Uncertainties surround new funding for "Most Responsible Physicians"

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The eligibility and accountability requirements of a new program to improve Most Responsible Physician (MRP) services in Ontario hospitals are "confusing" and "vague," doctors say.

This fall, Ontario will roll out the first phase of a $33-million MRP Collaboration Incentive Fund to reward attending physicians who agree to participate in quality improvement projects to handle unscheduled or "orphan" patients in hospitals.

The MRP is the doctor with day-to-day responsibility for a patient's care. His duties include the provision of most of a patient's primary care, from on-call admission assessments to consultations, discharge and subsequent visits.

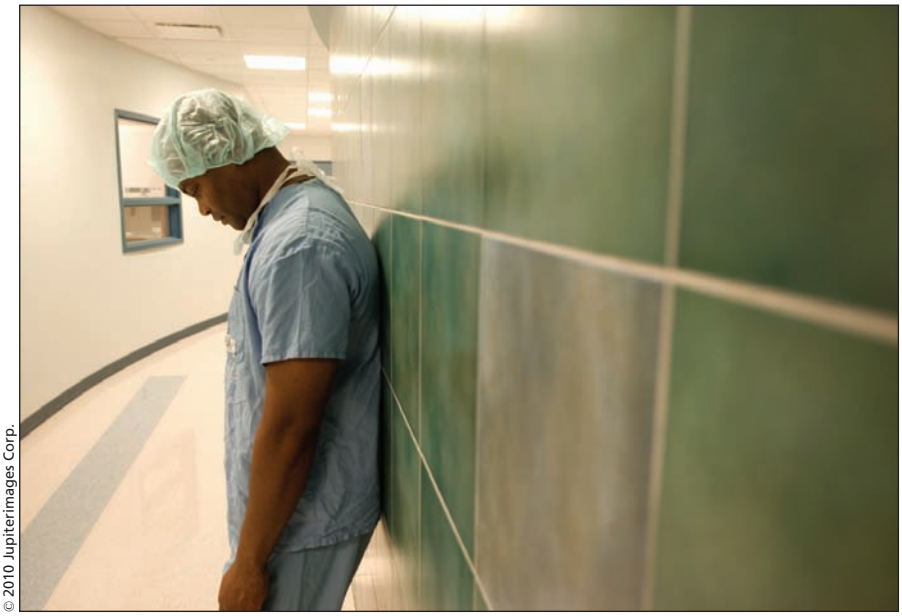
The fund will distribute $11 million to participating physicians in 2010, and another $22 million in 2011, largely in hopes of encouraging more physicians to provide and improve MRP services for unscheduled patients.

Part of the 2008 Physician Services Agreement, the fund is among Ontario's initial efforts to address the shortage in doctors willing or able to provide unscheduled MRP services.

The role has typically required doctors to undertake extra work for which they are not adequately paid, says Dr. Alan Karovitch of the Ottawa Hospital in Ontario "They're just understaffed and overwhelmed, particularly at the smaller hospitals."

Still, the initiative has been met with confusion over who is eligible for the funding and what kind of return the province expects on its investment.

Controversy emerged earlier this summer when the province released a list of MRPs deemed eligible for funding, Karovitch says. "There were people who clearly should be on the list who weren't, and people who clearly shouldn't be on the list who were."



Many doctors believe that they haven't been adequately compensated in the past for the extra and often exhausting work associated with providing care for unscheduled hospital patients.

In order to sign up for the initiative and funding, a physician must have active hospital privileges in the province, provide at least 200 unscheduled MRP services annually and be eligible to bill MRP fee premiums.

"The problem is that those MRP premium codes were only introduced last October, so for January to September of 2009, the province estimated the number and type of services provided using a variety of other billing codes, some of which are reflective of MRP work, and some of which are not," says Karovitch. "There was a lot of consternation about that, because we thought you'd only ever see the money if you had your name on the list."

The province will use the billing code data from 2009 to determine the percentage of total MRP services each hospital provided and will divvy the funding accordingly. But it's up to the MRPs at each hospital to decide how to carve up their collective share.

Karovitch assumes most MRP groups will disregard the province's list when deciding how to split the money, if they split it at all. "It's ultimately not a lot of money when you split it up between individual MRPs. We'll probably divide it up between the departments based on the number of services they provided and they can choose to split it individually or keep it in a lump sum for programming."

Some hospitals have yet to establish MRP groups. Others, particularly smaller hospitals, haven't even heard of the fund.

"It's not surprising some hospitals don't know about it, because this was all done very quickly," says Dr. Richard McLean, vice-president of medical affairs and quality at Hamilton Health Sciences in Ontario. "Beyond the money, doctors don't know what they're signing up for and whether or not it's worth the hassle."

According to the province, participating MRPs must commit to ensuring

"24/7/365" coverage for unscheduled patients, developing and implementing a quality improvement plan, and reviewing their performance on key indicators, such as average length of stay, emergency department wait times, readmission rates and patient satisfaction.

But how MRPs will be held accountable is still unclear, says McLean. "It's all kind of vague. All I'm seeing is that MRPs have to engage in some kind of quality improvement program, but there are no metrics laid out for what that will look like, and no real deliverables."

As far as performance reviews go, there's no obligation for MRPs to report their findings, or any penalty for failing to implement systemic changes. As such, some doctors wonder if the new initiative will simply fall into the old fee-for-service trap, with those hospitals providing more MRP services getting a bigger slice of the funding pie without necessarily improving the quality of care.

Under Ontario's fee-for-service model, there's little enough incentive for doctors to provide MRP services to hospital inpatients in the first place, let alone track the quality of those services.

"[Doctors] are so busy responding to what they have to do to get their fees, there's no mechanism that can free people up to engage in system issues," says McLean.

Whether a patient is well-treated or not, doctors get the same amount of money, adds Dr. Charles Chan, vice-president of medical affairs and quality at the University Health Network in Toronto, Ontario. "There is no differentiation between a well-treated asthmatic who is on minimal medication and has minimal visits to the emergency room because I gave them a comprehensive educational plan, versus a poorly treated asthmatic who is basically left to manage on their own apart from a brief consultation, has wildly uncontrolled asthma and is a huge burden on the health care system."

How MRPs will find the time to run quality assurance initiatives is also a concern, says McLean. "In reality, MRPs are going to have to take time out of their practices to run this thing. Not to mention, it's usually the hospitals that drive this sort of project, and the docs may come up with a plan the hospital is challenged in resources to support."

Without a "robust accountability framework," the fund won't amount to much more than a premium of a few dollars extra per service per MRP, McLean says. But the situation isn't entirely grim. The province has simultaneously increased MRP billing codes by 30%.

The program is expected to yield the greatest dividends for physicians working in smaller hospitals, where staffing limitations force all doctors to take on the extra work of providing MRP services.

"There's little recognition given to the time and effort required to participate in hospital care," says Dr. Cindy Morrison, chief of staff at the Arnprior Hospital in Ontario. "OHIP payment certainly does not balance out the equation."

The province will roll out the first phase of funding to hospitals in November. — Lauren Vogel, *CMAJ*

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