

# Models and Innovations of Primary Health Care: Ontario

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CAHSR, 2015

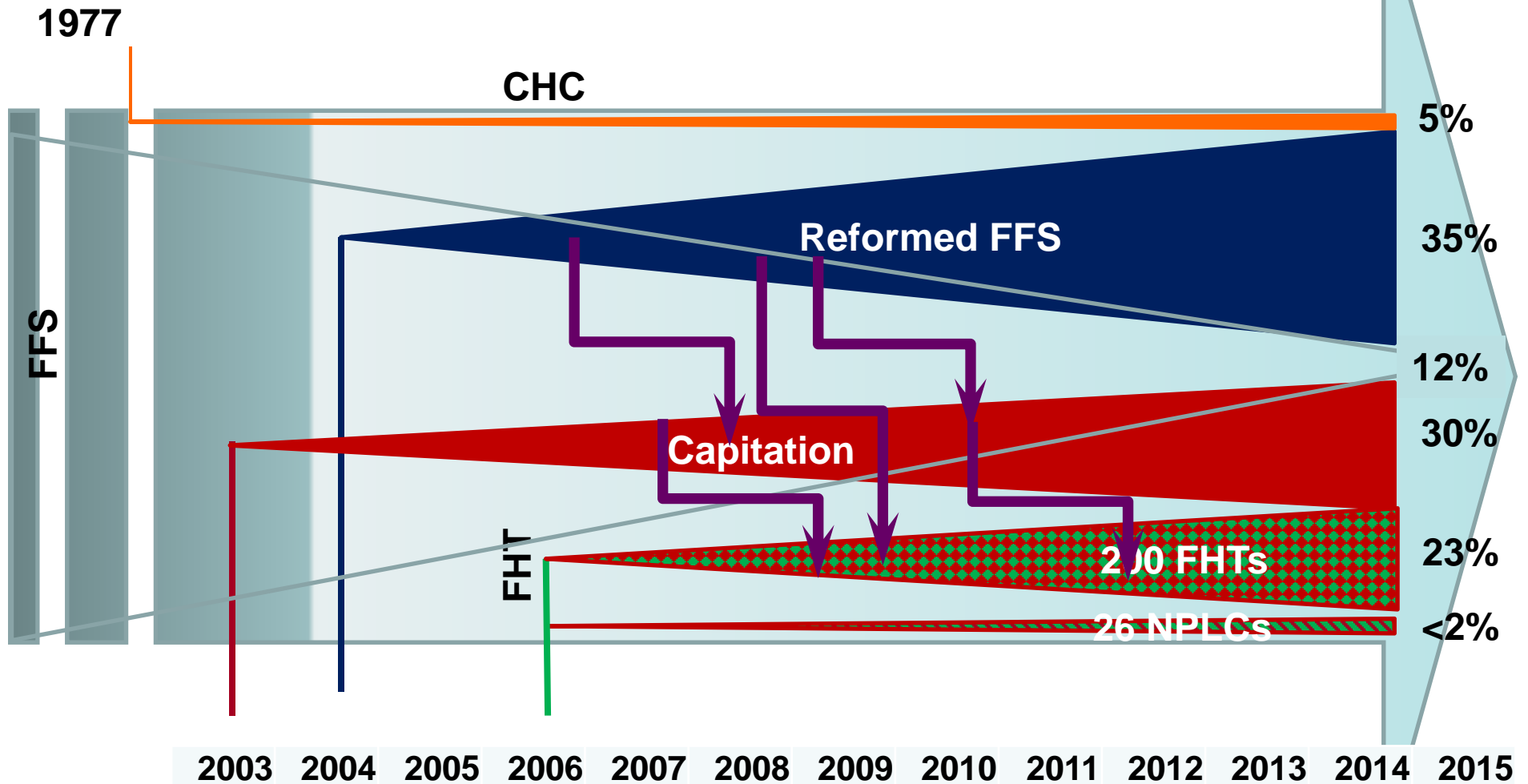
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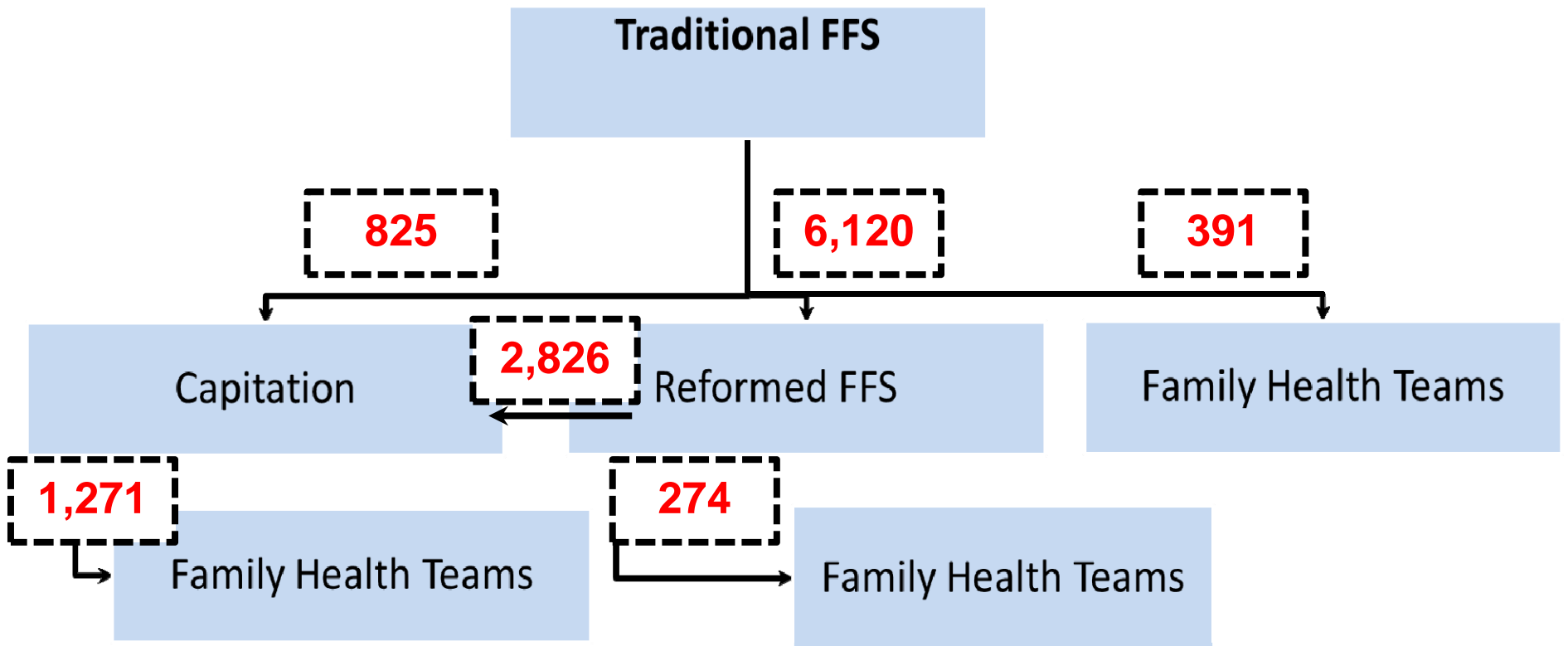


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# Primary Care Model Evolution





# Limitations

- Most work is based on health administrative data
  - No direct patient centered measures
  - Mostly processes
  - Some outcomes
- The system hasn't reach stability. There are still migrations across models, and models haven't matured.
- Limited evaluation data
- Best approach is longitudinal – CAHSPR 2016...

# Models Description

	<b>Reformed FFS</b>	<b>Capitation</b>	<b>CHC</b>
<b>Enrolment</b>	Optional	Required	Registration
<b>Patient population</b>	General	General	Priority (geog & risk)
<b>Panel size</b>	Unrestricted	Cap reduced 2,500+	Smaller





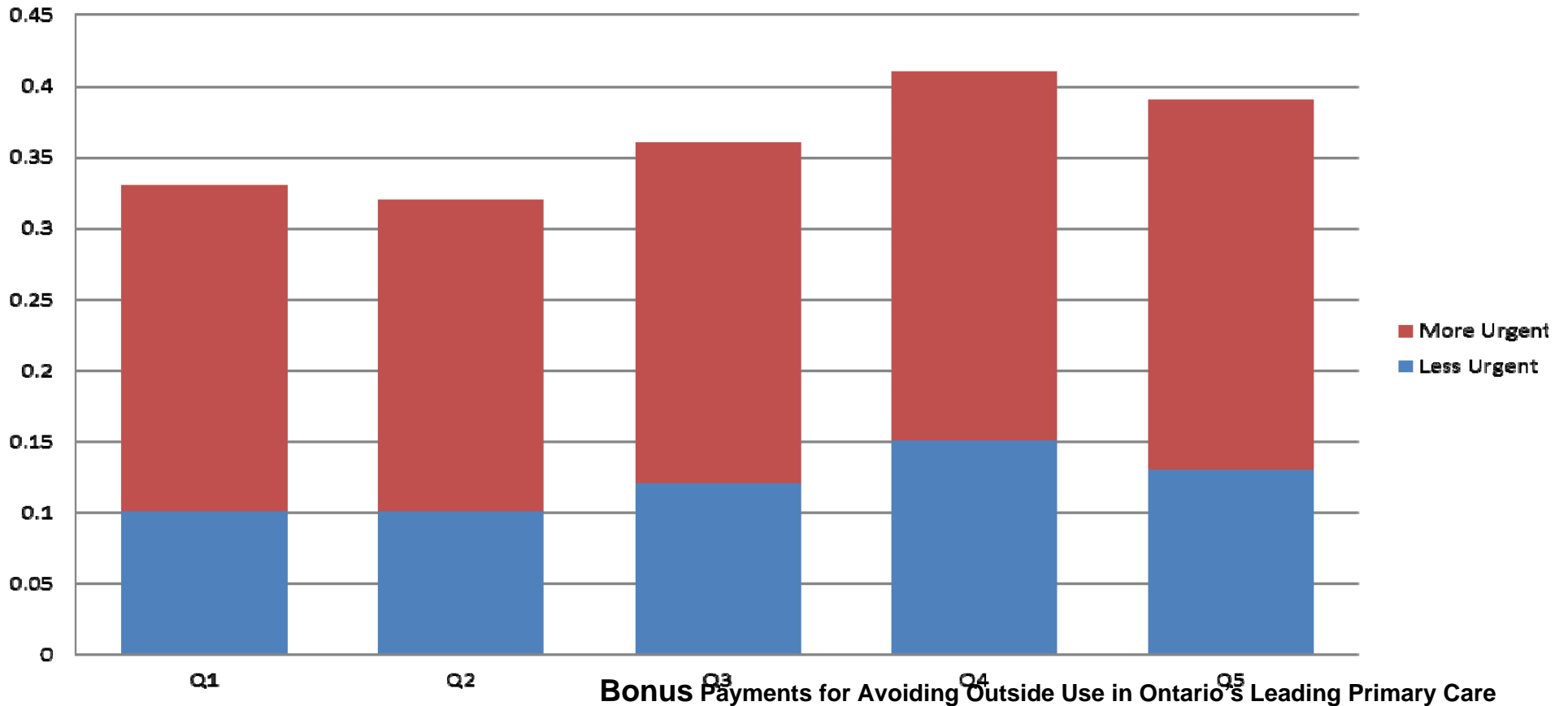
# Access

Reformed FFS

Capitation

CHC

**Mean Annual Emergency Department Visits per Person by Triage Level and Quintile of Access Bonus, Major Urban Areas**  
(Q1 = Lowest Access Bonus, Q5 = Highest)



<b>Premiums</b>		<b>Bonus Payments for Avoiding Outside Use in Ontario's Leading Primary Care</b>	
		<b>Capitation Model</b>	
		RICK GLAZIER Senior Scientist, Institute for Clinical Evaluative Sciences	
	Geriatric	· Per visit	Per Patient
	New/complex enrolment	Per Patient	Per Patient



# Unintended consequences

“PCPs in CAP models were more likely to have **healthier, wealthier** and lower cost patients than PCPs in FFS models. While there is evidence that **PCPs did alter the composition of their rosters**, the majority of the differences observed across payment models were a result of **PCPs selecting payment models** based on pre-existing patient and practice characteristics. PCPs in CAP models were also **less likely to enroll sicker/higher-cost patients**, but continued to treat these patients off-roster”

Paying for Primary Care: Payment Reform and Primary Care Physician Behaviour in Ontario

Presented by RAISA DEBER Professor, University of Toronto  
CAHSPR, 2015

	Reformed FFS	Capitation	CHC
Enrolment			Capitation
Patient			& risk)
Patient			
Table			
Poisson			
that p			
Variable			(95% CI)
Medical			
Enha			
Blend			-0.95)
Team			-0.94)
Table			1.000
In			2013, 13:517
Screeni			
Diabetes managemen...	Per Patient	Per Patient	
Heart Failure management	Per Patient	Per Patient	
<b>Premiums</b>			
Geriatric	Per visit	Per Patient	
New/complex enrolment	Per Patient	Per Patient	

# What works, How and for Whom?

## Reformed FFS

- Health Systems Planner
  - Unpredictable
  - Lower costs
- Family Physicians
  - Flexibility?
- Patients
  - Access
  - Quality of care?

# What works, How and for Whom?

## Capitation

- Health Systems Planner
  - Predictable
  - Higher costs
- Family Physicians
  - Better remuneration
  - Fee structure?
- Patients
  - Quality of care
  - Access?

# What works, How and for Whom?

## Family Health Teams

- Health Systems Planner
  - Higher costs – Efficiency
  - What form?
- Family Physicians
  - Better support
- Patients
  - Quality of care, longer term outcomes?
  - Access?
  - Inequity

# What works, How and for Whom?

## Community Health Centres

- Health Systems Planner
  - Higher costs – Efficient
  - Population needs planning
- Family Physicians – Primary Care Team
  - Better support
- Patients
  - Comprehensive
  - Quality of care and access

# What works, How and for Whom?

## Incentives ?

**Support organizational elements that help optimal care delivery**

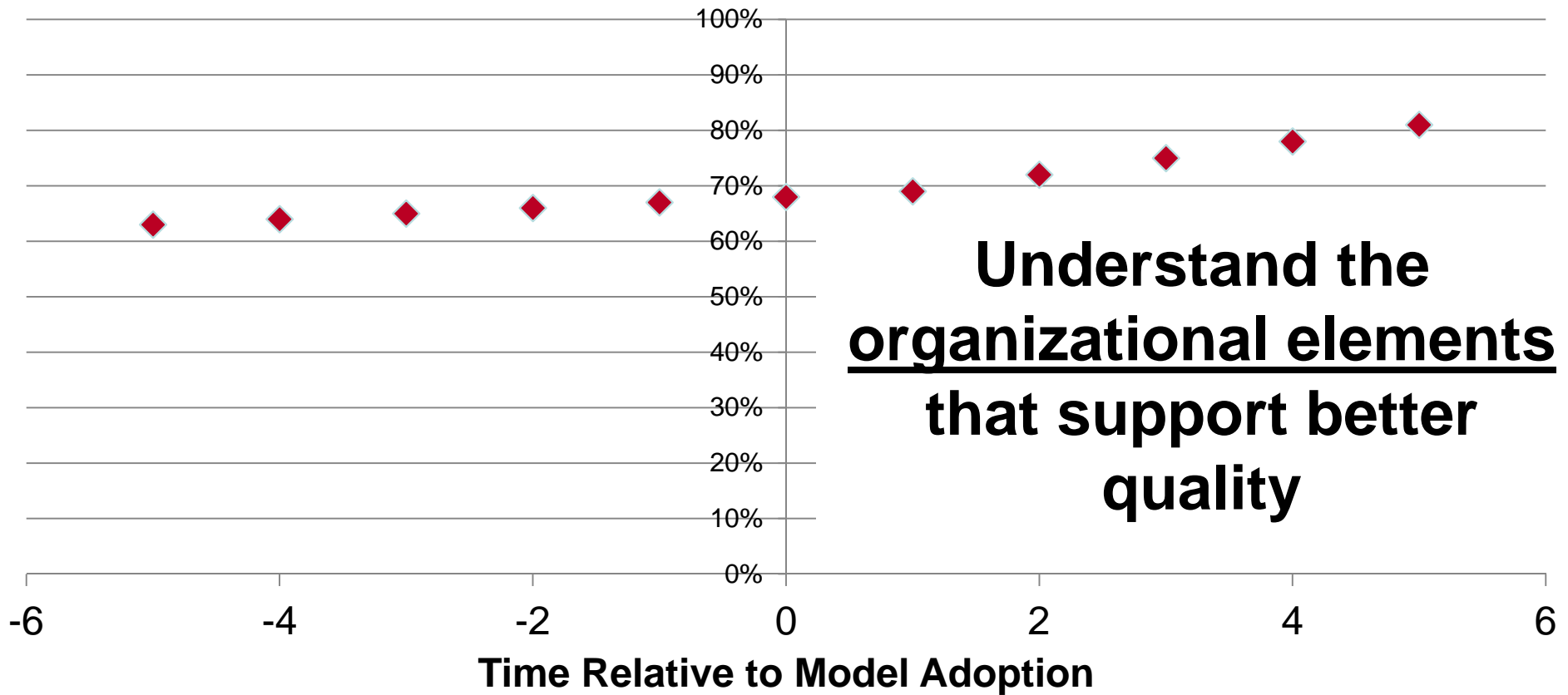
- EMR
- Quality Improvement Initiatives
- Leadership Training
- Facilitate Change

# What's next

- MOHLTC restricted adoption of Capitation Model
- Consider?
  - Larger FFS component for Capitation Model
  - How to adequately account for complexity in Capitation
  - Defined roles for Health Professionals
  - Price Report

# Research

## "Primary Care Quality"







Thank you!