FAQ

Primary Care Data Reports for Ontario Health Teams (OHTs)

Version Date: January 9, 2023

1. **What is the intent of having these reports?** To provide a deeper understanding of the attributed population of each OHT. The tables are for baseline planning and thinking about issues/problem areas in each OHT.
    a. Improved understanding of the scope of the issues in the regions
    b. Improved understanding of primary care involvement with priority populations
    c. Understanding priority population characteristics
2. **Can we use tables for QI or patient identification?** No-patients are not identifiable. These reports are not appropriate for PDSA/QI.
3. **Are we able to use for individual patient or physician identification purposes such as CPSO physician numbers?** No. We are not able or permitted to identify by name or CPSO # the list of individual MDs included in the tables. These are all anonymized in our data. The same applies to individual patients- we are not able or permitted to identify specific patients.
4. **Do these reports function as performance metrics?** No not performance metrics! Not population segmentation.
5. **What have other OHTs used these reports for?** Some of the uses of these reports are:
    a. Baseline and benchmarking for targets
    b. Assist in scoping of projects within OHTs
    c. Identifying opportunities for collaboration with other OHTs
    d. Identifying needs for AHRQs
    e. Coordination with MOH branches, Ontario Health, RISE and HSPN
6. **When will they reports be made available?** The reports are available December 20, 2021, on the OCHPP platform: www.OntarioHealthProfiles.ca
    To access the OHTs page from the OCHPP website:
    - Home page (Primary Care Data Reports for Ontario Health Teams (OHTs) button)
    - Data, Charts and Maps page (Ontario Health Teams button)

    This OHTs website is hosted by Ontario Community Health Profiles Partnership (OCHPP).
7. **Where do patients of NPLCs fall within the reports?** Unfortunately, this information is not included in these reports. We are unable to designate which patients have seen NPs. For a patient that is only seen by NPLC over a 2 year period prior to index, they would be in our dataset but not designated as attached (captured as uncertainly attached).
8. **What is the time period of the report data?** The data included is as of March 31, 2020.
9. **Where did the attribution model for OHTs come from and are there any scientific papers written on this?** Yes, Dr. Therese Stukel originally conceived of the idea in conjunction with Dr. Rick Glazier. See their paper here for all the background on the model: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863751/
10. **The report has a lot of data and focuses on attaching patients to primary care providers. Are there any limitations in this data?** Yes, there are limitations with the data. Some of the main limitations are listed on page 740 in this paper here: https://pubmed.ncbi.nlm.nih.gov/34304401/#:~:text=J%20Health%20Organ,05-2020-0171

11. **Can you give more detail on how mental health was measured?** Mental health diagnosis came from definitions algorithm to identify patients with a mental health diagnosis links different databases at ICES DAD and OHIP and is based on having two physician billing claims in OHIP over 2 years or one hospitalization with one of the listed mental health service codes: OHIP fee codes: mental health services: K005, K007, K623; ICD 9 codes: psychotic disorders (excluding dementia and delirium): 295x, 296x 297x, 298xnon-psychotic disorders: 300x, 301x, 302x, 306x, 309x, 311xsubstance-use disorders: 303x. 304xother family circumstances or social problems: V61.10, V61.1, V61.2, V61.3, V61.3, V61.03, V62.4, V62.2, V62.5 or 897, 898, 899, 900, 901,902, 904, 905, 906, 909 ICD 10 codes: F10-F99 (excluding dementia and delirium and F50.0, F50.1, F50.2, F50.3, F50.8, F50.9).
12. **Can you give more detail on how frailty was measured?** Frailty was measured using the Johns Hopkins Adjusted Clinical Groups (ACG) frailty-defining diagnoses indicator. It is based on 10 clusters of frailty-defining diagnoses (i.e., malnutrition, dementia, impaired vision, decubitus ulcer, incontinence of urine, loss of weight, poverty, barriers to access to care, difficulty in walking, and falls). The ACG frailty indicator captures patients with multidimensional frailty at the population level and has been shown to accurately identify patients with limitations in activities of daily living.
13. **Can you give more detail on how palliative care was measured**? Palliative care was derived from an algorithm using the following 31 OHIP fee codes. If the physician of a patient had a record of one of these 31 fee codes, the patient was said to have received palliative care.

A900	Complex house call assessment
A901	House call assessment
A945	Special palliative care consultation in clinic, office, home; minimum 50 minutes
B960	Special visit to a patient's home, weekdays – both elective and non-elective
B961	Special visit to a patient's home, Mon-Fri. Sacrifice of office hours non-elective
B962	Special visit to a patient's home, Mon-Fri. Non-elective
B963	Special visit to a patient's home, weekends & holidays. Non-elective
B964	Special visit to a patient's home, Nights. Non-elective
B966	Travel premium for palliative care (billed with B998/B996)
B986	Geriatric home visit, travel premium
B987	Geriatric home visit, first person seen
B988	Geriatric home visit, first person seen
B990	Special visit to a patient's home
B992	Special visit to a patient's home
B993	Special visit to a patient's home
B994	Special visit to a patient's home
B996	Special visit to a patient's home

B997	Home visit for palliative care between 24:00 and 07:00, only applicable on October 1, 2009 and onwards
B997	Special visit to a patient's home, non-palliative specific, applicable before October 1, 2009.
B998	Home visit for palliative care between 07:00 and 24:00
C882	Inpatient subsequent visits by MRP following transfer from an intensive care area – palliative care
C945	Inpatient special palliative care consultation subject to the same conditions as A945
C982	Inpatient palliative care
G511	Telephone services to patient receiving primary care at home
G512	Weekly care case management from palliative primary care management
K015	Counselling of relatives – on behalf of catastrophically or terminally ill patient
K023	Palliative care support in half hour increments; may be used to add time for longer consultations
K700	Palliative care out-patient case conference
W872	Nursing home or home for the aged – palliative care per visit
W882	Chronic care or convalescent hospital – palliative care per visit
W972	Subsequent visits – nursing home or home for the aged – palliative care
W982	Subsequent visits – chronic care or convalescent hospital – palliative care

14. The total attribution numbers in these reports varies slightly with the MOH recorded attribution numbers. Can you give the breakdown by OHT of what this differenceis?

OHT #	OHT Teams	Population Assigned in OHT (MOH) -- based on RPDB FY2019	Our cohort	Difference N	Difference %
	Total of 51 OHTs	**13,944,521**	**13,536,624**	**407,897**	**2.9%**
1001	Algoma OHT	101,325	98,142	3,183	3.1%
1002	All Nations Health Partners OHT	28,839	27,741	1,098	3.8%
1003	Burlington OHT	235,975	229,815	6,160	2.6%
1004	Cambridge North Dumfries OHT	153,677	149,993	3,684	2.4%
1005	Chatham-Kent OHT	102,289	98,601	3,688	3.6%
1006	Kawartha Lakes OHT	53,757	51,414	2,343	4.4%
1007	Connected Care Halton OHT	415,123	404,685	10,438	2.5%
1008	Couchiching OHT	68,440	66,501	1,939	2.8%
1009	Downtown East Toronto OHT	143,663	139,248	4,415	3.1%
1010	Durham OHT	485,498	472,273	13,225	2.7%
1011	East Toronto Health Partners OHT	379,763	369,400	10,363	2.7%
1012	Eastern York Region and North Durham OHT	326,246	318,771	7,475	2.3%
1013	ÉSO Archipel / Archipel OHT	197,659	191,361	6,298	3.2%
1014	Frontenac, Lennox and Addington OHT	221,758	214,766	6,992	3.2%
1015	Guelph Wellington OHT	227,513	221,713	5,800	2.5%
1016	Greater Hamilton Health Network OHT	633,502	614,818	18,684	2.9%
1017	Hills of Headwaters Collaborative OHT	84,254	81,832	2,422	2.9%
1018	Huron Perth and Area OHT	151,407	146,687	4,720	3.1%
1019	Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT	406,823	396,140	10,683	2.6%
1020	Lanark, Leeds and Grenville OHT	126,621	122,267	4,354	3.4%
1021	Mid-West Toronto OHT	580,616	559,407	21,209	3.7%
1022	Mississauga OHT	941,174	916,842	24,332	2.6%
1023	Muskoka and Area OHT	65,238	63,242	1,996	3.1%
1024	Nipissing Wellness OHT	117,420	113,712	3,708	3.2%
1025	Niagara OHT	384,226	371,186	13,040	3.4%
1026	North Toronto OHT	187,374	181,401	5,973	3.2%
1027	North Western Toronto OHT	414,669	402,878	11,791	2.8%
1028	North York Toronto Health Partners OHT	518,805	503,291	15,514	3.0%
1029	Northumberland OHT	54,298	52,656	1,642	3.0%
1030	Ottawa OHT/Équipe Santé Ottawa	606,453	586,801	19,652	3.2%
1031	Oxford and Area OHT	102,404	99,350	3,054	3.0%
1032	Peterborough OHT	170,627	165,322	5,305	3.1%
1033	Rainy River District OHT	21,670	20,881	789	3.6%
1034	Sarnia Lambton OHT	118,199	114,269	3,930	3.3%
1035	Scarborough OHT	854,401	833,840	20,561	2.4%
1036	South Georgian Bay OHT	64,487	62,682	1,805	2.8%
1037	Southlake Community OHT	351,666	341,382	10,284	2.9%
1038	West Toronto OHT	239,233	232,087	7,146	3.0%
1039	Middlesex London OHT	526,801	511,620	15,181	2.9%
1040	Western York Region OHT	375,423	365,950	9,473	2.5%
1041	Central West OHT	904,493	879,144	25,349	2.8%
1042	Brantford Brant OHT	202,033	194,608	7,425	3.7%
1043	Barrie and Area OHT	200,005	193,802	6,203	3.1%
1044	Elgin OHT	71,024	68,703	2,321	3.3%
1045	Ottawa - West Four Rivers OHT	330,239	320,581	9,658	2.9%
1046	Grey Bruce OHT	138,710	134,074	4,636	3.3%
1047	Hastings Prince Edward OHT	158,100	152,731	5,369	3.4%
1048	Ottawa Valley OHT	78,751	75,748	3,003	3.8%
1049	North Simcoe OHT	52,226	50,640	1,586	3.0%
1050	Great River OHT	133,023	128,995	4,028	3.0%
1051	Windsor Essex OHT	436,601	422,631	13,970	3.2%

15. **The maps have regions identified with a 2-digit code and others identified with a 4-digit code. What is the difference?** INSPIRE PHC has designated Physician Specialty Networks (initial prescribed areas prior to OHT approval) regions with 2-digit codes. Regions with 4-digit codes are approved OHTs. Work is in progress by the Ministry of Health to establish the remaining PhysNets into OHTs.
16. **Since the original posting in December 2021, have there been any updates to any of the posted reports?** Yes, see below for details:
    a. **Ottawa East maps** - Maps updated to reflect the Hawkesbury General Hospital should be attributed to the Ottawa East OHT. Originally, the Hawkesbury General Hospital was included in the network of Hopital Monfort (January 2022)
    b. **Brantford Brant OHT** - Due to partnership updates, Brantford Brant OHT linked to Norfolk, Network 18 (updated report to be posted February 2022 with maps to follow)
    c. **Network 24 OHT** – Name change to Ottawa Valley OHT (March 2022)
    d. **ESO/Ottawa East OHT** – Name change to Ottawa East OHT (June 2022)
    e. **Ottawa Health Team OHT** – Name change to Ottawa OHT (June 2022)
    f. **Upper Canada, Cornwall and Area OHT** – Name change to Great River OHT (July 2022)
    g. **Connected for Care – Lanark, Leeds and Grenville OHT** – Name change to Lanark, Leeds and Grenville OHT (July 2022)
    h. **Ottawa East OHT** – Name change to ÉSO Archipel/Archipel OHT (January 2023)
17. **Can the data in the reports be provided for sub portions of OHTs, for example, by FHT or Care Team?** No, this type of reporting is not within the scope of this project. If your OHT does not have the analytic capacity to disaggregate data within your OHT, please bring your query forward and we may be able to assist.
18. **What are the definitions of "attached" and "uncertainly attached" patients? "**Attached" are those with a regular source of primary care (a provider). "Uncertainly attached" are those without a regular source of primary care. See criteria for each of these groups illustrated in the flow chart below.