Taking the Pulse of Primary Health Care Reform

Rethinking the way we do business: Template for the future

Focus on Payment Reform and Teams

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Faculty/Presenter Disclosure

Faculty: Rick Glazier

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- Consulting Fees: none
- Other: none

How We Pay for Health Care

<u>hospitals</u>
global budget

<u>long-term care</u>
number of beds

<u>doctors</u>
FFS

} Paid from separate budgets

Primary care physicians

- few accountabilities
- weak measurement
- few networks
- little governance
- not many teams
- mostly FFS
- groups and solo

→ few connections, perilous transitions
→ little support for care coordination

Primary Care Payment

- Physician payment negotiated
  - provincial Ministry and medical association
  - needs physician ratification
  - few agree to decreased fees, change in relativity
  - few changes can be made
  - large changes must be bought

- Payment reform commonly used as a tool to invest in primary care

Why Change is Needed

"Burning Platform is a business lexicon that emphasizes immediate and radical change due to dire circumstances."

http://www.problem-solving-techniques.com/Burning-Platform.html

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Primary Care Transformation

TABLE 1
System-level Primary Health Care Initiatives

		BC[a]	AB[b]	SK[c]	MB[d]	ON[e]	QC[f]	NB[g]	PE[h]	NS[i]	NL[j]	NT[k]	YT[l]	NU[m]
Inter-professional teams			+			+	+							
Group practices/networks			+			+	+							
Patient enrollment			+			+	+							
Payment/incentive schemes		+	+		+	+	+					+		
Governance		+					+							
Additional providers	FPs[n]	+	+		+	+	+	+	+	+	+		+	+
	Other		+			+	+							
EMR Implementation[o]		39%	56%	28%	35%	40%	20%	30%	13%	40%	47%	65%[p]	ND	ND
Quality improvement support		+	+	+		+								

Hutchison B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. Milbank Q. 2011;89(2):256-88. doi: 10.1111/j.1468-0009.2011.00628.x.

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Payment/incentive schemes		+	+		+	+	+					+		
Governance		+					+							
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	Other		+			+	+							
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Canadian Payment Reforms

FFS remains dominant

- B.C. chronic disease payments
- Alberta networks (PC, SCN), new staff, capitation pilots
- Ontario enrolment, capitation, teams, P4P
- Quebec groups with nurses, registration
- Others expanded roles, a few models, efforts to tweak FFS

Ontario's Large-Scale Experiment

EXHIBIT 1

Primary Care Organizational And Funding Models In Ontario

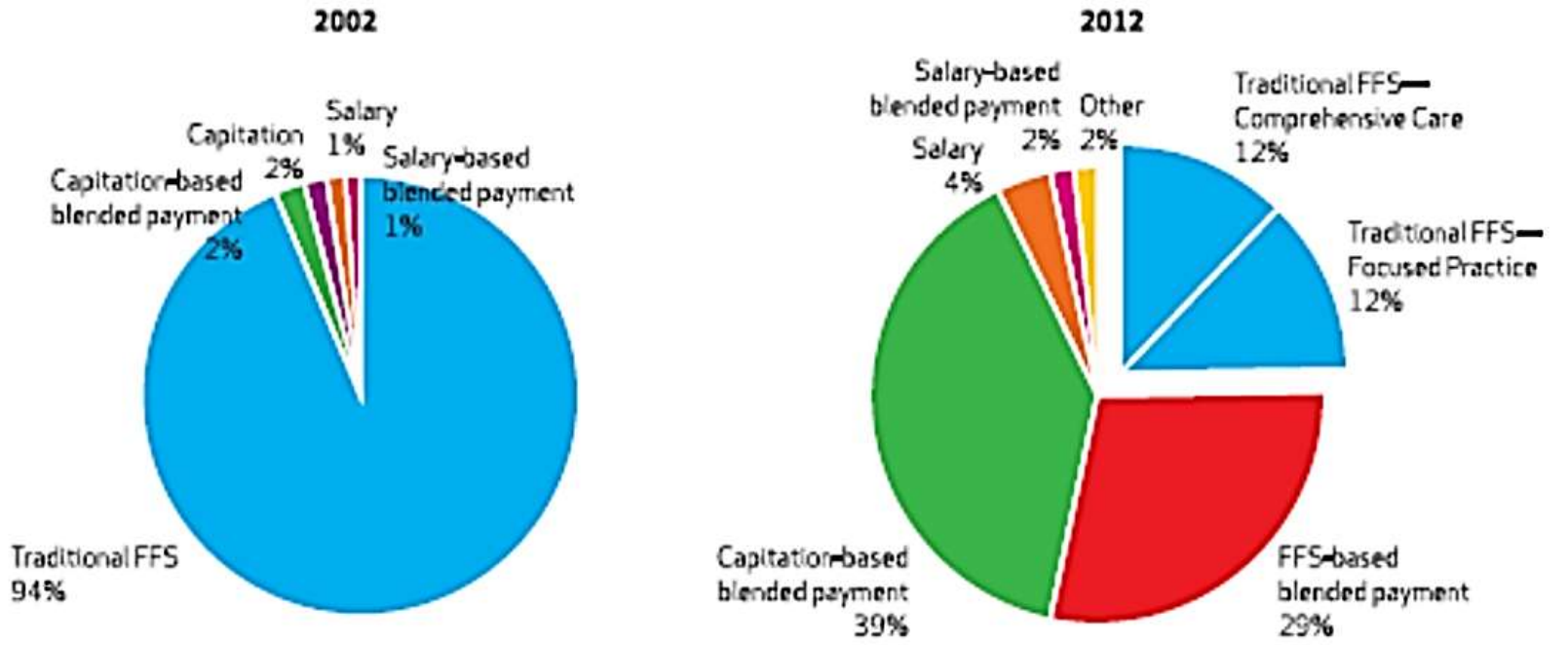
Characteristic	Model (year introduced)						
	Community Health Centre (1979)	Family Health Network (2002)	Family Health Group (2003)	Rural and Northern Physician Group Agreement (2004)	Comprehensive Care Model (2005)	Family Health Team (2005)	Family Health Organization[a] (2007)
Physician reimbursement	Salary	Blended capitation	Blended fee-for-service	Blended salary	Blended fee-for-service	Blended capitation or blended salary	Blended capitation
Targeted financial incentives	No	Yes	Yes	Yes	Yes	Yes	Yes
Formal patient enrollment	No	Yes	Yes	Yes	Yes	Yes	Yes
Minimum group size (physicians)	None	3	3	1	1	3	3
Governance	Community board	Physician-led	Physician-led	Physician-led	Physician-led	Physician-led, community board, or mixed	Physician-led
Interprofessional team members	Yes	Limited	Limited	No	No	Yes	Limited
After-hours care requirements	Yes	Yes	Yes	Yes	Optional	Yes	Yes

Hutchison B, Glazier RH. Health Affairs 2013:32:695-703

Transformation in Physician Payment

EXHIBIT 2

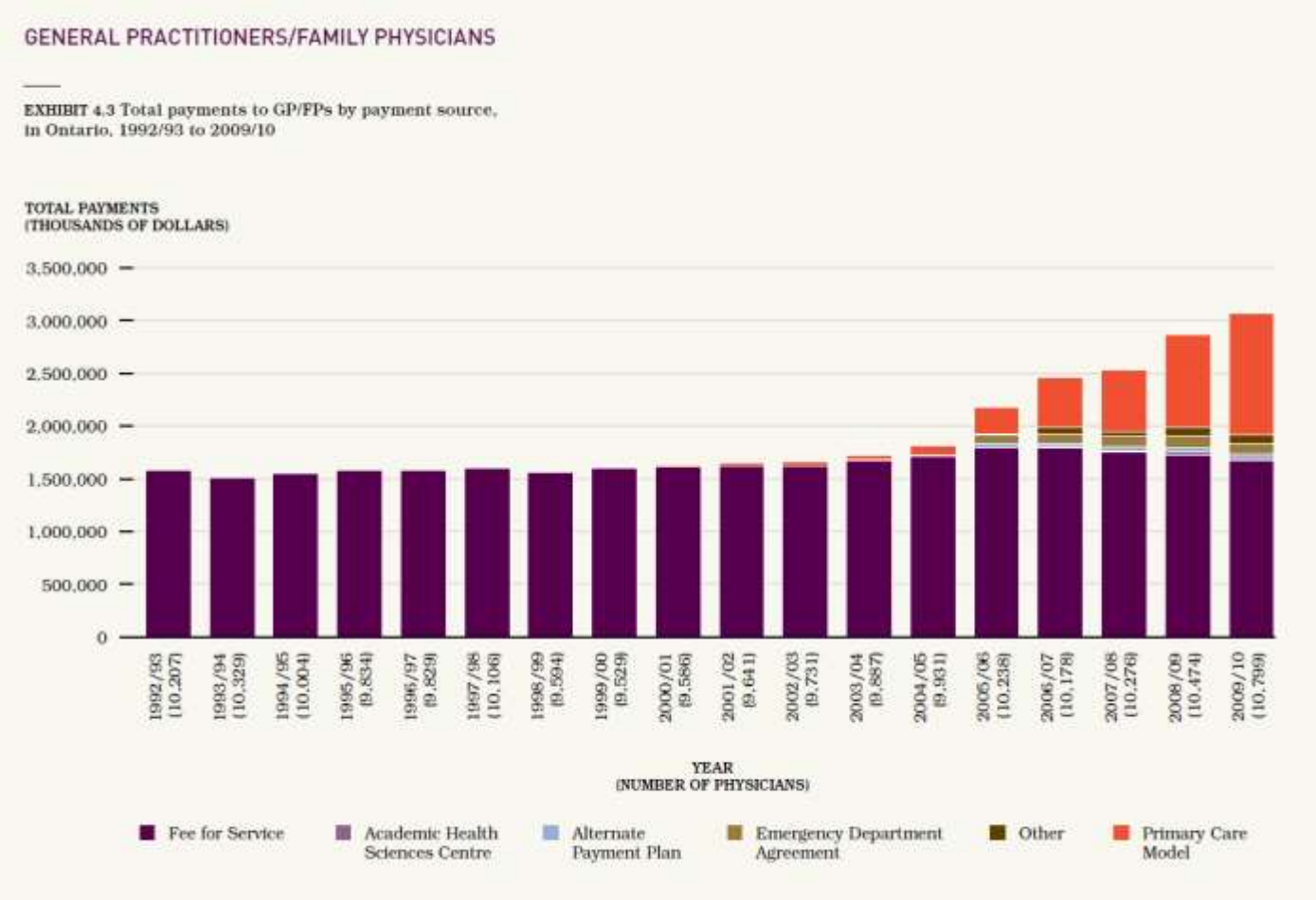
Distribution Of Ontario Family Physicians, By Payment Model, 2002 And 2012



SOURCES Ontario Ministry of Health and Long-Term Care and Institute for Clinical Evaluative Sciences. **NOTE** FFS is fee-for-service.

Hutchison B, Glazier R. Health Affairs 2013;32:1-9

Payments


GENERAL PRACTITIONERS/FAMILY PHYSICIANS
EXHIBIT 4.3 Total payments to GP/FPs by payment source, in Ontario, 1992/93 to 2009/10
TOTAL PAYMENTS (THOUSANDS OF DOLLARS)
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
1992/93 (10,207)
1993/94 (10,329)
1994/95 (10,004)
1995/96 (9,834)
1996/97 (9,829)
1997/98 (10,106)
1998/99 (9,594)
1999/00 (9,529)
2000/01 (9,586)
2001/02 (9,641)
2002/03 (9,731)
2003/04 (9,887)
2004/05 (9,931)
2005/06 (10,238)
2006/07 (10,178)
2007/08 (10,276)
2008/09 (10,474)
2009/10 (10,799)
YEAR (NUMBER OF PHYSICIANS)
Fee for Service
Academic Health Sciences Centre
Alternate Payment Plan
Emergency Department Agreement
Other
Primary Care Model

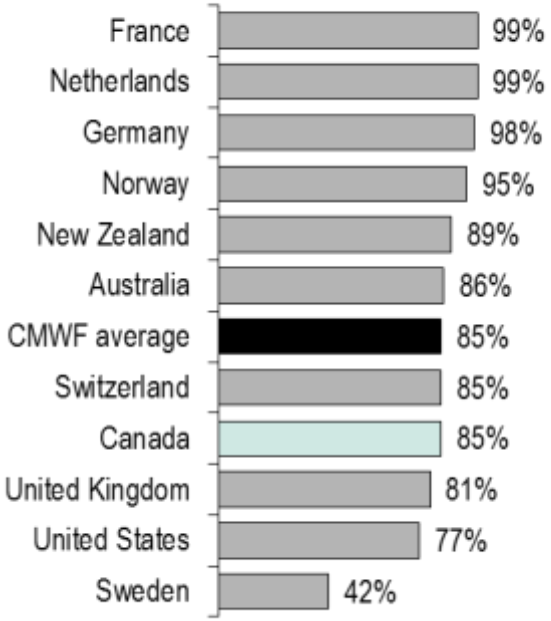
Successes

- Higher payment
    - FPs did not fall farther behind specialists
- Medical student choice of primary care
    - Canada-wide improvement
- More diverse and expanded roles
- High attachment
- Excellent patient experience

Most Canadians have a regular doctor or place where they receive care

Is there one doctor you usually go to for your medical care?

How does Canada compare (2016)?



85% of Canadians have a usual **doctor**

93% of Canadians have a usual **doctor** or **place** they go to for medical care

Above average Same as average Below average

2016 Commonwealth Fund Survey

Provinces vary when it comes to perceptions of the health care system

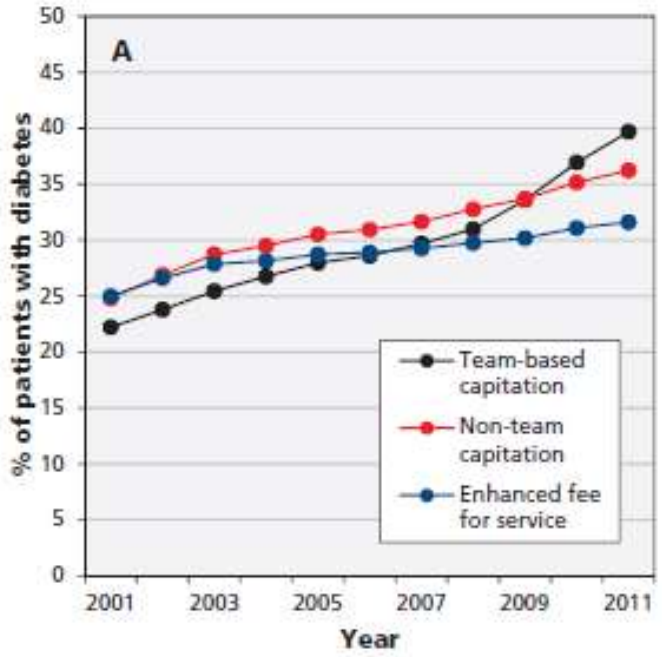
	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Can.	CMWF avg.
Is there one doctor you usually go to for your medical care?	85%	92%	85%	88%	75%	92%	83%	79%	84%	83%	85%	85%
Overall, how do you rate the medical care that you have received in the past 12 months from your regular doctor's practice or clinic? *(Excellent/very good)*	76%	77%	78%	76%	66%	76%	75%	75%	78%	77%	74%	65%

Above average Same as average Below average

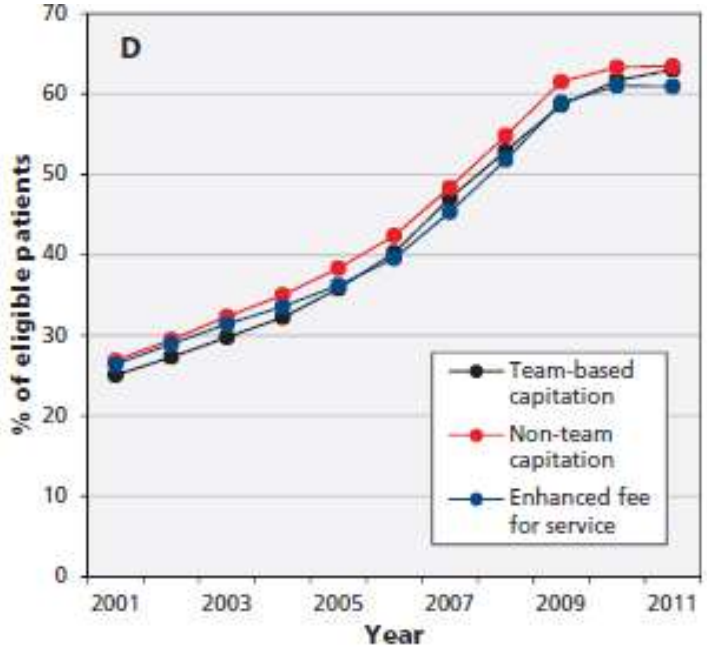
2016 Commonwealth Fund Survey

Successes of the Ontario Transformation

Diabetes processes of care screening



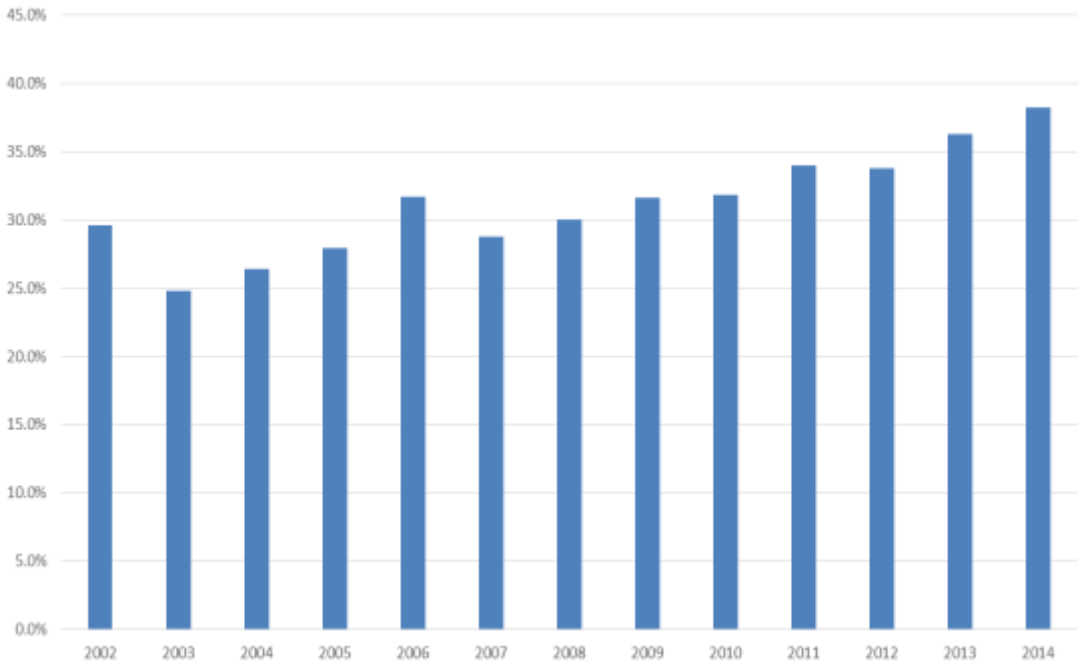
Colorectal cancer



Kiran T et al CMAJ 2015

Successes of the Transformation (Canada)

Medical student choice for family medicine



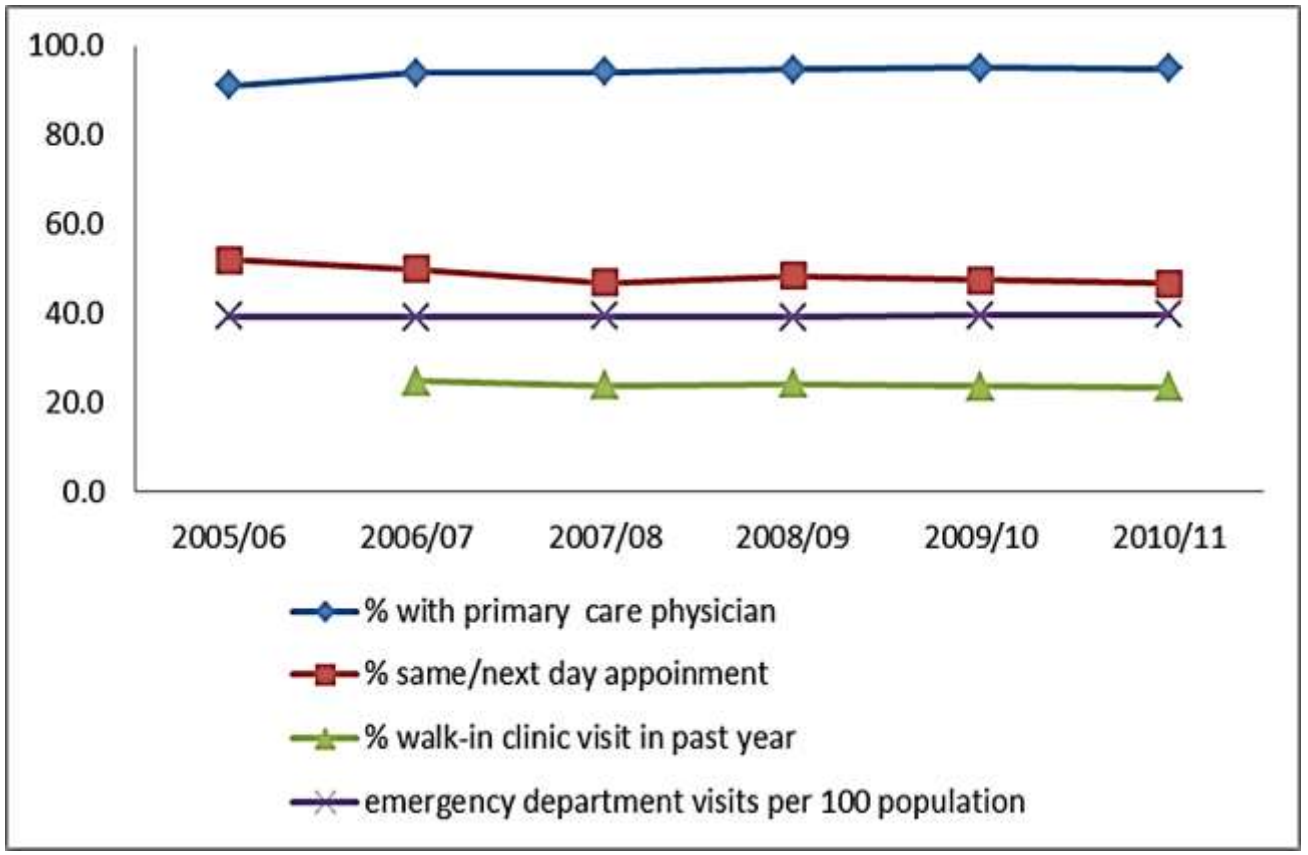
Canadian Resident Matching Service

Ontario Payment Reform Challenges

Devil in the Details

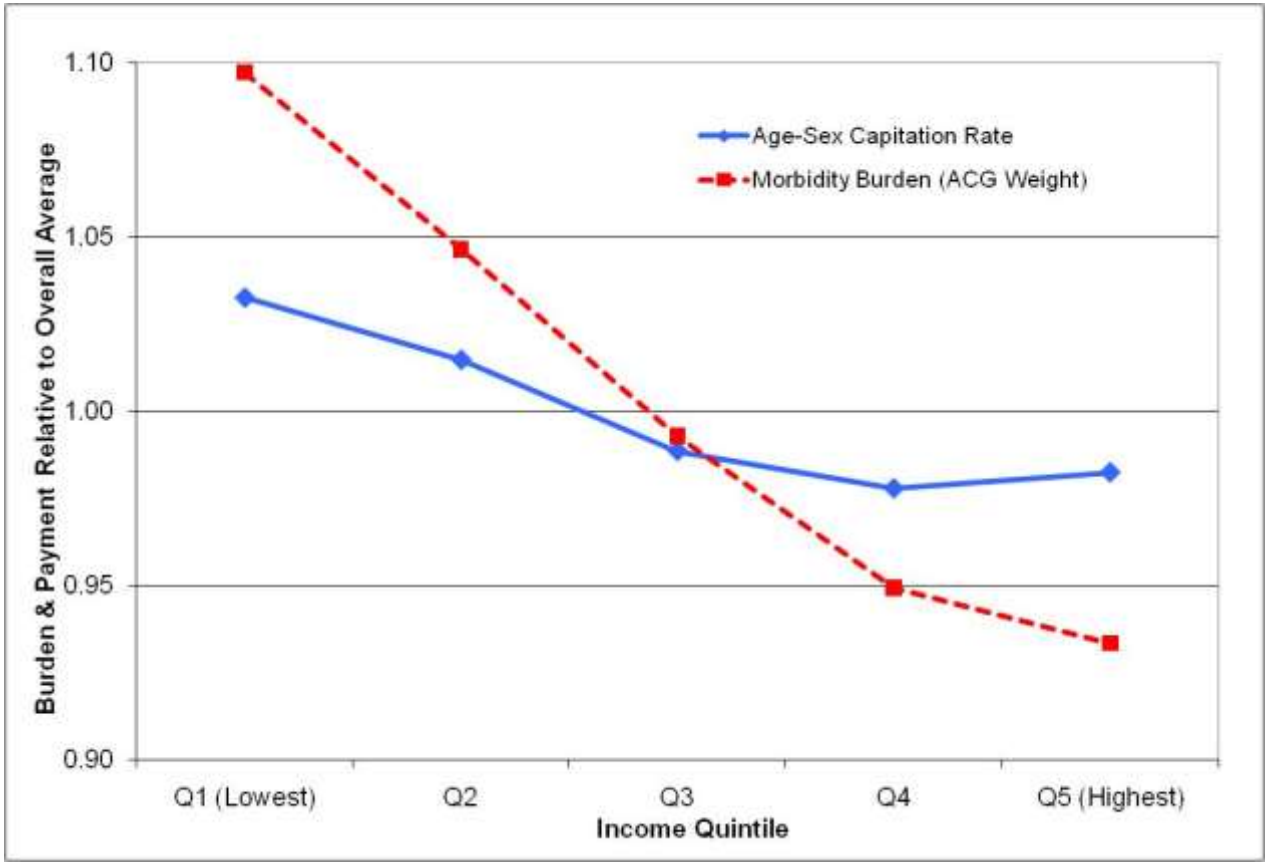
- Increased costs
  - self-selection based on increased income
  - cancer screening, diabetes care incentives
- Selection of healthier practices
  - payment the same for healthy and sick patients
- Misalignment with system needs
  - 20% bonus if patients go to ED and not to walk-in clinics
- Timely access to care did not improve
- Improved processes of care, no cost savings yet
- No models changed in past decade: “paradigm freeze”

Access – Time Trends



Glazier RH, Kopp A, Schultz SE, Kiran T, Henry DA. Healthc Q. 2012;15(3):17-21

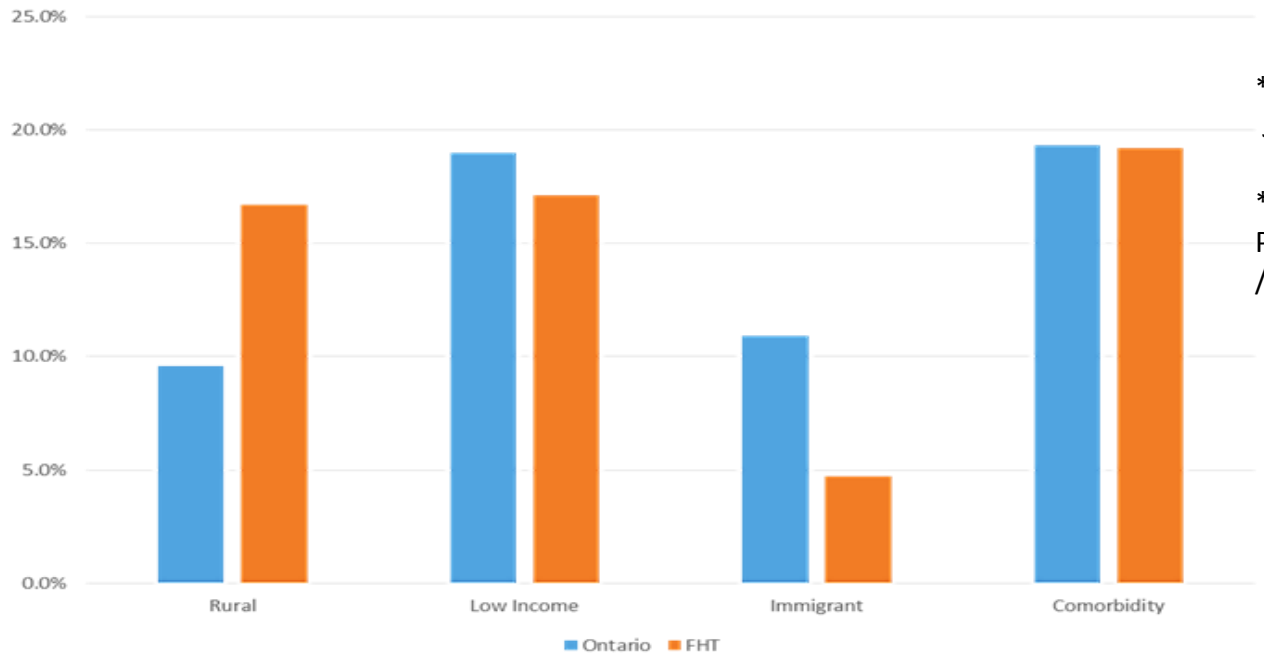
Capitation Payments



Sibley LM, Glazier RH. Health Policy. 2012;104(2):186-92.

Transition to Capitation: Selection

- Lower cost patients*
- More rural, more advantaged, average comorbidity**



*Rudoler D et al. Soc Sci Med. 2015 Jan;124:18-28.

** Glazier R et al. http://www.ices.on.ca/Publications/Atlases-and-Reports/2012/Comparison-of-Primary-Care-Models

Those Left Behind

Kiran T, et al Ann Fam Med 2016;14:517-525.

Figure 1A-B. Percentage of patients receiving chronic disease management and prevention between 2001 and 2011 stratified by whether patient is attached to a medical home or a fee-for-service physician in 2011.

A. Recommended testing for diabetes

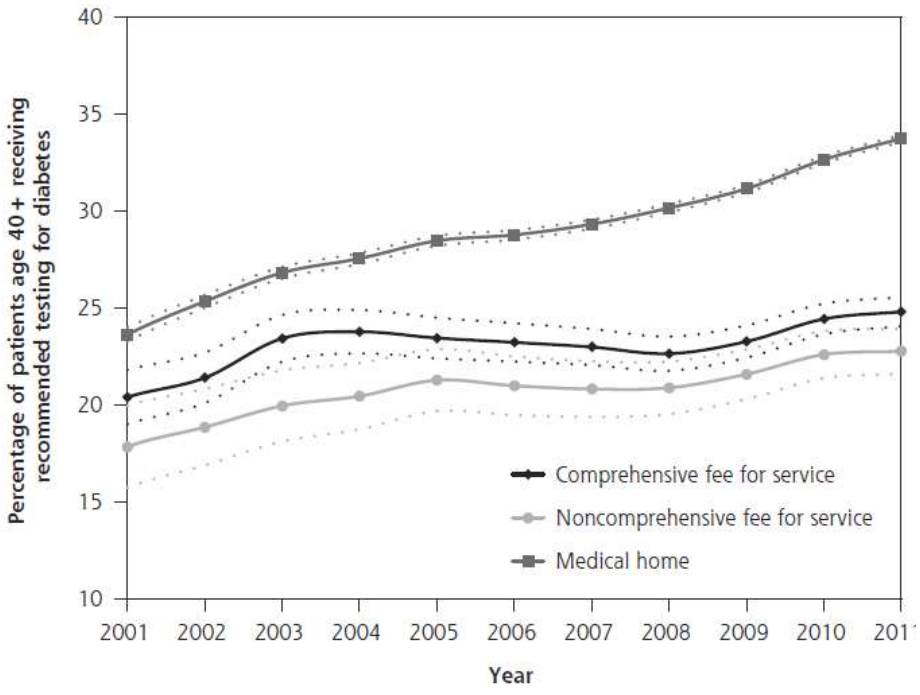
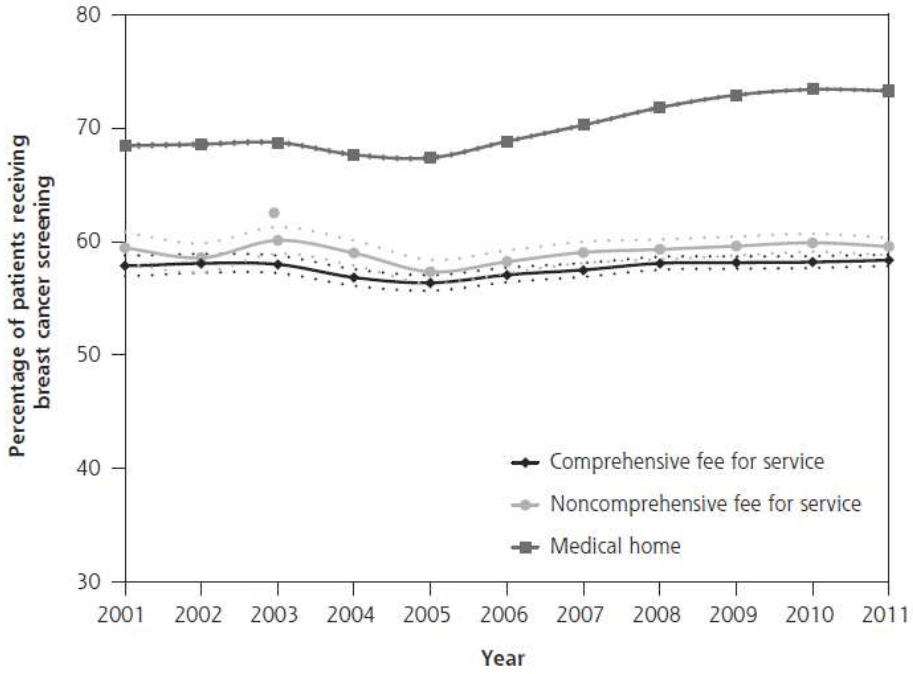


Figure 1C-D. Percentage of patients receiving chronic disease management and prevention between 2001 and 2011 stratified by whether patient is attached to a medical home or a fee-for-service physician in 2011.

C. Breast cancer screening



Payment and Team Reforms Across Canada

mostly add-ons to fee-for-service

- BC's Complex Care Initiative
  - $315 annual payment, in addition to regular visit fees (FFS)
  - responsibility for longitudinal, coordinated care of the patient
  - impact mixed but access, continuity, utilization not impacted
- Alberta's PCNs
  - "… funding methodology does not align with their need for consistent, sustainable funding, nor does it address the complexity of patient health care needs"
- Quebec's FMGs
  - slight improvements in accessibility of care and responsiveness
  - "does not seem to have had an impact on continuity, comprehensiveness, perceived care outcomes, use of services, and unmet needs."

Lavergne MR. CMAJ 2016. DOI:10.1503 / cmaj.150858
http://www.health.alberta.ca/initiatives/PCN-review.html
Pineault, R. International Journal of Family Medicine Volume 2016, Article ID 8938420

Payment Reform

- Fee-for-service
  - rewards volume – pros and cons
  - hard to support team work, QI activities, care coordination, accountability
  - so far add-on fees have had mixed results
- Capitation
  - aligns with system goals of cost savings, shifting risk
  - highly rated by providers (who choose it)
  - details are key: risk adjustment, negation, avoid perverse incentives
- Payment
  - is only one building block, won't work by itself
  - must support accountability, measurement, teams
  - align with system needs for integration, coordination

Parting Words

"Primary Care In Canada: So Much Innovation, So Little Change"

Brian Hutchison, Julia Abelson, and John Lavis

Health Affairs 2001

"More than anything else though, what Canada needs to fix its systemic health-care woes is to create a semblance of a system."

André Picard, Globe and Mail 2017