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Supporting PMH:
Physician payment models and incentives

June 20, 2017

BRITISH COLUMBIA

doctors of bc

Presenter Disclosure

- Presenter: Mark Armitage, Executive Director Strategic Priorities, Ministry of Health (IWG co-chair)
- Relationship with commercial interests:
  - Grants/Research Support: none
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Other: none

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Managing Potential Bias

- N/A

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Session objectives

Discuss and learn about:

- primary care transformation

- role of physician payment models and incentives

- changes to GPSC incentives

Part 1:

Physician Payment Options

Presenter Disclosure

- Presenter: Dr. Brenda Hefford, Executive Director CPQI, Doctors of BC
- Relationship with commercial interests:
  - Grants/Research Support: none
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Other: none

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Managing Potential Bias

- N/A

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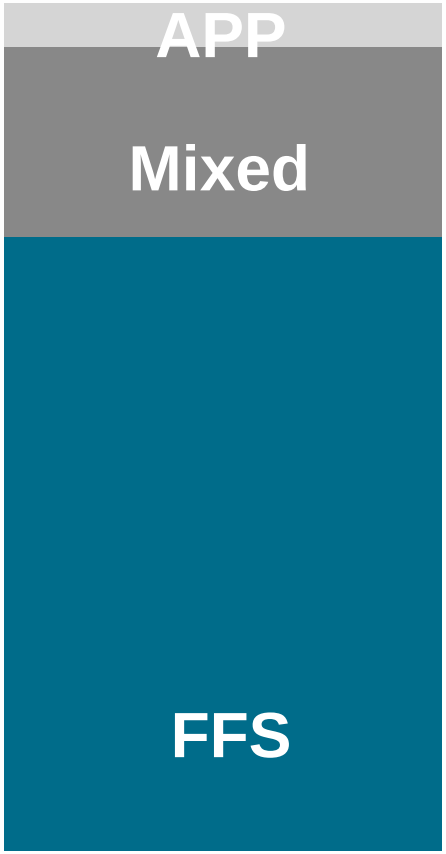
Physician payment models

- Payment models
  - BC and Canada
  - Internationally

Physician payment models in BC and Canada

- Majority of BC family physicians are paid through FFS
- Similar trends observed across most of Canada



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Physician payment models internationally

	Predominant payment method for primary care physicians
Australia	Blended payment
Denmark	Blended payment
England	Blended payment
France	Fee-for-service
Japan	Fee-for-service
New Zealand	Fee-for-service, capitation
United States	Varied

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Physician payment model highlights

- United States
  - Alternate payment models and value-based or quality-based reimbursements
- United Kingdom
  - Pay-for-performance

What can we learn from other jurisdictions?

- There is no single best pay model
- Each model has its pros and cons
- CFPC best advice guide: http://www.cfpc.ca/best_advice_tools/

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Feedback from BC physicians

- Visioning consultations
- A GP for Me initiative and impact projects
- PMH proposals
- CYMHSU collaborative
- Divisions
- ISC

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Physician master agreement: physician payment models

- Sets out 3 payment mechanisms:
  1. FFS
  2. AP models: service, salary, and sessional contracts
  3. As defined by JCC's
- Does not describe all possible pay arrangements
- Allows for the negotiation of other pay arrangements

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Physician master agreement: JCCs

- Flexibility to design new incentive fees within broad mandate set by PMA.
- This can help to inform the development of new pay models.
- Examples :
  - Maternity networking fees
  - In patient Care fees
  - Residential Care Initiative

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Physician master agreement: an opportunity

Design

Experiment

Refine

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Important considerations for physician payment models in BC

- Support PMH/PCN strategy
- Prioritization
- Opportunity for testing and refining
- Sustainability and spread
- Early adopters
- Other considerations?
- USE THE **YELLOW** STICKIE

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BC Payment Models

Strategic Context

- Incent the Strategic Direction – PMH/PCN
- Auditor General's Report
- Value-based compensation

Models

- Fee for service
- Population-based funding
- APP
- Blended funding model

Fee-for-service

Benefits

- Doctors work hard to provide high quality care; they are financially motivated to provide services
- Rewards good doctor-patient relations, so that patients will return

Concerns

- Incents high volume; low acuity care
- Does not necessarily incent illness prevention
- Incents single issue visits

Population-based funding

Benefits

- An enhanced level of care for patients, delivered in a flexible way
- Longitudinal care for patients with complex or chronic conditions
- Team-based care

Concerns

- Administratively complex
- No evaluation has been completed

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APP Contracts – Salaried Positions

Benefits

- Administratively simple
- Supports service in less attractive areas

Concerns

- Concerns about physician autonomy
- No productivity incentive

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Blended funding model

Benefits

- Supports team based care within FFS
- Allows for health care professionals to maximize their scope of practice

Concerns

- Unknown if it will substantially increase access and/or attachment.
- Potentially administratively challenging

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Next Steps

- Political Context
- Policy Context
- Budget/Funding
- Evaluation
- PMA renegotiations
- Provincial Implementation Plan

Discussion questions

1. When you look at the various models we have described today, what is it about them that excites you? **GREEN**
2. What concerns or worries you? **PINK**
3. Are there aspects of other models that you know of or have experienced that you think are worth considering here? Why? **ORANGE**

Part 2:

Incentives as enablers of patient medical home and team- based care

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Presenter Disclosure

- Presenter: Dr. Shelley Ross, GPSC Co-chair
- Relationship with commercial interests:
  - Grants/Research Support: none
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Other: none

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Managing potential bias

- N/A

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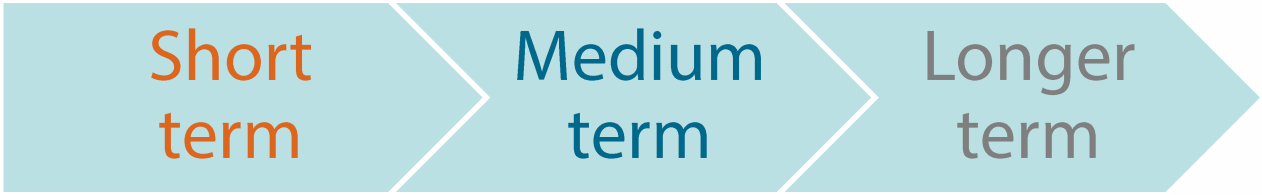
Phases of incentive changes



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Short term changes: objectives

1. Support team-based care
2. Simplify and align similar fees
3. Continue commitment to longitudinal care

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Short term changes: implementation

- Effective October 1, 2017
- Updated fee guides and FAQs in progress
- Informational webinars

- Post questions on the wall or email GPSC (gpsc@doctorsofbc.ca)
- Visit GPSCbc.ca for latest news and updates

Looking to the future

Presenter Disclosure

- Presenter: Dr. George Watson, Incentive Working Group Co-chair
- Relationship with commercial interests:
  - Grants/Research Support: none
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Other: none

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Managing Potential Bias

- N/A

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Objectives for this workshop

- Consult you on our current ideas
- Collect new ideas for the IWG to consider
- Get feedback on how to prioritize the new ideas
- Learn how you would like to further engage

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Designing new incentives: guiding principles

- Support the implementation of the patient medical home and primary care networks
- Support team-based care, to better serve the target populations
- Reflect the complexity and level of effort needed to treat the patient
- Provide a simplified fee structure and guides to encourage utilization
- All changes will be made while maintaining the full value of the overall incentive budget

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Today's workshop

- What are the strengths of this idea?
- What concerns do you have with this idea?
- What might be the implications of this incentive be to your practice?
- What else do you need to know about this idea?
- Other ideas?

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1) Expanding access to complex care planning fees

- Aim
  - To move away from a disease-focused to a patient-focused support of chronic condition care
- Options
  a) quarterly payment for complexity
  b) chronic and complex patient management (expand eligible populations)

2) Tiered approach to attachment

- Aim
  - Support attachment for all patients

- Base fee plus add-ons for low complexity, newborns, and medium to high complexity

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3) Optimizing care by understanding your panel

- Aim
  - Support team-based care and improved chronic disease management through panel assessment and maintenance

- Support application of the understanding of one's panel
- Support over a continuum

4) Block payment

- Aim
  - Provide GPs with a more flexible and less administratively burdensome payment method for incentives
- Some or all GPSC fees bundled
- Payment based on previous year's GPSC incentive billing (interim step)
- Block payments made prospectively, quarterly basis

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Other ideas to support PMH

- Do you have ideas outside the scope of these four?

Next steps

1. IWG will consider all your feedback.
   - Ideas discussed today will be assessed for viability
2. IWG will prepare for the informational webinars on current changes using your questions
3. Summary of our workshop available on the Summit website: gpscevents.ca
4. Sign-up for further engagement opportunities

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Thank You

Send feedback to: gpsc@doctorsofbc.ca

Find more information at: gpscbc.ca

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