HSPRN
health system performance research network

Primary Care Physician Groups in Ontario.

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Outline

- Background
- What the team has learned
- Capitation payments
- Current and future projects

Background: Primary Care Challenges

- human resource shortages and maldistribution
- unattractiveness to trainees of a primary care career
- provider and patient dissatisfaction
- gap between guideline-recommended care and actual provision
- 4 million people do not have a family physician
- > 2 million report difficulties accessing routine care and immediate care for a minor health problem
- ~ 5% of the population of southwestern Ontario requires an FP.

Bodenheimer 2006; Statistics Canada 2007; Health Council of Canada 2006; Stewart 2010

Background: Patient Enrolment Models

- Family Health Network (FHN)
- Family Health Organization (FHO)
- Family Health Group (FHG)
- Family Health Team (FHT)

Background: Common Elements

- physicians work in groups
- enroll patients (8.8 million Ontarians)
- after-hours clinic and call requirements
- retention bonuses/penalties
- pay-for-performance
  - diabetes, mental health, heart failure, smoking cessation
  - preventive care (but only if >650 patients enrolled)

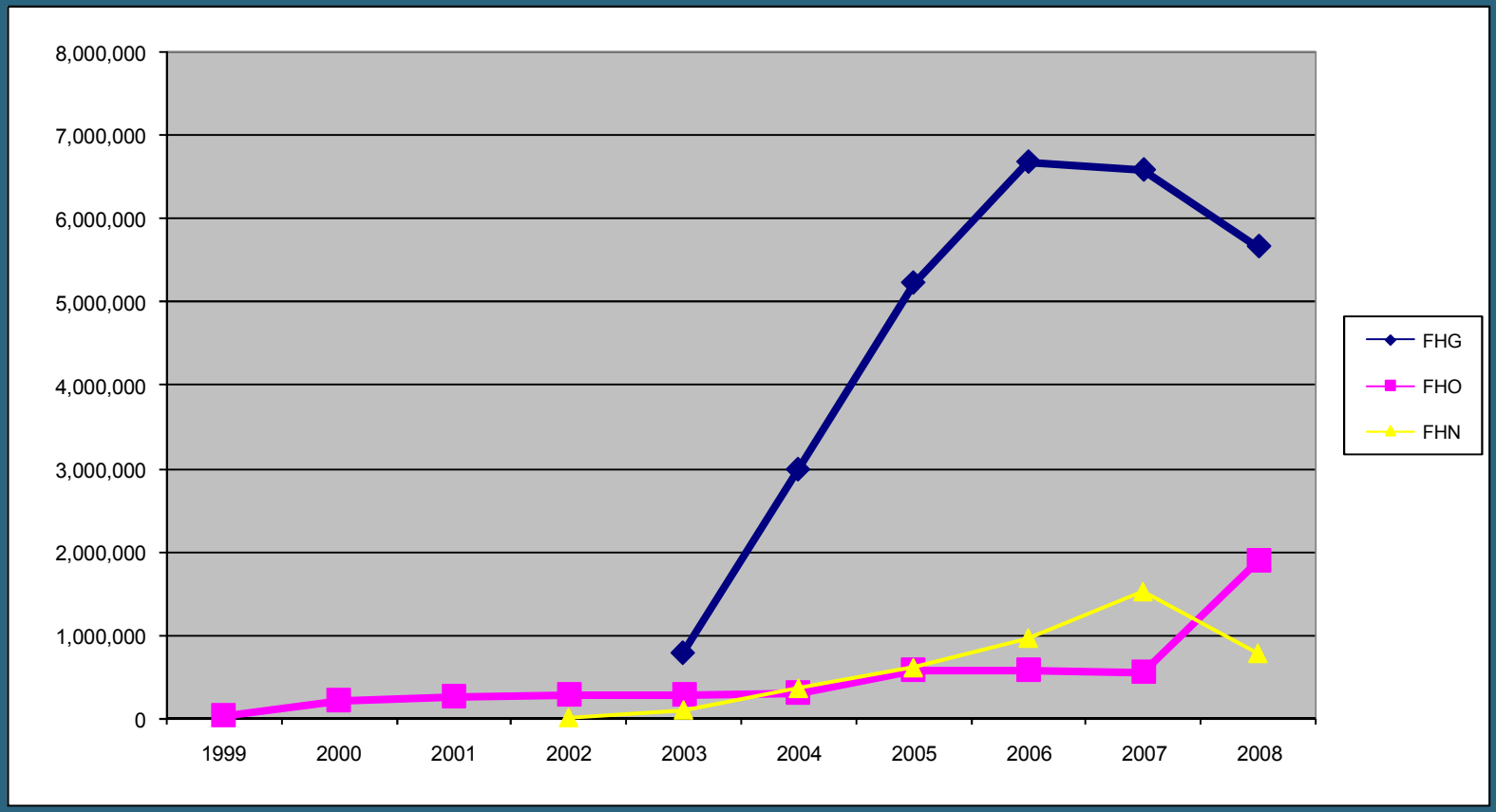
Background: Model Types

- Enhanced fee-for-service (FFS)
  - FHG began in 2003, capitation element ($2/person/month)
  - 100% FFS
  - largest model
- Capitation
  - older – HSO, PCN
  - newer – FHN in 2002, FHO in 2005
  - primarily capitation eg $140/person/year
  - age-sex adjustment but not health status
  - 10% shadow billing
- Team
  - FHT in 2005, now 150 teams
  - multidisciplinary teams
  - doctors required to be on capitation or salary

Goals/Objectives:

- Attract physicians to family medicine
- Enroll “unattached” patients
- Offer convenient hours
- Provide non-emergency urgent care
- Align care with guidelines
- Increase screening and disease prevention

Patient Rostering by Model by Year 1999-2008

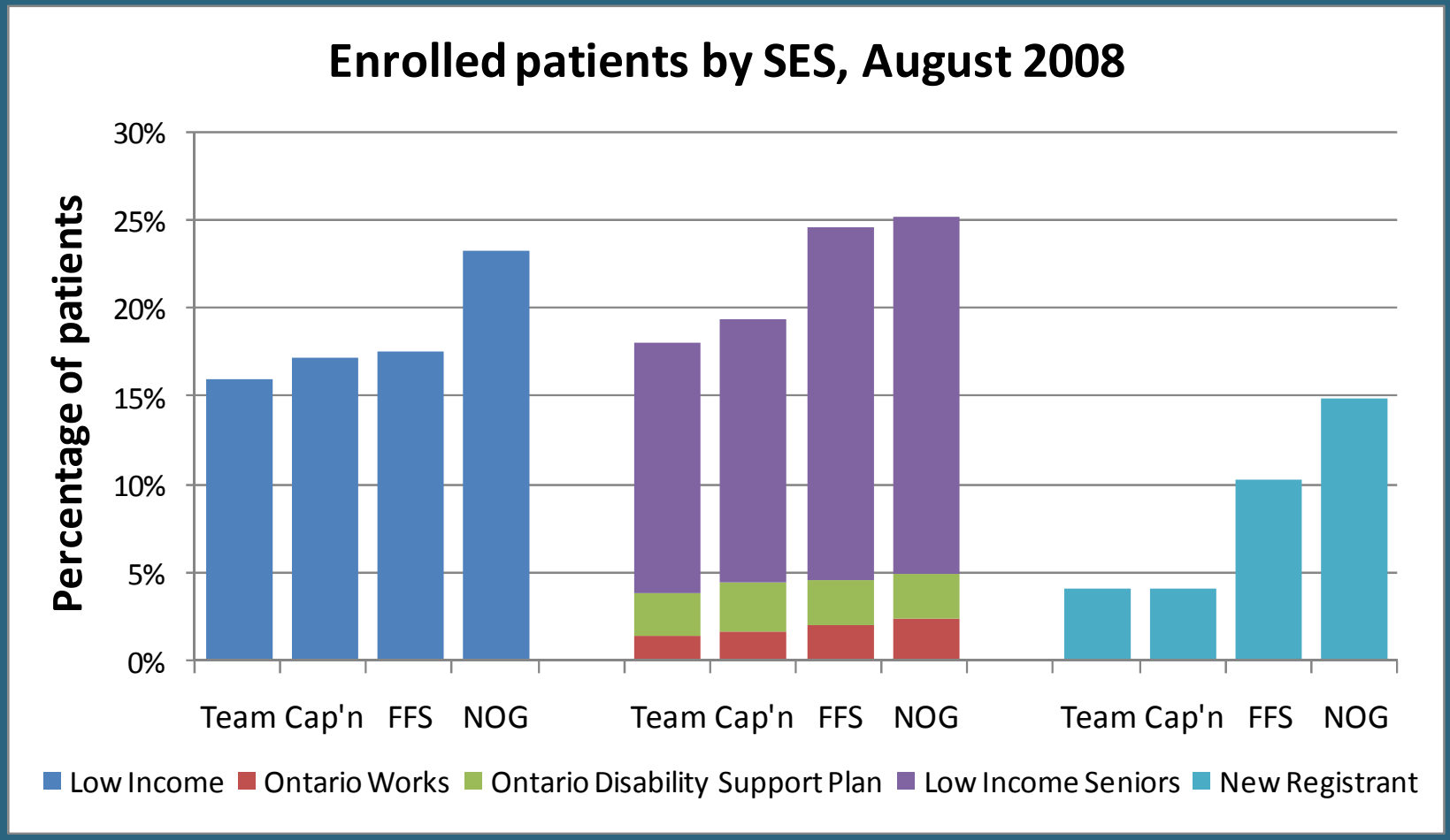


What we have learned: FHNs vs FHGs

- FHNs
  - Healthier patients (lower levels of chronic disease, morbidity and co-morbidity than FHGs)
  - less after-hours care (32% lower)*
  - higher ED visit rates (20% higher)*
- Both FHNs and FHGs
  - fewer low SES patients and more high SES patients than their communities (rural FHNs only exception)

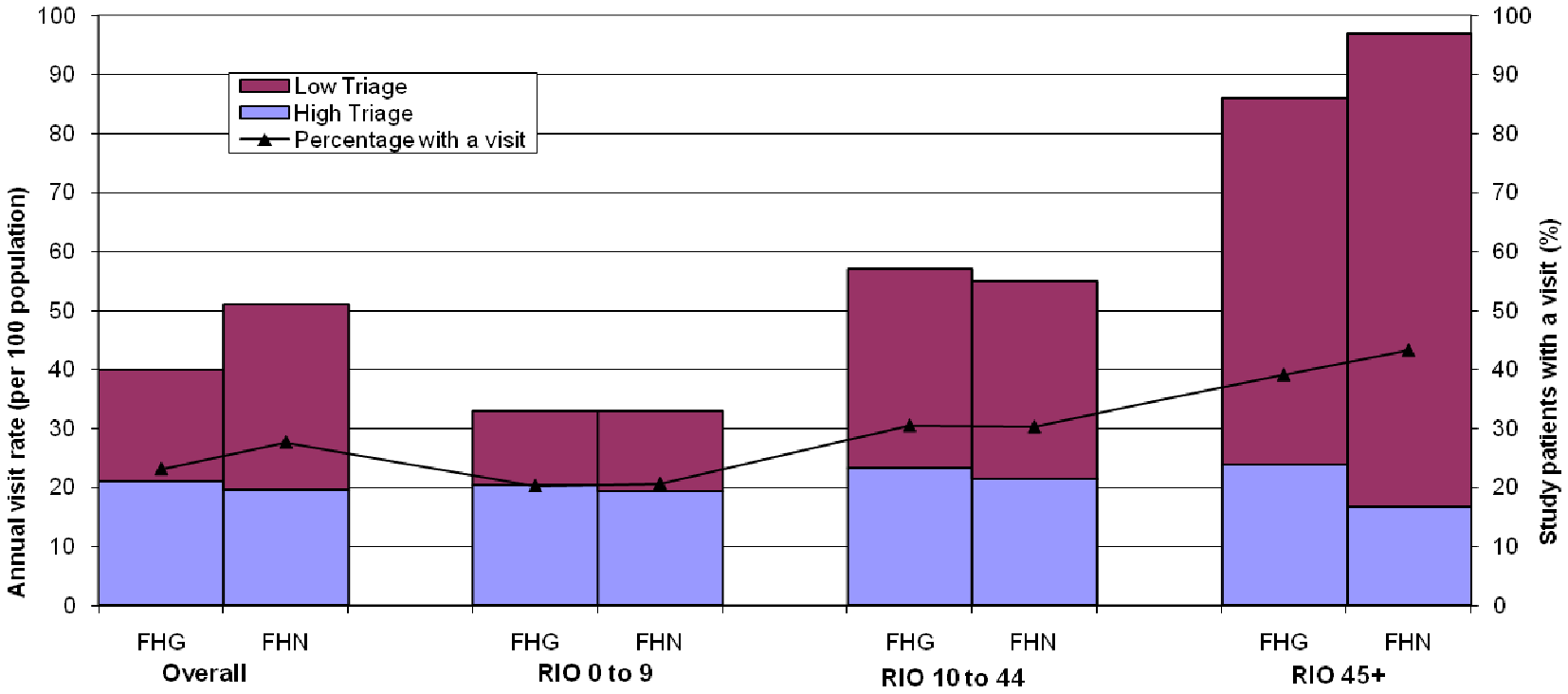
*after controlling for urban-rural, provider and patient characteristics

What we have learned: Socioeconomic Status



What we have learned: Rural vs. Urban

High and low triage* visits per 100 population and percentage of study patients with an emergency department visit during the year of study, by RIO band and group type.



*Triage categories, according to the Canadian Emergency Department Triage and Acuity Scale (CTAS), of 4 and 5 (semi-urgent and non-urgent, respectively)

What we have learned: Performance After vs Before

- Few FHN vs FHG differences
- No major changes
  - Pap smears, mammograms, heart failure, asthma, low back pain
- Improvements
  - colorectal cancer screening in FHNs and FHGs, greatest increase in FOBT in FHNs
  - diabetes prescribing
- Worsening
  - diabetes eye exams in younger patients (-50%)

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Evaluation of Age-sex Adjusted Capitation Payments

leveraging the culture of performance excellence in health systems

Incentives

- Fee-for-service -- have many visits
  hazard: induce demand
- Capitation – have many patients
  hazard: cream skim and underservice

Research Question

- Do age-sex adjusted capitation rates account for the higher level of morbidity associated with lower socioeconomic status?

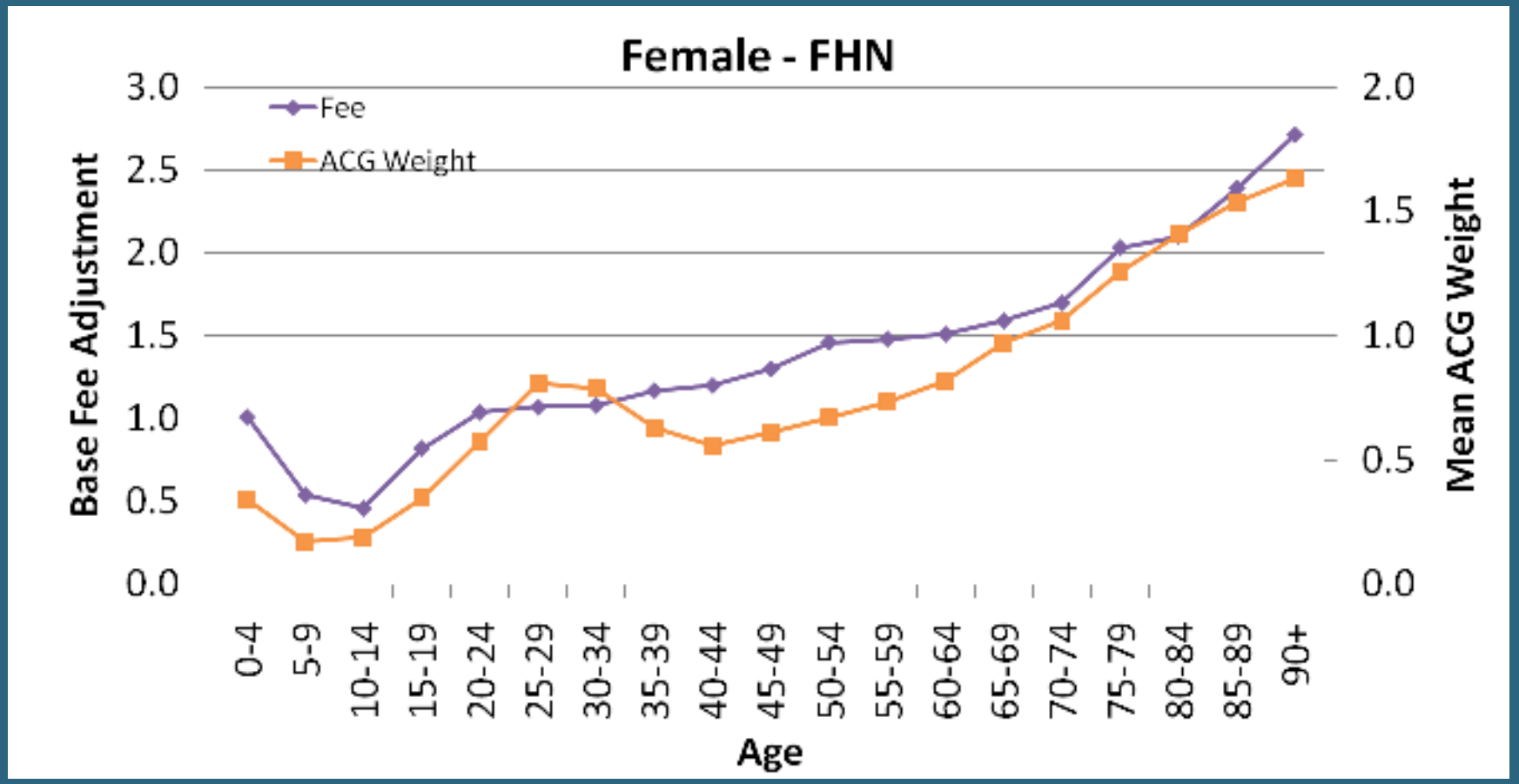
Methods: Study Sample

- Family Health Networks (FHNs)
- September 1, 2005 to August 31, 2006
- ≥ 3 physicians
- Patients who were continuously enrolled
- Administrative data

Methods: Variables

- Socioeconomic status
- Age-sex adjustment index
- Morbidity burden
  - Johns Hopkins University Adjusted Clinical Groups (ACG) Case-Mix System
  - ACG Weights

Results: Capitation fee vs. Sample ACG Weight



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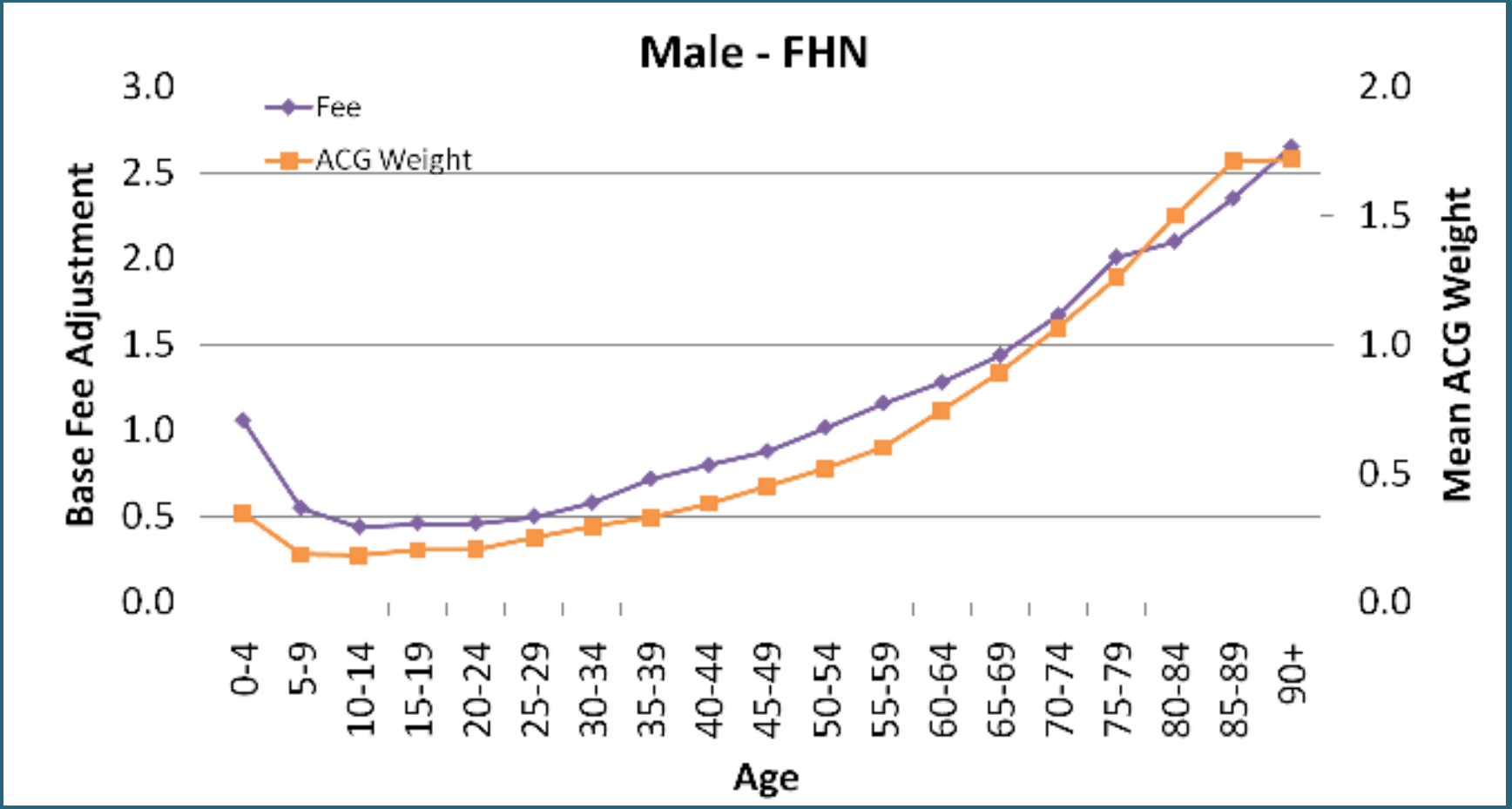
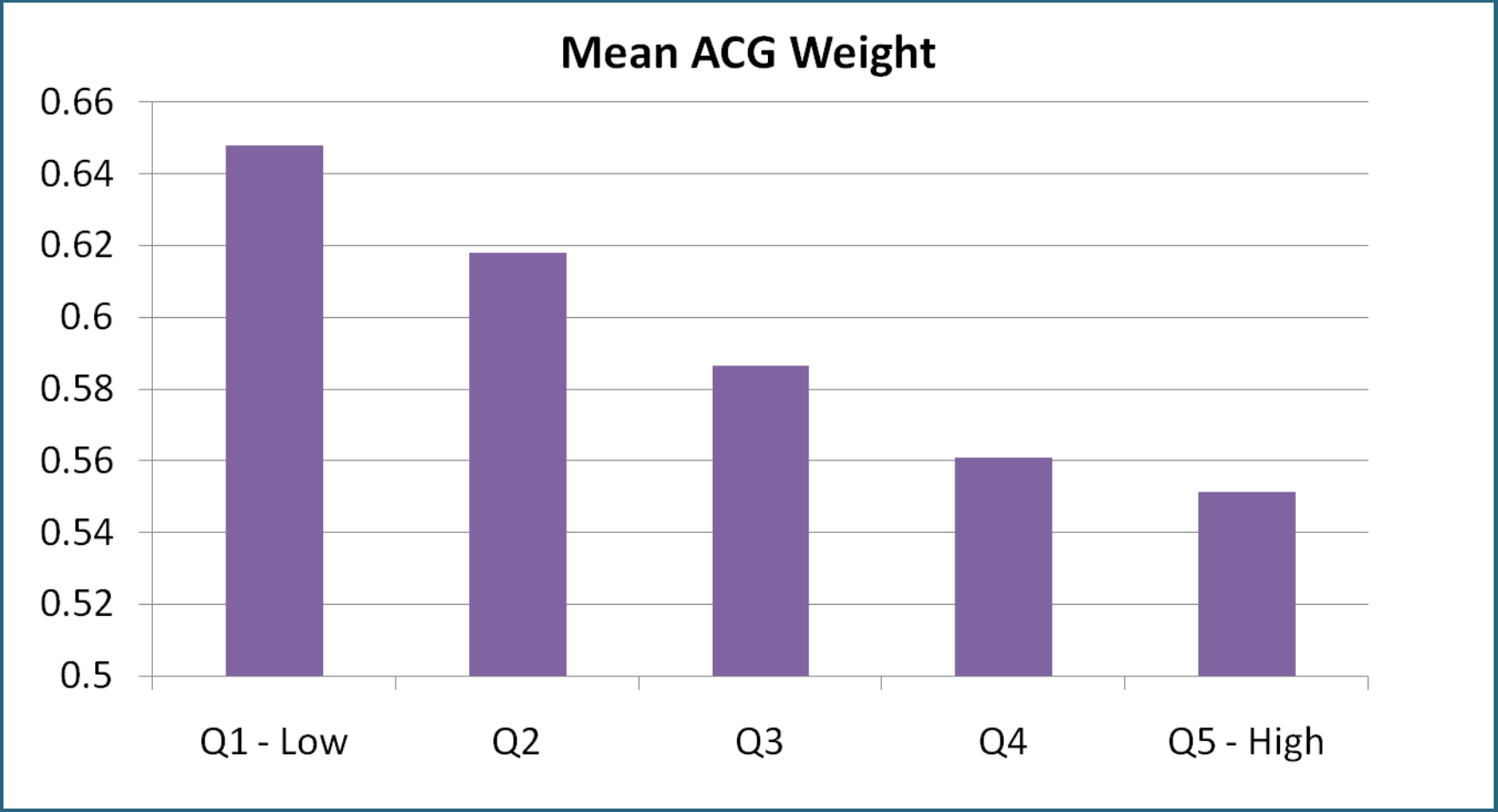
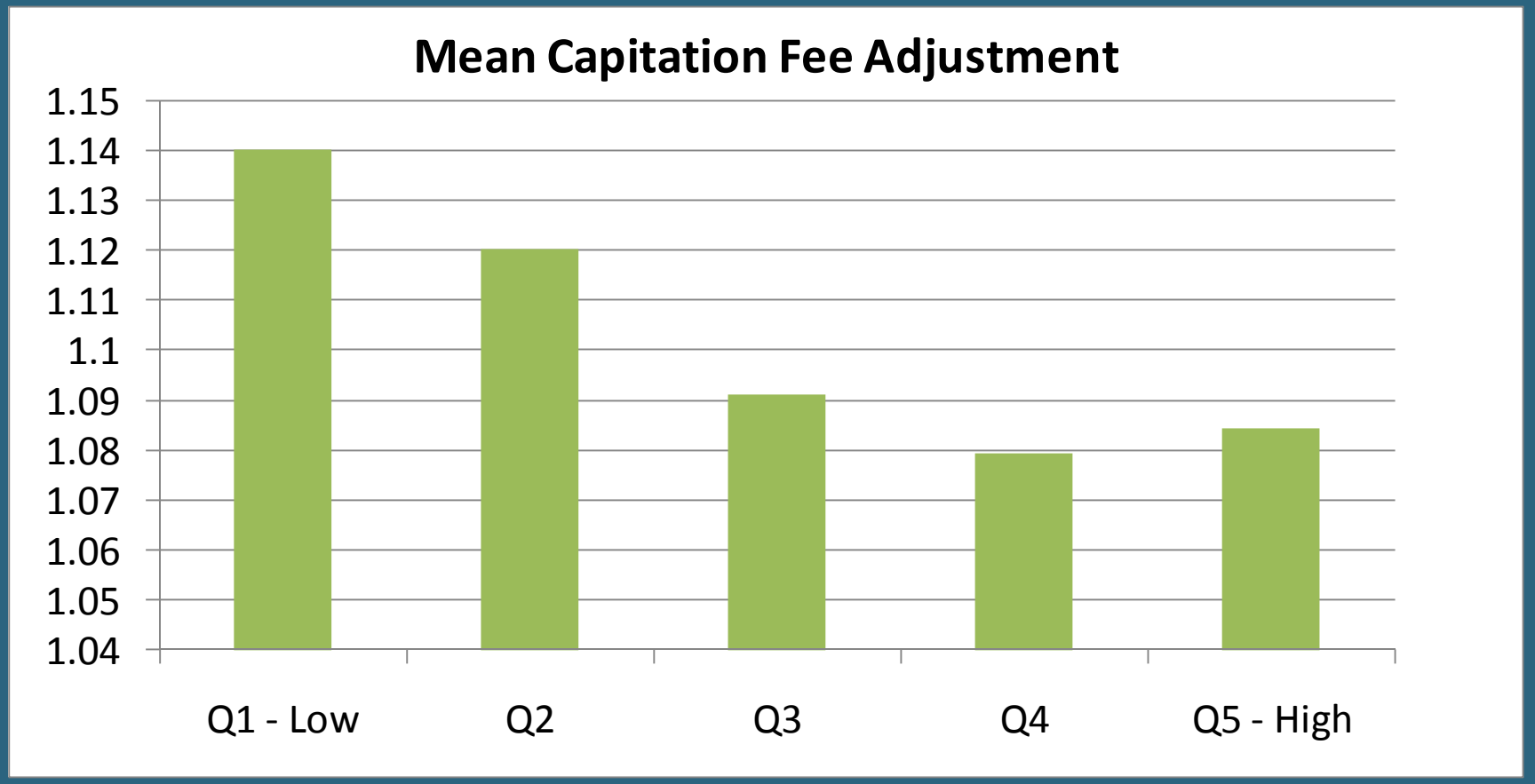


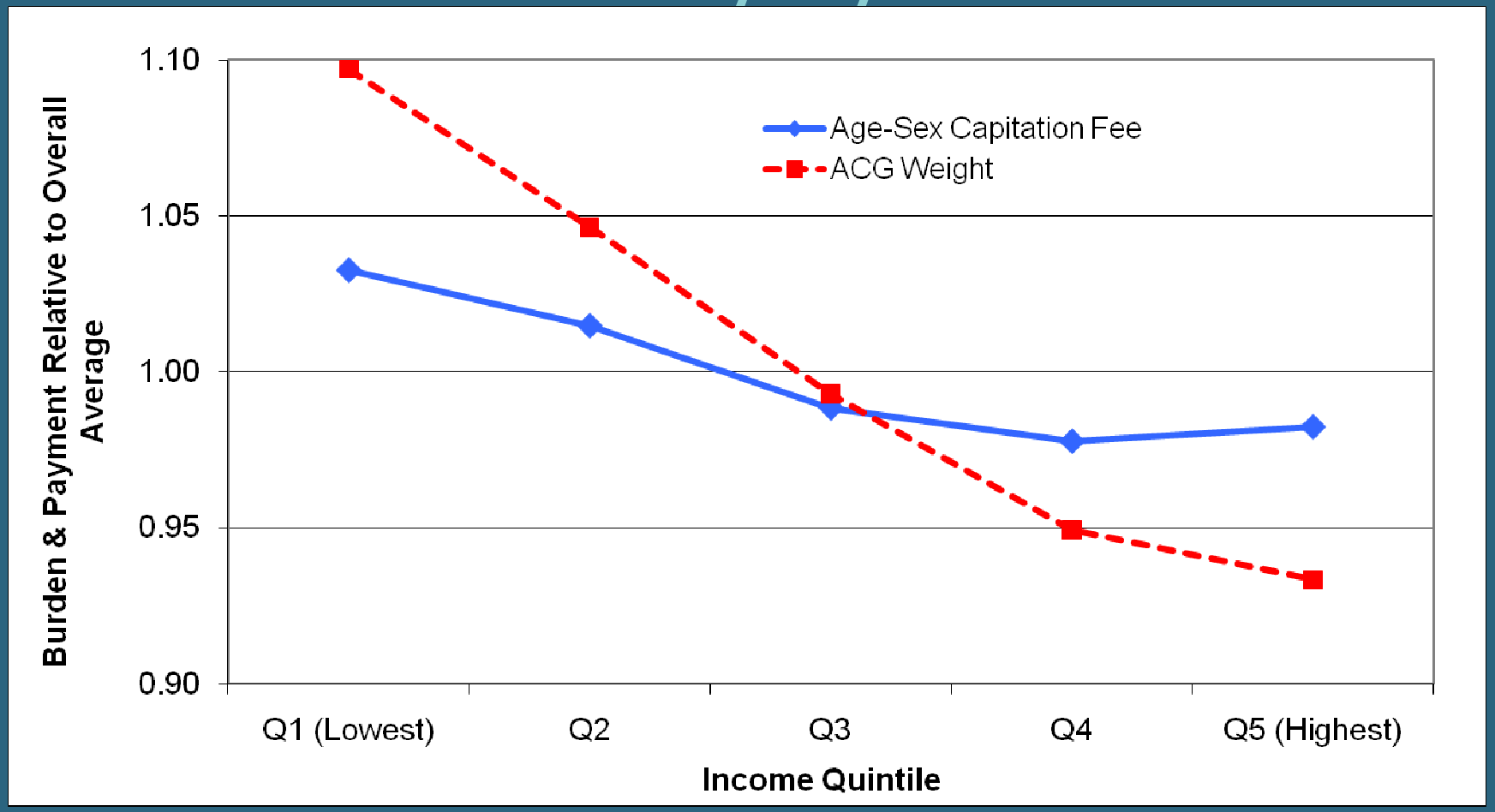
Results: Morbidity by SES



Results: Capitation Index by SES



Results: Capitation Fee and Morbidity by SES



Conclusion

- Capitation rates take into account some of the variation in morbidity burden associated with SES.
- The physician reimbursement system in FHNs do not take into account all of the variation associated with socioeconomic status.

Implications

- There is a risk that adjusting capitation rates for age and sex alone introduces an incentive to preferentially enrol patients with higher socioeconomic status.
- This policy may also incentivise physicians to practice in areas where residents have higher socioeconomic status.

Current Projects

- Calibrate ACGs to Ontario data
- Evaluate and recommend method for risk-adjusting capitation payments in Ontario

Future Work

- Assess performance measures of “over-” and “under-paid” primary care physicians
- Determine “needs-based” rather than “utilization-based” ACG weights
- Evaluate the return on investment of Primary Care Reform in Ontario.

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