About the Data: Primary Care

Last Updated: November 17, 2022

<u>Attachment to Primary Care, 2020</u>

Introduction

Information and data about attachment to a primary care provider is key to addressing major health system challenges of equitable access to high quality primary health care. For example, what degree does primary care capacity meet population health needs? How successful is primary care reform in eliminating unattached patients?

For this indicator related to "attachment" the Ontario Community Health Profiles Partnership (OCHPP) provides data and maps about attachment to primary care for neighbourhoods in Toronto. More data for other health areas such as sub-regions is forthcoming.

Multiple indicators, each providing insight into the attachment status of Ontarians to care such as attachment to care, uncertainly attached to care as well as attachment status of children to care, will be posted on the OCHPP over several months (commencing November 2022).

The first data to be posted (maps only) are for: Attached, Uncertainly Attached and All (Attached + Uncertainly Attached).

The data are provided at the following levels of geography (maps only):

- Toronto Neighbourhoods
    •   140 Neighbourhoods

<u>Data Source(s)</u>: ICES Primary Care Population dataset.

For detailed information about the ICES PCPOP dataset including the algorithms to define "attachment" see the link on the OCHPP website here:

https://www.ontariohealthprofiles.ca/ontarioHealthTeam.php

Click on any of the reported areas on the maps for an overview of the methodology.

Inter-Professional Team Care 2016

Introduction

Family Health Teams are primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community. (Source: Ministry of Health and Long-Term Care, 2017)

The typology will be developed hierarchically, starting with those enrolled to a Patient Enrolment Model or actively registered as a CHC primary care client. The remaining population will be classified according to their contact with primary care physicians over the previous two years. The categorization of visits will include: no visits; 1-2 visits; 3+ visits. In the case of these analyses, a CHC patient is defined as any patient seen at a CHC anytime during the two-year period prior to index. These patients were seen in primary care at a CHC and/or who were registered for primary care services at a CHC. This definition holds even if the patient had primary care visits outside the CHC.

The data are provided at the following levels of geography:
- Ontario Neighbourhoods
    • 140 Neighbourhoods in LHIN 7 (Toronto Central and City of Toronto)
    • 105 Neighbourhoods in LHIN 8 (Central)
- 76 Ontario Sub-Regions
- 14 Ontario Local Health Integration Network (LHIN)

Data Sources: Corporate Provider Database (CPDB) (physician and group data from Ministry of Health and Long-Term Care [MOHLTC]), CPDB library also Includes Family Health Team (FHT) data, Community Health Centre (CHC) data.

Locations of Primary Care Services in Toronto indicators 2013 (maps only)

Introduction

Primary care comprehensiveness is based on a primary care physician's fee-for-service billings and shadow-billings which are used to track the scope of services provided. A physician is defined as being in a comprehensive primary care practice if he or she meets the following criteria, which are applied in a hierarchical manner: -They must have worked a minimum of 44 days during the year;
-More than 50% of their services must have been for 'core primary care services' and - These core primary care services must fall within a minimum of 7 out of 22 'activity areas'.

Maps are provided at the following levels of geography:
- Ontario Neighbourhoods
   • 140 Neighbourhoods in LHIN 7 (Toronto Central and City of Toronto)

Data Sources: IPDB, RPDB, OHIP, ODB, DAD and NACRS.

Multispecialty Physician Networks Central LHIN   2011/12 to 2012/13 (maps only)
Multispecialty Physician Networks were created by the team of researchers led by Dr Thérèse Stukel in the Institute for Clinical Evaluative Sciences. They reflect the natural linkages among patients, physicians, and hospitals based on existing patient flow.
Maps are provided at the following levels of geography:
- Ontario Neighbourhoods
   • 105 Neighbourhoods in LHIN 8 (Central)

Data Sources: Discharge Abstract Database, National Ambulatory Care Reporting System for ED visits, the Ontario Health Insurance Plan (OHIP), the Ontario Drug Benefits Plan, Registered Persons Database.

Enrolment and Continuity of Care 2011/12 to 2012/13

Introduction

About the Data: Primary Care Attachment and Continuity in Relation to Health Care Use
Purpose: This study aims to analyze patterns of primary care enrolment and continuity in relation to health care use.

The data are provided at the following levels of geography:
- Ontario Neighbourhoods
   • 140 Neighbourhoods in LHIN 7 (Toronto Central and City of Toronto)
   • 105 Neighbourhoods in LHIN 8 (Central) - 82 Ontario Health Links
  (Archived) - Ontario Sub-LHINs:
   • 5 Toronto Central LHIN (LHIN 7) (Archived)
   • 6 Central LHIN (LHIN 8) (Archived)
- 14 Ontario Local Health Integration Network (LHIN)

Data Sources: The datasets to be used include the Registered Persons Database (RPDB), Ontario Health Insurance Plan (OHIP) physician claims, Client Agency Provider Enrolment (CAPE) tables, Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD), Ontario Mental Health Reporting System (OMHRS), National Ambulatory Care Reporting System (NACRS), Ontario Cancer

Registry (OCR), Cytobase, Ontario Breast Screening Program (OBSP), Ontario Drug Benefit (ODB) Program, and Community Health Centre (CHC) data. Chronic conditions will be identified according to validated datasets on diabetes, COPD, asthma, hypertension, CHF, MI and a validated algorithm on identifying mental health primary care visits. These datasets will be linked using unique, encoded identifiers and analyzed at the Institute for Clinical Evaluative Sciences (ICES).

Phase I of Data Analysis: The first phase will be the development and description of a typology of primary care enrollment and continuity. The typology will be developed for individual physicians. The typology will be developed hierarchically, starting with those enrolled to a Patient Enrolment Model or actively registered as a CHC primary care client. The remaining population will be classified according to their contact with primary care physicians over the previous two years. The categorization of visits will include: no visits; 1-2 visits; 3+ visits.

The typology will be developed hierarchically, starting with those enrolled to a Patient Enrolment Model or actively registered as a CHC primary care client. The remaining population will be classified according to their contact with primary care physicians over the previous two years. The categorization of visits will include: no visits; 1-2 visits; 3+ visits. In the case of these analyses, a CHC patient is defined as any patient seen at a CHC anytime during the two year period prior to index. These patients were seen in primary care at a CHC and/or who were registered for primary care services at a CHC. This definition holds even if the patient had primary care visits outside the CHC.

The group with 3+ visits will be further divided into those with high (>80%), medium (5080%) and low (<50%) continuity of care according to the proportion of visits to their most frequent primary care group during April 1, 2009 - March 31, 2013. Alternative groupings will be explored depending on the distribution of visits. The Continuity of Care Index will be used to further categorize the 3+ visits group according to the dispersion of their visits across a number of primary care providers and groups. Patients in each of these categories will be compared by age, sex, income quintile (using postal code), recent immigrant (using first OHIP registration in past 10 years), rurality (using the Rurality Index of Ontario), chronic conditions, LHIN, Sub-LHIN, Health Links (where applicable) and neighbourhood (where applicable).