Supplemental material for :

Kiran T, Kopp A, Glazier RH. Those left behind from voluntary medical home reforms in Ontario, Canada. *Ann Fam Med*. 2016;14(6):517-525.

Supplemental Appendix

Appendix Table 1. Primary care billing codes used to assign non-enrolled patients to a primary care physician

Billing Code	Description
A001	Minor Assessment
A002	18 Month Well Baby Check
A003	General Assessment
A007	Intermediate Assessment
A903	Pre-dental General Assess. FP/GP
E075	Geriatric General Assessment Premium
G212	Allergy-hyposensitization injection (G700+G202) (sole reason visit)
G271	Cardiovascular/Anticoagulation supervision (max one per month)
G372	Injection/infusion intramuscular/subcutaneous/intradermal with visit
G373	Injection/infusion as G372 but sole reason for visit, 1st injection
G365	Pap Tests
G538	Each Individual Injection with non-influenza agents
G539	Injection of unspecified agent - sole reason (first injection)
G590	Influenza agent – with visit
G591	Influenza agent – sole reason
K005	Primary Mental Health Care – Individual Care
K013	Educational Counseling – Individual Care
K017	Annual Health Exam – Child after second birthday
P004	Minor Prenatal Assessment
A261	Minor Assessment – pediatrics
A268	18 Month Well Baby Check – pediatrics
K267	Annual Health Exam – Child after 2nd birthday, pediatrics
K269	Annual Health Exam – Pediatrics or adolescent, office

*Residents who are not formally enrolled to a primary care physician were assigned to the primary care physician who billed the maximum value of the 23 commonly billed primary care codes listed above. In the case of a tie (approximately 8% of occurrences), residents are assigned to the primary care physician with the lowest encrypted identifier. Encrypted identifiers are assigned to physicians randomly.

Appendix Text 1. Methodology for using administrative data to determine which fee-for-service physicians practice comprehensive primary care

Comprehensive fee-for-service physicians were defined as follows:

- Physicians not practicing in a Patient-Centred Medical Home
- AND worked 50+ days per year (day of work defined as physician billing for a minimum of 5 unique patients)
- AND 50%+ of services reflected core primary care (see Table 2 for list of core primary care services)
- AND no more than 50% of billings in a single activity area
- AND no billing of a special 'focus practice' code
- AND billings reflected at least seven of twenty-two activity areas (Table 2)

Non-comprehensive fee-for-service physicians included all physicians not practicing in a PCMH who were not defined as comprehensive per the algorithm above

Appendix Table 2. Core primary care services and activity areas

Core primary care services and activity areas			
Fee Service Code	**Description**	**Included in every year**	**Activity Area**
A001A	Minor assessment.- GP/FP.	*	1. Mini/ minor assessments
A008A	Mini assessment- GP/FP.		1. Mini/ minor assessments
A003A	Gen. assessment/ Annual health exam – GP/FP	*	2. General assessment/ re-assessment
A004A	General.re-assessment– GP/FP		2. General assessment/ re-assessment
A007A	Intermed.assessment/well baby care	*	3. Intermediate assessment
K017A	Annual health exam-child aft.2nd birthday	*	4. Annual health exam - child
E070A	Geriatric general assessment prem		5. Geriatric care
E071A	Geriatric intermediate assessment prem		5. Geriatric care
E075A	Geriatric general assessment prem		5. Geriatric care
K004A	Family psychotherapy-2 or more members		6. Primary mental health care
K005A	Primary mental health care – individual – per unit		6. Primary mental health care
K007A	Individual psychotherapy	*	6. Primary mental health care
K013A	Counselling-one or more people	*	6. Primary mental health care
K025A	Group psychotherapy – 6-12 people	*	6. Primary mental health care
K099A	GP psychotherapy premium		6. Primary mental health care
C002A	Hospital visits-To 5wks-GP/FP	*	7. Hospital care
C004A	General re-assessment in hospital – GP/FP		7. Hospital care
C007A	Hospital visits-6th-13th Week – GP/FP	*	7. Hospital care
C008A	Concurrent care in hospital – GP/FP		7. Hospital care
C010A	Supportive care in hospital - GP/FP	*	7. Hospital care
A901A	Housecall assessment – GP/FP	*	8. Housecalls
B990A	Special visit to patient's home, wk/daytime		8. Housecalls
B991A	Each additional patient./Same visit Mini-assessment		8. Housecalls
B994A	Special visit to patient's home/non-elective		8. Housecalls
W001A	Chronic care/convalescent hospital visit – subseq	*	9. Chronic care/long-term care visits
W002A	Chronic care/convalescent hospital visit - First fou	*	9. Chronic care/long-term care visits
W003A	Nursing home visit - first two visits per month	*	9. Chronic care/long-term care visits
W008A	Nursing home visits – subsequent – GP/FP	*	9. Chronic care/long-term care visits
W010A	LTC Monthly management fee		9. Chronic care/long-term care visits
W121A	Add'l NH vis due to intercurrent illness		9. Chronic care/long-term care visits
A888A	Partial. assessment – ED equivalent		10. Emergency department or equivalent
E030A	1992-1994 Emerg.Dept		10. Emergency department or equivalent
H151A	ED.phys.on duty sat./sun		10. Emergency department or equivalent
K995A	Spec vis - ED, mon-fr		10. Emergency department or equivalent
A009A	Oculo-visual. Assessment – GP/FP.		11. Vision care
A111A	Periodic oculo-visual assessment		11. Vision care
G512A	Weekly palliative care case management		12. Palliative care
K023A	Palliative care support /per unit		12. Palliative care
G590A	Influenza agent with visit		13. Flu shots
G591A	Influenza agent sole reason for visit		13. Flu shots
G538A	Immunization-with visit, excl flu	*	14. Other immunization
G539A	Immunization - sole reason – excl flu	*	14. Other immunization
G489A	Venipuncture- adolescent/adult	*	15. Office lab procedures
G202A	Allergy-hyposensitivity injection with visit	*	16. Allergy shots
G212A	Allergy-hyposensit inj – w/visit		16. Allergy shots
G372A	Injection – with visit	*	17. Other injections
G373A	Injection - sole reason for visit	*	17. Other injections
G387A	1992-1994 Injection/infusion		17. Other injections
G388A	1992-1995 Injection/infustion		17. Other injections
E430A	Pap smear performed outside hosp		18. Pap smears
G365A	Pap smear – with visit	*	18. Pap smears
G271A	Anticoagulant supervision	*	19. Anticoagulant therapy
A903A	Pre-dental/operative assessment – GP/FP		20. Pre-operative assessment
K030A	Diabetic management fee		21. Diabetes management
E079A	Smoking cessation. – Initial discussion		22. Smoking cessation

Appendix Table 3. Definitions for identifying patients eligible and up-to-date for cancer screening

Type of Screening	Eligible patients	Definition of up-to-date for screening	Exclusions
Cervical	Women age 35 to 69	Received a Pap test in the 30 months prior to March 31 of the fiscal year	Women who have had a hysterectomy
Breast	Women age 50 to 69	Received a mammogram in the 30 months prior to March 31 of the fiscal year	Women who have had a mastectomy or who were being treated for breast cancer
Colorectal	Adults age 50 to 74	Received either Fecal Occult Blood Testing in the two years prior to March 31 of the fiscal year or a colonoscopy in the previous ten years	Adults who have had colon cancer