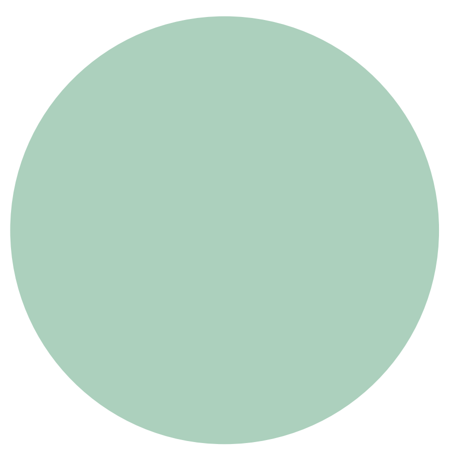
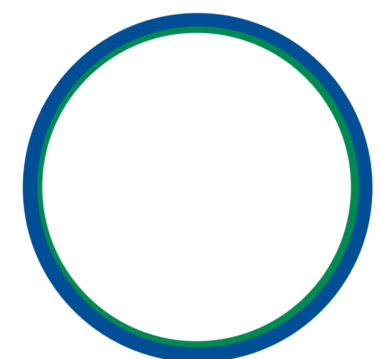
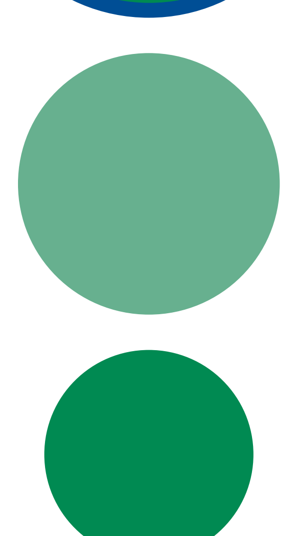




Guide to **Panel Identification**

For Alberta Primary Care

April 2014



Contents

Background 2

Introduction 3

Getting Started 4

A. Patient Focus Steps 5

A1. Identify Relationships with Each Patient 5

A2. Document Consistently in Each Patient Chart 5

A3. Book Patients to Optimize Continuity 6

B. Physician Focus Steps 6

B1. Generate Panel List for Each Physician 7

B2. Review Panel List Regularly for Each Physician 7

B3. Plan Panel-based Care with Physician and Team 8

Externally Generated Panel Reports 8

Getting Support and Resources 9

References 10

Appendix A 10 Goals of Patient Medical Home 11

Appendix B Panel Maintenance Tool 12

Appendix C Standard Demographic Data 13

Appendix D Panel Process Development Overview 14

Appendix E Externally Generated Reports 15

Notes 16

Background

Primary care organizations and partners in Alberta are committed to providing consistent and coordinated supports to primary care teams. The Guide to Panel Identification is among the first to be disseminated as part of this partnership approach by Access Improvement Measures (AIM), the Alberta College of Family Physicians (ACFP), Alberta Health Services (AHS), Alberta Medical Association (AMA), Health Quality Council of Alberta (HQCA), Physician Learning Program (PLP), Practice Management Program (PMP), Primary Care Network Program Management Office (PCN PMO), Toward Optimized Practice (TOP), and University of Alberta, Department of Family Medicine.

The College of Family Physicians of Canada (CFPC[1]) is focusing on strengthening the physician-patient relationship (relational continuity[2]) as the foundation for quality of care. Relational continuity, coupled with the optimization of multidisciplinary teams, supports excellence in clinical care delivery.

In September of 2011, CFPC described its vision for the Patient Medical Home. Ten goals were identified that characterize this new vision[1] (see Appendix A). Of these, three address the issues of panel identification, continuity and the power of the multidisciplinary team.

Patient Medical Home

Panel related goals:

- Each patient has a personal family physician, the most responsible provider for his/her medical care
- Primary providers commit to continuity of care, relationships and information for patients
- Patient care is optimized by inter-disciplinary teams for clinical services and access to care

CFPC 2011

Primary care physicians and teams require structured supports and tools to realize this vision, particularly around panel identification and management.

This document is for Alberta primary care physicians and teams who are implementing panel identification processes in their clinics to support their objectives of improved clinical care for the population they serve. It is created in partnership with organizations invested in supporting strong patient-physician/team relationships. This practical guide will assist in establishing the processes of panel identification and management within the Alberta context. It does not address the theory and evidence of attachment, panel management and continuity that is covered in *Coordinated Approach to Continuity Attachment and Panel.*[3] Nor does this document address the many opportunities to improve efficiency and effectiveness that are available once a panel has been identified. The concept of panel-based service delivery is introduced in this guide and will be more fully addressed through future resources.

Introduction

What is a Patient Panel and Why is it Important?

A patient panel, or roster, lists the unique patients that have an established relationship with a physician. There is an implicit or explicit agreement that the identified physician will provide primary care services.[4] Relational continuity (an ongoing relationship between a physician and a patient) is a key objective of establishing panel identification processes. Evidence shows that patients who consistently see the same physician use significantly fewer health care services,[5] have better outcomes and lower costs.[6-11] The higher the level of continuity between physician and patient the better the clinical care,[12] improved efficiency and patient[6,13] and physician satisfaction.

Through the steps outlined (see Figure 1 for overview), physicians will know which patients consider them to be their primary physician, and will easily be able to describe the specific characteristics of their own panel. Once established, this sets the foundation for operational and clinical care improvements customized to each physician's panel population.[14]

Panel identification is not physician work, it is teamwork

Knowing your panel is fundamental to:

- Continuity of care in general
  - Improving clinical care outcomes
  - Improving patient and physician/team satisfaction
- Establishing relationship and accountability
  - Continuity to a single primary care physician
  - Allowing for reliable follow-up
- Understanding the clinical needs for a given panel of patients
  - Planning service delivery to support pro-active panel population based care for screening, abnormal labs and chronic disease management, or responsive care due to drug recalls, guideline changes or even sudden physician events
- Achieving and maintaining access for patients
  - Measuring demand and supply within the practice to achieve balance between patient needs and physician and team ability to deliver care
- Supporting clinic level business planning and funding models
- Planning distribution of work with the physician and team, as appropriate

Leveraging the Power of Your Clinic Team

The panel identification process involves different team members at various steps. As such, involving all team roles in a working group to generate ideas, identify clear, measureable goals and develop and test changes at each step of the process, is crucial. Physician leadership and commitment to panel identification and continuity are keys to success. Early engagement and communication of the overall goals help to create alignment of objectives.

Getting Started

Knowing Your Current Panel Identification Process

Primary care is all about relationships

Your clinic may already have processes for panel identification. These may have developed over time and not been explicitly outlined. In addition, while patients may be identifiable within a panel, demographic data may be lacking or not well organized, which may result in the inability to generate panel reports that inform clinical care strategies. Clearly outlining your process will:

- Assist in identifying gaps or inconsistencies in the way steps are carried out
- Build common understanding among team members
- Identify opportunities for improvement

There are a number of process steps that are important to panel identification and are summarized in Figure 1.

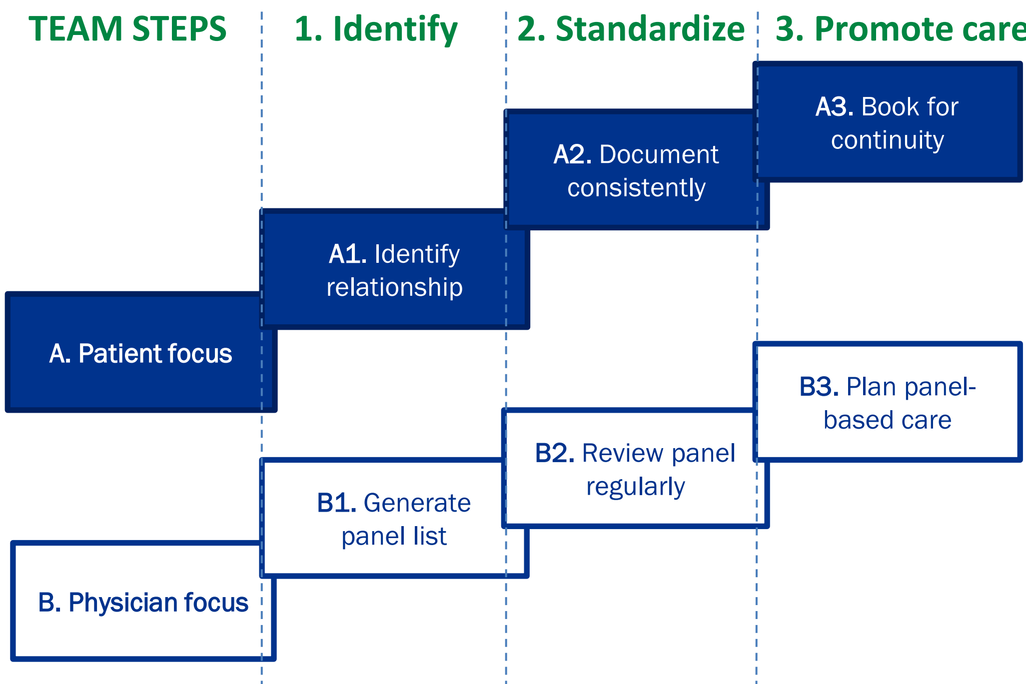


Figure 1. Overview of Panel Process Steps: This diagram illustrates panel identification and maintenance for patient continuity of care and physician panel care management.

Does Your Team Have Reliable Panel Processes in Place?

Key questions:

1. Does each patient record indicate the responsible physician?

2. Can the physician or team generate a list of the patients attached to each physician?

TIP: Many teams are surprised to discover that the answer for them is ‘sometimes’ and ‘somewhat,’ in which case this is a good time to review your steps to build in reliability.

A. Patient Focus Steps

Patients are added to a physician's panel through a mutual agreement to develop and maintain a healing relationship. As such, each team interaction with a patient should be designed to strengthen relational continuity between the patient and the physician. This is best accomplished by asking each patient who they consider to be their primary physician, documenting the information and then supporting continuity through planned scheduling.

Sample Script

Confirm the primary physician for each patient:

Hello 'Mary'

I'd just like to check our information before you go in for your appointment.

- Are you still at 123 Lane Road?
- Is your phone number 123-4567?
- I see your appointment is with Dr. Lee today. Is Dr. Lee your primary physician? (If not, who is your primary physician?)

Thank you

A1. Identify Relationship with Each Patient

Each patient visit to the clinic is an opportunity to confirm patient information, including the name of his/her physician. Best practice is to make this a routine part of the patient check-in process. This simple step builds a reliable panel list. Electronic medical records (EMRs) have a field that allows front office staff to mark when the patient's status and attachment have been verified or updated. This action stamps the chart with the date. Scanning over this field at patient check-in tells the receptionist or medical office assistant when this was last done. (See EMR Tip Sheets at the TOP website.) Patient information should be validated at minimum every six to 12 months.

A good process has well defined steps that are reliably done

A2. Document Consistently in Each Patient Chart

Assigning a patient to a physician should be documented on the chart in a standardized manner and in an agreed upon location. EMRs have a location assigned for this information and a standard location can be agreed upon and established in paper charts.

Data entry for recording the primary physician must be standardized clinic-wide

It is imperative that ALL individuals responsible for recording the primary physician within the EMR follow standard processes and procedures for data entry. This should be adopted clinic-wide and not vary by individual physician preference.

Only when information has been recorded consistently within an EMR can the information be searched reliably. If patients are recorded by status (Walk-in, Hospital, Long-term Care) you will need to identify

and exclude this field when generating panel reports in order to remove them from physician panels. Some clinics may choose to (also or instead of) create generic physicians for each category (e.g., Dr. Walk-in, Dr. Long-term Care, and Dr. Hospital). Patients assigned to generic physicians will be excluded from each true physician's panel as each of these generic physician categories will generate their own panel.

The following are examples of discrete fields from various EMRs and recommendations for how they may be utilized:

Discrete Field	Recommended Information
Primary Physician	Patient's physician at the clinic with whom they have an ongoing relationship
Secondary Physician	Secondary physician and/or a team member assigned to support patient care (e.g., Nurse Practitioner [NP], Registered Nurse [RN], Licensed Practical Nurse [LPN], medical student, resident)
Provider Group	Patient care team name
Referring Provider	Name of physician who referred patient to clinic
Family Provider	This field exists for specialist office use. For primary offices leave this field blank.

A3. Book Patients to Optimize Continuity

Alberta patients have stated a desire for an ongoing and trust-based relationship with their primary care provider or providers[5]. Continuity is strengthened by building the relationship between patients and their own identified primary care physician or multidisciplinary team members, rather than with other primary care physicians or teams. Having a defined panel assists in continuity by allowing the team to schedule patients with their chosen and identified physician. All team members have a role in communicating the importance of booking with the primary physician and team. When discussing and scheduling future visits with patients:

- Team members can indicate the specific team member appropriate for future visits
- Reception staff can prioritize scheduling with the right panel team when booking future appointments as patients are leaving clinic, or on the phone
- Physicians and team members who will be away can pre-plan coverage of specific services to maintain continuity to the team

B. Physician Focus Steps

Generating a panel list of patients requires standardized processes to ensure accuracy of information over time. EMR-based clinics can use their EMR as a database to generate the lists. Paper-based clinics also have the ability to create and maintain panel lists from either an electronic scheduler or billing data. The inherent processes are foundational to both systems. The sequence is to first learn to generate the panel report, second to review the process to identify patients who are or are not on the panel and third to use the panel report to plan care services for the patients by the physician and team.

B1. Generate Panel List for Each Physician

The patient-physician panel relationship is based on mutual agreement

Generate the panel list for each physician and team to review. In order to capture clinic or physician panels you need to input specific parameters in the system search function. Some EMRs will have predefined searches and/or "canned" reports with supporting panel information (see EMR Tip Sheet). To generate a physician panel report showing all active patients attached to a physician, you will need to identify the primary physician and indicate search parameters to only select active patients. Include demographic data (e.g., age, gender) in the search parameters to use this list for service care planning. This will also help inform the physician and team about the demand of services for these patients.

B2. Review Panel List Regularly for Each Physician

Maintaining the panel list is a team process that is recommended every six to 12 months at a minimum; some practices do it monthly. The following steps are typical at panel review meetings:

- Review the steps carried out to maintain the panel list (see Appendix B).
- Review the panel list for active and inactive patient accuracy. Flag inactive patients – ones who have not been to the clinic in three years or more – and review their status.
- Identify the inactive patients who are being kept on the list because they are part of the 'living panel' – patients who may be well and visit infrequently. You do not want to lose them when it becomes time for screening.
- Remove inactive patients who are deceased, have moved away or are receiving their primary care elsewhere.
- Review the profile of the panel. Discuss any implications for service delivery planning:
  - What are the percentages of males vs. females?
  - What are their age distributions?
  - How many patients have specific clinical diagnosis?

The Panel Maintenance Tool is provided in Appendix B to outline sample processes that should be planned as a team in order to maintain the panel list accuracy. While the tasks may seem simple, it is important that all front staff are oriented to perform them as part of their role at patient check-in and that it is done the same way by all. Managing patient panel is an everyday task and not an activity only associated with a project.

Each EMR or chart has a page where patient demographics and/or registration are stored. This may be named the client card, demographics or registration page but regardless of the name there are some commonalties amongst the EMRs. In this page it is important to manage the status of the patient and primary care physician attachment.

When the status, attachment and verification activities are complete, the information can be used to generate EMR reports by using the search or query functionality in the system. A clinic user can run reports that will produce lists of active patients by physician. More detailed searches can run these reports and add information about age, gender, problems, diagnoses or billing.

EMR Tip Sheets

Tip sheets outline steps to generate panel lists from the following EMR systems:

- Jonoke
- Microquest HealthQuest
- Telus Wolf
- QHR Accuro
- Med Access
- Telin Mediplan
- Telus PS Suite
- And more in progress!

http://www.topalbertadoctors.org/asap/resourcestools/emrkt/

B3. Plan Panel-based Care with Physician and Team

A description of the panel characteristics (e.g., age, sex, clinical diagnosis) allows for panel population-based care planning and provides valuable information to guide decision making for clinical services and priorities. Trends regarding health and disease status of the panel patients provide knowledge about the current and emerging demand for health care services.

For example, age of the panel may be the single most important factor in predicting demand for services. The team that is serving a predominantly young population may choose to emphasize programs that support reproductive health whereas an older population with chronic conditions would be well served by self-management program supports.

Externally Generated Panel Reports

Externally generated panel reports include contextual data and historic information from multiple sources outside the clinic (e.g., visits to physicians outside the practice) which provide valuable insights to both EMR and paper based clinics. It is recommended that any and all external reports be reviewed as a supplement to internally generated reports to allow for the review of health system utilization patterns.

External physician panel reports are available through specific program initiatives in Alberta (see Appendix E). They allow for the review of health system utilization patterns, which typically include:

- Continuity across primary care system
- Visits to specialists
- Visits to emergency departments
- General practitioner sensitive conditions
- Inpatient length of stay
- Detailed report information available may vary

Getting Support and Resources

The following Alberta resources are available for reference or support:

Organization	Website and Resources
ALBERTA AIM ACCESS · IMPROVEMENT · MEASURES	www.albertaaim.ca • Panel Reference Articles • Collaborative Information
Alberta College of Family Physicians	www.acfp.ca • Patient's Medical Home Resources
Alberta Health Services	www.albertahealthservices.ca
Alberta Medical Association	www.albertadoctors.org
HQCA Health Quality Council of Alberta	www.hqca.ca For HQCA Panel Report information, contact markus.lahtinen@hqca.ca
Physician Learning Program	www.albertaplp.ca
Alberta Medical Association Practice Management Program	www.albertadoctors.org/services/physicians/pmp
Primary Care Networks Program Management Office	www.albertapci.ca
TOP Toward Optimized Practice	www.topalbertadoctors.org • EMR Tip Sheets; vendor specific • QI Guide • Programs and Support • Clinical Practice Guidelines
University of Alberta Faculty of Medicine & Dentistry Department of Family Medicine	www.familymed.med.ualberta.ca

References

1. College of Family Physicians of Canada. *A vision for Canada: family practice, the patient's medical home.* Mississauga, ON: College of Family Physicians of Canada, 2011 Sep. 66 p. Available from: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf

2. Haggerty J, Reid RJ, Freeman GK, Starfield B, Adair CE, McKendry R. Continuity of care – a multidisciplinary review. British Medical Journal 2003;327:1219-21.

3. Coordinating Committee. Coordinated approach to continuity attachment and panel. Draft report. Edmonton, AB: Published by Toward Optimized Practice; 2014 Feb.

4. College of Family Physicians of Canada. Best Advice; *Patient rostering in family practice*; November 2012.

5. Cooke, T. System Level Opportunities for Panel Management in Alberta Symposium: Using Panel Management to Improve Primary Healthcare Practice and Patient Outcomes Wednesday, December 4, 2013; http://www.hqca.ca/assets/files/January%202014/Symposium%20Presentation%20Summaries.pdf

6. Van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. J Eval Clin Pract. 2010 Oct;16(5):947–56.

7. Wolinsky FD, Bentler SE, Liu L, Geweke JF, Cook EA, Obrizan M, et al. Continuity of care with a primary care physician and mortality in older adults. J Gerontol A Biol Sci Med Sci. 2010 Apr;65(4):421–8.

8. Ionescu-Ittu R, McCusker J, Ciampi A, Vadeboncoeur A-M, Roberge D, Larouche D, et al. Continuity of primary care and emergency department utilization among elderly people. CMAJ Can Med Assoc J J Assoc Medicale Can. 2007 Nov 20;177(11):1362–8.

9. Raddish M, Horn SD, Sharkey PD. Continuity of care: is it cost effective? Am J Manag Care. 1999 Jun;5(6):727–34.

10. De Maeseneer JM, De Prins L, Gosset C, Heyerick J. Provider continuity in family medicine: does it make a difference for total health care costs? Ann Fam Med. 2003 Oct;1(3):144–8.

11. Hollander MJ, Kadlec H, Hamdi R, Tessaro A. Increasing value for money in the Canadian healthcare system: new findings on the contribution of primary care services. Healthc Q. 2009;12(4):32-44.

12. Kringos DS, Boerma WG, Hutchinson A, Zee J van der, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res. 2010 Mar 13;10(1):65.

13. Adler R, Vasiliadis A, Bickell N. The relationship between continuity and patient satisfaction: a systematic review. Fam Pract. 2010 Apr;27(2):171–8.

14. Murray M, Davies M, Boushon B. Panel Size, How many patients can one doctor manage? Family practice management. 2007, April; 44-51.

Appendix A
10 Goals of Patient Medical Home

College of Family Physicians of Canada, 2011

Goal 1: A Patient's Medical Home will be patient centred.

Goal 2: A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.

Goal 3: A Patient's Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses and others.

Goal 4: A Patient's Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.

Goal 5: A Patient's Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

Goal 6: A Patient's Medical Home will provide continuity of care, relationships and information for its patients.

Goal 7: A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.

Goal 8: Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.

Goal 9: A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).

Goal 10: Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

Appendix B
Panel Maintenance Tool

This tool is designed to assist clinics in assessing or developing their current processes for maintaining their panel lists. Capture all relevant processes and improve on them by building clarity and team agreement for each process.

New Patients Added to Panel	How is this Confirmed?	How is this Documented?	Who is Responsible?
New patient phones and requests a physician.	Patient calls reception, requests a physician, and is accepted by a physician with an open panel.	Patient is assigned a primary physician in EMR field or paper chart/manual database.	Front of office admin staff.
Patient requests/receives a “Meet and Greet” appointment, but is not yet assigned.			
Unassigned patient does not belong to any panel, but has been accepted into the practice.			
Non-panel child or relative attends appointment or separate visit is generated.			
Newborn patient.			
Patients Removed from Panel	**How is this Confirmed?**	**How is this Documented?**	**Who is Responsible?**
Patient deceased.			
Patient moved away, has stated ended relationship with clinic.			
Patient moved away for extended period, but intends to return to community (e.g., university/college, mission).			
Lapsed patient: has not attended clinic in 36 months (or other specified time period).			
Orphaned patient: physician leaves the clinic, resulting in unassigned panel.			
Patient belongs to a physician panel, but is seen by other physician more frequently.			
Diagnostic Imaging visit: non-clinic patients.			
Emergency Department/”O/P” visits: Non-panel patients.			
Patients Seen, Not Added to Panel	**How is this Confirmed?**	**How is this Documented?**	**Who is Responsible?**
Walk-in patient: has a primary physician in another clinic in region.			
Transient patient: has a primary physician in a clinic outside of region.			
Specialty care (seen for specialized services, not accepted to panel).			
Other			

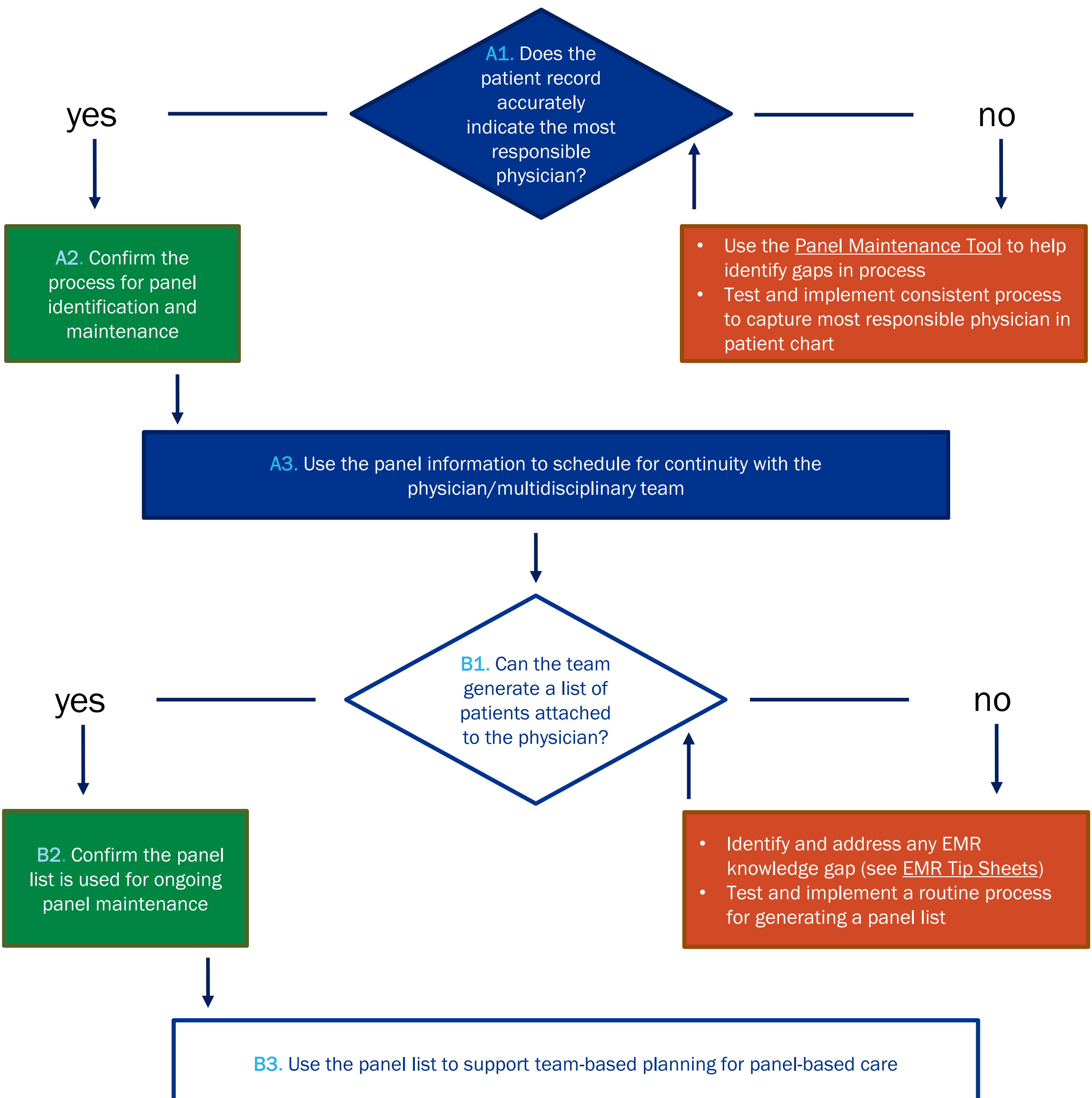
This tool is adapted from Chinook Primary Care Network Clinic Panel Management Process Assessment. We gratefully acknowledge their contribution.

Appendix C
Standard Demographic Data

The table below outlines standard demographic data which should be entered into the EMR and which will support effective panel management. In addition, the table outlines a suggested approach for verifying the data and suggested frequency of verification. The best approach and process for achieving ongoing data integrity will be determined on an individual clinic basis.

Demographic Data	Purpose	Verification Approach	Suggested Frequency of Verification
Name	To identify patient name.	Picture ID for new patients	Verbal each time patient presents
Personal Health Number (PHN)	Unique identifier. Required for billing.	Present Personal Health Care (PHC) Card	Annually
Date of Birth (DOB)	Required for billing. Required for identifying age of patients for generating age-specific reports/rules/etc. within EMR.	Picture ID for new patients	New patients and annually with PHC card
Gender	Required for billing. Required for identifying gender of patients for generating gender-specific reports/rules/etc. within EMR.	Picture ID for new patients	New patients and annually with PHC card
Primary Physician	Required for establishing patient attachment to a primary physician.	Look up in EMR to ensure attachment	Each time patient presents
Telephone	Primary contact method.	Verbal	Each time patient presents
Address	Secondary contact method.	Verbal	Each time patients presents
Patient Status — Inactive	To track inactive patient statuses (e.g., deceased, left practice, etc.). Reduces unnecessary patient follow-up (e.g., patient does not get identified for specific screening and prevention maneuvers).	As identified	As identified
Patient Status — Walk-in	Walk-in patients are not to be included as part of the physician panel and should be identified as such in the EMR to avoid unnecessary patient follow-up.	Look up in EMR to ensure properly identified	Each time patient presents
Patient Status — Patient seen outside the clinic	Patient seen outside the clinic (e.g., hospital patients or long-term care patients) may have lab results returned to clinic. These patients are not to be included as part of the physician panel and should be identified as such in the EMR to avoid unnecessary patient follow-up.	Look up in EMR to ensure properly identified	Each time patient presents

Appendix D
Panel Process Development Overview



Appendix E
Externally Generated Reports

In Alberta it is possible to obtain panel reports generated from organizations external to the primary care practice. The two most common are from Alberta Health and the Health Quality Council of Alberta, and an overview of each is provided below. It should be noted that other groups, such as cancer screening registries, may also provide panel specific information to primary care groups who are reviewing their practice patterns and working on improving care for their patients.

Comparison of physician panel reports in Alberta

	Alberta Health Physician Panel Report	**Health Quality Council of Alberta**
How are reports made available?	Participants of AIM Special group project requests	Participants of Alberta Screening and Prevention Initiative (ASaP) Special PCN initiative requests
Can reports be generated based on a validated patient list (VPL)?	Reports are generated based on the 4-cut proxy method.	Yes, with appropriate privacy documentation in place, as set out by specific program initiatives.
How are proxy panel reports generated? Individuals can be assigned to a general practitioner (GP), NP, or pediatrician using the steps outlined. The assignments are based on the past three years of visits based on all health services provided in all health facilities.	Based on a proxy panel list using the 4-cut method. 1. Single provider – if an individual has only seen one provider, they are assigned to that provider. 2. Majority provider – if an individual has seen more than one provider, but one was seen for the majority of visits, they are assigned to that provider. 3. Last physical – if an individual has seen multiple providers the same number of times, they are assigned to the one who did the last physical. 4. If an individual has seen multiple providers the same number of times and not had a physical, they are assigned to the provider they saw last.	Based on a proxy panel list using the HQCA Panel Selection Algorithm.* 1. Single provider - if an individual only saw one physician, they are assigned to that provider. Remaining patients are assigned to a clinical risk grouper for the next steps. 2. Frequency of procedures codes – looks at 11 common procedure codes. 3. Frequency of diagnostic codes – looks at 10 diagnostic codes. 4. Frequency of visits, excluding certain codes that are not strong predictors of primary physician. 5. Looks at frequency of all visits, including the codes excluded in step 4. 6. This looks at the most recent physician visited by an individual.
What information is provided in the physician panel report?	Panel characteristics (including degree of attachment)	Panel characteristics (including degree of attachment) Chronic conditions and frequent diagnoses • Healthcare service utilization • GP visits • Special visits • Emergency department (ED) visits • Hospitalizations
*The HQCA algorithm was developed using a set of validated patient panels as a gold standard. It is hierarchical and applies steps in order of reliability. Full documentation is available upon request. HQCA's panel report program is presently under review.		

It is important to note that proxy panels such as those generated by the 4-cut or HQCA method are not equivalent to the more robust panels that are the objective of this document. Proxy panels may be useful for analytical purposes or to estimate per capita funding, but are not sufficient to achieve the potential benefits of effective panel management.

Notes

Notes

This Guide was developed through input and feedback from the organizations listed as well as primary care team members across Alberta. We thank each person for their valuable input.

This Guide will continue to be updated regularly to keep up with the Alberta context. To ensure you have the most current version, please visit the website of one of the partner organizations listed in ‘Getting Support and Resources’ on Page 9 of this Guide. This version was released April 1, 2014.

For questions about this Guide, or recommendations for future versions, please contact top@topalbertadoctors.org