Understanding the 2021 Practice Profile

Frequently Asked Questions (FAQ)

General Questions

(Skip ahead to questions about calculation of SAMI score and panel size)

1. **What data are included in the practice profile? For example, some centres provide health supports to clients/patients not affiliated with an interprofessional team. This could be clients facing systemic barriers, those without private health insurance, and may live in more rural isolated communities.**

The data for these particular clients would be included as long as they saw a nurse practitioner or physician, and also met all inclusion criteria (see technical appendix).

2. **The data in our JReport does not reconcile with the data included in the Practice Profile. Is it possible that there were encounters missing that were not reconciled before ICES ran their report?**

For some data, the data in JReports will not match. This is because of the inclusion criteria and the linkage with administrative databases throughout the health system.

3. **There is a significant difference in the practice profile indicators for cancer screening when compared to those in BIRT/MSAA indicators. Why is this? Are there thoughts on reconciling the two indicators to decrease confusion for the CHC Board and other staff members?**

The cancer screening indicators in the practice profile only include those who have completed their cancer screening (lab result), whereas the MSAA indicator is calculated for those who were offered OR completed. The completed cancer screening is being used in the cQIPs and is a provincially defined indicator and cannot be changed.

4. **If a patient agrees to a pap test, but doesn't complete the test, how should that be recorded in MSAA Tracker? Accepted, Declined?**

The test should be recorded as “Accepted.” They would not be recorded or changed to “Declined” unless a conversation was had between the provider and client and they *explicitly* declined. A reminder should be set to ensure the test was completed or to follow up with the client.

5. **There are many reasons a client may not accept a screening test for preventative care. Why would we track just the completed tests? The real work is the discussion had with each client and the agreement of whether or not they want to complete?**

The practice profile only includes the cancer screening data for those completed screenings, but the MSAA and other indicators look at both offered and completed.

6. **Follow up to question 3 and speaking to the variance between PP and MSAA performance indicators, is there a specific indicator the centre should focus their efforts on?**

The MSAA indicator is important because centre-specific performance targets have been established. The Practice Profile data could be used to understand how many of the tests that your providers have offered that have been actually done. The goal of cancer screening is to actually do screening, so this data is important.

7. **What role does "Services provided" and “Office procedures” play in practice profile?**

The services provided do not count towards the SAMI score, but these codes are used for other indicators, for example the MSAAs.

8. **What happens to all the data/ issues addressed entered by allied health providers?**

All of this data is at ICES and is included in studies but cannot be used in the Practice Profile due to the reliance on diagnoses.

9. **Can we get a drill down look at client-level data that informs the roll up data we are provided?**

You could look at internal CHC data, but that would be missing those data where your clients are interacting elsewhere in the health care system. Understanding the pattern of documentation of your providers, looking at the ENCODEs and ICPC codes used by your providers, you can review encountering practices of your provider and ensure that the diagnosis codes are being used as required.

10. **Can CHCs monitor clients who are rostered or accessing care under another primary care model? Could this help reduce duplication?**

There is no way to get identifiable information from ICES. The practice profile provides a percentage of clients who receive a majority of their care either from a CHC only or a non-CHC model. This is a fairly common occurrence and not necessarily devaluing CHC care, but rather supporting clients' needs as it relates to shared care model. It may also reflect clients who are still enrolled at other primary care models but receiving their primary care from the CHC physician or nurse practitioner.

11. **With regards to overlapping clients, is there any possibility that specialist referrals may be construed as the provision of care by non-CHC models? Have you found any regional bias?**

Specialist visit data are included in the practice profile; therefore, this should not be the case. We have pulled out the family physicians with specialized practices, and there are regional differences with specialist visits. For example, specialist visits for francophone CHCs or northern CHCs are not as high as other areas.

Questions about the SAMI Score and Panel Size

12. **Can you please advise which primary care groups are part of the 1.0 SAMI benchmark?**

Every person in Ontario is included in the standardization for the SAMI. It is set so that the average Ontarian has a SAMI of 1.

13. **Is there a formula available for determining panel size/high SAMI score?**

1137.5/SAMI=adjusted panel size/PCP for CHCs.

14. Can the adjusted panel size target be applied to a provider and not just a centre?

No. Because the SAMI score is provided at the centre level, there is no way to tease apart the SAMI score by provider. There may be other metrics that one could review at individual centre level (e.g., primary care dashboard).

15. In the past, the SAMI score was provided for individual sites (e.g., satellite sites). Why is it no longer calculated for individual sites (these sites serve different priority populations)?

There has been a lot of change and fluctuation with satellite sites, and as a result of this, the small cell counts and need for data suppression, ICES stopped producing the data in this way. There are data available in BIRT through the primary care dashboard that could provide some of this information in terms of client complexity. It may not provide all indicators included in the practice profile, but due to the already small cell counts, a lot of the data would be supressed.

16. What do we do if we noticed a significant drop in our SAMI but there seems to be a disconnect from what we are seeing in terms of client complexity?

Remember that the SAMI score is only as good as the data entry into PSS, and it also takes into account other health care systems accessed by the client (e.g., hospital, specialists, etc.). The trend for the majority of CHCs was an increase in their SAMI score.

17. When we talk about documenting encounters that count towards the SAMI score, are they those that are under "issues addressed"?

Yes, and be as specific as possible to all issues. For example, ensure the diagnosis received is noted vs. just the symptoms. For example, if the client has high blood pressure record hypertension vs. visit for blood pressure. The SAMI score is calculated for the specific time period, and keep in mind that all diagnoses across the client's journey through the health care system (e.g., hospital, specialist care) are included and not simply the care they receive within the CHC.

18. Is there a specific list of diagnoses that can be shared for data entry [for accurate calculation of SAMI score]? If so, where can this be found?

There are over 10,000 codes that are clustered into the Adjusted Diagnostic Groups (ADGs). There is a clinician's guide to the SAMI and reporting, linked here[1]. Calculation of the SAMI is very complicated, and is done through the mix of ADGs, which are a combination of codes from various health care sectors (e.g., CHCs, hospitals, specialists etc.). The key takeaway message is that it is important to include all issues addressed at each visit (e.g., diagnosis, symptoms, socio-demographic pieces like poverty etc.).

19. As charting and data entry take time and dedication to ensure accuracy, and specific diagnoses may have a variety of symptoms associated or various different sub-choices, would it be possible to have these weighted ENCODEs so that we can accurately reflect care delivered while reducing the administrative burden on our clinicians?

The diagnoses trigger an ADG (adjusted diagnostic group) as the first step in the SAMI calculation. The diagnosis will count more heavily towards your SAMI score, and the important piece is ensuring you include all of the diagnoses. As stated above, there are over 10,000 codes and it is impossible to provide this as well as the interactions between the various combinations of diagnoses.

Your DMC (data management coordinator) can also support reviewing whether these more vague codes are being used and to support accuracy of diagnosis that ensure complexity is measured more accurately.

20. Our team was advised that diagnoses should be added at least twice/year in order to be captured for the SAMI. Is this correct?

The SAMI contains two years' worth of diagnoses, however it is not always easy for providers to remember or have time to investigate the last time they entered a diagnosis. For simplicity's sake, and as documented in the SAMI guide for clinicians, we advise to "record all diagnoses as specifically and comprehensively as possible, whenever they are addressed either implicitly or explicitly during a visit."

[1] NOTE: You will need to be connected to the Alliance community portal to access this document.

21. Does the sociodemographic data [health equity indicators] in CHC demographic profile influence your SAMI score?

No. The data in the registration and intake form do not count towards the SAMI score. However, if you are using the ENCODEs under issues addressed (e.g., poverty and homelessness), these will count towards your SAMI score. In addition, there are a set of explanatory measures that have been established to provide further context to your panel size (see the panel size handbook).

22. Palliative care clients require a lot of CHC resources near the end of life. As noted in the exclusion criteria, can you clarify who is included and excluded?

Palliative care clients are excluded from the practice profile, with the exception of those receiving all care from their CHC. Due to the need for 2 full years of data retrospectively linked for the clients, they are excluded. They are excluded from the entire practice profile cohort and not just the SAMI score.

23. If clients don't have a valid HC in the EMR, are they excluded from the SAMI calculation?

All clients with a valid health care are included in the practice profile. They are excluded from the entire practice profile and not simply the SAMI score if they do not have a valid health card/non-insured. If they have a health card without a version code, they are still included.

24. Will non-insured clients be considered in the calculation of SAMI? Some centres see a high percentages of non-insured clients.

We cannot link the non-insured clients to any other data in the health system. A distinct project was completed a few years back which reviewed the (clinical) complexity for non-insured, and found that it was actually quite low. Much of the work centred on preventative and prenatal visits. With that, we understand the factors that do make uninsured clients complex, and have included the percentage of non-insured as a contextual measure in the panel size handbook.