Attribution and Older Adults Living with Complex Health Conditions[1] Considerations

Introduction

The Ontario Government has embarked on health system redesign that will result in the creation of new "Ontario Health Teams" (OHTs), a novel made-in-Ontario amalgam of multiagency, accountable care organizations. These OHTs will have an assigned, or attributed population, for which each OHT is to provide the majority of health care services.

Central to this model is the attribution of Ontario residents to a specific OHT. This process is being facilitated by an attribution model, based on the work of Stukel et al[2].

Key features of this model include:

- Linking each Ontario resident to his or her usual provider of primary care
- Linking each specialist to the hospital where he or she performed the most inpatient services
- Linking each primary care physician to the hospital where most of his or her ambulatory patients were admitted for non-maternal medical care.
- Linking each resident to the same hospital as his or her usual provider of primary care.
- Computing "loyalty" as the proportion of care to network residents provided by physicians and hospitals within their network.
- Aggregating smaller clusters to create networks based on a minimum population size, distance, and loyalty.
- Note: Networks are not constrained geographically.

Considerations

- An earlier version of this model excluded individuals older than 100. In 2016, there were 3,005 Ontarians older than age 100[3]. It is not clear whether this assumption informed the recent data extractions of the Ministry of Health and subsequent population attributions provided to OHT applicants. Exclusion of the population older than 100 would impact a small but potentially resource intensive group, and may be of particular concern to smaller OHTs in rural communities.
- Newer residents in rural communities (e.g. retirees) may retain their primary care provider who may be located some distance away. This attachment would attribute these

[1] Complex health conditions may include mental health and addictions concerns, dementia and multiple, interacting medical conditions (sometimes called frailty)

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863751/pdf/OpenMed-07-e40.pdf

[3] https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/Page.cfm?Lang=E&Geo1=PR&Code1=35&Geo2=&Code2=&SearchText=Ontario&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=35&type=0

individuals to an OHT that is in a different location from that in which the individual would need to receive home and community based supports.

- Specialists providing community-based geriatric services (e.g. geriatricians, geriatric psychiatrists) may be located some distance from the communities in which their patients live. This is particularly true in remote northern communities, who may be served by specialists from distant locations who connect via telemedicine technology, or the Ontario Telemedicine Network (OTN) e-consult platform. These specialists may be linked to a hospital that is outside the community in which the patient lives, and in which the individual would need to receive home and community based supports to remain living at home. It is not clear how attribution has been considered in this scenario.
- Regionalized ambulatory geriatric services (e.g. geriatric day hospitals etc.) may draw patients from many communities to a central location. It is unclear how this has been considered in the attribution model.
- Many people who live with complex health concerns are seen in Community Health Centres or by nurse practitioners (NPs). The data of these providers has not been included in the current attribution model. This may disproportionately exclude older adult living with complex medical or mental health & addictions concerns from attributed populations.
- Exclusions from an attributed population may have greater implications in smaller OHTs, where resources are more constrained.