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PRIVATE AND CONFIDENTIAL

MyPractice
Primary Care

A tailored report for quality care

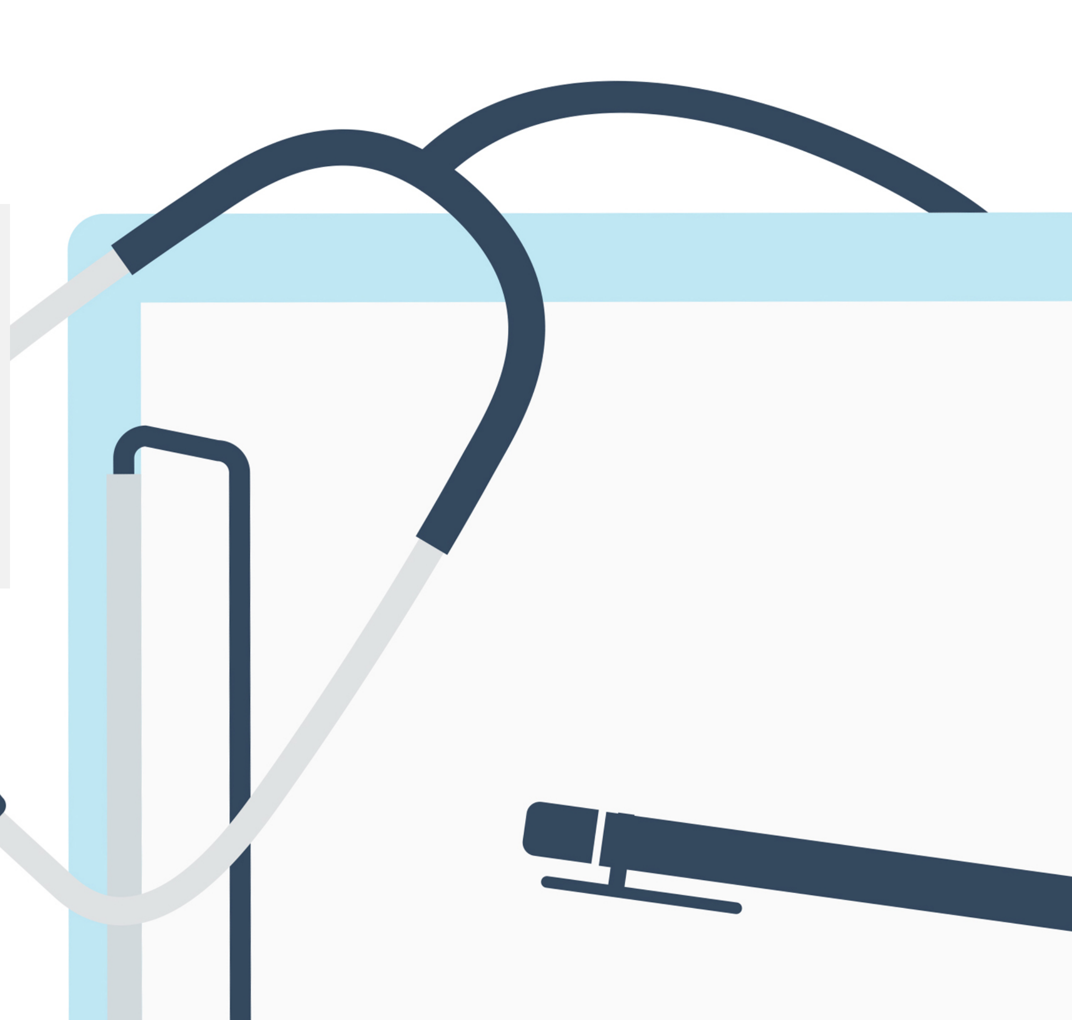
Kawartha North Family Health Team

Reporting Period: March 31, 2020

Release: November 2020

FHT Rurality Index of Ontario Score: Semi Urban (10 to 39)

FHT LHIN: Central East



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Report Overview

Background

The *MyPractice:* Primary Care report can help you focus your quality improvement efforts.

This report DOES

- Use billing data and other administrative data.
- Give an overview of your practice activities.
- Provide the LHIN and provincial percentages for context.
- Provide you with ideas for improvement.
- Include rostered and virtually rostered patients.

This report does NOT

- Use EMR data held in your practice or provide direct links to your EMR.
- Provide details about specific patients.
- Include palliative care patients.
- Provide specific instructions for clinical care.
- Tell you what targets are best for your practice.

This report was developed by

Ontario Health and ICES in partnership with the Association of Family Health Teams of Ontario (AFHTO).

Additional information

- For more information about the *MyPractice:* Primary Care Report, please email us at PracticeReport@ontariohealth.ca.
- For more information on indicator definitions, please refer to the methodological notes on page 24. For more technical details, please refer to the technical appendix on the *MyPractice* web portal.

> *"I would strongly recommend that my colleagues sign up to receive this report. I think that it doesn't matter what model you are working in […] this information tells you what you're doing as a family physician, and it tells you who you're looking after and how you're using the system"*
>
> *- Dr. Cathy Faulds, Chief Clinical Lead, South West LHIN*

Overall Indicators Summary

Data as of March 31, 2020

Opioid Prescribing in my FHT (pages 5-8)	# Patients Dispensed an Opioid	# Patients Newly Dispensed an Opioid	# Patients Dispensed an Opioid and Benzodiazepine	# Patients With a High-Dose Opioid >90 mg MEQ Daily
	391	**212**	**74**	**48**

	My Priority Indicators for Review (below 40th percentile)	My Indicators Around Average (between 40th - 75th percentile)	My Indicators Above Average (above 75th percentile)
Cancer Screening (pages 11-13)	None	Pap smear testing Mammogram testing Any Colorectal screening	None
Diabetes Management (pages 15-17)	None	HbA1c testing Retinal Exam testing	None

*Percentiles are based on FHTs registered for the *MyPractice:* Primary Care report

Whom are we caring for?

# of Patients	Age (mean)	% Male	% Rural
4,102	**53.0**	**48.0%**	**11.1%**

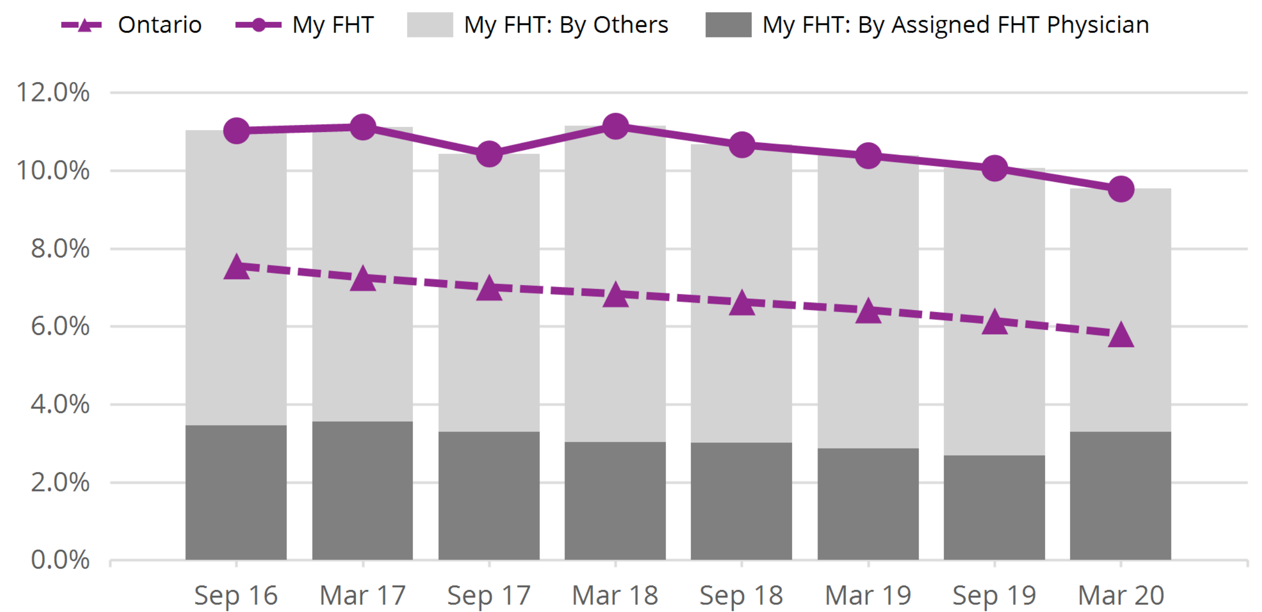
† Data suppressed where counts are between 1 and 5; additional suppression may be applied where counts are greater than 5 to prevent residual disclosure of suppressed values; N/A: Data not available; ¨ Please interpret with caution, denominator ≤ 30. For more details, refer to the Methods section on page 24.

Opioids Section | Opioids Dispensed

Data as of March 31, 2020

What percentage of my FHT's non-palliative care patients have been dispensed an opioid prescription (excluding opioid agonist therapy) within the last 6 months?

- As of March 31, 2020, 9.5% of my FHT's patients have been dispensed an opioid prescription. 34.5% of those opioids were prescribed by the patients' physician within the FHT and 65.5% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 6.4%. The provincial percentage is 5.8%. **These percentages are for context only and do not represent a target.**



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Palliative care patients are not included; they were identified from hospital and physician billing claims data. For this indicator, the opioid medication's definition does not include opioid agonist therapy, opioid cough and anti-diarrheal medications.

Number of my FHT's patients who have been dispensed an opioid within the last 6 months
By their physician within the FHT: **135**
By Other Providers within or outside of the FHT: **256**

Your patients who have pain need your primary care team.

Sometimes opioid prescriptions are appropriate. The data cannot weigh the benefits against the possible harms, but they can point to practice patterns worthy of reflection.

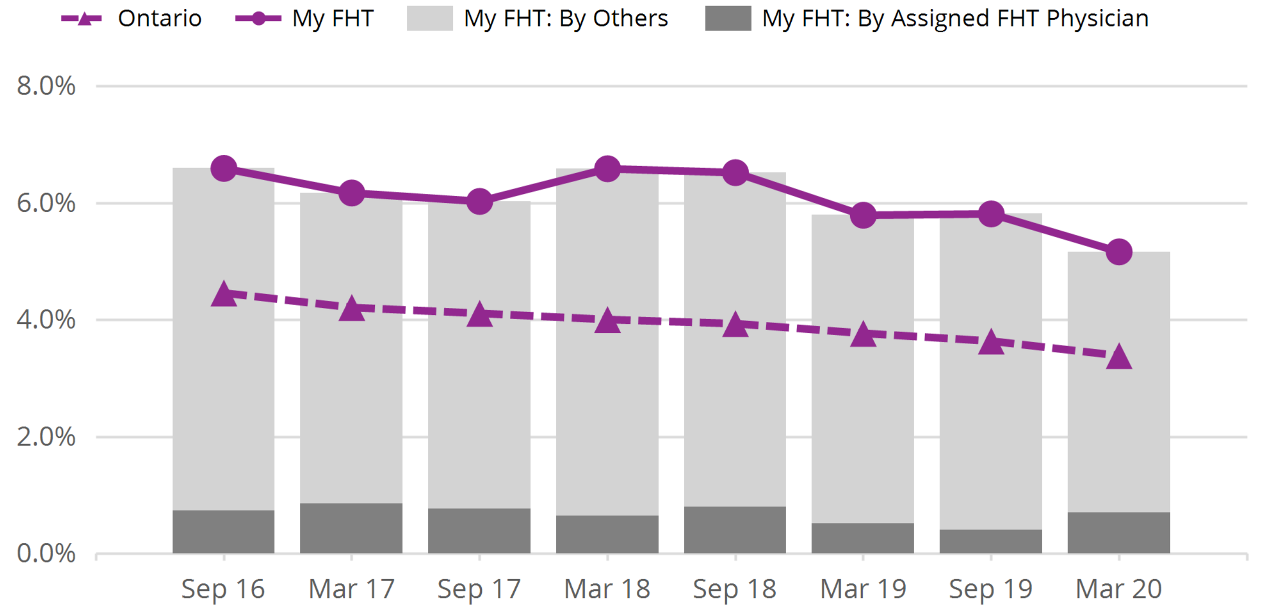
How many patients are taking opioids for a short-term acute use? Longer-term chronic use? (page 9)

New Opioids Dispensed

Data as of March 31, 2020

What percentage of my FHT's non-palliative care patients have been newly dispensed an opioid prescription (excluding opioid agonist therapy) within the last 6 months?

- As of March 31, 2020, 5.2% of my FHT's patients have been newly dispensed an opioid prescription. 13.7% of those opioids were prescribed by the patients' physician within the FHT and 86.3% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 3.7%. The provincial percentage is 3.4%. **These percentages are for context only and do not represent a target.**



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Palliative care patients are not included; they were identified from hospital and physician billing claims data. For this indicator, the opioid medications' definition does not include opioid agonist therapy, opioid cough or anti-diarrheal medications.

Number of my FHT's patients newly dispensed an opioid within the last 6 months
By their physician within the FHT: **29**
By Other Providers within or outside of the FHT: **183**

Your patients who have pain need your primary care team.

Sometimes opioid prescriptions are appropriate. The data cannot weigh the benefits against the possible harms, but they can point to practice patterns worthy of reflection.

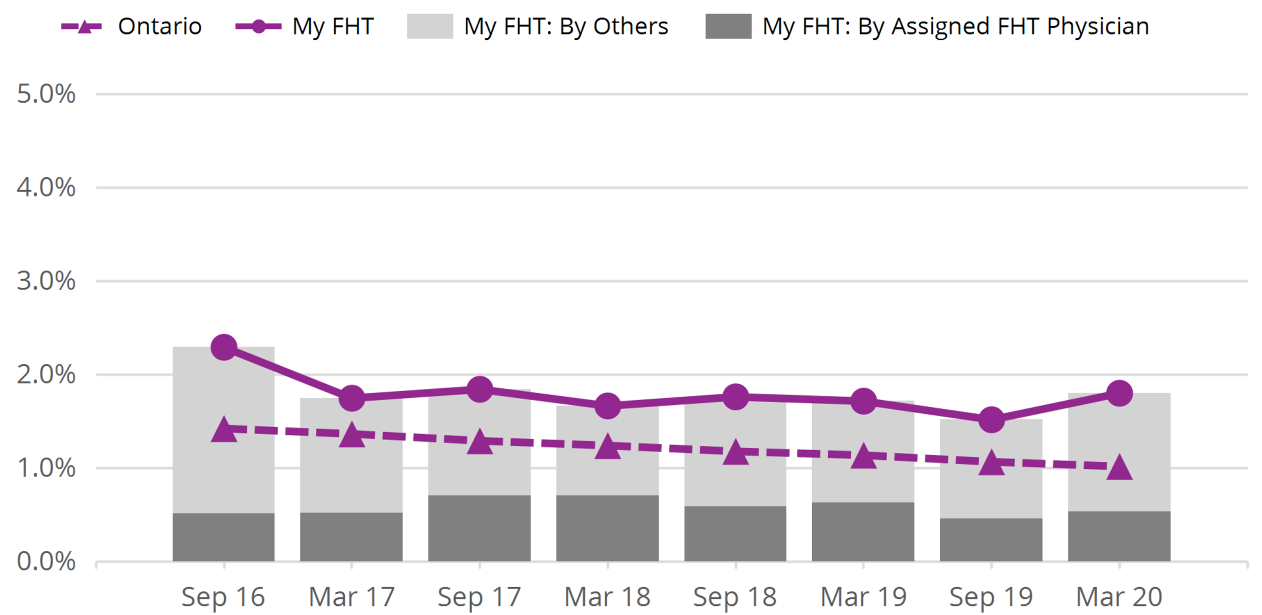
How can we reflect on opioid prescribing patterns in our FHT? (page 9)

Opioids and Benzodiazepines Dispensed

Data as of March 31, 2020

What percentage of my FHT's non-palliative care patients have been dispensed an opioid (including opioid agonist therapy) and benzodiazepine within the last 6 months?

- As of March 31, 2020, 1.8% of my FHT's patients have been dispensed an opioid and benzodiazepine. 29.7% of those opioids were prescribed by the patients' physician within the FHT and 70.3% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 1.1%. The provincial percentage is 1.0%. **These percentages are for context only and do not represent a target.**



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Palliative care patients are not included; they were identified from hospital and physician billing claims data. For this indicator, the opioid medications' definition does not include opioid cough or anti-diarrheal medications.

Number of my FHT's patients dispensed an opioid and benzodiazepine within the last 6 months
Both by their physician within the FHT: **22** One or Both by Other Providers within or outside of the FHT: **52**

Your patients who have pain need your primary care team.

The pharmacology suggests that sedatives and opioids enhance the depressant effect of the other, worsening the balance of harms versus benefits, though supporting evidence is unavailable. The expert perspective is that opioids and benzodiazepines should very rarely be prescribed together (1).

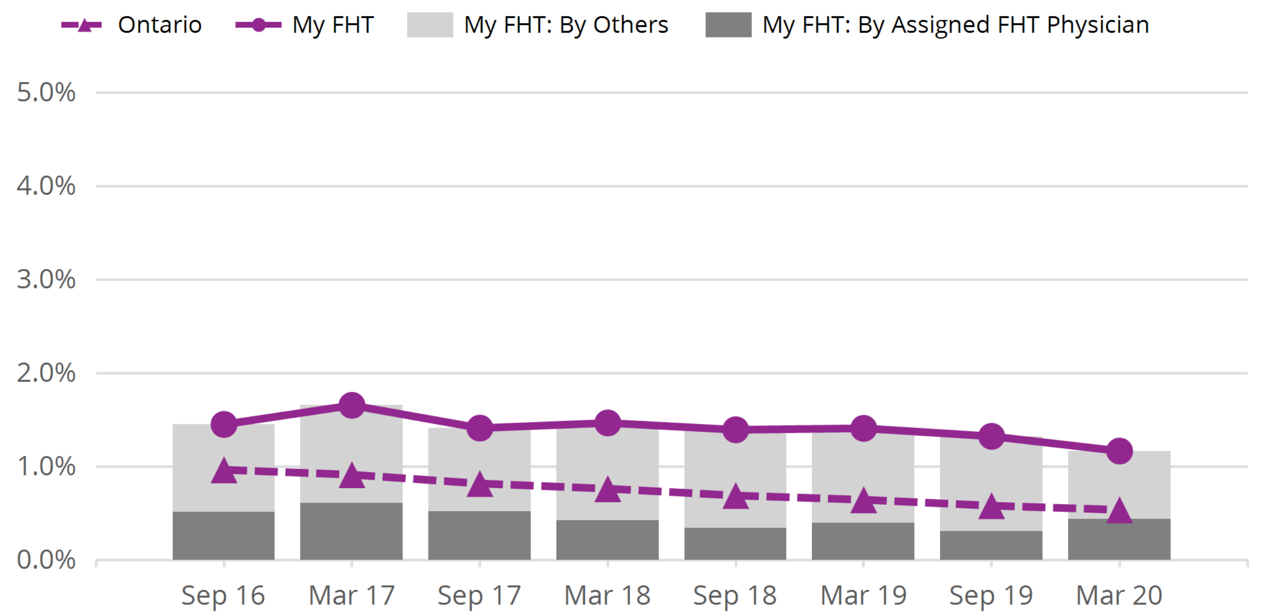
How can we reflect on opioid prescribing patterns in our FHT? (page 9)

High-Dose Opioids Dispensed

Data as of March 31, 2020

What percentage of my FHT's non-palliative care patients have at least one high-dose opioid >90 mg MEQ daily within the last 6 months?

- As of March 31, 2020, 1.2% of my FHT's patients have a high-dose opioid >90 mg MEQ daily. 37.5% of those opioids were prescribed by the patients' physician within the FHT and 62.5% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 0.6%. The provincial percentage is 0.5%. **These percentages are for context only and do not represent a target.**



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Palliative care patients are not included; they were identified from hospital and physician billing claims data. For this indicator, the opioid medications' definition does not include opioid agonist therapy, opioid cough or anti-diarrheal medications.

Number of my FHT's patients with a high-dose opioid >90mg MEQ daily within the last 6 months
By their physician within the FHT: **18** By Other Providers within or outside of the FHT: **30**

Your patients who have pain need your primary care team.

Moderate quality evidence suggests a dose-dependent increase in risk as the prescribed dose of opioids increases. Some patients may gain important benefit at a dose of more than 90 mg MEQ daily (1). The data need to be interpreted in that context.

How many of my FHT's patients with chronic non-cancer pain are taking opioids outside of the recommended use guidelines? (page 9)

Quality Improvement Ideas

How to Improve Opioid Prescribing in my Practice

Use the following steps to proactively deliver appropriate pain management and guide improvements for safe opioid prescribing in your practice.

Step 1: Identify patients prescribed an opioid for pain using your EMR

GENERATE a registry of patients prescribed an opioid for pain by using:

- ICD-10 diagnostic codes for pain (781, 847, 780, 346, 726, 787, 350)
- EMR keyword search for opioid medications

IDENTIFY the patients on this registry who have been prescribed an opioid:

- By you
- By other prescribers (data available through the Digital Health Drug Repository)

ASSESS the quality of your registry:

- Assess data quality and review your inclusion and exclusion criteria to ensure your registry is complete and correct
- Consider creating a separate list of patients in pain but not on opioids

Resources to help create an up-to-date registry:

EMR support

- Getting Started With an Opioid Use Registry (AFHTO)

In-person support

- i4C Advisory Service (OntarioMD)
- EMR Practice Enhancement Program (OntarioMD)
- Quality Improvement Decision Support Specialists (AFHTO)

To proactively deliver safe management, document every patient encounter completely and accurately in your EMR so that you can extract practice and patient level data electronically.

Step 2: Review current treatment plans for patients with pain to identify gaps in the provision of evidence based care

ASSESS the management plans of the patients on the registry to identify opportunities for improvement.

IDENTIFY which (and how many) patients meet the following criteria:

- Are at risk for opioid use disorder
- Are on a tapering regime or have had their opioid prescriptions abruptly stopped
- Have been prescribed opioids outside of the Canadian Guideline for Opioids for Chronic Non-Cancer Pain
- Are outside of the National Guideline for the Clinical Management of OUD (CRISM) for the use of opioid agonist treatment
- Are prescribed opioids for acute (<3 months) or chronic (>3 months) pain
- Have had a documented comprehensive assessment for pain (and assess how often this has been reviewed)
- Have a multimodal treatment plan to manage pain (e.g., self management, psychological supports, non-opioid pharmacological options)

Evidence-based guidelines and recommendations:

For opioid prescribing

- Opioid Prescribing for Acute Pain (Ontario Health)
- Opioid Prescribing for Chronic Pain (Ontario Health)
- Opioid Tapering Template (CEP)
- Opioid Tapering Template (RxFiles)
- Opioid Wisely Recommendations (Choosing Wisely)

For treating patients with opioid use disorder

- Opioid Use Disorder Quality Standard (Ontario Health)

Quality Improvement Ideas | How to Improve Opioid Prescribing in my Practice

STEP 3: Explore opportunities for improvement

The following are common actionable themes and resources that can help support your quality improvement initiatives in safer opioid prescribing.

Connect with peers and external supports

- Contact a practice facilitator to help build capacity for improvement
  - Quality improvement decision support specialists (AFHTO)
  - FHTs/NPLCs/CHCs: Resources are available on their Trello Board platform. Email improve@afhto.ca to sign up and gain access
- Participate in practice coaching and peer group mentorship
  - Peer Leaders (OntarioMD)

Access continuing education

- Explore continuing professional development opportunities:
- Safe and Effective Use of Opioids for Chronic Non-Cancer Pain online course (Centre for Addiction and Mental Health)
- MacHealth's Opioids Clinical Primer (McMaster University)
- Collaborative Mentoring Networks (Ontario College of Family Physicians)
- Ontario Chronic Pain and Opioid Stewardship (Project ECHO)
- Safer Opioid Prescribing Program (University of Toronto)
- Opioid Use Disorder (OUD) in the COVID-19 Context (Centre for Effective Practice)

Redesign your system and leverage digital health solutions

- Ensure your systems and processes support comprehensive assessments for people with pain
- Develop a virtual care strategy to support patient care management
  - Adopting and Integrating virtual visits into care (Ontario Health)
- Develop EMR reminder systems to recall patients due for tests, medication review, or examination
- Map your team's care process using QI Process Mapping Instructions
- Measure impact by using process indicators included in the opioid quality standards (Section: "How Success Can Be Measured") to guide your QI initiatives

Patient engagement

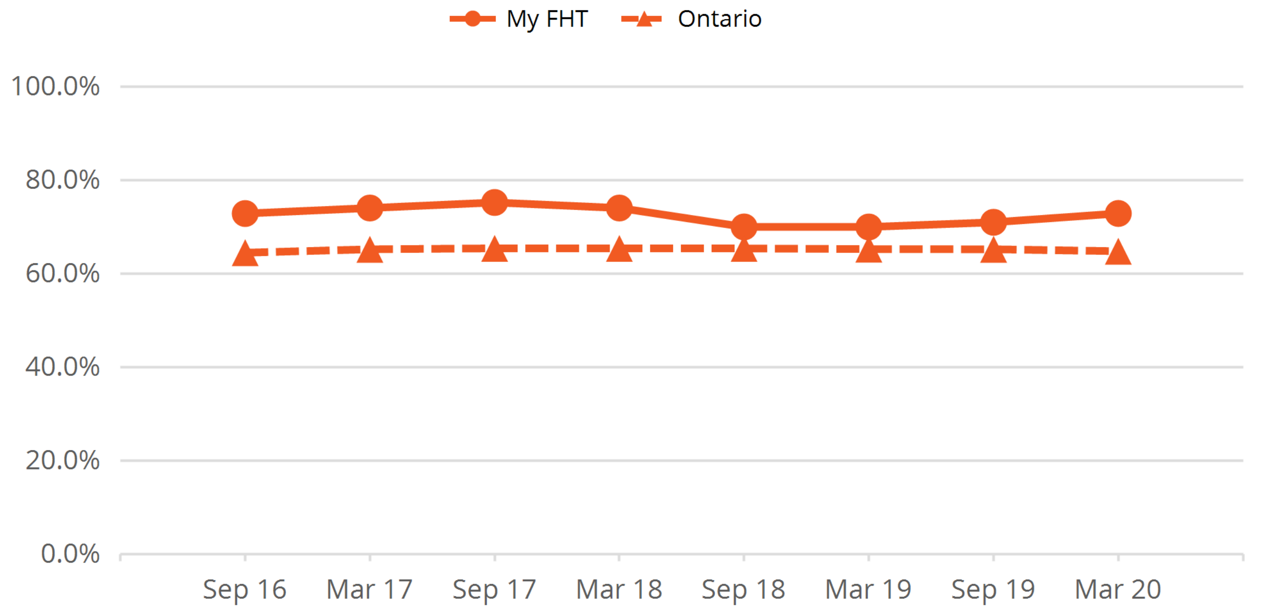
- Use the following patient reference guides to support conversations with your patients
  - Opioid Prescribing for Acute Pain
  - Opioid Prescribing for Chronic Pain
  - Opioid Use Disorder
- Consider using a treatment agreement to document informed consent and clarify expectations for both patient and physician
- Use Ontario Health's Patient Partnering Framework to guide planning, implementing, and evaluating patient partnering activities

Find more resources at Ontario Pain Management Resources: A partnership to help clinicians support their patients.

Join the conversation on Quorum:
1. Opioid Stories **2.** Opioids Indicators page **3.** Review Quorum's QI Tools & Resources for information and guidance on conducting quality improvement initiatives.

What percentage of my eligible patients aged 52-74 are up-to-date with any colorectal screening?

- As of March 31, 2020, 72.9% of patients in my FHT were up-to-date with colorectal screening. My LHIN percentage is 67.1%.
- My FHT is **higher than** the provincial percentage of 64.9%.



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Beginning with the September 2019 data cycle, the CRC screening indicator has been updated, including the addition of FIT. Please see the Technical Appendix for details.

A small proportion of FOBTs performed as diagnostic tests could not be excluded from the analysis.

Number of my FHT's eligible patients not screened
517

Evidence for screening continues to evolve. We will continue to monitor screening guidelines and modify the indicator, as appropriate (2).

Tests performed in hospital laboratories or paid through alternative payment plans are not captured.

How can my FHT improve its CRC screening? (page 14)

Identify your patients requiring follow up for cancer screening, through Ontario Health's screening activity report (SAR)

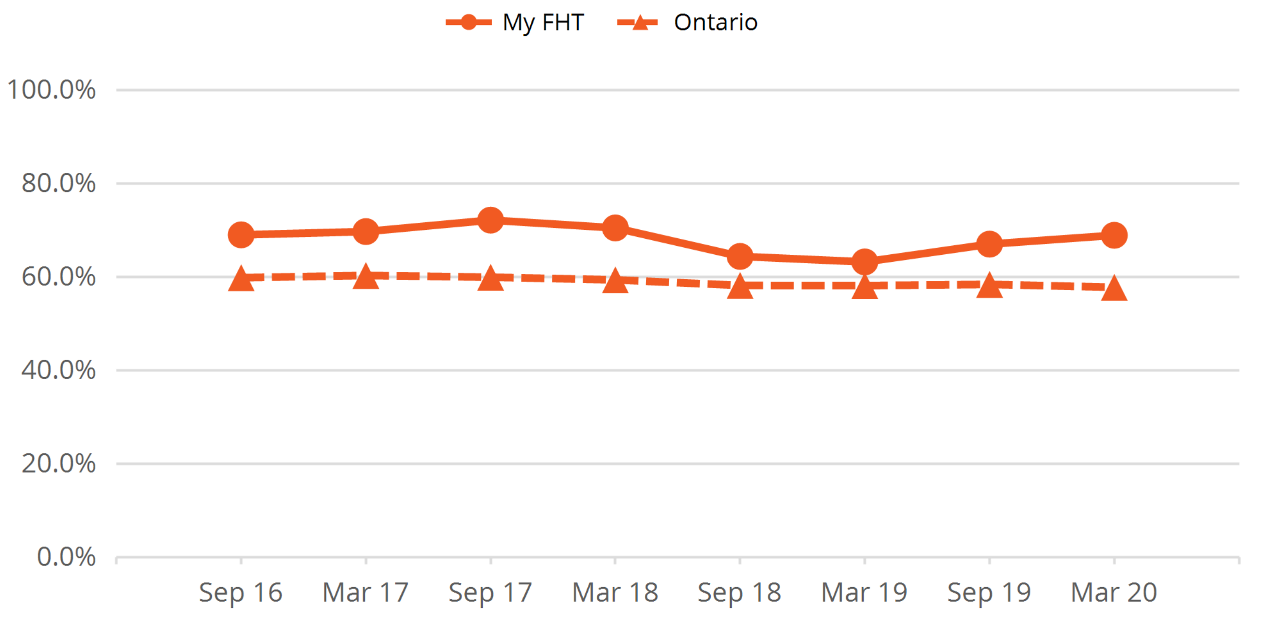
SAR Report Portal

Pap Smear Screening

Data as of March 31, 2020

What percentage of my FHT's eligible patients aged 23-69 are up-to-date with Pap smear screening within the past three years?

- As of March 31, 2020, 69.0% of patients in my FHT had an up-to-date Pap smear test. My LHIN percentage is 59.7%.
- My FHT is **higher than** the provincial percentage of 57.8%.



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Patients who have had cervical cancer, endometrial or ovarian cancer, and patients who have had a hysterectomy are excluded.

Number of my FHT's eligible patients not screened within the past three years
329

Evidence for cancer screening continues to evolve. We will continue to monitor screening guidelines and modify the indicator, as appropriate (3).

Tests performed in hospital laboratories or paid through alternative payment plans are not captured.

How can my FHT improve its Pap smear screening? (page 14)

Identify your patients requiring follow up for cancer screening, through Ontario Health's screening activity report (SAR)

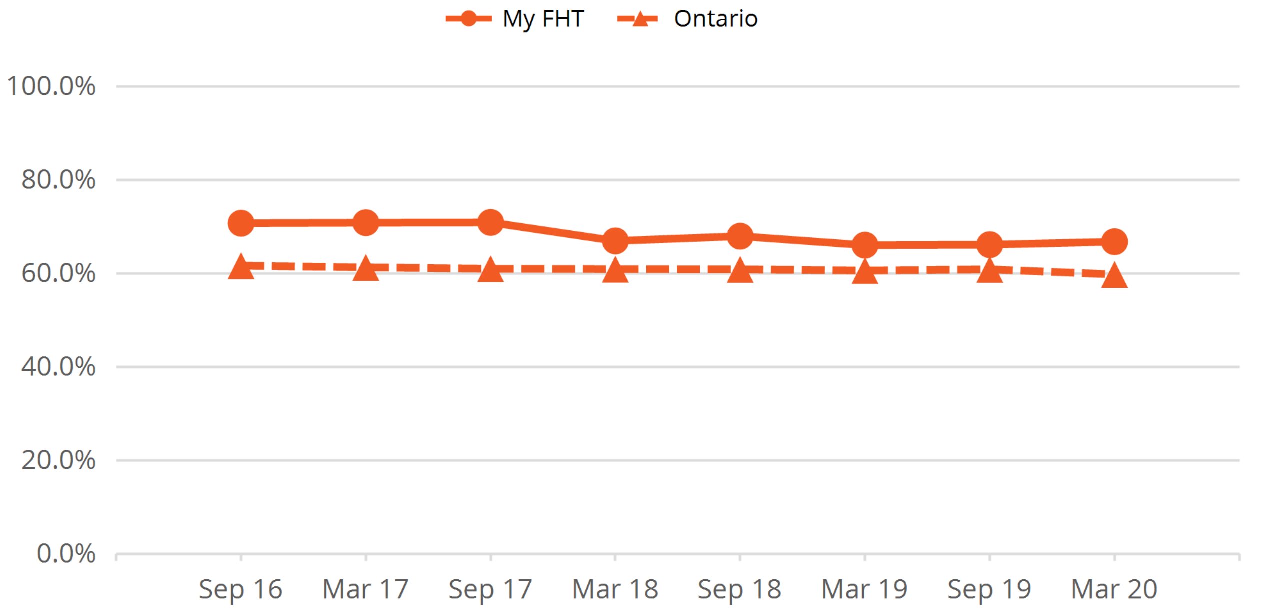
SAR Report Portal

Mammogram Screening

Data as of March 31, 2020

What percentage of my FHT's eligible patients aged 52-69 are up-to-date with mammogram screening within the past two years?

- As of March 31, 2020, 66.8% of patients in my FHT had an up-to-date mammogram. My LHIN percentage is 63.1%.
- My FHT is **higher than** the provincial percentage of 59.8%.



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Patients with a history of breast cancer are excluded.

Number of my FHT's eligible patients not screened within the past two years
254

We recognize that the current recommendation is to have an active discussion with women about the benefits and limitations of breast screening (4-6). Some women who are eligible to be screened choose not to. Thus, the data need to be interpreted in that context.

How can my FHT improve its mammogram screening? (page 14)

Identify patients requiring follow up for cancer screening though Ontario Health's screening activity report (SAR)

SAR Report Portal

Quality Improvement Ideas for Cancer Screening

Use the following steps to help guide improvements for cancer screening in your practice

1 Identify and verify which patients are due/overdue for cancer screening

- Encourage providers to register for and view their Ontario Health Screening Activity Report (SAR) to find the screening status of my patients.
- Ask our billing administrator or nurse to run an EMR report listing patients due/overdue for screening.
- Support providers in updating the EMR by comparing the EMR output with their Ontario Health SAR.

2 Set goals for improvement

- Use your up-to-date list of patients due/overdue for screening to set goals, including numerical and time-sensitive targets (how many patients are screened by which dates).

3 Map current cancer screening process

- Outline the steps involved and the people responsible. This will help you identify inefficiencies and opportunities for improvement.

4 Update process to track patients eligible for screening

- Create screening reminder letters for patients using these templates from Ontario Health or encourage providers to sign up for physician linked correspondence for automatic screening reminders for patients.
- Support providers in updating EMR when reminder notices are issued, and regularly reviewing for patients due/overdue for screening.

5 Follow up with patients who haven't been screened

- Consider how issues of equity might be affecting patients who haven't been screened. Review Poverty: A Clinical Tool for Primary Care from the Ontario College of Family Physicians. For an example of how a health centre analyzed inequities in screening rates, read the story from TAIBU CHC in Toronto.

Learn from your peers

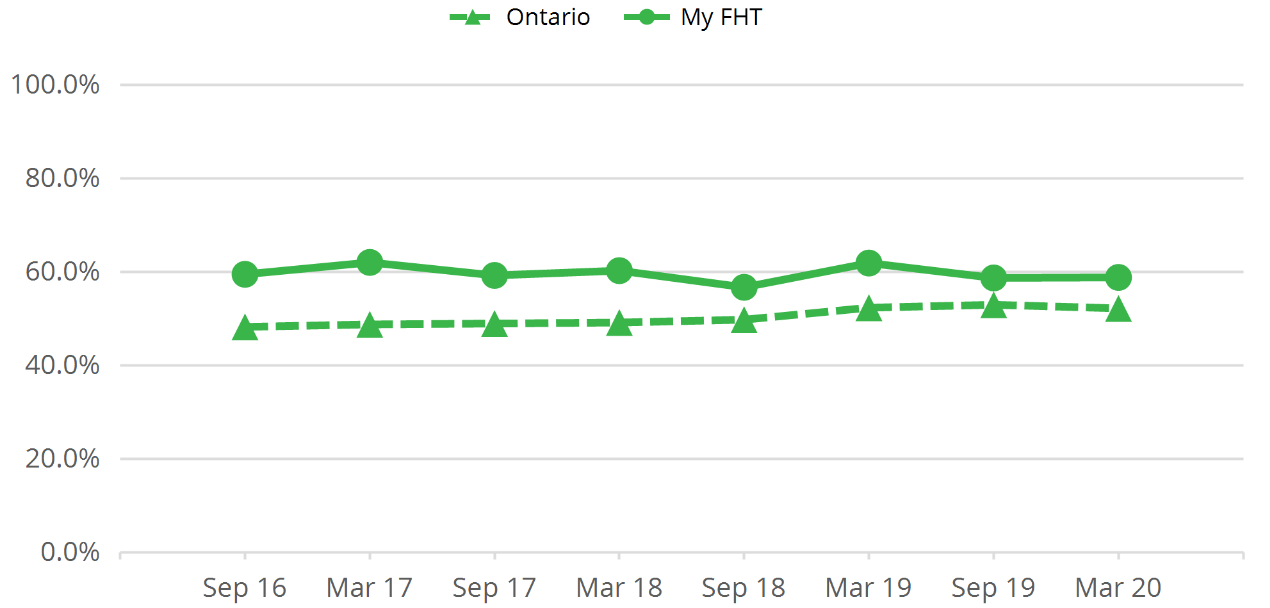
- Reach out to local leaders working with the Provincial Primary Care and Cancer Network.
- See additional screening process improvement ideas and measures from Ontario Health.

Diabetes Section | HbA1c Testing to Prevent Complications from Diabetes

Data as of March 31, 2020

What percentage of my FHT's patients with diabetes had two or more HbA1c tests within the past 12 months?

- As of March 31, 2020, 58.9% of patients with diabetes in my FHT were up-to-date with HbA1c testing. My LHIN percentage is 54.7%.
- My FHT is **higher than** the provincial percentage of 52.3%.



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This indicator does not differentiate between type I and type II diabetes but does exclude gestational diabetes.

Number of my FHT's patients with diabetes with fewer than two HbA1c tests within the past 12 months
211

Ontario Health will continue to monitor testing guidelines and adjust the indicator, as appropriate (7).

Tests performed in hospital laboratories or paid through alternative payment plans are not captured.

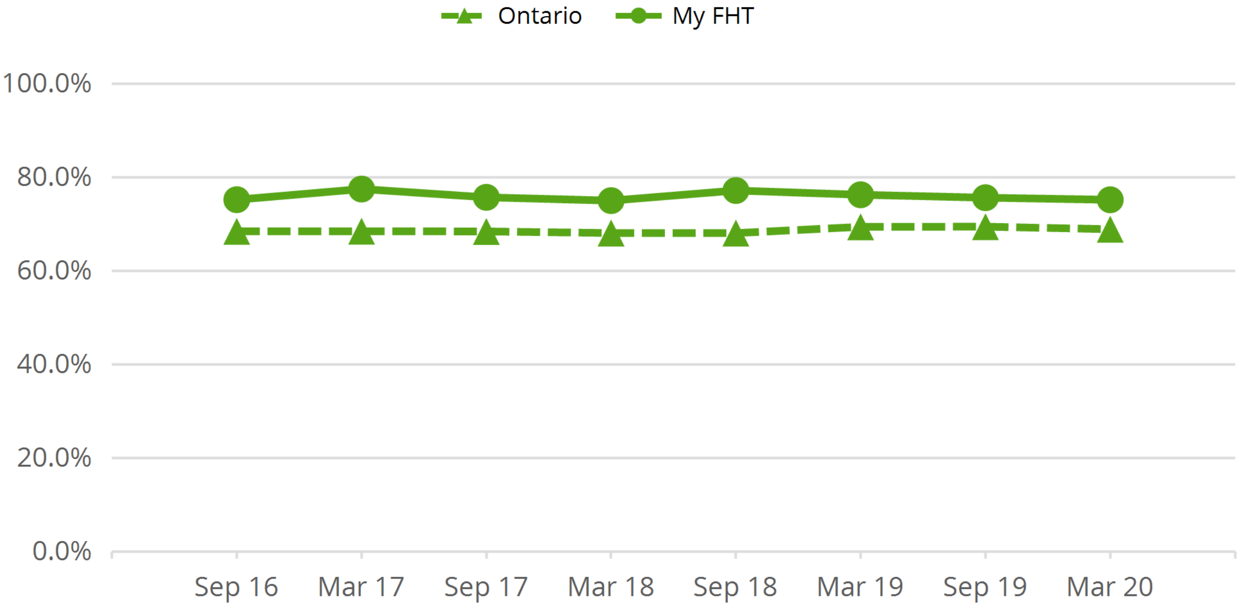
How can my FHT improve its HbA1c screening? (page 18)

Retinal Exam Testing to Prevent Complications from Diabetic Retinopathy

Data as of March 31, 2020

What percentage of my FHT's patients with diabetes are up-to-date with retinal testing with an ophthalmologist or optometrist within the past 24 months?

- As of March 31, 2020, 75.2% of patients with diabetes in my FHT had an up-to-date retinal exam. My LHIN percentage is 70.7%.
- My FHT is **higher than** the provincial percentage of 69.0%.



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This indicator does not differentiate between type I and type II diabetes but does exclude gestational diabetes.

Number of my FHT's patients with diabetes not tested within the past 24 months
127

Ontario Health will continue to monitor testing guidelines and adjust the indicator, as appropriate (8).

Tests performed in hospital laboratories or paid through alternative payment plans are not captured.

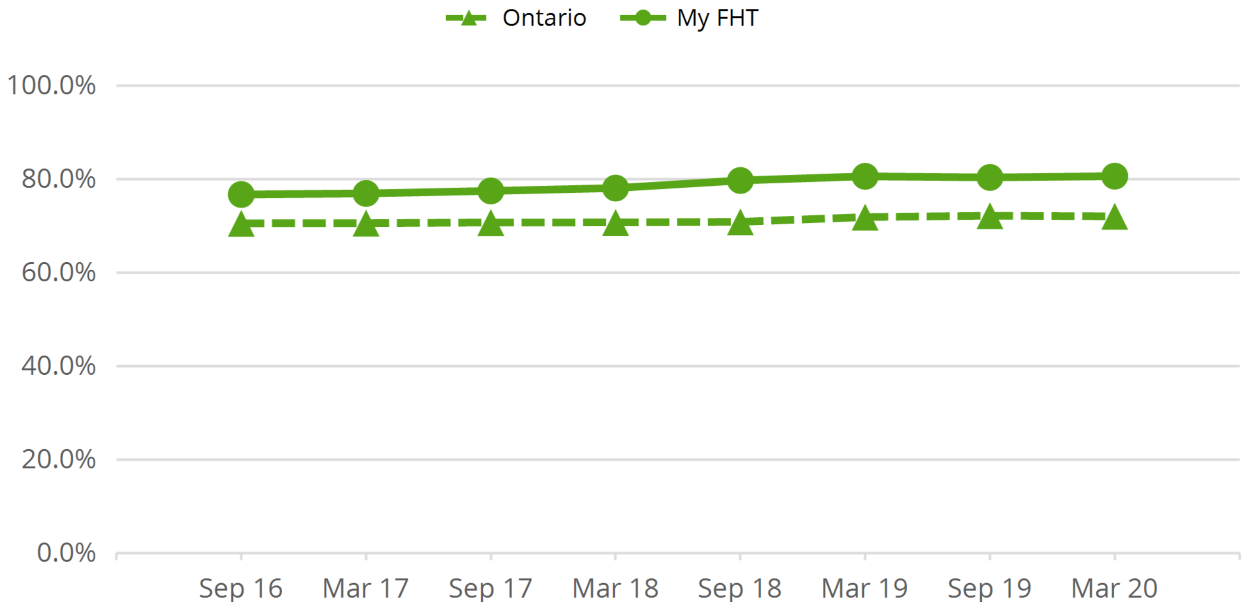
How can my FHT improve its retinal exam rate? (page 18)

Statins Dispensed to Prevent Vascular Complications from Diabetes

Data as of March 31, 2020

What percentage of my FHT's patients with diabetes aged 66 and older have been dispensed a statin within the past 12 months?

- As of March 31, 2020, 80.7% of patients with diabetes in my FHT were dispensed a statin. My LHIN percentage is 75.9%.
- My FHT is **higher than** the provincial percentage of 72.1%.



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This indicator does not differentiate between type I and type II diabetes. Data are not available for patients with diabetes below the age of 65 as they are not included in the ODB program. Prescriptions purchased outside of the ODB program are not included.

Number of my FHT's patients with diabetes who were not dispensed a statin within the past 12 months
68

Statin prescriptions may be more appropriate for some patients than others depending on baseline level of risk, co-morbid conditions, patient preferences and life expectancy (9,10).

How can my FHT improve its statin dispensing rate? (page 18)

Quality Improvement Ideas — How to Improve Diabetes Management in my Practice

Use the following steps to help guide improvements for diabetes management in your practice

STEP 1: Identify people living with prediabetes and diabetes

- **GENERATE** an up-to-date registry of people with prediabetes by running an EMR search for ICD-10 diagnostic code 249 (prediabetes)
- **GENERATE** an up-to-date registry of people living with diabetes by running an EMR search for the following ICD-10 diagnostic codes:
  - 250 (diabetes mellitus)
  - 251 (other disorders of pancreatic internal secretions)
- **ASSESS** the quality of your registries/data:
  - Is my registry list complete?
  - Are there included and excluded patients that are incorrectly labelled?
  - Do I need to clean up my data prior to creating my registry to ensure correctness?

Resources to help create an up-to-date registry:

- EMR Practice Enhancement Program (OntarioMD)
- EMR Queries: Diabetes (AFHTO)
- i4C Advisory Service (OntarioMD)

To proactively deliver safe management, document every patient encounter completely and accurately in your EMR so that you can extract practice and patient level data electronically

STEP 2: Review current management plan of prediabetes and diabetes

- **REVIEW** your management of each patient living with **prediabetes, Type 1 diabetes, Type 2 diabetes**, and **diabetes in pregnancy** on the registry to ensure treatment plans are current with evidence-based management, and that their elements of care are assessed at regular intervals.
- **REFER** to the Ontario Health Quality Standards for guidance on how to deliver high-quality care
  - Type 1 Diabetes
  - Prediabetes and Type 2 Diabetes
  - Diabetes in Pregnancy
- **REFLECT** on the following questions to identify opportunities for improvement:
  - Am I using the correct diabetes care flow sheet?
  - Am I using the most up to date clinical practice guidelines?
  - Have management plans and lab results been reviewed in the last 3 months?
  - Is my documentation on elements of care up to date?

Resources for management support:

- Clinical Practice Guidelines (Diabetes Canada)
- Framingham Risk Score (Canadian Cardiovascular Society)
- Sample Diabetes Patient Care Flow Sheet for Adults (Diabetes Canada)

To efficiently and effectively document your management, consider uploading fillable forms (e.g., diabetes care flow sheet, Framingham Risk Score) to your EMR. These forms can be found in repositories of your EMR providers

Quality Improvement Ideas — How to Improve Diabetes Management in my Practice

STEP 3: Explore opportunities for improvement

The following are common actionable themes and resources that can help support your quality improvement initiatives in diabetes management.

Connect with peers and external supports

- Contact a practice facilitator to help build capacity for improvement
  - Quality improvement decision support specialists (AFHTO)
  - FHTs/NPLCs/CHCs: Resources are available on their Trello Board platform. Email improve@afhto.ca to sign up and gain access
- Consider referral pathways that improve patients outcomes such as Diabetes Education Programs, self management group, registered dieticians, etc.
- Participate in practice coaching and peer group mentorship
  - Peer Leaders (OntarioMD)

Access continuing education

- Explore continuing professional development opportunities:
  - Diabetes Canada Webinars
  - Access tools, resources, and academic detailing for Type 2 Diabetes (Centre for Effective Practice)
- Review best practices in delivering high-quality care from the Ontario Health Quality Standards
  - Diabetes (Type 1)
  - Diabetes (Prediabetes and Type 2)
  - Diabetes in Pregnancy

Redesign your system and leverage digital health solutions

- Ensure your systems and processes support comprehensive diabetes management
- Support access and collaboration with inter-professional care teams to address comprehensive health needs
- Develop a virtual care strategy to support patient care management
  - Adopting and Integrating virtual visits into care (Ontario Health)
- Develop EMR reminder systems to recall patients due for tests, medication review, or examinations
- Map your team's care process using QI Process Mapping Instructions
- Measure impact by using process indicators included in the opioid quality standards (Section: "How Success Can Be Measured") to guide your QI initiatives

Partner with patients

- Encourage patients to be active in their management plans
- Access reference guides to engage patients in conversations about their care using the following resources:
  - Quorum's Patient Involvement in decisions about care
  - Newly Diagnosed (Diabetes Canada)
  - The following quality standards patient conversation guides:
    - Diabetes (Type 1)
    - Diabetes (Prediabetes and Type 2)
    - Diabetes in Pregnancy
- Use Ontario Health's Patient Partnering Framework to guide planning, implementing, and evaluating patient partnering activities

Join the conversation on Quorum:

- Review Quorum's QI Tools & Resources for information and guidance on conducting quality improvement initiatives.

Health Service Utilization

Data as of March 31, 2020

Indicator	Definition	My FHT (unadjusted)	My FHT (adjusted)	My LHIN	Ontario
Total ED visits	Rate of total hospital emergency department visits per 1,000 patients	**603.4**	556.4*	339.9*	386.1
Urgent ED visits	Rate of urgent hospital emergency department visits measured as CTAS level 1-3 per 1,000 patients	**364.2**	326.6*	244.2*	269.4
Less Urgent ED visits	Rate of less urgent hospital emergency department visits measured as CTAS level 4-5 per 1,000 of your patients	†	230.8*	94.6*	115.3
Hospital Readmissions within 30 days	Percentage of hospital readmissions within 30 days of discharge among your admitted patients	**7.0%**	7.3%*	5.4%*	5.6%
Hospital Readmissions within 1 year	Percentage of hospital readmissions within 1 year of discharge among your admitted patients	**20.2%**	20.5%*	15.2%*	16.3%
SAMI Score	The mean ACG weight of expected resource use in your practice *(definition updated to include additional fee codes as of Sept 2016)*	**1.0**	N/A	1.1	1.0
Visits to Own Physician	Percent of visits to own physician (continuity of care)	**54.8%**	N/A	68.4%	68.0%
Visits to Own Group	Percent of visits to own physician group (continuity of care)	**56.6%**	N/A	75.5%	74.4%

* risk adjustment takes into account differences among patient populations to allow for fairer comparisons between your practice and other comparators. The adjustment is made for age, sex, rurality, income, and co-morbidities.

† Data suppressed where counts are between 1 and 5; additional suppression may be applied where counts are greater than 5 to prevent residual disclosure of suppressed values; N/A: Data not available; ¨ Please interpret with caution, denominator ≤ 30. For more details, refer to the Methods section on page 24.

Health Service Utilization

Data as of March 31, 2020

Indicator	Definition	My FHT (unadjusted)	My FHT (adjusted)	My LHIN	Ontario
ACSC Admissions - Total	Rate of hospital admissions for one or more of the following conditions: asthma, CHF, COPD, and diabetes per 1,000 patients	**7.3**	5.1*	3.1*	3.4
ACSC Admissions - Asthma	Rate of hospital admissions for asthma per 1,000 patients	†	0.9*	0.3*	0.3
ACSC Admissions - CHF	Rate of hospital admissions for CHF per 1,000 patients	†	0.7*	1.1*	1.2
ACSC Admissions - COPD	Rate of hospital admissions for COPD per 1,000 patients	**4.1**	2.5*	1.1*	1.3
ACSC Admissions - Diabetes	Rate of hospital admissions for diabetes per 1,000 patients	**1.5**	1.2*	0.6*	0.7

* risk adjustment takes into account differences among patient populations to allow for fairer comparisons between your practice and other comparators. The adjustment is made for age, sex, rurality, income, and co-morbidities.

† Data suppressed where counts are between 1 and 5; additional suppression may be applied where counts are greater than 5 to prevent residual disclosure of suppressed values; N/A: Data not available; ¨ Please interpret with caution, denominator ≤ 30. For more details, refer to the Methods section on page 24.

Use the following steps to help guide improvements for less urgent emergency department visits in your practice

We recognize there are many factors associated with emergency department visits that are outside your control. In some areas of the province, emergency departments may play a role in providing timely access for less-urgent primary care. Below you will find some suggestions that can help you better understand your patients' emergency department visits.

1 Identify and verify the patients who are going to the ED

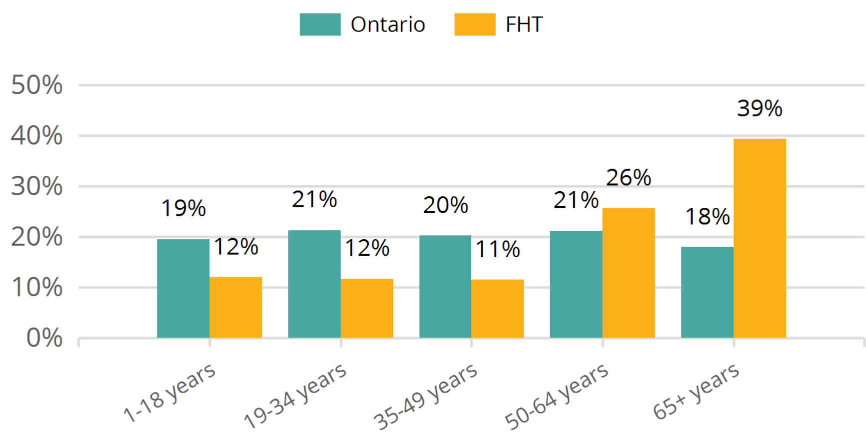
- Are there any patterns associated with ED use (e.g. day of week, time of day)?
- Consider how issues of equity may be contributing to this pattern.

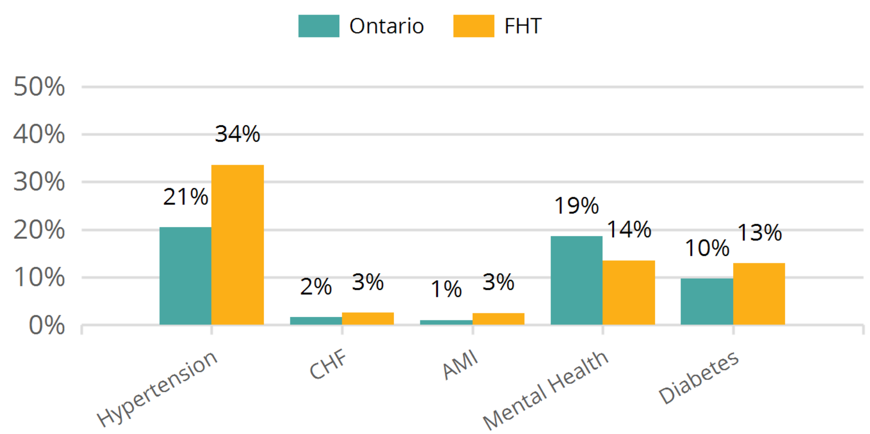
Learn from your peers	• Learn from others on Quorum, Ontario Health's quality improvement online community.

"I looked at my data and found that the hospital readmission numbers started to rise when I decided to stop doing inpatient services. So that's one of the areas we are focusing on, to better work with the local hospital to know when admissions and discharges are happening so we can target patients for a 7-day post hospital visit."
– Dr. Ben Stobo, Athens District Family Health Team

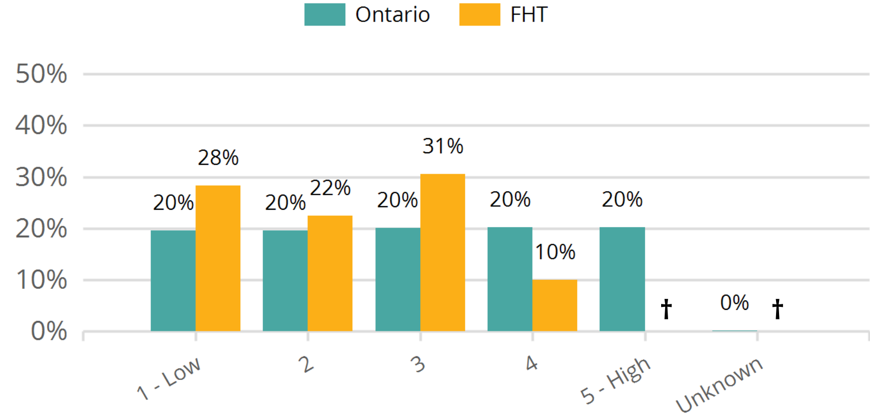
My FHT's Patient Demographics and Disease Cohorts

Data as of March 31, 2020





**Please note: Chronic Disease Cohort values for the most recent three data points provided are subject to change in future reporting cycles due to updates of chronic diseases datasets.*



	My FHT	Ontario
Total Number of Patients	4,102	14,581,900
% Virtually Rostered	2.0%	9.6%
% Recent Immigrants	1.4%	10.4%
Specialists Visits per 1,000 Patients		
Cardiologist	126.8	79.2
Endocrinologist	10.5	48.9
Internal Medicine	189.4	83.1
Psychiatry	56.3	119.1
Respirologist	65.3	32.4

† Data suppressed where counts are between 1 and 5; additional suppression may be applied where counts are greater than 5 to prevent residual disclosure of suppressed values; N/A: Data not available; ¨ Please interpret with caution, denominator ≤ 30. For more details, refer to the Methods section on page 24.

“I was particularly interested to see the demographics data on my patients, especially the income quintiles. While our EMRs are able to provide us with lots of clinical data, a snapshot of the socioeconomic status of our practices is something completely unique to the MyPractice: Primary Care Reports.”
- Dr. Mario Elia, Family Physician, London Ontario

Methods and Acknowledgements

Your FHT physicians' College of Physicians and Surgeons of Ontario (CPSO) number were used to identify the patients they cared for and the associated data for calculating the indicators that appear in this report.

Identifying your patients - To identify the patients whom your FHT physicians' cared for, their CPSO number were linked to health care administrative databases housed at ICES. The report includes patients rostered to your FHT's physicians and patients for whom those physicians were the highest billing provider for a set of core primary care Ontario Health Insurance Plan (OHIP) fee codes. To find out more about this process, please refer to the Technical Appendix.

Indicator calculation - After your patients were identified, ICES used various administrative datasets to calculate each indicator. For instance, to calculate the percentage of patients with diabetes who had two or more glycated hemoglobin (HbA1C) tests within the past 12 months, OHIP claims and hospitalization records were used to identify patients with diabetes, and those who had HbA1C tests. The data sources and details about how each indicator is calculated can be found in the Technical Appendix.

Data sources - Administrative databases that were used to generate this report include: The Registered Persons Database (RPDB) for patient demographic information; the OHIP database for physician claims data; the National Ambulatory Care Reporting System (NACRS) database for emergency department visits; the Discharge Abstract Database (DAD) for hospitalization records, the Narcotics Monitoring System (NMS) for dispensing data. For a complete list of databases used, please refer to the Technical Appendix.

Data Interpretation Considerations:

Data suppression – Data are suppressed or additionally suppressed as per ICES' privacy policy for the following reasons: (a) Counts or summary statistics are between 1 and 5; or (b) To prevent residual disclosure of suppressed values.

Data comprehensiveness - Administrative databases cannot capture all the information that we would like when calculating these indicators. Limitations of the data to consider when reviewing this report are detailed in the table below.

What information is not included in the report?	What does this mean for me?
For diabetes management indicators, prescriptions for those under 65 years of age are not captured.	All diabetes management prescription related indicators only apply to your patients with diabetes who are older than 65.
Tests performed at hospital laboratories are not captured (e.g. HbA1c testing).	If your patients' tests are performed at a hospital laboratory, your test rates will appear **lower** than the actual rate.
Palliative care patients identified from hospital and physician billing claims data are excluded from all indicators.	There may be a slight difference in values for a number of indicators in this report compared to previous reports where palliative patients were included.

Methods and Acknowledgements (continued)

Data timeliness - Data included in this report are not as current as would be preferred. However, they do provide a snapshot of your performance at a moment in time and a comparison to your peers at the group (if you are in a PEM), LHIN and Ontario levels for context. While HQO and our partners are always looking for ways to provide more timely data, we encourage you to also use local data sources to track and measure your progress.

Calculations used to generate indicators are not perfect - Complex calculations are used to translate information contained in the administrative databases into useful indicators. These calculations have been validated and/or used by researchers, public reporting or quality improvement initiatives. However, they are not always perfect. For instance, the number of diabetes patients in this report is unlikely to be a perfect match to the number identified through your EMR. In spite of this, information provided in this report provides a starting point so that you can assess your performance with your peers.

About Ontario Health

For information about Ontario Health, please visit www.ontariohealth.ca.

About ICES:

This study was supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health and Long-Term Care (MOHLTC). The opinions, results and conclusions reported in this paper are those of the authors and are independent from the funding sources. No endorsement by ICES or the Ontario MOHLTC is intended or should be inferred. Parts of this material are based on data and information compiled and provided by CIHI. However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI.

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Participation and confidentiality:

You are receiving this report because you have registered at Ontario Health's website. Your MyPractice report will only be sent to the validated email address you provided upon registration and will not be shared with others, including other agencies, the college, physician groups, or other members of your team.

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