Evaluation of the Ontario Academic Health Science Centres Alternative Funding Program (Phase 1): A Major Step Forward

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We would like to thank all those who participated at such short notice in this evaluation and we apologize for the inconvenience caused to so many by the time constraints and the need to centralize the interview process in Toronto. We appreciate the time given and especially the open forthright manner in which all of the exchanges were conducted.

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Executive Summary

The serious problems currently facing Academic Health Science Centres (AHSC) in Canada have been well documented, including difficulty recruiting and retaining highly skilled and educated academic physicians, growing competition from the increasing tertiary care capacity in community hospitals, inappropriate fee schedules, inadequate funding for academic activities, unhealthy competition among AHSCs for personnel and resources, practice plans that are in danger of failure, and increasing teaching loads.. There is an urgent need for changes that could address these problems in Ontario and bring stability to the clinical academic institutions that are so essential to the present and future health needs of the population.

The Ontario Ministry of Health and Long Term Care (MOHLTC), the universities, the teaching hospitals, the clinicians, and the Ontario Medical Association (OMA) have all recognized these problems and over the last few years they have begun to work on potential solutions. Extremely important issues in this arena are the relationship of physicians to their AHSC and their financial stability. In recent years there has been increasing interest in funding methods other than fee-for-service (FFS) and these Alternative Funding Plans (AFPs) have been introduced already in many provinces, including some in Ontario, with remarkable success. Early attempts to introduce AFPs on a more extensive scale in Ontario's AHSCs met with difficulties due mainly to the perception that the amount of money offered by the Ministry in the process was fixed and inadequate. Plans were then revised into a 3-Phase process, and Phase 1 was implemented in 2003.

This report is the result of the Ministry's request for an external evaluation of the process and results of the Phase 1 AFPs in each of the AHSCs in the province (see Terms of Reference, page iv). The evaluators have reviewed relevant documents and literature, and interviewed the deans of the 5 medical schools, chairs of the governing bodies at the various sites, and medical and hospital leaders from every academic health sciences centre (AHSC) and major affiliated hospital in the province of Ontario. Although it would be premature to carry out an evaluation of Phase 1 based on objective data, the extensive information gathered was consistent and it permitted a detailed analysis of the history and present situation leading to the recommendations in this report.

The problems surrounding the process of negotiating the Phase 1 contracts, particularly at the beginning, included lack of trust among the participants, the perceived lack of a well conceived plan, lack of fairness and transparency in the formula for distribution of funds, and inadequacy of the funds available. However, the negotiations succeeded eventually in attracting a large proportion of the clinical teachers at all sites. The main issues noted concerning the implementation of Phase 1 were:

- successful creation of governance structures, although they are functioning at different levels of effectiveness
- distribution of the new "non-conversion" funds was largely flow-through per capita, although some sites used a more selective approach
- minimal accountability provisions were included in the contracts at this stage
- creation of practice plans has been proceeding, but not yet accomplished fully at all sites
- administrative difficulties due to inadequate allocation of resources for management of the AFP
- difficulties in efficient management of the 10% FFS conversion process.

The results of the Phase 1 AFP implementation are encouraging. Many expressed the view that the prospect of more complete alternative funding facilitated recruitment. It was consistently seen as a stimulus to cooperation and there is already an atmosphere of less suspicion of Ministry motives. Some practice plans on the brink of dissolution have been rescued and there is general satisfaction that academic activities are at last beginning to be recognized in funding. No adverse effects of the Phase 1 plan were identified, but it must be noted that many of the participating groups and individuals are still strongly independent and have yet to achieve the culture change that would facilitate the development of full AFPs.

Strong messages were heard during this evaluation process, and after careful consideration the evaluators were able to make a series of observations and recommendations that will help all of the partners involved to move ahead:

- there is overwhelming interest in moving to a full AFP rather than progressing through the 50% conversion Phase 2 that was proposed
- the parties need to establish a central provincial team to guide a more horizontal process for negotiations
- the clinicians are looking for a clear message that the development of AFPs will proceed and that further funding will be negotiated
- the governing bodies will eventually have to understand and implement governance rather than only management that is the current predominant role

- the values of fairness and transparency are held in high esteem but must apply equally to all partners
- appropriate designation of in-scope and out-of-scope activities is crucial
- AFP contracts must include a meaningful accountability framework based on a province-wide template that addresses clinical activities (including quality management), academic productivity, and administrative work
- participation in AFPs should be voluntary for clinicians now in place, but new recruits should join the AFP
- pre-existing alternative funding arrangements must be accommodated into the full site AFPs as they develop, and equity in further AFP development should include those already in place at the Hospital for Sick Children in Toronto and in Kingston

The overarching objective of Phase 1 of the alternative funding project was, in a single phrase, to stabilize academic health science centres. Although Phase 1 is only what might be called an introductory plan of partial alternative funding, it has succeeded in moving toward this objective. It has facilitated the creation of governance structures, recognized the special needs of AHSCs, begun the process of compensating AHSC clinicians for academic and special clinical activities and, most importantly, created an environment conducive to further negotiations that could lead to mature AFPs such as those that have already been so successful in the province pf Ontario and elsewhere in North America.

There is general willingness to move ahead towards full alternative funding plans, given a clear policy direction for the Ministry to pursue this direction and the necessary process of negotiations. Achieving an appropriate financial package will be critical to achieving a final buy-in by physicians.

On the basis of this evaluation and previous experience with alternative funding, the successful negotiation of full AFPs in the AHSCs is likely to lead to stability of personnel, facilitated recruitment, predictability of budgets, enhancement of academic output, more appropriate clinical activity, especially in the areas of tertiary and quaternary care, alignment of Ministry, hospital and university objectives, and appropriate adjustment of incentives. Above all this could lead to positive change in the attitudes, culture and relationships among the various groups as true partners in the complex joint enterprise of academic medicine.

Summary of Recommendations

Recommendation 1: It is recommended that the AFP governing bodies in the AHSCs that have not yet allocated resources for efficient management of the AFP correct this deficiency as soon as possible.

Recommendation 2: It is recommended that the AFP governing bodies address as soon as possible the requirement within the Phase 1 Agreement for participants to belong to a practice plan or functional equivalent.

Recommendation 3: It is recommended that the Ministry, in consultation with the AFP governing bodies, revise the plan for the three-phase approach to the implementation of alternative funding. Negotiations should begin as soon as possible, but with flexible timelines for the different AHSCs, in order to complete the process.

Recommendation 4: It is recommended that an AFP provincial working group be established with representation from each of the partners and each site to guide the extensive negotiation process that will have to occur.

Recommendation 5: It is recommended that the provincial AFP steering group develop a clear and concise number of objectives to satisfy the Ministry, the Universities, the clinicians and the hospitals as a basis for further negotiations.

Recommendation 6: It is recommended that the AFP governing bodies begin to address the prospect of their ultimate role in promoting the priorities of the academic health science centre as a whole.

Recommendation 7: It is recommended that the full AFP contracts make provision for flexibility in the use of new funding in order for the local governance eventually to be able to make appropriate decisions on recruitment and allocation of resources.

Recommendation 8: It is recommended that in preparation for further negotiations the AFP governing bodies prepare the necessary documentation of any and all sources of clinicians' income and prepare a plan on how they will be treated in the negotiations.

Recommendation 9: It is recommended that "out-of-scope" activities be minimal and carefully defined in full AFP contracts.

Recommendation 10: It is recommended that further negotiations be conducted on the basis of equitable contracts for all of the academic health science centres in the province of Ontario.

Recommendation 11: It is recommended that the AFP contracts include accountability measures addressing deliverables in clinical service, teaching, research, medical administration and management of clinical quality and resource utilization.

Recommendation 12: It is recommended that the Ministry discontinue the inappropriate requirement for "shadow billing" in alternative funding arrangements in favour of more relevant accountability measures for clinical activities in AHSCs. The 90% conversion model may be an alternative to be considered.

Recommendation 13: It is recommended that the AFP provincial steering group adopt a standard template for the accountability sections in AFP contracts to be used as the basis for negotiation on the contractual accountability provisions for each site.

Recommendation 14: It is recommended that the accountability sections in contracts include provision for regular monitoring of the reported deliverables for each of the partners and appropriate feedback.

Recommendation 15: It is recommended that in negotiations leading to full AFP contracts, the participation of current medical staff continue to be voluntary.

Recommendation 16: It is recommended that the AFP governing bodies set policy to require all new full time recruits to participate in the AFP.

Recommendation 17: It is recommended that all pre-existing funding agreements be open and on the table at each involved site for the process of negotiation of the site AFP.

Recommendation 18: It is recommended that the AFP governing bodies continue negotiation with departments of radiology in an attempt to satisfy their issues and attract them into the AFP.

Recommendation 19: It is recommended that the Ministry be prepared to modify the existing AFP contracts if necessary to be consistent with the new contract template to be developed with the other AHSCs.

Recommendation 20: It is recommended that each AFP contract include a dispute resolution mechanism that is independent, responsive and authoritative.

Recommendation 21: It is recommended that AFP governance organizations ensure that their local decisions concerning the distribution of funds for personal compensation include at least a portion of income that is dependent on agreed criteria for performance.

Terms of Reference -- AHSC AFP Project Evaluation
January 30, 2003

Background

The Deputy Minister of Health and Long-Term Care has requested a review of the Academic Health Science Centres (AHSC) Alternative Funding Project's progress to date. The Project has, to date, signed Phase I and Phase III Alternative Funding Plan (AFP) agreements with 12 of 13 AHSCs in Ontario, allocated $75M in funding for AHSCs that have been signed agreements, and begun implementing real time conversion of FFS billings by AFP physicians.

There are two types of evaluation: formative and summative. Formative evaluations are process-based evaluations and are appropriate for programs/projects that are relatively early in their mandates. As the AHSC AFP project is early in its mandate, a formative evaluation will be most helpful in identifying strengths and opportunities for improvement as the project moves forward. The evaluation will be based on the components of the project, project activities, process outcomes, and short- and long-term outcomes that are expected for the project.

Objectives of the Evaluation

Based on the early nature of this evaluation in the life of the AHSC project, the over-arching evaluation questions are: *How will the progress made to date in the AHSC AFP project lead to the fulfillment of its long-term goals? How could the process be improved to better achieve those goals?*

The following questions will be addressed within the evaluation:

1. To what extent is the project strategically aligned with ministry/government direction?
2. To what extent is the project achieving its intended outcomes?
3. To what extent are clients or customers satisfied with the project's services?
4. To what extent did the project achieve value for money (i.e., achieving its objectives within the established timeframes and costs)?

The evaluation will take place from the following three perspectives:

1. Physician: how has the AFP affected physicians focused on clinical work?
2. University/Academic: how has the AFP affected clinical teachers and researchers within the agreement?
3. Hospital: how has the AFP affected hospital operations and hospital relations with the physicians participating in the AFP?

The evaluation will be conducted by an external, objective three-person panel composed of individuals with experience and credibility in academic medicine and evaluation techniques. One of the evaluators will be assigned the role of lead evaluator.

Process

Components of the Evaluation

The evaluation will comprise the following components:

Introduction, Kick-off, and Documentation Review
This component includes a meeting to agree on the terms of reference, a review of project documentation, and a meeting of the evaluator(s) with the Assistant Deputy Minister.
Supporting documentation for review by the evaluator(s) will include:

- Report of the Provincial Working Group
- Web site material
- Phase I AFP agreements
- Feedback from the Physician Summit, August 2003
- "Components" document of phased AFP approach
- Results from the Inter-jurisdictional Review
- Other related government documents:
  - OMA Agreement 2000
  - Throne speech
  - Provincial Budget

Qualitative Interviews with Key Stakeholders
This component could include site visits, focus groups, and individual interviews with key stakeholders in the AFP project. A list of potential interviewees includes:

- AHSCs
  - Chair, Governance Organization
  - Executive Committee, Governance Organization
- Ontario Medical Association

Final Report
This component entails the summary and analysis of findings in the review and advice related to the findings. A presentation of the final report to the Assistant Deputy Minister will complete the evaluation.

Evaluation Support
An AHSC Project contact person will be assigned to support the evaluation panel.

Timing
The evaluation will begin February 2004, and be completed by mid- to late-March 2004.

Deliverables
The evaluators will provide the following deliverables for the evaluation:

- An interim status update to the Assistant Deputy Minister, approximately half-way through the evaluation, outlining key findings and issues encountered.
- A final confidential report to the Assistant Deputy Minister containing findings and advice regarding the evaluation.

Process Followed by the Evaluators

The evaluators reviewed the documents listed in Appendix A and interviewed all those individuals listed in Appendix B. The list of interviewees included the deans of the 5 medical schools, chairs of the governing bodies at the various sites, and medical and hospital leaders from every academic health sciences centre (AHSC) and major affiliated hospital in the province of Ontario. In several instances, the team interview included a business manager hired by the governing body to manage the alternative funding project (AFP). The Ontario Medical Association (OMA) was represented at the interview by the chief executive (CEO) and chief operating officers (COO). The evaluators considered it important to interview also the leaders at the Hospital for Sick Children (HSC) and the South Eastern Ontario Academic Medical Organization (SEAMO, Kingston) in order to discuss their experience with longstanding AFPs. Finally, the insights provided by Dr. David McCutcheon, the ADM responsible for the AHSC AFP project and two of the senior Ministry negotiators were extremely valuable.

The large majority of those interviewed felt that an evaluation of the AFP Phase 1 initiative was premature now, but nevertheless everyone willingly agreed to answer questions and share experiences. At an early stage in the process, the evaluators realized that it was indeed too early to assess results based on objective data but the documentation and the interviews did provide useful information that formed the basis of this report and that should be helpful in the evolution of the AHSC AFP process.

Development of the Alternative Funding Program

The background to the development of alternative funding for Academic Health Science Centres is described clearly and in detail in the report of the "Provincial Working Group: Alternative Funding Plans for Academic Health Science Centres", February 2002. This report also referred to several previous reports on the problems facing AHSCs. The major problems may be summarized under the following headings:

1. Competitive international market for highly skilled and educated academic physicians
2. Growing capacity in community hospitals for the management of patients requiring tertiary care. AHSCs need to maintain their prime role in the management of tertiary and quaternary care patients in order to fulfill their academic role

3. Fee schedules for medical services that are anomalous and inequitable, and often do not provide adequate compensation for highly specialized tertiary, quaternary and innovative clinical activities
4. Inadequate and inequitable funding for academic activities
5. Increasing difficulties with recruitment and retention of academic physicians
6. Unhealthy competition between the individual AHSCs in Ontario (and, indeed, in Canada) for personnel and resources
7. Absence of functioning practice plans in some of the AHSCs and in others practice plans under serious threat of bankruptcy
8. Increasing demand for teaching services with expansion of medical student numbers and changes in the balance of teaching and service in the training programs prescribed by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC).
9. Marked changes in the lifestyle choices being made by young physicians of either sex, but driven to a large extent by the large increase in the proportion of women in all branches of the profession

In recognition of these and other related issues, the Provincial Working Group stated *"The MOHLTC and the OMA agreed that physicians working at Academic Health Science Centres (AHSC) need to be funded in innovative ways in order for these institutions to fulfill their important patient service and academic activities. The MOHLTC intends to make physician alternate (sic) payment plans available to the individual AHSCs on a voluntary basis"*.

The provincial working group outlined seven necessary components in the development of alternative funding plans, namely governance structure, funding, measurable deliverables, methodology for payment, human resources plan, provisions for change and broad participation.

The goals of the process as outlined in Appendix A of that report included improving the capacity of Ontario's AHSCs, recruitment and retention of academic physicians, creating an attractive AHSC environment, enhancing the reputation of AHSCs, achieving adequate physician funding levels, defining deliverables, encouraging team work among health care providers, supporting rural and remote communities, stabilizing physicians human resources, and advancing the integration of healthcare services.

Development of the Phased Approach to Implementing Alternative Funding Plans

The negotiations in 2000 between the profession and the Ministry of Health and Long-Term Care (MOHLTC) included the provision of $75 million for AHSCs to establish AFPs. The first attempt to move AHSCs into alternative funding using this sum of money was met with great resistance from the clinical teachers. Most felt that the original proposal was going too far too fast and, more significantly, that the identified funding was completely inadequate.

The phased approach that was subsequently developed met with a much better reception and this evaluation report focuses mainly on the process and results of the implementation of Phase 1. In this context the components of the proposed phased approach must be briefly described. An alternative funding plan can be regarded fundamentally as a contract between clinicians working in AHSCs who have university appointments and the other foundation partners namely the MOHLTC, the University, the Hospitals, and the OMA.

Phase 1

- Began in mid 2003 and due to end in the Fall of 2004
- Large majority of eligible academic physicians must sign on
- A satisfactory governance organization must be structured at each of the AHSCs, with representatives from each of the partners. The governing bodies need to establish a dispute resolution mechanism
- All clinician participants must agree to participate in a practice plan
- $75 million distributed among the AHSCs
- “Conversion” of 10% of fee for service billings to be returned to each governing organization as an aggregate sum
- Clear identification of in-scope and out-of-scope activities.
- General requirement for maintenance or enhancement of clinical and academic activities
- Recognition that a framework for accountability and reporting will need to be developed (largely unspecified in Phase 1)
- Participation voluntary but a requirement for any participating group to sign up at least 85% of members.

Phase 2

- Begin in the fall 2004 and end fall 2006
- Integration of most previously existing alternative payment plans within the Academic Health Science Centres
- "Conversion" of 50% of fee for service billings into block payments to the governance organizations
- Further development of accountability and reporting mechanisms
- Some additional new funding derived through the OMA/MOHLTC negotiations

Phase 3

- Begin fall 2006
- Mature governance structure with integrated strategic plans for medical staff, hospital and university
- All funding flows through the governance structure
- All existing alternative payment plans integrated
- 100% fee for service "conversion"
- Full implementation of performance measures with clear deliverables and reporting mechanism.
- Full and comprehensive alternative funding plan with all departments and divisions participating

As the interviews for this evaluation mainly involved leadership individuals among the various stakeholders in AFPs, it was decided to design a questionnaire for distribution to all clinicians in the Ontario AHSCs. Because of the ongoing negotiations between the Ministry and the OMA on physician fees in general, the distribution of the questionnaire was delayed until a later date. When that has been done and the results analyzed they will be added as an additional appendix to this report.

What was heard at the interviews

There was remarkable convergence among the leaders of the twelve AHSCs on their perceptions of the main issues that arose during the negotiation and implementation of the Phase 1 AFP and also of the main issues now to be addressed in moving forward. These will be dealt with separately.

The Negotiations leading to the Phase 1 Agreement

The question of trust among the participants

There was a general sense of frustration concerning the negotiation process in developing the Phase 1 Plan. Some of the reasons for this frustration are captured in the bullet points in the section above but the overriding theme seemed to be a lack of trust of the Ministry by the physicians and a feeling by the physicians that this lack of trust was reciprocated. As will be noted in the results section of this report the prevailing attitudes on trust are improving but for many individuals it is still an important issue.

Lack of a well conceived plan

The majority of those interviewed felt that there was considerable confusion concerning the objectives of the Phase 1 Program in general and in particular for the use of the added "non-conversion" funds. It was clear that the final decision on this was left to the site governing bodies but most of them would have preferred clearer guidelines as to how they should be distributed. There is no doubt, however, that these additional funds provided the main incentive to physician participation in Phase 1.

On the other hand, from the perspective of the Ministry negotiators it was generally known that appropriate use of the funds included both academic and clinical purposes with the final decision being left to the governing bodies. This was perfectly appropriate and, as will be discussed in detail later, it is apparent that the so called governing bodies were in fact reluctant to govern and were acting mainly as management groups.

Considerable frustration was also expressed by those groups involved in negotiations in which the Ministry representatives changed repeatedly. The Ministry was not seen to have adequate resources for the negotiating process. The

lack of trust also manifested in skepticism that the Ministry did indeed wish to pursue a meaningful process with added resources to stabilize the AHSCs**.**

Fairness and transparency

These words were used frequently during the interview process. Regardless of the merits of the formula that was eventually used by the Ministry for the distribution of the $75 million non-conversion funds, many participants were upset that it was opaque to them. Obviously no formula would succeed in pleasing everyone but to be defensible it needs to be transparent to the participants.

Adequacy of resources

Although there was dismay at first about the inadequacy of $75 million to satisfy all the needs of the health science centres, there is no doubt that the development of the phased approach with the $75 million being available for Phase 1 was a major step forward. This enabled the negotiations to proceed and contracts to be signed.

The role of the Ontario Medical Association

There was general agreement from all parties that the OMA was instrumental in the initiation of the process in the year 2000 and in the negotiations which set aside the funds for dealing with the AHSC problems. Its role in the actual negotiation process with the individual AHSCs was both critical and helpful. The OMA is of course a required partner in the process of developing AFPs and its role in recognizing the special issues surrounding AHSCs has been extremely important and is appreciated by the other participants.

The role of the Universities and the Hospitals

As the other partners in the process (in addition to the Ministry and the clinicians), the universities and the hospitals were enthusiastic participants in the negotiations. In particular, when it looked as if the original plans would fall apart completely (before the phased plan was developed) it is clear that the deans of the medical schools exerted major influence in keeping everyone focused on the major objectives here.

Successful recruitment to Phase 1 of the AFP

The negotiations leading to the Phase 1 Agreements were ultimately remarkably successful. Table 1 displays the number of eligible physicians and the proportion participating at each site. Appendix C contains the details of the individual participation by department at each site. It is particularly noteworthy that many sites have participation by Laboratory Medicine but Radiology has chosen not to participate with the exception of one group in London.

Table 1

AHSC TOTAL PHYSICIANS

	# of Eligible Physicians	# of Participating Physicians	% of Eligible Physicians	Notes
Baycrest	**39**	**39**	**100.0%**	
CAMH	**110**	**107**	**97.3%**	
Hamilton	**501**	**490**	**97.8%**	
London a)	**433**	**406**	**93.8%**	(not including APPs)
London b)	**460**	**433**	**94.1%**	(including APPs)
UOHI	**44**	**44**	**100.0%**	
ROH		**30**		
SCO		**29**		
TOH	**411**	**384**	**93.4%**	
St. Mike's a)	**266**	**258**	**97.0%**	(not including APPs)
St. Mike's b)	**285**	**277**	**97.2%**	(including APPs)
Sunnybrook a)	**294**	**272**	**92.5%**	(not including APPs)
Sunnybrook b)	**315**	**293**	**93.0%**	(including APPs)
Toronto Rehab	**42**	**41**	**97.6%**	
UHN/MSH a)	**560**	**560**	**100.0%**	(not including APPs)
UHN/MSH b)	**602**	**602**	**100.0%**	(including APPs)
TOTALS:	**2,700**	**2,660**	**96.9%**	(not including APPs)
	2,809	**2,769**	**97.0%**	(including APPs)

Implementation of the Phase 1 Agreements

The Phase 1 contracts with the Academic Health Science Centres were signed at various intervals over the last nine months of 2003. It is therefore not surprising that implementation of the provisions in the contracts is at different stages throughout the province. Phase 1 is widely regarded as an interim measure that does not in fact require major change and therefore there have been varying levels of enthusiasm and rates of

implementation. The important implementation issues heard during the interviews are described under the headings below.

Site governance structures

Phase 1 required the creation of a site governance structure within guidelines that were consistent for each site. The governance body has been created at each site without exception but it is clear that very few of them are actually exercising any governance function yet. Most have adopted only a management role at present, undoubtedly because of anxiety and mistrust on the part of many individuals and departments concerning the potential loss of autonomy to a site-wide governing body. The leaders interviewed are well aware of this deficiency but feel that it is necessary to proceed very cautiously down this path in order to achieve ultimate success of AFPs. It was recognized that much of the governance is taking place at the level of practice plans, that often have dense legal arrangements governing the behaviour and rewards of the individual physicians.

The distribution of the new "non conversion" dollars

There was wide variation in the local decisions adopted concerning the distribution of the new funds. In many they were simply distributed to the departmental or group plans or individuals on a per capita basis while in others there were various amounts reserved for specific academic or clinical purposes and distributed in a variety of ways.

As previously mentioned, the decisions concerning this distribution were left to the local governing bodies, but in retrospect it is regrettable that guidelines were not incorporated in the agreements. For example, a guideline worded something like "...a proportion of the funds will be allocated according to academic needs and merit…" would still have left the important decisions about the details of the distribution to the local body.

Some of the AHSCs sensibly allocated some of these funds to provide for the business management that is necessary. Those that did not are, as could have been predicted, inevitably encountering difficulties in satisfying the requirements for registration, billing conversion, reporting, etc.

Recommendation 1: It is recommended that the AFP governing bodies in the AHSCs that have not yet allocated resources for efficient management of the AFP correct this deficiency as soon as possible.

Distribution of the 10% "conversion" funds

The Phase 1 agreements required only that 10% of billings be "converted" and returned to the governing body of the AHSCs. In every case, the governing body returned the funds wholly to the source at which they were generated whether that be a practice plan, a group, or an individual. Opinion was unanimous that this redistribution back to the physicians was necessary at this stage to attract physicians to sign on to the Phase 1 Plan and to ensure that the mechanism for conversion was functioning both at the Ministry and the governing bodies.

Accountability and Deliverables

The reporting requirements in the Phase 1 contracts include information on current participants, a human resources plan and a report on teaching activities, but they are not comprehensive or detailed. As discussed later in this report, development of a full alternative funding plan must be accompanied by more extensive provision for accountability and the deliverables among each of the partners: the academic clinicians, the universities, the hospitals and the Ministry.

The requirement to participate in practice plans

The Phase 1 contract requires all participants to join a "practice plan or *functional equivalent*". There are many practice plans of long standing throughout the AHSCs but many individuals who were not previous practice plan participants have signed onto Phase 1. This requires them to participate in a "practice plan or *functional equivalent*" but it is not clear that this requirement has been implemented yet.

The development of AFPs implies a change in the culture and attitudes of participating physicians from independent contractors to members of a team. Although the Phase 1 AFP has facilitated important steps in this direction, it is clear that this change has not yet occurred in all areas. On the other hand, the contract makes it clear that all those who have signed on are expected to participate in practice plans and the governing bodies will need to deal with this, albeit with caution and sensitivity to their local issues. It should also be noted that

a major part of the difficulty and confusion with the 10% conversion of funds (see below) is due to the large number of independent groups in some of the sites and solo practitioners who do not yet appear to have joined any significant practice plan.

Recommendation 2: It is recommended that the AFP governing bodies address as soon as possible the requirement within the Phase 1 Agreement for participants to belong to a practice plan or functional equivalent.

The Results to Date

Hospital for Sick Children, Toronto and the South East Ontario Academic Medical Organization, Kingston

Although not strictly within the terms of reference, the evaluators considered it important to interview leaders from these organizations as they now have a decade or more of experience with comprehensive alternative funding plans. The opinions heard were unanimous in that these AHSCs could not have fulfilled their academic and clinical mandates without the AFP and that it has succeeded in stabilizing the medical workforce and the academic enterprise in general. The governing bodies are inevitably still dealing with many internal and external relationship issues but the leaders interviewed felt strongly that their organization is now stronger, and more stable and functional. It is clear that these opinions are shared not only by the leaders of the organizations but by the rank and file members of the medical staff who have voted overwhelmingly for continuation of alternative funding. SEAMO in particular has a mature governance system that permits the issues of allocation and priorities to be addressed locally and appropriately, in addition to working on a comprehensive accountability framework that could be extended into a template for the province.

It is very interesting to note that few if any clinicians involved in AFPs ever want to return to an independent fee for service system. For the other AHSCs in Ontario, now just embarking on the AFP process, there is a long way to go but the results in Kingston and Sick Kids in Toronto should be very encouraging.

Recruitment and Retention of Medical Staff

There was some difference of opinion among those interviewed on the effect that the Phase 1 Plan has had on recruitment but the majority felt that the prospect of further negotiations leading to a more complete alternative funding plan did facilitate dialogue with prospective recruits.

Stimulus to cooperation

It is widely acknowledged by the participants that the Phase 1 AFP has facilitated partnerships and cooperation in general among groups that have historically tended to be quite separate. There is an evolving change in attitudes towards AFPs as a potentially satisfactory method of funding. This is in marked contrast to prevailing opinion among academic clinicians ten years ago when it was hazardous even to discuss the subject at medical meetings.

Although most of the medical leaders pointed to this changing culture, it is slow and they realize that this kind of culture change in organizations usually takes many years. There is certainly a minority of academic clinicians who are still resistant.

Trust and further negotiations

Although trust and recognition of good faith in negotiations are still issues, the majority of those interviewed commented that there is now less suspicion by the medical staff of Ministry motives and intent.

However, an overwhelming majority of those interviewed was supportive of further negotiations with the intent of finalizing comprehensive alternative funding plans. According to the interview testimony heard, there are still some cynics that “took the money but have no intention to continue with AFPs” but they are few.

Stabilization of practice plans

Opinions varied on this but the prevailing view was that the effect of Phase 1 was positive, especially in the non-technical departments and in some a serious impending practice plan crisis was averted.

Academic productivity

Any objective change in academic productivity is not yet measurable as only months have elapsed, but interesting comments were heard. There is satisfaction that academic contributions are finally being recognized although the sum involved is not yet considered adequate. Several of the academic leaders reported a notable improvement in the teaching situation with greater willingness to be involved and with greater enthusiasm.

Have there been any adverse effects?

No adverse effects of the Phase 1 AFP were discovered throughout this extensive interview process. A small proportion of clinicians is opposed to relinquishing fee for service billing on philosophical grounds. This group tends to suspect the motives of the Ministry and the Universities and it is likely that satisfactory negotiation of an attractive contract will reduce their number even further. However, their numbers are so small that they will not negatively impact the ongoing process

The Path to further Progress

This section deals with the issues that have been identified as important in moving ahead from Phase 1 into further development of more comprehensive alternative funding plans for the AHSCs in Ontario. The accompanying recommendations are made in the interest of helping the partners participating and the AFP process in general to progress.

The Phased Approach

There is overwhelming interest on the part of the clinical leadership, the Universities and the Hospitals in moving to a full AFP rather than moving through the 50% conversion Phase 2 that has been described. The Phase 1 Plan is regarded as an interim measure but, with one single exception, those interviewed see the interposition of a 50% conversion stage as cumbersome and unnecessary, resulting in undesirable delay. There would be considerable risk in losing valuable momentum if the process does not progress soon. However, it is clear that the various AHSCs are at different stages of readiness to proceed at this time.

Recommendation 3: It is recommended that the Ministry, in consultation with the AFP governing bodies, revise the plan for the three-phase approach to the implementation of alternative funding. Negotiations should begin as soon as possible, but with flexible timelines for the different AHSCs, in order to complete the process.

The necessity of a central provincial team

It has become apparent during this evaluation process that progress will require some central management to deal with all the issues discussed above and to guide the negotiation process that will have to occur with each site.

Recommendation 4: It is recommended that an AFP provincial working group be established with representation from each of the partners and each site to guide the extensive negotiation process that will have to occur.

Clear Objectives and intent to proceed

The AHSC leadership is looking for a clear message that the Ministry still wishes to pursue this policy initiative and all the partners need to be clear about the objectives.

Recommendation 5: It is recommended that the provincial AFP steering group develop a clear and concise number of objectives to satisfy the Ministry, the Universities, the clinicians and the hospitals as a basis for further negotiations.

The need for additional funds

The need for further funds in the negotiations for the final phase is widely recognized although the sum has not yet been estimated within any reasonable boundaries. Although this may turn out to be the most difficult issue in negotiations, it will be necessary for the Ministry to acknowledge that additional funding is necessary and for the governing bodies to agree on a reasonable formula for the determination of the amount, the timing of its injection into the system, and a formula for its distribution.

Maturation of the governing bodies

The governing bodies are at various stages of development from actually exerting governance activity to simply acting as a flow through mechanism for funds. Some of the groups will have to pay attention to the development of

governance. The issue of governance decision-making on the allocation of resources was extensively discussed during the interviews. This is obviously a particularly sensitive issue in some centres and there is little prospect in the near future of the governing bodies exerting any influence on the distribution of ***currently available resources***. However, there is general agreement that the addition of new funds under specific objectives in the development of a full AFP would enable the governance bodies to begin to address these issues.

It was considered acceptable in the Phase 1 Plan for governing bodies simply to pass around the available new resources but in full AFP contracts it would be advisable to include guidelines on distribution around the concepts of academic deliverables and clinical payment rationalization.

Recommendation 6: It is recommended that the AFP governing bodies begin to address the prospect of their ultimate role in promoting the priorities of the academic health science centre as a whole.

Local governance needs to retain the necessary flexibility to govern appropriately. Resources must be reallocated from time to time as practice patterns, patient needs and therapeutic options change. The governing body must have the flexibility to do this when appropriate without being hidebound to rigid departmental or personnel structures dictated in the AFP contracts.

Recommendation 7: It is recommended that the full AFP contracts make provision for flexibility in the use of new funding in order for the local governance eventually to be able to make appropriate decisions on recruitment and allocation of resources.

Fairness and transparency

These are extremely important values and to overcome the prevailing trust problem they must apply equally to all partners involved in the development of AFPs. Just as it is important for the Ministry to be open about the derivation of any formula used in determining additional funding, it is equally important for the universities, hospitals and clinicians to be open about the multiple, complex sources of payments that may constitute the clinician's income. These payments usually reflect special deals arising from historical precedents or crisis-management and they often relate (that is, when their purpose and expectations

are clearly documented) to activities that would be considered in-scope within an AFP. They are often unfair and opaque, and the recipients are not always enthusiastic about disclosing them. In any event, it is essential in the development of a full AFP and in the interests of fairness and transparency that they are dealt with openly. They include but are not limited to the following:

- Salaries or stipends from the university
- Grants, chairs or other awards
- Administrative salaries or stipends from the hospital
- Payments for clinical services from hospital operating funds
- Provision of 'free' or subsidized office space by the hospital or university
- Provision of secretarial support
- Medical-legal fees
- Workmen's Safety Insurance Board payments (WSIB)
- Uninsured patients
- Hospital on-call payments (provincial HOCC program)
- Extra hospital on-call payments from hospital operating budgets
- Royalties
- Special awards for professional merit

There may be some of the items on this list that would be designated out-of-scope (the last two are obvious examples) but many would obviously have to be considered as fully in-scope. The point is that they must be openly considered in the development of a comprehensive AFP.

In this context it must be noted that the hospitals, and in some instances their foundations, are likely to nurture the notion of recovering many payments that are currently going to academic clinicians, generated by previously unfunded requirements and episodes of crisis etc. How this issue is handled will have important effects on the financial requirements for AFPs.

In-scope and out-of-scope activities

Further negotiations must deal with this issue very carefully. It would be difficult if not impossible to keep out-of-scope activities within the values of fairness and transparency and they would have the potential to destroy trust in the whole system. There will obviously be some out-of-scope activities that are permitted in the contracts, such as royalties and special awards, but out-of-scope clinical activities should be minimal for full-time AHSC clinicians subscribing to

an AFP. The concepts of teamwork and shared commitment that are inherent in AFPs and practice plans are undermined if significant out-of-scope activities are permitted.

Recommendation 8: It is recommended that in preparation for further negotiations the AFP governing bodies prepare the necessary documentation of any and all sources of clinicians' income and prepare a plan on how they will be treated in the negotiations.

Recommendation 9: It is recommended that "out-of-scope" activities be minimal and carefully defined in full AFP contracts.

Strong opinion was presented during the interviews that the fairness and transparency principles be applied in a reasonably horizontal fashion across the AHSCs in the province. Arguments concerning cost of living carry little weight as there are positives and negatives in all areas of practice in the province. In addition, horizontal equity will be necessary in order to promote harmony among the AHSCs and to prevent inappropriate poaching of personnel.

Recommendation 10: It is recommended that further negotiations be conducted on the basis of equitable contracts for all of the academic health science centres in the province of Ontario.

Accountability Measures

One of the most attractive aspects of AFP development for the Ministry, the universities and the hospitals is that, for the first time, meaningful accountability measures for all the various necessary activities for AHSC clinicians can be developed and included in the contract, and from the clinicians point of view there was unanimous agreement that meaningful accountability measures are important. In fact, many are pleased that finally all of their legitimate activities would be properly acknowledged.

The evaluators are aware that much work is already being done on the issue of accountability at the Ministry and in particular by SEAMO. It will be very important to have a relatively standardized template for the accountability provisions in AFP contracts, albeit with provision for local detailed issues.

The accountability framework must include clinical service, research, education, administration and quality management.

- **Clinical Services**:

  Current AFP and APP agreements generally call for "shadow billing", but the use of billings data only creates an illusion of accountability and must be rejected as a meaningful measure that would be relevant for the complex life of clinicians in the AHSC setting. Fee codes are used so disparately (and sometimes creatively) by different physicians that billings are an unsatisfactory surrogate for clinical activity. This problem is compounded by the fact that interest in accurate billing falls precipitously within a system that provides funding stability. In organizations where AFPs or APPs currently are in place, there are younger physicians who have never had to depend on fee for service billing and who have no interest in it as an unnecessary and useless bureaucratic requirement. This view is supported by the fact that no meaningful use has ever been made to date of the "shadow billing" data that has been regularly submitted to the Ministry over the last ten years.

  It is necessary to replace shadow billing with a contractual section on accountability for clinical activities that is appropriate for a setting of stable funding. A large number of options are available here, including outpatient and inpatient data, length of stay and resource intensity, operating room cases and hours, waiting lists, emergency visits, response to Criticall etc. Ideally, and this should happen eventually in any case, the clinical accountability framework would include much more important information than these simple numbers provide, namely objective measures of intervention appropriateness, patient clinical and self reported quality of life outcome, and patient satisfaction. These are the measures that really matter.

  A model that may be attractive in the negotiations leading to the final phase of AFP development is that already mentioned in the

Phase 1 contracts *"…..It is expected that the Phase III AHSC AFP will include a minimum of ninety per cent conversion of the fee-for-service funding for clinical services…."* In moving to a "full" AFP the 90% conversion model was chosen by the Sisters of Charity in Ottawa and it appears to be working well. This model would provide a modest disincentive to letting clinical services decline and at least a modest attempt to make continued billing meaningful. This model may prove useful both to the Ministry and physicians in certain sites although large majority opinion would prefer full conversion and more meaningful clinical accountability measures than shadow billing can provide.

- **Research activity:**

  There are many well established templates that can be followed for the analysis of research activity and productivity. Such a template must be included in the overall accountability framework.

- **Education activity:**

  The AHSCs exist as special and separate entities for the purpose of developing new knowledge and for educating students. The expectations for teaching activity must be set by the university with reference to its overall mission and obligations. The accountability framework for the AFPs must include reference to the teaching obligations and deliverables.

- **Administration activity:**

  Efficient and effective administrative medical leadership is an essential ingredient for the success of divisions and departments within AHSCs. This activity falls under the requirements both of the University and the Hospital and must also be included in the contract accountability section.

- **Quality management:**

  Within any group of academic clinicians, some individuals will perform more or fewer of the clinical, research and teaching activities depending on their skills and interests but the deliverables must refer to the group as a whole and quality

management is every member's business. The accountability template should include the evaluation of clinical activities and outcomes and appropriate utilization of clinical resources.

The accountability framework will have to be consistent with the objectives of the AFP development in general and there must be internal consistency among the different AHSCs in the province.

Recommendation 11: It is recommended that the AFP contracts include accountability measures addressing deliverables in clinical service, teaching, research, medical administration and management of clinical quality and resource utilization.

Recommendation 12: It is recommended that the Ministry discontinue the inappropriate requirement for "shadow billing" in alternative funding arrangements in favour of more relevant accountability measures for clinical activities in AHSCs. The 90% conversion model may be an alternative to be considered.

Recommendation 13: It is recommended that the AFP provincial steering group adopt a standard template for the accountability sections in AFP contracts to be used as the basis for negotiation on the contractual accountability provisions for each site.

Recommendation 14: It is recommended that the accountability sections in contracts include provision for regular monitoring of the reported deliverables for each of the partners and appropriate feedback.

The potential effect of alternative funding on patterns of practice

This is a very sensitive issue, but there is abundant evidence in the literature and from anecdotes that the method of remuneration has an effect on physicians' practice. Fortunately, the great majority of physicians deliver appropriate care but there is an undeniable tendency to exploit the fee schedule in ways that are not always wholly appropriate. One interviewee stated a well known phenomenon

about the fee for service system very succinctly “you get paid for what you do but you don’t do what you don’t get paid for”.

Some interesting comments were heard about the effect of alternative funding on practice. These comments must also inform the debate surrounding shadow billing.

- “There is less resistance from physicians to planning a more appropriate mix of secondary, tertiary and quaternary cases *(it must be noted however that this can only be done responsibly in a regional strategic planning context).*
- The number of repeat visits that may not always be medically necessary tends to fall.
- Effective bed utilization management is facilitated. Physicians tend to consolidate services better where previously multiple visits were scheduled.
- Reduced inappropriate demand for OR cases to be done out of normal hours.
- Reduced scheduling of OR cases to begin immediately after the billing premium period begins.

The voluntary nature of participation

The voluntary approach to the whole AFP issue has been much appreciated by the medical staff but they realize that difficult issues will arise.

Negotiations for a full AFP will have to deal with those few who absolutely refuse to participate, whether for philosophical reasons or in those specialties that enjoy a substantially over-privileged status in the current fee for service system. In any given division or department there will obviously be a minimum participation rate below which an AFP would be unsustainable.

In the case of new recruits the issue of participation is easier to manage. There would be no justification whatever in pursuing the policies and culture of alternative funding on the one hand and at the same time recruiting new members of staff who would be given the option of not participating in the AFP. This may seem draconian to some, but with the experience of the high level of satisfaction with AFP contracts, making participation mandatory for new recruits is unlikely

to be a significant problem. In fact, quite the reverse has been the case in those centres with a decade of experience.

Recommendation 15: It is recommended that in negotiations leading to full AFP contracts, the participation of current medical staff continue to be voluntary.

Recommendation 16: It is recommended that the AFP governing bodies set policy to require all new full time recruits to participate in the AFP.

Special pre existing agreements

Over the last year the Ministry has had to deal with crises in some areas of specialty practice in AHSCs, including medical oncology, radiation oncology, surgical oncology, transplantation, family practice and neurosurgery. In some cases this has led to additional payment to the physicians. In the negotiations leading to full AFPs, these agreements will have to be rolled into the site AFP contracts with all the financial and other information on the table. It was disturbing to hear during the interviews that there were instances during the implementation of the Phase 1 agreements where previous alternative funding agreements were not on the table. This created the perception of double dipping which is always so destructive to group morale.

Recommendation 17: It is recommended that all pre-existing funding agreements be open and on the table at each involved site for the process of negotiation of the site AFP.

The objectives for new funding in a full AFP.

The objectives for the use of new funding fall under the two headings of academic recognition and clinical "repair". The objective of recognizing and stabilizing academic activity is well understood but the objective of clinical "repair" is somewhat confused and requires clarification.

Stripped of innuendo and political correctness, clinical "repair" simply means the process of recognizing the inappropriateness of the current fee schedule in general, the fact that some of the cognitive specialty groups in AHSCs cannot be adequately remunerated by it, and the fact that many highly skilled specialized procedures are inadequately compensated in comparison with multiple minor

interventions. A more appropriate phrase to use for this objective in establishing AFPs would be clinical payment rationalization (CPR) in spite of, or perhaps even because of, its other connotation.

It was repeatedly stated during the interviews, and the evaluators agree, that the AFP project cannot be used as a means to correct the fee schedule for those specialties that are currently over-privileged. This is an unfortunate reality, but people holding four aces are not usually enthused about a second deal. On the other hand the AFP project does have the potential to do something about those that are significantly disadvantaged in the current system.

It is unfortunate that, with one exception, the departments of radiology were not attracted to the alternative funding plan. As with the special arrangements mentioned above, it should be possible to negotiate a satisfactory package for the radiologists within alternative funding also and every effort should be made by the AFP governing bodies to attract the radiologists into the plan.

Recommendation 18: It is recommended that the AFP governing bodies continue negotiation with departments of radiology in an attempt to satisfy their issues and attract them into the AFP.

Consideration of the existing alternative funding plans

There is justifiable concern among the leadership of the Hospital for Sick Children in Toronto and SEAMO in Kingston that the negotiations for AFPs in the other AHSCs will leave them out. This clearly would not be in the interests of academic health science centre stability in Ontario and would also be inconsistent with the principles of fairness and transparency. Ultimately the AFP contracts for HSC and SEAMO must converge with each other and with the new AFPs negotiated in the other Ontario AHSCs.

Recommendation 19: It is recommended that the Ministry be prepared to modify the existing AFP contracts if necessary to be consistent with the new contract template to be developed with the other AHSCs.

Dispute resolution mechanism

Experience and current universal opinion dictate that all AFP contracts require a functional mechanism for resolving disputes. The evaluators are not sufficiently

knowledgeable about the detailed situation in each AHSC to make any specific recommendations on this but the dispute resolution mechanism must be effective which would mean a degree of independence, quick responsiveness and authority.

Recommendation 20: It is recommended that each AFP contract include a dispute resolution mechanism that is independent, responsive and authoritative.

Tax implications in AFPs

Experience across the country has demonstrated that the Canada Customs and Revenue Agency (CCRA) can aggressively pursue the designation of individuals as employees in circumstances where compensation comes wholly or even largely from a single source. This would have serious consequences for the success of AHSCs under AFPs and great care must be taken to avoid this possibility. Many physicians would have no interest in AFPs if this were to occur. It so happens that the steps necessary to protect from this are in any case in the best interest of the AHSC. These include ensuring that all payments go to the governance of the AFP and not to individuals, contracts that make it clear that professional freedom is maintained and that do not contain specific activity directions within the accountability framework, and a significant portion of personal income for the members that is "at risk". In other words, although considerable latitude is being given to the individual AFPs in how they distribute the AFP funds, it would be very inappropriate simply to divide them equally among the members. Individual member's compensation should be built on a reasonable base with the addition of monies to recognize particular contributions in any of the many aspects of activity described in the accountability template.

Recommendation 21: It is recommended that AFP governance organizations ensure that their local decisions concerning the distribution of funds for personal compensation include at least a portion of income that is dependent on agreed criteria for performance.

Summary

The overarching objective of Phase 1 of the alternative funding project was, in a single phrase, to stabilize academic health science centres. Although Phase 1 is only what might be called an introductory plan of partial alternative funding, it has succeeded in moving toward this objective. It has facilitated the creation of

governance structures, recognized the special needs of AHSCs, begun the process of compensating AHSC clinicians for academic and special clinical activities and, most importantly, created an environment conducive to further negotiations that could lead to mature AFPs such as those that have already been so successful in the province pf Ontario and elsewhere in North America.

There is general willingness to move ahead towards full alternative funding plans, given a clear policy direction for the Ministry to pursue this direction and the necessary process of negotiations. Achieving an appropriate financial package will be critical to achieving a final buy-in by physicians.

On the basis of this evaluation and previous experience with alternative funding, the successful negotiation of full AFPs in the AHSCs is likely to lead to stability of personnel, facilitated recruitment, predictability of budgets, enhancement of academic output, more appropriate clinical activity, especially in the areas of tertiary and quaternary care, alignment of Ministry, hospital and university objectives, and appropriate adjustment of incentives. Above all this could lead to positive change in the attitudes, culture and relationships among the various groups as true partners in the complex joint enterprise of academic medicine.

Appendix A

List of Documents Reviewed

Report of the Provincial Working Group: Alternative Funding Plans for Academic Health Science Centres, February 2002

Components of AFP Described by Phases One, Two and Three

Summary of Lessons Learned from Phase1– Physicians Summit Meeting, August 2003

AHSC AFP Update – Presentations to the OMA/MOHLTC Negotiations Committee, January 2004

Sunnybrook and Women's College Health Sciences Centre Phase 1 Agreement

Sisters of Charity of Ottawa Health Services Inc. Full AFP Agreement

Website material on alternative funding plans for academic health science centres in Ontario

Ontario Medical Association/Ministry of Health and Long Term Care Agreement 2000

Speech from the throne, Ontario, November 2003

Evaluation of the Alternative Funding Plan at the South Eastern Ontario Academic Medical Organization – Final Report 2002

Evaluation of the Alternative Funding Plan at the South Eastern Ontario Academic Medical Organization- Final Report 2003

BMJ editorial. BMJ Publishing Group to launch an international campaign to promote academic medicine. BMJ 2003;327:1001-1002

Evaluation of the Alternative Funding Plan at the South Eastern Ontario Academic Medical Organization - April 1999

Review of Governance and Accountability South Eastern Ontario Academic Medical Organization April 2002

Anderson M., Cosby J. Evaluating an Alternative Funding Plan. Healthcare Management Forum 1998;11:28-32.

Godwin M, Sequin Rochelle, Wilson R. Queens University Alternative Funding Plan Canadian Family Physician 2000; 46:1438-1444

Haslam R, Walker, N, Alternative funding plans: Is there a place in academic medicine?
CMAJ 1993;148:1141-1146

Greenwald M, Alternative funding plans. CMAJ 1993;149:536

Gellman D, Paying physicians in teaching hospitals. CMAJ 1993;148:1127-1129

O'Brodovich H, Career development and compensation: Strategies for physicians in academic health science centers. J Pediatr 200l;139:171

Organization	Participants	Type of Interview	Title	Other Comments
Baycrest Centre for Geriatric Care	Dr. Michael Gordon Ms. Tricia Rickwood	In person	Vice President, Medical Services Manager, AFP Project	Chair, Governance Organization
Bloorview MacMillan	Dr. Golda Milo-Manson	In person	Chief of Medical Staff	Chair, Governance Organization
Ctre.for Addict.& Mental Health	Dr. Joel Jeffries	In person	Psychiatrist	Chair, Governance Organization
Council of Ontario Faculties of Medicine - Dean's Meeting	Dr. Arlington Dungy Dr. Carol Herbert Dr. John Kelton Dr. David Naylor Ms. Mary-Kay Whittaker	Teleconference	Associate Dean, Alumni and Student Affairs, Faculty of Medicine, U. Ottawa Dean, Faculty of Medicine,University of Western Ontario Dean and Vice President, Faculty of Health Sciences, McMaster University Dean, Faculty of Medicine, University of Toronto Director, Council of Ontario Faculties of Medicine	
Hamilton Academic Health Sciences Centre	Dr. Peter Dent Dr. John Kelton Dr. William Orovan Mr. Kevin Sulewski	In person Teleconference Teleconference In person	Associate Vice President, Clin. Services, Faculty of Health Sciences, McMaster U. Dean and Vice President, Faculty of Health Sciences, McMaster University President, Hamilton Physicians Association; Professor and Chair, Dept. Surg. AFP Administrator	Chair, Governance Organization
Hospital for Sick Children	Dr. John Wedge Dr. Jim Wright	In person	Surgeon-in-chief; Chair, Department of Surgery Associate surgeon-in-chief	
London Academic Health Sciences Centre	Dr. John Brown Dr. Gillian Kernaghan Dr. Nigel Paterson Ms. Patricia Telfer	Teleconference	Director, EMG, Clinical Neurological Sciences Vice President, Medical Affairs, St. Joseph's Health Care Chair, Division of Respirology, University of Western Ontario Executive Director, Academic Medical Organization of Southwestern Ontario	Chair, Governance Organization
Ontario Medical Association	Dr. David Pattenden Mr. Darrel Weinkauf	In person	Chief Executive Officer Chief Operating Officer	
South-Eastern Ontario Academic Medical Organization	Dr. John Jeffrey Mr. Paul Rosenbaum	Teleconference	Associate Professor and Department Head, Obstetrics/Gynaecology Director, Policy and Planning, SEAMO	
Sisters of Charity of Ottawa	Dr. Jean Chouinard Dr. Paul Crabtree Mr. Louis O'Brien	Teleconference	Lead physician negotiator; Family Physician President, Medical Staff Board Member; Chair of AFP; Vice President, Canada Post	 Chair, Governance Organization
St. Michael's Hospital	Dr. Philip Berger Dr. Paul Dorian Dr. Patrician Houston Ms. Laurie Malone	In person	Chief, Family and Community Medicine AFP Board member; Cardiac Electrophysiology AFP Board member; Department of Anaesthesia AFP Manager	Chair, Governance Organization
Sunnybrook and Women's College Health Sciences Centre	Ms. Phyllis Heaphy Dr. Chris Morgan Dr. John Wedge	In person	Implementation Consultant fpr the AFP Deputy Head of Cardiology; Medical Director of the Cardiac Care Unit Vice President & Provost, Faculty of Medicine, University of Toronto	 Chair, Governance Organization
The Ottawa Hospital	Mr. Gregory Doiron Dr. Arlington Dungy Dr. Gary Garber Dr. Geraint Lewis	Teleconference	Director, Medical Affairs; Executive Director, TOHAMO AFP Associate Dean, Alumni and Student Affairs, Faculty of Medicine, U. Ottawa Lead physician negotiator, AFP; TOHAMO Board Member Anaesthetist	 Chair, Governance Organization
Toronto Rehabilitation Institute	Dr. Gaetan Tardif	In person	Vice President of Medicine	Chair, Governance Organization
University of Ottawa Heart Institute	Mr. Richard Batty Dr. Martin Green	Teleconference	AFP Project Manager Cardiologist	 Chair, Governance Organization
University Health Network/ Mount Sinai Hospital	Mr. Tom Closson Dr. Zane Cohen Dr. Molyn Leszcz Dr. Barry Rubin Dr. John Wedge Dr. John Wright	In person	President and CEO, University Health Network Surgeon-in-Chief, Mount Sinai Hospital Staff Psychiatrist, Mount Sinai Hospital Division Head, Vascular Surgery Vice President & Provost, Faculty of Medicine, University of Toronto Vice President of Medical Affairs, University Health Network	 Chair, Governance Organization
MOHLTC	Ms. Bernita Drenth Dr. David McCutcheon Ms. Linda Tennant	In person Teleconference In person	Lead AHSC AFP negotiator, Hamilton, Ottawa, and London Assistant Deputy Minister, Health Services Division, Ministry of Health and LTC Lead AHSC AFP negotiator, Toronto	

Appendix B

Appendix C

Baycrest Centre for Geriatric Care
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Family and Community Medicine	22	16	72.73%	16	72.73%	100.00%
Geriatric & Internal Medicine	10	8	80.00%	8	80.00%	100.00%
Psychiatry	19	15	78.95%	15	78.95%	100.00%
Other Specialties	15	0	0.00%	0	0.00%	0.00%
TOTALS:	66	39	59.09%	39	59.09%	100.00%

Centre for Addiction and Mental Health

	Total # Physicians	# Eligible Physicians	% of Total Physicians	# Partic Physicians	% of Total Billings	% of Total Physicians
OHIP	178	86	48.31%	83	46.63%	96.51%
Salaried	24	24	100.00%	24	100.00%	100.00%
TOTALS:	202	110	54.5%	107	53.0%	97.3%

Hamilton Academic Health Science Centres
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	69	60	86.96%	60	86.96%	100.00%
Medicine	301	187	62.13%	187	62.13%	100.00%
Surgery	138	85	61.59%	74	53.62%	87.06%
Gynecological Oncology	3	3	100.00%	3	100.00%	100.00%
Obs/Gyn	38	31	81.58%	31	81.58%	100.00%
Lab Medicine	87	38	43.68%	38	43.68%	100.00%
Psychiatry	87	69	79.31%	69	79.31%	100.00%
Family Medicine	283	31	10.95%	31	10.95%	100.00%
TOTALS:	1,003	501	49.95%	490	48.85%	97.80%

Appendix C (contd.)

London Academic Health Science Centres
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	69	57	82.61%	48	69.57%	84.21%
Neurology	26	20	76.92%	20	76.92%	100.00%
Otolaryngology	12	10	83.33%	9	75.00%	90.00%
Physical Mdicine & Rehabilitation	10	8	80.00%	8	80.00%	100.00%
Medicine	159	128	80.50%	128	80.50%	100.00%
Surgery	106	74	69.81%	74	69.81%	100.00%
Obs/Gyn	33	25	75.76%	25	75.76%	100.00%
Psychiatry	43	33	76.74%	33	76.74%	100.00%
Family Medicine	228	20	8.77%	16	7.02%	80.00%
Diagnostic Radiology	38	34	89.47%	21	55.26%	61.76%
Nuclear Medicine	11	7	63.64%	7	63.64%	100.00%
Ophthalmology	18	17	94.44%	17	94.44%	100.00%
Lab Medicine (Pathology APP)	27	27	100.00%	27	100.00%	100.00%
TOTAL excluding APPs	753	433	57.50%	406	53.92%	93.76%
TOTAL including APPs	780	460	58.97%	433	55.51%	94.13%

Ottawa Heart Institute (OHI)
Department Participation

Department	Total # Physicians	# Eligible Physicians	% of Total Physicians	# Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia (Cardiac)	11	11	100.00%	11	100.00%	100.00%
Medicine (Cardiology)	31	24	77.42%	24	77.42%	100.00%
Surgery (Cardiac)	10	9	90.00%	9	90.00%	100.00%

TOTALS:	52	44	84.62%	44	84.62%	100.00%

Appendix C (contd.)

St. Michael's Hospital
Department Participation Analysis

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	**57**	**39**	**68.42%**	**39**	**68.42%**	**100.00%**
Medicine	**205**	**109**	**53.17%**	**109**	**53.17%**	**100.00%**
Surgery	**77**	**30**	**38.96%**	**24**	**31.17%**	**80.00%**
Obs/Gyn	**25**	**16**	**64.00%**	**16**	**64.00%**	**100.00%**
Psychiatry	**28**	**16**	**57.14%**	**16**	**57.14%**	**100.00%**
Other (Participating Physicians)	**72**	**22**	**30.56%**	**20**	**27.78%**	**90.91%**
Pathology	15	8	53.33%	8	53.33%	100.00%
Ophthalmology	24	6	25.00%	4	16.67%	66.67%
Otolaryngology	13	2	15.38%	2	15.38%	100.00%
Paediatrics	17	4	23.53%	4	23.53%	100.00%
Occupational Health	3	2	66.67%	2	66.67%	100.00%
Family Medicine	**108**	**34**	**31.48%**	**34**	**31.48%**	**100.00%**
APPs	**19**	**19**	**100.00%**	**19**	**100.00%**	**100.00%**
ED AFA	19	19	100.0%	19	100.00%	100.00%
TOTAL excluding APPs	**572**	**266**	**46.50%**	**258**	**40.88%**	**78.78%**
TOTAL including APPs	**591**	**285**	**48.22%**	**277**	**43.32%**	**80.36%**

Toronto Rehabilitation Institute

Total # Physicians	# Eligible Physicians	% of Total Physicians	# Partic Physicians	% of Total Physicians	% of Eligible Physicians
61	**42**	**68.85%**	**41**	**67.21%**	**97.62%**

Note: 41 participating physicians represent 26 FTE
25 participating physicians have no earnings associated with TRI according to 2002/03 OHIP data
These individuals are either new to the facility or have not been using the facility number

Appendix C (contd.)

Sunnybrook and Womens' College Hospital
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	**46**	**33**	**71.74%**	**33**	**71.74%**	**100.00%**
Medicine	**240**	**79**	**32.92%**	**79**	**32.92%**	**100.00%**
Critical Care	4	4	100.00%	4	100.00%	100.00%
Surgery	**103**	**57**	**55.34%**	**45**	**43.69%**	**78.95%**
Obs/Gyn	**41**	**24**	**58.54%**	**21**	**51.22%**	**87.50%**
Psychiatry	**53**	**34**	**64.15%**	**29**	**54.72%**	**85.29%**
Other Participating Physicians	**76**	**35**	**46.05%**	**33**	**43.42%**	**94.29%**
ENT	9	4	44.44%	4	44.44%	100.00%
Ophthalmology	15	6	40.00%	6	40.00%	100.00%
Neonatology (Paediatrics)	31	8	25.81%	6	19.35%	75.00%
Lab Medicine	21	17	80.95%	17	80.95%	100.00%
Family Medicine	**239**	**32**	**13.39%**	**32**	**13.39%**	**100.00%**
ER AFA	21	21	100.00%	21	100.00%	100.00%
TOTAL excluding APPs *	**798**	**294**	**36.84%**	**272**	**34.09%**	**92.52%**
TOTAL including APPs *	**819**	**315**	**38.46%**	**293**	**35.78%**	**93.02%**

Appendix C (contd.)

The Ottawa Hospital
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	**74**	**62**	**83.78%**	**58**	**78.38%**	**93.55%**
Medicine (includes Critical Care)	**199**	**134**	**67.34%**	**130**	**65.33%**	**97.01%**
Surgery (minus Plastic Surgery)	**102**	**63**	**61.76%**	**53**	**51.96%**	**84.13%**
Obs/Gyn (minus Neonatology)	**63**	**50**	**79.37%**	**39**	**61.90%**	**78.00%**
Psychiatry	**75**	**25**	**33.33%**	**24**	**32.00%**	**96.00%**
Other Participating Physicians						
ENT	12	10	83.33%	10	83.33%	100.00%
Emergency	23	17	73.91%	23	100.00%	135.29%
Total Other Participating Physicians	**35**	**27**	**77.14%**	**33**	**94.29%**	**122.22%**
Total Participating Physicians	**548**	**361**	**65.88%**	**337**	**61.50%**	**93.35%**
Other (Non-Participating Physicians)						
Lab Medicine	20					
Medical Oncology	14					
Nephrology	19					
Ophthalmology	34					
Diagnostic Radiology	41					
Radiation Oncology	18					
Geriatrics	5					
Total Other (Non-Participating Phys)	**151**					
Sub-Totals	**699**	**361**	**51.65%**	**337**	**48.21%**	**93.35%**

Family Medicine	**230**	**50**	**21.74%**	**47**	**20.43%**	**94.00%**

Appendix C (contd.)

UHN-Mount Sinai Hospitals
Department Participation

Department	Total # of Physicians	# of Eligible Physicians	% of Total Physicians	# of Partic Physicians	% of Total Physicians	% of Eligible Physicians
Anaesthesia	**104**	**72**	**69.23%**	**72**	**69.23%**	**100.00%**
Medicine (excluding Oncology)	**341**	**194**	**56.89%**	**194**	**56.89%**	**100.00%**
Surgery	**163**	**89**	**54.60%**	**89**	**54.60%**	**100.00%**
Obs/Gyn	**56**	**37**	**66.07%**	**37**	**66.07%**	**100.00%**
Psychiatry	**117**	**80**	**68.38%**	**80**	**68.38%**	**100.00%**
Other Participating Physicians	**74**	**40**	**54.05%**	**40**	**54.05%**	**100.00%**
ENT	17	10	58.82%	10	58.82%	100.00%
Ophthalmology	57	30	52.63%	30	52.63%	100.00%
Family Medicine	**234**	**48**	**20.51%**	**48**	**20.51%**	**100.00%**
APP Totals	**42**	**42**	**100.00%**	**42**	**100.00%**	**100.00%**
ED AFA	37	37	100.00%	37	100.00%	100.00%
Gynecology Oncology	5	5	100.00%	5	100.00%	100.00%
TOTAL excluding APPs	**1,089**	**560**	**51.42%**	**560**	**51.42%**	**100.00%**
TOTAL including APPs	**1,131**	**602**	**53.23%**	**602**	**53.23%**	**100.00%**