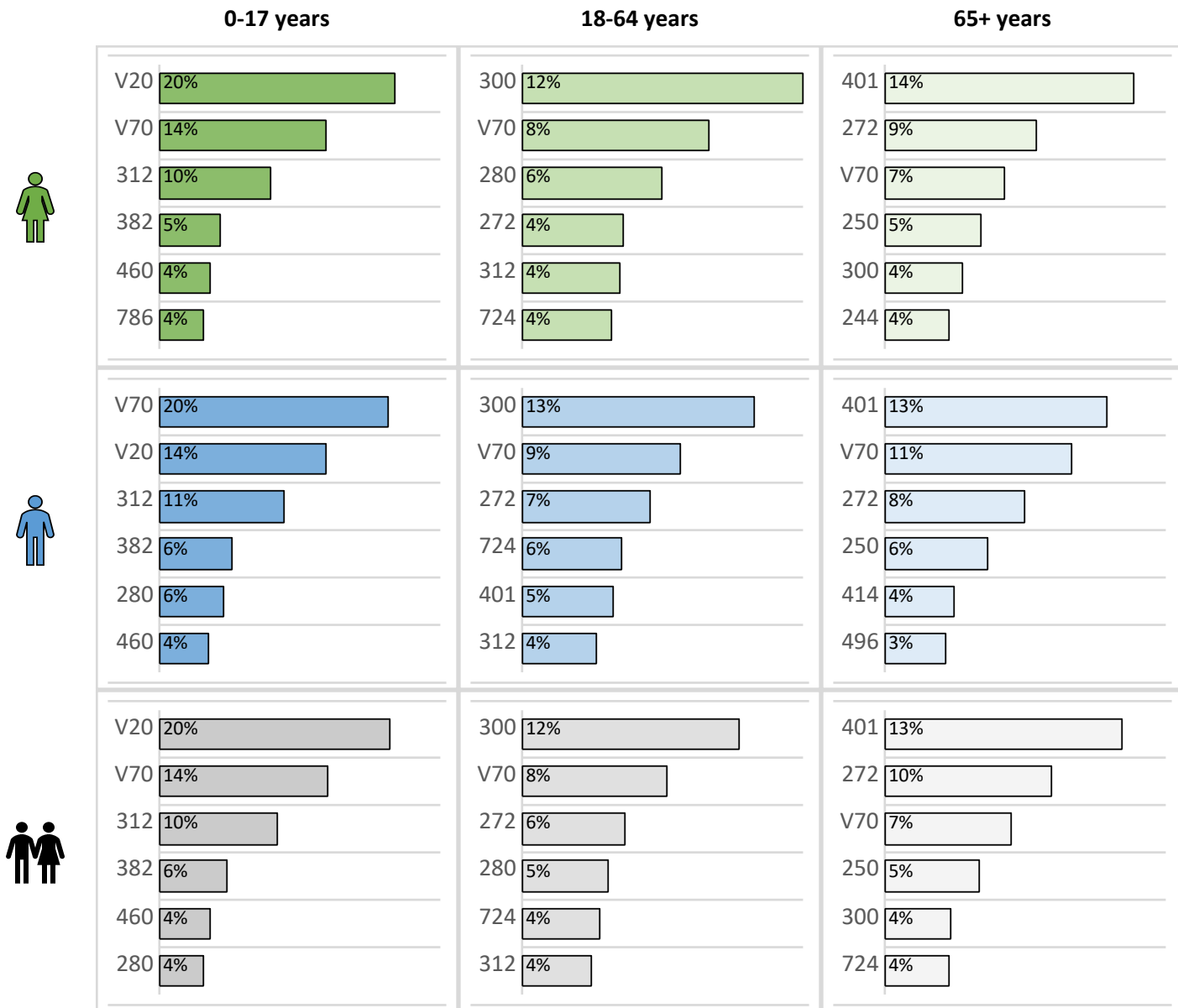
This section shows the most frequent reasons (i.e. ICD-9 diagnosis codes as billed to MSB) for which patients in your panel saw ANY family physician during the reference period.



The diagnoses shown are based on billing data. One of the biggest limitations of the MSB billing data is that only one diagnosis code is associated with each visit and multiple diagnosis codes cannot be captured for a single visit. Similarly, the ICD-9 codes shown may be affected depending on the individual billing practices.

## Diagnoses driving visits to you from patients in your panel

This subsection only includes reasons for which patients in your panel saw YOU and excludes visits to other primary care physicians.



## Most visited medical specialists

The following figures show the specialists that patients in your panel have visited the most frequently during the reference period. The percentages represent the proportion of patients in your panel who have had at least one visit with a physician of a given speciality. The same patient might be counted towards the percentage in multiple specialities if they had visits with more than one specialist during the reference period.

These visits include all visits to specialist regardless of where the reference to the specialist came from, or whether these were initial or follow-up visits. Only one visit per day to the same specialist was counted.

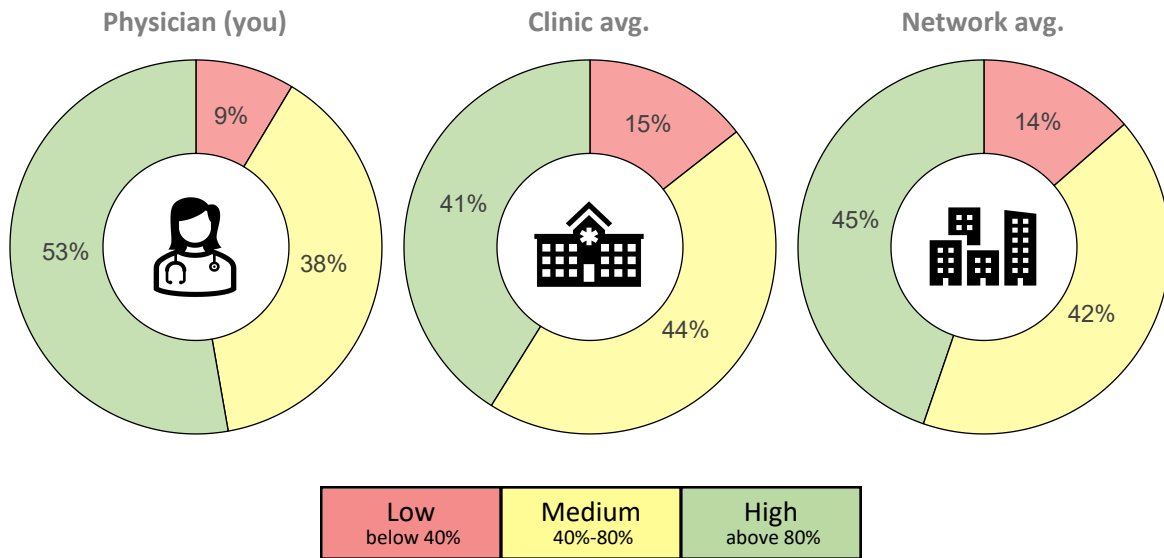


The MSB billing data contains a variable indicating the specialty of the physicians submitting a claim.

## Continuity of Care

For this report, continuity is defined as the percentage of all family physician visits that all patients in your panel had with you/your clinic throughout the reference period. Patients with a single or no visits during the reference period are excluded.

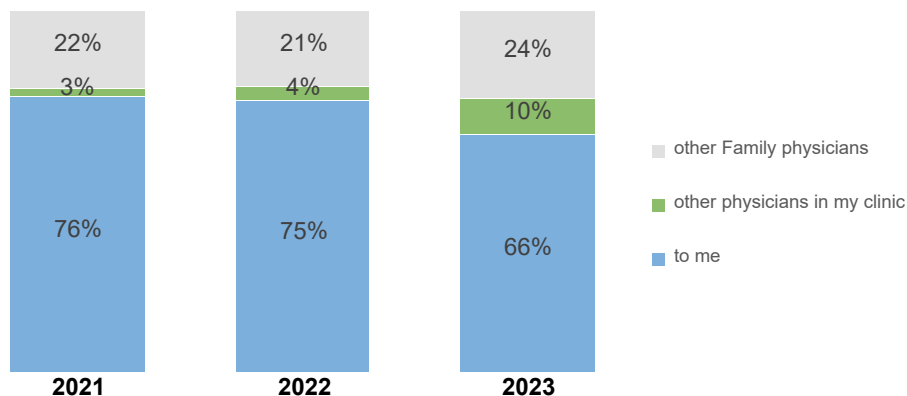
Continuity has been classified as low (40% of less), medium (between 40 and 80%), and high (more than 80%), based on the percentage of visits for a given patient in your panel that were billed by you (physician continuity) or someone in your clinic (clinic continuity).



The **average physician continuity** (with you), the percentage represents the proportion of patients in your panel with Low-Medium-High physician continuity. Patient with low continuity with you may have higher continuity with a given clinic (your clinic or a different clinic).

The following graphics show the percentage of all visits from patients in your panel to different primary care providers for each of the calendar years included in the reference period.

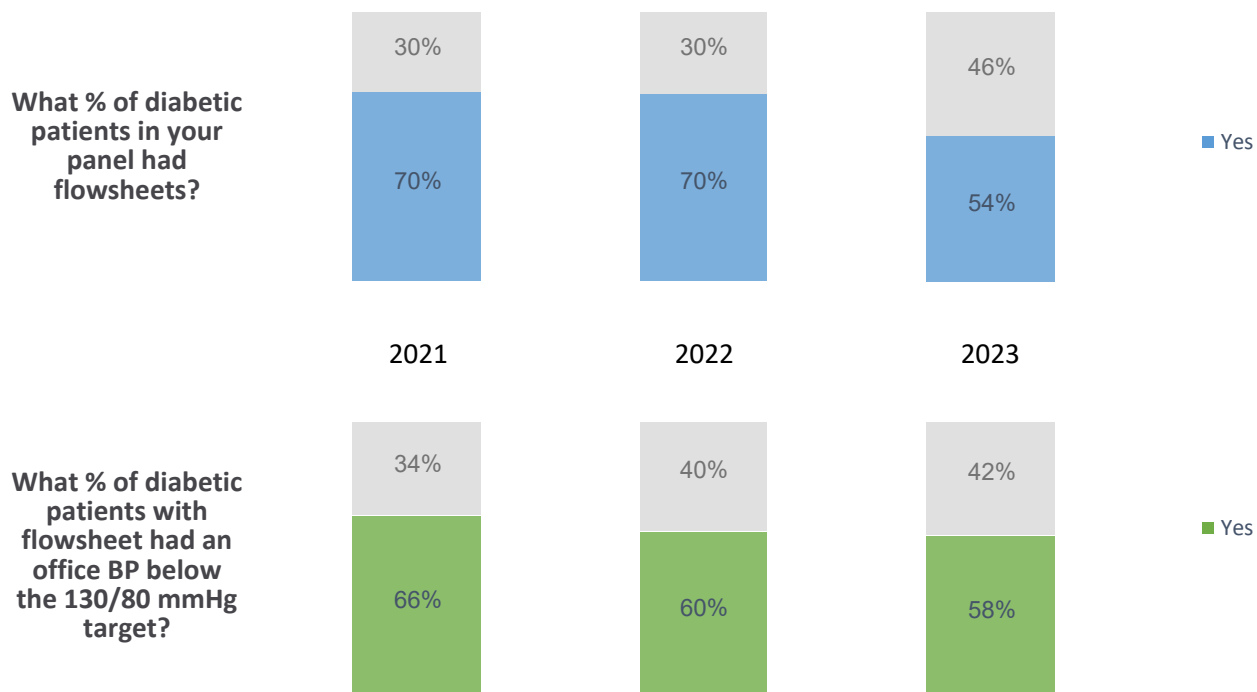
**% of visits from patients in your panel by provider**



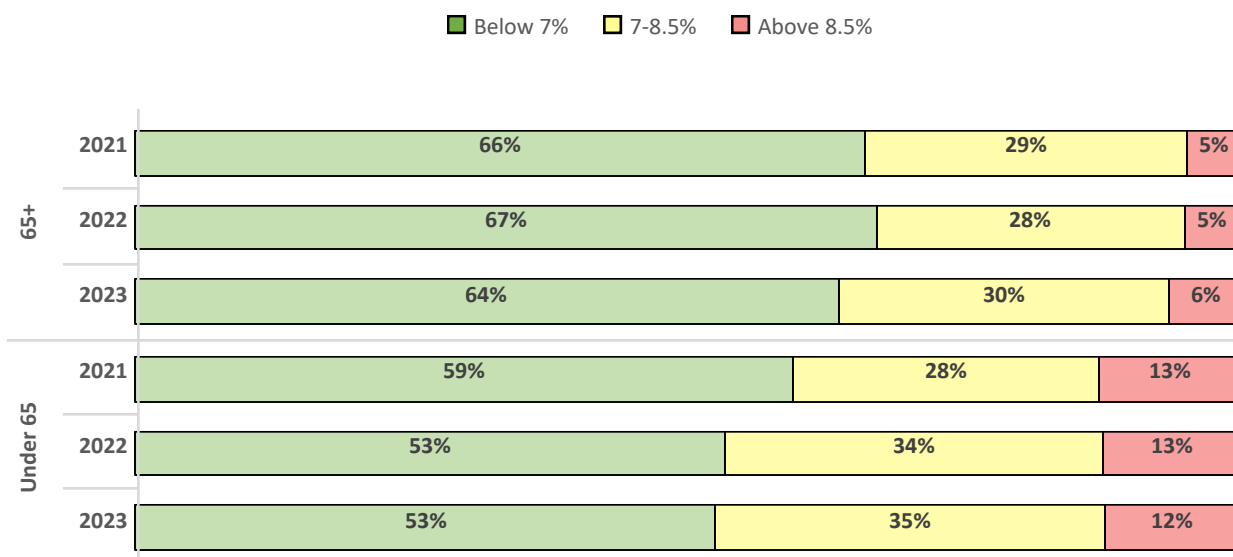
# Chronic conditions

## DIABETES

The Saskatchewan Chronic Disease Management Quality Improvement Project (CDM-QIP) flow sheets were created using evidence based best-practice guidelines. Diabetes Canada recommends an A1C Hb target of less than 7% and an office blood pressure of no more than 130/80 mmHg for most diabetic patients (Type 1 & 2).



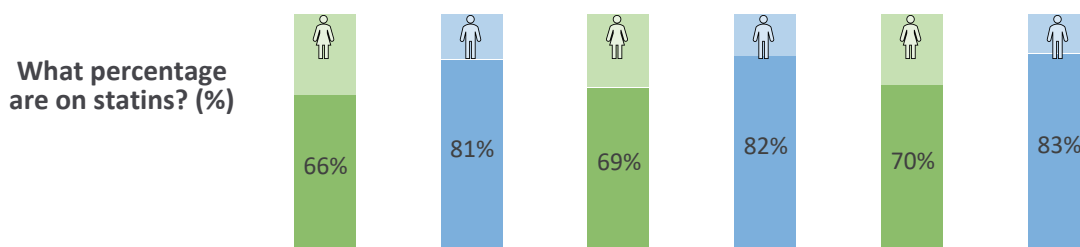
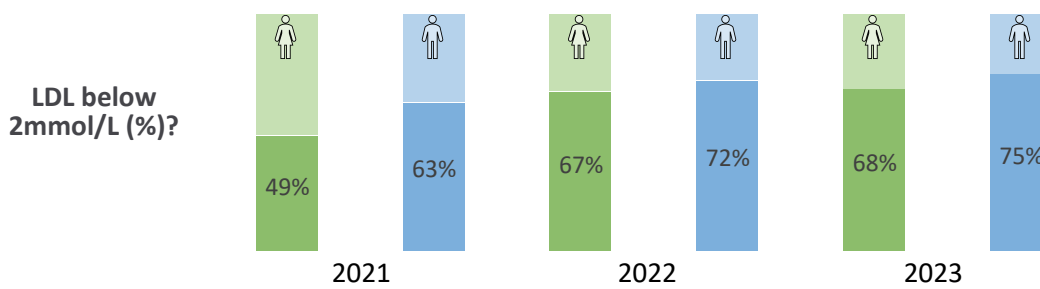
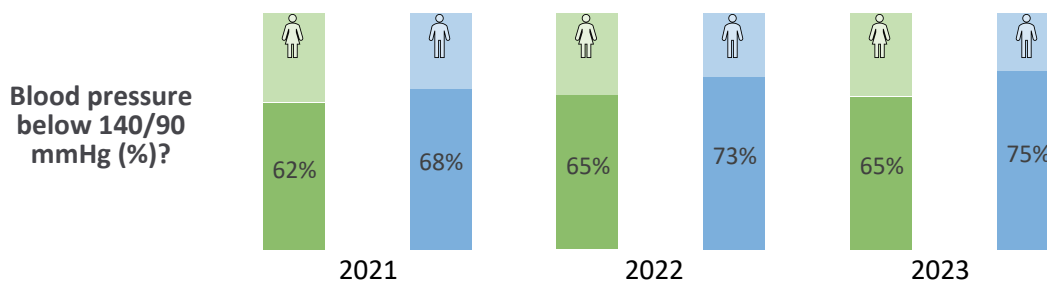
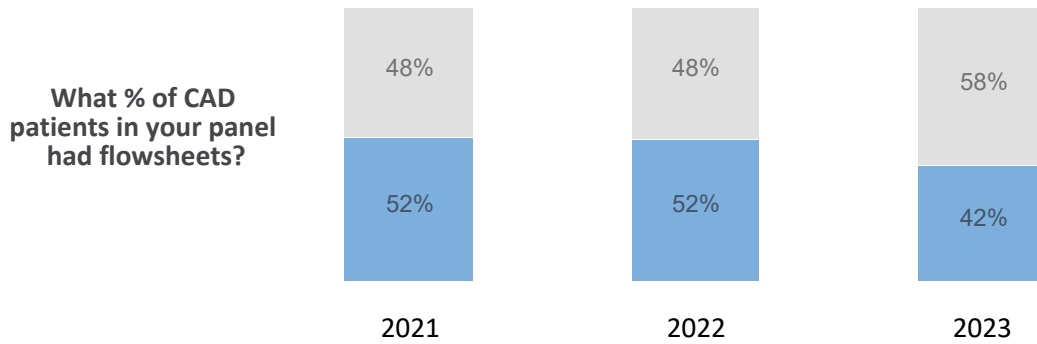
What was the A1C Hb profile of diabetic patients in your panel with completed flowsheets?



## CORONARY ARTERY DISEASE

Coronary artery disease (CAD) is also targeted through the CDM-QIP. The Canadian Cardiovascular Society recommends an LDL <2 mmol/L or >50% reduction in LDL with statin therapy for all CAD patients. Target blood pressure is <140/90 mmHg according to Hypertension Canada’s guidelines.

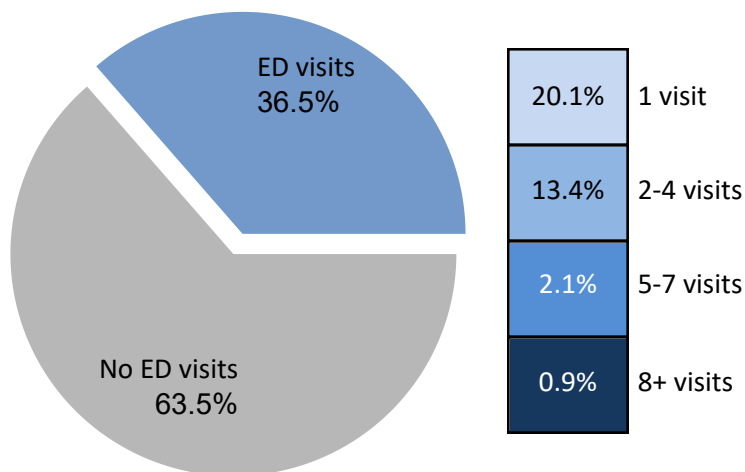
The figures below show the proportion of your panel who have CAD, how many of them had flow sheets, their statin usage, and proportions meeting blood pressure and LDL targets.



# Healthcare utilization

## Emergency Department Visits (ED)

The figure below presents a summary of ED visits among patients in your cohort. The proportion of patients with at least one ED visit during the reference period are shown to the right (vertical bar).



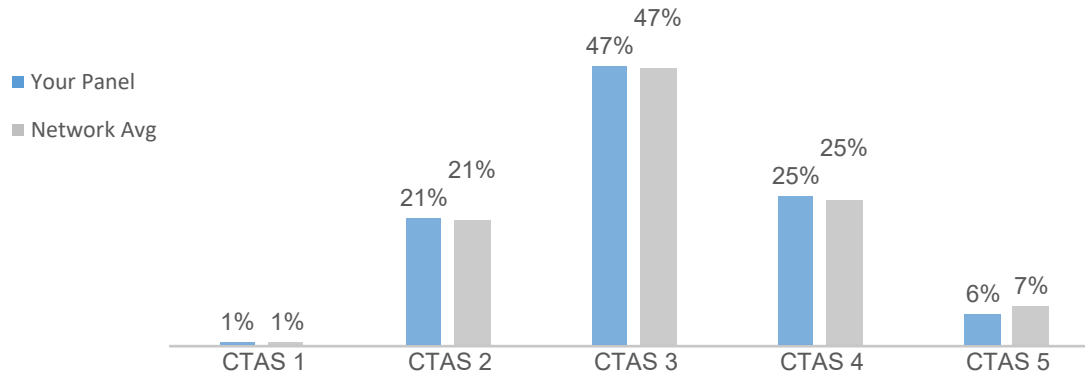
**36.5%** of the patients in your panel has at least one ED visit during the reference period.

**The average in your network is 38%**

The following table presents a detailed breakdown of the number of visits per calendar year:

ED visits	2021	2022	2023	All
No visits	2,300 (85.5%)	2,229 (82.8%)	2,213 (82.2%)	1,709 (63.5%)
1 visit	278 (10.3%)	312 (11.6%)	335 (12.4%)	541 (20.1%)
2-4 visits	102 (3.8%)	133 (4.9%)	130 (4.8%)	360 (13.4%)
5-7 visits	6 (0.2%)	12 (0.4%)	9 (0.3%)	57 (2.1%)
8+ visits	3 (0.1%)	2 (0.1%)	2 (0.1%)	23 (0.9%)

**Potentially avoidable ED visits** - Potentially avoidable visits are those with an ED triage score of the Canadian Triage and Acuity Scale (CTAS) of 4 or 5 (non-urgent) when accompanied by a discharge diagnosis that is considered to be *potentially* treatable by a family physician in the office. The CTAS is a 5-level triage system used to prioritize patient care requirements of ED. The following graphic shows the overall distribution of ED visits from patients in your panel by CTAS level.



The following tables show the number and percentages of all ED visits among patients in your panel by age group, sex, CTAS level, and time of arrival at the ED (Daytime (8h – 17h), Evening (17h – 22h), or Overnight (22h -8h)).

**Patients less than 65 years**

Time of Day	CTAS 1 to 3		CTAS 4		CTAS 5	
	M	F	M	F	M	F
All (n)	461	597	223	218	45	51
Daytime (%)	46%	49%	53%	50%	56%	61%
Evening (%)	28%	27%	25%	29%	24%	24%
Overnight (%)	26%	24%	22%	21%	20%	16%

**Patients 65 years and older**

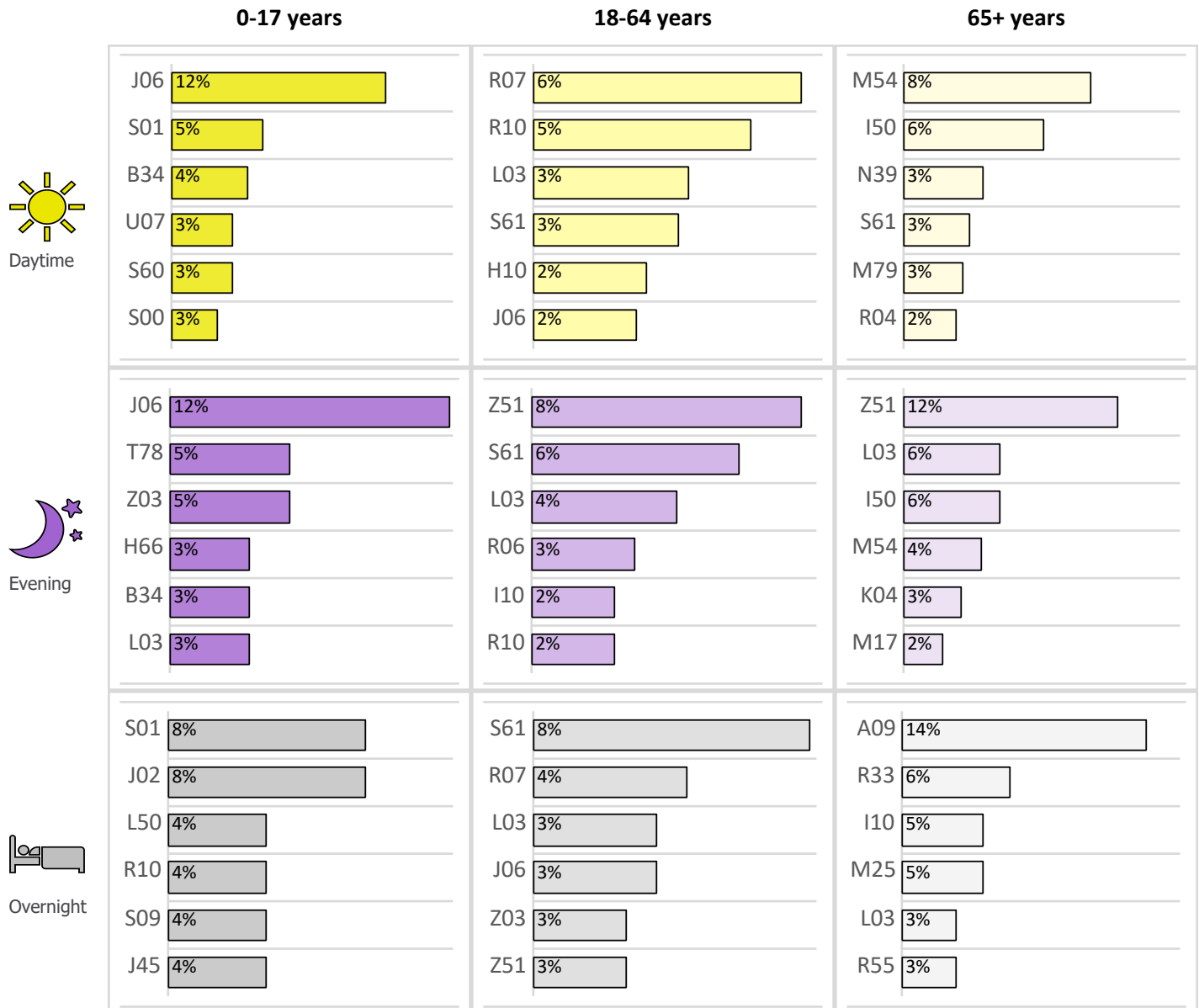
Time of Day	CTAS 1 to 3		CTAS 4		CTAS 5	
	M	F	M	F	M	F
All (n)	151	212	31	45	8	8
Daytime (%)	58%	59%	68%	67%	75%	63%
Evening (%)	23%	23%	16%	18%	13%	13%
Overnight (%)	20%	18%	16%	16%	13%	25%

CTAS Levels	Level I	Resuscitation	see patient immediately
	Level II	Emergency	within 15 minutes
	Level III	Urgency	within 30 minutes
	Level IV	Less Urgency	within 60 minutes
	Level V	Non Urgency	within 120 minutes



The following graphics show the top discharge diagnoses (ICD-10 codes category) of visits classified as CTAS 4/5 from patients in your panel by age group, and time of arrival at the ED (Daytime (8h – 17h), Evening (17h – 22h), or Overnight (22h -8h)).

Percentage of CTAS4/5 ED visits by discharge diagnosis (toICD-10), age group & time of day



A large proportion of ED visits for conditions that are potentially treatable in a primary care setting may be the result of lack of availability of short notice access to a family physician in the community highlighting the need to increase on-demand short notice access to family physicians.

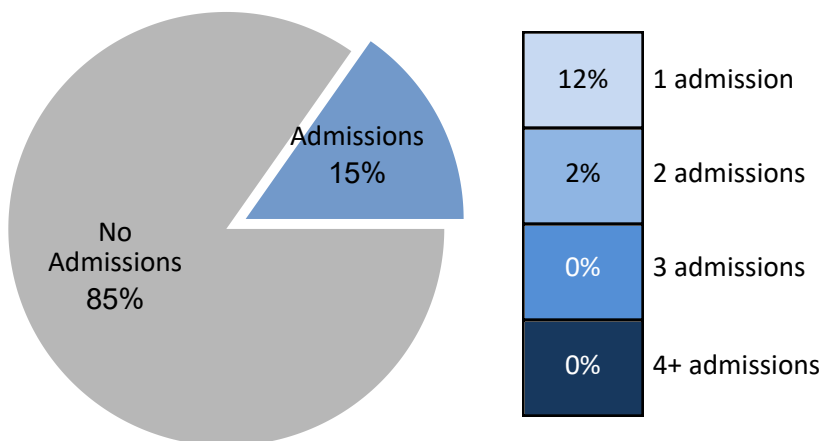
Avoidable ED visits can result in delayed treatment for more urgent patients, can lead to unnecessary treatments, increased care costs and can put patient safety at risk.

## Acute care (hospitalizations)

The following table shows the proportion of patients in your panel who had any inpatient admissions (excluding day surgeries/procedures) to any hospital(s) in the province. The information presented is based on the 2023 calendar year.

Age Group	Your Panel		Network Average	
	Admitted at least once	Average length of stay (days)	Admitted at least once	Average length of stay (days)
0-17 years	25 (5%)	3	4 (7%)	3
18-64 years	82 (5%)	5	10 (6%)	6
65+ years	82 (5%)	5	10 (6%)	6

The following figure shows the percentage of patients in your panel by the number of in-patient hospital admissions during the 2023 calendar year.



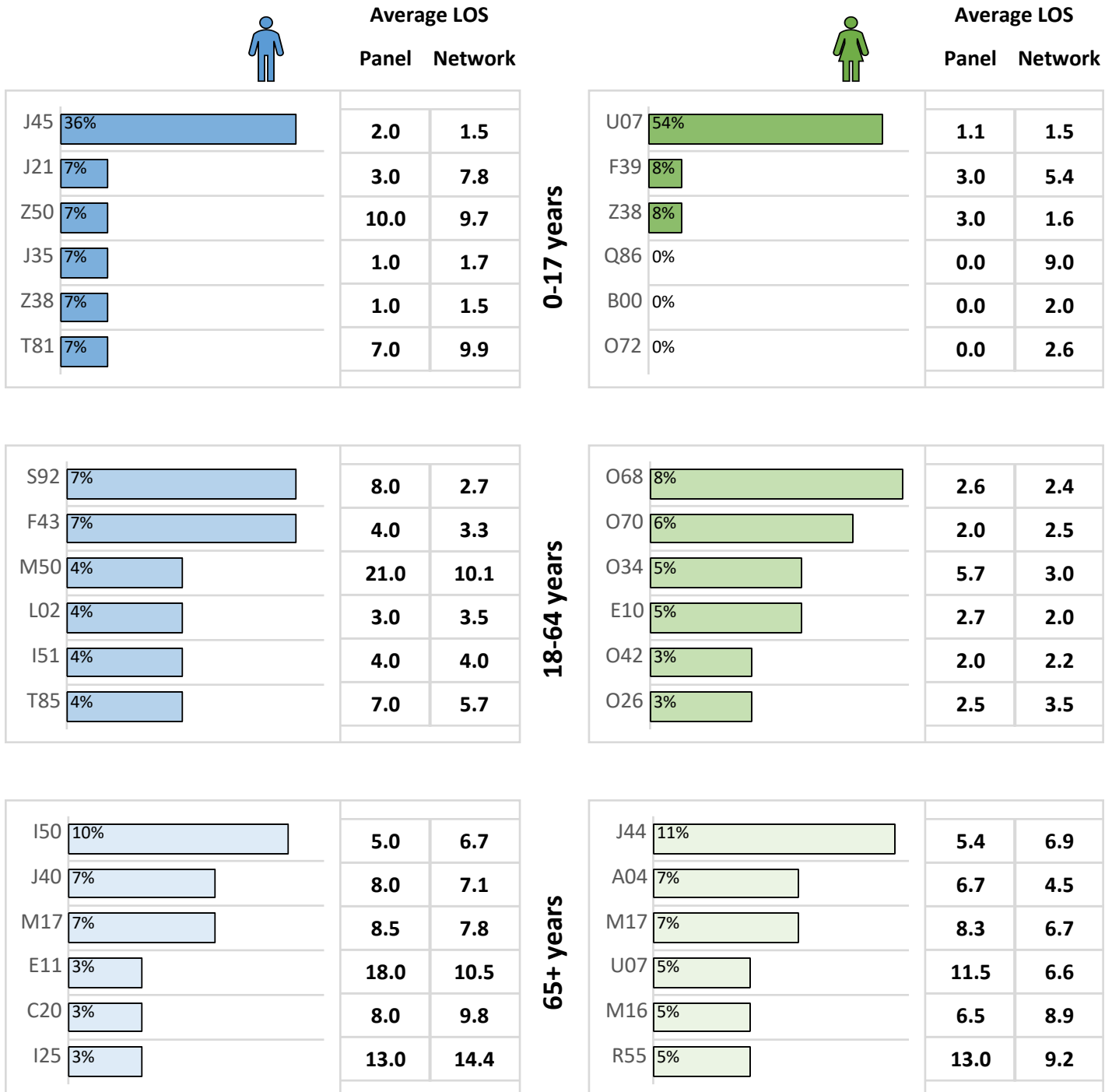
The following table presents a detailed breakdown of the number of admissions per calendar year:

Hospital admissions	2021	2022	2023	All
No admissions	2,545 (95%)	2,527 (94%)	2,523 (94%)	2,280 (85%)
1 admission	133 (5%)	146 (5%)	147 (5%)	325 (12%)
2 admissions	10 (0%)	14 (1%)	17 (1%)	60 (2%)
3 admissions	1 (0%)	1 (0%)	2 (0%)	13 (0%)
4+ admissions	0 (0%)	0 (0%)	1 (0%)	11 (0%)

The following section will present the most frequent most responsible diagnoses for which patients in your panel were hospitalized during the reference period. The most responsible diagnosis is the ICD-10 code in the first diagnosis field in the Discharge Abstract Dataset (DAD).

The figure below provides a breakdown of the most common reasons (i.e. most responsible ICD-10 diagnosis code category) and average length of stay (LOS) of all inpatient hospitalizations (excluding day surgeries/procedures) of patients in your panel.

**Percentage of hospitalizations by discharge code category (ICD-10) by age group & sex**

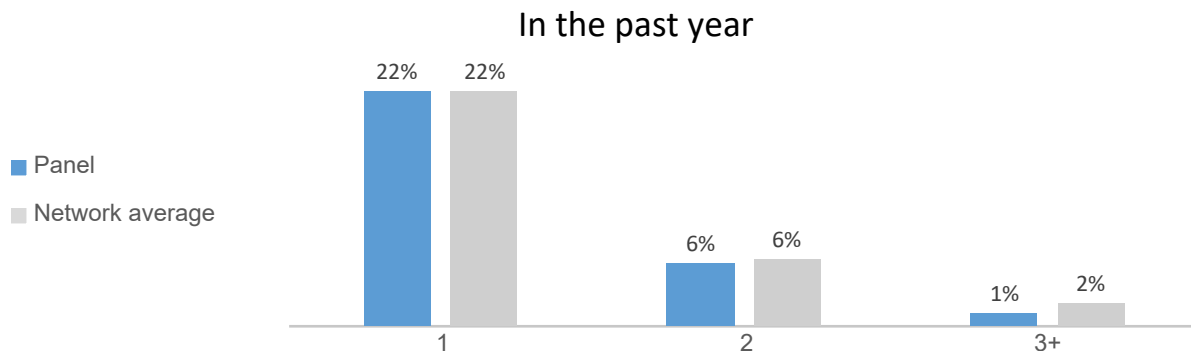


## Prescribing indicators

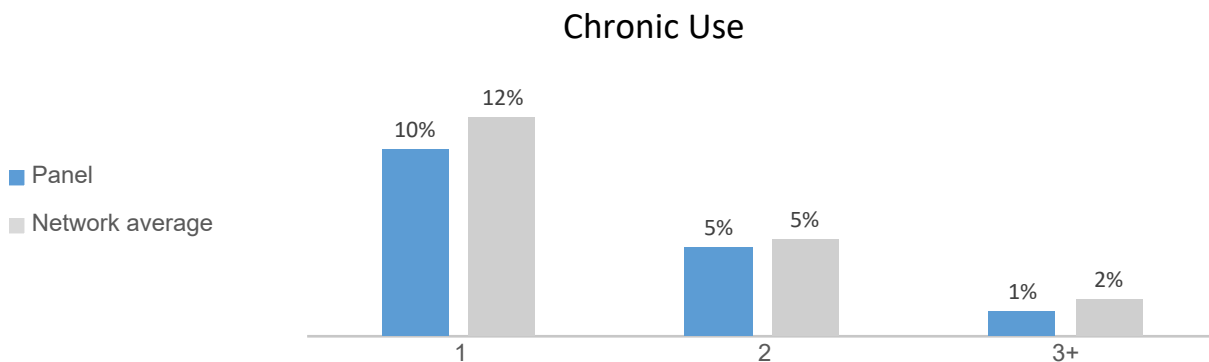
### High risk medications (seniors)

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.

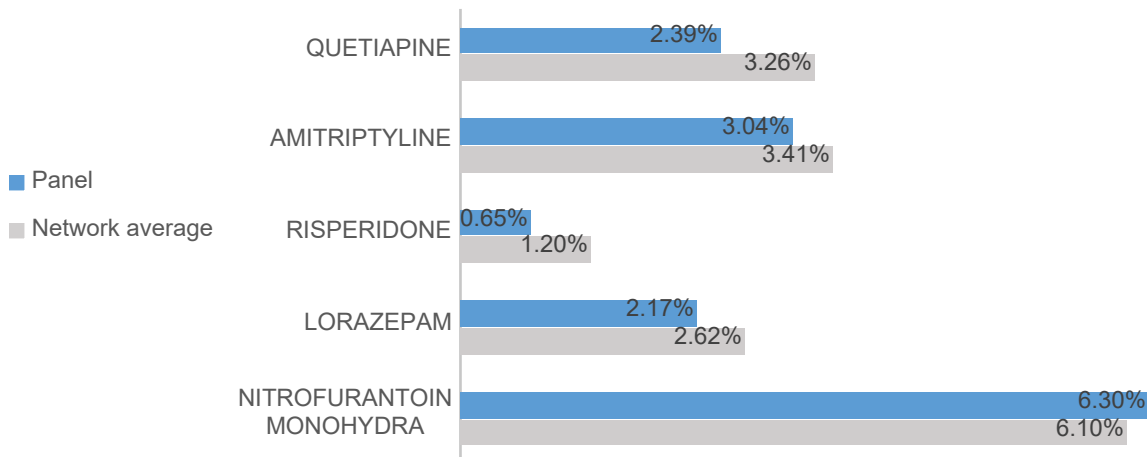
The following graphic displays the percentage of patients aged 65+ in your panel who filled 1 or more prescriptions of at least one of the medications listed in the Beers Criteria during the calendar year 2023.



Chronic users are defined as, *patients having at least 2 dispensations for the same Beers drug within 6 weeks of each other and at least 1 additional dispensation of the same drug within 180 days.*



The figure below shows the proportion of patients in your panel and the network average of the 5 most frequently prescribed drugs from the Beers criteria in the province.

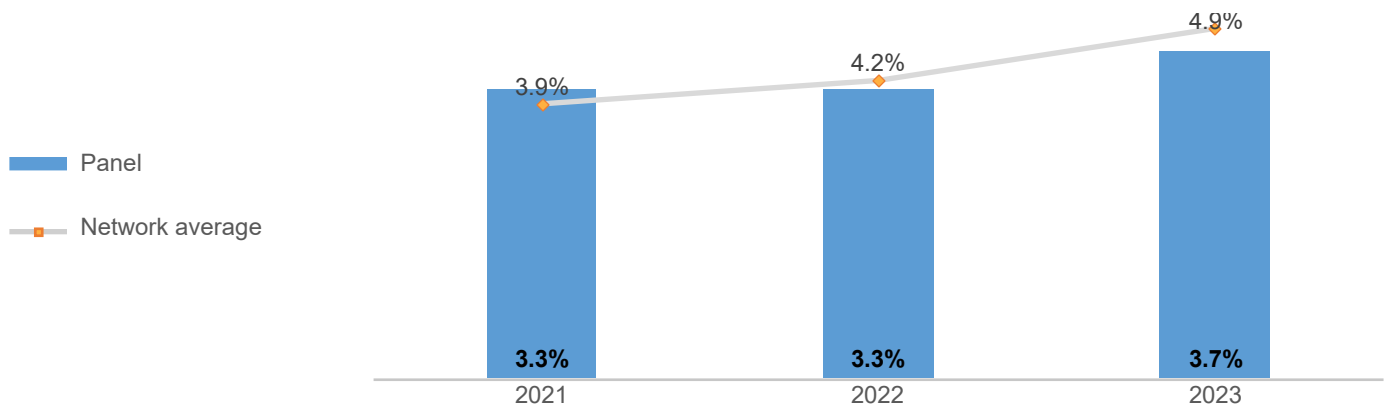


## Antipsychotics (seniors)

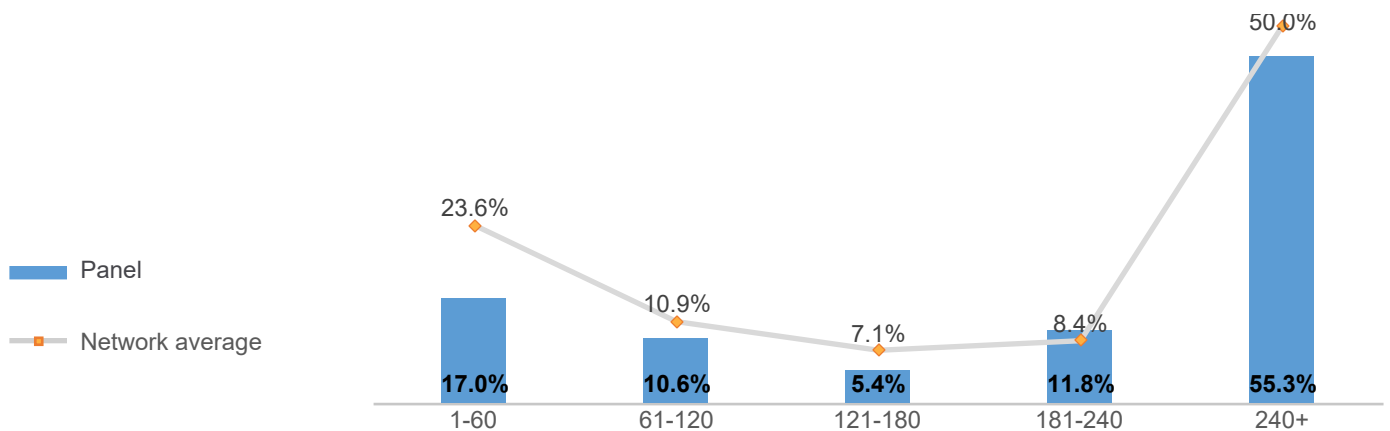
Antipsychotics are commonly prescribed to seniors with dementia who experience behavioural and psychological symptoms, including delusions, aggression, and agitation.

The American Geriatric Society recommends avoiding their use unless non-pharmacologic options have failed, and patient is 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 people with dementia.

**Percentage of senior patients in your panel who filled antipsychotic prescriptions by year**



**Percentage of senior patients in your panel by number of days for which they received antipsychotics in 2023**



### Who prescribed them?

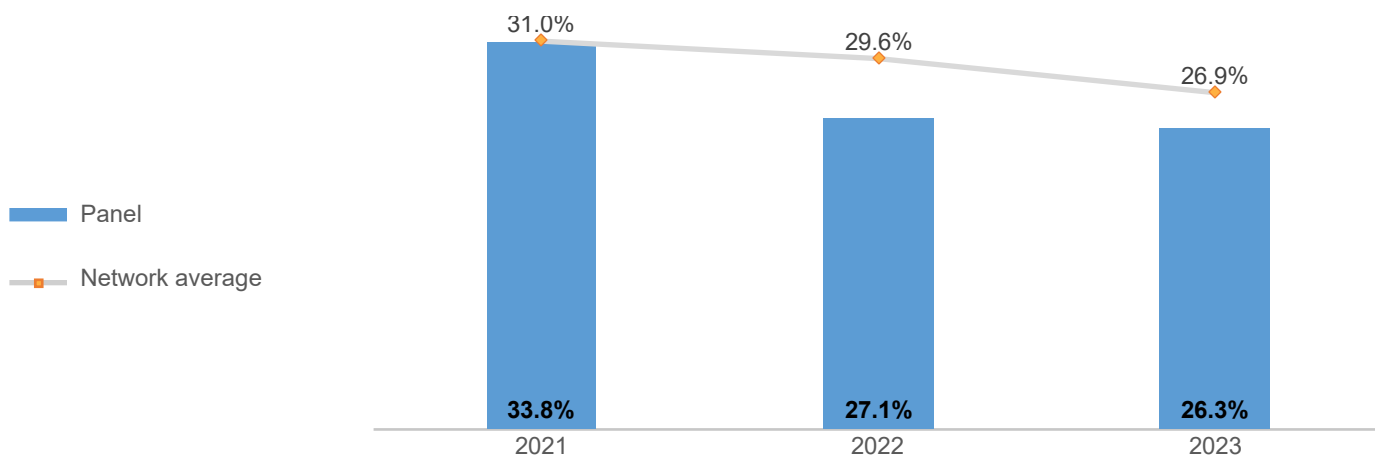
You only	20%
You & others in clinic	0%
You & others not in clinic	35%
All (you & others)	0%
Other in clinic	0%
Others in and not in clinic	0%
Others not in clinic only	35%

## Opioids

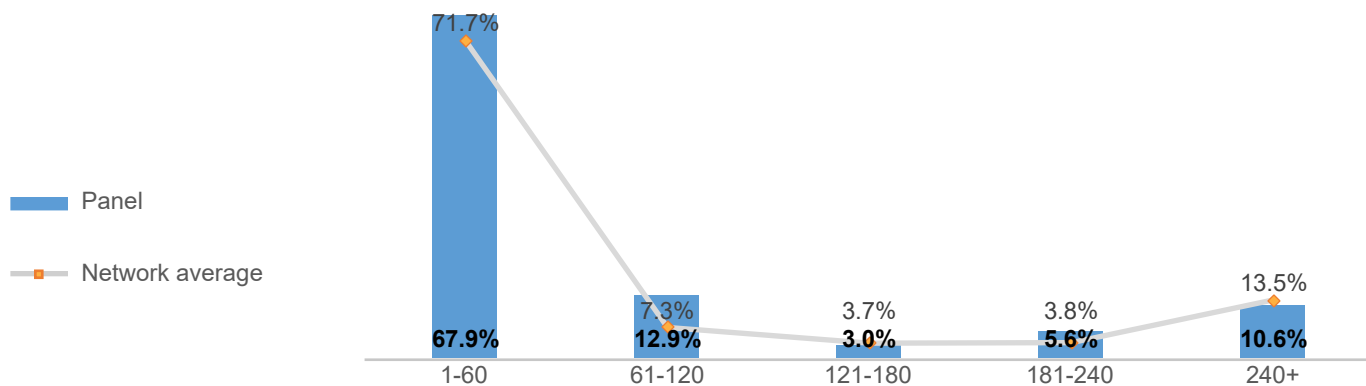
The College of Family Physicians of Canada has published guidelines for family physicians regarding opioid prescribing:

- Don't continue opioid analgesia beyond the immediate postoperative period or other episode of acute and 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.

**Percentage of patients in your panel who filled opioids prescriptions by year**



**Percentage of patients in your panel by number of days for which they received opioids in 2023**



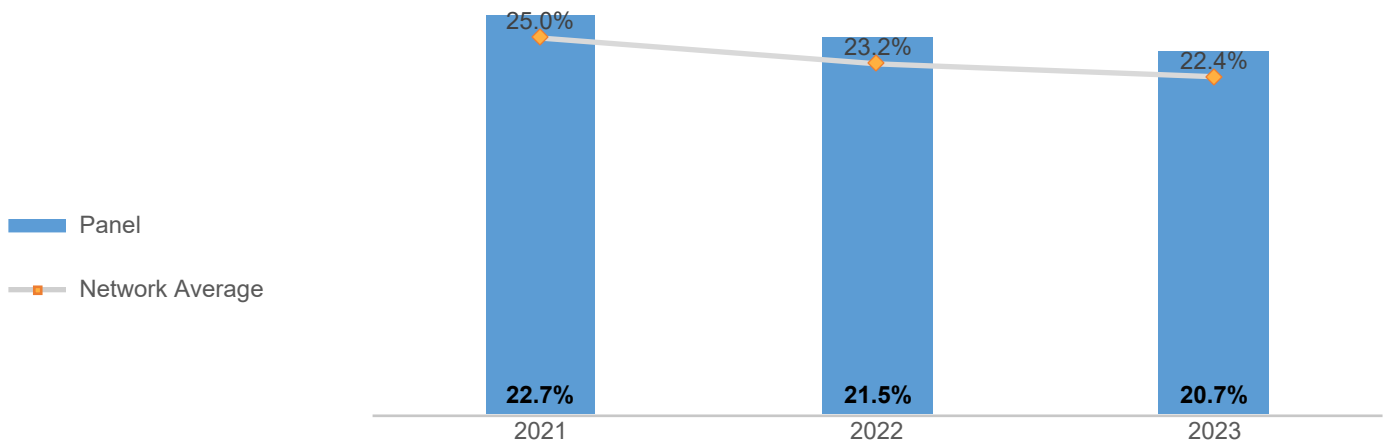
### Who prescribed them?

You only	25%
You & others in clinic	1%
You & others not in clinic	9%
All (you & others)	1%
Other in clinic	1%
Others in and not in clinic	1%
Others not in clinic only	62%

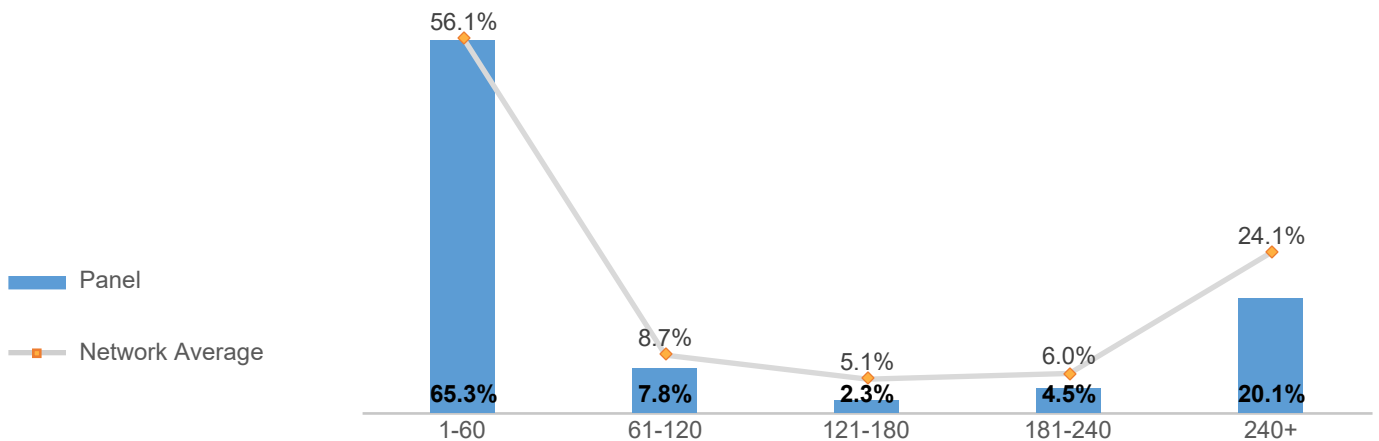
## Benzodiazepines

Benzodiazepines may be of benefit to some patients experiencing Generalized Anxiety Disorder (GAD). They can reduce both somatic and emotional symptoms of GAD. There is significant concern regarding dependence and withdrawal (depending on duration of use), tolerance, impaired psychomotor function, and memory, rebound anxiety (after short term use), and increased risk of opioid toxicity and overdose.

**Percentage of patients in your panel who filled benzodiazepines prescriptions by year**



**Percentage of patients in your panel by number of days for which they received benzodiazepines in 2023**



### Who prescribed them?

You only	41%
You & others in clinic	1%
You & others not in clinic	12%
All (you & others)	4%
Other in clinic	2%
Others in and not in clinic	1%
Others not in clinic only	39%