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ABOUT THE HQCA

Who is the Health Quality Council of Alberta?
The Health Quality Council of Alberta is a provincial agency that pursues opportunities to improve patient safety and health service quality for Albertans. Working collaboratively with healthcare providers and partners, the HQCA drives actionable improvement by:

- Measuring and monitoring health system indicators
- Reviewing issues with patient safety and the delivery of healthcare, and recommending improvements at the system-level
- Transparently reporting the information it collects with government and healthcare provider organizations, as well as the public
- Enabling stakeholders to develop skills in health system improvement through education and other learning opportunities
What type of reports does the HQCA provide on patient panels?
The HQCA provides many different types of reports for different audiences. For physicians there are three types of reports:

- **Proxy panel reports**: these reports are based on patients assigned over the past three fiscal years to a physician based on a probabilistic algorithm developed by the HQCA. This option is the least amount of work for the physician and is best suited to physicians who have been working in a stable practice in the same location for the previous three years. These reports will compare the proxy panel to the PCN and the zone.

- **Confirmed patient list (CPL) panel reports** (formerly validated patient list panel reports): these reports are best suited to physicians who have gone through a rigorous panelling process; are able to extract a patient list from their electronic medical records (EMRs); and are willing to sign a data-sharing agreement. These reports will compare the CPL to the PCN and the zone.

- **Clinic panel reports**: these reports are best suited to physicians who work in clinics where physicians may cover each other’s patients. This option requires multiple CPLs to be submitted to the HQCA and multiple data-sharing agreements to be signed (which are different from the CPL data-sharing agreements). Each physician will receive a report comparing their patient panel to the aggregated clinic panel and the PCN. If requested, an aggregate report can also be provided which compares the clinic to the PCN and the zone.

Other possible types of reports:

- **PCN reports**: these reports aggregate all of the physicians in a PCN and compare them to the zone and the entire province. These reports are sent to executive directors of PCNs and are often used for business and strategic planning.

- **Geographical area reports**: these reports look at patients by their geographic location. Examples include local geographic area reports, zone reports, reports by the first three digits of the patients’ postal codes, etc. These reports are generally used to assess needs of patients in areas of the province and for business and strategic planning.

- **Program reports**: these reports are used to summarize the patients in a particular PCN program. These reports require a confirmed patient list to be submitted.
Why should I request a report?
The reports are an important tool for physicians, clinics, and PCNs to improve the quality of care they deliver.

How is my privacy protected?
The HQCA does not share individual reports with anyone other than the physician unless requested by that physician.

How do I request a report?
Physician level reports can be requested through our website: http://hqca-physicianreports.azurewebsites.net/. In cases where the physician requests a proxy panel report, the individualized report will be sent to the email address provided in the request within a week. In cases where a confirmed patient list report or a clinic level report is requested, the physician will be emailed a data-sharing agreement and instructions on how to send the confirmed patient list(s). Depending on demand, these reports will be provided in about three weeks after the physician has submitted their data-sharing agreement and patient list.

PCN level reports will be provided to the executive director of each PCN.

For other types of reports, such as PCN program reports, geographical reports, or zone reports, you must email primaryhealthcarereports@hqca.ca.

Can specialists request an HQCA panel report?
Yes they can, but they must submit a confirmed patient list report and some of the metrics won’t be very useful (such as degree of attachment to the physician which only looks at GPs). Specialists are not assigned panels by the HQCA.

Can the HQCA do custom reports on metrics that aren’t currently included in the report?
At this point, the HQCA doesn’t have the resources or capacity to do custom reporting. However, if you have suggestions for things you’d like to see in the reports please don’t hesitate to contact us to suggest it.

How do I find out who has been assigned to my proxy panel?
The HQCA has a panelling support initiative that provides identifiable data to physicians about patients assigned to them based on the HQCA assignment algorithm (see the Data Dictionary for full details).
information is meant to be used to speed up the process of panelling patients. For more information on this project, please contact Dale Wright, Senior Lead, Project Management Support, at dale.wright@hqca.ca.

What needs to be done to receive a confirmed patient list report?
Physicians must first request a confirmed patient list report on the report request website at http://hqca-physicianreports.azurewebsites.net/. The physician will be sent a data-sharing agreement and instructions for submitting a confirmed patient list report.

How does the HQCA know and determine which physician belongs to which PCN?
The HQCA is provided this information by Alberta Health.

Is there information on patient experience in the reports?
Information on patient experience is not included in administrative data, which the reports are based off of. However, the HQCA conducts a patient experience survey. For more information on this initiative, please contact Roland Simon, Senior Analyst, Health System Analytics, at roland.simons@hqca.ca.

Are there things that are generally under-estimated in administrative data?
Generally, addictions, mental health conditions, and obesity are three of the most common things to be under-represented in administrative healthcare data.

What is in store for the future of the content of the reports?
The HQCA strives to provide physicians and primary healthcare stakeholders with the most relevant and useful information in these reports. As such, we have put together a Primary Healthcare Panel Report Reference Group and other primary healthcare stakeholders to help us review the current report, the measures we include, and how we organize the information to make sure it is useful to all primary healthcare stakeholders. We also send out a yearly survey to recipients of the reports to find out what was valuable in the report and what wasn’t valuable or what was confusing.

Can the HQCA do custom reports on metrics that aren’t currently included in the report?
Unfortunately, at this point the HQCA doesn’t have the resources or capacity to do custom reporting. However, if you have suggestions for things you’d like to see in the reports please don’t hesitate to contact us to suggest it.
Are there materials available to assist me in interpreting my report?
If you are interested in a multi-faceted educational intervention designed to support family physicians on
topics related to screening measures and Choosing Wisely Canada measures or learning more about how
physicians can learn from individual practice based information, please visit the Physician Learning Program
(PLP) website: www.albertaplp.ca.

If you are interested in support related to improving access please visit the Access Improvement Measures
(AIM) website: http://aimalberta.ca/index.php/course/access-improvement-essential-measures-and-high-
leverage-changes/.
UNDERSTANDING THE REPORT

What does it mean if the text in a graph is blue?
When the text in a graph turns blue and bold it means that your panel is doing well on that particular measure when compared to your zone. Your panel (based on a normal distribution) is in the top 16 per cent of physician’s panels in your zone for that measure.

![Adjusted GPSC Visits](image)

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN Panel</td>
<td>0.07</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>Zone Panel</td>
<td>0.06</td>
<td>0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>Alberta Panel</td>
<td>0.11</td>
<td>0.11</td>
<td>0.10</td>
</tr>
</tbody>
</table>

What does it mean if the text in a graph is red?
When the text in a graph turns red and italic it means that your panel is not doing well on that particular measure when compared to your zone. Your panel (based on a normal distribution) is in the bottom 16 per cent of physician’s panels in your zone for that measure.

![Raw ED Visits](image)

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN Panel</td>
<td>1.03</td>
<td>1.08</td>
<td>1.00</td>
</tr>
<tr>
<td>Zone Panel</td>
<td>0.61</td>
<td>0.63</td>
<td>0.63</td>
</tr>
<tr>
<td>Alberta Panel</td>
<td>0.40</td>
<td>0.42</td>
<td>0.42</td>
</tr>
</tbody>
</table>
METHODOLOGY AND SECTION SPECIFIC QUESTIONS

How are patients assigned to my proxy panel?

Confirmed patient lists (CPLs) are not available for all GPs and PCNs so the HQCA developed its own probabilistic algorithm to create the various panels used throughout the report. While similar to Alberta Health's (AH) four-cut methodology, the HQCA algorithm was developed using both patient and GP validated CPLs. The HQCA algorithm also takes additional criteria into account when linking patients and GPs, and uses clinical risk grouper (CRG) information to inform the proxy panels. The panels developed were based on data from fiscal year 2013-14 to fiscal year 2015-16. The HQCA algorithm is more sensitive for females as compared with males due to a number of gender-linked fee codes. The algorithm is ordered so that the most accurate steps of the methodology assign patients first – see the Data Dictionary for more details.

How are my areas of success and opportunities for improvement determined?

The HQCA examines the below metrics and compares your value on the metric to the zone’s value. By comparing, you can see where you are doing well and where you may have room for improvement.

- Average Physician Degree of Attachment
- Average Business Arrangement Degree of Attachment
- Average Facility ID Degree of Attachment
- Papanicolaou (Pap) Test
- Lipids Screening Test
- Diabetes Screening Test
- Colorectal Cancer Screening Test
- Summary of GP Visits (raw)
- Summary of Specialist Visits (raw)
- Summary of Urgent Care Center Visits (raw)
- Summary of Emergency Department Visits (raw)
- Summary of GPSC Visits (raw)
- Summary of Inpatient Length of Stay (raw)
- Summary of Inpatient Length of Stay for those who spent time as an inpatient (raw)
- Summary of Adjusted GP Visits
- Summary of Adjusted Specialist Visits
- Summary of Adjusted Urgent Care Center Visits
- Summary of Adjusted Emergency Department Visits
- Summary of Adjusted GPSC Visits
Summary of Adjusted Inpatient Length of Stay

We look at your relative value and compare it to the zone panel's value (numerator: your panel's score-the zone panel's score; denominator: the zone panel's score). In cases where a lower value is preferable, based on available evidence, we then multiply this value by -1. We then rank order these scores and include your top 5 values in the top 5 areas of success and the lowest ranked values are included in the top 5 opportunities for improvement. In cases where the values for the top 5 areas of success are not a positive value “N/A” will appear and in cases where the values for the top 5 opportunities for improvement are not a negative value “N/A” will appear in the list.

What are community material and social deprivation indices?
Both of these measures come from Statistics Canada and are linked to the patient by their postal code/dissemination area. The material deprivation index, put simply, looks at the wealth of the neighbourhood a patient lives. The social deprivation index looks at the family conditions in a neighbourhood, such as marital status, single-parent families, and individuals living alone.

What is a clinical risk grouper and what is it used for?
The clinical risk grouper is software developed by 3M to look at future healthcare costs. However, it also doubles as a burden of illness measure. At its most aggregate level it categorizes patients into 1 of 9 levels which are organized into an ordinal measure. A CRG of 1 is the most healthy while a CRG of 9 is the least healthy. When it comes to chronic conditions, it is measured by organ systems such that if you had a CRG of 5 you would have a chronic condition in one organ system while a CRG of 6 would indicate chronic conditions in 2 organ systems and a CRG of 7 would indicate chronic conditions in 3 or more organ systems. If you had two chronic conditions in the same organ system and no other chronic conditions this would be registered as a CRG of 5. The CRG is then used in the report as a factor to predict things such as the filling of pharmaceutical prescriptions and adjust populations for the sake of an “apples to apples” comparison between the various comparator groups.

<table>
<thead>
<tr>
<th>CRG level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Healthy, no major conditions</td>
</tr>
<tr>
<td>2. Significant acute</td>
</tr>
<tr>
<td>3. Single minor chronic</td>
</tr>
<tr>
<td>4. Multiple minor chronic</td>
</tr>
<tr>
<td>5. Single dominant or moderate chronic</td>
</tr>
<tr>
<td>6. Pairs- multiple</td>
</tr>
</tbody>
</table>
What is different between physician degree of attachment, degree of attachment to a business arrangement, and degree of attachment to a facility ID and how do I interpret it?

Physician degree of attachment is the percentage of the time the patient panel sees their assigned physician (based on the HQCA assignment algorithm for proxy panel reports, and a CPL for physicians who submit a CPL) as opposed to another GP. This measure is related most closely to relational continuity.

Degree of attachment to a business arrangement is the percentage of the time the patient sees physicians which belong to the business arrangement to which the patient is assigned (based on the HQCA assignment algorithm).

Degree of attachment to a facility ID is the percentage of the time the patient sees physicians which belong to the facility ID to which the patient is assigned (based on the HQCA assignment algorithm).

Both degree of attachment to a business arrangement and degree of attachment to a facility are proxy measures for the "medical home" of a patient and aim to be indicative of informational and management continuity. Both measures are provided because physicians may have multiple facilities in which they work or multiple business arrangements within the same facility and, as such, the physician is left to choose the measure that best represents the way they practice between these two measures.

Where does the data on pap tests come from?

All of the data on pap tests comes from administrative data such as physician claims, ambulatory data (NACRS), and inpatient data (DAD). Unfortunately, at this point the HQCA does not have access to pathology data on pap tests.

Why isn't there data on mammograms?

Unfortunately, the HQCA has yet to be able to get access to reliable mammography data. We hope to include this data in future reports.
How are chronic diseases figured out in the report?
Chronic diseases were identified with episode disease category (EDC) aggregate codes produced by AHS using the CRG software. This tool identifies 267 different possible categories of conditions.

How are comprehensive annual care plans measured?
The HQCA uses the conditions listed on the comprehensive annual care plan (CCP) form and examines the last year of data to see who meets the criteria of either two group A conditions or one group A and one group B condition and this represents the denominator. The numerator is defined by examining whether or not the eligible patients (in the denominator) had the procedure code 03.04J billed during one of their encounters with the healthcare system in the claims data. As such, CCPs done by healthcare providers who don’t have their claims included in the physician claims data will not be included.

How do I interpret frequency of diagnoses in the emergency department?
We report this measure based on chapter of the ICD-10 manual. While, in some cases, the definitions are very broad reporting at a lower level of aggregation tends to reduce the number of cases of each category to the point where the information wouldn’t be actionable for the physician level report.

What is the difference between statistical prediction and statistical adjustment, and why are each used?
Both methodologies aim to predict what the value of a metric would be if the characteristics of the panel were changed to a particular value. However, the mathematics behind each methodology is slightly different. One of the main reasons we use these two methodologies in different places is because of the nature of the metric we are looking at. We tend to use adjustment in cases where we have a continuous variable and prediction in cases where we have a dichotomous variable. The most ideal outcome for the predicted percentage of patients receiving a drug class values is for them to match, or be similar to, the raw percentage of patients receiving a drug class graph’s values. The most ideal outcome for the adjusted graphs is for the value in the graph for the physician panel to be lower than the corresponding raw value as well as lower than the comparator groups in the adjusted graph (PCN and zone).

What specialties are included in the specialist visits section?
Please see the Data Dictionary for a complete list of specialties.

What are General Practitioner Sensitive Conditions (GPSC)?
Please see the Data Dictionary for a complete list of GPSC conditions.
**Why are there multiple graphs on inpatient length of stay?**
The first two graphs are representative of how much your whole panel is using inpatient resources. The third graph identifies for you whether your panel’s usage of inpatient services is due to more patients using the services for a shorter period of time or if less patients are using inpatient services for a longer period of time.

**What are alternate level of care days?**
These are days spent as an inpatient in the hospital waiting for continuing care.

**Why is there no information on things like third next available appointment?**
Information, such as third next available appointment, are not included in administrative data. They would need to be extracted from either your booking software or your electronic medical records system.