connect

18th Canadian Collaborative Mental Health Care Conference (2017)

Connecting People in Need with Care

June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario

A Grounded Theory Study to Develop an Incentive Model for Quality Care of Depression and Anxiety in Ontario Family Health Teams: Initial Findings from Phase 1

RESEARCH TEAM

Rachelle Ashcroft

Faculty of Social Work
University of Toronto

Simone Dahrouge

Department of Family Medicine
University of Ottawa

Kwame Mackenzie

Wellesley Institute
University of Toronto

Jose Silveira

Department of Psychiatry
University of Toronto

ASSISTANTS:
Jocelyn Booton
Monica Emode

FUNDING SOURCE:

IRSC CIHR
Instituts de recherche en santé du Canada
Canadian Institutes of Health Research

PRESENTER DISCLOSURE

- **Presenter:** Matthew Menear, PhD
  Department of Family Medicine and Emergency Medicine
  Laval University

- **Relationships with commercial interests:**
  - **I have not received commercial support and have no conflicts of interest to declare**

LEARNING OBJECTIVES

1) Describe financial and non-financial incentives influencing the quality of care for depression and anxiety disorders in Family Health Teams (FHTs)

2) Learn about the qualitative processes being used to create a preliminary theoretical model to help stakeholders understand which incentives to leverage to improve quality of care

3) Share perspectives on how various incentives influence different quality of care dimensions (e.g. access to care, technical quality, structural quality, person-centred care, costs)

BACKGROUND

- **Family Health Teams (FHTs):** Ontario's flagship initiative for primary care reform since mid-2000s
  - 184 FHTs across the province
  - Serve over 3 million people (≈ 22% of the population)
  - Focus on interprofessional care

BACKGROUND

- Family Health Teams seem well positioned to improve access to high quality mental health care in primary care
- However, early evidence suggests that many FHTs have not embraced mental health care as one of their core services
  - Reports of poor access to mental health treatment and services (e.g. psychotherapy, psychiatric care)
  - Inconsistent collaboration between providers in primary care, mental health, and in the community

OBJECTIVE

To develop a model that describes the **system of incentives** that can be leveraged by stakeholders to improve access to **high-quality care** for depression and anxiety disorders in Family Health Teams

INCENTIVES & DISINCENTIVES

Incentive

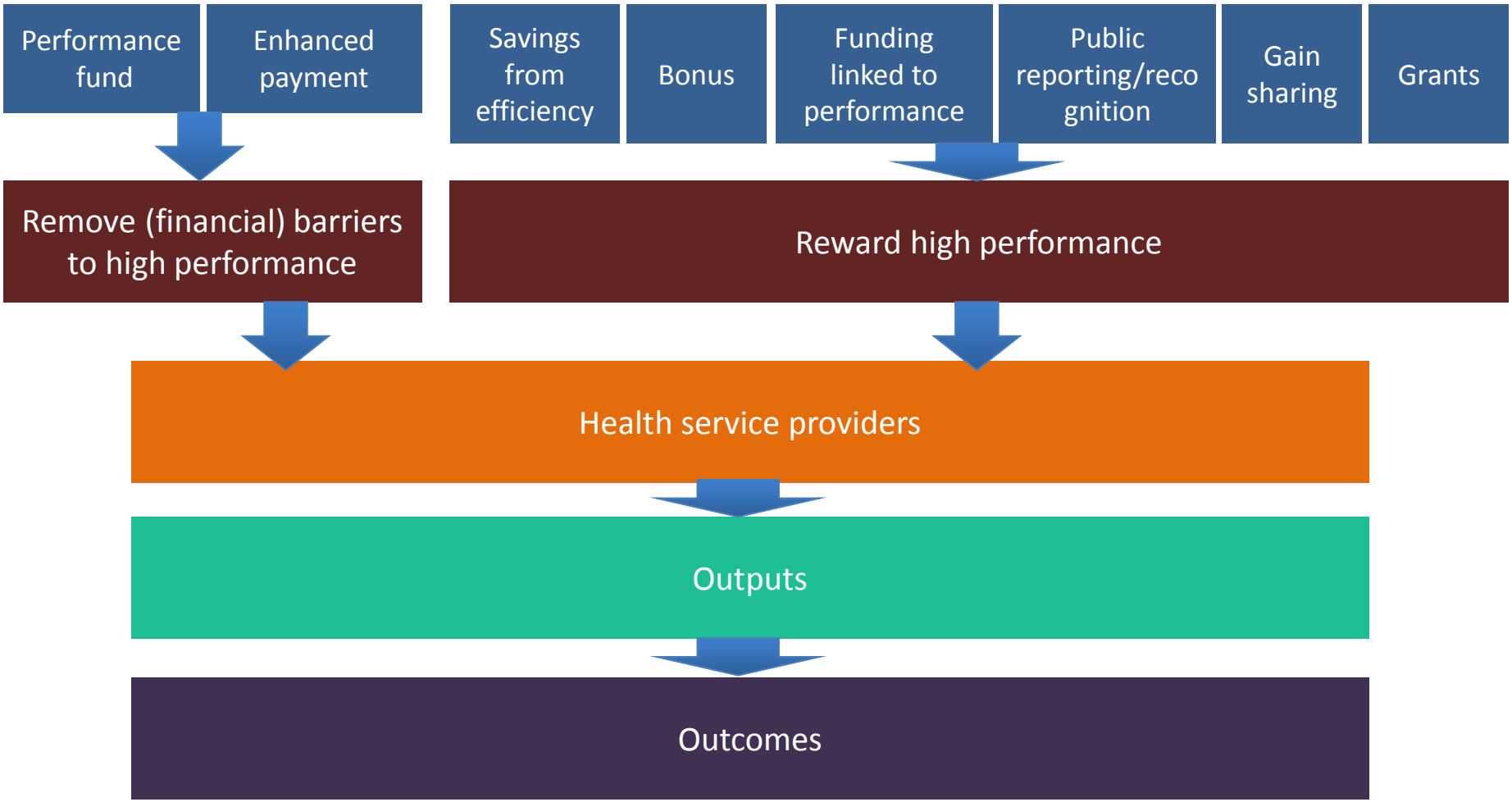
- A catalyst that encourages or motivates a particular action by an individual, group or organization

Disincentive

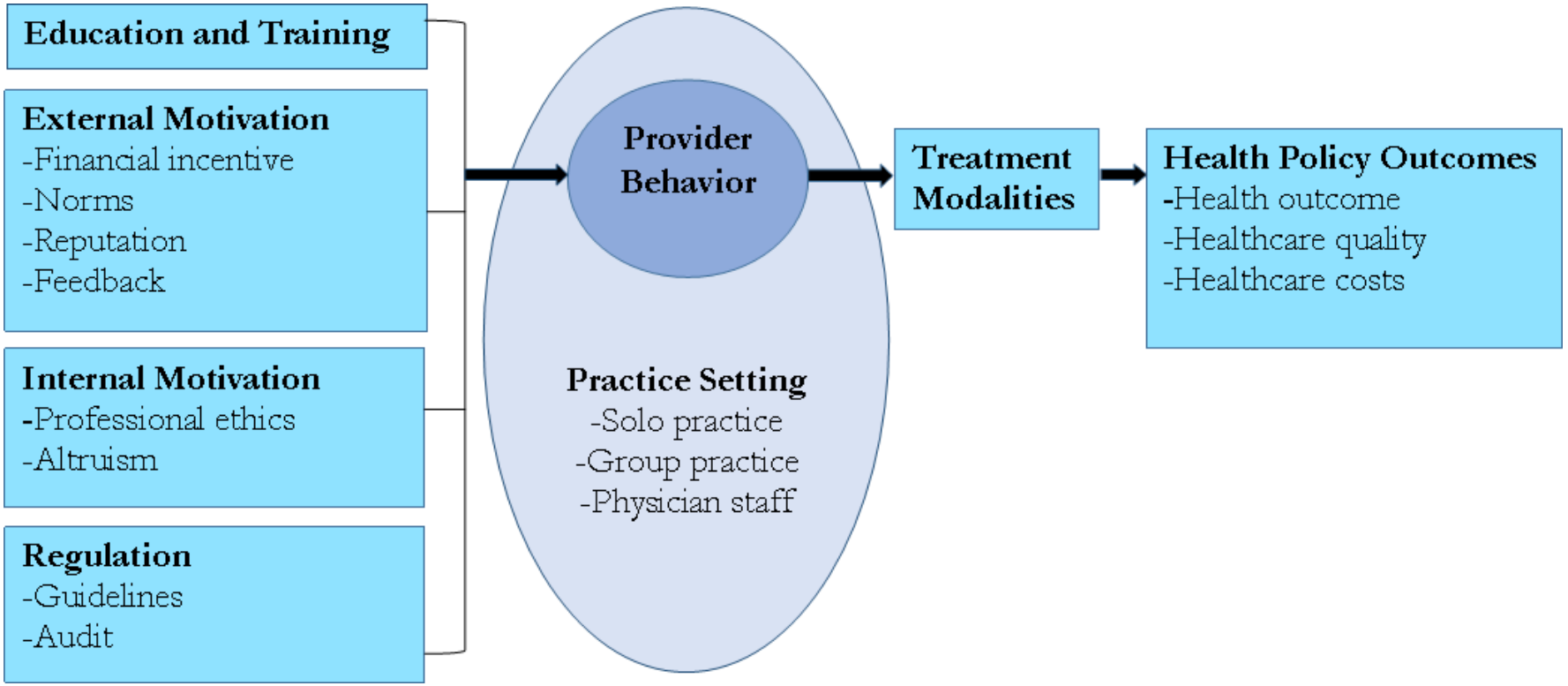
- Something that discourages or deters a particular action, making it less likely that an individual, group or organization will do something

TYPES OF INCENTIVES

Financial incentives (Custers 2007)



TYPES OF INCENTIVES



(Yip et al., 2010)

QUALITY DIMENSIONS

Access	Technical quality	Structural quality
Equity	Person-centredness	Cost & Efficiency

METHODS

- **Grounded theory** approach
  - A qualitative methodology that aims to guide theory construction that is “grounded” in data and fieldwork
  - Adopted a constructivist approach informed by the work of Charmaz
  - Line by line coding, constant comparison, weekly analysis meetings

METHODS

- **Phase 1: 2015 – 2017**
  - Descriptive phase
  - Initial sampling (n = 50)

Where we are now

- **Phase 2: 2017 – 2019**
  - Explanatory phase
  - Theoretical sampling (n = 50)

Target : N = 100

PHASE 1

- Individual participants: **50 semi-structured interviews**
- 15 Family Health Teams
- 9 Local Health Integration Networks (LHINs)

PHASE 1

- FHT participants (n = 42):
  - FHT Executive Director (6)
  - Program manager (2)
  - Physician (6)
  - Social worker (10)
  - Mental health counsellor (7)
  - Nurse or nurse practitioner (3)
  - Psychiatrist (4)
  - Other (e.g. Psychologist, OT, outreach worker) (5)
- Policy informants (n = 3)
- Community informants (n = 5)

PHASE 1

Interview guide question examples

Access to care	What makes it more or less likely that family physicians or other clinicians at your FHT will take on and care for a patient with depression or anxiety?
Technical quality	What incentives or disincentives influence whether psychotherapy is delivered to patients in your FHT?
Structural quality	What incentives or disincentives influence your ability to provide collaborative care for depression and anxiety disorders?

INITIAL FINDINGS

INITIAL FINDINGS

- **Financial incentives and disincentives**
  - Physician remuneration: Capitation
  - Access bonus
  - Remuneration for psychiatrists
  - Bonuses and quality improvement
- **Non-financial incentives and disincentives**
  - Internal motivation
  - Education and training

CAPITATION

PROS	CONS
Flexibility in how time is used Promotes teamwork Can engage patients in new ways	Capitation payments not well adapted for complex patients Not advantageous for heavy service users (e.g. chronic depression)

CAPITATION

Capitation works well when people need longer visits…or things where you have to bring a team together…. It doesn't work as well when people need lots and lots of visits…and this is actually where it probably hurts mental health care the most… That becomes a disincentive.

Physician, 116

ACCESS BONUS

- **What is the Access Bonus?**

  - Bonus for family physicians
  - Designed to prevent or “negate” rostered patients from seeking services from other providers that could be provided by the FHT family physician
  - Encourages physicians to extend office hours or provide group coverage so patients can be seen in a more timely fashion

ACCESS BONUS

- **Unintended consequences**
  - Physicians not getting their bonuses when rostered patients receive care in the community

  - This is happening when patients with depression or anxiety see other physicians in their community for counselling or crisis services
  - An issue for patients with higher service needs – **leads to de-rostering of more complex patients**

PSYCHIATRIST REMUNERATION

- **Psychiatrists receive sessional funding to compensate for indirect case management and consulting of primary care professionals**
  - Sessional funding does not take into consideration travel time
  - Indirect consultation time is not being used, especially by fee-for-service family physicians

QUALITY IMPROVEMENT

- **Bonuses are guiding primary care QI initiatives**
  - Bonuses for better management of chronic diseases (e.g. diabetes) or severe mental illness
  - No similar bonuses for mild-moderate common mental disorders – **disincentive to do QI for these patients**

QUALITY IMPROVEMENT

Prime example, the quality improvement initiatives. I sat on that one year and they were… "What were the financial bonuses?" **So we just picked the three financial bonuses and that was our target**….I mean obviously the government chose them because they were the key issues, but did they speak to everyone? Probably not.

Occupational therapist, 110

INTERNAL MOTIVATION

I get asked by my patients a lot, “Aren’t you tired?” Like, no, I get to bear witness to your amazing change and your resilience, and what a privilege to do this job.

Psychologist

INTERNAL MOTIVATION

My purpose in life is to be a voice for people who either can't or aren't strong enough to speak for themselves… I come alive when I'm engaged in supporting people with mental health issues.

System navigator

…There's incentives from a more personal and compassion perspective…if you actually help someone through their mental illness and they're getting better, you've made a big difference.

Physician

EDUCATION & TRAINING

- Many providers do not feel prepared to manage people with depression or anxiety disorders
- Some FHTs are investing in training for staff
- Most FHTs reported having **limited budgets** for education and training
    - Lack of training narrows professionals' scope of practice and decreases access to effective care

CONCLUSION

- Family Health Teams are improving capacity to deliver mental health care in primary care
- However, there are **clear misalignments** in the current system of incentives and disincentives that impact care delivered to people with depression and anxiety disorders
  - **Especially vulnerable patients that have more chronic presentations or greater needs for services**

NEXT STEPS

- Phase 2 interviews (n = 50)
- Build the incentive model
  - Establish clearer links between incentives/disincentives and our dimensions of quality
- Received funding to conduct interviews with primary care patients

DISCUSSION

- **Questions for the audience:**
  - How do our findings resonate with you?
  - What are the financial incentives or disincentives to providing team-based mental health care in Family Health Teams?
  - What are the major incentives impacting the practices of non-physician clinicians in FHTs?

CONTACT INFORMATION

Matthew Menear
matthew.menear.1@ulaval.ca

Rachelle Ashcroft
rachelle.ashcroft@utoronto.ca

THANK YOU

UNIVERSITY OF TORONTO

ST. JOSEPH'S HEALTH CENTRE | TORONTO

CIHR IRSC
Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

INSTITUT DE RECHERCHE Bruyère RESEARCH INSTITUTE

UNIVERSITÉ LAVAL

connect

18th Canadian Collaborative Mental Health Care Conference (2017)
Connecting People in Need with Care
June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario

uOttawa
Faculté de médecine
Faculty of Medicine

Bureau du développement professionnel continu
Office of Continuing Professional Development

uOttawa
Department of Family Medicine
Department of Psychiatry

CANADA 150
1867-2017

BE HERE FOR CANADA'S BIG YEAR!
2017 OTTAWA
OÙ LE CANADA ENTIER CÉLÈBRERA SA FIERTÉ!