THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

BEST ADVICE

Patient Rostering in Family Practice

NOVEMBER 2012

BEST ADVICE PATIENT ROSTERING IN FAMILY PRACTICE

Patient rostering in family practice is a process by which patients register with a family practice, family physician, or team. Patient rostering facilitates accountability by defining the population for which the primary care organization or provider is responsible[1] and facilitates an ongoing relationship between the patient and provider.

Rostering is a key component of newer primary care models now emerging in Canada, the United States, the United Kingdom, the Netherlands, Denmark, and New Zealand. In some jurisdictions, rostering is formalized through an agreement signed by both patients and providers that includes the commitments each makes to the other. In other settings, rostering is an informal agreement.

The objective of this paper is to provide guidance for Canadian family physicians who have already implemented or are considering patient rostering in their practices. The paper highlights the benefits and limitations of patient rostering and provides information to help physicians implement rostering in family practice.

While it is recommended that all family physicians consider rostering their patients, for those practising in Patient's Medical Home[2] (PMH) models—that is, with family physicians and teams of providers, electronic medical records (EMRs), and continuous quality improvement (CQI) programs—patient rostering is being recommended as a core element.

PMH recommendation 2.4: Each patient in a Patient's Medical Home should be registered to the practice of his or her personal family physician.[2]

USING ROSTERING TO IMPROVE PATIENT CARE

Patient rostering has been recognized as an important feature of a high-performing primary health care system.[3] Rostering has been implemented in many provinces across Canada. In Ontario, patient rostering has widespread or system-wide implementations.[3] In British Columbia, Manitoba, Quebec, New Brunswick, and Prince Edward Island, patient rostering has limited implementation (eg, local initiatives, pilot/demonstration projects, or implementation as part of a research project).[3] Some provinces provide materials to assist practices in setting up a practice roster (see Appendix B).

How would patient rostering help improve your practice?

Helps define the patient population

Provides better access to information about each patient

Supports optimal scheduling of visits

Facilitates preventive care

Enhances chronic disease management

Strengthens the patient–family physician team relationship

For physicians and teams, rostering can enable the practice to more readily define its panel size, organize appointment scheduling, track health indicators and outcomes, and potentially increase team member and patient satisfaction (see Benefits and Limitations of Rostering).

Factors Impacted by Patient Rostering

1. HEALTH OUTCOMES

For a family physician and health care team, rostering can facilitate the development and strengthening of the continuing relationship between patients and their personal family physician, nurses, and other team members, which is a critical factor contributing to better health outcomes, particularly for chronic disease management. Patient rostering with a family physician and team also facilitates effective preventive care and supports CQI activities in the practice.

Evidence suggests that patient rostering is associated with improved clinical outcomes for chronic disease management and diabetes care.[4]

2. PHYSICIAN-PATIENT COMMITMENTS

Patient rostering facilitates clear commitments from both family physicians and their patients. It enables proactive care opportunities by identifying patients and their clinical problems, thus facilitating the development of care plans. In Ontario, although patient rostering is voluntary, it involves a dual commitment from the patient and physician:

- Patients commit to seek treatment from their enrolling physician or group to which the family physician belongs unless they are traveling or find themselves in an emergency situation.
- Physicians commit to provide comprehensive care to their patients, including access to round-the-clock care through a combination of regular office hours, access to telephone health, and on-call services.

3. TIMELY ACCESS TO APPOINTMENTS

Patient rostering supports timely access to appointments in family practice with the patient's personal family physician and other members of the health care team. By helping to organize appointments efficiently, rostering enhances the capacity of teams comprised of the patient's family physician, nurses, and other health professionals to offer a comprehensive basket of services (see the College of Family Physicians of Canada's [CFPC's] *Timely Access to Appointments in Family Practice: Same-Day/ Advanced Access Scheduling*[5]).

4. ELECTRONIC MEDICAL RECORDS (EMRs)

In a rostered practice, EMRs support both individual and population-based care, particularly with respect to chronic diseases. They also support the information needed in the referral-consultation process, teaching, conducting practice-based research, and evaluation of the effectiveness of the practice as part of a commitment to CQI.[2]

5. FUNDING STRATEGIES

By identifying the patient population of a practice, rostering serves as an enabler for capitation or blended funding strategies. However, practices can benefit from rostering their patients regardless of the remuneration model.

In Ontario (see inset), family physicians in a patient-rostered family health team (FHT) primary care model are compensated through blended funding, which includes a base capitation payment for a comprehensive menu of core office-based services plus incentives and special payments for the provision of additional areas of care. For governments, rostering provides the opportunity for more predictable funding related to payments based on the number of registered patients rather than the number of services.[6]

In Quebec, family physicians in Groupes de médecine de famille (GMF) or in private practice receive a bonus for each enrolled patient.[7] Like Ontario's FHTs, GMFs are intended to facilitate access to a family physician and to improve the quality of medical services for the population.[7]

In Alberta, Primary Care Networks (PCNs) are funded via a virtual roster utilizing the "four-cut method".*[8] Physicians in a PCN receive a capitated fee of $62/rostered patient in addition to the fee-for-services provided.

ONTARIO PRIMARY CARE/FAMILY PRACTICE FUNDING MODEL

The number of primary care/family physicians practising in primary health care models (eg, family health teams) has **grown from 2,034** in January 2004 **to 7,514** physicians as of October 2010. More than **9.35 million patients** are rostered to a primary health care/family practice physician, representing approximately 70% of the population in Ontario.

Ontario's primary care models (see Appendix B) reward physicians for providing comprehensive primary health care services to their patients.

Models are based on alternative funding contracts, which set out physician obligations of care and requirements to provide a formal patient enrolment process.

Compensation is based on blended payments and a blend of financial incentives, premiums, and other types of payments.

Patient rostering improves the efficiency by which provincial funding and physician compensation are administered. Compensation can be adjusted in response to demographic or population characteristic changes and allocated based on population needs and requirements.[6]

From: Fleming M. Ontario Patient Rostering. CHSRF: Picking Up the Pace. Available at: http://www.chsrf.ca/Libraries/Picking_up_the_pace_files/Mary_Fleming.sflb.ashx.

*Example of a "four-cut" method:

1. Patients who have seen only one provider for all visits are assigned to that provider.
2. Patients who have seen more than one provider are assigned to the provider they have seen most often.
3. The remaining patients who have seen multiple providers the same number of times are assigned to the provider who performed their most recent physical or health check.
4. The remaining patients who have seen multiple providers the same number of times but have not had a sentinel exam are assigned to the provider they saw last.

From: Murray M, et al. How Many Patients Can One Doctor Manage? www.aafp.org/fpm/2007/0400/ p44.html[8]

6. CONTINUITY OF CARE

Continuity of care is enhanced by patient rostering. Research shows that those who see the same primary care physician continuously over time have better health outcomes than those who receive frequent care from several different physicians.[7] In a rostered practice, patients benefit by being able to access health care with and through the same health care provider over time and by facilitating their use of other health-related services when required.[6] The long-term relationship creates incentives for physicians to advise appropriate care[6]; patients are more likely to adhere to care when they develop a long-term relationship with their physician.[7] In recent years, the rate of rostered patients presenting in emergency departments for semi-urgent and non-urgent conditions has declined.[9]

> "The more physicians patients see, the greater the likelihood of adverse effects; seeking care from multiple physicians in the presence of high burdens of morbidity will be associated with a greater likelihood of adverse side effects."[7]
>
> From: Wranik DW, et al. *Health Care Anal* 2010;18:357

7. PREVENTIVE CARE AND CHRONIC DISEASE MANAGEMENT

Patient rostering provides patients access to a regular source of care which has been found to be the most important factor associated with receiving preventive care services, even after considering the effect of demographic characteristics, financial status, and need for ongoing care.[10] Receiving optimal primary care (in terms of availability, continuity, comprehensiveness, and communication) from a regular source of care further increases this likelihood.[11]

Rostering helps family physicians and teams identify patients with chronic diseases, facilitating the provision of important services, including:

- Preventive health counseling
- Screening and immunization programs
- Comprehensive, continuing coordinated care
- Teaching and supporting self-care for patients and their personal caregivers
- Advocacy for those with complex medical problems as they try to navigate their way through the health system[2]

8. PANEL SIZE

Panel size is the number of individual patients under the care of a specific provider. Rostering patients, particularly with the use of an EMR, enables more accurate and up-to-date information about both the panel size of a practice and the demographic and diagnostic information about the population being served. Although patient rostering can increase physician/patient accountability and encourage accessibility for patients,[6] it is important that the panel size not exceed the ability of the family physician and team to provide timely access and quality care. When deciding on panel size, each practice must determine how rostering more patients into the practice might impact access to appointments and care not only for potential new patients but also for the current practice population. Panel size should take into consideration both the workload of the health care providers and the safety of the patients.[2] Defining practice populations (ie, both the number of patients in a practice and their medical problems) is paramount when beginning active outreach to patients for chronic disease management, preventive measures, or other quality assurance activities (see CFPC's *Best Advice on Panel Size*[12]).

Case Study: A Family Practice Experience

"Since rostering my patients I now know exactly how many diabetic patients I have, how many children need immunization, and how many elderly patients might need house calls. This helps me approach my work not just on an individual basis as patients come to the office, but it also helps me reach out to patients who have missed regular monitoring, thus ensuring better uptake of important primary and secondary prevention interventions."

Dr Ruth Wilson, family physician
Kingston, Ontario

BENEFITS AND LIMITATIONS OF PATIENT ROSTERING

Family physicians should consider both the benefits and limitations associated with transforming a traditional practice into a system that rosters or registers patients. The transition to a rostered system will entail changes requiring a commitment of resources and energy, but can yield positive results over time. See *Appendix A* for questions to think about when considering formal rostering.

1. BENEFITS OF ROSTERING

A. For family physicians and teams

- Helps a practice more clearly define its patient population
- Strengthens the physician-patient relationship by facilitating continuity of care provided by each patient's personal family physician and team
- Helps identify the needs of specific groups within the overall practice population (eg, underserved patients, patients with mental health problems)
- Helps to identify cases for research and teaching
- Enhances gathering of information required to provide optimal preventive care and effective management of patients with complex and chronic diseases
- Provides better information about each patient
- Facilitates the gathering of data, which can be used for measurement of practice performance and quality improvement[6]
- Assists in patient scheduling, reminders for visits, and monitoring of care
- Provides a clear understanding of the obligations of physicians and patients to one another
- Identifies unique needs of the practice in order to address them. For example, an inner-city practice might have differing needs (and hence a different set of team skills) than a highly ethnic practice. In addition, from a system perspective, rostering provides information on unattached patients, including those in geographic pockets and in specific underserved populations
- Facilitates implementing a capitation or blended funding model

B. For patients and health system

- Links each patient more formally to his or her own family doctor and team
- Enables more timely appointments
- Supports more effective preventive and chronic disease care
- Supports patients' access to a comprehensive range of services
- Increases the likelihood of continuity of care
- Facilitates access to information needed for referrals to other specialists and health services
- Patients will not be refused rostering due to their health status or need for services

2. LIMITATIONS OF ROSTERING

A. For family physicians and teams

- Creating a roster requires staff time, resources, administrative expertise, training, and IT support
- Patients retain the right to seek health care services in other primary care settings
- Under a capitated payment system, a family practice cannot roster a patient who is already rostered with another practice
- In some jurisdictions, there are financial penalties if a rostered patient receives non-urgent primary care services elsewhere
- There could be a requirement for a minimum number of patients in a practice in order to qualify for formal rostering and alternate payment options

B. For patients and health system

- It might be more difficult to switch family physicians and practices
- In capitated/rostered practices, there is no guarantee that physicians and teams will maintain or increase services for patients

References

1. Hutchison B. A long time coming: primary healthcare renewal in Canada. *Healthc Pap* 2008;8:10-24.
2. College of Family Physicians of Canada. *A Vision for Canada: Family Practice – The Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2011. Available from: www.cfpc.ca/A_Vision_for_Canada_Family_Practice_2011/. Accessed 2012 Oct 09.
3. Canadian Working Group for Primary Healthcare Improvement. Toward a Primary Health Care Strategy for Canada. 2012.
4. Manns BJ, Tonelli M, Zhang J, et al. Enrolment in primary care networks: Impact on outcomes and processes of care for patients with diabetes. *CMAJ* 2012;184:E144-E152.
5. College of Family Physicians of Canada. *Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: www.cfpc.ca/Timely_Access/. Accessed 2012 Oct 10.
6. Fleming M. Ontario Patient Rostering. CHSRF: Picking Up the Pace. Available from: www.chsrf.ca/Libraries/Picking_up_the_pace_files/Mary_Fleming.sflb.ashx. Accessed April 17, 2012.
7. Wranik DW, Durier-Copp M. Physician remuneration methods for family physicians in Canada: expected outcomes and lessons learned. *Health Care Anal* 2010;18:35-59.
8. Murray M, Davies M, Boushon B. Panel Size: How Many Patients Can One Doctor Manage? American Academy of Family Physicians website. 2007. www.aafp.org/fpm/2007/0400/p44.html. Accessed 2012 Oct 10.
9. Kralj B, Kantarevic J. Primary Care in Ontario: Reforms, Investments and Achievements. Ontario Medical Review. Feb 2012. Available from: https://www.oma.org/Resources/Documents/PrimaryCareFeature.pdf. Accessed October 2, 2012.
10. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004;113(5 Suppl):1493-1498.
11. Bindman AB, Grumbach K, Osmond D, Vranizan K, Stewart AL. Primary care and receipt of preventive services. *J Gen Intern Med* 1996;11:269-276.
12. College of Family Physicians of Canada. *Best Advice – Panel Size*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Final%20June%209%2011%20Final%20Panel%20Size%20Best%20Advice.pdf. Accessed 2012 Oct 10.

Appendix A

Questions to ask before rostering your practice

- Do I want to establish a rostered practice where my relationship with my patients will include more clearly defined expectations of and commitments to one another?
- If I am practising as part of a team or group, do my colleagues support rostering our patients?
- Do I think rostering can help me and the team in my practice offer more timely access to appointments for patients? (See the CFPC's *Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling*[1]).
- Do I think rostering will help individuals and their families participate in making the best decisions in areas requiring health promotion, disease prevention, and chronic disease management?
- Do I think rostering will help me provide comprehensive, continuing care for my patients?
- Do I want to know how many of my patient files/charts represent "active" patients? (See the CFPC's *Best Advice on Panel Size*[2].)
- Do I want to know more about the diagnoses of individual patients and my practice population?
- Do I have an electronic medical record (EMR)? If yes, is the EMR I have able to accommodate the recommended rostering system?
- Am I interested in being paid through different models of remuneration than only fee-for-service (eg, capitation, blended funding)? If yes, do I think rostering will facilitate this?

"Yes" responses are consistent with readiness to consider rostering your patients.

References

1. College of Family Physicians of Canada. *Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: www.cfpc.ca/Timely_Access/. Accessed 2012 Oct 10.
2. College of Family Physicians of Canada. *Best Advice – Panel Size*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Final%20June%209%2011%20Final%20Panel%20Size%20Best%20Advice.pdf. Accessed 2012 Oct 10.

Appendix B

Rostering in Canada and other countries

Canada:

Alberta – Primary Care Networks (PCNs)

- PCNs are funded via a virtual roster utilizing the "four-cut method." Physicians in PCNs receive a capitated fee of $62/rostered patient in addition to the fee-for-services provided.
  - Eg, Chinook PCN – Taber Clinic (Taber Integrated Primary Health Care Project), employs capitation funding with patient rostering

Ontario – Patient Enrolment Models (PEMS)[1]:

- Comprehensive Care Model (CCM)
- Family Health Group (FHG)
- Family Health Network (FHN)
- Family Health Organization (FHO)
- Blended Salary Model (BSM):
  - Available to primary care physicians employed by a community-sponsored or mixed-governance family health team
- South Eastern Ontario Academic Medical Organization (SEAMO)
- Rural and Northern Physicians Groups Agreement (RNPGA)
- Group Health Centre (GHC)
- St. Joseph's Health Centre (SJHC)
- Weeneebayko Health Ahtuskaywin (WHA)
- Strathroy Medical Clinic

Ontario provides a Central Forms Repository at: www.health.gov.on.ca/en/public/forms/primary_fm.aspx.

Quebec

Quebec offers rostering information (in French) on the following website: www.fmoq.org/fr/remuneration/support/special/default.aspx.

Denmark:

- General practice in Denmark is characterized by five key components[2]:
  1. A list system, with an average of close to 1,600 persons on the list of a typical general practitioner (GP)
  2. The GP acts as gatekeeper and first-line provider in the sense that a referral from a GP is required for most office-based specialists and always for in- and outpatient hospital treatment
  3. An after-hours system staffed by GPs on a rota basis
  4. A mixed capitation and fee-for-service system
  5. GPs are self-employed, working on contract for the public funder based on a national agreement that details not only services and reimbursement but also office hours and required postgraduate education

Netherlands:

- The International Health Centre – The Hague[3]
  - Patients in the Dutch health care system register with one "*huisarts*" (family practice) of their choice before receiving access to a variety of services.
  - Not registering with a family practice can delay care when patients become ill; patients could also encounter difficulty finding a nearby doctor who is taking patients
  - Patients require a referral from a *huisarts* to receive non-urgent hospital or specialist treatment that is covered by Dutch medical insurance

New Zealand:

- Capitation funding in New Zealand requires patients to be enrolled to a primary care provider[4]
- Enrolled patients have the advantage of lower-cost GP visits, cheaper prescriptions, access to free doctor and nurse consultations for certain medical conditions, and many other benefits
- Example enrolment form (Roselands Doctors, South Auckland)[5]

Norway:

- Referred to as the "patient list system"
- All people age 12 and older apply to join the roster/list of one permanent physician
- Those who already had a regular physician would generally remain on that physician's roster
- Individuals may transfer to another physician once per year
- Each physician is responsible for providing the necessary health care to the patients on his or her list and for collaborating with other health care professionals and referring to specialists or hospitals as necessary[6]

United Kingdom:

- Mandatory universal registration with a single practice (General Practitioner Surgery) of the patient's choice
- The General Practitioner Surgery must be within the patient's catchment area
- All primary medical care is provided by GPs/family doctors
- Under these contracts, approximately 75% of practice income comes from capitation[7]
- Patients complete NHS Patient Registration Forms[8]
- NHS GP FAQs are available
- If patients have difficulty finding a GP or registering, they can contact their local primary care trust

United States:

- Kaiser Permanente – Patients can be enrolled if they meet certain criteria[9]
- American Academy of Family Physicians (AAFP) Patient-Centered Medical Home (PCMH)[10]:
  - Patient registration is a key component of the PCMH
  - Patient registries are used to monitor and set population health goals

References

1. Fleming M. Ontario Patient Rostering. CHSRF: Picking Up the Pace. Available from: www.chsrf.ca/Libraries/Picking_up_the_pace_files/Mary_Fleming.sflb.ashx. Accessed April 17, 2012.
2. Pedersen KM, Andersen JS, Søndergaard J. General practice and primary health care in Denmark. *J Am Board Fam Med* 2012;25(Suppl 1):S34-S38.
3. The International Health Centre website. The Hague. www.internationalhealth.nl/. Accessed 2012 Oct 10.
4. Ministry of Health website. Visiting a Doctor – Enrolling with a GP. New Zealand. 2012. www.health.govt.nz/yourhealth-topics/health-care-services/visiting-doctor. Accessed 2012 Oct 10.
5. Roselands Doctors website. Patient Enrolment Form [example]. New Zealand. www.roselandsdoctors.co.nz/EnrolmentForm.pdf. Accessed 2012 Oct 10.
6. Ostbye T, Hunskaar S. A new primary care rostering and capitation system in Norway: lessons for Canada? *CMAJ* 1997;157:45-50.
7. Roland M, Guthrie B, Thomé DC. Primary medical care in the United Kingdom. *J Am Board Fam Med* 2012;25(Suppl 1):S6-S11.
8. National Health System website. Family Doctor Services Registration. www.nhs.uk/choiceintheNHS/Yourchoices/GPchoice/Documents/GMS1%5B1%5D.pdf. Accessed 2012 Oct 10.
9. Kaiser Permanente website. We Make Enrolment Easy. https://medicare.kaiserpermanente.org/wps/portal/medicare/plans/enroll. Accessed 2012 Oct 10.
10. American Academy of Family Physicians website. Patient-Centered Medical Home (PCMH). Building Your PCMH? 2012. www.aafp.org/online/en/home/membership/initiatives/pcmh.html. Accessed 2012 Sep 7.

NOVEMBER 2012

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA