Report of the Provincial Working Group:

Alternative Funding Plans for Academic Health Science Centres

Ontario

February 2002

Hon. Tony Clement
Minister of Health & Long-Term Care
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Dear Minister, Dr. McKibbon and Dr. McCutcheon:

We are pleased to provide you with the Report of the Provincial Working Group (PWG) on Alternative Funding Plans (AFPs) for Academic Health Science Centres (AHSCs). Since your appointment of the members in August 2001, the PWG has worked intensively for close to five months. We believe that the resulting Report charts a clear path towards the development and implementation of AFPs in Ontario's AHSCs. We also believe that the AHSC community will embrace the report as a practical guide to AFP development and implementation and accordingly we encourage the Ministry to begin the implementation phase as soon as possible.

We would like to take this opportunity to thank the members of the Provincial Working Group for their hard work, time and dedication in the creation of this Report. It has been a pleasure to serve the Ministry, the Physician Services Committee and the AHSC community as Chair and Vice-Chair of the PWG.

Sincerely,

Dr. William Orovan
Chair
Provincial Working Group

Dr. Arnie Aberman
Vice-Chair
Provincial Working Group

Report of the Provincial Working Group on Alternative Funding Plans for Academic Health Science Centres

I Introduction

Historical Context

The history of funding and support for academic health sciences stretches back c. 100 years to the work of Drs. William Osler and Abraham Flexner who first recognized the unique circumstances that arise out of a merger of clinical service, education and research. Both Osler and Flexner advised of the need for special care regarding the role and contribution of these unnamed entities now known as academic health science centres (AHSCs).

In a more recent era (post 1975), various parties in Ontario/Canada have issued a number of related reports calling for a coordinated and organized approach that recognizes, supports and enhances the unique role and contribution of AHSCs. These reports include but are not limited to the following:

- The Funding of Clinical Education in the Province of Ontario - Hickling Johnson Report,1975;
- Cost/Financing of Clinical Medical Education - Woods Gordon, 1989;
- The Future Development of Academic Health Science Centres in Ontario: A Strategic Framework - J. Wade, 1991;
- Planning the Future Academic Medical Centre - L. Valberg, M. Gonyea, D. Sinclair, 1994;
- Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) Reports - Ontario's Academic Health Science Centres: Sustaining Ventures for Their Communities, 1995;
- Fulfilling the Mission - National Conference on the Future and Funding of Academic Health Science Centres - Conference Summary (December 1995);
- Medical Education and the Changing Hospital Environment - A Discussion Paper for Consideration at the ACTH Invitational Conference - R. S. Rowand, E.R. Smith, 1996; and
- PCCCAR Reports - Funding Academic Health Science Networks: An Investment in the Future (1997) - An unpublished but frequently cited paper.

In each case the authors of these reports echo the calls for special care that Osler and Flexner signaled many years earlier.

Immediate Historical Context

Ontario has a long history of alternative funding arrangements in AHSCs. Most of the existing arrangements are small and narrowly focused, e.g., trauma care at St. Michael's Hospital in Toronto, the Ottawa regional perinatal program. The arrangements with the Hospital for Sick Children in Toronto (first negotiated in April 1990) and with Queen's University in Kingston, i.e., SEAMO (first negotiated in July 1994) are considerably larger in terms of physicians and budget and broader in terms of the scope of services. Other academic health science centres have expressed some interest in negotiating broad arrangements but have failed for a variety of reasons.

The pressure to create special arrangements for AHSCs has wavered over the years. More recently, however, a number of issues have come to bear raising the pressure to create special arrangements for AHSCs to new levels. For example:

- Ontario's AHSCs compete in an international market for highly skilled and educated academic physicians.
- Changes in the Ontario Health Insurance Plan and hospital restructuring have altered the range of services that academic physicians provide in teaching hospitals and consequently have altered the potential for generating revenue.
- AHSCs are facing recruitment and retention challenges for increasingly scarce academic physicians.
- Challenges have heightened inter-AHSC competition. More and more frequently, AHSCs call out for a so-called level playing field between AHSCs to minimize the incentive for inter-AHSC recruitment and retention.
- Large community hospitals are increasingly viewed by academic physicians as attractive alternatives to the traditional AHSC.

For these and other reasons, representatives of the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association agreed in the course of their negotiations in Spring 2000, that the implementation of alternative funding plans (AFPs) for the four AHSCs in Hamilton, London, Ottawa and Toronto should be a priority. This agreement resulted in the inclusion of the following Section in the 2000 OMA/MOHLTC Agreement.

> *The MOHLTC and the OMA agree that physicians working at Academic Health Science Centres ("AHSC) need to be funded in innovative ways in order for these institutions to fulfil their important patient service and academic activities. The MOHLTC intends to make physician alternate payment plans available to the individual AHSCs on a voluntary basis. Implementation issues with respect to such AHSCs are apart and separate from this Agreement. However, the parties acknowledge that conversion of the actual value of services provided by physicians from fee-for-service pool or pools will take place. The manner in which such conversions out of the*

fee-for-service pool or pools shall be calculated shall be agreed between the parties prior to such conversion. The MOHLTC acknowledges that it will incur additional costs to implement these alternative payment modalities.

This intention was enlarged upon in 2000 Ontario Budget - Our Health Care Commitment. In a section entitled "Improving Access to Health Care Services," the Budget paper reads:

Additional funding will be provided over four years to enhance medical services to provide better care for patients. This includes… $75 million to transfer doctors in academic health science centres to alternative payment plans.

In an attempt to move the AFP initiative forward the Physician Services Committee (PSC), which is charged with developing a strong relationship between Ontario's physicians and the MOHLTC, established an AHSC Sub-committee. The AHSC Sub-Committee contracted Ms. Maureen Quigley and Mr. Graham Scott to undertake a readiness survey that would measure the extent to which AHSCs were prepared to undertake AFP negotiations. The Quigley/Scott report was submitted to the AHSC Sub-Committee in February 2001. Using the report as a point of departure the members of the AHSC Sub-Committee prepared a draft 'policy framework' for developing AFPs in AHSCs. The Quigley/Scott Report and the draft policy framework served as the basis for discussions at a PSC-hosted forum in March 2000 including representatives from teaching hospitals, faculties of medicine and academic clinicians - an estimated total of 85-90 participants.

Following the March 2001 Forum, the PSC took the comments from the participants and redrafted the policy framework. The policy framework, along with a statement of proceedings, was then circulated to forum participants in May 2001 (Appendix A).

The AHSC Sub-Committee subsequently recommended the establishment of a Provincial Working Group to take ownership of the task and responsibility for moving the creation of AFPs in AHSCs forward. In August 2001, Hon. Tony Clement, Minister of Health and Long-Term Care established a Provincial Working Group (PWG) Chaired by Dr. William Orovan and Vice-Chaired by Dr. Arnie Aberman. Through the PWG Terms of Reference (Appendix B) Dr. Orovan and the other members of the PWG were charged with the development of a Provincial AFP Design with a December 31, 2001 reporting deadline.

The PWG held its first meeting on September 12, 2001 and established four sub-committees responsible for different aspects of the final report. The four sub-committees included:

1) Data Sub-Committee
2) Sub-Committee for the Definition of Provincial and Local Elements of an AFP
3) Environmental Scan Sub-Committee, and
4) Process Sub-Committee

The sub-committees then met separately to develop and fulfill their respective terms of reference (Appendix C).

II The Vision for Creating AFPs in Ontario's AHSCs

For the purposes of developing AFPs in AHSCs the PWG offers the following working definitions.

Academic Health Science Centre (AHSC) – The jurisdictional intersection of i) a university with a faculty of health sciences or a school of medicine, ii) a fully affiliated teaching hospital(s), and iii) medical staff who hold both privileges at the teaching hospital and an academic appointment from the university.

Alternative Funding Plan (AFP) – An alternative funding plan aligns the interests of the university, the teaching hospital and the involved medical staff by merging (notionally or actually) multiple funding sources for the remuneration of involved medical staff for clinical service, education, research and associated administration. In exchange for the merger of funding sources, the parties of an AFP agree to meet a comprehensive set of deliverables in each of clinical service, education, research and associated administration.

Parties to an AFP – There are five possible parties to an AFP as follows:

1) Universities – Ontario has five universities that offer undergraduate and postgraduate medical education. These same universities also have a major interest in health science research. Research and education, representing the dual mission of universities, are also two parts of an AHSC's tri-partite mission. (The AHSC in Kingston includes Queen's University. This AHSC is already covered under its own AFP, i.e., the South Eastern Ontario Academic Medical Organization (SEAMO)). For the purposes of this AFP initiative the following four universities are included in the schedule of parties:

- McMaster University
- University of Western Ontario
- University of Ottawa and
- University of Toronto.

2) Teaching Hospitals – Teaching hospitals work with their university partners to offer undergraduate and postgraduate medical education. The primary role is the provision of an infrastructure for the clinical education part of the curricula. Teaching hospitals are also active in health science research. Indeed many teaching hospitals have research foundations dedicated to that part of the mission. Finally, teaching hospitals offer clinical service. Equal priority is given to each of these elements of a teaching hospital's tri-partite mission. For the purposes of this AFP initiative those teaching hospitals with full university affiliation agreements are included in the schedule of parties:

- Hamilton (affiliated with McMaster University):
- Hamilton Health Sciences Corporation
- St. Joseph's Healthcare
- London (affiliated with University of Western Ontario:
- London Health Sciences Centre
- St. Joseph's Health Care
- Ottawa (affiliated with University of Ottawa):
- The Ottawa Hospital
- Sisters of Charity of Ottawa Health Services Inc.
- Royal Ottawa Health Care Group
- Children's Hospital of Eastern Ontario
- Toronto (affiliated with the University of Toronto):
- Baycrest Centre for Geriatric Care
- Bloorview MacMillan Centre
- Centre for Addiction and Mental Health
- Mount Sinai Hospital
- St. Michael's Hospital
- Sunnybrook & Women's College Health Sciences Centre
- Toronto Rehabilitation Hospital
- University Health Network.

3) Medical Staff - Without the medical staff neither the teaching hospital nor university could deliver their respective missions. These academic physicians routinely engage in a mix of education, research, clinical service and administration for each of the foregoing. The involved medical staff associated with the universities and teaching hospitals noted above are included in the schedule of parties.

4) The Ontario Medical Association - The OMA is the official representative of the medical profession in Ontario. Through their negotiations with the Ministry of Health and Long-Term Care the AFP initiative has finally reached a stage of concrete development. In keeping with the MOHLTC/OMA Agreement the OMA is a party in its own right at all AFP negotiations.

5) The Government of Ontario - The Government of Ontario provides the vast majority of funding to AHSCs albeit in a variety of streams. Those funding streams include but are not limited to OHIP revenue, hospital operating dollars, university operating dollars, research funding and clinical education funding. The Government of Ontario is included in the schedule of parties.

Within the context noted above all AFPs developed for the AHSCs in Hamilton, London, Ottawa and Toronto must incorporate the following seven components.

Component One: Governance Structure

(See Appendix D for additional details on governance structure.)

All AHSCs that hope to develop an AFP must establish a body responsible for overseeing the activities of the AHSC under the AFP and ensuring accountability between the parties of the AFP. The PWG recognizes that there are many viable forms of governance. In developing structures for governing their AFPs, the AHSCs in Hamilton, London, Ottawa and Toronto must adhere to the following five principles:

1) Requirement for Legitimate Representation

- Membership in the governing structure must include legitimate representation from: the involved medical staff; the teaching hospital; and the university - if involved.
- Legitimate representation is defined as the authority of a representative to act on behalf of their respective constituency.
- Authority is realized as follows:
  - **a)** Medical staff representatives are granted authority through a democratic process. Such a process may draw from existing democratic structures, e.g., a medical staff association, the Clinical Teachers Association, or create a new process or body that ensures individual academic physicians are represented. The body that represents the involved medical staff must have a legal structure.
  - **b)** Hospital representatives are granted authority through the hospital's board or management structure.
  - **c)** University representatives are granted authority through the university's senior governance structure.

2) Responsibility for Meeting Defined Deliverables

- AFP governing structures shall be responsible for meeting defined deliverables in the areas of clinical service, education, research, and associated administration.

3) Accountability

- The governing structures shall be accountable to the Government of Ontario for the management of the AFP.
- Management of the AFP shall be understood to mean meeting the deliverables. These deliverables include annual planning as well as financial management and allocation of resources.
- AFP resources are defined as funding (i.e., dollars flowing), human resources and capital infrastructure.

4) Merger of Revenue Sources

- Recognizing that direct and indirect AFP funding will be derived from a number of different sources within government, there should be a merger (notional or actual) of these funds before they are flowed to the individual AFP governance structures in the AHSCs.
- All local governance structures should have the capacity to receive merged (notionally or actually) resources and reallocate them to the members of the AFP.

5) Dispute Resolution

- All AHSC AFPs must have established dispute resolution procedures for dealing with conflicts and disagreements arising in the course of operating its governance, such as :
- The allocation of funds to participating physicians
- The movement of funds within the AHSC
- Changes in physician complement, including issues involving retention and recruitment, and
- The locations where services are to be provided.
- It is strongly recommended that the dispute resolution systems rely heavily on consensus-building, using facilitation, mediation and third-party non-binding adjudication. Assistance in designing appropriate systems will be provided to the AHSC.

Component Two: Funding

AFP funding must include new and existing dollars to support education, research, clinical service and administration in an AHSC.

New Dollars

- New dollars are currently defined as the $75 million announced in *Budget 2000 – Our Health Care Commitment*.
- For each AHSC, new funding will be contingent on the breadth of participation of clinical departments and the range of services for each of education, research and clinical service defined under the AFP.

Existing Direct Educational Funding

All AFPs must account for the funding that directly or indirectly supports the educational mission of the AHSCs and consider the extent to which that funding might be part of the AFP. A comprehensive schedule of those funding sources includes the following.

Ministry of Training, Colleges & Universities

- Notional grant funding to the Faculties of Medicine through the universities' funding formula

Ministry of Health & Long-Term Care

- Clinical Education Budget funding including a) residents' salaries and benefits, b) GFT funding to Faculties of Medicine, c) Medical Education Supplies funding to the teaching hospitals, and d) GFT Secretarial Support

University

- Tuition fee revenue from undergraduate medical students flowing to the Faculty of Medicine
- Administrative fees from postgraduate medical residents & fellows
- Pool C off-shore stipends

Hospital

- Hospital operating dollars support of educational activity
- Hospital Foundation support of educational activity where such support exists

Clinician Generated Revenue

- Physician practice plan revenue support of educational activity, e.g., clinical fellowships

Other Funding Sources

- Non-MOHLTC resident funding
- Private Foundations

Existing Direct Funding for Clinical Service

All AFPs will need to account for the funding that directly or indirectly supports the respective clinical service mission for AHSCs and consider the extent to which that funding might be part of the AFP. A comprehensive schedule of those funding sources includes the following.

Clinician Generated Revenue

- OHIP and non-OHIP fee revenue for:
  - **a)** Specialists and sub-specialists with privileges at a fully affiliated teaching hospital and an academic appointment from the relevant university's faculty of medicine/health sciences.
  - **b)** Family physicians with hospital privileges at a fully affiliated teaching hospital and designated as geographic full-time (GFT) by the Faculty of Medicine.

Hospital Resources

- Hospital operating dollars and other funding sources, e.g., national or regional programs, associated with the provision of clinical service by physicians within an AHSC.

- Hospital in-kind support for the provision of clinical service by physicians within an AHSC.

University Resources

- University resources associated with the provision of clinical service by physicians.

Existing Direct Research Funding

All AFPs will need to account for the funding that directly or indirectly supports the respective research mission for AHSCs and consider the extent to which that funding might be part of the AFP. A comprehensive schedule of those funding sources includes the following.

- National Agencies
- Provincial Agencies
- Government contract research
- Industry contract research
- Fee-for-service sponsored research
- University sponsored research within the AHSC context
- Hospital and Foundation sponsored research
- Independent research units
- Research collaboratives

Component Three: Measurable Deliverables

(Appendix E - Data Report)

All AFPs must include a schedule of measurable deliverables for each of education, research, clinical service and administration. Resistance to paper-based reporting systems in the absence of a fee-for-service environment is recognized. Nonetheless accurate and timely performance measures are required to ensure accountability of the parties. Other AHSCs (e.g. the Department of Paediatrics in the Faculty of Medicine at the University of Calgary) have pioneered technological solutions that have resolved this tension. Palm-based technology, for example, has been developed that will: allow for the measurement of clinical, educational and research services; reduce significantly if not totally eliminate the need for paper-based records; and improve the timeliness and quality of the data collected. AHSCs are strongly encouraged to investigate such technological solutions. The PWG believes that a modest investment could yield positive results and resolve a long-standing tension.

Education

- Educational deliverables must be expressed through the provincially and nationally defined units of measurement for quantifying teaching workload in each of: pre-clerkship education; clerkship education; postgraduate

education (residency & fellowship); continuing medical education; public education and other graduate level education.

Research

- Research deliverables must be expressed through the provincially and nationally defined units of measurement for quantifying research performance

Clinical Service

- Clinical deliverables must be expressed through provincially accepted measures of activity. Notwithstanding the need to create new performance measures these new measures should be expressed in terms that are consistent with current activity measures.

Administration

- Each of the deliverables, education, research, and clinical service, should include a measurable unit of service associated with administration. AHSCs are strongly encouraged to review the administrative workload associated with managing an AFP governance structure and incorporate that workload into the AFP.

Component Four: Methodology for Payment

The governance structure for each AFP in an AHSC must design, implement and manage a payment methodology for participating physicians. The payment of participating physicians will be a function of the total value of the AFP, and the individual physician's specific deliverables in the context of the AFP. In all cases the remuneration of an individual physician must be based on agreed upon volume measures for each of education, research, clinical service and administration.

Component Five: Human Resources Plan

All AHSC AFPs must develop a physician human resources plan, for the term of the AFP, to ensure that the parties succeed in meeting their deliverables. The plan must clearly articulate the medical human resources required to meet each deliverable.

Component Six: Provisions for Change

Given the fluid nature of education, research and clinical service the AFP must include a mechanism for forecasting and reporting changes in the deliverables. The AFP must also include a mechanism for responding to unforeseen changes affecting the AHSCs ability to meet the deliverables.

Component Seven: Broad Participation

In order to maximize the opportunities for potential AFP members to meet their deliverables the AFP should only move forward if there is broad physician participation from each of the core programs within the AHSC.

III Suggested Steps to Assist AHSCs in Developing an AFP

The PWG recommends the following process to assist AHSCs in developing an AFP.

1) Each AHSC is strongly encouraged to establish its own AHSC AFP Working Group that will move the potential AFP members through the suggested steps below. The following steps are suggested as a guide to assist AHSCs in developing an AFP. The AHSC AFP Working Group is strongly encouraged to work through each of the steps collectively.

2) In accordance with the OMA/MOHLTC Agreement, the MOHLTC will notify the OMA of any expression of interest regarding the development of an AFP in an AHSC. Physicians in the AHSC may wish to enlist the assistance of the OMA in the development of an AFP. In cases where the physicians do not wish to enlist the assistance of the OMA, the OMA is a party to the developments in its own right.

3) In order to facilitate uniform development and ensure provincial equity in AFPs across Ontario's AHSCs it is recommended that the Ministry of Health and Long Term Care establish a Provincial AFP Steering Committee as follows:

Steering Committee Membership: The membership of the Steering Committee should include appropriate representation from each of the following parties:

- academic physicians, i.e., physicians with expertise in the fields of education, research, clinical service and administration
- fully affiliated teaching hospitals
- medical faculties/schools
- Physician Services Committee
- Ontario Medical Association
- Ministry of Health and Long Term Care (including representation from the Health Services Division and the Health Care Programs Division and the Integtrated Policy and Planning Division)

The membership of the Steering Committee should be large and diverse enough to ensure that all perspectives are available. The Assistant Deputy Minister, Health Services Division, should Chair the Steering Committee.

Steering Committee Mandate: The Steering Committee should advise the Chair, i.e., the Assistant Deputy Minister of Health and Long Term Care, Health Services Division under the following mandate.

- Monitor the schedule of AFP negotiations.
- Serve as a general reference panel for the MOHLTC Negotiation Teams on the subject of ongoing AFP negotiations.
- Review each step of the AFP implementation plan for each AFP negotiation and advise the MOHLTC Negotiating Teams accordingly.
- Review all draft AFPs and advise the ADM, Health Services Division regarding viability.

4) The PWG recognizes that there are many paths that may be followed leading to the successful development of an AFP. Regardless of the path chosen, however, each AHSC will need to work through each of the steps listed below. Irrespective of the order chosen the parties should adhere to the content of each of the steps. Members of the Provincial Steering Committee should be available to explain to respective parties each of the steps outlined below as a general introduction. Ideally the parties would engage directly on each of the steps.

Step One: Pre-AFP Self Assessment

(See Appendix F: Pre-AFP Self Assessment)

Each of the potential members of an AFP (i.e., medical staff, teaching hospital and university) have different methods and rationale for measuring and monitoring their respective activities. The Pre-AFP Self-Assessment is intended as a preliminary attempt to collect and coordinate the various information sources that will be necessary to measure and monitor the educational, research, clinical service and administrative activities of an AHSC under an AFP.

The pre-AFP self-assessment should include the following information:

a) a description of the existing organizational structures in an AHSC;

b) a description of current Activities in the AHSC for each of Education, Research and Clinical Service - the description should include indicators that allow measurement of the volume, scope and location of activities;

c) an accounting of the total resource base currently dedicated to the AHSC - the accounting should include all direct and indirect resources; and

d) based on the seven components of a Vision for AFPs set out above and flowing from the results of the self-assessment, a preliminary assessment of interest in pursuing an AFP should be ascertained.

The parties will engage in the execution of the pre-AFP self-assessment.

Step Two: Defining a Common Data Set To Articulate the Deliverables of an AHSC

(Appendix E: Data Report)

Based on the estimated level of participatory interest and in accordance with the four principles of governance structure set out under Component One, the respective AHSC AFP Working Group should define a common data set that will serve as a basis for articulating AHSC deliverables. Appendix E: Building a Common Data Set is intended as a guide to the Working Group for this exercise.

The parties will engage in the definition of a common data set.

Step Three: Articulation of AHSC Activities Under an AFP

Flowing from the definition of a common data set, the AHSC's AFP working group should engage with the MOHLTC Negotiation Team to articulate:

a) Activities that the AHSC intends to maintain.

b) Activities that the AHSC intends to change.

c) New activities that the AHSC hopes to meet following implementation of the AFP.

The parties should ensure that the deliverables are measurable and that they are expressed in a style consistent with the common data set. Deliverable performance measures should also be consistent with the measures in hospital operating plans or the evolving institutional service agreements.

Step Four: Creation of a Governing Body

(Appendix D - Process Report)

Flowing from Component One above, all AHSCs will be required to develop a body responsible for overseeing the activities of the AHSC and ensuring accountability between the AHSC and Government. Although the creation of a governing body is set out here as step four it should be understood that its creation is evolutionary. In that regard, AHSCs are encouraged to engage in discussions concerning the development of a governance structure in tandem with each of the steps outlined above.

While the creation of a governance structure must adhere to the principles outlined in Component One, it should be noted that governance structures are likely to vary across AHSCs. Irrespective of the form that an AHSC adopts for its governance structure, it is critical that the governing body ensures that the parties of the AFP meet their respective deliverables.

The final establishment of a governance structure is therefore not a pre-requisite to the commencement of negotiations.

The parties will engage in the creation of a governance structure.

Step Five: Finalizing the Agreement - Ensuring Consistency with the Seven Components Referenced in the Vision for AFPs in Ontario's AHSCs

Notwithstanding the evolutionary nature of the development of an AFP, the final agreement must conform to the seven components outlined in the Vision for AFPs in Ontario's AHSCs. The seven components are reiterated below:

Component One:	Governance Structure
Component Two:	Funding
Component Three:	Measurable Deliverables
Component Four:	Payment Methodology
Component Five:	Human Resources Plan
Component Six:	Provisions for Change
Component Seven:	Broad Participation

A draft AFP proposal will be submitted to the Provincial AFP Steering Committee for comment. The Steering Committee will advise the Assistant Deputy Minister of Health and Long Term Care, Health Services Division, on the viability of the AFP proposal.

Step Six: Approval

The parties must approve the final agreement as follows:

- Universities should approve the final agreement through the standard processes and governance required by its senior administration, e.g., board of governors or governing council.
- Teaching hospitals should approve the final agreement through the standard processes and governance required by its senior administration, i.e., the hospital board.
- Involved medical staff should approve the agreement through a ratification process. (See Appendix D: Options for Structuring the Governing Body, for a discussion of involved physicians.)
- In accordance with the OMA/MOHLTC Agreement the OMA should approve the agreement on the basis of medical staff ratification after the OMA and the MOHLTC have agreed to the conversion mechanism for OHIP funds.
- The Government of Ontario should approve the agreement through its standard approval processes.

IV AFP Maintenance

Given the complexity of an AFP in AHSCs, the Provincial Working Group strongly recommends the establishment of a formal secretariat that will manage the various AFPs. While there are any number of management options the PWG

recommends that the Health Services Division (HSD) of the MOHLTC assume overall responsibility for ongoing management and maintenance of the AFPs. The Division would facilitate the sharing of responsibility across HSD Branches, other MOHLTC Divisions and other government Ministries. The PWG further recommends that the Physician Services Committee (PSC), or a sub-committee of the PSC be regularly informed and involved in the ongoing evaluation and development of this initiative.

I Provincial AFP Steering Committee

(See above for proposed membership and mandate)

II MOHLTC Negotiation Teams

The PWG recommends the establishment of two negotiating teams: Team 1 will focus on AFPs in Toronto's AHSC and Team 2 will focus on AFPs in Hamilton, London and Ottawa AHSCs.

The teams should include the following skill set:

- intimate knowledge of the workings of AHSCs, i.e., education, research, clinical service and administration,
- good understanding of the interests of the parties, i.e., academic physicians, teaching hospitals, faculties/schools of medicine and government,
- strong financial analytical capacity,
- strong communication skills, and
- proven capacity to negotiate complex multi-party agreements.

III MOHLTC Negotiation Support Team

A dedicated network of MOHLTC staff will support the two negotiation teams noted above. Staff will be drawn, notionally and actually, from the Health Care Programs Division, the Health Services Division and other government management units as required.

IV AFP Management & Monitoring Team

The Ministry of Health and Long-Term Care is obligated to manage, monitor and evaluate all AFPs. Accordingly those functions will be delegated to the Alternate Payment Programs Branch of the Health Services Division following the completion and ratification of all AFPs. In keeping with the spirit of shared responsibility the Ministry should share the results of monitoring and evaluation exercises with the relevant parties and with the PSC or its relevant sub-committee.

Appendix A

Alternate Funding Plans for Academic Health Science Centres

Physician Services Committee Sub-Committee on AFPs

Actions arising from the March 27 AFP Forum
May 11, 2001

AFP Definition

An Alternative Funding Plan (AFP) aligns the interests of physicians, universities and participating hospitals by amalgamating multiple sources of funding into a single envelope for the remuneration of participating physicians for clinical services, teaching, research and administration. The sources of funding may include in total or in part:

- Fee-for-service income from the Ontario Health Insurance Plan:
- Technical fee income;
- Hospital operating funding;
- Clinical Education Budget funding;
- University operating funding;
- Health sciences research funding.

AFP Goals

Goal 1: Improving the Capacity of Ontario's AHSCs

AFPs will improve the capacity of Ontario's AHSCs to:

- Provide quality patient care;
- Provide appropriate physician incomes;
- Enhance teaching and research;
- Effectively recruit and retain academic physicians.

Goal 2: Recruitment and Retention of Academic Physicians

The recruitment and retention of academic physicians will be more successful through appropriate recognition and remuneration of work including administration, patient care, research and teaching.

Goal 3: An Attractive AHSC Environment

The AHSC environment will be attractive in comparison with other practice environments.

Goal 4: Enhancing the Reputation of AHSCs

The enhanced reputation of AHSCs in education and research will provide economic benefit to Ontario.

The reputation of AHSCs will be enhanced by new modes of clinical practice, improved education and research, thus providing social and economic benefit to Ontario.

Goal 5: Physician Funding Levels

There will be equitable, predictable and sustainable funding levels for physicians based on a defined and realistic physician human resources plan.

Goal 6: Defined Deliverables

There will be realistic defined deliverables for AHSC clinical, research, teaching and administrative activities.

Goal 7: Other Health Care Providers

AFPs will facilitate the appropriate use of other health care providers to maximize the effective use of resources within the patient care team and to supplement physician shortages in specialist areas.

Goal 8: Support to Rural and Remote Communities

AHSCs will each have defined responsibilities and resources within the AFP to provide AFP physician consulting expertise and support to rural and remote hospitals and physicians.

Goal 9: Stabilizing Physician Human Resources

Consistent physician recruitment and retention policies among AHSCs will stabilize physician human resources within and among AHSCs.

Goal 10: Advancing Integrated Health Care

AHSCs and their physicians and other health care providers and professional will work cooperatively to advance integrated health care.

Essential Components

Essential Component 1: An Accountable Governance Structure

The AFP will include a governance structure agreed to by the parties, comprising physician, hospital and university representatives. The governance structure is accountable for the achievement of defined deliverables, the overall management of the funds and plan and allocation of resources to participating physicians.

Essential Component 2: New Funding

The plan must be built on a realistic base and include both existing and new dollars to address clinical service, teaching, research and administration.

Essential Component 3: Measurable Deliverables

a) Defined Deliverables: The AFP will define deliverables for clinical service, teaching, research and administration for the AHSC and internally at the level of the department and the individual physician.

b) Governance Structure: The AFP will commit the AFP governance structure to measure clinical service, teaching, research and administrative performance and be accountable through regular defined reporting requirements.

c) Accountability: The AFP governance structure is accountable to the Government of Ontario for the achievement of the deliverables.

Essential Component 4: Payment Methodology

a) *Individual Remuneration:* The AFP must include a payment methodology that ensures the individual participating physicians are remunerated for their clinical service, teaching, research and administration in accordance with the specific mission of the AHSC.

b) *Clinical Services:* Clinical services covered by the Plan will include all insured services provided by participating physicians specified in the agreement.

c) *Flexibility:* The AFP must have the flexibility to address both the complexity and volume of work performed by participating physicians in an AHSC.

d) *Volume Changes:* The AFP must address appropriate changes in patient care volumes between AHSCs and community hospitals arising from planned changes in participating physician practice patterns.

Essential Component 5: Human Resources Plan

The AFP must include a comprehensive human resources plan for the term of the AFP that supports the achievement of its deliverables.

Essential Component 6: Provisions for Change

The AFP must contain agreed upon provisions for addressing both planned and unforeseen changes in clinical volumes and programs during the term of the agreement.

Essential Component 7: Dispute Resolution

The AFP must include a mechanism for resolving disputes.

Essential Component 8: Provisions for Conversion from the Fee-For-Service Pool

The Ontario Medical Association and the Ministry of Health and Long-Term Care will define a conversion methodology for all AFPs.

Local Variation

While each AFP must include all eight components noted above, the specifics within each component might vary from one AHSC to another.

Principles to Guide Discussion Toward the Implementation of AFPs with Revisions

Discussion Principle 1: Interested Parties

The interested parties in the discussions toward the development of an AFP at an AHSC are:

- Physicians
- Teaching hospitals
- Universities and/or faculties of medicine/health sciences
- Ontario Medical Association
- Ministry of Health and Long-Term Care
- Other relevant Ontario Government Ministries

Discussion Principle 2: Voluntary Participation

Participation in AFP discussions and implementation will be voluntary.

Discussion Principle 3: Communicating the Framework

The framework for AFP discussions among the parties will be widely communicated.

Discussion Principle 4: Communication Protocols

Protocols should established by the parties for communication to interested physicians on the progress of discussions.

Discussion Principle 5: Approval Process

All participating AFP physicians will be involved in the approval process prior to the implementation of an AFP.

Discussion Principle 6: Discussion Forum

A provincial forum on Alternate Funding Plans will be established to discuss issues of mutual interest to the parties across AHSCs.

Appendix B

Provincial Working Group (PWG) on AFPs for AHSCs

PWG Membership: The PWG will be comprised of the following members to reflect the following perspectives:

Chair – Dr. William Orovan, St. Joseph's Healthcare, Hamilton

Vice-Chair – Dr. Arnie Aberman, University Health Network

Faculty of Medicine

- Dr. Peter Walker, University of Ottawa

Teaching Hospital

- Mr. Tony Dagnone, London Health Sciences Centre
- Mr. Jeff Lozon, St. Michael's Hospital

Academic Physician

- Dr. Don Livingstone, Sunnybrook & Women's College Health Sciences Centre
- Dr. John Sangster, London Health Sciences Centre
- Dr. Chris Carruthers, The Ottawa Hospital
- Dr. Peter Dent, Hamilton Health Sciences
- Dr. James Wilson, Kingston General Hospital
- Dr. Catherine Zahn, Toronto Western Hospital, University Health Network
- Dr. Jennifer Blake, Sunnybrook & Women's College Health Sciences Centre

Private Sector

- To be determined by the Minister's Office.

Physician Services Committee (PSC)

- Dr. Chris McKibbon, PSC Co-Chair
- Mr. John King, PSC
- Mr. Harvey Beresford, PSC
- Mr. Mark Geiger, PSC

Government of Ontario

- Mr. Colin Anderson, Integrated Policy and Planning Division, Ministry of Health and Long-Term Care
- Representative from the Ministry of Training, Colleges and Universities (TBD)
- Representative from the Ministry of Finance (TBD)

MOHLTC Staff Support

- Mr. Brad Sinclair, Senior Policy Advisor, Academic Health Science Centres, Health Services Division
- Dr. Alison Pilla, Director, Operational Support Branch, Health Services Division
- Ms. Marsha Barnes, Director, Alternative Payment Programs Branch, Health Services Division
- Mr. John McKinley, Director, Finance and Information Management Branch, Health Care Programs Division

PWG Mandate: Advise the Minister of Health and Long-Term Care and the Physician Services Committee (PSC) on implementation of the Provincial Policy Framework for AFP discussions. Such advice will include the following tasks:

1. In light of provincial AFP Definition, AFP Goals, AFP Essential Components and AFP Principles to Guide Discussions, undertake a common fact gathering process for quantifying AHSC activities (see Attachment A) in each of:
   - Clinical service provision
   - Health science education
   - Health science research and
   - Associated administration for each of clinical service, education and research.
2. Define the components of the common elements and the methodologies for collecting and presenting those components required for local AFP discussions and implementation.
3. Advise the Minister of Health and Long-Term Care and the PSC on which elements should be common for all AFPs and which may be unique to individual AHSCs.
4. Building on the AFP Definition, AFP Goals, AFP Essential Components and AFP Principles to Guide Discussion, in addition to the results of the common fact gathering process, prepare a draft *Provincial AFP Design (PAD)*.
5. Consult with local AHSCs on the draft PAD and confirm a final *Provincial AFP Design (PAD)*. The final PAD will confirm the central issues and articulate the issues requiring resolution in local negotiations.
6. Advise the Minister of Health of Health and Long-Term Care and the PSC on the process necessary to advance local discussions on AFPs with interested AHSCs.
7. Advise the Minister of Health and Long-Term Care and the PSC on steps and process required to ensure effective communication with and among physicians, hospitals and universities as AFP planning and implementation proceeds.

8. Regularly advise the Minister of Health and Long-Term Care and the PSC on the progress of their work, anticipating completion of such work by December 31, 2001.

PWG Accountability

1. PWG reports to the Minister of Health and Long-Term Care and the Physician Services Committee.
2. PWG serves as an official liaison between local AHSC committees and the Government of Ontario on the subject of a provincial policy framework.
3. PWG serves as the official liaison for all external parties interested in AFPs in Ontario's AHSCs.

Appendix C

Terms of Reference for PWG Sub-Committees

PWG Sub-Committee I

Data Sub-Committee of the Provincial Working Group on AFPs for AHSCs

Building on item 1 from the PWG Terms of Reference, the Data Sub-Committee of the PWG is further charged with defining the data requirements for AFPs.

There are four fundamental issues that need to be addressed consistently by each AHSC for the purposes of an AFP. These issues are loosely defined as 1) What 2) Who 3) Resources & 4) Measurement & Accountability.

1) What

a) What activities are included in the schedule of activities that comprise an AHSC for each of:

- Education? E.g. undergraduate, postgraduate, CME, graduate science education
- Research? E.g. clinical science, basic science, applied science, social science
- Clinical Service? E.g. insured services including primary, secondary, tertiary and quaternary care, uninsured services
- Administration associated with each of Education, Research and Clinical Service?

b) Which of these activities should fall under the jurisdiction of an AFP?

c) Under whose jurisdiction does the activity currently fall?

2) Who

a) Who currently undertakes the various activities within the schedule defined in Issue 1) above? E.g. Clinicians, clinician scientists, basic scientists, social scientists, postgraduate medical students, educational administrators

b) Which of the individuals noted in a) above, should fall under the jurisdiction of an AFP?

3) Resources

a) What resources - direct, indirect and in kind - support the schedule of activities articulated in Issue 1) above? E.g. OHIP revenue, MOHLTC funding from the Clinical Education Budget, hospital operating funds, university funds, university tuition and administrative fees, voluntary teaching contributions, hospital & university infrastructure

b) Which of the resources noted in a) above, should fall under the jurisdiction of an AFP?

4) Measurement & Accountability

a) What information is currently available to quantify the performance or volume for the schedule of activities articulated in Issue 1) above? E.g. student enrolment data, data describing the complement of clinical faculty, research funding, OHIP billing data, hospital operating plans

b) What new information will be required to address the respective concerns of the parties engaged in an AFP for an AHSC?

The Sub-Committee may choose to offer additional comments and/or advice to the PWG related to data requirements for AFPs in AHSCs.

The Data Sub-Committee of the PWG on AFPs for AHSCs will respond comprehensively to each of the issues noted above by October 19, 2001.

PWG Sub-Committee II

PWG Sub-Committee for the Definition of Provincial and Local Elements of an AFP

Building on items 2 and 3 in the PWG Terms of Reference, the Provincial/Local Sub-Committee of the PWG is further charged with the development of principles that allow for the designation of AFP elements as provincial or local.

The Sub-Committee will begin with a review of the *Essential Components of an AFP* that were defined and revised at the March 27, 2001 Forum on AFPs for AHSCs.

These essential components cover the following issues:

1) An Accountable Governance Structure
2) New Funding
3) Measurable deliverables
4) Payment Methodology
5) Human Resources Plan
6) Provisions for Change
7) Dispute Resolution
8) Provisions for the Conversion from the Fee-For-Service Pool

The Sub-Committee will review each of these issues and the constituent components therein and develop principles that allow for the designation particular elements or sub-elements as provincial or local.

In the course of its deliberations the Sub-Committee may choose to recommend additional issues.

The Provincial/Local Sub-Committee of the PWG on AFPs for AHSCs will respond comprehensively to each of the issues noted above by October 19, 2001.

PWG Sub-Committee III

Environmental Scan Sub-Committee of the Provincial Working Group on AFPs for AHSCs

Building on the *Final Report to the Physician Services Committee: Academic Health Science Centre Perspectives on Alternate Funding Plans*, the Environmental Scan Sub-Committee of the Provincial Working Group on AFPs for AHSCs is further charged with preparing a detailed description of the current situation at each of the Hamilton, London, Ottawa and Toronto AHSCs with respect to AFPs.

The Sub-Committee will also answer the following questions for each AHSC.

1) What is the relative approximate size and scope of the enterprise for each of a) clinical service, e.g., number of clinical programs and clinical volume for each b) education, e.g., student enrolment and c) research, e.g. number of clinical investigators, total grant funding.

2) How will an AFP improve the current situation for a) clinical faculty, b) teaching hospitals, c) faculty of medicine and d) other relevant parties?

3) What are the most significant barriers to establishing an AFP for the AHSC in each of Hamilton, London, Ottawa and Toronto?

The Sub-Committee may also wish to offer advice to the PWG regarding features particular to one of the AHSCs that is not covered in the terms of reference noted above.

The Environmental Scan Sub-Committee of the PWG on AFPs for AHSCs will respond comprehensively to each of the issues noted above by October 19, 2001.

PWG Sub-Committee IV

Process Sub-Committee of the Provincial Working Group on AFPs for AHSCs

Building on items 6 and 7 in the PWG terms of reference the Process Sub-Committee is further charged with the preparation of a strategic outline for engaging in AFP discussions. The Sub-Committee will also review the *Principles to Guide Discussions*, revised at the March 27, 2001 forum on AFPs for AHSCs.

Such an outline will include:

1) A description of the process for consulting with AHSCs collectively, and

2) A description of the respective processes for each AHSC AFP discussion. This may include advice on the relative order of discussions, the pace of discussions. It may also include advice on the models of discussion.

The Process Sub-Committee of the PWG on AFPs for AHSCs will respond comprehensively to each of the issues noted above by October 19, 2001.

Appendix D

Options for Structuring the Governing Body

Practice Plans as a Starting Point

When considering how to structure the governing body for and AFP in an AHSC one point of departure is the governance structure for extant practice plans.

There is a wide variety of practice plan arrangements currently in place both across and within the AHSCs in Hamilton, London, Ottawa and Toronto. In some practice plans membership is a prerequisite to practising in an AHSC while in other cases membership is optional. The extent of membership also varies across practice plans. Some participants, for example, contribute all or the vast majority of their revenue to the plan and are remunerated accordingly by the plan. In other instances participants contribute a token amount to the practice plan but make strong contributions in the areas of education and research. The situation may be further complicated by the geographic proximity of hospitals. While Toronto, for example, has seven fully affiliated teaching hospitals where academic physicians can hold privileges, it also has a number of large community hospitals (not fully affiliated) that offer a broad range of clinical services. Toronto-based medical specialists or sub-specialists may have the option of working in a fully affiliated teaching hospital, i.e., within an AHSC or a non-fully-affiliated teaching hospital, i.e., outside an AHSC. The Toronto situation contrasts markedly with the AHSC in London where all of the city's hospitals are fully affiliated teaching hospitals. The largest community hospitals are some distance away from city and do not afford the London-based specialist or sub-specialist the same options as are available in Toronto.

Given the complexity and the breadth of variability it is not appropriate to insist that all physicians practising in an AHSC must belong to the AFP as a precondition for its creation. In the situations where mandatory practice plan participation currently exists it is not unreasonable to expect that physicians would demand a similar commitment with respect to an AFP. This demand, however, should not be mandatory. It is therefore possible that the AFP may not encompass all of the physicians in an AHSC. It will be important, therefore, for discussion concerning participation to take plan at the commencement of AFP discussions. The structure of the AFP governance structure and whether or not the AFP is indeed viable will, in a large measure, be driven by the number of physicians who choose to participate. If an insufficient number of physicians or clinical units (e.g., departments or divisions), are interested in pursuing the development of an AFP, it is unlikely that the Ministry of Health and Long-Term Care would agree to pursue such a development until greater participation is obtained.

In addition, it will be necessary to decide who to include in discussions and in the ratification process required once an AFP agreement has been finalized. The PWG recommends the development of a protocol at the front end of the process whereby individual who are in mixed plans, i.e., plans that contain both geographical full-time and geographical part-time members, identify a preliminary interest in involvement so that the relevant billing data with respect to these individuals is available and they have the ability to participate in the discussions in the same fashion as any other physician. As indicated, this issue is directly related to the question of ratification. The PWG recommends that in locations where geographic full-time and part-time physicians are part of an existing practice plan a dual process is required. Before discussions commence physicians need to indicate their decision to participate. Final ratification would involve all of those physicians who had expressed interest in participation by the time the process had been completed.

Existing Models of Governance

The Hospital for Sick Children

The Hospital for Sick Children's AFP is structured as a contract between the Government of Ontario, the Hospital for Sick Children and a partnership comprised of two practice partnerships. This AFP does not include an overall governance structure. The contract provides deliverables and accountability for various parties dependent on the particular deliverable. In addition, the contract does not include a dispute resolution mechanism.

Southeastern Ontario Academic Medical Organization (SEAMO)

In the case of SEAMO the AFP takes the form of an "Association." The Association has a number of member classes but the Association is not incorporated and is therefore not a legal entity but a collection of its various members. In addition, the relationship between individual members of one class and members of another class is not clearly defined. In order to be bound by the AFP individual physicians are required to enter into elaborate multi-party contracts.

Theoretical Models of Governance

There are effectively four kinds of legal structures that could be created under existing legislation that might serve as models for AFPs in Ontario's AHSCs.

Model 1 – A "for profit" corporation could be established under the *Ontario Business Corporations Act* (Ontario) or the *Federal Alternative*. For a number of reasons this structure is not considered to be appropriate for an AHSC AFP.

Model 2 – A "not-for-profit" corporation could be established under the *Corporations Act* (Ontario) or the *Federal Alternative*.

Model 3 – AHSC AFPs could be established through a "partnership", a joint venture agreement or as an unincorporated association. While a joint venture agreement or unincorporated associations could allow for infinite variety with respect to constitution and by-laws, they would not establish a legal entity.

Model 4 – The Government could create special legislation allowing for the establishment of AHSCs as separate and special legal entities. This approach would allow the AFP to have an internal structure uniquely designed to assist in the delivery of the AHSC's mandate. Such legislation could create an AHSC AFP structure that would allow for the unique relationship between various entities and groups of physicians involved, without the artificial restrictions present in either partnership or corporate law.

Theoretical Example of a Governance Structure Under the Corporations Act

One possible example of a governance structure is as follows. The Board of the AFP could be comprised of representatives of various classes of AFP members, and facilitated by a neutral chair with a tie casting vote only. The structure could include sub-committees to oversee the clinical, research and educational missions as an audit committee to ensure adherence to the deliverables. The structure might also include a CEO and an administrative staff that reports to the Board, and could further facilitate a dispute resolution through a standing committee appointed by or elected from representatives of the various classes of members.

The classes of members would include the university, the hospital(s) and the medical staff. The medical staff might comprise a single class or could comprise several different classes based on departmental structures or existing practice plans. The university, if it were to be a member of the plan, would appoint members in accordance with its own governing process. The hospital would appoint members in accordance with its own Board of Governors. The medical staff would elect their Board representatives through an existing structure, e.g., Medical Staff Association or Clinical Teachers' Association, or through a new process.

This structure is similar to that used at SEAMO except that SEAMO is not an incorporated entity. If incorporation is desired, care should be taken when drafting the corporate documents to ensure the relevant provisions of the relevant act are taken into account.

Appendix E

Data Requirements for an AHSC AFP

Framing the Issue

There are three fundamental elements to this discussion. 1) What is the data required to ensure that an AHSC is meeting its deliverables as they are defined in the AFP? 2) What is the unit of measure for each individual data requirement? 3) At what level is the data required to ensure that an AFP is meeting its deliverables as they are defined in the AFP i.e., AHSC-wide, at the level of a unit within an AHSC or at the level of the individual participant? The chart below provides some preliminary definitions of the requirements recognizing that some fine-tuning of the definition will arise out of local negotiations.

Physician resistance to so-called shadow billing is well recognized. Equally well recognized is the government's need to monitor performance and thereby ensure accountability. Individual patient data can also be extremely valuable in assisting the Ministry and other interested parties in establishing appropriate research data with respect to utilization and patient treatment. Technological solutions have been pioneered in other AHSCs, e.g., the Department of Paediatrics at the University of Calgary, that have resolved the tension between physician resistance to shadow billing and the government's need for accountability. Palm-based technology has been developed that will: allow for the measurement of clinical, educational and research services; reduce significantly if not totally eliminate the need for paper-based records; and improve the timeliness and the quality of the data collected through paper-based records. A modest technological investment at the front end of the AFP process could yield some very positive results and resolve a long-standing tension.

Three Elements of the Discussion

1) What is the data required to ensure that an AFP is functioning in accordance with its deliverables? If one accepts the premise that an AHSC engages in education, research and clinical service then it follows that the data requirements quantifying the respective volumes of activity should be developed for each one of the three activities. In addition, each one of the activities (education, research and clinical service) can be further broken down into additional sub-sets. Educational data, for example, may be required for each of undergraduate medical education, postgraduate medical education, continuing medical education, other health sciences education, graduate science education and public education.

2) What is the unit of measure that should be applied to individual data requirements? AHSCs are notorious for the amount of information they collect. There is an equally notorious impression that for all of the information that is collected in an AHSC, the data integrity is at best uneven. One way of improving the integrity of the data is by creating clarifying definitions for the unit of measure. Using the first indicator in the chart below as an example, it is evident that there are a number of different ways of measuring the volume of undergraduate educational activity. The broadest definition speaks to the total number of students, e.g., c. 300 FTEs at McMaster per year. That measure alone does not account for variations in the commitment arising, for example, from a) local differences in the undergraduate structure and curriculum, b) breadth and availability of clinical resources, and c) relations with other enterprises, e.g., postgraduate education. For the purposes of a Provincial AFP Design it is critical that there be uniform units of measure.

3) At what level is the data required to ensure that an AFP is meetings its deliverables? There are three levels at which the data could be collected: i) data that sits at the broadest level of the AFP, e.g., total enrolment for an AHSC, ii) data that relates to the individual clinical unit, e.g., department, division, program, service, and iii) data that relates to the individual physician.

If one accepts that information yields data and that data, in turn, supports performance indicators, then it follows that performance indicators can be used as criteria for funding or remuneration. Such criteria could be useful at the broadest level of the AFP, at the level of individual clinical units or at the level of the individual physician. Part of the discussion may be driven by data availability, i.e., while it might be desirable to collect data at the level of the individual physician, it might not be currently available or practical to contemplate insisting on such a requirement.

With the foregoing remarks as context, the following chart begins the process of identifying the data elements of an AFP, defining the unit of measure and determining the level at which the information should be collected.

UG Education

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Total UG Enrollment	UG Student FTEs	Total UG enrollment data is available from the universities. It is also available at the level of individual teaching hospitals via the JPPC reporting mechanisms. This data should be required in an AFP.	UG enrollment data does not reflect the contribution of discrete clinical units. It should not be required data in an AFP.	UG enrollment data does not reflect the contribution of individual physicians. It should not be required data in an AFP.
UG Pre-Clerkship (defined as Years I-III for Ottawa, Queen's, Toronto & Western and Years I&II for McMaster UG medical programs)	UG Student Day or Student Contact Hours	Total data is available as a function of a) the UG curriculum and b) student enrollment. This data should be required in an AFP but it should be cross-referenced against the cumulative total of contributions made by discrete clinical units.	Total data for clinical units should be available as a function of the a) UG curriculum and the respective role of discrete clinical units and b) student enrollment. This data, however, should be cross-referenced against the actual experience of clinical units. Both notional data derived from the function and data collected to document the actual experience should be a requirement for the AFP.	Data for individuals within discrete clinical units should be available. The total contribution of physicians in a clinical unit should equate to the contribution reported by the clinical unit at the mid-macro level. Data, however, for individual physicians should not be required data in an AFP.
UG Clerkship (defined as Year IV for Ottawa, Queen's, Toronto & Western and Year III for McMaster)	UG Student Day	Total data is available as a function of a) the UG curriculum and b) student enrollment. This data should be required in an AFP but it should be cross-referenced against the cumulative total of contributions made by discrete clinical units.	Total data for clinical units should be available as a function of the a) UG curriculum and the respective role of discrete clinical units and b) student enrollment. This data, however, should be cross-referenced against the actual experience of clinical units. Both notional data derived from the function and the data derived from the actual experience should be required in an AFP.	Data for individuals within discrete clinical units should be available. The total contribution of n physicians in a clinical unit should equate to the contribution reported by the clinical unit at the mid-macro level. Data, however, for individual physicians should not be required data in an AFP.

PG Education

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Pool A Enrolment	PG Student Day	Notional data is available as a function of a) residency curricula, b) PG enrollment, and c) PAIRO/OCOTH Agreement. Actual data is available through the PG Administrative Offices in the universities. Both data should be required in an AFP. These data should be cross-referenced against the cumulative total of residency program contributions.	Notional data for discrete residency programs is available as a function of a) program curricula, b) program residency enrollment, and c) PAIRO/OCOTH Agreement. Actual data is available through the respective residency program offices. Both data should be required in an AFP.	Data for individuals within discrete residency programs should be available. The total contribution of physicians in a residency program should equate to the contribution reported by the residency program at the mid-macro level. Data, however, for individual physicians should not be required data in an AFP.
Pool B Enrolment	PG Student Day			
Pool C Enrolment	PG Student Day			
Pool D Enrolment	PG Student Day			
Pool E Enrolment	PG Student Day			

Grad Science Education

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
MSc Enrolment	MSc Student Day	Total enrolment data should be available through the universities. AFP should focus on education that requires the contribution of clinical faculty. This data should be required in an AFP. This data should be a function of the sum of respective university departmental data.	Total data for each clinical unit should be available through relevant university departments. AFP should focus on education that requires the contribution of clinical faculty through the respective university department.	Individual contributions of clinical faculty should be available through the respective university department. The sum of contributions by physicians in a discrete clinical unit should equate with the contribution reported by the university department at the mid-macro level.
PhD Enrolment	PhD Student Day			
Post Doc Enrolment	Post Doc Day			

Continuing Medical Education

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Annual CME Volume	CME Sessions, CME Participating Physicians, Estimated Curriculum Development Time	Total CME contribution should be available through the university for university-based CME offerings. Total contributions for non-university-based CME should be available as a sum of the total contributions of discrete clinical units within an AHSC. This should be required data in an AFP.	Total CME contributions - both university-based and other CME - should be available through the university for discrete clinical units as a sum of the total contributions for physicians in that unit. This should be required data in an AFP.	Individual CME contributions are available at the level of the individual physician. Data quantifying the contribution for university-based CME and for other CME should be required data in an AFP.

Public Education

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Annual Public Education Volume	Public Education Physician Hours, Other Undefined Units	Total Public Education contribution should be available for the AHSC as a sum of the total contributions for discrete clinical units in an AHSC. This should be required data in an AFP.	Total Public Education contributions should be available for discrete clinical units as a sum of the total contributions for physicians in that unit. This should be required data in an AFP.	Individual Public Education contributions are available the level of the individual physician. Data quantifying this contribution should be required data in an AFP.

Educational Administration

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Administrative Support for UG Education	Admin. FTE	Data quantifying educational administration for the entire AHSC is available through teaching hospitals and universities. This data should equate with the aggregate of data reported by discrete clinical units.	Data quantifying educational administration is available through discrete clinical units. This should be required data in an AFP.	The individual physicians engaged in educational administration are easily defined, e.g., program directors, chairs of clinical units. Their respective administrative contribution is a function of the job description. This should be required data in an AFP.
Administrative Support for PG Education				
Administrative Support for Graduate Science Education				
Administrative Support for CME				
Administrative Support for Public Education				

Research Activity

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
National & Provincial Grants	Value of Peer-Reviewed Funding	Data describing total funding awarded is available through the granting agencies. Such data is also reported to the ACMC for publication by the universities. The AFP should require reconciled data between the various sources to avoid errors or double counting. This data should be cross-referenced against the cumulative total of funding reported by discrete clinical units. This should be required data in an AFP.	Data describing funding awarded to discrete clinical units should be available through their respective administrative offices. This should be required data in an AFP.	Data describing the funding awarded to individuals should be available through the administrative offices of the respective clinical units. This should be required data in an AFP. The sum of awards to n individuals in a discrete clinical unit should equate to the total sum reported by the discrete clinical unit at the mid-macro level.
Industry/Contract Grants	Value of Funding	Data describing total industry/contract funding is available through the research administration offices. This should be required data in an AFP.	Data describing funding awarded to discrete clinical units should be available through their respective administrative offices. This should be required data in an AFP.	Data describing the funding awarded to individuals should be available through the administrative offices of the respective clinical units. This should be required data in an AFP. The sum of awards to n individuals in a discrete clinical unit should equate to the total sum reported by the discrete clinical unit at the mid-macro level.
Practice Plans	Value of FundingData describing total practice plan supported research	should be available through the research administration offices. This should be required data in an AFP.	Data describing practice plan supported research should be available through the respective practice plan administrative offices. This should be required data in an AFP.	Data describing practice plan the funding awarded to individuals should be available through the administrative offices of the respective clinical units. This should be required data in an AFP. The sum of awards to n individuals in a discrete clinical unit should equate to the total sum reported by the discrete clinical unit at the mid-macro level.
Other Support	Peer-Reviewed Funding, Financial Estimates of University or Hospital In-Kind Support	Data describing the university and/or hospital in kind support for research should be available from the university and the hospital. This should be required data in an AFP.	Data describing the university and/or hospital in kind support for research within a discrete clinical unit should be available at the level of the discrete clinical unit. This should be required data in an AFP.	Data equating university and/or hospital in kind support for research at the level of the individual physician is extraneous. This should not be required data in an AFP.

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Publications & Citations in Peer-Reviewed Journals	# of Publications	Data describing total number of publications should be available through the research administrative offices in the universities and the teaching hospitals. This should be required data for an AFP.	Data describing total number of publications should be available through the research administration offices for each discrete clinical unit. This should be required data for an AFP.	Data documenting number of publications for individual physicians should be available through the administrative offices of the respective clinical units. This should be required data in an AFP. The sum of publications by n individuals in a discrete clinical unit should equate to the total number of publications reported by the discrete clinical unit at the mid-macro level.
Publications & Citations in Non-Peer-Reviewed Journals	# of Publications	Data describing total number of publications should be available through the research administrative offices in the universities and the teaching hospitals. This should be required data for an AFP.	Data describing total number of publications should be available through the research administration offices for each discrete clinical unit. This should be required data for an AFP.	Data documenting number of publications for individual physicians should be available through the administrative offices of the respective clinical units. This should be required data in an AFP. The sum of publications by n individuals in a discrete clinical unit should equate to the total number of publications reported by the discrete clinical unit at the mid-macro level.
Administrative Support for Research	FTE Admin Support	Data describing administrative overhead for research programs in an AHSC should be available through the research administrative offices in the universities and the teaching hospitals. This should be required data in an AFP.	Data describing administrative overhead for research programs in an AHSC as the level of a discrete clinical unit should be available through each discrete clinical unit. This should be required data in an AFP.	Data describing administrative overhead for research programs at the level of individual physicians is extraneous. This should not be required data for an AFP.

Clinical Activity

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Hospital Operating Funding	MOHLTC Funding	Total operating funding is available in the hospital operating plans. Total operating funding dedicated to physician activity is available at the hospital level. This should be required data for an AFP.	Operating funding for discrete clinical units is available at the hospital level. Operating funding dedicated to physician services in discrete clinical units is also available at the hospital level. This should be required data for an AFP.	Operating funding dedicated to individual physicians is available at the hospital level. This should be required data in an AFP.
In-Patient Visits	# of Visits	Data describing the total in-patient visits for a hospital of group of hospitals is available through the hospital operating plans. These should be required data for an AFP.	Data describing total in-patient visits for a discrete clinical unit is available through the hospital operating plans. These should be required data for an AFP.	Data attributing in-patient visits to an individual physician are not available. A proxy for such data may be available through analysis of OHIP billings but would need to be integrated with hospital reporting systems. These should be required data for an AFP.
Bed Capacity	# of Active Beds	Data describing total bed capacity for a hospital or group of hospitals is available through the hospital operating plans. These should be required data for an AFP.	Data describing bed capacity for discrete clinical units is available through the hospital operating plans. These should be required data for an AFP.	Data attributing bed capacity to an individual physician are not available. Such data is extraneous and should not be required for an AFP.
Out-Patient Visits	# of Visits	Data describing total outpatient visits for a hospital or a group of hospitals is available through the hospital operating plans. These should be required data for an AFP.	Data describing outpatient visits for discrete clinical units is available through the hospital operating plans. These should be required data.	Data attributing hospital outpatient visits to an individual physician are not available. A proxy for such data may be available through analysis and manipulation of OHIP billings may be available but would need to be integrated with hospital reporting systems. These should be required data for an AFP.
Separations	# of Separations	Data describing total patient separations for a hospital or group of hospitals is available through the hospital operating plans. These should be required data for an AFP.	Data describing patient separations for discrete clinical units is available through the hospital operating plans. These should be required data for an AFP.	Data attributing patient separations to an individual physician are not available. Such data is extraneous and should not be required for an AFP.

AFP Indicator	Unit of Measure	Macro Level Data (Total for the AFP)	Mid-Macro Level Data (Clinical Unit Total)	Micro Level Data (Individual Academic Physician's Contribution)
Weighted Cases	# of Cases	Data describing the total number of weighted cases for a hospital or a group of hospitals is available through the MIS Reporting system. These should be required data for an AFP.	Data describing the number of weighted cases for a discrete clinical unit is available through the MIS reporting system. These should be required data for an AFP.	Data attributing the number of weighted cases to an individual physician are not available. A proxy for such data may be available through analysis and manipulation of OHIP billings but would need to be integrated with hospital reporting systems. These should be required data for an AFP.
Insured Physician Services	# of OHIP Services	Data describing the total number of insured physician services in a hospital or a group of hospitals is not available. A proxy for such data may be available through analysis and manipulation of OHIP billings. These should be required data for an AFP.	Data describing the number of insured physician services in discrete clinical units may be available where such units have practice plans. These should be required data for an AFP.	Data attributing insured physician services to individual physicians is available through OHIP billings.
Uninsured Services	NA	Data describing the total number of uninsured physician services in a hospital or a group of hospitals is not available. The total data for a hospital, however, should be available as a sum of practice plan reports and/or individual physician reports. These should be required data for an AFP.	Data describing the number of uninsured physician services in discrete clinical units may be available where such units have practice plans. These should be required data for an AFP.	Data describing the number of uninsured services should be available at the individual physician level. These should be required data for an AFP.
Administrative Support for Clinical Activity	Admin FTEs	Data describing the administrative contributions/ responsibility of physicians in a hospital or a group of hospitals for clinical activities is available through hospital operating plans. These should be required data for an AFP.	Data describing the administrative contributions/ responsibilities of physicians in a discrete clinical unit may be available where such units have practice plans. These should be required data for an AFP.	Data describing the individual administrative contribution/ responsibility of an individual physician should be available at the individual physician level. These should be required data for an AFP.

Appendix F

Pre-AFP Self-Assessment

Introduction: Purpose of the Pre-AFP Self-Assessment

Academic Health Science Centres (AHSCs) may be characterized as the jurisdictional intersection for three parties, i.e., health professionals (in particular the medical staff), teaching hospitals and a university. Each of these jurisdictions possess a varying degree of responsibility for the operation of an AHSC but none has ultimate authority. In addition, each of the jurisdictions has its own methodology for measuring and monitoring its activities. Collectively, the results of these varying methodologies represent a remarkable mass of information. This information, however, is not always as helpful as it could be in measuring and monitoring the activities of the collective.

The Pre-AFP Self-Assessment is an exercise designed to help AHSCs begin the process of amassing its collective information and transforming it into data. In turn, such data could be used to develop performance indicators. Ultimately these performance indicators could be used as a basis for remuneration for participating members of the AFP. Most reasonable would agree that remunerating professionals on the basis of information, as opposed to performance indicators, is an inherently flawed practice.

The Self-Assessment is presented in five stages:

I) A Description of the AHSC's Organizational Structure Relative to an AFP
II) A Description of the AHSC's Research Enterprises
III) A Description of the AHSC's Clinical Enterprises
IV) A Description of the AHSCs Educational Enterprises
V) A Preliminary Estimate of Interest in an AFP

The AHSC is encouraged to assemble an AFP working group to conduct the assessment noted above. Ideally the membership of the AFP working group would reflect the principle of legitimate representation outlined in component one of the Vision for AFPs in Ontario's AHSCs.

The final product of the self-assessment exercise should be a document that serves a guide for initiating AFP discussions in AHSCs. The final product should be available to all parties/members within the AHSC and should also be copied to the Health Services Division of the MOHLTC.

I) AHSC Organizational Structure

Names of Institutions

Medical Staff Organizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Teaching Hospitals:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

University: _____

List of Official Inter-Institutional Affiliations:

Between University & Hospitals:	**Official Affiliation Agreement?**
1. _____	Yes _____ No _____
2. _____	Yes _____ No _____
3. _____	Yes _____ No _____
4. _____	Yes _____ No _____
5. _____	Yes _____ No _____
6. _____	Yes _____ No _____
7. _____	Yes _____ No _____

Hospital to Hospital:	**Official Affiliation Agreement?**
1. _____	Yes _____ No _____
2. _____	Yes _____ No _____
3. _____	Yes _____ No _____
4. _____	Yes _____ No _____
5. _____	Yes _____ No _____
6. _____	Yes _____ No _____

Any other organizational affiliations deemed relevant to AFP discussions by the AHSC	**Official Affiliation Agreement?**
1. _____	Yes _____ No _____
2. _____	Yes _____ No _____
3. _____	Yes _____ No _____
4. _____	Yes _____ No _____
5. _____	Yes _____ No _____
6. _____	Yes _____ No _____
7. _____	Yes _____ No _____
8. _____	Yes _____ No _____
9. _____	Yes _____ No _____
10. _____	Yes _____ No _____

Provide Copies of Institutional Organizational Charts for both the University and the faculty/school of health sciences/medicine

University

- Ensure that the relationship of the faculty/school of medicine within the university is clearly articulated in the university organizational chart.

Faculty/School of Medicine/Health Sciences:

- For the faculty/school of medicine/health sciences indicate the academic and clinical staff for each department.
- For each department of the faculty/school of medicine/health sciences indicate the number and nature of the academic appointment of clinical faculty members, i.e., full professor, association professor, assistant professor, lecturer, and their GFT status.

Provide Copies of Institutional Organizational Charts for each of the Fully Affiliated Teaching Hospitals

- For each clinical unit (department, division, program, service) indicate the number of medical staff.
- Estimate the total staff FTE for each clinical unit.
- Indicate those staff who do not hold academic appointments with the university.

Existing MOHLTC-Sponsored Alternative Funding Arrangements

Provide a schedule of existing MOHLTC-Sponsored alternative funding arrangements (alternative payment plans, alternative funding plans). For each arrangement indicate: a) the base hospital(s) and clinical unit(s) and b) the participation rate by eligible physicians.

Existing Fee-for-Service Based Practice Plans

Provide a schedule of existing fee-for-service based practice plans. For each practice plan indicate a) the base hospital(s) and clinical unit(s) and b) the participation rate by eligible physicians.

II) The Research Enterprises

Research Organization:

How is research organized in the AHSC, i.e., hospital institutes, university-based, independent research institutes, and research collaboratives? Describe the administrative infrastructure for each organizational research unit.

Research Resources:

What are the available resources for each organizational research unit, i.e., hospital institute, university base, independent research institute and research collaborative?

a) What is the annual budget for each organizational research unit?

b) What is the total square footage for each organizational research unit?

For each of peer-reviewed and non-peer-reviewed research, what is the total operating grant support by agency?

List all government contracted research grants.

List all industry contracted research grants (including clinical trials).

List all fee-for-service revenue sponsored research.

Within the context of an AHSC list all university sponsored research.

List all hospital sponsored research.

Research Personnel:

For each organizational research unit indicate:

1) the number of clinical scientists by department and sponsoring agency,

2) the number of research scholars, i.e., post-doctoral fellows, by department and sponsoring agency,

3) the number of PhD and MSc students actively engaged in research by department and sponsoring agency, and

4) the number of research assistants by department and sponsoring agency.

Research Productivity:

For each organizational research unit describe the mechanism for measuring research productivity.

III) The Clinical Enterprises

General Catchment Area:

Describe in general terms the geographic area/population base served by the entire Academic Health Science Centre.

Description of Clinical Units

Set out each clinical unit, e.g., department, division, program, service, etc and provide a short and clear statement of function or purpose.

For each such clinical unit describe:

1) the geographic area/population base served,

2) the sponsoring agency of the unit, e.g., regional funding, national funding, institutional funding,

3) the nature and number of allied health professionals, e.g., nurse practitioners, medical technologists supported by fee-for-service revenue,

4) the nature of the clinical coverage provided, e.g., outreach, outpatient, inpatient, 24/7/52 coverage, or a mix of various modes, and
5) the volume and value of insured and uninsured services delivered by
   a) specialists and sub-specialists with privileges at one of the fully affiliated teaching hospitals and an academic appointment from the university's faculty of medicine/health sciences, and
   b) family physicians with hospital privileges at one of the fully affiliated teaching hospitals and designated as geographic full-time (GFT) by the faculty of medicine.

IV) The Educational Enterprise

For the Undergraduate MD program, provide

- student enrolment at each level of the MD program (Year I, II, III or IV)
- commitment to the MD program by clinical unit measured in contact hours or student days or some other measure

For Postgraduate Medical Education, provide

- a list of accredited residency programs offered at the AHSC
- a list of any unaccredited residency programs offered at the AHSC
- enrolment levels for residents and clinical fellows by program and Pool classification
- commitment to postgraduate education by program, measured in contact hours or resident days or some other measure

For Graduate Science Education, provide

- enrolment levels by year and department for MSc or PhD programs offered at the AHSC
- commitment to graduate science education by program, measured in contact hours or student days or some other measure

Some AHSCs may also wish to assess their contribution to other undergraduate health sciences education, continuing medical education and public education. Such an assessment should be guided by the following.

For Other Undergraduate Education, provide the following information where medical staff are directly or indirectly involved in the educational mission

- enrolment levels by year for other health professional educational programs offered at the AHSC, e.g., nursing, OT, PT, Speech Pathology, Audiology, medical technologies
- commitment to other undergraduate education by program, measured in contact hours or student days or some other measure.

For Continuing Medical Education, provide

- the volume of continuing medical education delivered by the AHSC, measured in the number of CME sessions or contact hours or number of participants or some other measure.

For Public Education, provide

- the volume of public education delivered by the AHSC, measured in Public Education sessions or contact hours or number of participants or some other measure.

V) An Estimate of Interest in an AFP

Using the Vision for AFPs in Ontario's AHSCs, as it is outlined in the PWG Final Report, as a point of departure the AHSC should conduct a preliminary interest survey. Ideally the group that led the first four stages of the assessment would also complete this final stage of the assessment.

The survey should measure preliminary interest for each of medical staff, teaching hospital(s) and university. Such a preliminary interest would serve as a notice of intent to proceed to the next step of the developmental process leading to an AFP.

Appendix G

Glossary of Terms

Academic Health Science Centre (AHSC) - The jurisdictional intersection of I) a university with a faculty of health sciences or a school of medicine, ii) a full affiliated teaching hospital(s), and iii) medical staff who hold both privileges at the teaching hospital(s) and an academic appointment from the university.

Teaching Hospital - A hospital that is fully affiliated with an Ontario university. For the purposes of AFPs those hospitals include the following:

Hamilton

- Hamilton Health Sciences
- St. Joseph's Health Care

Kingston

- Hotel Dieu Hospital
- Kingston General Hospital
- Providence Continuing Care Centre

London

- London Health Sciences Centre
- St. Joseph's Health Centre

Ottawa

- Children's Hospital of Eastern Ontario
- The Ottawa Hospital
- Royal Ottawa Health Care Group
- Sister of Charity Health Services

Toronto

- Baycrest Centre for Geriatric Care
- Bloorview MacMillan Centre
- Centre for Addiction and Mental Health
- The Hospital for Sick Children
- Mount Sinai Hospital
- St. Michael's Hospital
- Sunnybrook & Women's College Health Sciences Centre
- University Health Network

University - One of five post-secondary educational institutions established as a legal entity through provincial legislation with the authority to a) grant undergraduate degrees, b) offer postgraduate residency programs in consultation with fully affiliated teaching hospitals, and c) receive research support that is targeted exclusively to institutes of higher education. The five universities include the following:

- McMaster University
- University of Ottawa
- Queen's University
- University of Toronto
- University of Western Ontario

Clinical Academic Staff, Medical Staff, Clinical Faculty - One of the following:

- A medical specialist or sub-specialist who has privileges at one of the fully affiliated teaching hospitals and who has an academic appointment from the university's faculty of medicine/health sciences;
- A family physicians who has privileges at one of the fully affiliated teaching hospitals and who is designated as geographic full-time (GFT) by a university's faculty of medicine/health sciences.

Alternative Funding Arrangement (AFA) - A mechanism for funding physicians that is different from the traditional fee-for-service remunerative mechanism.

Alternative Funding Plan (AFP) - An AFP aligns the interests of the university, the teaching hospital and the involved medical staff by merging (notionally or actually) multiple funding sources for the remuneration of involved medical staff for clinical service, teaching, research and associated administration. In exchange for the merger funding sources, the parties of an AFP agree to meet a comprehensive set of deliverables in each of clinical service, teaching, research and associated administration.

Alternate Payment Plan (APP) - An amalgamation of clinical earnings for a designated group of physicians who agree to provide designated clinical services in exchange for the revenue security that an APP offers.