Ontario Hospital Association

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OHA SUBMISSION

September 30, 2020

2021 Physician Services Agreement Negotiations
OHA Proposals for Consideration

The Ontario Hospital Association (OHA) appreciates the opportunity to share the hospital perspective on key issues and areas of focus for the 2021 Physician Services Agreement (PSA) negotiations between the Ministry of Health (MOH) and the Ontario Medical Association (OMA).

Summary

The OHA represents 141 hospital corporations of varying size, type, and geographical location. As you know, strengthening the relationship between hospitals and physicians is crucial to improving health service delivery and physicians' work lives. Given that the provisions contained in the PSA impact the hospital sector, it is vital for hospitals to provide input on the PSA negotiations, including potential solutions to address issues affecting hospitals and physicians. This input is even more important in this round of negotiations due to the impacts of COVID-19.

COVID-19 has shifted our collective understanding of the healthcare system, including how we think about physician compensation and models of care. Many of the issues that the OHA raised in previous rounds of negotiations remain valid (see the OHA's 2017 submission included in the package). The impacts of COVID-19 present a once-in-a-generation opportunity for bold, transformative thinking on innovative physician compensation models and better regional care planning.

As a system, we need to think differently about how we can meet the desires of physicians while also supporting quality care for patients in a collaborative way. Through Wave 1 of COVID-19, many physicians, both in hospitals and in the community, closed their practices without pay and devoted their time and expertise to caring for those impacted by COVID-19 in other settings. This leadership was sorely needed and appreciated.

Now, we are at a critical juncture: either accepting a return to the status quo or embarking on something different that thoughtfully addresses pressures across the system.

The OHA leveraged the robust expertise of its Physician Provincial Leadership Council (PPLC) and formed a 2021 PSA Advisory Group comprised of hospital executives and physician leaders to identify key priorities and recommendations for the MOH and OMA 2021 PSA Negotiations Committees to consider.

These recommendations discuss modernizing physician compensation and models of care, appropriate hospitalist remuneration, changes to the hospital on-call coverage (HOCC)

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program, and the challenges that many of the existing remuneration models have had for recruitment and retention.

At their core, our recommendations suggest that continued top-ups by hospitals for programs such as HOCC and for hospitalist remuneration are not sustainable. Utilizing hospital global budgets to offset low fee-for-service payments has created substantive inequities among physicians and has driven up competition for physicians in many communities, who are in short supply. Ontario needs more flexibility to meet regional needs through modernized physician compensation.

The 2021 PSA negotiations can help shape how we provide healthcare in the future. As a system, we need to be prepared to remunerate physicians for the type of leadership that we expect and need. COVID-19 has changed the role of physicians and the healthcare system more broadly and has highlighted the need for change – as a system, we cannot squander this opportunity.

Overview of Recommendations

Modernizing Physician Compensation and Models of Care

1. Provide appropriate and ongoing remuneration (e.g. through alternative payment plans (APPs)) to promote and embrace physician leadership in enhancing the healthcare system through regional planning, integration, quality improvement, administration, and other avenues outside of direct clinical practice.
2. Reinstate the COVID-19 administrative fee code to re-engage physicians in leadership work to maintain the momentum seen through the pandemic.
3. To support recruitment and retention, support flexibility in physician-hospital practices in providing alternative options for physicians looking for a remuneration model outside of the existing fee-for-service structure (e.g. APPs).
4. Provide improved incentives for virtual support and for alignment between community- and hospital-based practices.
5. Provide appropriate and equitable compensation for physicians to eliminate the need and financial burden of hospital ‘top-up’ payments.
6. Create a pipeline of physician leaders through appropriate incentives, compensation, and purposeful leadership mentoring.
7. Create compensation models for interprofessional team approaches to medical coverage that provide financial support for the entire team, including physicians and other healthcare providers.

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Hospitalist Remuneration

8. Reform the remuneration model for hospitalists recognizing the various hospital types, sizes and geographical communities (e.g. through APPs). Compensation should be consistent with current rates, including any 'top-up' payments.

Hospital On-Call Coverage (HOCC)

9. Unfreeze the HOCC program to allow for, at a minimum, the expansion of existing and creation of new HOCC groups.
10. In the future, a substantive review of the HOCC program should be completed. Flexible coverage models are needed to ensure predictability and consistency in coverage, remuneration for various components of coverage need to be equitable. In addition, given the tripartite accountability for HOCC, agreements should include the MOH, physicians, and hospitals.

Modernizing Physician Compensation and Models of Care

COVID-19 has forced an unprecedented response of our healthcare system – one that is both innovative and collaborative. This has been demonstrated by the incredible response of healthcare providers across the system in providing care in new and unique ways, including through mobile outreach, COVID-19 assessment centres and screening, virtual care in a variety of forms, and by extending their expertise to strengthen the partnerships and knowledge transfer between health organizations. Much of this work was supported through the COVID-19 fee codes that were created and these were immensely helpful in compensating physicians for their time and expertise, both in hospitals and in the community.

Historically, there has been a substantial reliance on fee-for-service models of compensation for physicians. Although this model has some advantages, it has become evident through COVID-19 that a modernization in physician compensation is sorely needed. Many physicians had a significant decrease in income due to shutdowns associated with Wave 1 of the pandemic.

Further, physicians' contributions outside of clinical practice are not typically compensated; the administrative fee code during COVID-19 provided some compensation to physicians for their vital work on pandemic-related work, however the end of this fee code means that physicians are no longer being compensated appropriately for their expertise away from the bedside. This actively harms our pandemic response.

Health Human Resources Planning

There is an ongoing evolution of the medical profession, with younger physicians often requesting more stability in their compensation and greater work-life balance. Along with the impacts of COVID-19, this has brought the system to a timely choice: the continuation of its

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heavy reliance on fee-for-service, or the modernization of physician compensation with more flexible and comprehensive models of remuneration.

These models would not only benefit physicians who choose to enter these arrangements with increased flexibility and collaboration, but would also benefit the system by strengthening physician leadership and considering a broader health human resources plan. This is inclusive of physicians in all specialties, working both in hospitals and in the community. This is particularly important for specialties where recruitment and retention have been challenging, such as psychiatry.

Demographic changes are further exacerbating recruitment and retention problems. More experienced physicians are nearing or entering retirement, and younger physicians are increasingly more interested in collaborative team environments instead of solo practices and are therefore more reluctant to replace retiring physicians.

More incentives, and possibly new models of care, are needed to bring these young physicians to rural and northern areas to help fulfil health human resource needs. New models of care may include bringing on additional providers in a team-based model and creating APPs to better stabilize physicians' compensation.

In the spirit of integrating care, there are also additional factors that would help support physicians across the province, particularly in rural and remote settings. Improved incentives are needed for specialists to offer their support and expertise to small hospital physicians through virtual tools such as OTN or similar, with appropriately resourced IT infrastructure. This is an essential requirement for providing quality care to patients in rural and remote areas, as well as helping to support physicians in a low-resource environment.

Further, virtual care has proven to be essential through COVID-19. The far-reaching impacts of virtual care have affected every aspect across the continuum: hospital physicians have been better able to engage with community physicians; perform remote patient monitoring; discharge patients from hospital sooner, due to the ability to virtually follow-up; and allow for better coordination of care between hospitals and long-term care. Patients have expressed their appreciation for the flexibility in reaching their providers virtually, and virtual care has been able to overcome challenges with follow-up in certain patient populations, such as mental health. Improving the accessibility of virtual care and aligning incentives between hospital- and community-based providers will be vital to our system moving forward.

In order to continue to promote high-quality care for patients and move to more integrated care models, the system needs to move towards a model of shared accountability between providers; one where a healthcare team delivers high quality patient care and incents positive patient outcomes. Funding physicians separately and per episode of care does not encourage physician participation in broader care networks, such as Ontario Health Teams or other teams of providers across the continuum of care. There needs to be further thought on regional health human resource planning to ensure patients are receiving the best care.

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The evolution of healthcare needs to consider the interprofessional nature of quality care, and how these models of care can be supported. In addition to a strong regional plan for health human resources, interprofessional models that include physicians should be considered as essential. Not only would these models support a team-based approach to patient care, they would also be an innovative approach to providing appropriate medical coverage to areas with fewer available physicians by delegating care to appropriate providers. Financial support could be provided to an entire team providing this care, as opposed to the fragmented methods of payment currently used in the fee-for-service model of physician compensation.

Compensation for Leadership

Compensating physicians solely for their clinical work through the Schedule of Benefits actively discourages physicians from contributing in other spheres, such as in an administrative capacity or by providing leadership at a system level. When a physicians' income is dependent on their clinical volumes, any time away from clinical practice is income lost. This does not incentivize the broader contributions we need from physicians in a modern healthcare system.

The system needs physicians' expertise and leadership, particularly as we embark on massive transformation efforts across the province. The administrative funding provided through COVID-19 was helpful in engaging physicians in planning efforts and unveiled clinical leadership gaps in the system.

Physicians are needed beyond COVID-19 – they are needed in regional planning, the development of Ontario Health Teams, quality improvement work, research and education, and administrative leadership as well. Consistent compensation could encourage young physicians to engage in leadership work with appropriate mentoring, improving the pipeline of well-trained physician leaders who can step into these leadership roles with ease.

We would never expect physicians to provide clinical care for free, and thus their non-clinical contributions should be compensated appropriately. The Schedule of Benefits could be used to encourage this much-needed engagement, or this could be included in broader APPs.

As we modernize Ontario's healthcare system and improve integration across the continuum, we need to equally modernize physician compensation. It is vital that we engage physicians in this modernization and transformation work, as their leadership and expertise is needed. This means we need to consider how we remunerate physicians appropriately. This may involve providing a stable base of income combined with additional compensation linked to their clinical service volume, quality care and patient outcomes, and patient experiences through innovative payment models that take these factors into account.

Equity and transparency in pay is needed; benchmarking for the additional responsibilities would be a key part of this modernization, such as for Chiefs of Staff and other leadership roles. This kind of benchmarking information is something the OHA collects and provides to its members on a voluntary basis. Broadly, these modern remuneration models should

contemplate clinical and non-clinical services that physicians provide and ensure that all a physician's contributions to the healthcare system are remunerated equitably.

Recommendations

1. *Provide appropriate and ongoing remuneration (e.g. through APPs) to promote and embrace physician leadership in enhancing the healthcare system through regional planning, integration, quality improvement, administration, and other avenues outside of direct clinical practice.*

2. *Reinstate the COVID-19 administrative fee code to re-engage physicians in leadership work to maintain the momentum seen through the pandemic.*

3. *To support recruitment and retention, support flexibility in physician-hospital practices in providing alternative options for physicians looking for a remuneration model outside of the existing fee-for-service structure (e.g. APPs).*

4. *Provide improved incentives for virtual support and for alignment between community- and hospital-based practices.*

5. *Provide appropriate and equitable compensation for physicians to eliminate the need and financial burden of hospital 'top-up' payments.*

6. *Create a pipeline of physician leaders through appropriate incentives, compensation, and purposeful leadership mentoring.*

7. *Create compensation models for interprofessional team approaches to medical coverage that provide financial support for the entire team, including physicians and other healthcare providers.*

Hospitalist Remuneration

For many years, hospitalist remuneration has been identified as a significant issue among hospitals. This was something that the OHA spoke about in detail in the 2017 submission.

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The way hospitalists are compensated for the care they provide varies significantly. For example, some hospitals retain their hospitalists' billings and pay them a guaranteed salary, while others allow their hospitalists to bill fee-for-service and supplement this amount with a 'top-up' stipend. Regardless of the compensation model, the Schedule of Benefits does not provide an appropriate level of compensation to hospitalists, evidenced partly by the number of supplemental payments or 'top-ups' paid from hospitals' global budgets to hospitalists, sometimes amounting to millions of dollars depending on the hospital.

Survey data from 2017 shows that hospitals across the province are paying more than $27.9M in hospital 'top-ups' to physicians for clinical services and provides these supplemental funds to hospitalists (approximately $10M) more than any other physician group. The practice of hospital global budgets offsetting hospitalists' remuneration simply isn't sustainable, and it creates significant variation and unnecessary competition for much of the same work. Hospitalist remuneration should evolve to a flexible and sustainable model, such as an APP, that allows hospitals and hospitalists to work together more effectively to provide care for patients, and to improve performance and accountability.

Inequities in work, such as hospitalists not being able to bill the same amount for the same work as Internal Medicine or being paid higher rates outside of the hospital in family practice, creates pressure for hospitals to attract and retain hospitalists through more competitive compensation packages. There is also a generational divide in the type and scope of work that physicians are interested in pursuing, further increasing the pressure, with hospital work being perceived as a higher workload.

There are also challenges in complex continuing care and rehabilitation centres in attracting hospitalists. These settings often require complex care planning and ongoing management, but often have reduced compensation compared to acute care and require 'top-ups' to recruit and retain physicians.

Often there are hospitalist agreements in place that have specific performance and accountability measures. Hospitals are not parties in these agreements, and therefore there are limitations in enforcing obligations. Agreements that have such obligations, such as APPs, need to be inclusive of hospitals in order to meet performance targets or other agreed-upon terms. This would improve the collaboration between hospitals and hospitalists, particularly in providing quality-based care.

During the last round of negotiations, the OHA and its members spent a considerable amount of time developing a proposed remuneration model for hospitalists. While the calculations were based upon available data at the time and the 2016 Auditor General's Report, the model is built upon the following six principles:

1. **Consistent** - Consistency in remunerative model, standards, and measurement among hospitals

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2. **Flexible** - Recognize and support distinct challenges, particularly for northern and remote communities
3. **Choice** - Physicians should retain autonomy in choosing a preferred model
4. **Accountable** - Balance of accountability and control between hospitals and physicians
5. **Fair** - Compensation should be reflective of the workload involved relative to other specialties
6. **Equitable** - Equity between acute, alternate level of care, and post-acute beds with variable workload based on acuity

Recommendation

8. Reform the remuneration model for hospitalists recognizing the various hospital types, sizes, and geographical communities (e.g. through APPs). Compensation should be consistent with current rates, including any 'top-up' payments.

Hospital On-Call Coverage (HOCC)

HOCC has been a constant and ongoing struggle for hospitals and physicians. These challenges were exacerbated in 2015 when rates were frozen by the previous government. While we can appreciate that a complete overhaul of HOCC may not be achievable at this time, some of these issues should be addressed, including unfreezing the program to allow current programs to expand and new programs to develop, and improving standardization across regions for appropriate medical coverage and quality care.

While HOCC funding strives to ensure predictability in physician on-call coverage across the province and to recognize the additional burden placed on physicians for providing on-call services beyond typical work hours, significant improvements are needed.

A variety of structural issues associated with availability, accountability, and program management continue to be significant concerns for hospitals. These were detailed extensively in the OHA's submission to the 2017 PSA Negotiations Task Force. This includes issues of insufficient funding for a growing pool of physicians providing coverage, the restrictions imposed on creating new HOCC programs for new hospital developments, and inequities in coverage.

There is insufficient funding to support the provision of on-call services, particularly in community hospitals. As a strategy to ensure coverage, hospitals often compensate physicians out of the operating budget above and beyond HOCC payments to fill on-call schedules. These additional payments vary depending on the hospital's needs, but amount to thousands to over a million dollars per year depending on the hospital. These payments should be part of the compensation provided through the PSA, not creating additional financial burden on hospitals who already struggle with limited budgets for service delivery.

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The implementation of HOCC has created concerns of equity, availability, and flexibility to ensure 24/7/365 coverage. HOCC payments can differ substantially for the same amount of coverage, even for physicians within the same specialty. For example, some physicians are more actively involved in providing patient care during on-call hours than others. Also, some patients require more complex care than others, yet the amount paid to the physician is the same. This is not equitable.

In smaller communities, HOCC does not allow for effective regional coverage and increases the dependence of hospitals on locum physicians, as physicians are not allowed to cover multiple departments across hospital sites. Further, non-acute care and some specialties (e.g. palliative care) are not included in HOCC coverage. Consideration should be given to expanding funding to cover these vital areas as well. Additionally, new HOCC envelopes are not being created, constraining the implementation of HOCC in new hospital developments and programs.

Hospitals have a variety of responsibilities for administering HOCC funding and ensuring that the physicians and hospitals comply with all HOCC requirements and policies. Hospitals are being held accountable for processes over which they often have little control given they are not parties to the HOCC agreements. Given that HOCC is a program that requires this administrative oversight, any agreements should include hospitals, physicians, and the Ministry of Health.

Recommendations

9. *Unfreeze the HOCC program to allow for, at a minimum, the expansion of existing and creation of new HOCC groups.*

10. *In the future, a substantive review of the HOCC program should be completed. Flexible coverage models are needed to ensure predictability and consistency in coverage, remuneration for various components of coverage need to be equitable. In addition, given the tripartite accountability for HOCC, agreements should include the MOH, physicians, and hospitals.*