Framework of Payment Methods
—
Interdisciplinary Primary Health Care Teams

3C&Q
Collaboration, Continuity, Comprehensiveness and Quality
www.primaryhealthcareteams.ca

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ID Primary Health Care Team

- Payment methods
- Mgmt models
- Other team traits

Region | ID PHC team
---|---
British Columbia | Primary HC Organizations
Alberta | Primary Care Networks
Saskatchewan | Primary Health Care Teams
Manitoba | Physician Integrated Network
Ontario | Family Health Teams
Ontario | Community Health Centres
Quebec | Family Medicine Groups
Nova Scotia | Primary Health Teams
P.E.I. | Primary HC Networks
New Zealand | Primary Health Organizations
United Kingdom | General Medical Services
ID PHC Teams in Canada - Interim Report

Wranik et al., 2014

Issue and Context

Methods

Literature

Models in Canada

Typology

Assessment

QUALITY

HEALTH OUTCOMES

CHRONIC CARE

CONTINUITY

COORDINATION

COMPREHENSIVE NESS

COMMUNICATION

PATIENT SELF-CARE

HEALTH PROMOTION

PREVENTION

JOB SATISFACTION

LOWER WORKLOADS

PRACTICE CLIMATE

LOWER COST

QUALITY

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PATIENT SELF-CARE

HEALTH PROMOTION

PREVENTION

JOB SATISFACTION

LOWER WORKLOADS

PRACTICE CLIMATE

LOWER COST
EFFECTIVE TEAM

- Transparency & Clarity
- Togetherness
- Supportive Processes
- Institutional Supports

Mis-management of:
- Resources
- Diversity
- Communication
- Poor Training & Education
**OBJECTIVES**

- To describe current models of funding/remuneration/governance of ID PHC teams.
- To assess what we know about appropriateness and feasibility of those models.
- To assess what we know about effectiveness of those models.

### Phase 1
- a. Literature review
- b. Document review

### Phase 2
- c. Qualitative interviews with directors
- d. Questionnaires to team members

### Phase 3
- e. A Roundtable meeting

<table>
<thead>
<tr>
<th>Phase</th>
<th>METHOD</th>
<th>OUTCOME</th>
</tr>
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<tbody>
<tr>
<td>Phase 1</td>
<td>a. Literature review</td>
<td>Initial framework</td>
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<tr>
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<td>b. Document review</td>
<td></td>
</tr>
<tr>
<td>Phase 2</td>
<td>c. Qualitative interviews with directors</td>
<td>Updated framework</td>
</tr>
<tr>
<td></td>
<td>d. Questionnaires to team members</td>
<td>Interim report</td>
</tr>
<tr>
<td>Phase 3</td>
<td>e. A Roundtable meeting</td>
<td>Validated framework</td>
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<td></td>
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<td>Application strategies</td>
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</table>

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<tr>
<th>Nova Scotia</th>
<th>Manitoba</th>
<th>Alberta</th>
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<td>Ian Bower</td>
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<td>n = 6 Directors, 6 DHAs</td>
<td>n = 7 Directors or Managers, 2 RHAs</td>
<td>n = 6 (Executive) Directors, PCNs</td>
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**Nova Scotia**
- Ian Bower
- n = 6 Directors, 6 DHAs

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- n = 6 (Executive) Directors, PCNs
<table>
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<tr>
<th>FUNDING</th>
<th>REMUNERATION</th>
<th>MANAGEMENT</th>
<th>LOGISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AB</strong></td>
<td>• Per capita funding for the physician non-profit corporation; based on a virtual panel calculation. • Other sources (e.g. Health Canada).</td>
<td>• Physicians can bill FFS, one PCN paid a salary plus capitation, one used hourly ARP rates. • Hourly pay for collaborative and learning tasks ($211/h). • Other providers and staff are paid from clinic funding.</td>
<td>• External governance committee (2 PCN mem, 2 AHS mem, recent: 2 community mem) • Board of Directors, often PCN physicians. • Executive Director • Team leads • Office coordinator (some)</td>
</tr>
<tr>
<td><strong>MB</strong></td>
<td>• Participating clinics can bill a P4P program; funding is at clinic level. • Clinics can have a service purchase agreement, or operate as NFP organizations. • Niche programs can receive additional funding.</td>
<td>• Physicians bill FFS, and can receive added funds through P4P. • Some physicians salaried by clinic or DHA. • P4P funding used to pay other providers. • P4P funding allocated at discretion of clinic.</td>
<td>• Board involved in setting strategic direction. • Management team in charge of day-to-day operations. • Most clinics work on consensus model. • Physician leads provider direction to staff.</td>
</tr>
<tr>
<td><strong>NS</strong></td>
<td>• Primary Health Teams operate under umbrella of nine DHAs. • Baseline funding from BHS from overall budget. • Annual fixed budget based on projected costs of service provision (salaries and operating). • Special funds available.</td>
<td>• Physicians receive salaries through an APP with the DHW, and shadow bill for top-up. • Other providers receive salaries from baseline funding, or other funds. • All physicians are eligible for P4P payments.</td>
<td>• DHA sets strategic direction, and distributes budget, in consultation with PHC team manager. • Community board involved. • PHC team manager responsible for team. • Varied relations of PHC team manager with team. • Physician team leads.</td>
</tr>
</tbody>
</table>
**FUNDING**

- The team/clinic receives funding as a separate entity.
- Funding is prospective, retrospective, or independent of activity levels.
- A pay-for-performance structure is available.

**REMUNERATION**

- Financially dependent
  Income of one provider affects the income of another provider.
- Financially independent
  Income of one provider does not affect the income of another provider.
- Financially interdependent
  Income to the group as a whole depends on every providers activities.

**GOVERNANCE**

- Decision making is hierarchical (medical provider at the centre), or decision making is collaborative.

**REMUNERATION**

- Competitive
  The activities of one provider affect the income of another provider.
- Non-competitive
  The activities of one provider do not affect the income of another provider.
Table 1 – Team remuneration models

<table>
<thead>
<tr>
<th></th>
<th>Non-Competitive</th>
<th>Competitive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model A</td>
<td>Clinic Block</td>
<td>Clinic Block</td>
</tr>
<tr>
<td>Doctor</td>
<td>Salary from 3rd party</td>
<td>Doctor FFS from 3rd party</td>
</tr>
<tr>
<td>Nurse</td>
<td>Salary from 3rd party</td>
<td>Nurse Salary from 3rd party</td>
</tr>
<tr>
<td><strong>Interdependent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model C</td>
<td>Clinic Activity based, whole C</td>
<td>Clinic Activity based, whole C</td>
</tr>
<tr>
<td>Doctor</td>
<td>Salary from clinic</td>
<td>Doctor Share from clinic</td>
</tr>
<tr>
<td>Nurse</td>
<td>Salary from clinic</td>
<td>Nurse Share from clinic</td>
</tr>
<tr>
<td><strong>Dependent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model E</td>
<td>Clinic From Doctor</td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>FFS from 3rd party</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>Salary from Doctor</td>
<td></td>
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</tbody>
</table>
ID PHC Teams in Canada - Interim Report

MODEL C
Best Supports Collaboration
Financially Interdependent

MODEL A
Non-Competitive
Financially Independent

MODEL B
Competitive

MODEL D
Financially Interdependent

MODEL E
Financially Dependent
Least Supports Collaboration
Below are perceptions of interview respondents.
We have not measured effectiveness in this project.
The literature has not measured effectiveness of funding/remuneration models of ID PHC teams on health system or outcomes.

<table>
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<tr>
<th>FUNDING/ REMUNERATION/ GOVERNANCE</th>
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<tbody>
<tr>
<td>AB</td>
</tr>
<tr>
<td>• Funding based on visits is essentially FFS (ties clinic funding to doc activities) and undermines collaboration.</td>
</tr>
<tr>
<td>• Semi-annual recalculation reduces stability of funding.</td>
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<tr>
<td>• Challenge: offer salaries high enough to attract providers. Counteracted by good work environment.</td>
</tr>
<tr>
<td>• Flatter decision making seen as positive, though not welcome by some physicians.</td>
</tr>
<tr>
<td>• Concerns over board composition (inclusion of AHS members, inclusion of community members).</td>
</tr>
<tr>
<td>MB</td>
</tr>
<tr>
<td>• Virtual (or actual) rostering should account for patient population acuity.</td>
</tr>
<tr>
<td>NS</td>
</tr>
<tr>
<td>• Funding for clinic is not tied to physicians’ activities, which facilitates distribution of tasks and delegation.</td>
</tr>
<tr>
<td>• Program manager cannot hold docs accountable, because they are administratively separate from clinic.</td>
</tr>
<tr>
<td>• Shadow billing system leaves room for improvement.</td>
</tr>
<tr>
<td>• Community needs better served when decision making enabled at the ground.</td>
</tr>
<tr>
<td>Q</td>
</tr>
<tr>
<td>• More time for patients under salaries (traditional FFS clinics not included in sample).</td>
</tr>
<tr>
<td>• Compensation method largely supports providers’ goals.</td>
</tr>
<tr>
<td>• Challenges with collaboration noted (scheduling, geographical distance).</td>
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</tbody>
</table>
Points for clarification

• How are salary rates set for physicians?
• How are benefits determined for physicians?
• How are salary rates and benefits determined for non-physician providers?
• How are salary rates and benefits determined for clerical workers/support staff?
• How is hourly fee determined for physicians working as leads (AB)?

• How is funding determined to individual networks/teams? Is this a uniform process across each province?

• To what extent are communities involved in decisions? Is this uniform across each province?

Further questions from decision makers

• How do we measure success?
• How do we track performance of teams?
• Who should take the lead and responsibility?
• How do we mitigate liability concerns?