ONTARIO'S NEW PRIMARY CARE MODELS PAY MORE FOR WEALTHY PATIENTS


Background:
- Ontario's system for paying primary care physicians is changing. Ten years ago, most providers were paid for each service they provided. Today, many providers are paid a flat fee for each rostered patient (i.e. “capitation”).
- Providers in Family Health Organizations (FHOs) and Networks (FHNs) are paid mostly through capitation. Only FHOs and FHNs are eligible to join Family Health Teams (FHTs), a model with electronic health records and interprofessional teams.
- Ontario's capitation system looks at each patient’s age and sex to predict how much health care they will need. It doesn’t account for health or socioeconomic status (people with lower incomes tend to have worse health and need more health care than people with higher incomes).

Study focus:
Does Ontario's capitation system pay primary care physicians appropriately for the care of low-income patients? We compared two methods for calculating capitation rates: one that looks at socioeconomic status as well as age and sex (Johns Hopkins Adjusted Clinical Groups Case-Mix System, www.acg.jhsph.org), vs. Ontario's method (only looks at age and sex).

Findings:
FHO and FHN providers are likely to be underpaid for the care of low-income patients, and overpaid for the care of high-income patients. This is because Ontario’s capitation system underestimates low-income patients' health care needs, and overestimates high-income patients’ needs.

Implications for health policy and practice:
We recommend that Ontario’s capitation rates be adjusted to account for patient health and socioeconomic status. Under the current system, providers who serve low-income patients may avoid joining FHOs and FHNs. As a result, their patients won't benefit from resources available through FHTs.

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TAKING PRESSURE OFF ONTARIO’S ACUTE CARE SYSTEM: COMMUNITY HEALTH CENTRES LEAD THE WAY


Background:
Ontario has several different primary care models, including:
- Community Health Centres (CHCs): Interprofessional teams, paid salaries.
- Family Health Groups (FHGs): Teams of 3+ providers, paid mostly through “fee-for-service”.
- Family Health Organizations and Family Health Networks (FHOs/FHNs): Teams of 3+ providers, paid mostly through “capitation” (see “Background,” left). Providers lose bonus payments if their patients go to walk-in clinics for care, but are not penalized if their patients visit emergency departments (EDs).

Study focus:
Which primary care model works best to keep patients from ending up in the ED? We looked at patients in several Ontario primary care models and compared their expected ED use to their actual ED use. We used Johns Hopkins Adjusted Clinical Groups Case-Mix System to calculate patients’ expected ED use.

Findings:
Among Ontario’s primary care models:
- CHCs were best at averting ED use. Their clients visited the ED much less often than expected.
- FHGs were also successful. Their patients visited the ED less often than expected.
- FHOs/FHNs were not as successful. Their patients visited the ED more often than expected.

Compared to the average patient in Ontario:
- CHC patients tended to be lower income and have greater health needs (e.g. mentally or chronically ill).
- FHG patients’ health needs were about the same.
- FHO/FHN patients tended to be healthier and wealthier.

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EVERY NEW MOTHER NEEDS CARE IN A LANGUAGE SHE CAN UNDERSTAND


Study focus:
Do immigrant women (lived in Canada ≤5 years) have different experiences of pregnancy, birth and early motherhood, compared to Canadian-born women? We analyzed a large Public Health Agency of Canada survey of new mothers across Canada.

Findings:
Twenty percent of immigrant mothers received pre-natal care in a language they couldn’t understand (i.e. couldn’t carry on a conversation). This had many implications. Compared to Canadian-born mothers, immigrants were:
- Half as likely to report that they had enough information about sudden infant death syndrome (SIDS).
- Less likely to place infants on their backs to sleep (therefore at higher risk of SIDS).
- Less likely to have known that folic acid could prevent some birth defects.
- Less likely to have taken folic acid before and during pregnancy.

The months after birth are particularly challenging for immigrant mothers. Compared to Canadian-born mothers, recent immigrants were twice as likely to have experienced post-partum depression.

Implications for health policy and practice:
To address these inequities, it’s important that primary care/public health providers (a) provide immigrant women with care that is culturally appropriate and in a language that patients can understand well, and (b) conduct routine depression screening for immigrant new mothers.

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TEN STEPS TO MAKING EVALUATIONS MATTER


Background:
Standardized evaluation models aren’t always appropriate for evaluating complex interventions (i.e. programs that have multiple components, are affected by context and can change over time).

Key arguments:
These 10 steps will help program staff and evaluators design and conduct evaluations that are more likely to have an impact, and are appropriate for complex interventions. Find out:
1. What are the program’s different components? Do they change over time? How?
2. How/why is the program expected to bring about change?
3. What insights can the research literature offer about the program’s components (e.g. reaching a particular target population) and the linkages between them?
4. What is the program’s anticipated trajectory (i.e. will you see slow, gradual improvements; rapid changes in outcomes followed by a plateau; or will outcomes get worse before they get better)? Different stakeholders (e.g. funders, program staff) may have different expectations.
5. What do you want to learn from the evaluation?
6. How could your learnings influence decisions about the current program, and future programs? Through what pathways?
7. What type of evaluation design will support your learning (Step 5) and influence plan (Step 6), and will shed light on how/under what circumstances the program works (Step 2)?
8. How will the program change over time? How can the evaluation adapt to the program as it changes?
9. How can the results of the evaluation be applied in other programs or settings? How can this knowledge be transferred?
10. How will the evaluation’s results affect the program’s sustainability? This question will likely need to be answered in partnership with funders.

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