MyPractice

Primary Care

A tailored report for quality care

Version Release: May 2019
PRIVATE AND CONFIDENTIAL

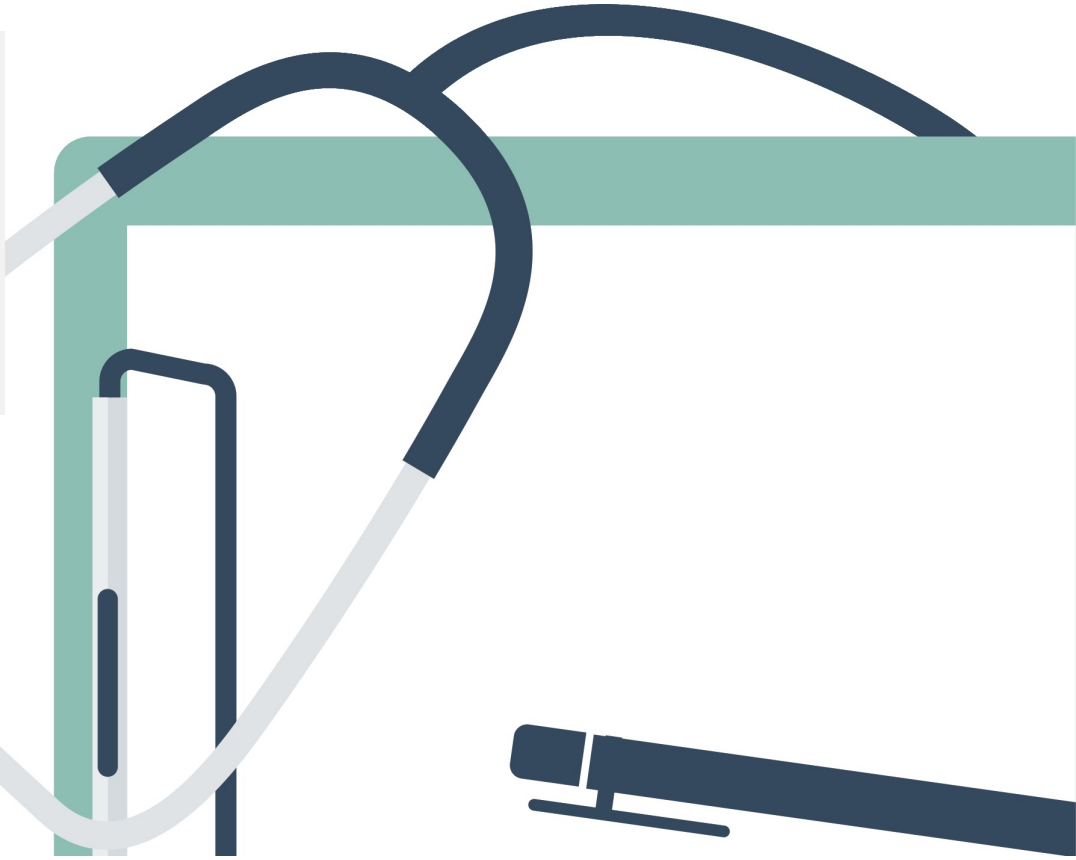
Kawartha North Family Health Team

Reporting Period: September 30, 2018

Release: May 2019

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

FHT LHIN: Central East



Health Quality Ontario
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IC/ES

Table of Contents

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

Health Quality Ontario (HQO) 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@hqontario.ca.
- For more information on indicator definitions, please refer to the methodological notes on page 23. For more technical details, please refer to the technical appendix on HQO's *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 September 30, 2018

	# 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
Opioid Prescribing in my FHT (pages 5-8)	**435**	**266**	**72**	**57**

	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)	· Pap smear testing	· Mammogram testing · Any Colorectal screening	None
Diabetes Management (pages 15-17)	None	· HbA1c testing	· Retinal Exam testing

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

Whom are we caring for?

# of Patients	Age (mean)	% Male	% Rural
4,078	**53.0**	**48.5%**	**11.0%**

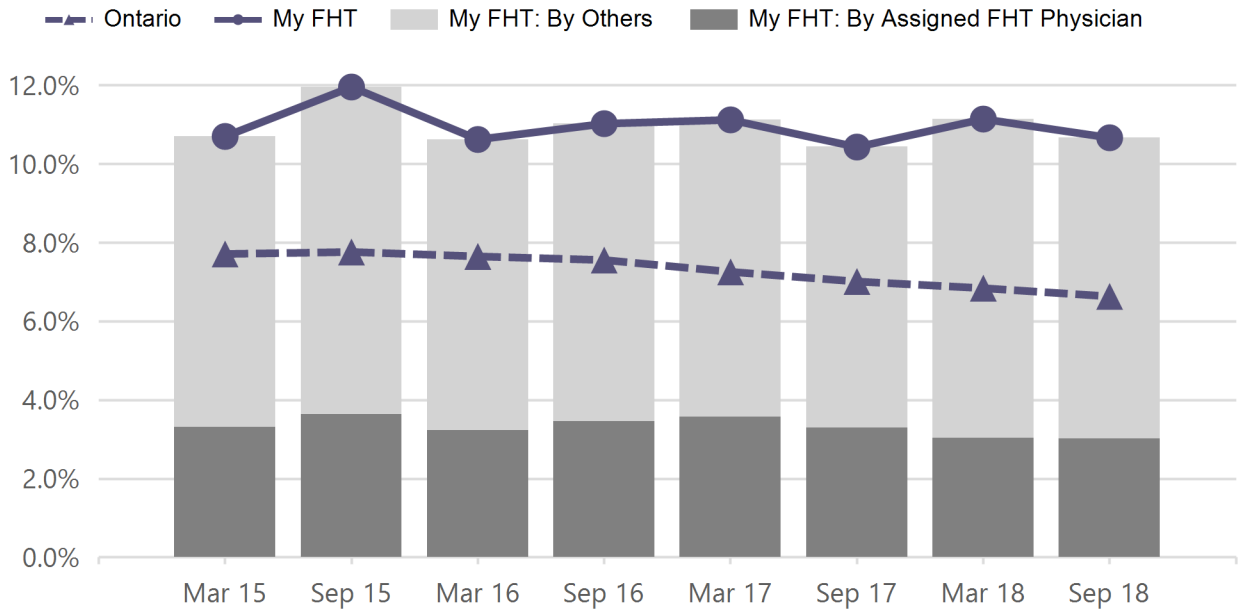
† Data suppressed where counts are between 1 and 5; additional suppression may be applied where counts are greater than 5 to prevent residual disclosure of suppressed values; N/A: Data not available; ¨ Please interpret with caution, denominator ≤ 30. For more details, refer to the Methods section on page 23.

Opioids Section
Opioids Dispensed

Data as of September 30, 2018

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 September 30, 2018, 10.7% of my FHT's patients have been dispensed an opioid prescription. 28.3% of those opioids were prescribed by the patients' physician within the FHT and 71.7% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 7.0%. The provincial percentage is 6.6%. **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: **123**
By Other Providers within or outside of the FHT: **312**

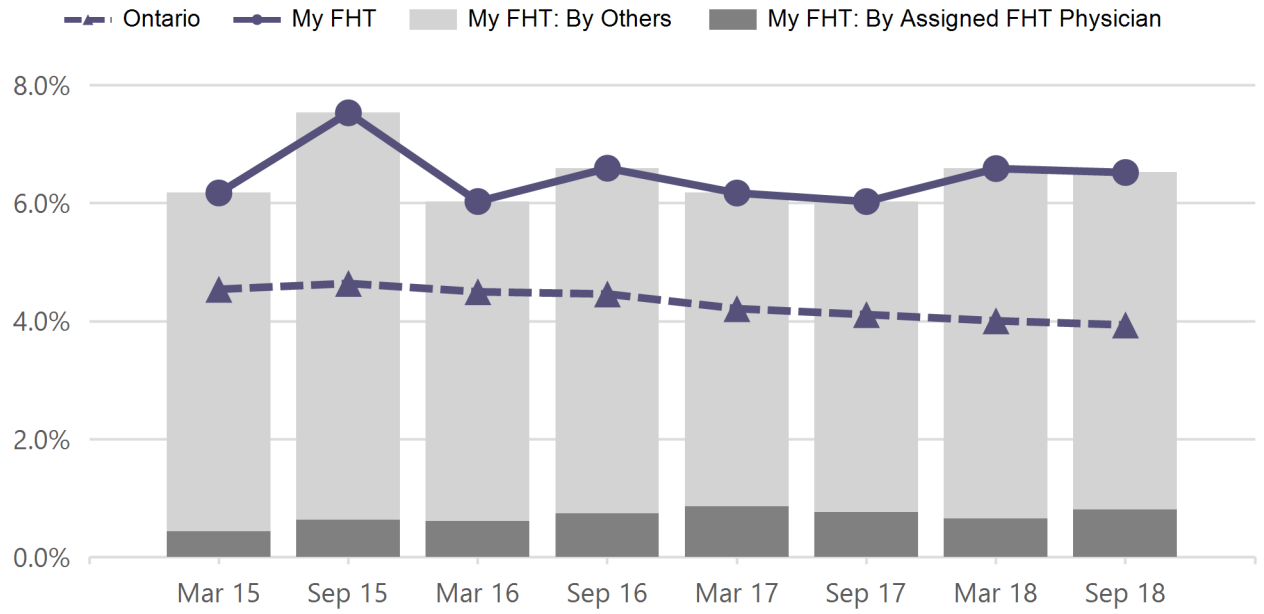
Your patients who have pain need your primary care team.

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)

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 September 30, 2018, 6.5% of my FHT's patients have been newly dispensed an opioid prescription. 12.4% of those opioids were prescribed by the patients' physician within the FHT and 87.6% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 4.2%. The provincial percentage is 3.9%. **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: **33**
By Other Providers within or outside of the FHT: **233**

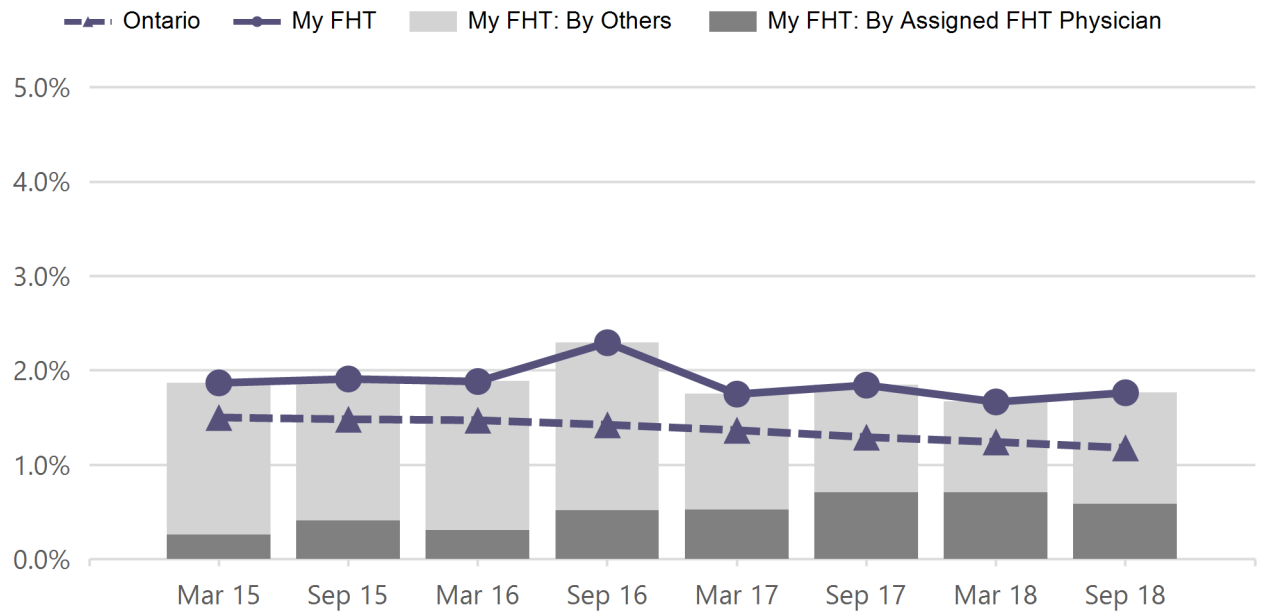
Your patients who have pain need your primary care team.

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)

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 September 30, 2018, 1.8% of my FHT's patients have been dispensed an opioid and benzodiazepine. 33.3% of those opioids were prescribed by the patients' physician within the FHT and 66.7% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 1.3%. The provincial percentage is 1.2%. **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: **24**
One or Both by Other Providers within or outside of the FHT: **48**

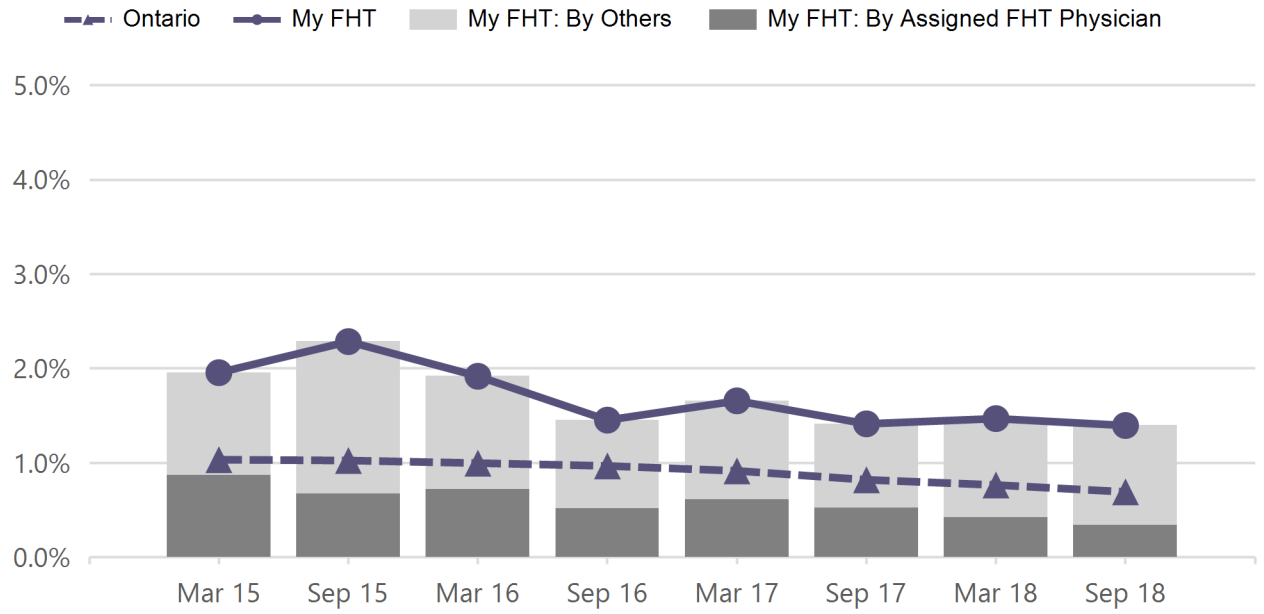
Your patients who have pain need your primary care team.

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)

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 September 30, 2018, 1.4% of my FHT's patients have a high-dose opioid >90 mg MEQ daily. 24.6% of those opioids were prescribed by the patients' physician within the FHT and 75.4% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT.
- My LHIN percentage is 0.7%. The provincial percentage is 0.7%. **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: **14**
By Other Providers within or outside of the FHT: **43**

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)

How can my FHT improve its opioid prescribing practices?

1 Better understand my FHT's current breakdown of patients being prescribed opioids

- Run a search in the electronic medical record (EMR) to verify data and to identify a list of patients being prescribed opioids by providers in my FHT
- Reflect on the reasons why patients in my FHT are taking opioids:
  - *How many are taking opioids for a short-term acute use? Longer-term chronic use?*
  - *How many of my FHT's patients with chronic non-cancer pain are taking opioids outside of the recommended use guidelines?*
  - *Are any of my FHT's patients at risk for or experiencing opioid use disorder?*
  - *How are my FHT's patients having some of their pain needs met via non-pharmacological treatments or non-opioid medications?*

Where can I access EMR queries to generate a list of my FHT's patients being prescribed an opioid?	• AFHTO: Opioid Query	***Who can help me make these lists?***	• OntarioMD Peer Leaders, EMR Practice Enhancement Consultants, and/or Practice Advisors • For Family Health Teams: Quality Improvement Decision Support Specialists • My office administrative staff	***Where can I access other EMR tools or supports?***	• CEP's: o Chronic Non-Cancer Pain Tool o Opioid Mananger (desktop or mobile app)

2 Review the most recent evidence for my FHT's patients who are being prescribed opioids for pain management.

Chronic Pain	Acute Pain	Opioid Use Disorder
HQO: *Quality Standard for Opioid Prescribing for Chronic Pain*	HQO: *Quality Standard for Opioid Prescribing for Acute Pain*	HQO: *Quality Standard for Opioid Use Disorder*
Choosing Wisely Canada: Opioid Wisely Recommendations		Canadian Research Initiative in Substance Misuse (CRISM): National Guidelines for best practices in the clinical management of opioid use disorders
McMaster University: Canadian Guidelines for Opioids for Chronic Non-Cancer Pain		Safe prescribing practices for addictive medications and management of substance use disorders in primary care: A pocket reference for primary care providers

Change Ideas for Opioid Prescribing (continued)

3 Identify opportunities for improvement

- Support providers to review patient charts and to consider the following:
  - Schedule a follow-up appointment for patients being prescribed opioids to update baseline assessment, review ongoing assessment of pain management, discuss pain management goals, and make any changes required to the treatment plan.
  - Identify patients who have a clear clinical indication tapering, and if appropriate, initiate tapering according to the recommended guidelines. Do not abruptly discontinue the use of opioids but rather seek help through one or more of the supports listed below when dealing with a challenging case (Resources: RXFiles Opioid tapering template).
  - If prescribing opioids for long-term use, consider reviewing patient history and initiate a shared decision-making dialogue to co-develop a safe management plan.
- If your FHT is signed up for one of the Connecting Ontario projects, your clinicians may be able to easily access client-specific relevant drug and pharmacy service information via the Digital Health Drug Repository (DHDR). To find out more about the DHDR, contact Connecting.Ontario@ehealthontario.on.ca or visit the eHealth Ontario website.

4 Support providers by recommending the Ontario Pain Management Resources: A Partnership to Help Clinicians

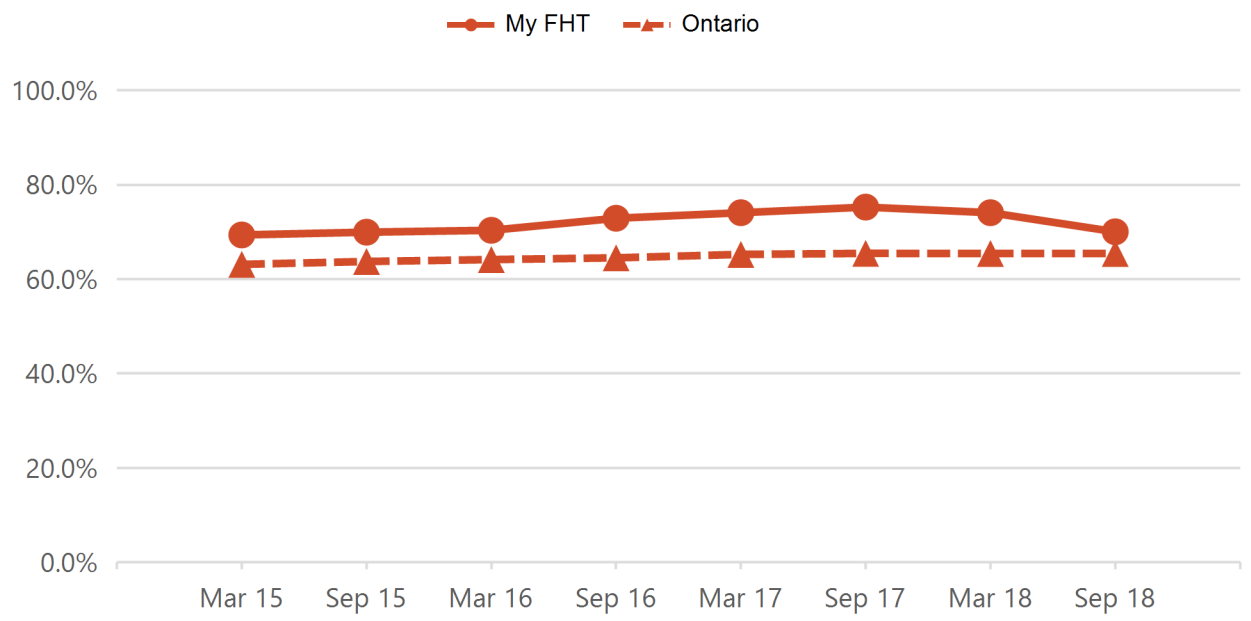
- Explore one or more of the following certified continuing professional development opportunities:
  - University of Toronto: Safer Opioid Prescribing Program - A multimodal program for chronic pain and opioids which includes a webinar series, followed by an in-person skills develoment workshop.
  - Centre for Addiction and Mental Health: Safe and Effective Use of Opioids for Chronic Non-cancer Pain Online Course.
  - Ontario College of Family Physician's Collaborative Mentoring Networks: On-demand support from an expert clinical mentor from the Medical Mentoring for Addictions and Pain Network is available to help me navigate complex clinical situations around opioids, pain and addictions. This program is certified by Mainpro+ at 3-credits per hour.
  - Project ECHO: Ontario Chronic Pain and Opioid Stewardship - A case-based learning program that includes weekly CME-accredited videoconferencing sessions with inter-professional pain specialist teams. During these interactive sessions participants learn about topics related to pain care and opioids, and discuss complex chronic pain cases.
  - McMaster University: MacHealth's Opioids Clinical Primer offers a suite of online courses to educate clinicians on topics such as safe opioid risk reduction and opioid use disorder.
- Find out more about pain management supports available in my LHIN (Resources: LHIN-specific websites; The Health Line).

5 Provide patients in my FHT with information about opioids and pain management

- To support conversations with my FHT's patients, access the following Patient Reference Guides from Health Quality Ontario's Quality Standards: Opioid Prescribing for Chronic Pain – Patient Reference Guide, Opioid Prescribing for Acute Pain – Patient Reference Guide, Opioid Use Disorder (Opioid Addiction) – Patient Reference Guide.

What percentage of my FHT's eligible patients aged 52-74 are up-to-date with any colorectal screening (FOBT within the past two years, colonoscopy within the past 10 years, or other investigations i.e. sigmoidoscopy within the past five years)?

- As of September 30, 2018, 70.0% of patients in my FHT were up-to-date with colorectal screening. My LHIN percentage is 67.9%.
- My FHT is **higher than** the provincial percentage of 65.4%.



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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

580

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.

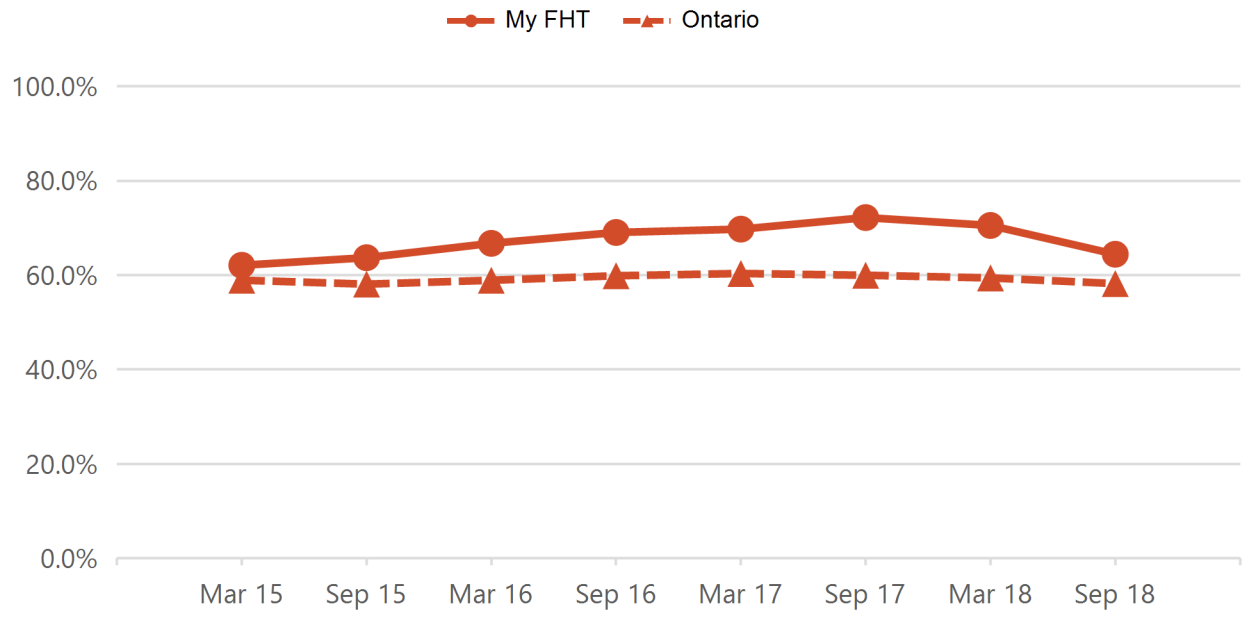
How can my FHT improve its CRC screening? (page 14)

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

SAR Report Portal

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 September 30, 2018, 64.4% of patients in my FHT had an up-to-date Pap smear test. My LHIN percentage is 59.6%.
- My FHT is **higher than** the provincial percentage of 58.2%.



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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

383

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.

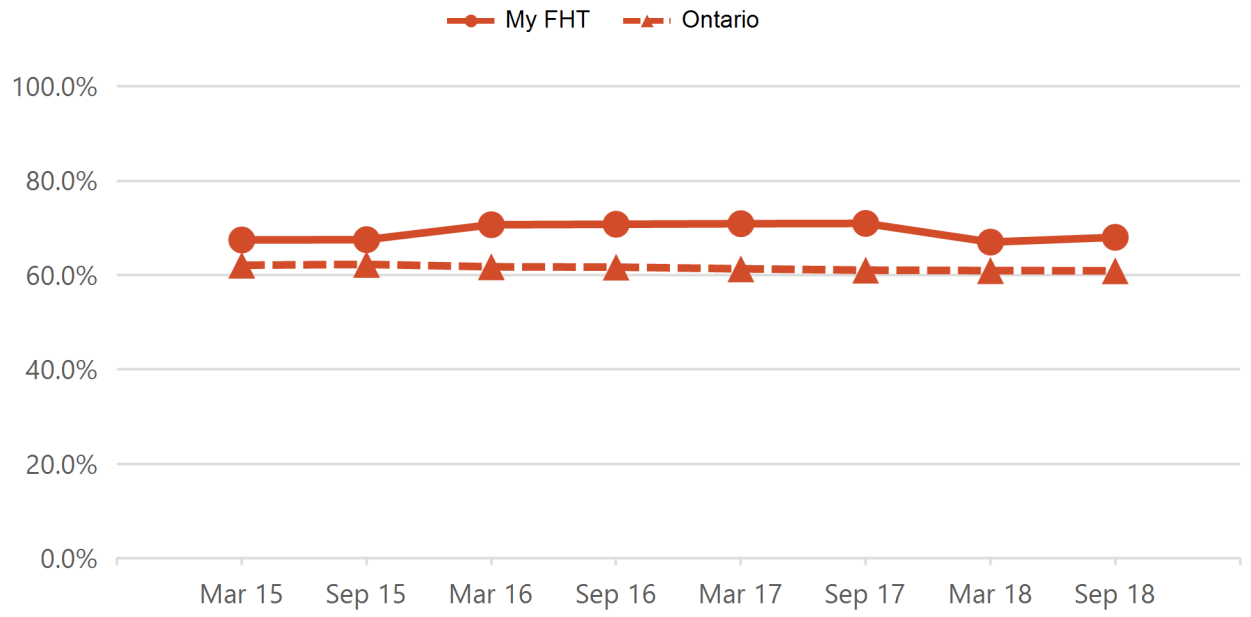
How can my FHT improve its Pap smear screening? (page 14)

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

SAR Report Portal

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 September 30, 2018, 68.0% of patients in my FHT had an up-to-date mammogram. My LHIN percentage is 63.4%.
- My FHT is **higher than** the provincial percentage of 60.9%.



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Patients with history of breast cancer are excluded.

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

252

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 Cancer Care Ontario's screening activity report (SAR)

SAR Report Portal

Change Ideas for Cancer Screening

How can my FHT improve its cancer screening indicators?

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

- Encourage providers to register for and view their Cancer Care Ontario (CCO) Screening Activity Report (SAR) to find the screening status of my FHT's 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 CCO SAR.

2 **Set your FHT's 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 your FHT's 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 Cancer Care Ontario 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 in your FHT who haven't been screened**

- Consider how issues of equity might be affecting your FHT's 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

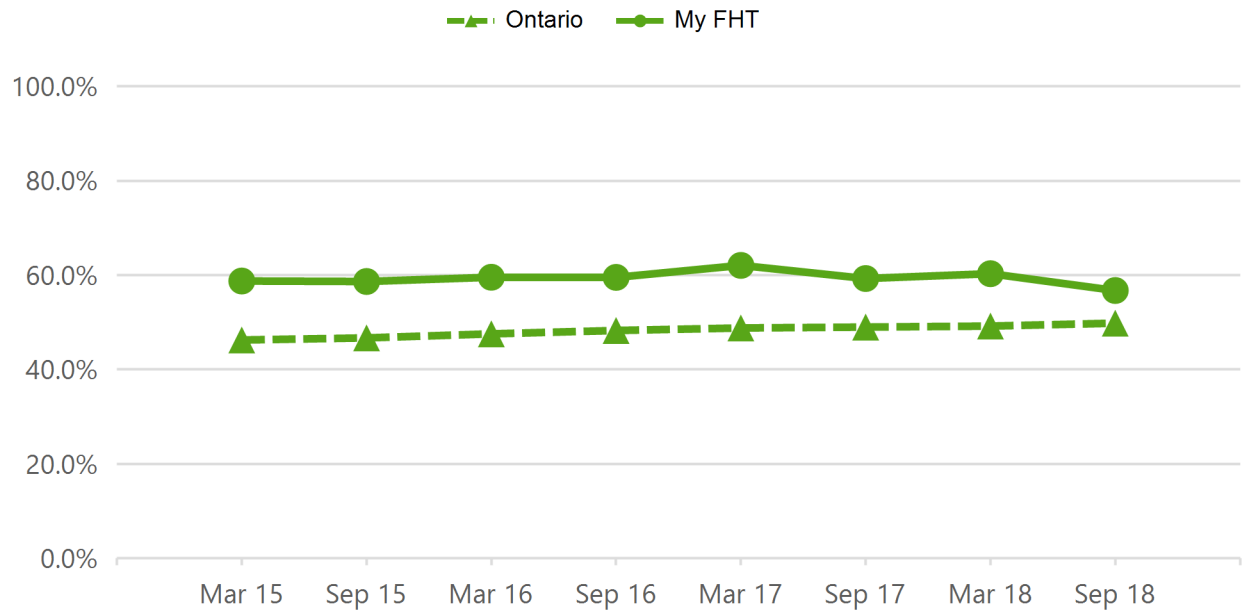
- Reach out to local leaders working with the Provincial Primary Care and Cancer Network.
- See additional screening process improvement ideas and measures from Cancer Care Ontario.

Diabetes Section
HbA1c Testing to Prevent Complications from Diabetes

Data as of September 30, 2018

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

- As of September 30, 2018, 56.8% of patients with diabetes in my FHT were up-to-date with HbA1c testing. My LHIN percentage is 52.7%.
- My FHT is **higher than** the provincial percentage of 49.8%.



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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

224

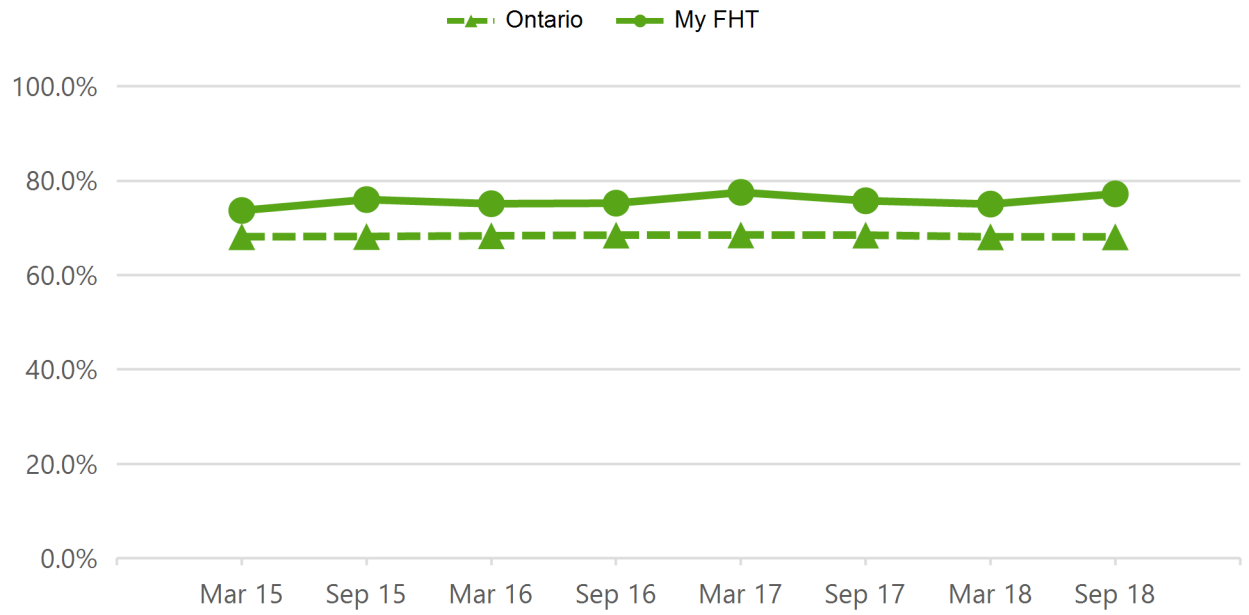
Health Quality Ontario will continue to monitor testing guidelines and adjust the indicator, as appropriate (7).

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

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

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 September 30, 2018, 77.2% of patients with diabetes in my FHT had an up-to-date retinal exam. My LHIN percentage is 69.2%.
- My FHT is **higher than** the provincial percentage of 68.1%.



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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

118

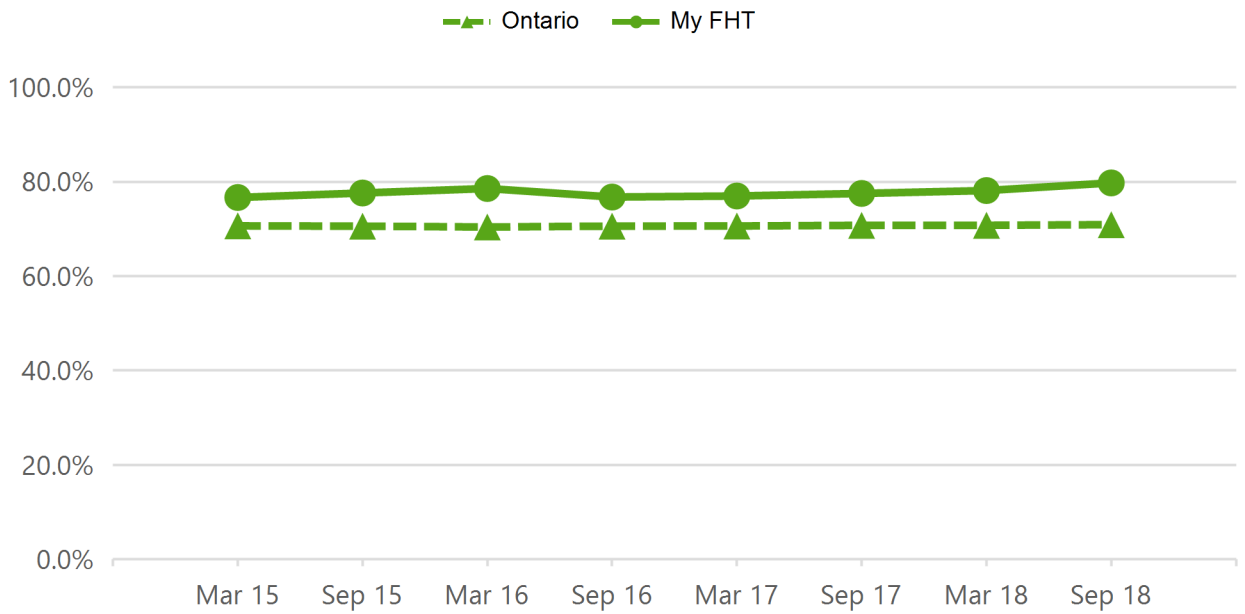
Health Quality Ontario will continue to monitor testing guidelines and adjust the indicator, as appropriate (8).

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)

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 September 30, 2018, 79.8% of patients with diabetes in my FHT were dispensed a statin. My LHIN percentage is 74.4%.
- My FHT is **higher than** the provincial percentage of 70.9%.



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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

67

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)

Change Ideas for Diabetes Management

How can my FHT improve its diabetes management indicators?

1 Identify and verify your FHT's patients with diabetes and create a registry

· Support providers in running a search of the EMR using diabetic billing codes (ICD-9 codes 250 or 251) to generate a list of your patients with diabetes, and verify this list is up-to-date. Involve your billing administrator or nursing support to assist. (11)

2 Set your FHT's goals for improvement

· Using your registry, set an achievable goal for improving one or more diabetic care elements for your patients, including numerical and time-sensitive targets (how many patients are up to date with their care by which dates).
· Encourage provides to use the CVD risk calculator to start discussions with your FHT's patients on goal-setting and self-management.

3 Map your FHT's current diabetes care process

· Map out your FHT's diabetes care process to identify the steps involved and people responsible. This will help you identify inefficiencies and opportunities for improvement: HQO QI Process Mapping Instructions.

4 Develop a recall and reminder system

· Support your providers in using a registry and the EMR to generate reminders to recall patients who are due/overdue for a test, medication review or exam. Designate a staff member to follow up. (12)
· Consider how issues of equity may be affecting your FHT's patients who haven't followed up after being issued a reminder.

5 Update your FHT's diabetes flow sheet

· Update your FHT's diabetes flow sheet using this template from Diabetes Canada.
· If using an EMR, link flow sheet with the diabetes registry and incoming lab results.
· Determine who will complete which sections of the flow sheet, and set aside a regular time to review.

Learn from your peers

- Use Health Quality Ontario's Query QIPs tool to see what other organizations across the province are doing in quality improvement.

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	**635.9**	493.6*	350.7*	404.0
Urgent ED visits	Rate of urgent hospital emergency department visits measured as CTAS level 1 -3 per 1,000 patients	**368.3**	307.9*	231.3*	266.8
Less Urgent ED visits	Rate of less urgent hospital emergency department visits measured as CTAS level 4 -5 per 1,000 of your patients	**†**	184.5*	118.9*	135.7
Hospital Readmissions within 30 days	Percentage of hospital readmissions within 30 days of discharge among your admitted patients	**5.0%**	5.3%*	5.3%*	5.6%
Hospital Readmissions within 1 year	Percentage of hospital readmissions within 1 year of discharge among your admitted patients	**20.7%**	20.6%*	15.2%*	16.2%
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)	**48.1%**	N/A	70.6%	67.8%
Visits to Own Group	Percent of visits to own physician group (continuity of care)	**51.5%**	N/A	76.9%	74.1%

* 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.

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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	**5.9**	3.5*	3.2*	3.6
ACSC Admissions - Asthma	Rate of hospital admissions for asthma per 1,000 patients	†	1.7*	0.4*	0.3
ACSC Admissions - CHF	Rate of hospital admissions for CHF per 1,000 patients	**2.5**	1.6*	1.1*	1.2
ACSC Admissions - COPD	Rate of hospital admissions for COPD per 1,000 patients	**2.0**	0.9*	1.2*	1.4
ACSC Admissions - Diabetes	Rate of hospital admissions for diabetes per 1,000 patients	†	0.2*	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 23.

How can my FHT improve its patients' emergency department visits for less urgent conditions?

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 in your FHT 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.

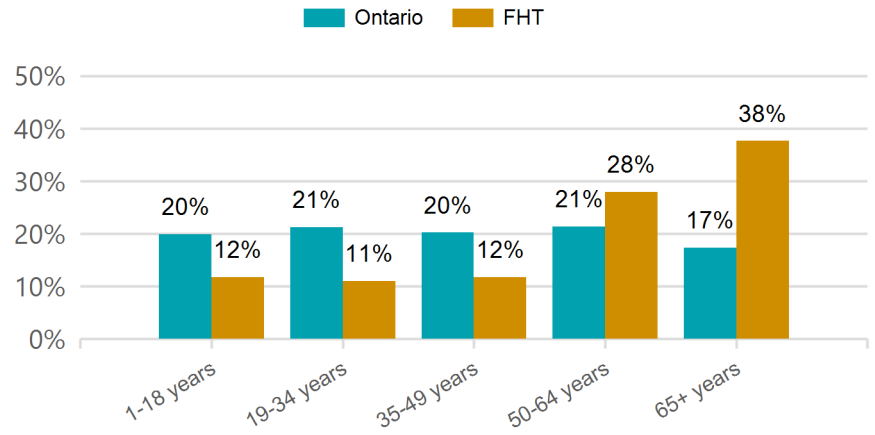
Learn from your peers	
	• Learn from others on Quorum, Health Quality Ontario's quality improvement online community.

"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

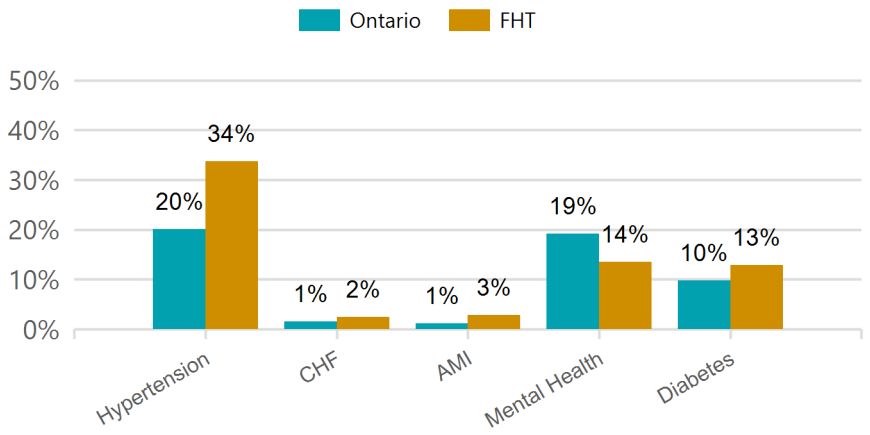
My FHT's Patient Demographics and Disease Cohorts

Data as of September 30, 2018

Percentage of Your Patients By Age Cohort

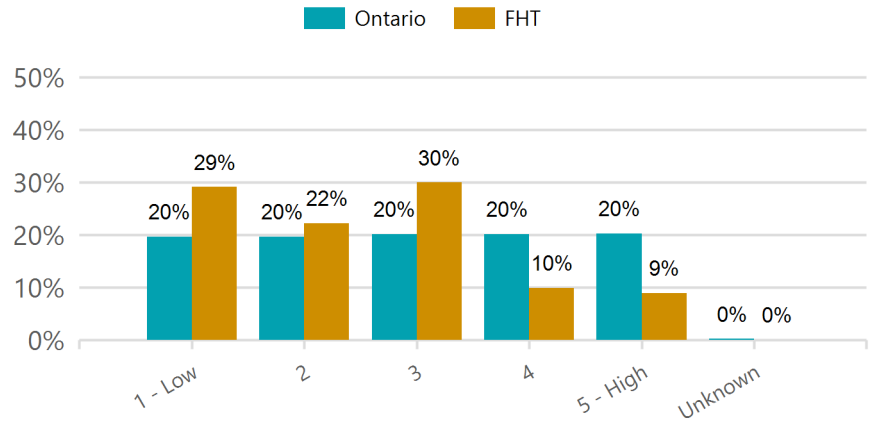


Percentage of Your Patients with Chronic Diseases



**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.*

Percentage of Your Patients By Income Quintile



	My FHT	Ontario
Total Number of Patients	4,078	14,201,549
% Virtually Rostered	2.5%	9.6%
% Recent Immigrants	1.6%	10.0%
Specialists Visits per 1,000 Patients		
Cardiologist	132.4	80.8
Endocrinologist	20.1	43.6
Internal Medicine	179.0	89.2
Psychiatry	77.0	143.8
Respirologist	72.8	34.0

† 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 23.

"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

Methodology:

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 (Hb1AC) tests within the past 12 months, OHIP claims and hospitalization records were used to identify patients with diabetes, and those who had Hb1AC 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 Health Quality Ontario and ICES:

Health Quality Ontario (HQO) is the provincial advisor on quality in health care. HQO reports to the public on the quality of the health care system, evaluates the effectiveness of new health care technologies and services, provides evidence-based recommendations, and supports the spread of quality improvement throughout the system.

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Participation and confidentiality:

You are receiving this report because you have provided consent to HQO and ICES to participate in this project. Neither HQO nor ICES will release identified/ identifiable data without your additional written consent. ICES is named as a prescribed entity under Section 45 of Ontario's health privacy legislation, Personal Health Information Protection Act (PHIPA), 2004, which provides the legal authority for ICES to conduct research about the practice patterns of health providers like you. ICES has very strict privacy policies, practices and procedures, as well as data security arrangements that have been reviewed and approved by the Privacy Commissioner of Ontario. A detailed report can be found on the ICES website: www.ices.on.ca.

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