Remuneration and Governance in Primary Health Care

3C&Q
Collaboration, Continuity, Comprehensiveness and Quality

www.primaryhealthcareteams.ca

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Maryna Korchagina, Alberta Health
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Importance of primary health care remuneration and governance

Population health needs
Health services needs

Remuneration Method
Governance Structure
Team traits
Team effectiveness
Health system outcomes

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What is a primary health care team?

Primary Health Care
Promotive, preventive, curative, rehabilitative and supportive care delivered to individuals, groups and communities.

Patient Centred Medical Home
Hub for timely provision and coordination of comprehensive health services in interdisciplinary teams.

Community Oriented Primary Care
Primary care and public health integrated to deliver services to defined population. Health problems addressed at individual and community level.

Team composition
Medical doctors, nurses, nurse practitioners, midwives, pharmacists, social workers, registered dieticians, psychologists, counselors, occupational therapists, etc.
Advantages of interdisciplinary primary health care teams/networks

- Quality
- Health outcomes
  - Coordination
  - Continuity
  - Chronic care
  - Comprehensive ness
- Communication
  - Health promotion
  - Patient self care
  - Prevention
- Job satisfaction
  - Lower workloads
  - Practice climate
  - Lower cost

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
### Advantages of highly functioning health care teams

<table>
<thead>
<tr>
<th>Advantage</th>
<th>Sources</th>
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<tbody>
<tr>
<td>Higher quality care, diversity of skills and knowledge, more creative solutions</td>
<td>Khan et al. (2008); Rodriguez (2007); Schuetz et al. (2010)</td>
</tr>
<tr>
<td>Better clinical performance, better health outcomes</td>
<td>Bower et al., (2003); Rodriguez (2007); Schuetz et al. (2010); Lowe &amp; O'Hara (2000); Shaw et al (2005); Khan et al. (2008); Schuetz et al. (2010); Lowe &amp; O'Hara (2000)</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Khan et al. (2008); Schuetz et al. (2010); Lowe &amp; O'Hara (2000)</td>
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<tr>
<td>Care continuity</td>
<td>Pearson et al. (2006); Lowe &amp; O'Hara (2000)</td>
</tr>
<tr>
<td>Improved whole person care, comprehensiveness</td>
<td>Khan et al. (2008); Rodriguez (2007); Schuetz et al. (2010)</td>
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<tr>
<td>Perform 40-90% better in care for chronic illness (diabetes, asthma, hypertension)</td>
<td>Schuetz et al. (2010)</td>
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<tr>
<td>Better health promotion</td>
<td>Khan et al. (2008);</td>
</tr>
<tr>
<td>Better illness prevention</td>
<td>Ferrante et al., (2010); Khan et al. (2008);</td>
</tr>
<tr>
<td>Improved patient self-care</td>
<td>Farris et al. (2004); Rodriguez (2007);</td>
</tr>
<tr>
<td>Better communication with patients</td>
<td>Pearson et al. (2006); Lowe &amp; O'Hara (2000)</td>
</tr>
<tr>
<td>Better financial performance, improved resource use, lower overall cost of care per patient</td>
<td>Schuetz et al. (2010); Rodriguez (2007); Solheim et al. (2007); Lowe &amp; O'Hara (2000)</td>
</tr>
<tr>
<td>Practice climate that features high degree of collaboration and teamwork</td>
<td>Schuetz et al. 2010</td>
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<tr>
<td>Lower provider workloads</td>
<td>Schuetz et al. (2010)</td>
</tr>
</tbody>
</table>
What affects team effectiveness?

- **Transparency & Clarity**
  - Explicit purpose, vision, goals, objectives
  - Clear definition of roles and expectations
  - Explication of team processes
  - Clear documentation
  - Measurable outcomes

- **Togetherness**

- **Supportive Processes**

- **Institutional Supports**

- **Mis-mgmt of resources**

- **Mis-mgmt of diversity**

- **Mis-communication**

- **Poor Training & Education**

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Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency & Clarity
  - Non-hierarchical structure, autonomy
  - Regular communication
  - Problem management and conflict resolution processes
  - Effective leadership
  - Coordination of activities
  - Education about teamwork

- Togetherness

- Mis-mgmt of resources

- Mis-mgmt of diversity

- Supportive Processes

- Mis-communication

- Institutional Supports

- Poor Training & Education

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Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency & Clarity
  - Redistribution of resources (time, money, energy)
  - Clinical and administrative systems
  - Whole practice transformation
  - Aesthetically pleasing workspace
- Togetherness
- Supportive Processes
- Institutional Supports
- Mis-mgmt of resources
- Mis-mgmt of diversity
- Mis-communication
- Poor Training & Education

EFFECTIVE TEAM

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency & Clarity
  - Payment method does not support collaboration
  - Limited physical resources
  - Insufficient resources
  - Team size too large

- Togetherness

- Supportive Processes

- Institutional Supports

- Mis-management of resources

- Mis-management of diversity

- Mis-communication

- Poor Training & Education

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency & Clarity
- Togetherness
- Supportive Processes
- Institutional Supports
- Professional silos
- Differences in pay and status
- Hierarchy, power and authority resting with one provider
- Mis-mgmt of resources
- Mis-mgmt of diversity
- Mis-communication
- Poor Training & Education

Effective Team

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency & Clarity
- Togetherness
- Supportive Processes
- Institutional Supports
- Mis-management of resources
- Mis-management of diversity
- Mis-management of communication
- Mis-communication

Effective Team

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
What affects team effectiveness?

- Transparency and Clarity
- Togetherness
- Supportive Processes
- Institutional Supports
- Mis-mgmt of resources
- Mis-mgmt of diversity
- Mis-communication
- Poor Training & Education

- Differences in educational preparation
- Insufficient time and training for collaborative practices
### Drivers of team effectiveness

<table>
<thead>
<tr>
<th>Category</th>
<th>Component</th>
<th>Sources</th>
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<tbody>
<tr>
<td><strong>Facilitators of team effectiveness</strong></td>
<td><strong>Explicit shared vision, goals, objectives, common purpose</strong></td>
<td>Shew et al. (2010); Griffiths et al. (2004); Grumbach and Bodenheimer (2004); Proudfoot et al. (2009); Rubin and Beckhard (1972); Sofi et al. (2007); Hurst et al. (2002); Xyrichis &amp; Lowton (2008); Shaw et al. (2005).</td>
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<tr>
<td><strong>Clear definition of roles and expectations</strong></td>
<td>Griffiths et al. (2004); Grumbach and Bodenheimer (2004); Proudfoot et al. (2009); Rubin and Beckhard (1972); Sofi et al. (2007); Hurst et al. (2002); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Explication of team processes (e.g. decision making processes; clinical processes)</strong></td>
<td>Cohen and Bailey (1977); Grumbach and Bodenheimer (2004); Rubin and Beckhard (1972); Sofi et al. (2007); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Clear documentation; measurable outcomes</strong></td>
<td>Griffiths et al. (2004); Grumbach and Bodenheimer (2004); Pearson et al. (2006); Hurst et al. (2002).</td>
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<tr>
<td><strong>Explicit shared vision, goals, objectives, common purpose</strong></td>
<td>Griffiths et al. (2004); Grumbach and Bodenheimer (2004); Proudfoot et al. (2009); Rubin and Beckhard (1972); Sofi et al. (2007); Hurst et al. (2002); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Togetherness</strong></td>
<td><strong>Individual enthusiasm, allegiance to team (and own profession) or lack of buy-in as obstacle</strong></td>
<td>Shew et al. (2010); Pearson et al. (2006); Sofi et al. (2007).</td>
</tr>
<tr>
<td><strong>Joint/shared decision making</strong></td>
<td>Pearson et al. (2006); Rubin and Beckhard (1972); Sofi et al. (2007); Hurst et al. (2002).</td>
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<tr>
<td><strong>Team composition broad-based, inclusive, interdisciplinary</strong></td>
<td>Sofi et al. (2007); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Non-hierarchical structure, autonomy</strong></td>
<td>Pearson et al. (2008); Sofi et al. (2007); Cohen and Bailey (1977); Hurst et al. (2002); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Good communication within teams (e.g. regular meetings)</strong></td>
<td>Shew et al. (2010); Grumbach and Bodenheimer (2004); Pearson et al. (2008); Proudfoot et al. (2009); Rubin and Beckhard (1972); Sofi et al. (2007); Hurst et al. (2002); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Supportive Processes</strong></td>
<td><strong>Problem management and conflict resolution; non-autocratic management style</strong></td>
<td>Griffiths et al. (2004); Proudfoot et al. (2009).</td>
</tr>
<tr>
<td><strong>Effective leadership</strong></td>
<td>Griffiths et al. (2004); Proudfoot et al. (2009); Sofi et al. (2007); Rubin and Beckhard (1972); West et al. (2001).</td>
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<tr>
<td><strong>Coordination of activities</strong></td>
<td>Grumbach and Bodenheimer (2004); Proudfoot et al. (2009).</td>
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<tr>
<td><strong>Education about teamwork</strong></td>
<td>Murray et al. (2008); Shew et al. (2010); Sofi et al. (2007).</td>
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<tr>
<td><strong>Redistribution of resources (time, money, energy)</strong></td>
<td>Shew et al. (2010); Nutting et al. (2009).</td>
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<tr>
<td><strong>Clinical and administrative systems</strong></td>
<td>Grumbach and Bodenheimer (2004); Grumbach and Bodenheimer (2004).</td>
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<tr>
<td><strong>Performance feedback</strong></td>
<td>Johnston et al. (2011)</td>
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<tr>
<td><strong>Whole practice transformation, reimaginaion and redesign</strong></td>
<td>Nutting et al. (2009)</td>
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<tr>
<td><strong>Institutional reinforcement</strong></td>
<td>Esthetically leasing workspace with modern equipment, technology etc.</td>
<td>Hurst et al. (2002).</td>
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### Barriers to team effectiveness

<table>
<thead>
<tr>
<th>Category</th>
<th>Component</th>
<th>Sources</th>
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</thead>
<tbody>
<tr>
<td><strong>Remuneration method does not address prevention, education, collaborative activities</strong></td>
<td>Murray et al. (2008); Pringle et al. (2006); McDonald et al. (2011).</td>
<td></td>
</tr>
<tr>
<td><strong>Limited physical resources such as cramped workspaces and lack of equipment</strong></td>
<td>Hurst et al. (2002); Xyrichis &amp; Lowton (2008).</td>
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<tr>
<td><strong>Insufficient human and material resources to support the professional team members</strong></td>
<td>Hurst et al. (2002).</td>
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<tr>
<td><strong>Too large a team, although the optimal group size is varies between 2 and 6.</strong></td>
<td>Griffiths et al. (2004); Grumbach and Bodenheimer (2004).</td>
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<tr>
<td><strong>Separation of roles into professional silos</strong></td>
<td>Chesluk &amp; Holmboe (2010); Jansen (2008).</td>
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<tr>
<td><strong>Differences in status and pay</strong></td>
<td>Griffiths et al. (2004); Murray et al. (2008).</td>
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<tr>
<td><strong>Power and authority resting with one provider (gatekeeper model) – this is also referred to as leadership and hierarchy</strong></td>
<td>Ross et al. (2000); Long (1996); Liu et al. (2010); Jansen (2008); Murray et al. (2008); Shaw et al. (2005).</td>
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</tr>
<tr>
<td><strong>Misunderstanding of roles</strong></td>
<td>Griffiths et al. (2004); Long (1996); Liu et al. (2010); Murray et al. (2008); Shaw et al. (2005).</td>
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<tr>
<td><strong>Insufficient communication / lack of formal communications</strong></td>
<td>Murray et al. (2008); Long (1996); Hurst et al. (2002); Shaw et al. (2005); Jansen (2008); Murray et al. (2008); Xyrichis &amp; Lowton (2008).</td>
<td></td>
</tr>
<tr>
<td><strong>Differences in educational preparation</strong></td>
<td>Griffiths et al. (2004); Murray et al. (2008).</td>
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<tr>
<td><strong>Insufficient time, training, resources for innovations.</strong></td>
<td>Murray et al. (2008); Jansen (2008).</td>
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DONE WITH THE LITERATURE ON TO THE WORLD OF DATA
Examples of primary health care teams/networks?

**Nova Scotia Family Health Teams**

- **Composition**: 3 MD + 1 other to qualify for bonus. Otherwise discretion.
- **Services**: Weekly collaboration req’d.
- **Payment**: FFS + collaborative bonus to MD. Others: varies.

**Manitoba Physician Integrated Network**

- **Composition**: 5+ FT MD, 6500 patients, other req’s vague
- **Services**: Goals: Access, quality care, info management, work-life balance
- **Payment**: FFS to MD. Bonus payments to clinic. Others paid from FFS.

**Alberta Primary Care Networks**

- **Composition**: Composition at team discretion. 1500 patient target.
- **Services**: Various. No stated requirement.
- **Payment**: FFS or APP to MD. Capitation to clinic. Others paid from cap.

**British Columbia Primary Health Care Organizations**

- **Composition**: 3 MD (recom), otherwise discretion. No ID req’d.
- **Services**: Extended hours. Continuous access.
- **Payment**: Capitation to MD. FFS top-up. Others paid by clinic.

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*Remuneration and Governance in Primary Health Care (Wranik et al. 2014)*
### Examples of primary health care teams/networks?

#### Ontario
**Family Health Teams (urban)**
- **COMPOSITION**: Varies, team discretion
- **SERVICES**: ID, extended hours, access to tele-health
- **PAYMENT**: Capitation to clinic, blended with FFS

#### Saskatchewan
**Primary Health Care Teams**
- **COMPOSITION**: 3-4 MDs + 1 NP co-located. Others may join, not co-loc.
- **SERVICES**: Goal: patient centred and community designed.
- **PAYMENT**: All receive salaries from RHA (employer).

#### United Kingdom
**General Medical Services**
- **COMPOSITION**: Varies. MD, nurse, midwife.
- **SERVICES**: Long range of target services and target payments.
- **PAYMENT**: Capitation and P4P to clinic. Providers paid by clinic.

#### New Zealand
**Primary Health Organizations**
- **COMPOSITION**: No ID req. Team composition based on local needs.
- **SERVICES**: Goals: better, sooner, more convenient.
- **PAYMENT**: Capitation to MD + FFS blend.

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*Remuneration and Governance in Primary Health Care (Wranik et al. 2014)*
## Preliminary classification of remuneration / governance models

### Model 1
**Physician as the clinic**

### ROSEDALE MEDICAL GROUP
**ONTARIO (FHT)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Part of Hamilton.</td>
</tr>
<tr>
<td>Focus</td>
<td>Comprehensive primary care. Part of Hamilton Family Health Team.</td>
</tr>
<tr>
<td>Who is in charge?</td>
<td>Physician owners.</td>
</tr>
<tr>
<td>Team members</td>
<td>6 MDs, 2 nurse practitioners, 1 nurse specialist, 7 registered nurses.</td>
</tr>
<tr>
<td>Processes</td>
<td>Co-location.</td>
</tr>
<tr>
<td>Financing and payment</td>
<td>FFS + capitation to MDs. Salaries and overhead funded from MDs’ revenues.</td>
</tr>
</tbody>
</table>

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
Preliminary classification of remuneration/governance models

FAMILY HEALTH TEAMS
NOVA SCOTA

Population: Geographical catchment (e.g. Liverpool, Lunenburg)
Focus: Generalist services
Who is in charge?: The physician owner
Team members: MDs, nurses, sometimes pharmacist.
Processes: Co-location.
Financing and payment: FFS to MD. Salaries of others funded by FFS revenues. Collaborative practice bonus.

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
ANNAPELI COLLABORATIVE PRACTICE
NOVA SCOTIA

Population: Geographical catchment area (~12,000 to 14,000 patients)

Focus: No particular focus.

Who is in charge?: We do not know yet.

Team members: 5 MDs (2 part time), 2 residents, 1 family practice nurse, 1 nurse practitioner, administrative staff

Processes: Consultation and collaboration, inter-professional rounds each morning.

Financing and payment: APP, or service contract. Some other staff are employed by DHA (not yet clear).
**C.W. WIEBE MEDICAL MANITOBA**

- **Population**: Geographical catchment area
- **Focus**: Integrated medical and non-medical care.
- **Who is in charge?**: Operated and managed by the physician group.
- **Team members**: MD, physician assistants, dieticians, nurses, respiratory technologists, clinical psychologists.
- **Processes**
- **Financing and payment**

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**Model 2**
Physician as separate from the clinic

- **Payer**
- **Capitation or block**
- **Salary**
- **FFS**
- **CLINIC**
- **HCP**
- **MD**

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*Remuneration and Governance in Primary Health Care (Wranik et al. 2014)*
NORTH END COMMUNITY HEALTH CENTRE
NOVA SCOTIA


Focus: Generalist services, chronic conditions, outreach programs.

Who is in charge?: The Centre is governed by a Board of Directors.

Team members: Physicians, nurse practitioners, nurses, nutritionists, social workers, dental hygienists, dentists, OTs, mental health professionals.

Processes: Co-location, inter-professional rounds

Financing and payment: Funded by DWH, managed through CDHA, MSI and other. Staff are salaried.
Preliminary classification of remuneration / governance models

SOUTH SHORE HEALTH
NOVA SCOTIA

Population: Geographical catchment area

Focus: Primary care. Not particular conditions.

Who is in charge?: Managed by DHA.

Team members: 9 MDs, 2 registered nurses, 7 nurse practitioners, administrative staff


Financing and payment: MDs have a service contract, all others salaried. DHW is the funder.

Model 4
Equivalent and segregated providers

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
DONE WITH WHAT WE KNOW
ON TO FILLING THE INFORMATION GAPS
Study protocol

Nova Scotia
n ≈ 10+

Manitoba
Jeanette Edwards
n ≈ 35

Alberta
Maryna Korchagina
n ≈ 40

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

Remuneration and Governance in Primary Health Care (Wranik et al. 2014)
We would welcome:

- A liaison from the DHW;
- Existing documents from the DHW;
- Participation in our roundtable by representatives from the DHW;
- Any other ideas from the DHW.