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Uptake of the New Fee Code for Ontario's Enhanced 18-Month Well Baby Visit: A Preliminary Evaluation

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About ICES

Ontario's resource for informed health care decision-making

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization that produces knowledge to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES' evidence supports health policy development and guides changes to the organization and delivery of health care services.

Key to our work is our ability to link population-based health information, at the patient-level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 12 million of 30 million Canadians allow us to follow patient populations through diagnosis and treatment, and to evaluate outcomes.

ICES brings together the best and the brightest talent across Ontario. Many of our scientists are not only internationally recognized leaders in their fields, but are also practicing clinicians who understand the grassroots of health care delivery, making the knowledge produced at ICES clinically-focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, and project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, our faculty and staff compete for peer-reviewed grants from federal funding agencies, such as the Canadian Institutes of Health Research, and project-specific funds are received from provincial and national organizations. These combined sources enable ICES to have a large number of projects underway, covering a broad range of topics. The knowledge that arises from these efforts is always produced independent of our funding bodies, which is critical to our success as Ontario's objective, credible source of *Evidence Guiding Health Care.*

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Background

The 18-month well baby visit is often the last in a series of routine visits (geared around the immunization schedule) with a primary care provider prior to school entry. This visit is widely acknowledged to be a critical point in the continuing care of the infant/child at which to assess developmental progress. By 18 months, major motor and communication milestones should have been reached, whereby delays in meeting these milestones may flag important concerns such as autism spectrum disorder. It is also a critical transition period for parenting, where the challenges of caring for an infant are rapidly being replaced by the challenges of caring for a toddler. Most parents have returned to work by this point and often require support and guidance in dealing with the challenges of this developmental period. The 18-month visit provides a critical opportunity for primary care providers to engage with parents and guardians.

In recognition of this, the Ontario Ministry of Children and Youth Services convened an Expert Panel on the 18-Month Well Baby Visit to develop a report that would provide the basis for a provincial strategy to support standardized developmental review and evaluation at 18 months for each child in Ontario. Recommendations from that 2005 report[1] called for progressing from a well baby check-up to a pivotal, broad-based assessment of developmental health. This included introducing a process that would use standardized tools to facilitate health professionals having a broader discussion with parents on the following key issues:

- Child development;
- Parenting;
- Connecting to local community programs and services that promote healthy child development and early learning; and,
- Promotion of early literacy through book reading.

In conjunction with the Ontario Ministry of Health and Long-Term Care, new fee codes (A002 for family physicians and A268 for paediatricians, valued at $62.20 and $61.00 respectively) were introduced in October 2009 as an incentive for conducting enhanced well baby visits at 18 months. The billing requirement to claim this increased fee is the documentation of a discussion of the child's development using screening tools completed by the parent/caregiver (the Nipissing District Developmental Screen) and by the physician (the Rourke Baby Record). (See the Appendix for detailed requirements.) If either instrument suggests that developmental milestones have not been met, referral to appropriate services or more specialized assessment is to be undertaken.

This report is a preliminary evaluation of the uptake of the enhanced 18-month visit. It is meant to describe the pattern of use of the new fee code over its first 14 months by Local Health Integration Network (LHIN), provider type and the socioeconomic status of eligible children as measured by neighbourhood income quintile. A more detailed evaluation of uptake will follow in late 2011.

Methods

Data Sources

This study was conducted at the Institute for Clinical Evaluative Sciences (ICES). At ICES, anonymized health information for all residents of Ontario eligible for the Ontario Health Insurance Plan (OHIP) is held. These data include routine administrative data from hospitals, emergency departments, and fee-for-service physicians billings from OHIP. Unique scrambled identifiers are used to link across these datasets.
For this study, we used the following databases:

- The Ontario's Registered Persons Database (RPDB) contains patient information, such as age, sex and place of residence, for all persons covered by OHIP.
- Neighbourhood income was derived by linking the child's postal code to 2006 Canadian Census data for the mean income quintile of a dissemination area (with a population of approximately 400 to 1,200 people).
- The OHIP database was used to enumerate physician billings for the enhanced visit and to define participating physicians by type of practice.

Study Period

For this study, we focused on the period from October 1, 2009, when the fee code was introduced, to December 31, 2010. Analyses were conducted in early March 2011. An important caveat: OHIP billings are considered to be complete from six months after the date of service, which means that some of the data from September 1 to December 31, 2010, may be incomplete.

Inclusion and Exclusion Criteria

We considered that children who were alive, who were eligible to receive health care services in Ontario and who were aged 17 to 24 months in the year 2010 (i.e., they were between 12 and 17 months of age on January 1, 2010), had qualified to receive the enhanced 18-month well baby visit (these formed the study denominator).

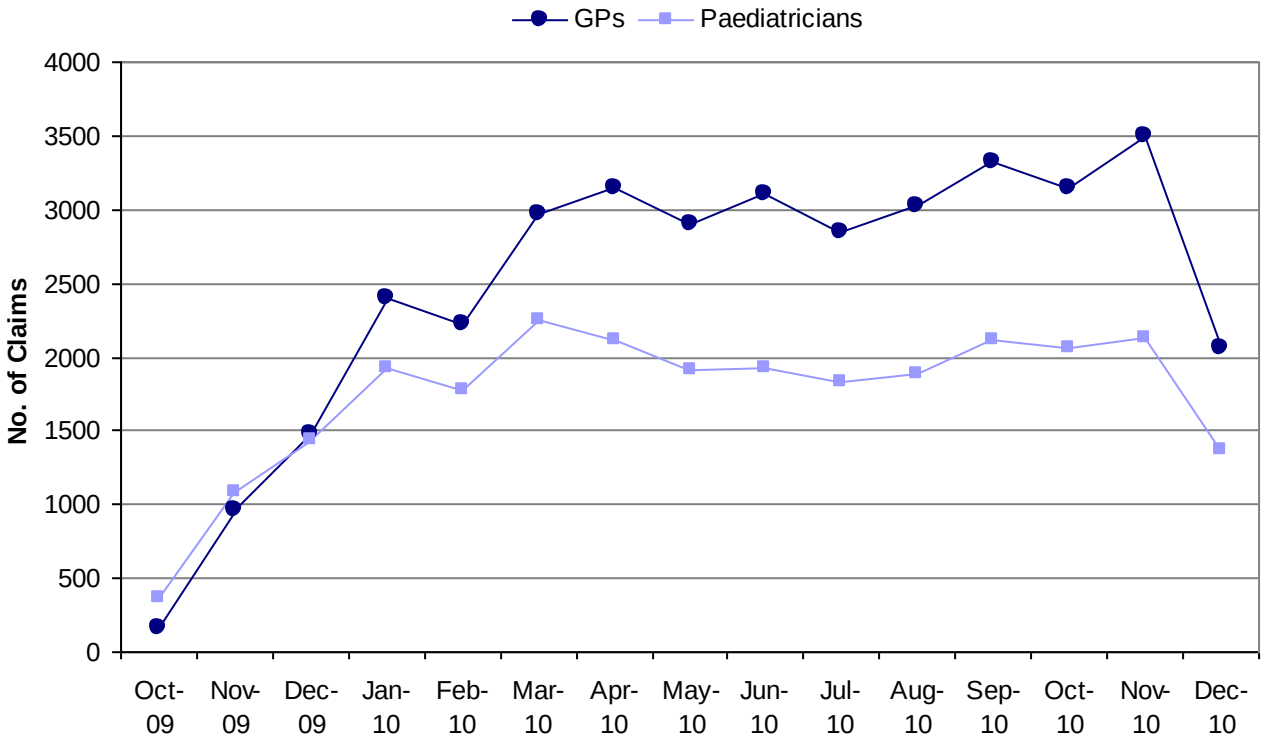
To identify physicians who provided primary care to young children, we looked at general practitioners and paediatricians who had submitted at least 10 office-based claims for children under six years of age during 2010. For general practitioners, we considered claims of A007 with diagnostic codes 916 or 917 (well baby visits); for paediatricians, we considered claims of A007 with diagnostic codes 916 or 917, or K267, K017, G538 or G539 (well baby visits or immunization visits).

Analysis

In order to assess temporal trends, we first examined the number of claims billed per month from October 2009 to December 2010 by physician specialty. Next, we generated the proportion of eligible children (by age) in 2010 who received the enhanced well baby visit by Local Health Integration Network (LHIN) and neighbourhood income quintile. Finally, we assessed, the proportion of primary care physicians who cared for young children and billed for the enhanced visit, by LHIN.

Exhibits and Findings

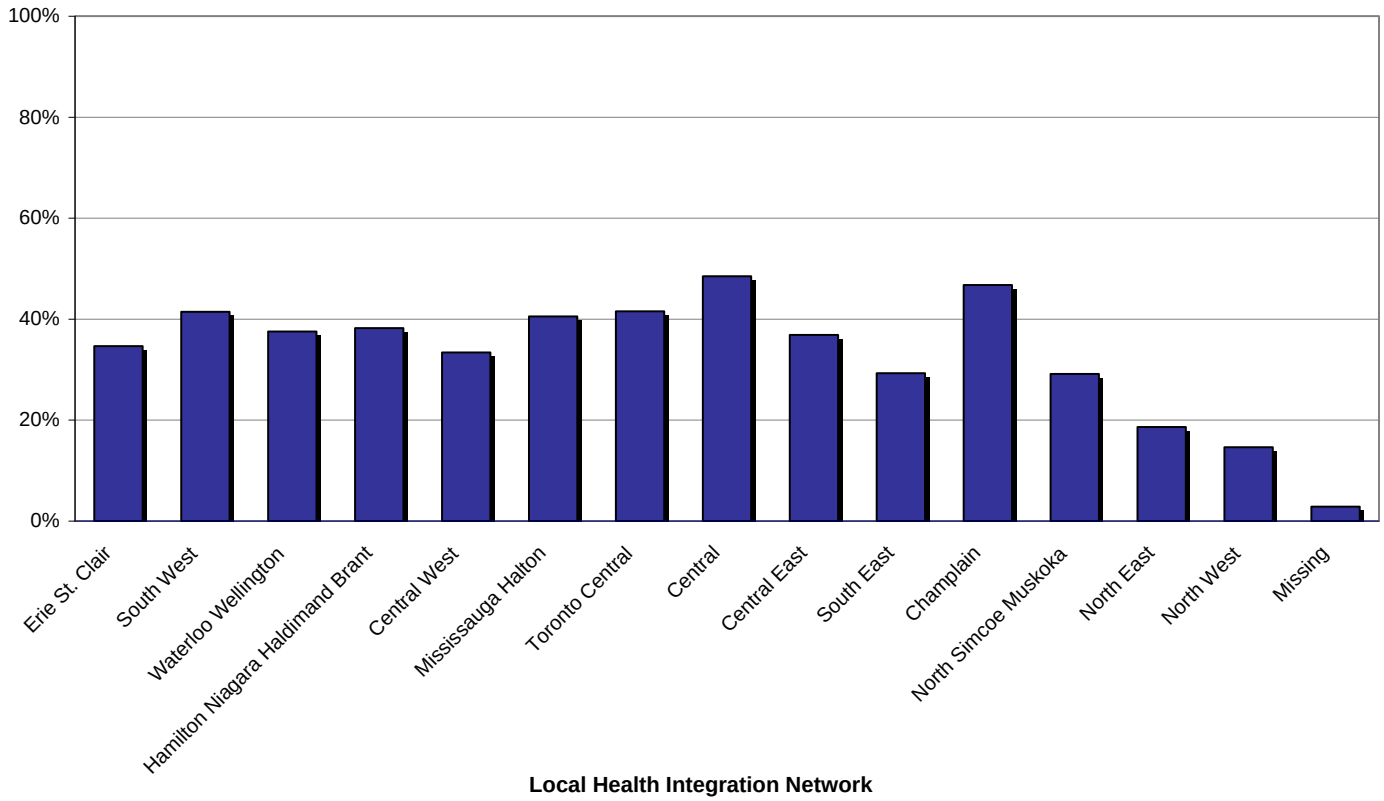
Exhibit 1 Claims for enhanced well baby visits over time, by physician specialty, in Ontario, October 2009 to December 2010



Findings

- Since the introduction of the enhanced well baby visit fee code in October 2009, the number of OHIP claims submitted by both general practitioners (fee code A002) and paediatricians (fee code A268) increased until March 2010 and then leveled off until November 2010 when there was a decline in billings.
- In comparison to paediatricians, family physicians submitted more claims for the enhanced well baby visit fee code. This would be expected as the majority of children in Ontario receive their primary care from family physicians.[2]

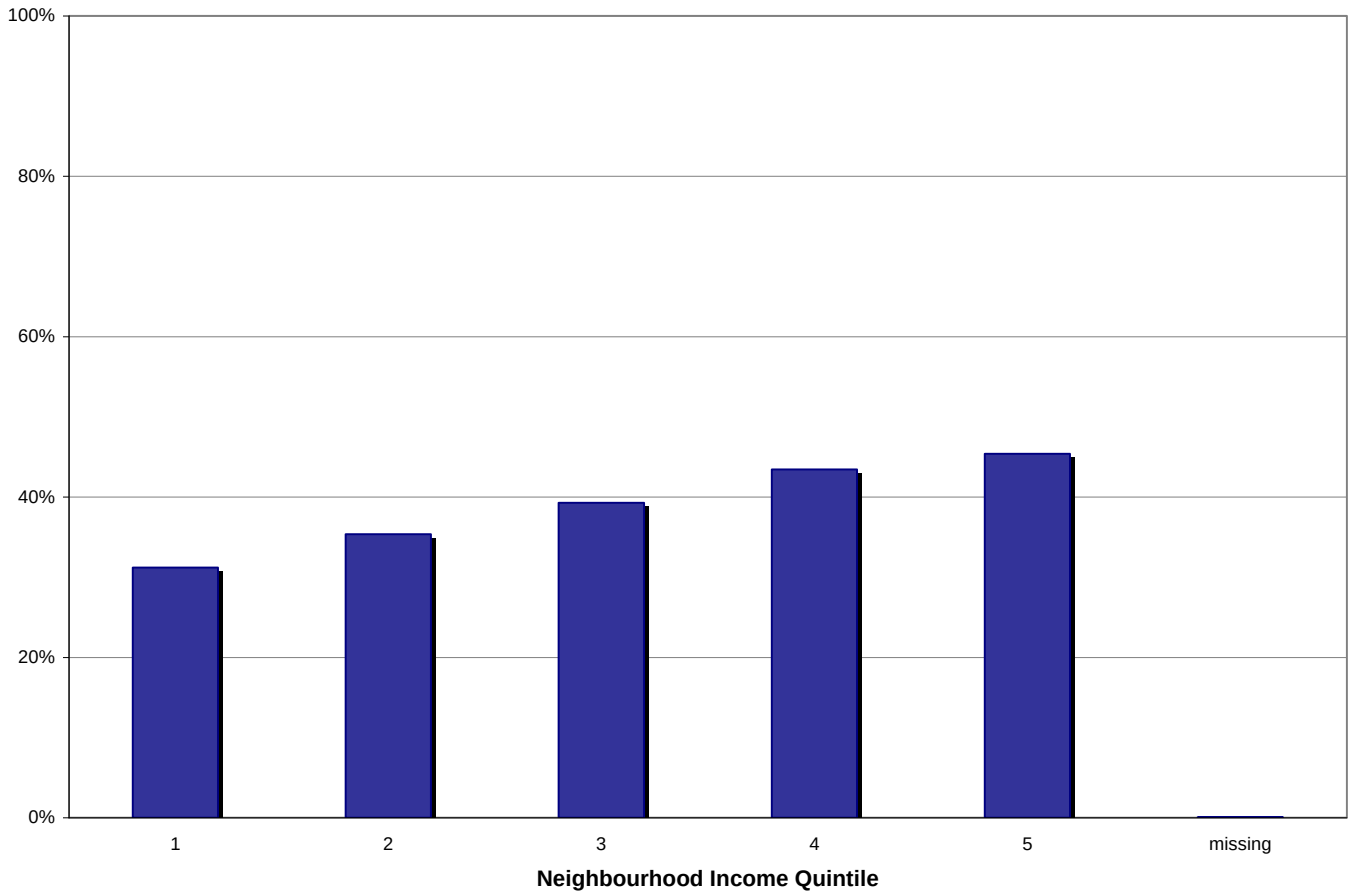
Exhibit 2 Proportion of children aged 17 to 24 months with an enhanced well baby visit, by Local Health Integration Network, in Ontario, 2010



Findings

- The overall proportion of eligible children receiving the enhanced screening was 38.2%
- A smaller proportion of children in the North East and North West LHINs received an enhanced well baby visit compared with children in other LHINs.
- The Central and Champlain LHINs had the largest proportion of children undergoing an enhanced well baby visit.

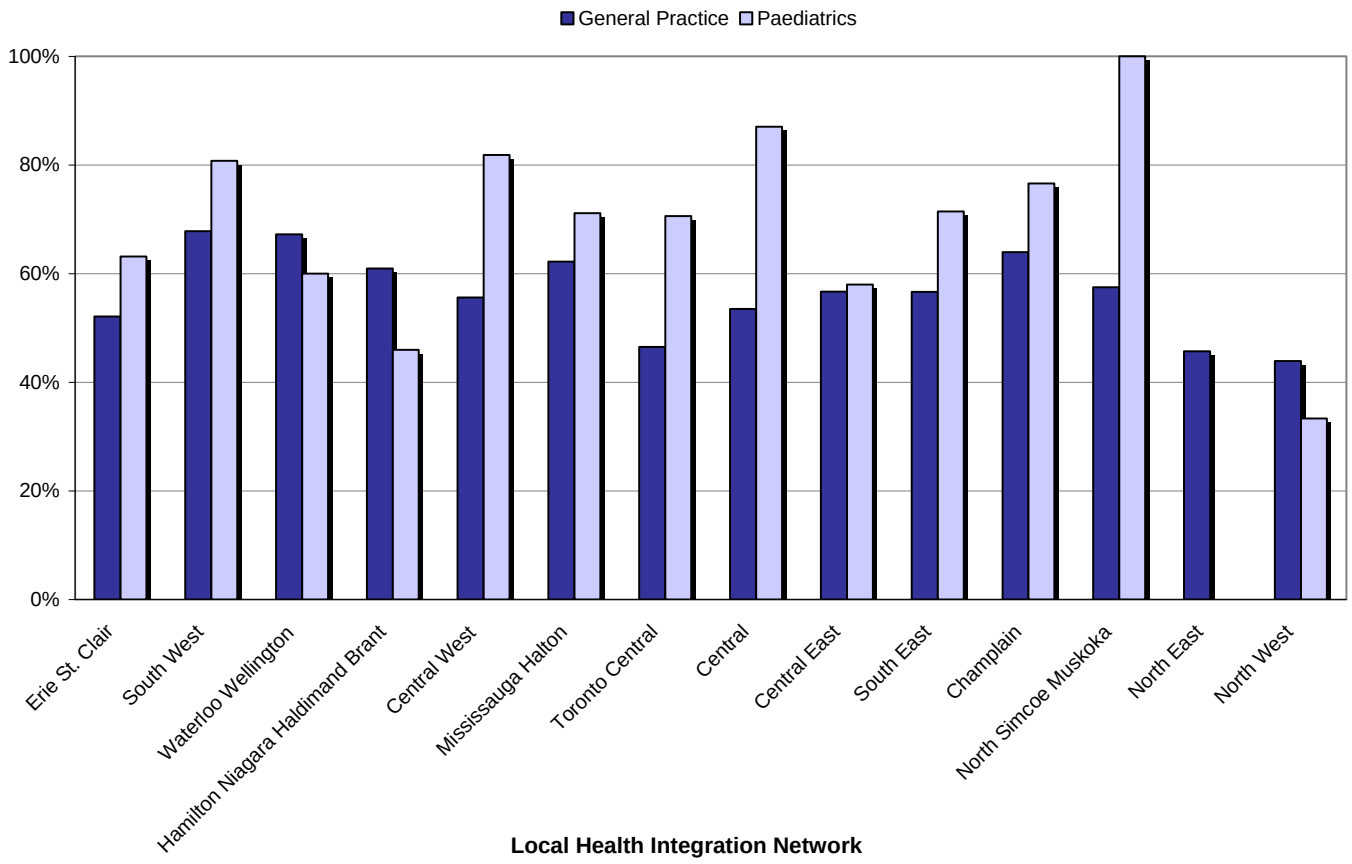
Exhibit 3 Proportion of children aged 17 to 24 months with an enhanced well baby visit, by neighbourhood income quintile, in Ontario, 2010



Finding

- As the income quintile increased, the proportion of children receiving an enhanced well baby visit increased. At the lowest income quintile, approximately 30% of children aged 17 to 24 months received an enhanced well baby visit. This number increased to a maximum of 45% in the highest income quintile.

Exhibit 4 Proportion of physicians with at least one claim for an enhanced well baby visit, by Local Health Integration Network and physician specialty, in Ontario, 2010



Findings

- The highest proportion of general practitioners billing at least once for an enhanced well baby visit belonged to the South West and Waterloo Wellington LHINs (68% and 67%, respectively) and the lowest proportion belonged to the Toronto Central, North East and North West LHINs (46%, 46% and 44%, respectively).
- The highest proportions of paediatricians billing for at least once for an enhanced well baby visit belonged to the North Simcoe Muskoka and Central LHINs (100% and 82%, respectively) and the lowest proportions belonged to the Hamilton Niagara Haldimand Brant, North West and North East LHINs (46%, 33% and 0%, respectively).
- With the exception of four LHINs, the proportion of paediatricians submitting at least one claim for an enhanced well baby visit exceeded the proportion of GPs doing so.

Discussion

Uptake of the enhanced 18-month well baby visit has increased since its introduction, but overall uptake is still not ideal. Better rates of uptake in some LHINs suggests that geographically targeted education for primary care providers is required, and our data suggests that many providers with eligible patients are not doing this enhanced screening. Our finding that lower income children, who are likely at greater risk of developmental disorders, are less likely to receive the enhanced visit suggests that physician practices with higher risk children may need to be targeted to increase uptake and develop systems to ensure these children are screened.

Limitations

This is a very preliminary evaluation of the uptake of the new fee code. OHIP billings are considered complete six months following the service date; thus, the tapering off of billings in late 2010 likely represents incomplete data rather than a decrease in actual billings. Some children in Ontario are seen by primary care providers who may not bill OHIP (such as those seen in Community Health Centres or nurse practitioner-led models) and thus our rates of uptake may be underestimated. Specifically, the relatively low rates of screening in the northern LHINs may reflect higher proportions of children cared for by nurse practitioners. Finally, there is currently no system in place to evaluate the content of the enhanced visit or assess that appropriate referrals are made and developmental services accessed.

References

1. Expert Panel on the 18 Month Well Baby Visit. *Getting It Right at 18 Months ... Making It Right for a Lifetime: Report of the Expert Panel on the 18 Month Well Baby Visit.* Toronto: Ministry of Children and Youth Services; 2005. Accessed on May 29, 2011, at http://www.ocfp.on.ca/local/files/CME/Research/FinalRpt-18MonthPrjct-ENG.pdf

2. Guttmann A, Lam K, Schultz SE, Jaakkimainen L. Primary care for children. In: Jaakkimainen L, Upshur R, Klein-Geltink JE et al, editors. *Primary Care in Ontario: ICES Atlas.* Toronto: Institute for Clinical Evaluative Sciences; 2006.

Appendix

Requirements from the OHIP Schedule of Reimbursement for the Enhanced 18-Month Well Baby Visit (Fee Codes A002, A268)

Definition/Required Elements of Service:

Enhanced 18-month well baby visit is the service rendered when a physician performs all of the following in respect of a child from age 17 to 24 months:

a) Those services defined as "well baby care";
b) An 18-month age-appropriate developmental screen; and
c) Review with the patient's parent/guardian, legal representative or other caregiver of a brief standardized tool (completed by the patient's parent/guardian, legal representative or other caregiver) that aids the identification of children at risk of a developmental disorder.

Medical Record Requirements:

This service is eligible for payment only when, in addition to the medical record requirements for well baby care, an 18-month, age-appropriate developmental screen and concerns identified from the review of the brief standardized tool with the parent/guardian, legal representative or other caregiver are recorded in the patient's permanent medical record.