Rapid Synthesis

Examining Compensation Models for Walk-In Clinics

27 July 2018

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Rapid Synthesis:
Examining Compensation Models for Walk-in Clinics
30-day response

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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Timeline

Rapid syntheses can be requested in a three-, 10-, 30-, 60- or 90-business-day timeframe. This synthesis was prepared over a 30-business-day timeframe. An overview of what can be provided and what cannot be provided in each of the different timelines is provided on McMaster Health Forum's Rapid Response program webpage (www.mcmasterforum.org/find-evidence/rapid-response).

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the rapid synthesis. The funder played no role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the rapid synthesis.

Merit review

The rapid synthesis was reviewed by a small number of policymakers, stakeholders and researchers in order to ensure its scientific rigour and system relevance.

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KEY MESSAGES

Questions

- How are health professionals compensated (whether in the form of fees and/or requirements for the use of fees) at walk-in clinics in Ontario, Alberta, Quebec, Manitoba and Saskatchewan, and how do these differ from compensation policies for traditional primary-care offices?
- What methods have been used to track care provided at walk-in clinics (i.e., how to determine if care was provided at a walk-in clinic; how to monitor the amount of physician billing through walk-in clinics)?

Why the issue is important

- Ensuring that primary-care providers are sufficiently accessible and able to respond to patients' health needs in a timely manner has proven difficult to achieve across Canadian provinces.
- Traditional primary-care providers in Canada are confronted with many challenges in their practices, including one or more of having to serve large geographical areas, providing care to uninsured populations, and managing high workloads as well as a mismatch between provider availability and the need for timely access to services (particularly after-hours and weekend care).
- Given this, many people lack access to a primary-care provider and/or to timely access to care and, as a result, turn to walk-in clinics for primary care.
- Walk-in clinics provide care for individuals without a regular primary-care provider or who are unable to reach them in a timely manner, and offer a range of basic medical services (typically on a first-come, first-serve basis), including advice, assessment and treatment for minor injuries and illnesses, prescriptions and referrals without an appointment.
- However, relatively little is known about providers working in walk-in clinics, the populations who seek care from them, the services provided or the amount of money that flows through them.
- This rapid synthesis seeks to address this through a jurisdictional scan of compensation models and approaches to data collection in walk-in clinics across five Canadian provinces prioritized by the requestor of this rapid synthesis.

What we found

- We undertook a jurisdictional scan using documentary analysis and key informant interviews with 10 policymakers and stakeholders across Alberta, Saskatchewan, Manitoba, Ontario and Quebec.
- All provinces rely on fee-for-service compensation models for walk-in clinics, with budgets for staff and operations being paid out of the clinic revenue.
- Quebec has placed a quarterly and annual cap on fee-for-service billings, after which services are remunerated at 75% of the fee schedule.
- Some jurisdictions such as Ontario and Alberta have chosen to take a lighter-touch approach to incentivizing the delivery of timely and responsive care by penalizing primary-care providers if their rostered patients seek care in a walk-in clinic.
- In primary-care practices (not just walk-in clinics), most provinces are increasingly shifting their emphasis away from fee-for-service remuneration towards salary, capitation and blended remuneration models.
- None of the provinces that were examined as part of the jurisdictional scan have put in place systems to track patients' use of walk-in clinics, and are instead dependent on data from provincial health card numbers and physician billing records for information about what services are being delivered in walk-in clinics.
- However, Manitoba is in the process of developing a clinic registry (including for episodic and home clinics), which will include data and quality requirements that may help to provide this information in the future.

QUESTIONS

- How are health professionals compensated (whether in the form of fees and/or requirements for the use of fees) at walk-in clinics in Ontario, Alberta, Quebec, Manitoba and Saskatchewan, and how do these differ from compensation policies for traditional primary-care offices?
- What methods have been used to track care provided at walk-in clinics (i.e., how to determine if care was provided at a walk-in clinic; how to monitor the amount of physician billing through walk-in clinics)?

Box 1: Background to the rapid synthesis

This rapid synthesis mobilizes both global and local research evidence about a question submitted to the McMaster Health Forum's Rapid Response program. Typically, rapid syntheses summarize research evidence drawn from systematic reviews of the research literature and occasionally from single research studies. However, this rapid synthesis focuses evidence on documentary analysis of government and stakeholder websites in the provinces included in the analysis, as well as on insights from key informants from each province. The rapid synthesis does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

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This rapid synthesis was prepared over a 30-business-day timeframe and involved five steps:

1) submission of a question from a policymaker or stakeholder (in this case, the Government of British Columbia);
2) identifying, selecting, appraising and synthesizing relevant evidence (in this case, documentary analysis of government and stakeholder websites in the provinces included in the analysis) about the question;
3) conducting key informant interviews;
4) drafting the rapid synthesis in such a way as to present concisely and in accessible language the research evidence; and
5) finalizing the rapid synthesis based on the input of at least two merit reviewers.

WHY THE ISSUE IS IMPORTANT

Positioning primary care as the cornerstone of the health system and establishing primary-care providers as the gatekeepers and coordinators of care has been a long-sought aim of health systems around the world. Further, a main aim of this goal in Canada has been to have a primary-care provider that is responsible for the health and well-being for each insured patient. However, ensuring that all citizens in a province are registered with a primary-care provider who is responsible for their care and can provide timely access to care when needed has proven difficult to achieve. This is not surprising given that primary-care providers in Canada are confronted with many challenges in their practices, including one or more of having to serve large geographical areas, providing care to uninsured populations, and managing high workloads as well as a mismatch between provider availability and the need for timely access to services (particularly after-hours and weekend care). When coupled with the policy legacies of how physicians in Canada have traditionally delivered care and been remunerated (e.g., as private business owners with public fee-for-service payment), the result is a patchwork of primary-care models.

Given the challenges faced in primary care, many people lack access to a primary-care provider who is responsible for their care and/or to timely access to care and, as a result, turn to walk-in clinics for primary care. Walk-in clinics provide care for individuals without a regular primary-care provider or who are unable to reach them in a timely manner. Such clinics offer (typically on a first-come, first-serve basis) a range of basic medical services including advice, assessment and treatment for minor injuries and illnesses, prescriptions and referrals without an appointment.

Acknowledging the need for a balance between providing timely access to primary-care and ensuring continuity of care for patients by having access to a primary-care provider who is responsible for their care, provinces across the country have focused on developing and implementing new models of primary care that aim to fill the gaps that walk-in clinics currently fill. This includes the use of urgent-care centres open after

hours and on weekends, dedicating time at physicians' offices for first-come, first-serve appointments, and creating specific models to serve homeless and other marginalized populations. However, walk-in clinics continue to be used by patients with and without a dedicated primary-care provider as means of receiving timely care for routine health concerns (e.g., assessment and diagnosis of and prescriptions for common illnesses).

Despite their continued presence in health systems across Canada, relatively little is known about providers working in walk-in clinics, the populations who seek care from them, the services provided or the amount of money that flows through them. This rapid synthesis seeks to address this through a jurisdictional scan of five Canadian provinces prioritized by the requestor of this rapid synthesis to identify:

- what models of compensation are being used to pay providers in walk-in clinics;
- whether any policies have been put in place that restrict the compensation of providers working in walk-in clinics or disincentivize their use;
- what models of compensation are being used in other models of primary care; and
- whether and how data is collected on the use and services provided in walk-in clinics.

Box 2: Identification, selection and synthesis evidence

To identify relevant information, we hand-searched government and relevant organizational websites for relevant policy documents. A document was included if it fit within the scope of the questions posed for the rapid synthesis.

In addition, we used government organizational charts and electronic directories to identify potential key informants working in government departments or stakeholder organizations focused on models of primary care or on remuneration for primary-care providers.

WHAT WE FOUND

We undertook a jurisdictional scan using documentary analysis and key informant interviews with 10 policymakers and stakeholders across Alberta, Saskatchewan, Manitoba, Ontario and Quebec. Details about the findings from the jurisdictional scan are presented in Table 1 and a brief summary is provided below.

All provinces rely on fee-for-service compensation models for walk-in clinics, with budgets for staff and operations being paid from revenue to the clinic. Quebec has placed a quarterly and annual cap on fee-for-service billing that is adjusted each year. After this cap, any fee-for-service billings are remunerated at 75% of the usual fee schedule. Some jurisdictions such as Ontario and Alberta take a lighter-touch approach to incentivizing the delivery of timely and responsive primary care by penalizing primary-care providers if their rostered patients seek care in a walk-in clinic (although this is only applicable for those providers working in rostered-care models).

While remuneration for care provided in walk-in clinics is fee-for-service, our reviews of websites and the feedback provided by key informants highlighted that most provinces are increasingly shifting their emphasis away from fee-for-service remuneration towards salary, capitation and blended remuneration models in primary-care clinics. This shift in remuneration has accompanied a broader health-system change away from individual provider practices towards more comprehensive models of primary care, including team-based care.

None of the provinces that were examined as part of the jurisdictional scan have put in place systems to track patients' use of walk-in clinics. However, Manitoba is in the process of developing a clinic registry (including for episodic and home clinics), which will include data and quality requirements that may help to provide this information in the future. Key informants from the province stressed that this registry was a year away from implementation.

All of the provinces are instead dependent on data from provincial health card numbers and physician billing records for information about what services are being delivered in walk-in clinics. However, a number of key informants stressed that triangulating this data with physician registration would only be possible for providers and clinics that operate solely as walk-in clinics and do not have an associated typical primary-care practice with a roster of patients. Similarly, key informants highlighted that no information is collected about the use of walk-in clinics by uninsured patients, though physicians are required to keep their own records of these interactions.

Table 1: Summary of findings from document analysis and key informant interviews about compensation in walk-in clinics (and primary care), and tracking of patients and services who access them

Province	Compensation in walk-in clinics		Compensation in primary care	Tracking of patients and services provided in walk-in clinics
	Compensation model	Compensation requirements		
Alberta	• Fee-for-service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing • Uninsured patients are required to pay out-of-pocket	• If patients rostered with another primary-care provider seek care at a walk-in clinic, the affiliated primary-care provider receives a 100% negation for the service provided ○ The primary-care provider may also be penalized up to 85% of the bi-weekly capitation payment that is provided to the physician (1; 2)	• Compensation at primary-care clinics varies based on the type of clinic • Most physicians working in solo practice are paid fee-for-service, but capitation and blended remuneration models are used for physicians who are part of a clinical or academic Alternative Relationship Plan (2)	• No tracking system has been put in place to differentiate services delivered at walk-in clinics compared to those at other primary-care clinics • No data is collected on the number of patients using walk-in clinics, the amount or type of services provided to them, or how much funding flows through these clinics • Physicians working at walk-in clinics document services provided to uninsured patients for their own records, but no data is collected at the provincial level for services provided to uninsured patients
Saskatchewan	• Fee-for-service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing • Uninsured patients are required to pay out-of-pocket • •	• No policies have been put in place to limit compensation at walk-in clinics	• Compensation at primary-care clinics varies based on the type of clinic • Physicians working in solo practice are paid fee-for-service • Physicians working in primary-care clinics funded by the Health Authority (e.g., Health Authority Clinics) are paid through salary, contractual or sessional payment arrangements	• No tracking system has been put in place to differentiate services delivered at walk-in clinics compared to those at other primary-care clinics • No data is collected on the number of patients using walk-in clinics, the amount or type of services provided to them, or how much funding flows through these clinics • Physicians working at walk-in clinics document services provided to uninsured patients for their own records, but no data is collected at the provincial level

				for services provided to uninsured patients • Recent efforts have been made by Health Authority Clinics to fill the role of walk-in clinics by dedicating a portion of a physician's clinic time to seeing patients on a first-come, first-serve basis (3)
Manitoba	• Fee-for-service • Uninsured patients are required to pay out-of-pocket	• No policies have been put in place to limit compensation at walk-in clinics	• Fee-for-service remains the most prevalent form of physician compensation • Clinics can become members of the Physician Integrated Network, which offers quality-based incentive funding in addition to fee-for-service funding • Alternate compensation and incentives for continuity of care in patient-centred medical-home models with the intention of incentivizing more physicians to move towards more robust models of primary care	• No tracking system has been put in place to differentiate services delivered at walk-in clinics compared to those at other primary-care clinics • No data is collected on the number of patients using walk-in clinics, the amount or type of services provided to them. or how much funding flows through these clinics • Province is in the process of establishing a registry for all clinics (including episodic and home clinics), which will include data and quality requirements, however implementation is approximately a year away
Ontario	• Fee-for-service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing • Uninsured patients are required to pay out-of-pocket •	• Physicians with a patient roster are paid a bonus for ensuring patients' access to care (calculated as 0.1859 of a physician's monthly base rate payment), but any billings for services for a rostered patient by an outside primary-care physician (e.g., at a walk-in clinic or other primary-care clinic) are subtracted from this access bonus	• Physicians working in a solo or group practice with no associated interprofessional team (e.g., Family Health Teams which use a blended salary model) are paid fee-for-service • Different compensation models are used for patient enrolment models and include (among others): o complement-based remuneration plus bonuses and incentives (Rural-	• An individual's Ontario Health Insurance Plan (OHIP) card is used to track their access to care, including visits to walk-in clinics and/or their typical primary-care offices • These services can be tracked by looking to specific fee codes (including premium codes to differentiate services provided on evenings, weekends and holidays) o However, none of these differentiate between

		• Urgent care centres (non-hospital-based centres that provide care for urgent, but non-life-threatening illnesses or injuries) and emergency departments are exempt from 'outside use' calculations (4)	Northern Physician Group Agreement) ○ blended salary model (community-sponsored Family Health Teams) ○ salaried model (Community Health Centre) • blended capitation (Family Health Networks and Family Health Organizations)(5)	traditional general practices and walk-in clinics. • Physicians working at walk-in clinics document services provided to uninsured patients for their own records ○ Some physicians may register the visit with a diagnostic code through the billing system but not bill OHIP for the interaction, but this can differ substantially from practice to practice • Uninsured patients may also seek care at Community Health Centres (CHC) for free ○ Uninsured patients are identified using a unique patient ID and ENCODE-FM (reporting on the reason for the visit, the diagnosis and assessment, and with data aggregation and mapping to ICD-10 and coding standards) • Records of these interactions are reported to the Ministry through the CHC medical information standards Program Evaluation System (6)
Quebec	• Fee-for-service • Uninsured patients are required to pay out-of-pocket	• No policies have been put in place specifically to limit compensation at walk-in clinics • However, there is a quarterly and annual cap applied to fee-for-service payments, and if this cap is met, remuneration for any additional services rendered is reduced to 75% (7)	• Compensation models vary depending on the type of clinic physicians work in • The majority of primary-care services continue to be paid for using a fee-for-service model, however some alternative payment models are being used, including salary, capitation and sessional payments	• No tracking system has been put in place to differentiate services delivered at walk-in clinics compared to those at other primary-care clinics • No data is collected on the number of patients using walk-in clinics, the amount or type of services provided to them or how

			• Salary payments are used to compensate physicians working in local community-service centres, while sessional reimbursement is used for physicians practising in community-health programs • Capitation and hourly payments are also used to reimburse, with additional payment supplements provided if a patient is a member of a recognized vulnerable population group (e.g., chronically ill; elderly) (8; 9)	much funding flows through these clinics

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