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Who is Doing What in Primary Care? An Administrative Data Method for Identifying Comprehensive Primary Care Physicians in Ontario, Canada

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Contributors:

Susan Schultz and Richard Glazier contributed substantially to conception and design and interpretation of data. Susan Schultz was primarily responsible for data analysis. Both authors drafted the article and revised it critically for important intellectual content and both gave final approval of the version to be published. Susan Schultz agrees to act as guarantor of the work.

Abstract (248 words)

Background: We sought to develop a method to identify comprehensive primary care physician practices from administrative data. We investigated how many and what proportion of primary care physicians in Ontario, Canada were providing comprehensive primary care and how this changed over time.

Methods: We identified the pool of active primary care physicians in linked population-based databases for Ontario, Canada from 1992/93 to 2014/15. After excluding those who saw patients fewer than 44 days per year, we identified physicians as comprehensive if more than half of their services were for core primary care, and these services fell into at least 7 of 22 activity areas. Those with $\leq 50\%$ of their services for core primary care but with more than 50% in a single location or type of service were identified as in 'focused practice'.

Results: In 2014/15 there were 12,891 physicians in the primary care pool: 1,254 (9.7%) worked fewer than 44 days per year, 1,619 (12.6%) were in focused practice and 1,009 (7.8%) could not be classified. The proportion in comprehensive practice ranged from 66-75% between 1992/93 and 2014/15 with a peak in 2002/03 and relative stability from 2009/10 to 2014/15. Over this period there was an 8.8% increase in population per comprehensive primary care physician.

Interpretation: We found that just over two-thirds of primary care physicians were providing comprehensive care, indicating that traditional primary care physician workforce estimates may be too high. Although implementation will vary by setting and available data, this approach is likely applicable elsewhere.

Introduction

Health human resource planning is challenging, given the need to project both patient demand for services and the supply of different types of health workers, their roles, and their distribution in a jurisdiction.¹ Primary care (PC) physicians are among the most commonly visited health workers in most developed country health systems and it is important to understand how to balance supply with future demand. The Institute of Medicine definition of primary care is understood as ‘the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community.’²

Primary care physician roles are many. Past research has focused on urban-rural and remote distribution of these physicians³, and on roles across settings such as offices, homes, hospital inpatients, obstetrical deliveries, emergency departments and long-term care homes.^{4,5,6,7} Over the past 2-3 decades, though, there has been a well-documented exodus of primary care physicians from many roles outside of the primary care office.^{4, 5, 7} In that context, comprehensiveness has also come to focus on the range of services provided within the office setting. Within office settings, some primary care physicians limit their practice to services such as psychotherapy or sports medicine, with several focused areas of practice supported by professional bodies.⁸ While these services are needed, there may consequently be fewer primary care physicians available to provide a broad range of services to all age groups and health conditions. Health planners need to take these patterns of care provision into account. Given the changing landscape of primary care, we propose an empirical approach to the definition of ‘comprehensive primary care’ using administrative data. We could not rely on previous definitions as they focused only on settings⁷ or depended on self-reported services or coding limited to specific payers and not available for the whole population.⁶ We investigated how many and what proportion of primary care physicians in Ontario, Canada were providing comprehensive primary care and how this changed over time. We also sought to investigate what roles non-comprehensive primary care physicians were playing.

Methods

Data sources

We carried out this study using datasets that were linked using unique, encoded identifiers and analyzed at the Institute for Clinical Evaluative Sciences (ICES). The Ontario Health Insurance Plan (OHIP) is a database of physician billings and ‘shadow-billings’ based on the fee-for-service (FFS) model. Shadow billings are submitted by physicians paid through alternate funding arrangements for which they may receive incentives of 10-30% of the full fee. The OHIP Corporate Provider Database (CPDB) provides physician characteristics, including affiliation with a primary care patient enrolment model (PEM). In Ontario these models represent types of patient-centred medical homes with the common characteristics of blended payments, formal patient enrolment, and incentives and bonuses for

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3 preventive care and chronic disease management.⁹ The ICES Physician Database (IPDB) comprises
4 information from the Ontario Physician Human Resource Data Centre (OPHRDC), the CPDB and OHIP
5 billings. It was used to determine physician specialty and active status.
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8 Definitions

9 10 The 'pool' of primary care physicians

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12 The process of identifying primary care physicians in comprehensive practice began with defining the
13 'pool' of primary care physicians. Using the specialty information available in ICES' administrative data,
14 the primary care pool (PC pool) included a) all physicians whose self-reported specialty was 'General
15 Practitioner' or 'Family Physician' (GP/FPs) plus b) those whose self-reported specialty was not GP/FP,
16 but whose 'functional specialty', that is, their practice pattern as defined by their fee-for-service (FFS)
17 billings, most closely matched those of a GP/FP. Also included with this latter group were specialists
18 with full-time affiliation with a PEM. Other specialists such as general internists or gynecologists were
19 not included as previous work has shown that they do not provide primary care in Ontario.¹⁰
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24 Core primary care services and activity areas

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26 To identify comprehensive primary care practice, we began by examining the pattern of billing by
27 primary care physicians in order to identify 'core' primary care services. We set two criteria which a
28 billing code had to meet to be included in the list of core PC services for the year: 1) 80% or more of all
29 billings for that code had to be submitted by physicians in the primary care pool and 2) total PC billings
30 for the code had to represent at least 0.1% of all billings by PC physicians for that year. This represents
31 between 70 and 80 percent of all services provided by PC physicians, depending on the year.
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35 A separate list was generated for each year, usually consisting of between 30 and 40 billing codes. The
36 combined list for all years can be found in Appendix A. Twenty-three billing codes were included in every
37 year. A further 45 were included in some years but not others, generally because they were either new
38 or had been discontinued.
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41 A physician billing more than 50% for core PC services could still be providing a narrow range of services
42 and thus not be truly 'comprehensive'. To address this issue, we grouped core PC services into 22
43 'activity areas'. Codes that could not be classified were excluded. These areas are roughly comparable to
44 both those developed by the American Board of Family Medicine which were derived from Medicare
45 claims⁶ and those reported by Canadian primary care physicians¹¹ but in this case they reflect billing
46 codes and patterns in Ontario.
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49 Comprehensiveness threshold

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52 Finally, it was necessary to define a threshold for number of activity areas necessary for a physician to
53 be considered 'comprehensive'. We plotted the proportion of physicians with billings in each activity
54 areas according to their total number of activity areas. Figure 1 shows the results for the 10 most
55 common service-related activity areas plus the four location-related activity areas across all years. A
56 minimum threshold of 7 activity areas was chosen. It would be very unlikely for a physician to be
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3 practising in either a limited range of venues (e.g. hospitalists) or providing a narrow range of services
4 (e.g. GP psychotherapists) and meet the 7 activity area threshold.
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7 The detailed steps for identifying physicians in comprehensive primary care practice are found in
8 Appendix B
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10 Ethics approval

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12 The Research Ethics Board of Sunnybrook Health Sciences Centre approved this study.
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14 **Results**

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16 In addition to tracing the decision pathway used to define comprehensive primary care physicians,
17 Figure 2 also shows the number of physicians, distinguishing between those in medical home models
18 (PEM) and those who were not, who met or did not meet the criteria at each step in 2014/15. Among all
19 physicians, 29,467 were active at the beginning of the fiscal year. The initial primary care pool consisted
20 of 12,891 physicians who were GP/FPs in either self-report or functional specialty plus 149 'specialists'
21 with full-time PEM affiliation.
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24 Of these, 1,254 (9.7%) were excluded because they had not worked the minimum 44 days during the
25 year, leaving 11,637. A further 2,252 (17.5%) did not have more than 50% of their services defined as
26 core primary care, leaving 9,385. The core primary care billings of 8,828 (68.5%) fell into seven or more
27 activity areas, comprising the total number of primary care physicians in comprehensive practice in
28 2014/15. After checking for focused practice we found that 58% (1,619) of the remaining 2,809 met this
29 definition. The remainder did not meet any of our thresholds.
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32 Appendix C and Figure 3 shows how the distribution of active physicians by type and year changed from
33 1992/93 to 2014/2015. Of note, the PC pool itself as a proportion of all active Ontario physicians
34 declined from 52% in 1992/93 to 44% in 2014/15. Although the total number of active physicians in
35 Ontario increased 40% during this time period, most of this increase was among specialists, whose
36 numbers increased by 63% compared with an 18% increase in the primary care pool and a 19% increase
37 in those in comprehensive primary care practice. While the population per active physician decreased
38 by 7.4% over this time period, there was an 8.8% increase in population per comprehensive primary care
39 physician. As a proportion of the PC pool, comprehensive physicians peaked in 2002/03 and then were
40 relatively stable from 2009/10 to 2014/15 at or slightly below 70%. The proportion working fewer than
41 44 days declined over time, while the focused practice and 'Other' groups increased in recent years.
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44 Figure 4 examines the distribution of primary care physicians by practice type and age group for three
45 select years – 1993/94, 2003/04 and 2013/14. During this time the proportion of physicians under 40
46 fell from 46% to 23%, while the proportion over 60 grew from 14% to 27% (data not shown). The
47 proportion in comprehensive practice fluctuated over time in each age group, but was generally lower in
48 2013/14 compared with the other two years, while at the same time the proportion in focused practice
49 increased in all age groups.
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3 Figure 5 shows the distribution by practice type and sex over the same years. The percentage of
4 physicians who were comprehensive was nearly identical for men and women across all three years.
5 However, women tended to have a higher proportion working fewer than 44 days per year, probably a
6 result of maternity leaves, while men tend to have a higher proportion in focused practice. In both sexes
7 the percentage in focused practice increased over time.
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10 11 Interpretation

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13 This paper's major contribution is its attempt to categorize primary care physicians according to
14 whether they provide comprehensive care or not. In a large Canadian single payer setting we found that
15 just over two-thirds of primary care physicians provided comprehensive care, a proportion that
16 declined from about 75% from after 2003/04. The main implication of these results is for health human
17 resources planning as a 'head count' approach to planning¹ would have over-estimated the physician
18 capacity to provide comprehensive primary care by about a third in our setting. Many physicians who
19 would traditionally be counted in primary care were in fact in focused practice such as hospitalist care,
20 emergency medicine or psychotherapy and a substantial proportion were relatively inactive. We also
21 found similar growth over time in the in overall primary care pool and in comprehensive primary care
22 physicians, with both groups lagging the overall increase in physician supply which was largely driven by
23 specialists. Despite an increase in physician numbers, population growth has meant that the availability
24 of comprehensive primary care physicians to the Ontario population declined substantially over time.
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Comprehensiveness is an imprecise concept in primary care, given the broad range of care provided in
community and institutional settings and increasingly by telephone, e-mail and other electronic means.
Not surprisingly, there have been numerous methods used to define and measure comprehensiveness
that have focused on settings of care⁷, types of care provided^{12,13,14} or a mix of settings, types of care
and procedures.⁶ Comprehensiveness can also be measured from a number of perspectives including
provider report, patient report and administrative claims. Each of these methods has strengths but also
methodological short-comings^{11, 12, 14,15,16} and data derived from different perspectives may not
correlate well.^{6,15,16} Nonetheless, measurement from different perspectives has had similar relationships
with outcomes.⁶ Although challenging to measure, comprehensiveness of care is a cornerstone of
primary care provision^{17,18} and has been demonstrated to be associated with decreased health costs and
hospitalizations.⁶

The activity areas used in this paper included locations of care such as hospital care and house calls but
the majority related to the scope of office-based care. There has been a decrease in primary care
physician roles outside of the primary care office.^{4, 5, 7} Office-based care also relates strongly to the
concept of the 'triple aim' of enhancing patient experience, improving population health, and reducing
costs¹⁹ as well as the Patient-Centered Medical Home (PCMH) in the U.S.²⁰ and as the Patient's Medical
Home (PMH) in Canada.²¹ Quality improvement efforts in primary care also tend to be focused on office
redesign and organization of health care teams in office settings.¹⁹

61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 Limitations

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3 This paper used population-based data from a large single payer jurisdiction and has the strength of
4 being relatively complete for physician billing claims and population coverage. Nonetheless,
5 administrative data such as these have several important limitations. In this setting, claims data only
6 cover the permanent resident population of Ontario and as such some recent immigrants and refugees
7 will be missed, as will temporary visitors, and those without documentation of their residency status.
8 The available data also did not include primary care nurse practitioners or physician assistants and they
9 did not include physicians at Community Health Centres who are salaried and provide primary care to
10 about 2% of Ontario's population.²² It also did not include most patient contacts by telephone, e-mail or
11 other electronic means as billing codes do not exist for most of those services. Diagnostic coding in
12 administrative data has been shown to be inadequate for measuring comprehensiveness.¹⁵ For that
13 reason we chose to establish primary care activity areas using fee codes which are expected to be fairly
14 complete as they are the basis for physician payment. The 22 activity areas used in this research were
15 developed using Ontario's core primary care fee codes and while this approach is likely applicable
16 elsewhere the details of coding and claims data would necessitate adaptation in other settings. Our
17 approach classifies primary care physicians as comprehensive or not, in contrast to others who have
18 relied on scales or scores.^{6,12,16} This dichotomous approach was designed to inform health human
19 resource planning but does not include part-time comprehensive care provided by physicians who spend
20 their time in multiple settings and may therefore under-estimate the total amount of comprehensive
21 care.
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29 Conclusion

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31 In this study we used administrative data to establish the active pool of primary care physicians, exclude
32 those who worked below a threshold number of days and then for the remainder required at least half
33 of billed services to be 'core primary care' and a minimum number of activity areas for
34 comprehensiveness. Finally, those who were not comprehensive were checked to see if they were in
35 some type of focused practice. We believe this general approach to be widely applicable although the
36 details of how it is implemented would be expected to differ by jurisdiction. We found that only two-
37 thirds of primary care physicians were providing comprehensive care in the most recent year, and that
38 this has declined slightly in the last decade, along with a substantial decline in the availability of
39 comprehensive primary care physicians to the growing Ontario population. The implication of these
40 findings for health human resource planning is that traditional primary care estimates may be too high if
41 the goal is to provide comprehensive primary care. Further analyses would be valuable for establishing
42 the supply of comprehensive primary care providers including inter-professional team members in
43 relation to population health needs, and for understanding the applicability of this approach to other
44 jurisdictions. We conclude that it is feasible to identify which primary care physicians provide
45 comprehensive primary care and that the findings are likely to be of value in health human resource
46 planning for population needs.
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Appendix A. Core primary care services and activity areas

A001A	Minor assessment.- GP/FP.	*	1. Mini/ minor assessment
A008A	Mini assessment- GP/FP.		
A003A	Gen. assessment/ Annual health exam – GP/FP	*	2. General assessment/ re-assessment
A004A	General.re-assessment– GP/FP		
A007A	Intermed.assessment/well baby care	*	3. Intermediate assessment
K017A	Annual health exam-child aft.2 nd birthday	*	4. Periodic health exam
K131A	Periodic hlth vis - Adult < 65 years		
K132A	Periodic hlth vis - Adult 65+ yrs		
E070A	Geriatric general assessment prem		
E071A	Geriatric intermediate assessment prem		5. Geriatric care
E075A	Geriatric general assessment prem		
K004A	Family psychotherapy-2 or more members		6. Mental health/addiction
K005A	Primary mental health care – individual – per unit		
K007A	Individual psychotherapy	*	
K013A	Counselling-one or more people	*	
K025A	Group psychotherapy – 6-12 people	*	
K099A	GP psychotherapy premium		
K682A	Opiod agonist maintenance program		
C002A	Hospital visits-To 5wks-GP/FP	*	
C004A	General re-assessment in hospital – GP/FP		
C007A	Hospital visits-6th-13th Week – GP/FP	*	
C008A	Concurrent care in hospital – GP/FP		
C010A	Supportive care in hospital - GP/FP	*	
A901A	Housecall assessment – GP/FP	*	8. Housecalls
B990A	Special visit to patient's home, wk/daytime		
B991A	Each additional patient./Same visit Mini-assessment		
B994A	Special visit to patient's home/non-elective		
W001A	Chronic care/convalescent hospital visit – subsequent. – GP/FP	*	9. Chronic care/long-term care visits
W002A	Chronic care/convalescent hospital visit - First four per month	*	
W003A	Nursing home visit - first two visits per month	*	
W008A	Nursing home visits – subsequent – GP/FP	*	

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2	W010A	LTC Monthly management fee	
3	W121A	Add'l NH vis due to intercurrent illness	
4	A888A	Partial. assessment – ED equivalent	
5	E030A	1992-1994 Emerg.Dept	10. Emergency department or
6	H151A	ED.phys.on duty sat./sun	equivalent
7	K995A	Spec vis - ED, mon-fr	
8	A009A	Oculo-visual. Assessment – GP/FP	11. Vision care
9	A111A	Periodic oculo-visual assessment	
10	G512A	Weekly palliative care case management	12. Palliative care
11	K023A	Palliative care support /per unit	
12	C882A	Terminal care in hosp GP/FP	
13	G590A	Influenza agent with visit	13. Flu shots
14	G591A	Influenza agent sole reason for visit	
15	G538A	Immunization-with visit, excl flu	*
16	G539A	Immunization - sole reason – excl flu	*
17	G847A	Tdap - Tetanus, diphtheria, pertussis	14. Other immunization
18	G489A	Venipuncture- adolescent/adult	*
19	G002A	Lab med. - glucose quantitative or semi-quant.	15. Office lab procedures
20	G005A	Lab med. - pregnancy test	
21	G014A	Lab me. - streptococcus in office	
22	G202A	Allergy-hyposensitivity injection with visit	*
23	G212A	Allergy-hyposensit inj – w/visit	16. Allergy shots
24	G372A	Injection – with visit	*
25	G373A	Injection - sole reason for visit	*
26	G387A	1992-1994 Injection/infusion	17. Other injections
27	G388A	1992-1995 Injection/infusion	
28	E430A	Pap smear performed outside hosp	18. Pap smear
29	G365A	Pap smear – with visit	*
30	G271A	Anticoagulant supervision	*
31	A903A	Pre-dental/operative assessment – GP/FP	19. Anticoagulant therapy
32	K030A	Diabetic management fee	20. Pre-operative assessment
33	E079A	Smoking cessation. – Initial discussion	21. Diabetes management
34	G467A	Miscellaneous therapeutic procedures	22. Smoking cessation
35	K055A	MCFCS-form-special diet	99. Not included
36	P018B	Surg. assist – C-section	99. Not included
37	R441B	Surg assist - Joint-reconst-arthroplasty	99. Not included
38	Z176A	Skin-suture-laceration-upto 5c	99. Not included
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Appendix B. Methodology for identifying physicians in comprehensive primary care practice

To be called 'comprehensive', primary care physicians had to meet the following criteria: He or she must be part of the primary care pool AND work at least 44 days during the year AND have more than 50% of billing for 'core primary care services' AND the 'core primary care services' must fall into 7 or more 'activity areas'. Physicians who failed to meet the comprehensiveness criteria were tested to see if they met the criteria for focused practice.

The above criteria were applied in a step-wise, hierarchical manner. The pathway and results for 2014/15 are shown in Figure 2 and the individual steps are described below:

Step 1. Define 'active' physicians

An active physician was defined as any physician whose OHIP billing eligibility status was listed as unrestricted, special or group at any time during the fiscal year (April 1 – March 31).

Step 2. Defining the 'pool' of primary care physicians

The methodology for this is described above. The PC pool is shown in Figure 2 as shaded boxes.

Step 3. Identifying physicians in medical home models

Using the CPDB we identified all physicians in the PC pool with a full-time affiliation with a medical home model during each year. In Ontario, these are called patient enrolment models (PEMs) and are designed to support a broad range of comprehensive primary care office practice services and participating physicians sign contracts that include provision of those services. We stratified physicians by whether they belonged to a medical home model but we did not use that status for assessing comprehensiveness.

Step 4. Days worked per year

The first criterion for comprehensiveness was that a physician had to have worked at least 44 days during the year, the equivalent of an average of 1 day/week, allowing eight weeks of vacation. Using the OHIP billings, a day of work was defined as any day on which a physician billed for at least five different patients. Physicians who did not meet this criterion were excluded from further analysis.

Step 5. Percent core primary care service

Next we calculated the proportion of each physician's services that was for core PC services using the list of services in Table 1. Those with more than 50% of their services for core primary care were flagged as such. This criterion was mandatory for identification as 'comprehensive'.

Step 6. Activity areas

In addition to having more than 50% of their services for core primary care, those services had to fall into at least 7 'activity areas'. This ensures that not only the volume of services but also the scope of primary care services met the definition of 'comprehensive'.

Step 7. Focused practices

Physicians who did not meet the criteria for comprehensive primary care practice, either because their services did not meet the >50% core primary care threshold or because those same services did not fall into at least 7 activity areas, were then checked to see if their billings fit the definition of 'focused practice'. A physician's practice is defined as 'focused' if more than 50% of his/her services are

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3 concentrated in a single location (e.g. > 50% patient visits take place in hospital) or type of service (e.g.
4 >50% services are for anesthesia). Possible types of focused practice include hospital care, emergency
5 department care, surgery or surgical assisting, mental health/addiction, psychotherapy/counselling or
6 anesthesia.
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Confidential

Figure 1. Proportion of primary care physicians with billings in selected activity areas, grouped by total number of pc activity areas

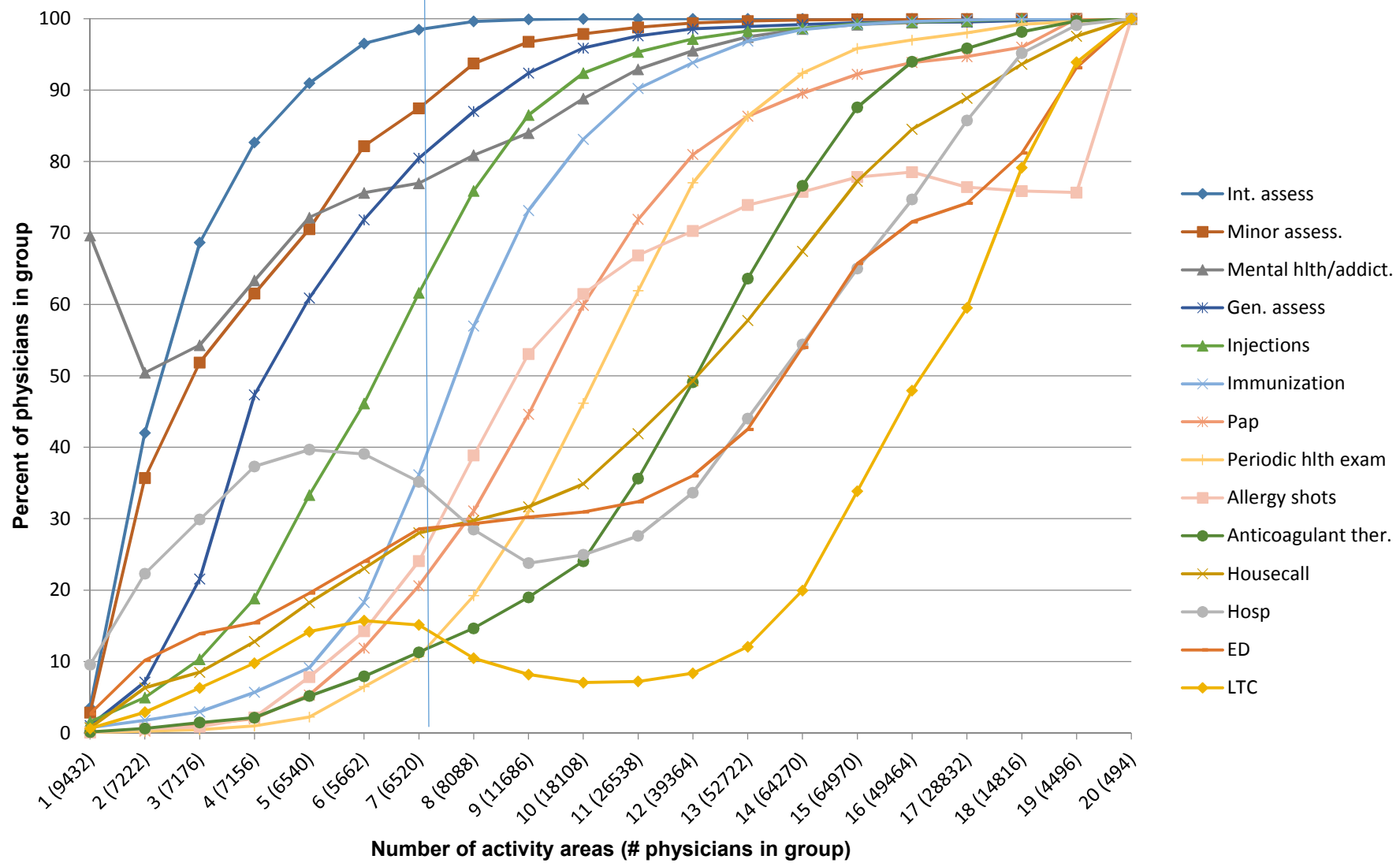
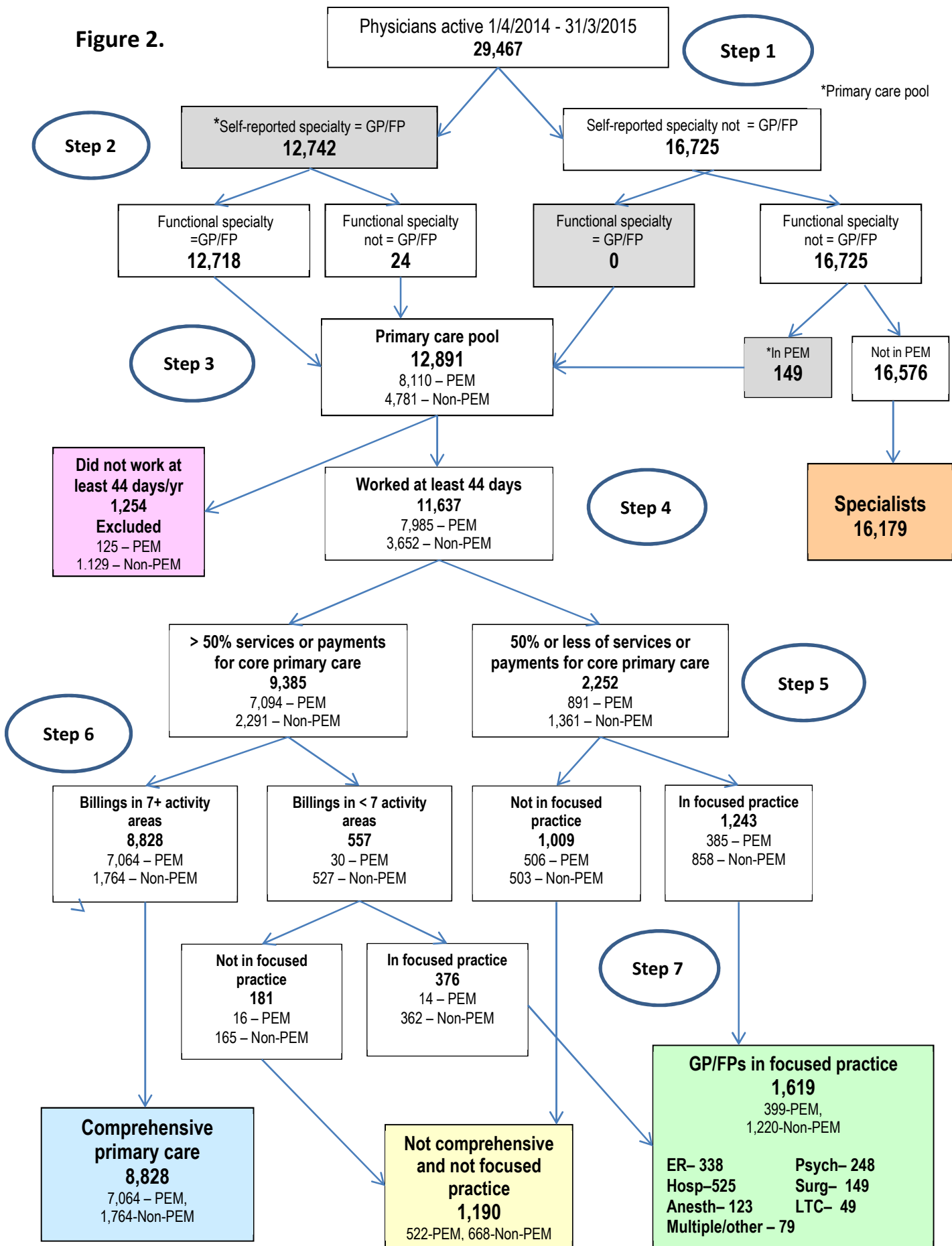


Figure 2.



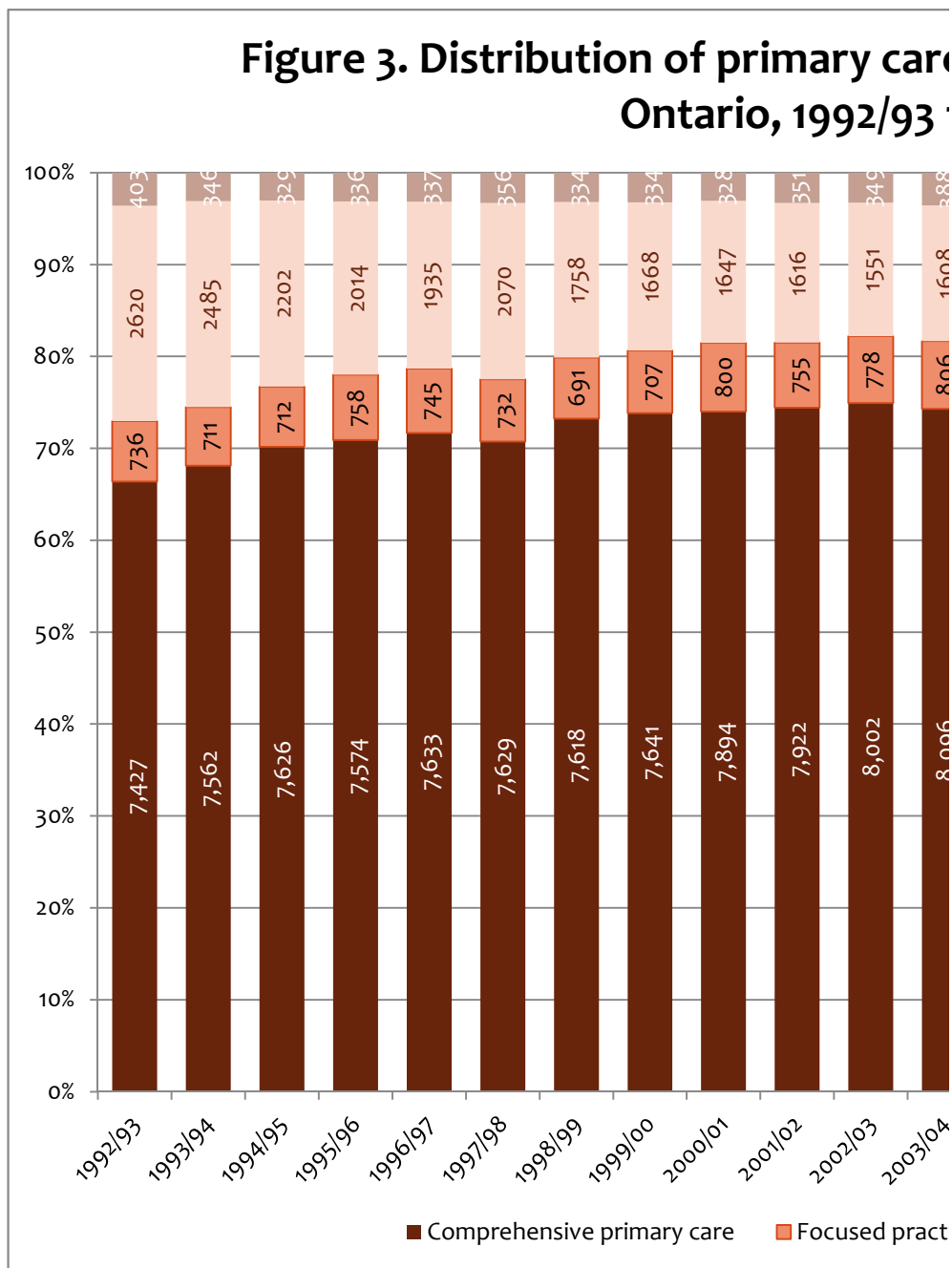
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Appendix C. Distribution of Ontario physicians by practice type, 1992/93 to 2014/15 (head counts)

Year	Total Ontario Population	A. Total Active Physicians		B. Not in primary care pool (specialists)	C. Primary care pool		D. Physicians In Comprehensive Primary Care Practice					E. Primary care, did not work 44 days		F. In Focused Practice		G. Other	
	Number	Number	Population per physician	Number	Number	% Active Phys	In a Patient Enrolment Model (PEM)	Not in a PEM	Total	Population per physician	% PC Pool	Number	% PC Pool	Number	% PC Pool	Number	% PC Pool
1992/93	10,569,806	21,083	501	10,150	10,933	52	0	7,424	7,424	1,424	68	2,375	22	734	7	400	4
1993/94	10,688,391	21,301	502	10,428	10,873	51	0	7,556	7,556	1,415	69	2,262	21	712	7	343	3
1994/95	10,818,251	21,335	507	10,684	10,651	50	0	7,624	7,624	1,419	72	1,990	19	710	7	327	3
1995/96	10,949,976	21,323	514	10,840	10,483	49	0	7,573	7,573	1,446	72	1,818	17	757	7	335	3
1996/97	11,082,903	21,491	516	11,023	10,468	49	0	7,632	7,632	1,452	73	1,755	17	744	7	337	3
1997/98	11,227,651	21,996	510	11,399	10,597	48	0	7,629	7,629	1,472	72	1,882	18	731	7	355	3
1998/99	11,365,901	21,641	525	11,393	10,248	47	7	7,611	7,618	1,492	74	1,607	16	690	7	333	3
1999/00	11,504,759	21,935	524	11,725	10,210	47	121	7,520	7,641	1,506	75	1,529	15	707	7	333	3
2000/01	11,683,290	22,018	531	11,482	10,536	48	162	7,731	7,893	1,480	75	1,516	14	800	8	327	3
2001/02	11,896,648	22,323	533	11,802	10,521	47	178	7,743	7,921	1,502	75	1,495	14	755	7	350	3
2002/03	12,091,049	22,669	533	12,104	10,565	47	314	7,687	8,001	1,511	76	1,438	14	778	7	348	3
2003/04	12,242,275	23,059	531	12,274	10,785	47	2,310	5,785	8,095	1,512	75	1,498	14	805	7	387	4
2004/05	12,390,597	23,454	528	12,555	10,899	46	3,745	4,365	8,110	1,528	74	1,541	14	820	8	428	4
2005/06	12,528,470	23,708	528	12,626	11,082	47	5,840	2,325	8,165	1,534	74	1,538	14	936	8	443	4
2006/07	12,661,548	24,213	523	13,071	11,142	46	6,227	1,905	8,132	1,557	73	1,533	14	987	9	490	4
2007/08	12,764,223	24,731	516	13,439	11,292	46	6,362	1,660	8,022	1,591	71	1,559	14	1,101	10	610	5
2008/09	12,882,620	25,600	503	14,075	11,525	45	6,549	1,527	8,076	1,595	70	1,667	14	1,129	10	653	6
2009/10	12,997,708	26,017	500	14,302	11,715	45	6,637	1,509	8,146	1,596	70	1,526	13	1,277	11	766	7
2010/11	13,135,065	26,751	491	14,882	11,869	44	6,754	1,428	8,182	1,605	69	1,608	14	1,194	10	885	7
2011/12	13,263,561	27,652	480	15,512	12,140	44	6,814	1,419	8,233	1,611	68	1,641	14	1,296	11	970	8
2012/13	13,409,553	27,747	483	15,717	12,030	43	6,855	1,413	8,268	1,622	69	1,213	10	1,414	12	1,135	9
2013/14	13,550,997	28,595	474	16,179	12,416	43	6,967	1,409	8,376	1,618	67	1,211	10	1,511	12	1,318	11
2014/15	13,677,702	29,467	464	16,576	12,891	44	7,064	1,764	8,828	1,549	68	1,254	10	1,619	13	1,190	9

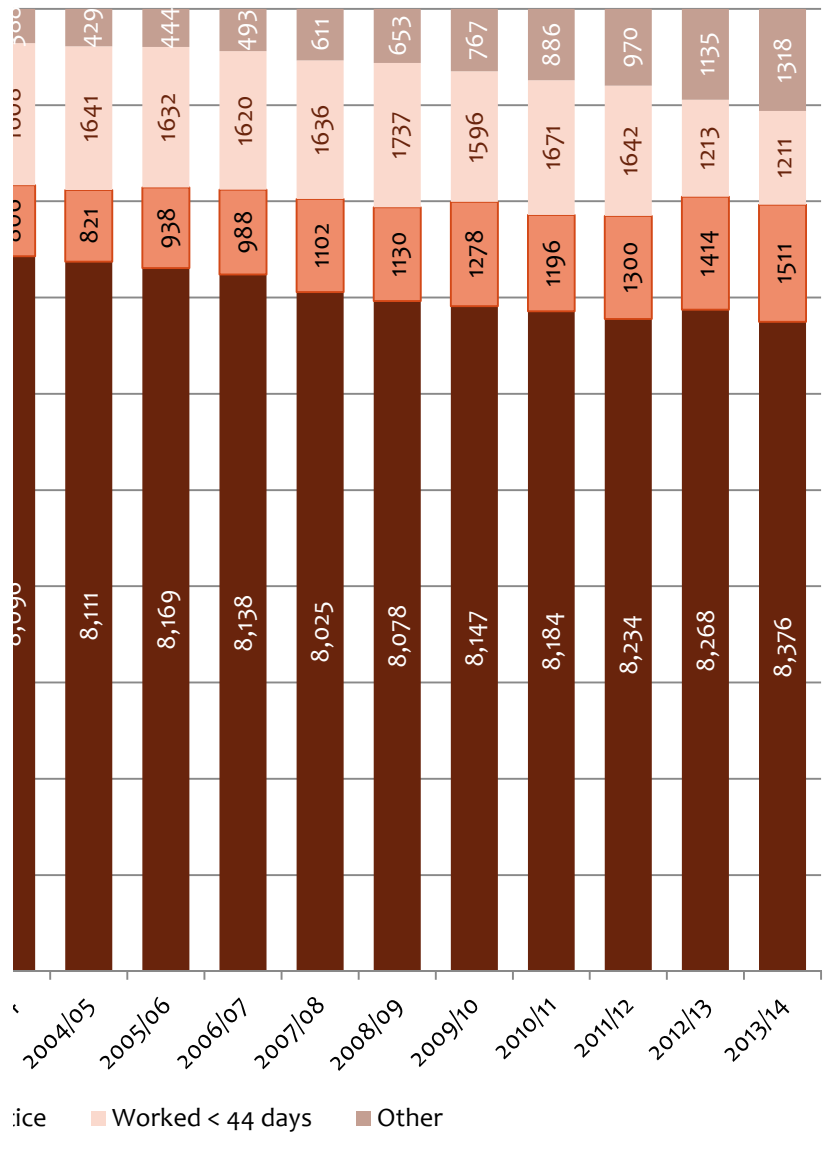
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Figure 3. Distribution of primary care Ontario, 1992/93



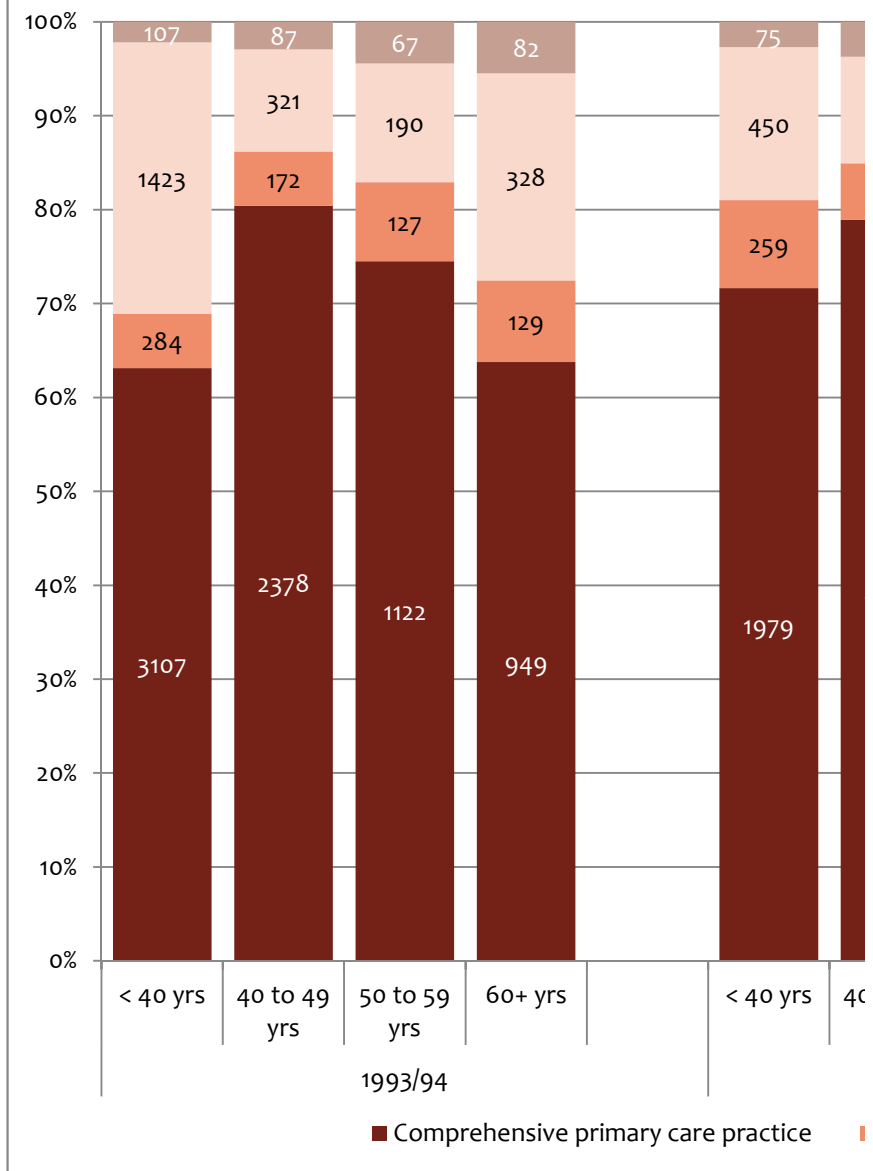
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Physicians by practice type, 2004/05 to 2013/14



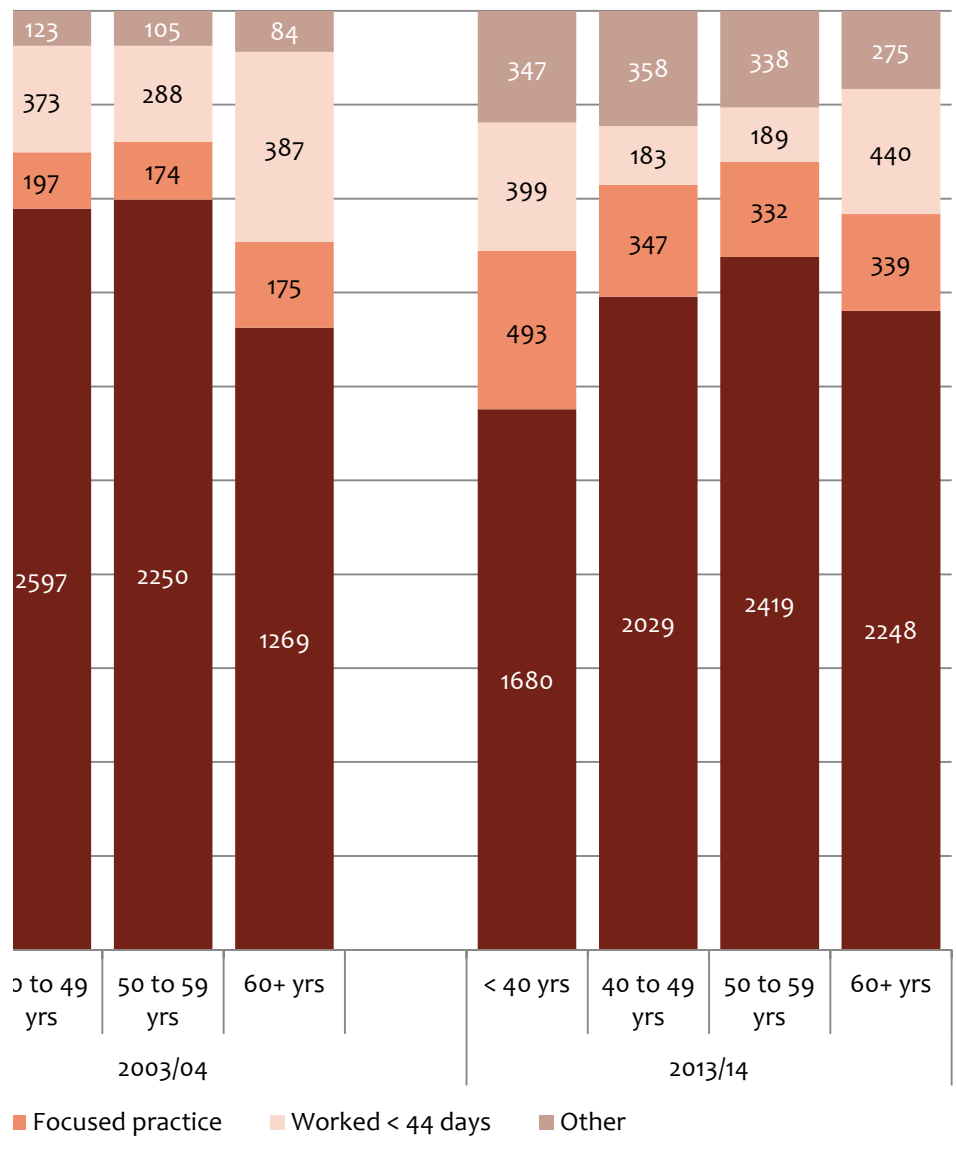
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Figure 4. Distribution of primary age group, 1993/94

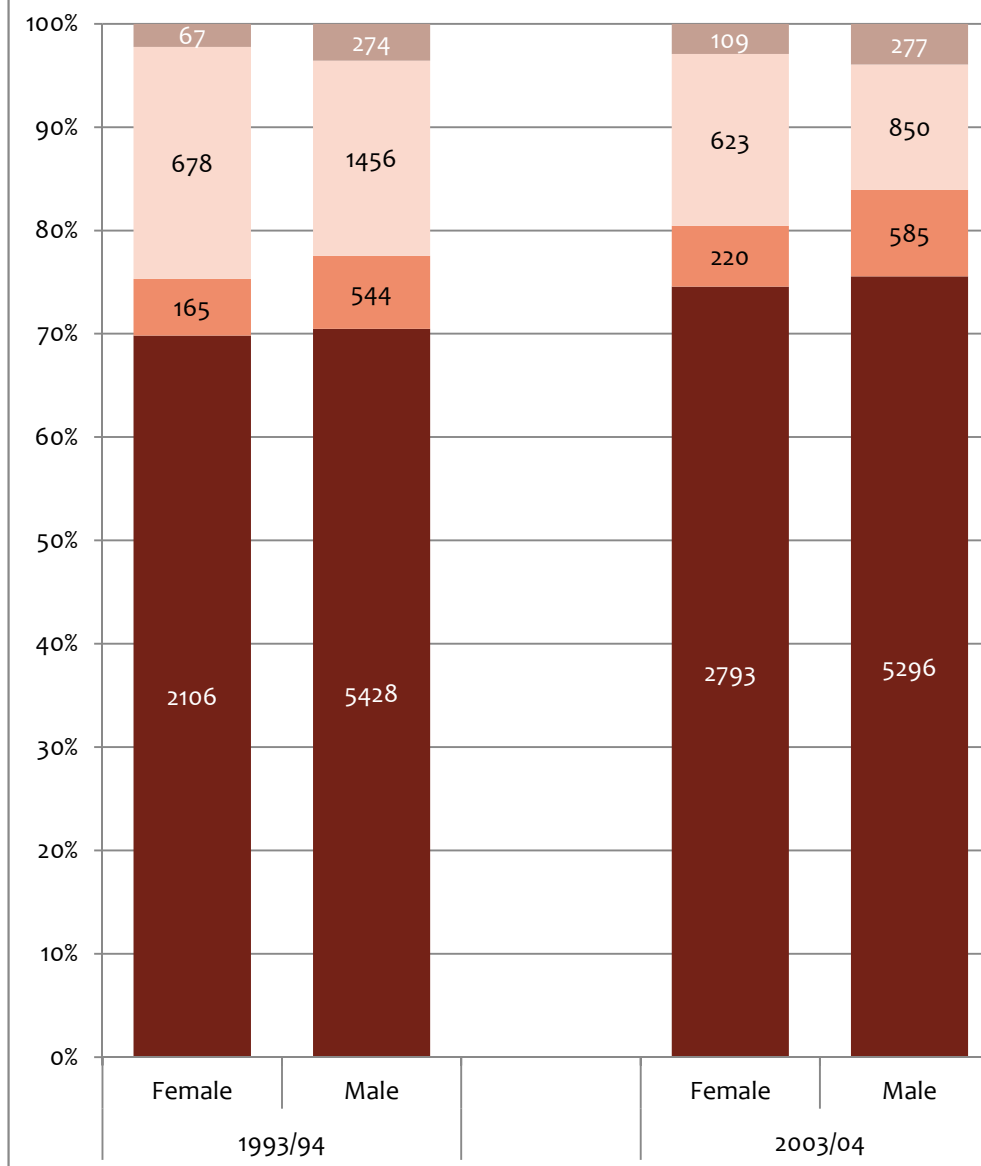


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Primary care physicians by practice type and age group, 2003/04 and 2013/14



**Figure 5. Percent distribution of physi
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icians by practice type and sex, 03/04, 2013/14

