

Hospitals Voice Their Opinions: Core Recommendations for the 2012 Physician Services Agreement

November 2011

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Background

The Ontario Hospital Association (OHA) believes that cooperation between hospitals and physicians is a key ingredient for driving quality improvement in health care. We also believe that effective and engaged physician leadership is critical to driving health system improvement.

For this reason, in November 2010, the OHA established a Physician Provincial Leadership Council (PPLC), comprised of 16 physicians and hospital CEOs representing acute teaching, addiction and mental health, community, complex continuing care/rehabilitation, and small hospitals. An important part of the PPLC's mandate is to provide strategic advice to the OHA on physician-related health system issues.

In 2012, the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) will begin negotiating a new Physician Services Agreement (PSA). It is very important that the 2012 PSA supports a system focus on quality and outcomes.

The OHA had only limited involvement with the 2008 PSA negotiations and its implementation even though many sections of the PSA have a direct impact on hospital operations. Therefore, it is the OHA's aim to provide input into the 2012 PSA through the leadership of the PPLC to ensure that our members' issues within the 2008 PSA are addressed, and that we move forward together.

The OHA is pleased to provide recommendations for the MOHLTC and the OMA to consider before and during the upcoming PSA negotiations. These recommendations are based on member feedback, and were developed through a three-stage process.

Stage 1: The OHA sent an electronic survey to hospital members in January 2011 to solicit feedback on the 2008 PSA, and in particular, to determine the impact that various sections had on hospital operations. The results of the 2008 PSA Evaluation Survey can be found in Appendix A.

Stage 2: The OHA hosted a complementary PSA Forum in Toronto on April 19, 2011, in order to have an in-depth discussion about members' issues, including those identified in the survey. The Forum was attended by 92 physician leaders and senior hospital executives representing all hospital types and locations throughout Ontario. The findings from the PSA Forum can also be found in Appendix A.

Stage 3: The results of the 2008 PSA Evaluation Survey and PSA Forum were subsequently discussed by the PPLC members at their meeting in June 2011. Based on the information gathered through OHA member consultations in combination with years of health system experience, the PPLC developed a number of recommendations for the 2012 PSA.

Guiding Principles

Our recommendations are based on the following principles:

1. Focus on the patient when aligning the interests of the government, physicians and hospitals and considering changes to Ontario's health care system.
2. Obtain consensus among major stakeholders with respect to the desired goals and outcomes of the PSA and improvements that can be made within the 2012 PSA.
3. Build upon the successes and learn from the challenges of previous PSAs.
4. Recognize and value the unique characteristics of physicians (i.e., urban or rural) and hospitals (i.e. hospital type or geographical region) when recommending changes.
5. Focus on defining incentives for physicians that are not limited to income increases. Incentives to consider could include group benefits and physician leadership training.

Core Recommendations for the 2012 Physician Services Agreement

Over the last several years, the OHA has advocated for changes to the health care system that may impact the hospital-physician relationship. For example, the OHA recommended that the MOHLTC review and update the *Public Hospitals Act*, which the Government of Ontario committed to during its 2010 Throne Speech, to better reflect current practice and align with related legislation such as the *Regulated Health Professions Act*. The MOHLTC has also committed to reviewing the *Local Health System Integration Act* beginning July 1, 2012 which may have an impact on how health care is delivered in Ontario. This year, the government appointed the Commission on the Reform of Ontario's Public Services, chaired by Don Dummond, to examine the way government delivers public services and to provide advice on how to increase the efficiency and effectiveness of this process.

The OHA continues to explore the topic of health system structural reform and we strongly believe that all health system stakeholders should also consider areas for improving system structure in a meaningful way. Given this context, and in the absence of significant changes to the health system structure and the hospital-physician relationship, the OHA offers the following recommendations:

1. Physician Funding Structures

OHA member hospitals have identified large variances in funding for certain physician groups in Ontario resulting from the inconsistent application of physician funding models. For example, some complex continuing care/rehabilitation hospitals have in place fee-for-service models, while others use alternate funding models (e.g., AFAs, AFPs, APPs) to remunerate their physicians, even though these physicians provide similar services. These variances not only create disparities among physician groups, but also among organizations that need to maintain their competitiveness when recruiting and

retaining clinicians. While all specialties should be examined, priority should be given to the most commonly identified groups: hospitalists, psychiatrists, complex continuing care/rehabilitation physicians and geriatricians.

Issues:

- Inequities in remuneration among physicians who perform similar work within and across specialties leads to competition for physician human resources among hospitals. To remain competitive when recruiting physicians, hospitals feel pressured to provide physicians with financial incentives (top ups) from hospital operating budgets. This is especially difficult for small hospitals with relatively small operating budgets, which often puts them at a disadvantage.
- There are a number of specialists who spend a great deal of time performing non-fee generating clinical activities in a primarily fee-for-service model. For example, complex continuing care/rehabilitation physicians spend a great deal of time coordinating care with allied health care providers to ensure safe transitions for their patients within and outside the organization. To ensure that these specialists are fairly compensated for their work, and more importantly, are encouraged to continue performing these activities, hospitals are pressured to provide financial incentives from hospital operating budgets.
- There is lack of consistency in the design and administration of alternate funding plans across Ontario which contributes to variation and inequity in funding among hospitals. These alternate funding plans are developed on a case-by-case basis, rather than through a coordinated approach. This results in similar hospitals, for example, negotiating different plans (often at different times).

- Over the last several years, the costs of providing insured services in certain areas have decreased, however, government continues to pay the same price for these services. For example, technological developments in areas such as cataract surgery, endoscopy, orthopaedics, diagnostic imaging and brain surgery have decreased the cost and time it takes to perform some procedures and services. Despite these developments, the fee-for-service model continues to compensate physicians at the same level as in previous years.

OHA Recommends¹:

Recommendation 1.1: The MOHLTC and OMA should critically evaluate and modify existing physician funding models (e.g., fee-for-service, salary-based, alternate funding arrangements) to promote consistency in physician payment mechanisms and eliminate the need for financial incentives (“top ups”) from hospital operating budgets. In the absence of targeted funding, funding of physicians for clinical activities should not come from hospital operating budgets.

Recommendation 1.2: The MOHLTC and OMA should develop alternate funding arrangements for the following physician groups: hospitalists, psychiatrists, complex continuing care/rehabilitation physicians and geriatricians.

Recommendation 1.3: The MOHLTC and OMA, in consultation with stakeholders, should conduct pilot studies to examine the effectiveness and outcomes of alternate funding models for different physician specialty types and also for different geographic regions (i.e., rural and remote communities), beginning with the priority groups mentioned in Recommendation 1.2.

Recommendation 1.4: The MOHLTC, in consultation with stakeholders, should develop guidelines for designing and administering alternate funding arrangements in Ontario to ensure consistency across and within specialties.

Recommendation 1.5: The MOHLTC, in consultation with stakeholders, should harmonize the current compensation system for psychiatrists to reduce inconsistencies that exist in the compensation of psychiatrists.

Recommendation 1.6: The MOHLTC, in consultation with stakeholders, should review and restructure Ontario Health Insurance Plan (OHIP) fee schedules to ensure that they reflect the changes in practices and evidence-based care.

2. Physician Engagement in Leadership Roles

Physician engagement and involvement are absolutely necessary for the success of quality improvement initiatives. Recently, a number of quality improvement measures and processes have been mandated by Ontario’s *Excellent Care for All Act*, and other legislative changes. Strengthening physician support and leadership in quality improvement requires a different approach to current practice. At present, there is no consistent approach to enhancing leadership among physicians.

Issues:

- Some OHA hospital members report a sense of division between hospital management and hospital physicians.
- Physicians involved in management may not have formal training in quality improvement processes and/or leadership training.
- Physicians who are paid through a fee-for-service model may lose income by participating in non-fee generating activities, such as hospital committee meetings and leadership initiatives, making it more difficult to engage physicians in such activities.

¹ These recommendations are consistent with ‘Management of Expenditure on Physician Services’ from the OHA’s *Ideas and Opportunities for Bending the Health Care Cost Curve*, April 2010, p.32.

OHA Recommends²:

Improve physician engagement and alignment of priorities respecting hospital-based initiatives:

Recommendation 2.1: Hospitals should involve physicians during the initial development of quality improvement (QI) initiatives, rather than solely during implementation, by appointing them to leadership roles directly involved in QI and by creating incentives for occupying these leadership roles.

Recommendation 2.2: The MOHLTC with hospitals, should support physicians in leadership roles by supporting them to undergo training in QI methodologies and in leadership skills. This training can help physicians become effective leaders of the organization.

Recommendation 2.3: The MOHLTC should conduct pilot studies for alternate funding mechanisms that focus on incenting greater physician involvement and leadership in hospital-based QI initiatives, recognizing that loss of income should not be a barrier to physician participation.

Recommendation 2.4: The MOHLTC and OMA, in consultation with hospitals, should review and evaluate the effectiveness of the 2008 PSA initiatives in incenting QI activities (e.g., the Most Responsible Physician (MRP) Collaboration Initiative).

3. Involvement of Primary Care Physicians in Hospital Care

Hospital members report a gradual decrease in the participation of family physicians in the hospital-based care of their patients. The increased use of hospitalists and the creation of Family Health Teams (FHTs) seem to have changed the role of the family physician in caring for his or her hospitalized patient.

It is important to note that with the *Local Health System Integration Act* review expected to begin prior to July 2012,

a broader discussion on primary care and how it can be better integrated into the system to support system goals, will be required. While this set of recommendations is premised on the existing structure, the OHA strongly supports a careful examination of how primary care links into regional structures to drive strategies for improving system integration and care delivery.

Issues:

- Today, community-based primary care physicians typically do not tend to their patients when they are hospitalized. This disrupts the continuity of care for the patient, when he or she is placed under another physician's care upon becoming an inpatient within the hospital.
- Hospital members report that the increased number of hospitalists in Ontario, while filling an important gap for unattached patients, may lead to the decreased involvement of family physicians in their patients' hospital care.
- While FHTs have many benefits, some members have suggested that the financial incentives offered to family physicians for forming FHTs, have decreased their willingness to participate in emergency department (ED) shifts at local hospitals. Lack of coverage in EDs by local physicians increases the need for locum physicians to provide appropriate coverage. Some remote hospitals have to compete for locum physicians using financial incentives.
- There is inconsistency in the agreements between FHTs and the MOHLTC; for example, some FHT agreements require hospital inpatient care as part of the funding agreement, whereas others do not. There are some concerns about the effectiveness of how these agreements are negotiated.

² These recommendations are consistent with OHA's *Four Pillars: Recommendations for Achieving a High Performing Health System*, June 2011; Recommendation 2 (include quality and efficiency improvement measures, with a focus on using funding incentives to drive positive change, p.9)

Recommendation 14 (promote adoption of proven process redesign techniques and strategies to improve efficiency and quality outcomes across the health system, and dedicate resources and supports to their implementation, p.20)

- After-hours coverage provided by FHTs has not been as expansive as originally hoped. The expected decrease of non-urgent visits to hospital emergency rooms after hours, on weekends and holidays, has not occurred, yet physicians in FHTs continue to receive financial incentives. This raises questions about the accountability of FHTs to expand hours of coverage for non-urgent care.

OHA Recommends³:

Recommendation 3.1: The MOHLTC and OMA should develop provisions in the PSA to increase the involvement of primary care physicians with their hospitalized patients to improve continuity of care for patients and ensure these patients receive care in the most appropriate location.

Recommendation 3.2: The MOHLTC should ensure greater consistency in the agreements between the FHTs and the MOHLTC to incent physicians to play an active role in the care of their hospitalized patients, which may include ED coverage, and expanded hours for FHTs during weekends, holidays and after-hours, to generate a measurable decrease in the number of non-urgent patients attending emergency rooms.

Recommendation 3.3: The MRP Expert Panel, with input from hospitals, needs to better define the role of the hospitalist within Ontario hospitals, especially with respect to community-based family physicians since they both provide hospital in-patient care as the designated MRP.

Recommendation 3.4: The MOHLTC needs to better integrate physicians into existing and future health system structures by including primary care physicians in regional structures and system-level planning.

4. Adoption of Information Technology

Progress has been made in Ontario through the Ontario MD program with incentives to encourage family physicians to adopt an electronic medical record (EMR). However, there is still a great degree of information technology fragmentation in the system, contributing to challenges during the transition of patients from the hospital to the community.

Issues:

- There are 12 different software programs that are available to choose from under OntarioMD funding.
- There is no consistent hospital information system used within Ontario hospitals.
- Without compatible systems, widespread dissemination of evidence-based guidelines and the ability to collect comparable quality of care information are difficult. Also, many laboratory and diagnostic tests are repeated unnecessarily on patients because of a lack of system-wide access to the results.

OHA Recommends⁴:

Recommendation 4.1: The MOHLTC should accelerate the adoption of province-wide compatible information technology to enable improved quality of care.

Recommendation 4.2: The MOHLTC and OMA should create incentives through the PSA to support collaboration between physicians and hospitals to adopt common clinical information systems.

³ These recommendations are consistent with OHA's *Four Pillars: Recommendations for Achieving a High Performing Health System*, June 2011;

Recommendation 10 (expedite the development of the *Excellent Care for All Act* to other key health care providers, p. 17)

Recommendation 11 (ensure that structures and processes are in place so that patients have their care connected across the continuum, p.19)

Recommendation 12 (examine how physicians can be better integrated with LHINs, CCACs, hospitals and community-based health providers, p.19)

⁴ These recommendations are consistent with OHA's *Four Pillars: Recommendations for Achieving a High Performing Health System*, June 2011; Recommendation 13 (Government of Ontario should make a comprehensive health information technology and adoption strategy a central part of its health system strategic plan, p.20).

5. Access to Specialized Clinical Care

There continues to be difficulty in recruiting and retaining primary and specialty care physicians in remote and rural areas of Ontario. Treating the majority of patients close to home can benefit both patients and their families and the government by reducing the cost of care.

Issues:

- There is an imbalance in the supply and demand of certain medical specialties in Ontario. The Ontario Population Needs-Based Physician Simulation Model⁵ developed by the Conference Board of Canada, predicts the continued undersupply and oversupply of certain specialties across the province, which affects patient access to certain clinical specialties.
- The practice of medicine in northern and rural locations of Ontario is different than in urban areas where most physicians receive their training; this may cause new physicians recruited to these areas to be unprepared to meet challenges of providing care to rural communities.
- Hospital members in northern and rural locations reported difficulty in obtaining consistent access to specialists which often results in the need to transfer patients to larger urban centres.
- Members from complex continuing care/rehabilitation hospitals reported that they also have difficulty accessing timely specialist consultation for their patients. This creates additional costs for the system since these hospitals are then required to transfer the patients to acute care hospitals for this type of assessment.

- The current Hospital On Call Coverage (HOCC) program does not allow for effective regional coverage and increases the dependence of hospitals on locum physicians. For example, the rules of HOCC do not permit physicians to cover a single department in multiple hospital locations or two departments at the same site. These limitations create problems for smaller hospitals, which have difficulty maintaining adequate specialty coverage, resulting in the need to use more locum physicians to meet the HOCC funding requirements.

OHA Recommends⁶:

Recommendation 5.1: The MOHLTC should perform comprehensive capacity planning for Ontario's health care system to ensure that there is an appropriate supply of physicians and other health care providers to meet health system demands and ensure access throughout the province. Models such as the Conference Board of Canada needs-based physician simulation model mentioned previously can be used to proactively plan future medical school enrolment, the allocation of residency positions, as well as the current granting of licenses to internationally educated medical professionals.

Recommendation 5.2: The MOHLTC and OMA should create provisions in the PSA to facilitate physician assistants and nurse practitioners to work to their full scope of practice to improve access to care. The use of incentives within the PSA to attract these professionals to underserved areas should also be considered (similar to Section 5.8 Interprofessional Shared Care of the 2008 PSA).

⁵ Conference Board of Canada, Final Report: Ontario Population Needs-Based Physician Simulation Model, October 2010; http://www.healthforceontario.ca/WhatIsHFO/evidence_hhr/physician_simulation_model.aspx

⁶ These recommendations are consistent with OHA's *Four Pillars: Recommendations for Achieving a High Performing Health System*, June 2011; Recommendation 5 (the Government of Ontario should facilitate the use of research to determine which staff mixes and models of care work best in different health care settings, from hospitals to home care, and the results should be used to inform the health system strategic plan as it evolves, p.11).

Recommendation 5.3: The MOHLTC and the Royal College of Physicians and Surgeons of Canada should recognize ‘rural medicine’ as a specialty and develop specific training for physicians recruited to these communities. The MOHLTC and OMA should consider including incentives (financial or otherwise) within the PSA for experienced ‘rural’ physicians to mentor new recruits.

Recommendation 5.4: The MOHLTC and OMA should create provisions within the PSA to compensate specialty physicians providing consultations, including those through the Ontario Telemedicine Network (OTN).

Recommendation 5.5: The MOHLTC and OMA should expeditiously implement the recommendations from the HOCC program review to provide effective regional coverage.

Summary

This document details hospital members’ key areas of concern with respect to the current PSA, and offers a number of recommendations for the 2012 PSA. The OHA would be pleased to provide further information on any issues and recommendations contained within this document.

As a follow-up to these recommendations, the OHA would greatly welcome the opportunity to provide input into the 2012 PSA. We genuinely believe that the OHA’s participation in the upcoming PSA negotiations can strengthen quality of care for patients and enhance the engagement of physicians in leadership roles and quality improvement initiatives.

Appendix A

OHA Member Consultations

Background

The Physician Services Agreement (PSA) is negotiated every four years between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA). The current agreement is set to expire on March 31, 2012. The Ontario Hospital Association (OHA) was not involved in the 2008 PSA negotiations despite the fact that many sections of the PSA have a direct impact on hospital operations. Since the implementation of the 2008 PSA, OHA members have reported a number of unintended challenges emerging from its provisions. To avoid similar issues in the future, the OHA's goal is to be more involved in the 2012 PSA negotiations.

As such, the OHA gathered feedback from hospital members to ensure that their concerns are accurately represented and communicated to the OMA and the MOHLTC. This report details the data collection process and results.

Methods

1) 2008 PSA Evaluation Survey

The OHA's 2008 PSA Evaluation Survey (Appendix B) was sent to hospital CEOs in January 2011. The goal of the online survey was to identify issues and solicit feedback on the 2008 PSA (Appendix C). The survey was completed by a representative from senior hospital administration (i.e., CEO, Chief of Staff or VP Medical Affairs). The survey was open from January 5 to March 21, 2011. Responses were obtained from 101 out of 154 hospitals (only one response was eligible per hospital corporation) – a 66% response rate.

2) PSA Forum

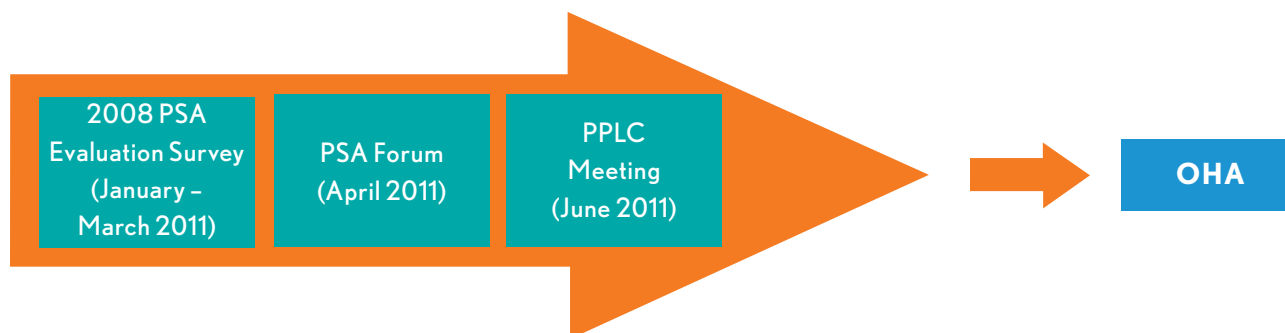
On April 19, 2011, the OHA hosted a complementary PSA Forum in Toronto to facilitate a discussion based on the 2008 PSA Evaluation Survey results, and solicit additional feedback from members about the PSA. Up to three senior hospital administrators per hospital corporation were invited to attend. Attendees included 92 delegates from Ontario hospitals, OHA staff, and representatives from the MOHLTC and the OMA.

Delegates had the opportunity to discuss issues particular to their own institution in smaller breakout sessions grouped by hospital type: community, small, acute teaching, mental health and addiction, and complex continuing care/rehabilitation. One member from each of the small groups acted as a facilitator, and led the group discussion. The sessions focused on identifying the top five issues that arose from the PSA, as well as future issues that need to be addressed in Ontario's health care system (Appendix D). The results of these group discussions were later shared with all delegates in a facilitated plenary session with time for discussion with the audience.

3) Physician Provincial Leadership Council (PPLC)

Taken together – 2008 PSA Evaluation Survey responses and feedback from delegates at the PSA Forum – the OHA received input from 76% of member hospitals (117 out of 154). The draft of the final report detailing the results of the 2008 PSA Evaluation Survey and the PSA Forum was reviewed by the PPLC members in advance of their quarterly meeting on June 9, 2011. The key findings were more thoroughly discussed by PPLC members. Based on the information collected through the 2008 PSA Evaluation Survey, PSA Forum and the PPLC discussions, the OHA has developed a number of recommendations for the MOHLTC and the OMA to consider before and during the 2012 PSA negotiations.

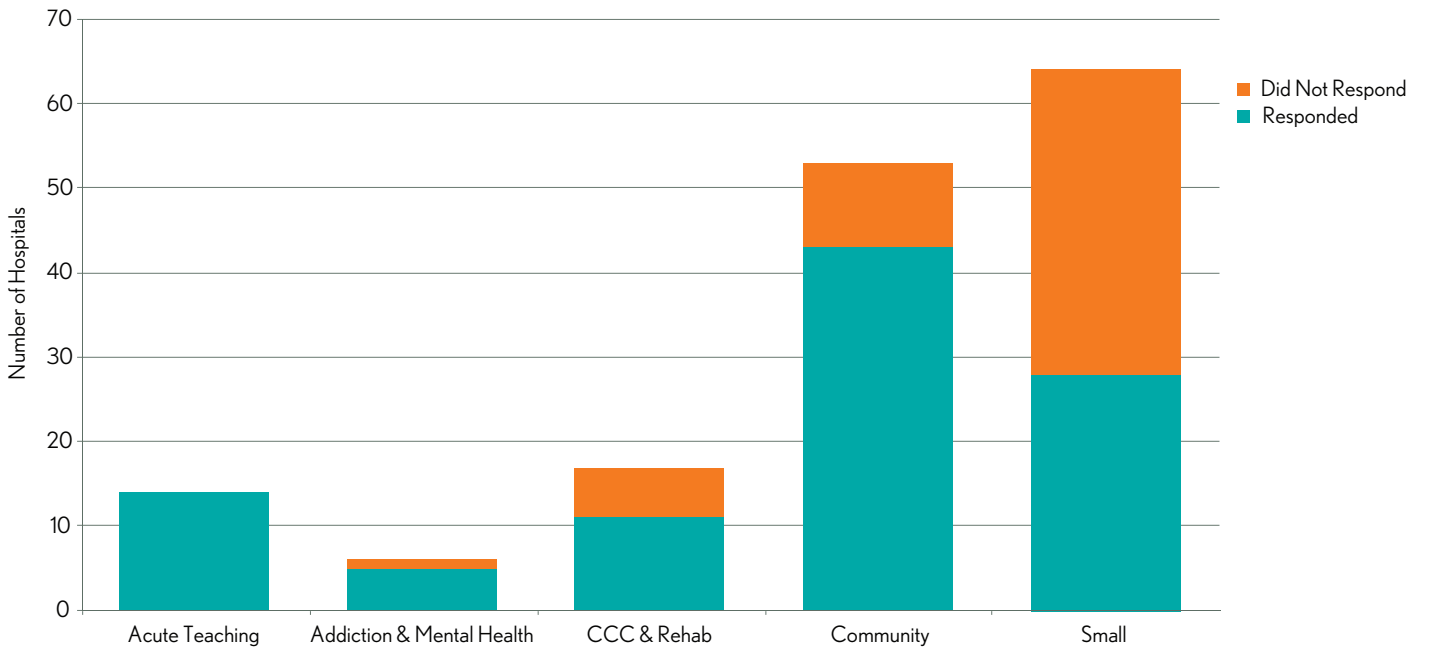
Figure 1: OHA's Member Consultation Process



2008 PSA Evaluation Survey Results by Hospital Type¹

The OHA achieved a 66% response rate overall. This ranged from 100% of acute teaching hospitals to 44% of small hospitals (Figure 2).

Figure 2: Response Rate to the OHA’s 2008 PSA Evaluation Survey by Hospital Type



Data was broken down by degree of impact (positive or negative), by PSA section number, and by hospital type. Table 1 shows the top three sections of the PSA that impacted hospitals, combined, and by OHA hospital type.

Table 1: Top Three PSA Section Priorities Among Ontario Hospitals

Priority Ranking			
Hospital Type	1	2	3
All Hospitals (n=101)	Hospital Care	General Fee Increase	Mental Health
Community (n=43)	Hospital Care	Mental Health	General Fee Increase, LHIN Collaborative Fund
Small (n=28)	Hospital Care	LHIN Collaborative Fund	Primary Care, Northern and Rural Programs
Acute Teaching (n=14)	Hospital Care	Alternate Payment Plans	Recruitment and Retention
CCC/Rehab (n=11)	Hospital Care	Enhanced Care for Frail Elderly	Recruitment and Retention
Mental Health & Addiction (n=5)	Hospital Care*	General Fee Increase*	Mental Health*

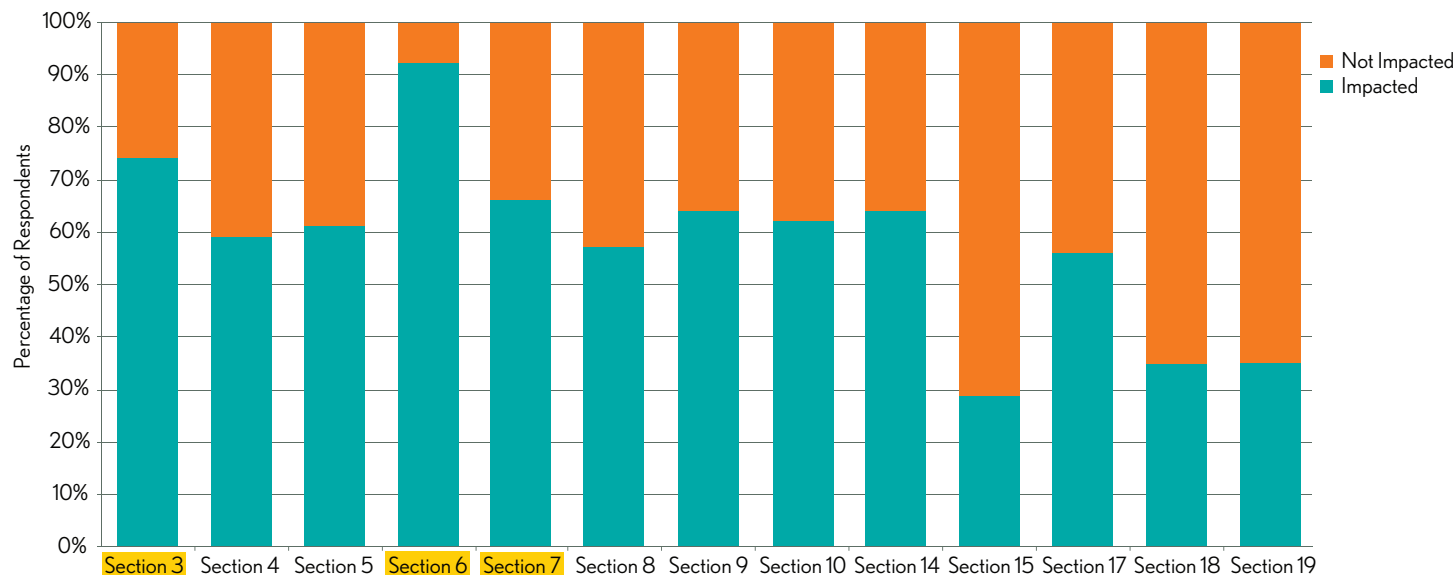
*all priorities were ranked of equal importance

¹ Sections 1, 2, 11, 12, 13, 16, 20 and 21 of the 2008 PSA were excluded from the survey as they were not relevant to Ontario hospitals

All Hospitals

The three sections with the greatest impact on Ontario hospitals were: Hospital Care (section 6) which impacted 91% of hospitals responding to the survey; General Fee Increase (section 3) at 74%; and Mental Health (section 7) at 65%, as shown in Figure 3 (n=101).

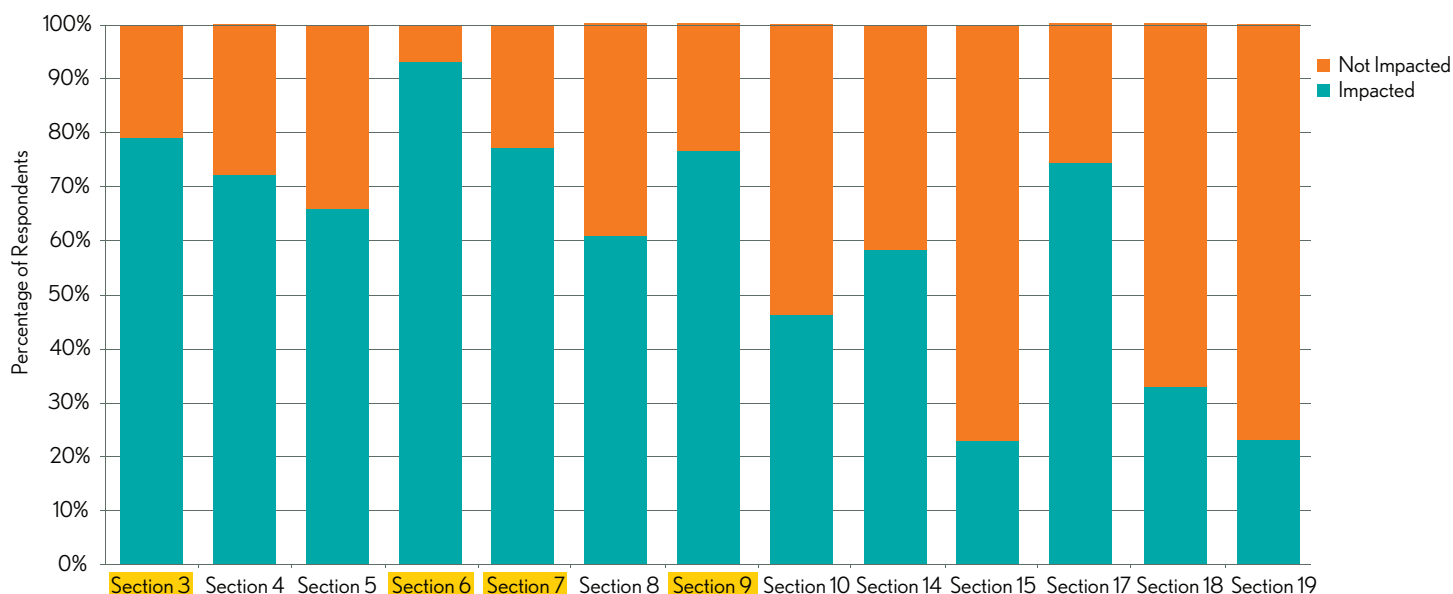
Figure 3: Significant Impacts of 2008 PSA – All Hospitals



Community Hospitals

The largest number of survey responses came from community hospitals (n=43). The sections of the PSA that had the most significant impact on these hospitals were Hospital Care (section 6) at 93%; General Fee Increase (section 3) at 79%; Mental Health (section 7) at 77%. In addition, 77% of community hospitals also identified the LHIN Collaboration Incentive Fund (section 9) as having a significant impact, as shown in Figure 4.

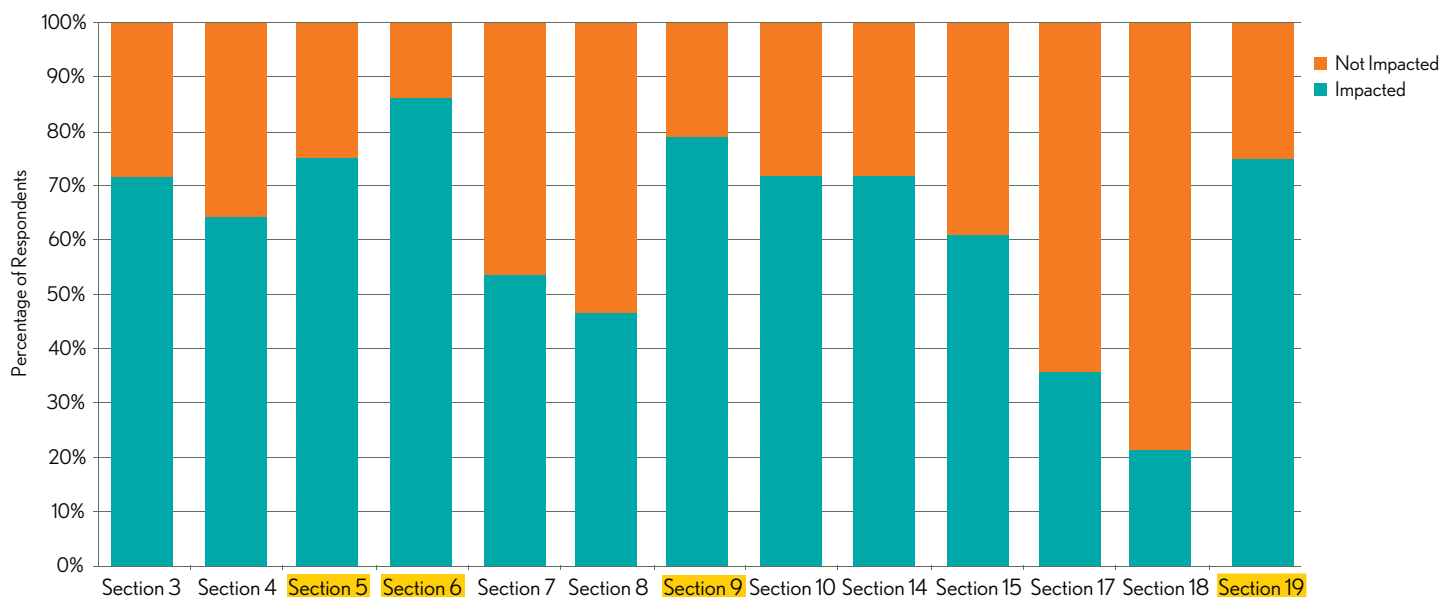
Figure 4: Impact of 2008 PSA – Community Hospitals



Small Hospitals

The second largest group of respondents to the survey were small hospitals (n=28). They identified Hospital Care (section 6) and LHIN Collaboration Incentive Fund (section 9) as having the most significant impact, at 86% and 79%, respectively. In addition, 75% of small hospitals were impacted by Primary Care (section 5) and Northern and Rural Programs (section 19) as shown in Figure 5.

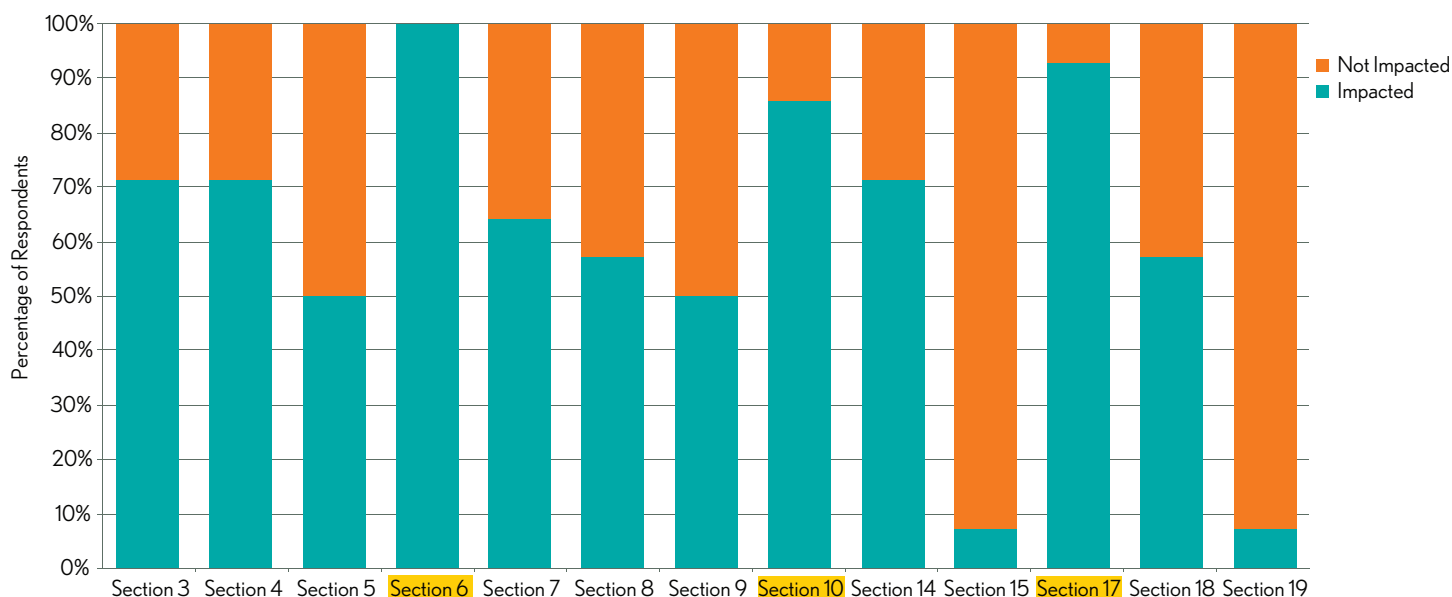
Figure 5: Impact of 2008 PSA – Small Hospitals



Acute Teaching Hospitals

A total of 14 acute teaching hospitals responded to the survey. Figure 6 demonstrates that all acute teaching hospitals were impacted by Hospital Care (section 6). Funds for Alternate Payment Plans (section 17) for genetics and infectious disease physicians as well as additional funding for laboratory physicians impacted 93% of these hospitals, while funds for Recruitment and Retention (section 10) affected 86%.

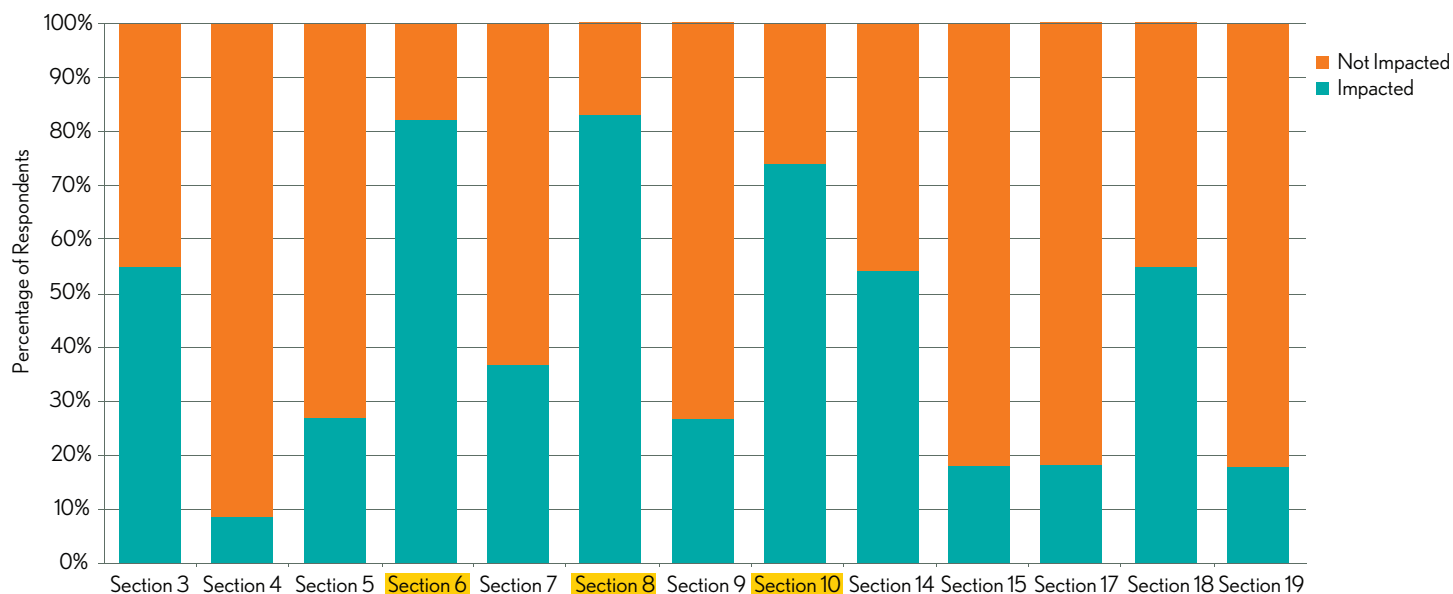
Figure 6: Impact of 2008 PSA – Acute Teaching



Complex Continuing Care/Rehabilitation Hospitals

The OHA received responses from 11 complex continuing care, and 17 rehabilitation hospitals. Figure 7 demonstrates that 82% identified Hospital Care (section 6) and Enhanced Care for Frail and Elderly (section 8) as having significant impacts. In addition, Recruitment and Retention (section 10) affected 64% of these organizations.

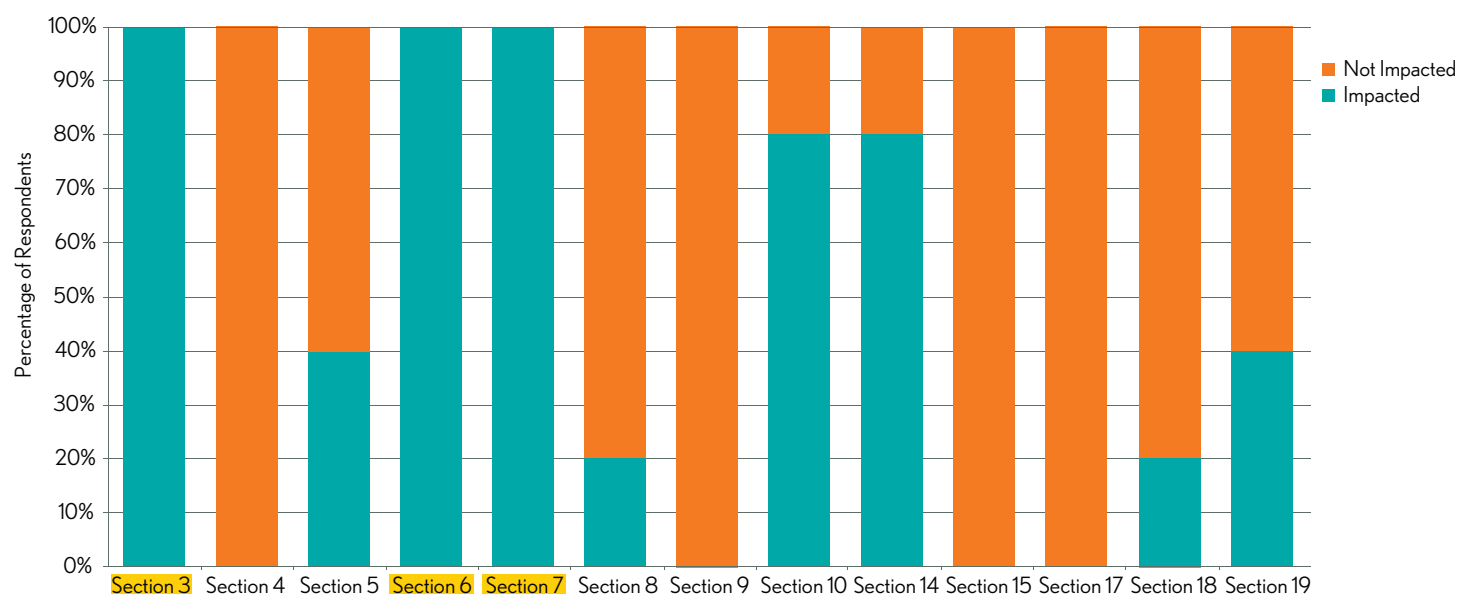
Figure 7: Impact of 2008 PSA – Complex Continuing Care/Rehabilitation



Mental Health & Addiction Hospitals

A total of 5 out of 6 mental health hospitals in Ontario responded to the PSA survey and all of them identified General Fee Increase (section 3), Hospital Care (section 6); and Mental Health (section 7) as impacting their organization, as shown in Figure 8.

Figure 8: Impact of 2008 PSA – Mental Health & Addiction



While these results demonstrate impact based on OHA hospital type, survey results are also provided by OHA region and by Local Health Integration Network (LHIN) (Appendix E).

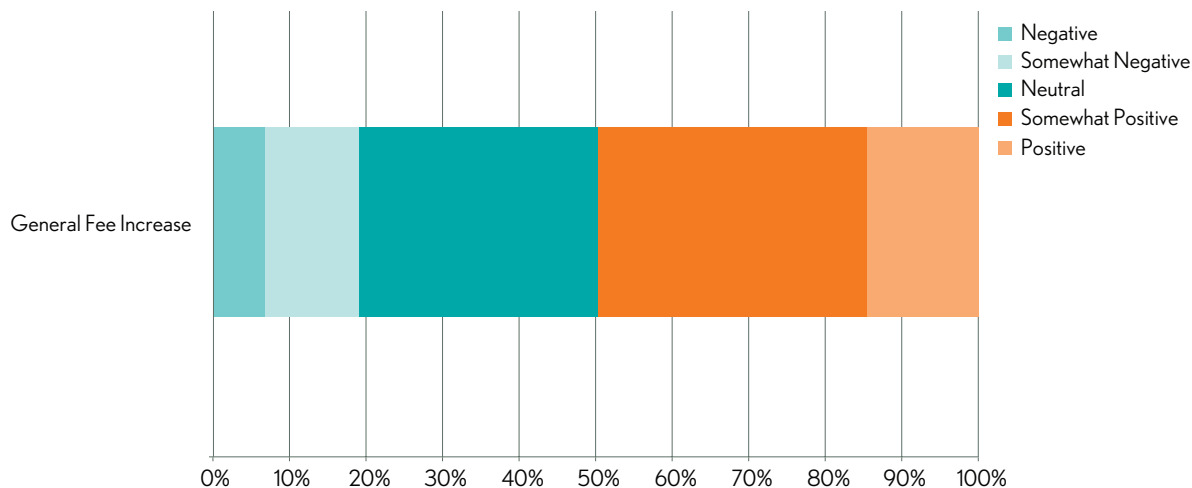
2088 PSA Evaluation Survey Results by PSA Section Number

This section of the report highlights the impact of each section of the PSA, with the exception of the sections that were not relevant to hospitals. These excluded sections are:

- Section 1, Relationship
- Section 2, Dispute Resolution
- Section 11, Incorporation
- Section 12, Benefits
- Section 13, Clerkships
- Section 16, Health Card Validation
- Section 20, Data Sharing
- Section 21, Term and Renewal

Section 3, General Fee Increase for physician payments impacted 75 out of 101 hospitals. Half of the respondents reported a somewhat positive or positive impact. Nearly one third reported a neutral impact (Figure 9).

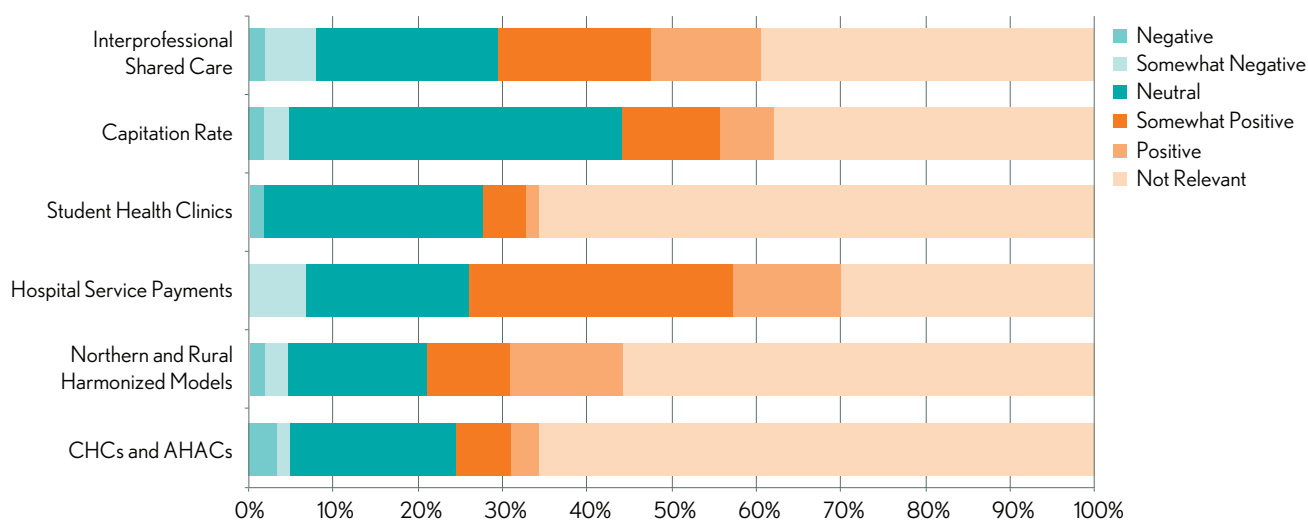
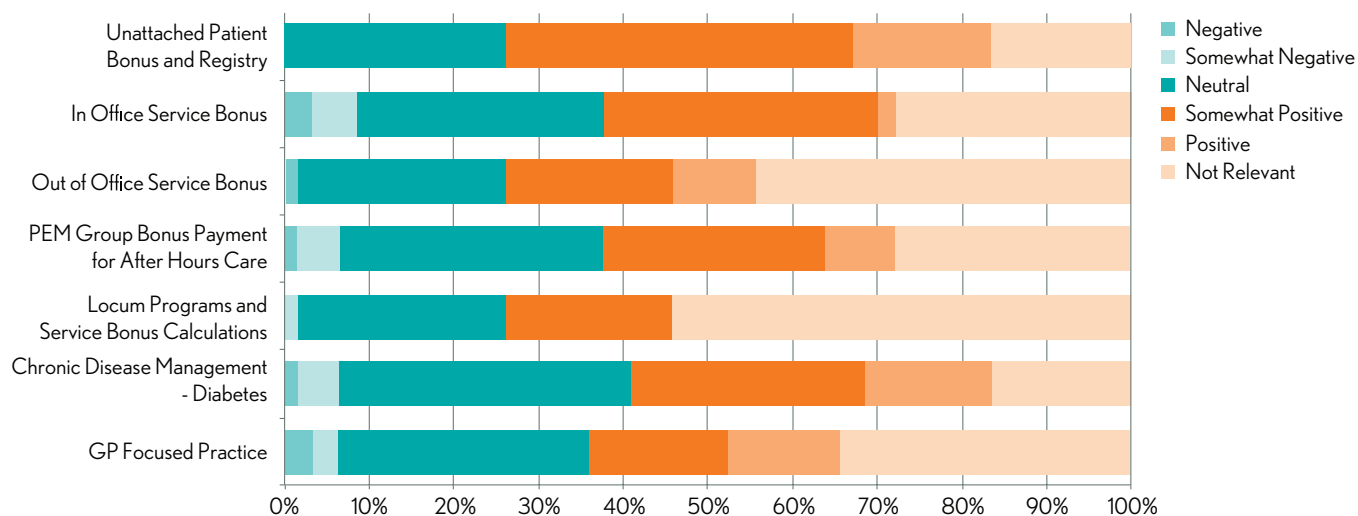
Figure 9: Degree of Impact – General Fee Increase (Section 3)



Section 4, Diagnostic Services which provides for segregation and funding of technical fees, impacted 60 out of 101 hospitals, having a somewhat positive impact on 30% and a neutral impact on 40%.

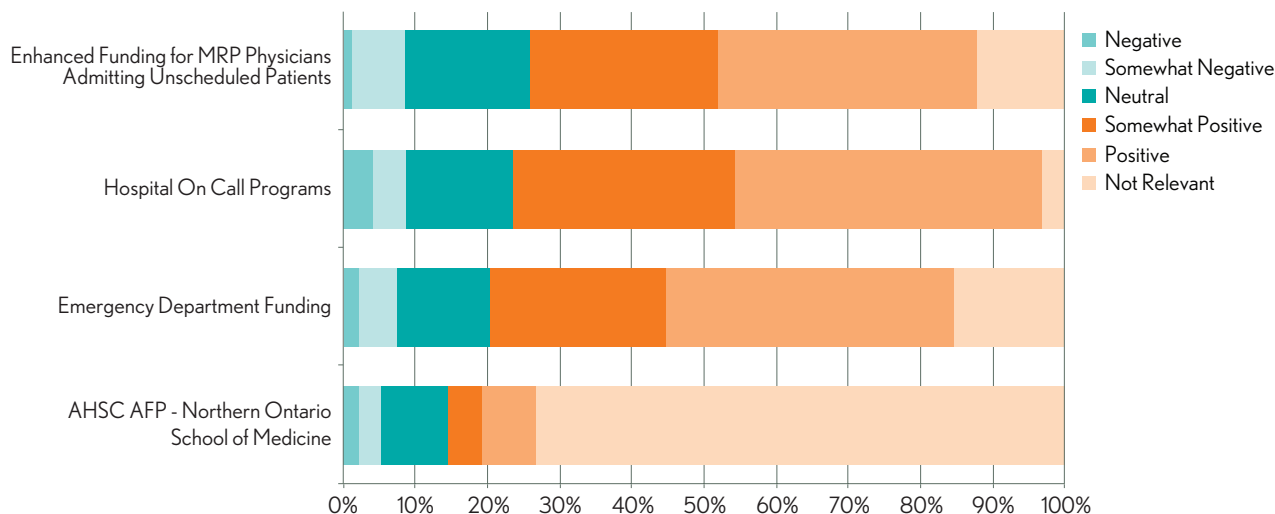
Section 5, Primary Care impacted 61 out of 101 hospital members. The primary care section of the PSA is composed of 13 subsections as shown in Figure 10. The subsections with the greatest positive impact were Hospital Service Payments, Unattached Patient Bonus and Registry, and Chronic Disease Management – Diabetes.

Figure 10: Degree of Impact – Primary Care (Section 5)



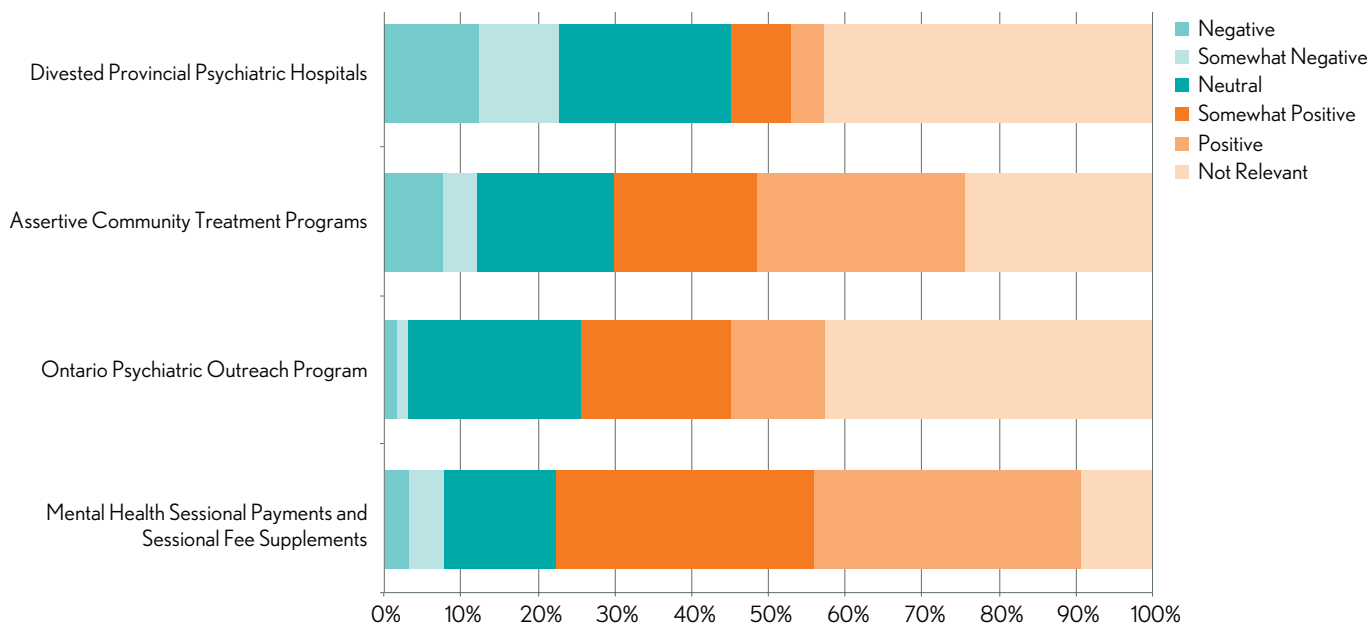
Section 6, Hospital Care, was the most important issue for members with 92 out of 101 hospitals reporting an impact. Overall, this section was found to be somewhat positive or positive for most Ontario hospitals. This section of the PSA contains four subsections shown in Figure 11. The greatest positive effect was seen with Hospital On Call Programs, followed by Emergency Department funding, then Enhanced Funding for MRP Physicians admitting unscheduled patients. The Academic Health Sciences Centre alternate funding program (AHSC AFP) for the Northern Ontario School of Medicine impacted the fewest number of hospitals, and had a varied effect.

Figure 11: Degree of Impact – Hospital Care (Section 6)



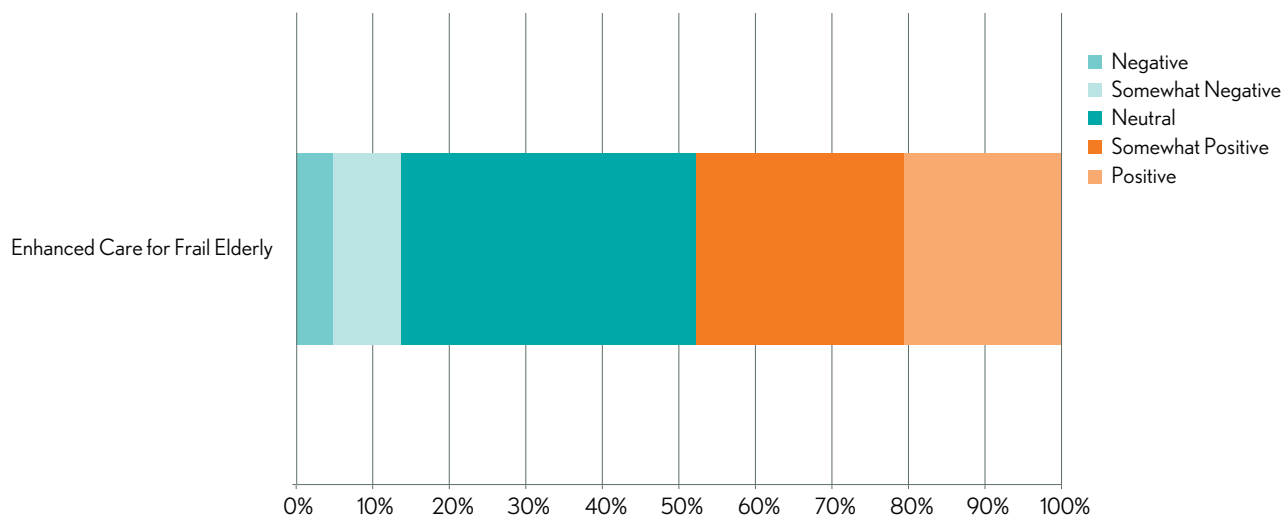
Section 7, Mental Health, largely impacted Mental Health and Addiction hospitals (p. 15), as well as Community Hospitals (p. 13). This section is also comprised of four subsections as shown in Figure 12. The Mental Health Sessional Payments and the Sessional Fee Supplements had the greatest positive impact on hospitals. This funding was provided to improve access to community mental health practitioners for high-risk patients. The greatest negative impact was seen in the Divested Provincial Psychiatric Hospitals subsection; 15 hospitals, covering all hospital types, identified funding for physicians in divested psychiatric hospital services as negative or somewhat negative.

Figure 12: Degree of Impact – Mental Health (Section 7)



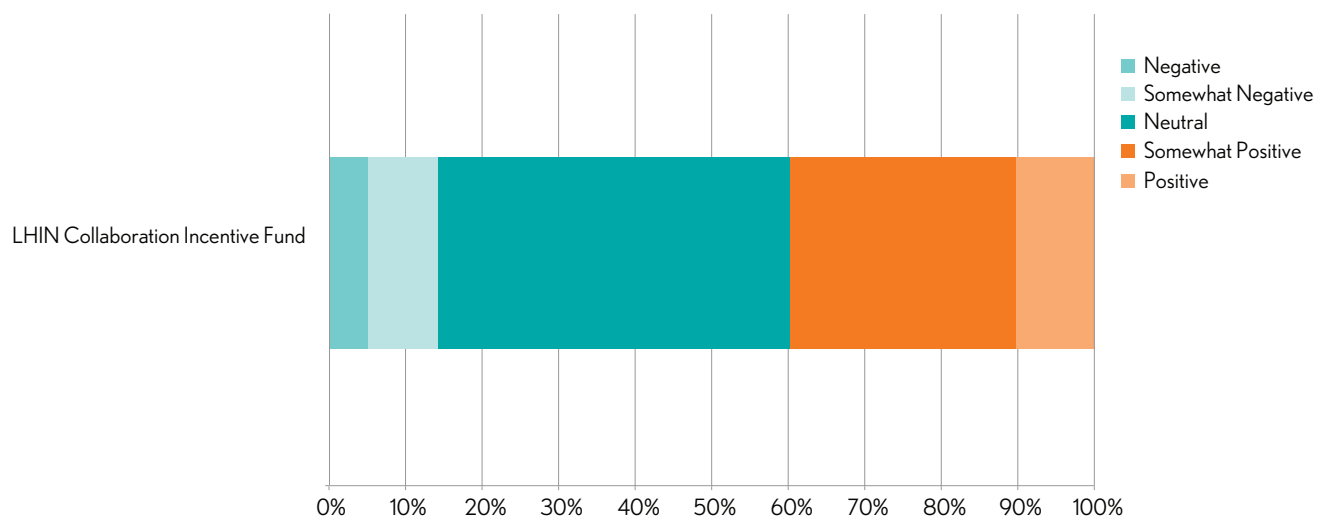
Section 8, Enhanced Care for the Frail Elderly impacted 57 out of 101 hospitals. Almost 50% of respondents identified this section, which provided increased funding for geriatricians, as somewhat positive or positive.

Figure 13: Degree of Impact – Enhanced Care for the Frail Elderly (Section 8)



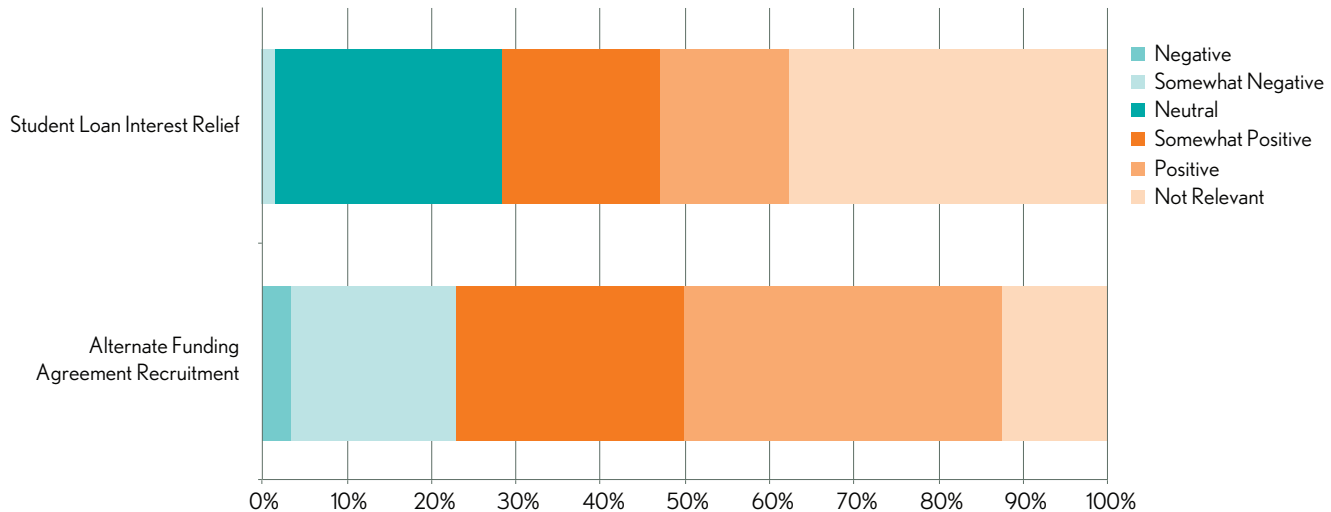
Section 9, LHIN Collaboration Incentive Fund impacted 65 out of 101 hospitals. While 40% of hospitals found a somewhat positive or positive impact from this fund, over 40% found the effect to be neutral (Figure 14).

Figure 14: Degree of Impact – LHIN Collaboration Incentive Fund (Section 9)



Section 10, Recruitment and Retention included two components, student interest loan relief to support new graduates, and funding to recruit physicians to join alternate funding agreements. This section impacted 63 out of 101 hospitals that completed the survey. The funds for recruitment to alternate funding agreements had a large positive effect as shown in Figure 15.

Figure 15: Degree of Impact – Recruitment and Retention (Section 10)

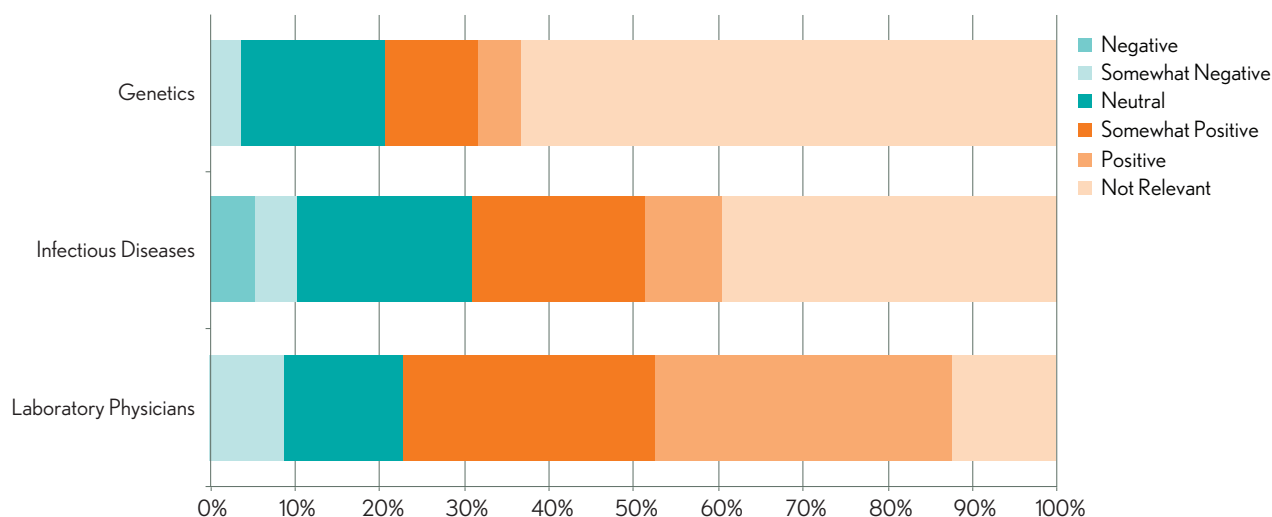


Section 14, Telemedicine impacted 65 out of 101 hospitals, and was found to have a positive or somewhat positive impact on more than two-thirds of these hospitals (44 out of 65).

Section 15, Visiting Specialist Clinic Program and Urgent Locum Tenens Program for Specialists impacted 30 out of 101 hospitals and had a somewhat positive or positive impact on 70% of these hospitals, most of which are small hospitals.

Section 17, Alternate Payment Plans affected 57 out of 101 hospitals. The section on funding specifically for laboratory physicians had the greatest positive effect (Figure 16).

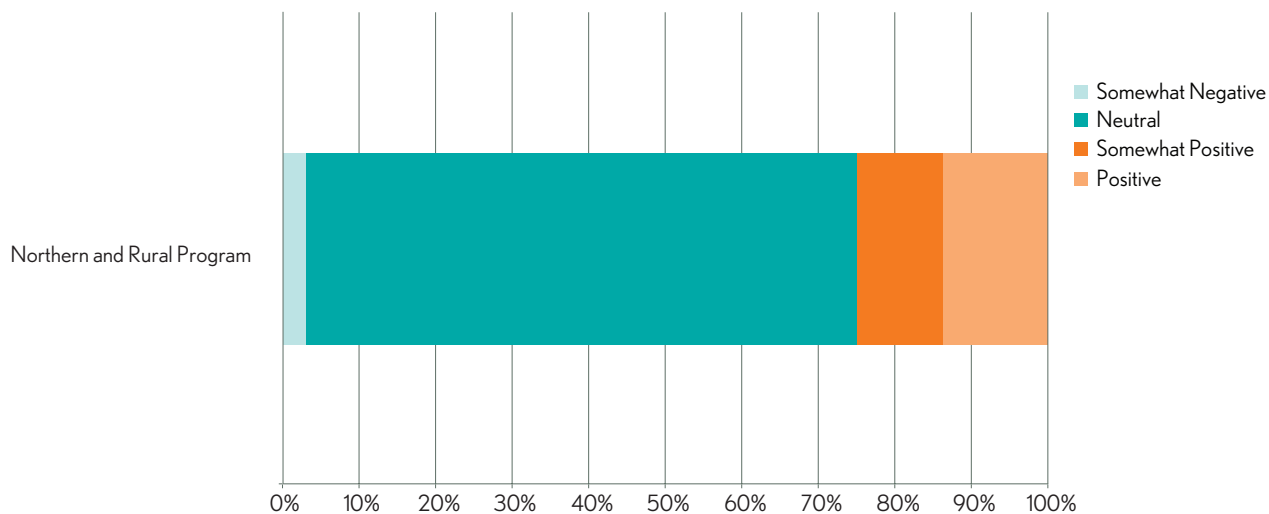
Figure 16: Degree of Impact – Alternate Payment Plans (Section 17)



Section 18, Interprofessional Health Care – Specialists impacted 35 out of 101 hospitals; 15 reported a neutral impact, and 13 a somewhat positive or positive impact.

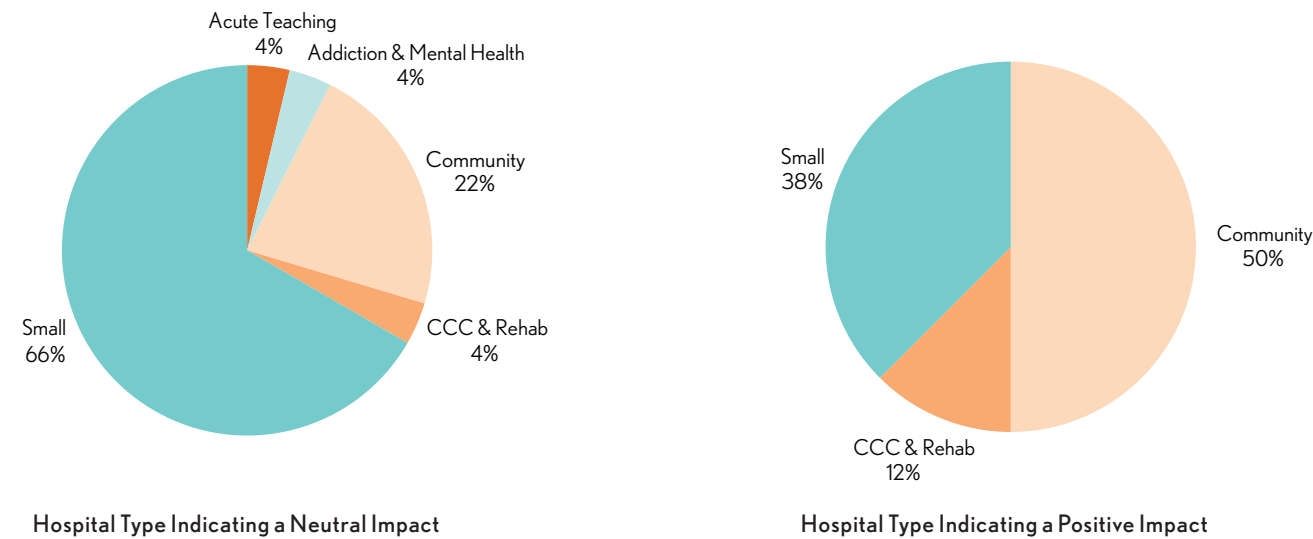
Section 19, the Northern and Rural Program, impacted 36 out of 101 hospitals; however, the majority (27 out of 36 hospitals) reported this impact as neutral, as shown in Figure 17.

Figure 17: Degree of Impact – Northern and Rural Program (Section 19)



Further analysis of these results indicates of the respondents rating the impact of this program as neutral, 60% were small hospitals (Figure 18A). Of the respondents rating the impact of this program as positive, 50% were community hospitals (Figure 18B).

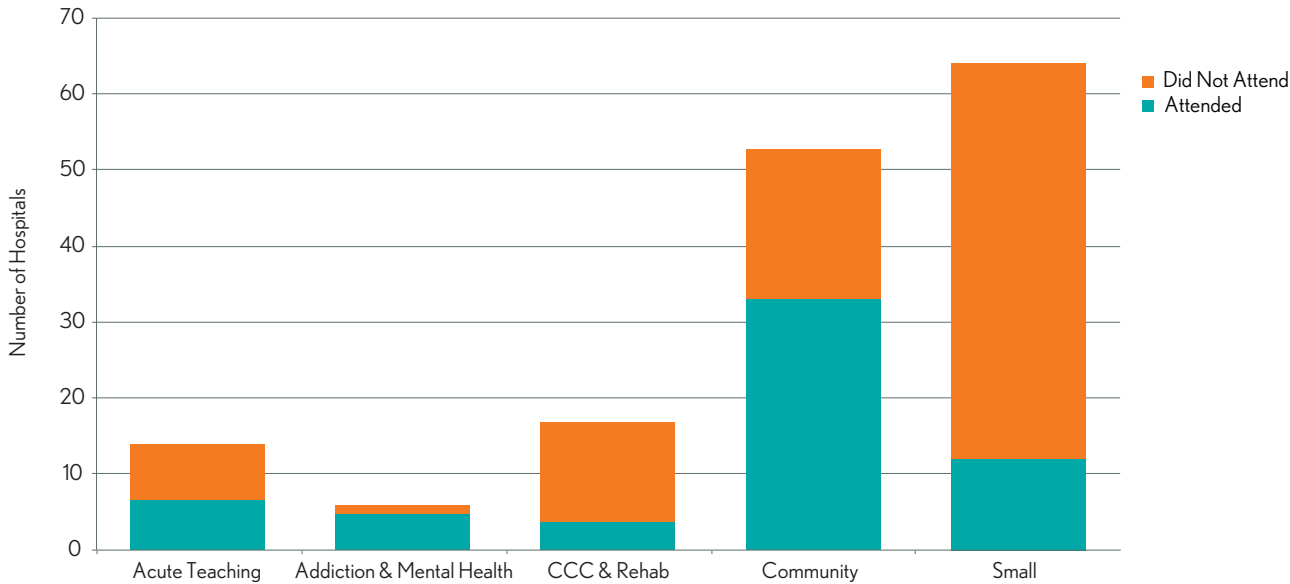
Figure 18: Impacts reported for Northern and Rural Programs (Section 19)



PSA Forum Results

To fully understand the PSA survey results, the OHA hosted a complementary forum open to senior management from all OHA member hospitals. A total of 92 hospital delegates attended the PSA Forum. Figure 19 shows the distribution of delegates based on OHA hospital type.

Figure 19: Number of Attendees to PSA Forum by Hospital Type



Taken together – PSA survey responses and input from delegates who attended the PSA Forum – the OHA received input from 76% OHA member hospitals (117 out of 154).

The summary that follows reflects the concerns, comments and suggestions offered by participants during the PSA Forum.

Issues Common to all Hospital Types

Hospitalists (Full Time MRPs)

Hospitalists are a priority issue among Ontario hospitals for a number of reasons (e.g., large number of orphaned patients, decreased number of family physicians willing to care for hospitalized patients).

Remuneration for hospitalists was also identified as a major issue in the 2008 PSA Evaluation Survey. The position of a hospitalist can be held by a family doctor or a general internal medicine specialist, which can contribute to the variation in remuneration for these physicians. Some hospitalists are paid through a fee-for-service model, others are paid a salary from the hospital, or a combination of the two. To reduce the large discrepancies among remuneration for physicians that are doing similar work, hospital members felt strongly that this group of physicians should be funded through an alternate funding arrangement.

A negative consequence of the increased utilization of hospitalists and the decreased involvement of family physicians in hospital care is the potential for decreased continuity of care for patients. Hospitals suggested developing a care model that involves family physicians in order to maximize continuity of care.

Hospital On Call Coverage (HOCC)

HOCC was also identified as a major issue for small and community hospitals. There are multiple issues with the HOCC funding model that may affect hospital operations. For example, one of the eligibility criteria for participants states that a physician can only be registered for HOCC at one hospital or one hospital site, and only for one specialty. This creates challenges for smaller hospitals that have difficulty maintaining adequate specialty coverage, resulting in the need to hire more locum physicians.

For example, if one looks at enhanced funding for Level II specialists, physicians in a group must provide the following levels of after-hours call coverage:

Table 2: HOCC Funding for Level II Specialists

Number of Physicians in a Group	Level of Coverage	HOCC Funding Received
5 or more	100%	\$192,000
4	91%	\$137,600
3	80%	\$137,600
2	80%	\$137,600
1	60%	\$103,200

This too may result in hospitals hiring locum physicians to afford patients adequate coverage. Hospital participants encouraged the HOCC Review Working Group to implement the regional on-call pilot program funded in the 2008 PSA as well as examine compensation models that reward and encourage physicians to increase on-call coverage.

Family Medicine Involvement in Hospital Medicine

Interestingly, this issue was raised by all Ontario hospital types from all geographical locations. As mentioned previously, with the increased presence of hospitalists, fewer family physicians are involved in hospital care. Delegates at the PSA Forum reported that since the introduction of various family health groups (FHTs, FHNs, FHOs, FHGs), family physicians are participating less in inpatient care as well as emergency department shifts due to family health group incentives to provide community care. This makes it difficult for smaller hospitals to staff their emergency department and many depend on locum coverage to keep their emergency department open 24/7.

Some hospitals are also concerned because some communities do not have FHT services available on weekends, evenings and holidays. As a result, there has not been the predicted decrease in emergency room visits that was anticipated as a result of forming these groups.

Some of the financial incentives for the FHTs also seem misaligned and not aimed at keeping patients out of emergency departments. In one example, a family physician working an emergency room shift can charge fee-for-service for seeing his or her own patient in the emergency room, whereas seeing this patient in his or her

office would be covered as part of the alternate funding plan. Further, FHTs are penalized if their patients receive after hours care from a walk-in clinic, but not if they go to emergency departments. Hospitals have suggested the agreements with the family health groups should be re-examined to encourage that patients be treated in the appropriate setting as well as stipulating the commitment of participating physicians to support their hospital both in emergency room care and MRP services.

Investment in Physician Leadership

Another common theme was the need for investment in physician leadership and support in developing these leaders. Many physician leaders have not had any formal training in leadership, management or administration areas such as the financial management of an organization.

Alignment of Physicians with Hospitals

Members commented that improved relationships between hospital management and hospital physicians are required to facilitate collaboration, and to achieve common objectives. Overall, there is a general feeling of division between the two groups. Although both groups are engaged in their work, their efforts and objectives may not be aligned. It was suggested that hospitals should strive to involve physicians in the development of hospital initiatives from the start so that physicians can assist in the creation, implementation and maintenance of these endeavours. Physicians can take part in the development of innovations, quality improvements, and in the establishment of hospital policies for following evidenced-based standardized practice guidelines.

Required Supporting Tools and Technology

Members strongly believed that investment in supporting technology infrastructure will greatly improve the efficiency of Ontario's health care system. For example, compatible electronic medical records can help avoid unnecessary duplication of testing. Videoconferencing, especially for rural areas is needed to improve their access to distant specialists for timely medical opinions. Dissemination and implementation of evidence-based

practice guidelines would also be greatly accelerated with appropriate use of technology. In addition, participants noted that guidelines for electronic communication from physicians to patients need to be supported and developed.

Issues Specific to Hospital Types

Community Hospitals

As mentioned previously, increased dependency on locums is a problem for small and community hospitals. Members have commented that HealthForceOntario could play a larger role in assisting hospitals, possibly by expanding the locum program to include common credentialing.

Incentives are needed to encourage physicians to commit to communities. Physicians who live and work in the same community are more likely to be engaged with the hospital.

Shared care models need to be developed more widely; for example, collaboration between family medicine and psychiatry to improve access to mental health services (e.g., the Hamilton Family Health Team).

Delegates emphasized that the government, in consultation with stakeholders, needs to determine what the health care system should NOT be doing – there is no incentive currently in the system to decrease inappropriate care. For example, over recent years there has been a large increase in diagnostics, but is there evidence to support improved outcomes?

Small Hospitals

Small, rural and northern hospitals have difficulty recruiting and retaining physicians. The practice of medicine in these areas is very different from urban areas where most physicians are trained. Some suggestions for addressing these challenges include recognizing 'Rural Medicine' as a specialty with specific training, providing compensation for experienced 'rural' physicians to mentor new physicians, and providing additional training that physicians may not have received at an urban centre.

More formal specialist infrastructure is needed to support rural physicians in complex hospital care. Rural hospitals

find it hard to receive timely access to specialists. Improved incentives are needed for specialists to offer their support and expertise to small hospital physicians through the Ontario Telemedicine Network or similar technology. This is an essential requirement for providing quality care to patients in rural and remote areas.

Creating a healthy workplace environment for physicians working in small hospitals is necessary for recruitment and retention.

Acute Teaching Hospitals

According to acute teaching hospitals that attended the PSA Forum, the consistency, delivery and governance of Alternate Payment Plans (APPs)/Alternate Funding Plans (AFPs) needs to be improved. Currently, each AFP is negotiated separately and therefore, AFPs are not consistent across hospitals in Ontario². These funds are important to teaching hospitals for retaining staff, and to provide financial support to physician researchers and physician educators who have less time to participate in fee-for-service activities.

With respect to inpatient care in acute teaching hospitals, medical trainee resources are decreasing, and there needs to be a basic level of these resources allocated for hospital-based care that are available to medical staff. These facilities could consider shared funded agreements between physicians and hospitals to provide alternate models – physician assistants, nurse practitioners – with local accountability to compensate for this decrease in medical trainee resources.

Better linkages (formal and informal) are needed between hospitals and primary care physicians, both within and outside family health groups. This is especially important for patients with chronic diseases who must be managed over time in a variety of care settings.

Acute care hospital funding mechanisms need to be examined. There is a potential increase in community-based centres of excellence (i.e., cataract, endoscopy clinics) that are able to perform a high volume of procedures on lower acuity patients. The higher acuity patients for the same procedure may require significantly more resources in an acute care hospital setting and the current funding model may not account for this.

Complex Continuing Care/Rehabilitation Hospitals

Currently, there is inequity in remuneration among complex continuing care/rehabilitation hospitals. They are providing sub-acute care to patients with a funding model that remunerates for chronic care. Also, some of these institutions have alternate funding models, while others bill fee-for-service. Within the fee-for-service model, inconsistencies in remuneration emerge because some hospitals are eligible to bill lower paying “W” codes, while others are billing higher paying acute care “C” codes, for the same type of care.

Among the hospitals that have alternate funding models, there needs to be flexibility within the existing AFPs to allow for expansion of the staffing complement to meet new demand. With AFPs, these funding contracts are signed to cover a number of years and hospitals are tied to the agreed-upon funding resources. However, if demand increases within this time period, the funding pool still remains the same, and therefore, there is no opportunity to expand the services.

Much of the care provided in complex continuing care/rehabilitation hospitals is performed by family physicians, many of whom have completed an accredited training year in Care of the Elderly. The new fee codes for enhanced care for the frail elderly are applicable only to geriatricians, and not to family physicians who have completed this extra training or have focused practice designations. This creates further disparity in income between these two groups, resulting in challenges recruiting family physicians to perform this work.

² Further details on Academic Health Science Centre AFP's can be found at: http://www.health.gov.on.ca/english/providers/project/ahsc/ahsc_mn.html

This group of practitioners would prefer alternate funding models (i.e., APP, AFP), as opposed to a fee-for-service model, which could help compensate them for the large amount of time spent on non-fee generating activities.

There is a lack of specialty consultation services available to complex continuing care/rehabilitation hospitals. Because there are no OHIP-based incentives for specialists to see complex continuing care/rehabilitation hospital patients, they may need to be sent by ambulance to be evaluated in the emergency department of an acute care hospital, which is much more expensive for the system. Some hospitals are offering sessional payments to attract specialists to consult with the complex continuing care/rehabilitation hospital, but this puts a strain on an often over-stretched hospital budget.

Greater development of outpatient and primary care models for managing complex and disabled patients outside of hospitals is required (e.g., Anne Johnston Health Station in Toronto which provides home-based/community-based complex continuing care). This will help provide patients with more appropriate care closer to home and within their communities, and help free up hospital resources.

Mental Health and Addiction Hospitals

It was suggested that simplification of the compensation system is needed while preserving funding for non-direct care. For example, creating a blended model with two streams:

- base funding based on numbers and types of beds that will support non-direct care activities, and
- OHIP billings (to support direct clinical care).

Eliminate disparities in psychiatrist compensation – fair and equitable compensation models should be developed to support psychiatrists appropriately regardless of whether they practice inpatient or outpatient care, specialty or community care.

Psychiatry is facing recruitment challenges, both to the specialty and to underserved areas. It is difficult to recruit psychiatrists, especially to Northern Ontario. In addition, there is a need to de-stigmatize mental health in order to recruit new trainees who choose psychiatry as a specialty in order to address current and future forecasted shortage of psychiatrists in Ontario.

Most urgent and emergent psychiatric care occurs in the evenings and on weekends. Although psychiatrists are considered Level II specialists, it is felt by some hospitals that the current HOCC funding is not meeting their needs. Therefore, hospitals feel pressured to compensate physicians for on-site coverage through funds from the hospital operating budget.

Appendix B

2008 PSA Evaluation Survey



2008 Physician Services Agreement Evaluation Survey

Please note that these worksheets are provided to assist you with completing the survey.
Only responses submitted using the web-based survey will be accepted.

Overview

The 2008 Physician Services Agreement (PSA) is a bipartite agreement between the Ministry of Health and Long Term Care (MOHLTC) and the Ontario Medical Association (OMA). In 2008, the Ontario Hospital Association (OHA) was not involved in the development or implementation of this Agreement.

Our member hospitals have communicated to us a number of issues arising from the implementation of the 2008 PSA in hospitals. In light of this feedback, the OHA would like to gain a comprehensive understanding of how the 2008 PSA has impacted your organization.

This Agreement occurs once every four years, and so it is crucial that hospitals take the time to complete the survey. With your feedback, we will be able to provide meaningful and valuable information to more effectively influence the upcoming negotiations process.

Purpose

1. To determine the impact of the 2008 PSA on hospitals in Ontario.
2. To identify hospital priority issues for the upcoming negotiations for the next PSA.
3. To inform the OHA in its discussions with the MOHLTC and the OMA regarding issues that impact the hospital-physician relationship.

Instructions

Please set aside 30 minutes to complete the survey (time to complete the survey may vary).

Hospital CEOs are strongly encouraged to complete this survey in collaboration with their Physician Leaders (i.e. Chief of Staff, VP Medical Affairs).

Only one survey per hospital corporation shall be accepted.

Responses must be submitted using the web-enabled survey.

OHA Support

If you have any questions or require assistance in completing this survey, please contact Laurie Cabanas at 416-205-1442.

PART A: Organization Information

Name of Organization: _____

Contact Name: _____

Position: _____

Other: _____

Email Address: _____

Telephone Number: _____

PART B: Identification of Issues

1. If you could identify the key issues for the OHA to focus on during the negotiations for the next Physician Services Agreement (PSA), what would they be? Please list your issues in priority order and be as specific as possible.

Priority Issue 1: _____

Priority Issue 2: _____

Priority Issue 3: _____

Priority Issue 4: _____

Priority Issue 5: _____

2. Do you have any suggestions for improving hospital-physician accountability through the PSA (i.e. for an individual's clinical practice, resource utilization within the hospital setting)?

3. The OHA is interested in exploring innovative solutions to improve the delivery of patient care in an environment of financial constraint. Hypothetically, if you were given a large sum of money that you could spend on physician services in Ontario, how would you spend it?

PART C: Impact of the Physician Services Agreement

The next portion of the survey will go through each section of the Physician Services Agreement to determine its impact on your organization. Please refer to the 2008 Physician Services Agreement document to assist you in completing this portion of the survey.

General Fee Increase

Please refer to Section 3 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Diagnostic Services)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Diagnostic Services

Please refer to Section 4 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Primary Care)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Primary Care

Please refer to Section 5 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Hospital Care)

2. Please indicate how each provision has impacted your organization.

Provision	Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact	Not Relevant to my hospital
Unattached Patient Bonus and Registry						
In Office Service Bonus						
Out of Office Service Bonus						
PEM Group Bonus Payment for After Hours Care						
Locum Programs and Service Bonus Calculations						
Chronic Disease Management - Diabetes						
GP Focused Practice						
Interprofessional Shared Care						
Capitation Rate						
Student Health Clinics						
Hospital Services Payments						
Northern and Rural Harmonized Models						
Community Health Centres (CHCs) and Aboriginal Health Access Centres						

Please provide any comments to elaborate on your responses.

If the Interprofessional Shared Care provision is relevant to your organization, please answer the following question:

1. Do you feel that the provision has impacted your organization's ability to retain and/or recruit nurses?

☐ Yes ☐ No ☐ Unsure

Comments:

Hospital Care

Please refer to Section 6 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Mental Health)

2. Please indicate how each provision has impacted your organization.

Provision	Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact	Not Relevant to my hospital
Enhanced Funding for MRP Physicians Admitted Unscheduled Patients						
Hospital On-Call Programs						
Emergency Department Funding						
AHSC AFP - Northern Ontario School of Medicine						

Please provide any comments to elaborate on your responses.

If the Hospital On-Call Programs provision is relevant to your organization, please answer the following questions.

1. If the HOCC (Hospital On-Call Coverage) recommendations as outlined in the 2008 PSA are implemented, do you believe they would assist your hospital with providing on call services?

☐ Yes ☐ No ☐ Unsure

Comments:

2. Do you believe that the incentives as outlined in the 2008 PSA have had a positive impact on hospital admissions?

☐ Yes ☐ No ☐ Unsure

Comments:

Mental Health

Please refer to Section 7 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?
☐ Yes ☐ No (If no, skip to next section, Enhanced Care for Frail Elderly)

2. Please indicate how each provision has impacted your organization.

Provision	Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact	Not Relevant to my hospital
Divested Provincial Psychiatric Hospitals						
Assertive Community Treatment Programs						
Ontario Psychiatric Outreach Program						
Mental Health Sessional Payments and the Sessional Fee Supplements						

Please provide any comments to elaborate on your responses.

Enhanced Care for Frail Elderly

Please refer to Section 8 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?
☐ Yes ☐ No (If no, skip to next section, LHIN Physician Collaboration Incentive Fund)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

LHIN Physician Collaboration Incentive Fund

Please refer to Section 9 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, LHIN Physician Collaboration Incentive Fund)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Recruitment and Retention Initiatives

Please refer to Section 10 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Telemedicine)

2. Please indicate how each provision has impacted your organization.

Provision	Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact	Not Relevant to my hospital
Student Loan Interest Relief						
Alternate Funding Agreement						
Recruitment						

Please provide any comments to elaborate on your responses.

Telemedicine

Please refer to Section 14 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Visiting Specialist Clinic Program and Urgent Locum Tenens Program for Specialists)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Visiting Specialist Clinic Program and Urgent Locum Tenens Program for Specialists

Please refer to Section 15 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Alternate Payment Plans)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Alternate Payment Plans

Please refer to Section 17 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Interprofessional Health Care-Specialists)

Provision	Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact	Not Relevant to my hospital
Genetics						
Infectious Diseases						
Laboratory Physicians						

Please provide any comments to elaborate on your responses.

Interprofessional Health Care – Specialists

Please refer to Section 18 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, Northern and Rural Programs)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

Northern and Rural Programs

Please refer to Section 19 of the 2008 PSA.

1. Are any of the provisions in this section of the 2008 PSA directly relevant to your organization?

☐ Yes ☐ No (If no, skip to next section, General Comments)

2. Please indicate how this section has impacted your organization.

Negative Impact	Somewhat Negative Impact	Neutral Impact	Somewhat Positive Impact	Positive Impact
1	2	3	4	5

Comments:

General Comments

Please provide any additional comments you may have regarding the 2008 PSA.

Confirmation of Responses

You have now reached the end of the survey. To submit your responses, please click on the “Submit” button below.

Survey Completed

Thank you for completing the 2008 Physician Services Agreement Evaluation Survey! Your responses have been successfully submitted. If you have any questions, please contact Laurie Cabanas at 416-205-1442 or lcabanas@oha.com.

Appendix C

Physician Services Agreement Topics

List of Physician Services Agreement Topics by Section Number

Section 1	Relationship
Section 2	Dispute Resolution
Section 3	General Fee Increase
Section 4	Diagnostic Services
Section 5	Primary Care
	Unattached Patient Bonus and Registry
	In Office Service Bonus
	Out of Office Service Bonus
	PEM Group Bonus Payment for After Hours Care
	Locum Programs and Service Bonus Calculations
	Chronic Disease Management - Diabetes
	GP Focused Practice
	Interprofessional Shared Care
	Capitation Rate
	Student Health Clinics
	Hospital Services Payments
	Northern and Rural Harmonized Models
	Community Health Centres and Aboriginal Health Access Centres
Section 6	Hospital Care
	Enhanced Funding for MRP Physicians Admitting Unscheduled Patients
	Hospital On Call Programs
	Emergency Department Funding
	AHSC AFP - NOSM
Section 7	Mental Health
	Divested Provincial Psychiatric Hospitals
	Assertive Community Treatment Programs
	Ontario Psychiatric Outreach Program
	Mental Health Sessional Payments and Sessional Fee Supplements
Section 8	Enhanced Care for Frail Elderly
Section 9	LHIN Physician Collaboration Incentive Fund
Section 10	Recruitment and Retention Initiatives
	Student Loan Interest Relief
	AFA Recruitment

Section 11	Incorporation
Section 12	Benefits
Section 13	Clerkships
Section 14	Telemedicine
Section 15	Visiting Specialist Clinic Program and Urgent Locum Tenens Program for Specialists
Section 16	Health Card Validation
Section 17	Alternate Payment Plans
	Genetics
	Infectious Diseases
	Laboratory Physicians
Section 18	Interprofessional Health Care - Specialists
Section 19	Northern and Rural Programs
Section 20	Data Sharing
Section 21	Term and Renewal

Appendix D

Physician Services Agreement Forum Breakout Session

Physician Services Agreement Forum, April 19, 2011

Breakout Session Questions

Part 1: 10:00am – 11:00am

Objective: The session facilitator will lead the group in order to determine each group's priority issues to be addressed in the 2012 Physician Services Agreement (PSA).

1. Please identify and give a brief explanation of the group's top 5 priorities.

- The OHA is aware from our survey that HOCC is a priority issue for hospitals; given that the HOCC review working group has submitted some recommendations to the MOHLTC, we ask that you spend minimal time on this issue.
- The OHA is aware from our survey that compensation for hospitalists is a priority issue for hospitals; please focus a limited discussion about potential solutions.

2. If time permits, please list any ideas on how the problems can be addressed.

Part 2: 11:15am – 12:15pm

Objective: The session facilitator will lead the group in generating broad-based solutions to address health system issues.

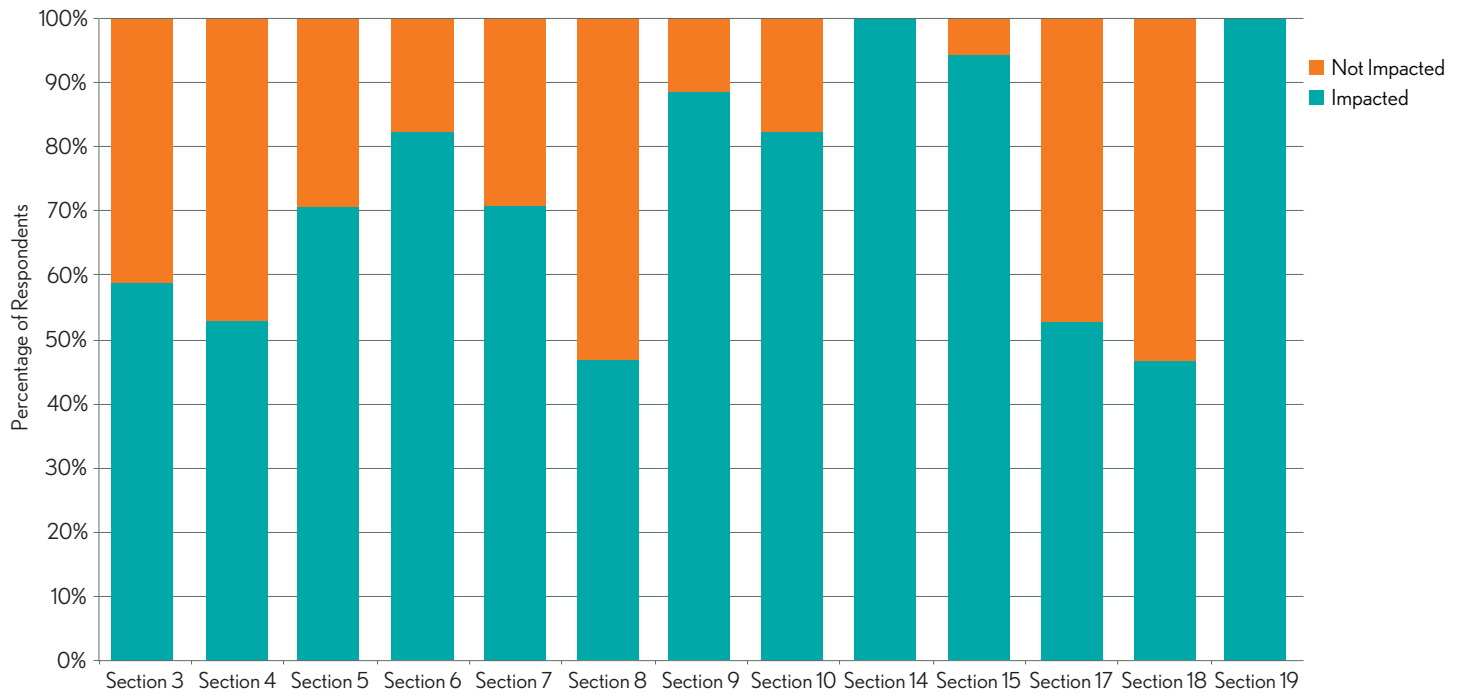
3. We all agree that Ontarians deserve a high performing, high quality health care system. How would you change the way physician services are organized and/or funded in Ontario to better promote this goal?
4. Please identify possible strategies for how these changes could be addressed within the PSA.
5. Please identify possible strategies for how these changes could be addressed outside of the PSA.

Appendix E

Impact of 2008 PSA By OHA Region and LHIN

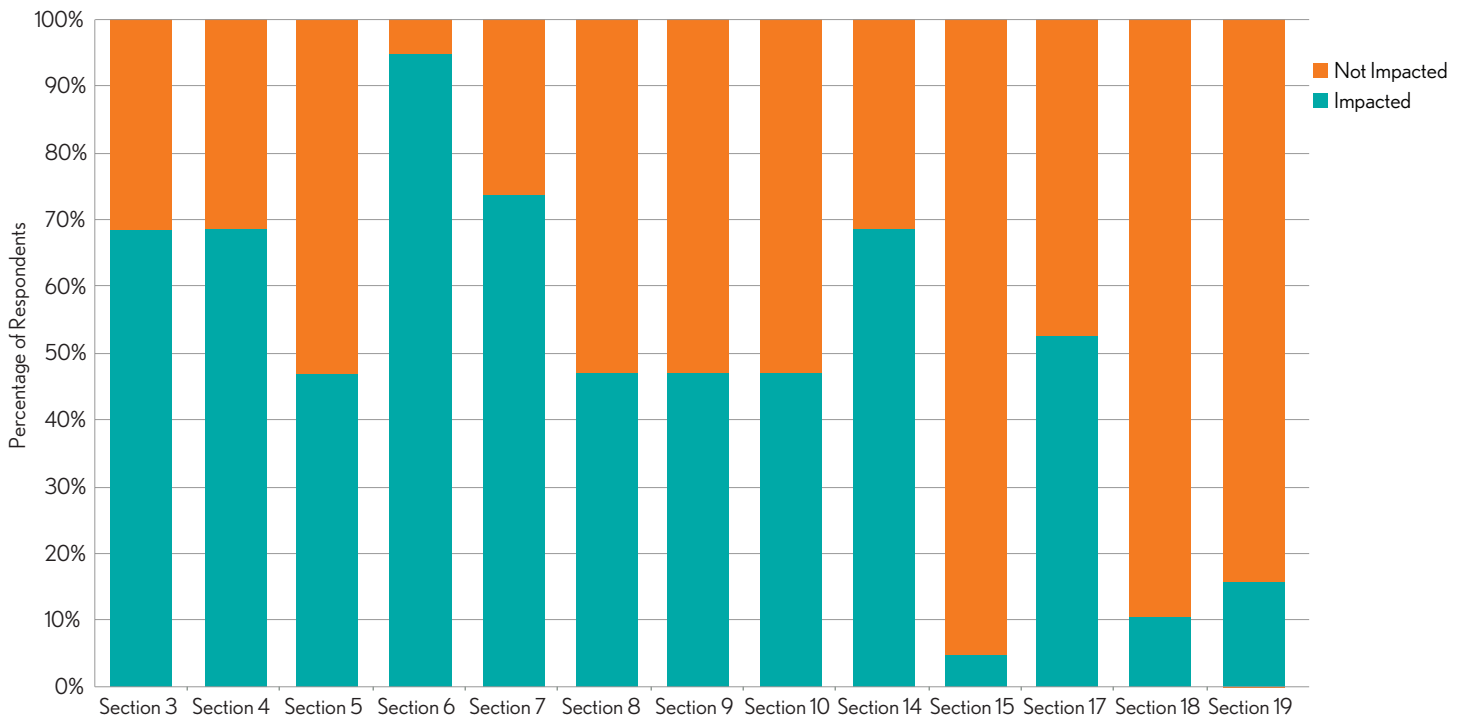
Impact of 2008 PSA By Region

Region 1 – North



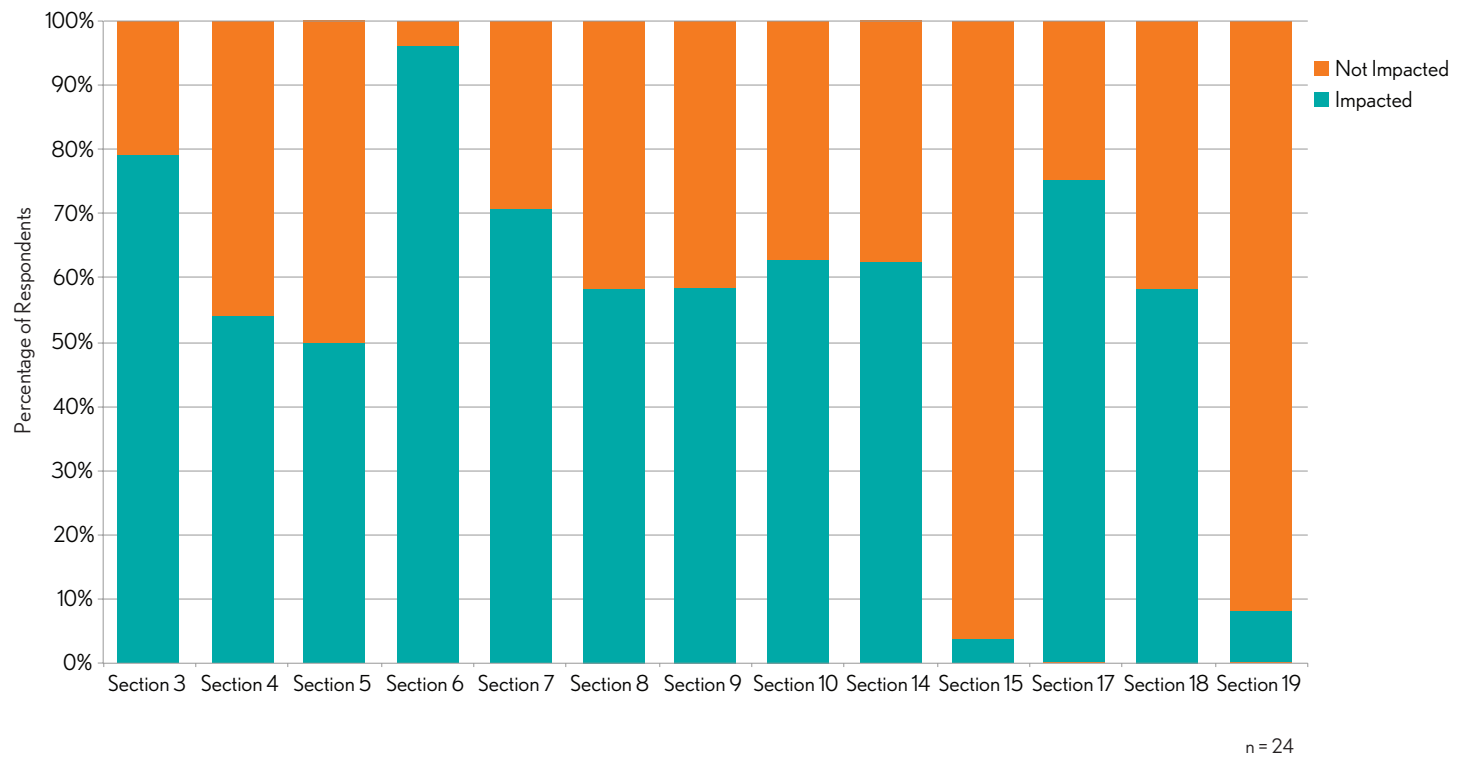
n = 17

Region 2 – East

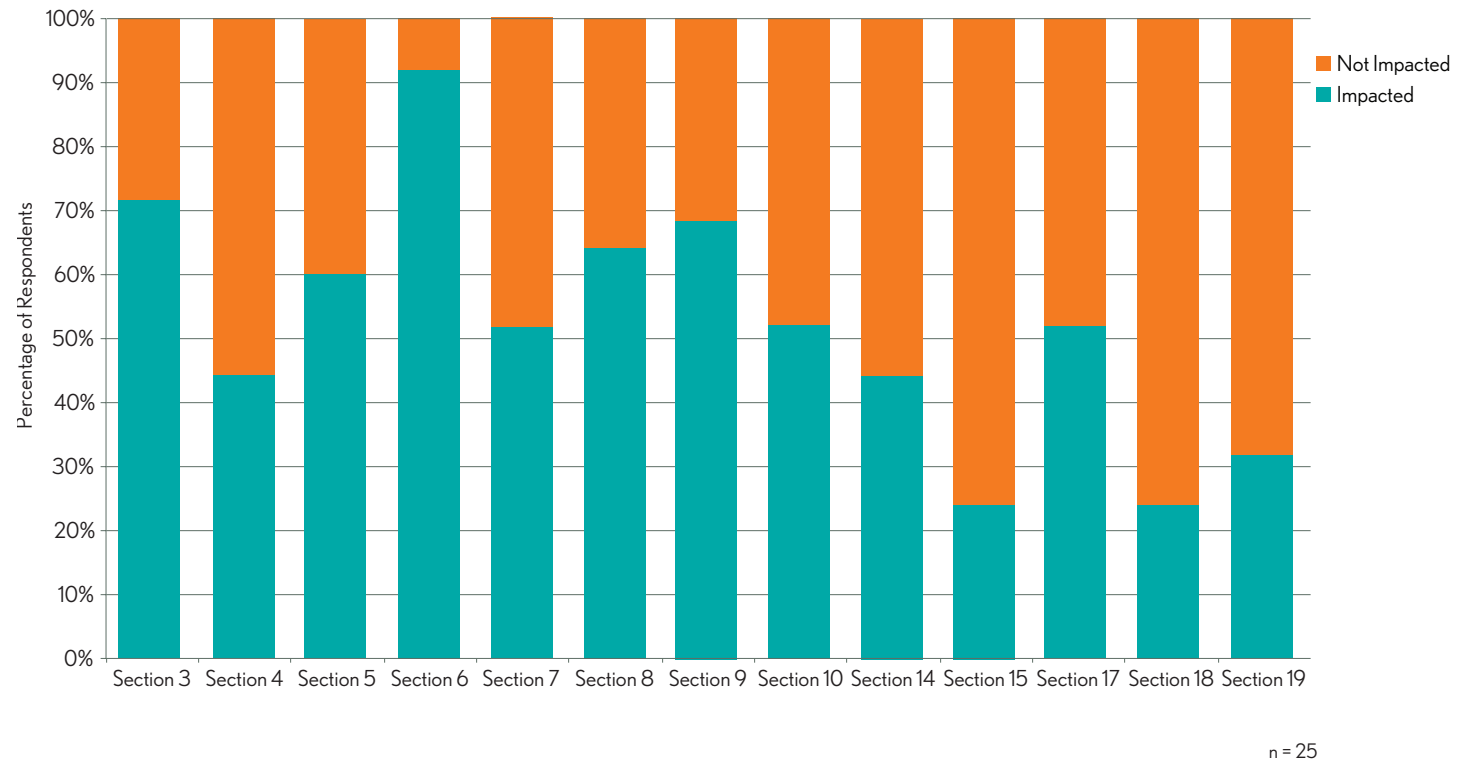


n = 19

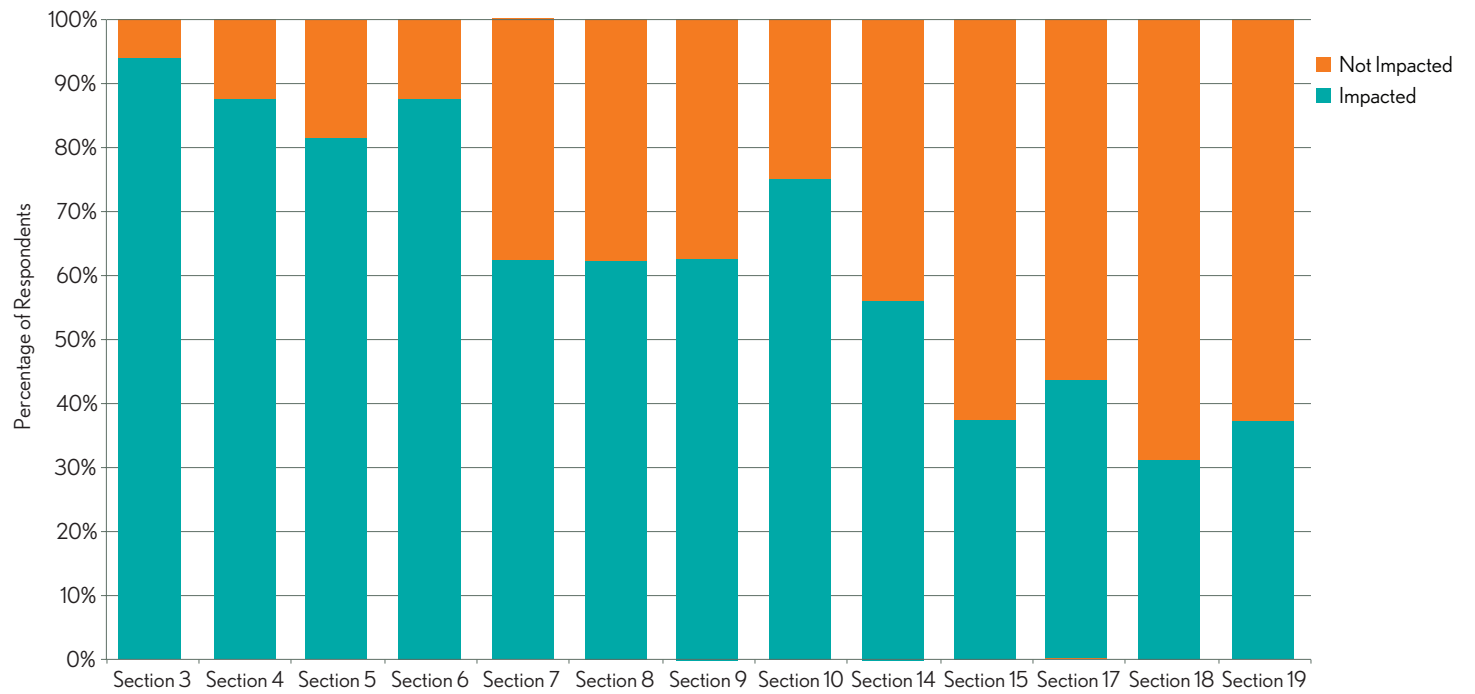
Region 3 – Central



Region 4 – South



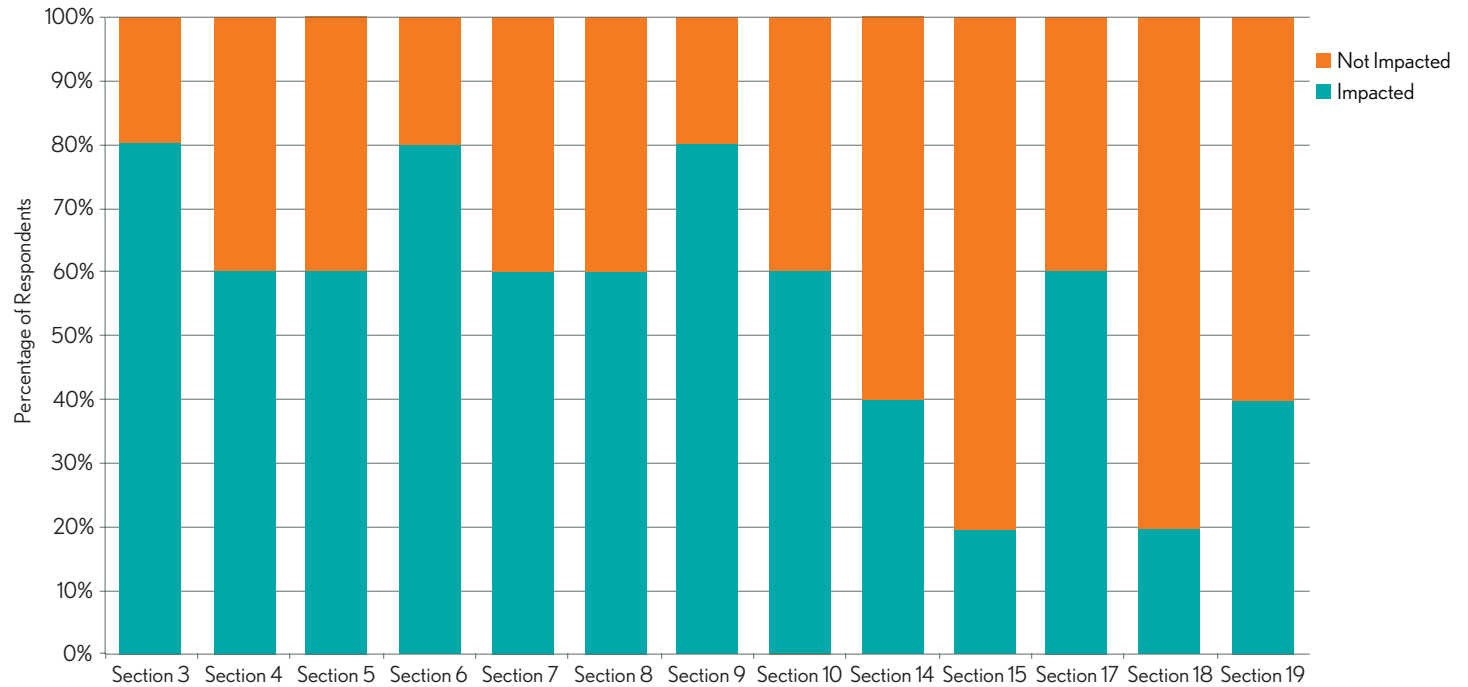
Region 5- West



n = 16

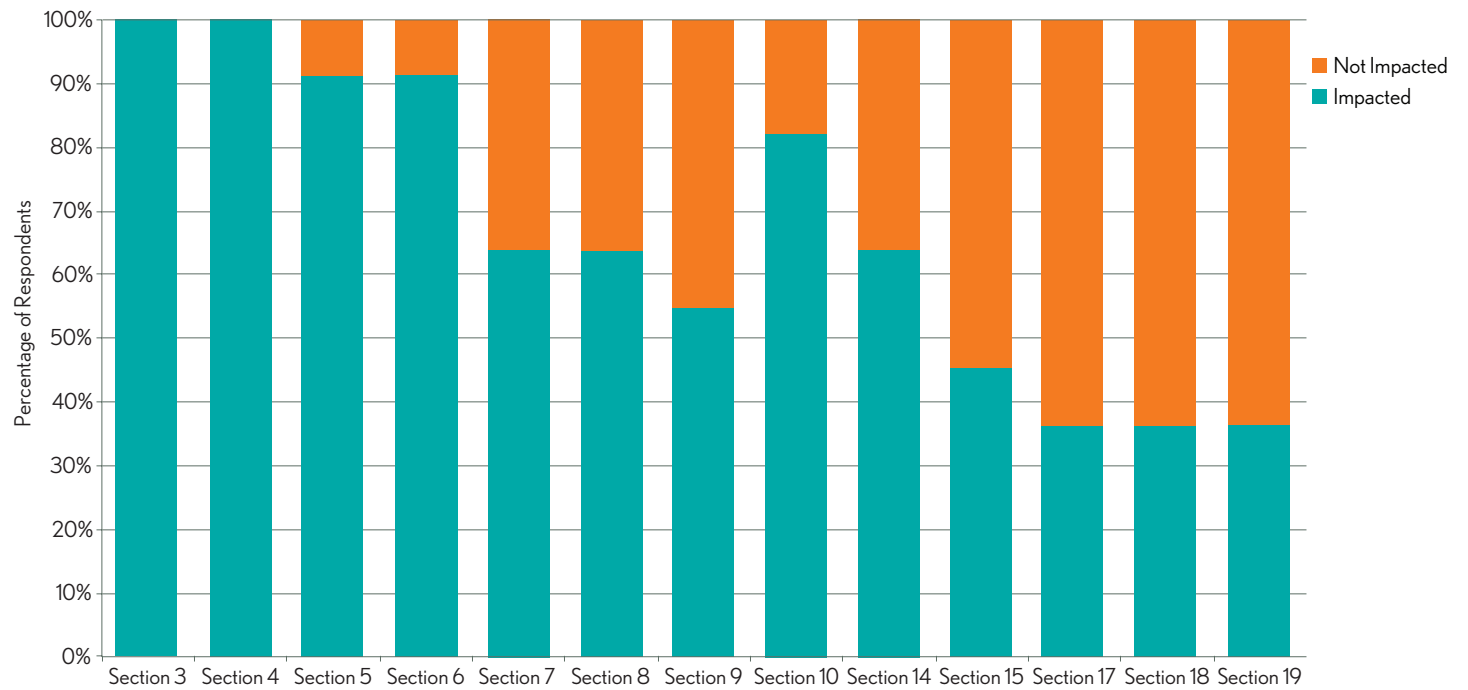
Impact of 2008 PSA By LHIN

LHIN1 – Erie St. Clair



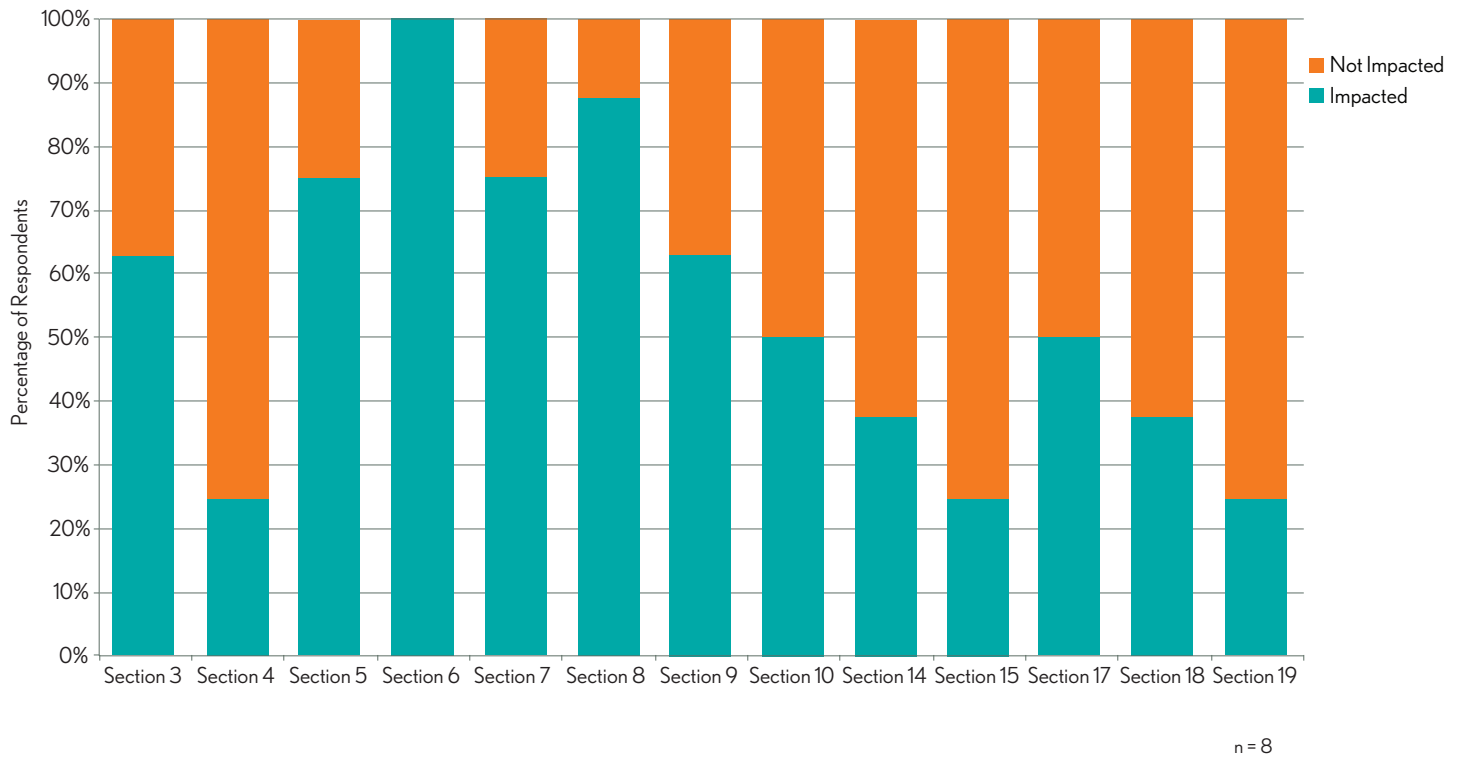
n = 5

LHIN2 – South West

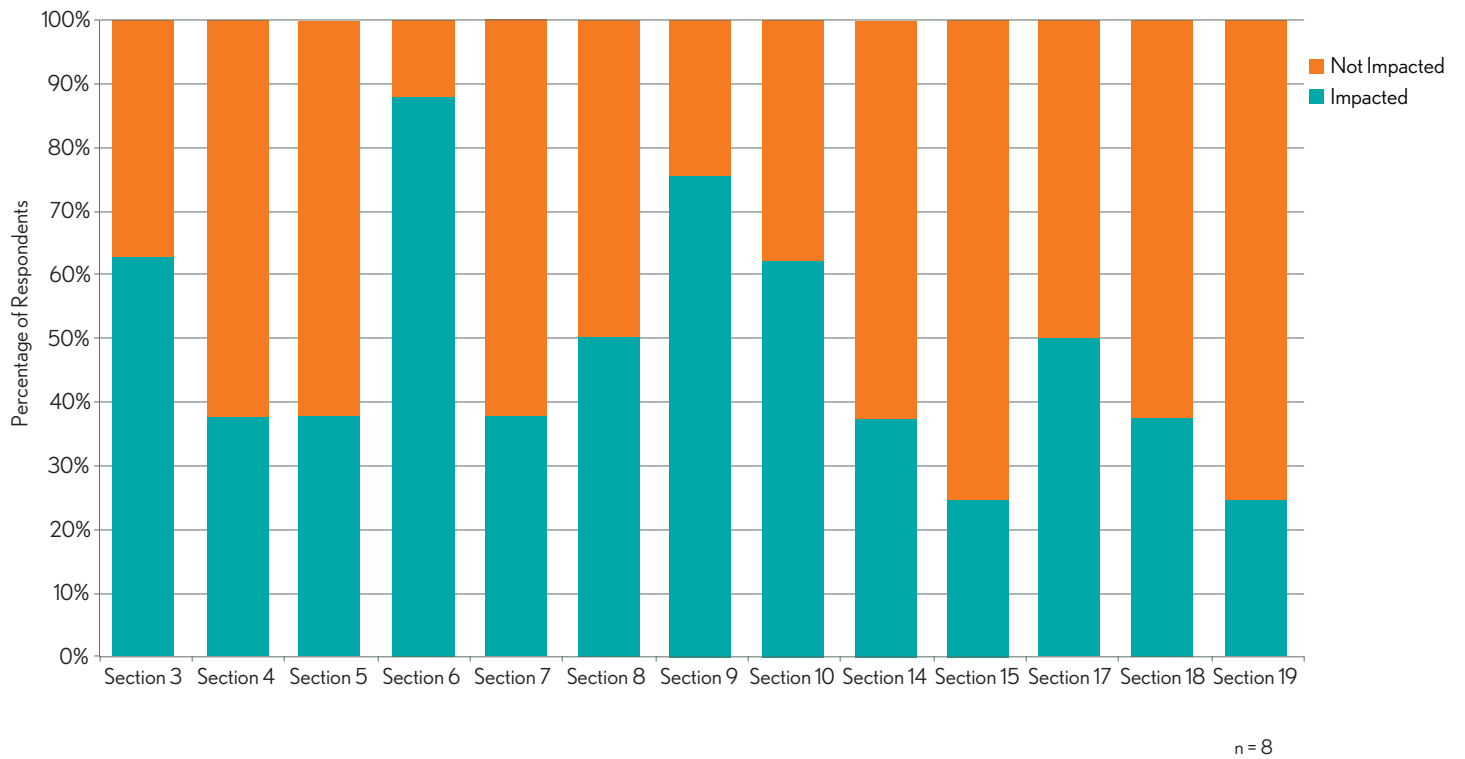


n = 11

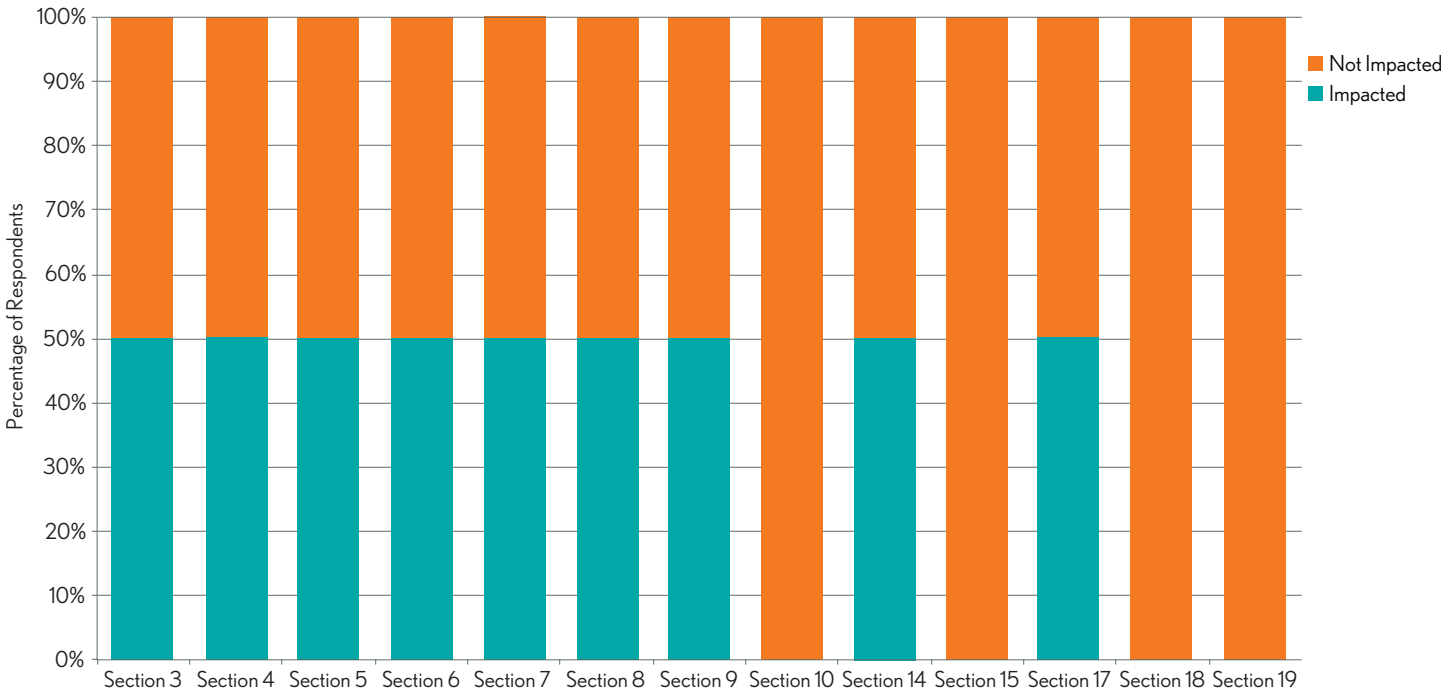
LHIN 3 – Waterloo Wellington



LHIN 4 – Hamilton Niagara Haldimand Brant

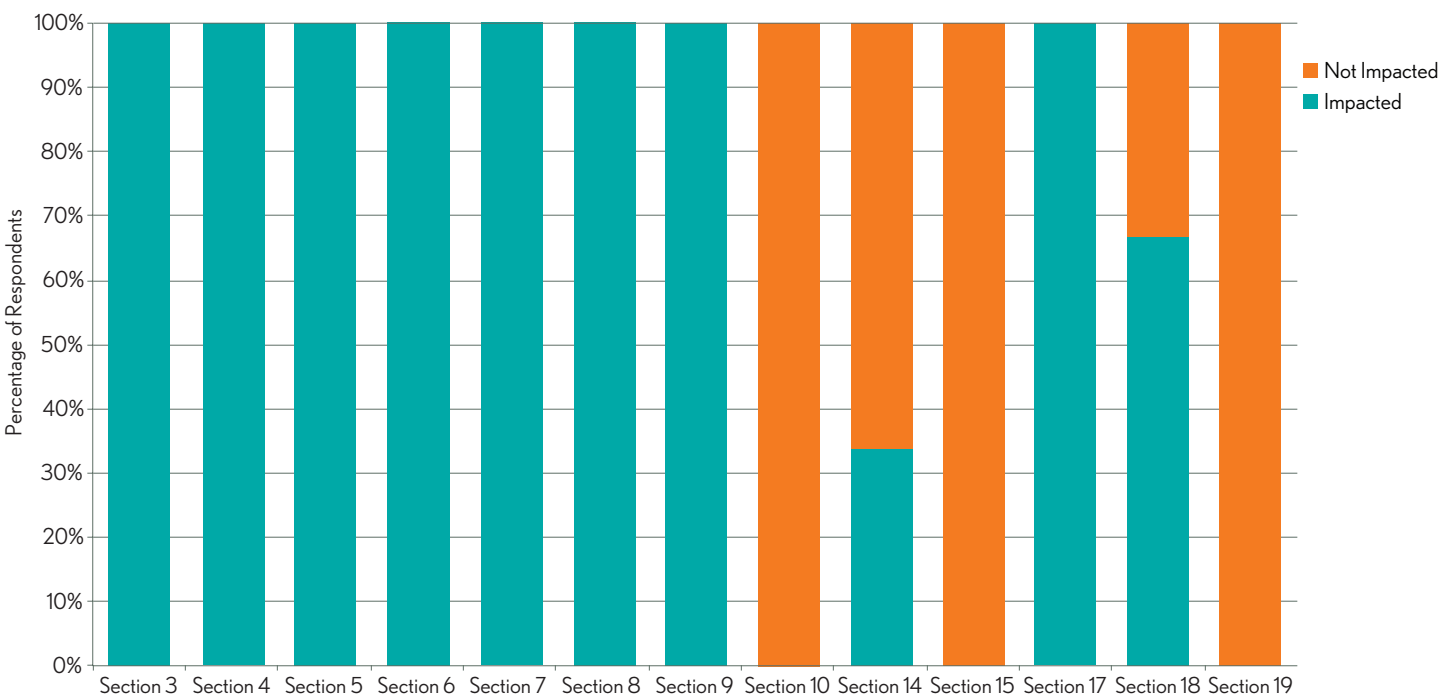


LHIN 5 – Central West



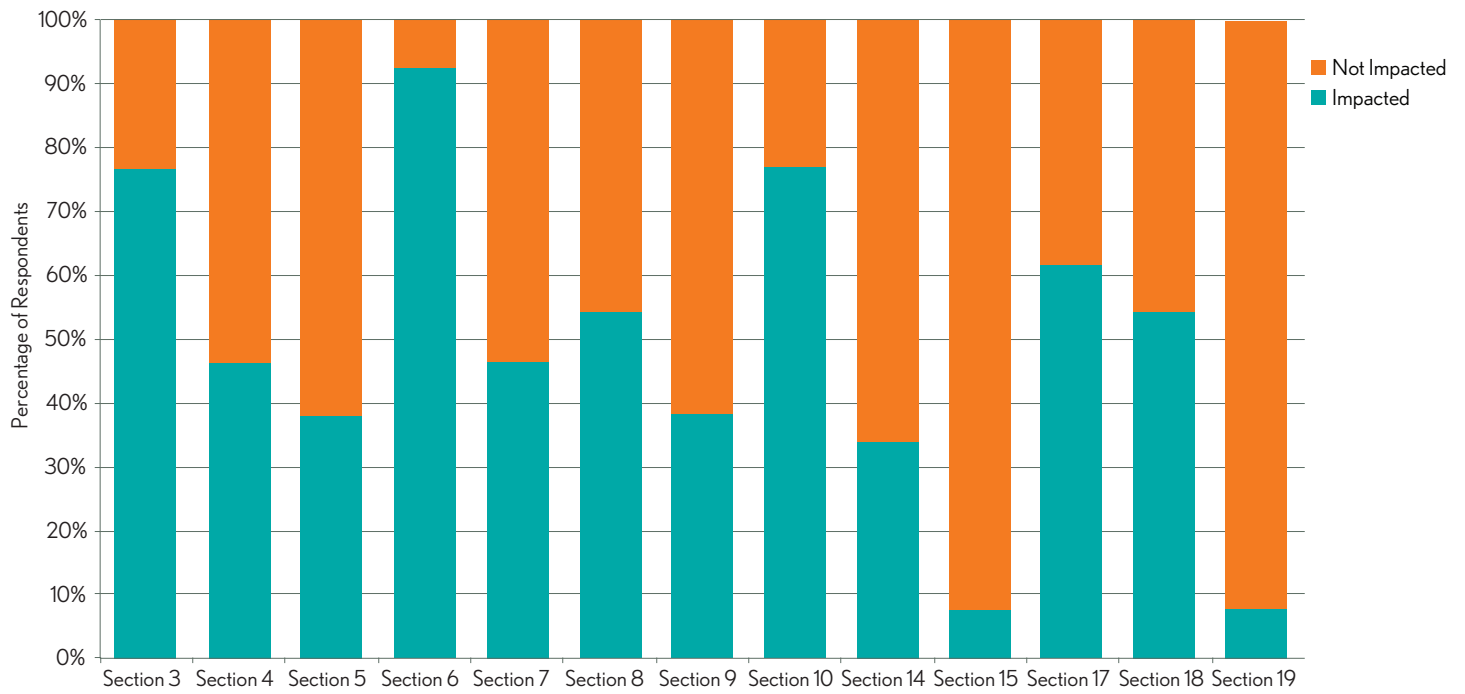
n = 2

LHIN 6 – Mississauga Halton



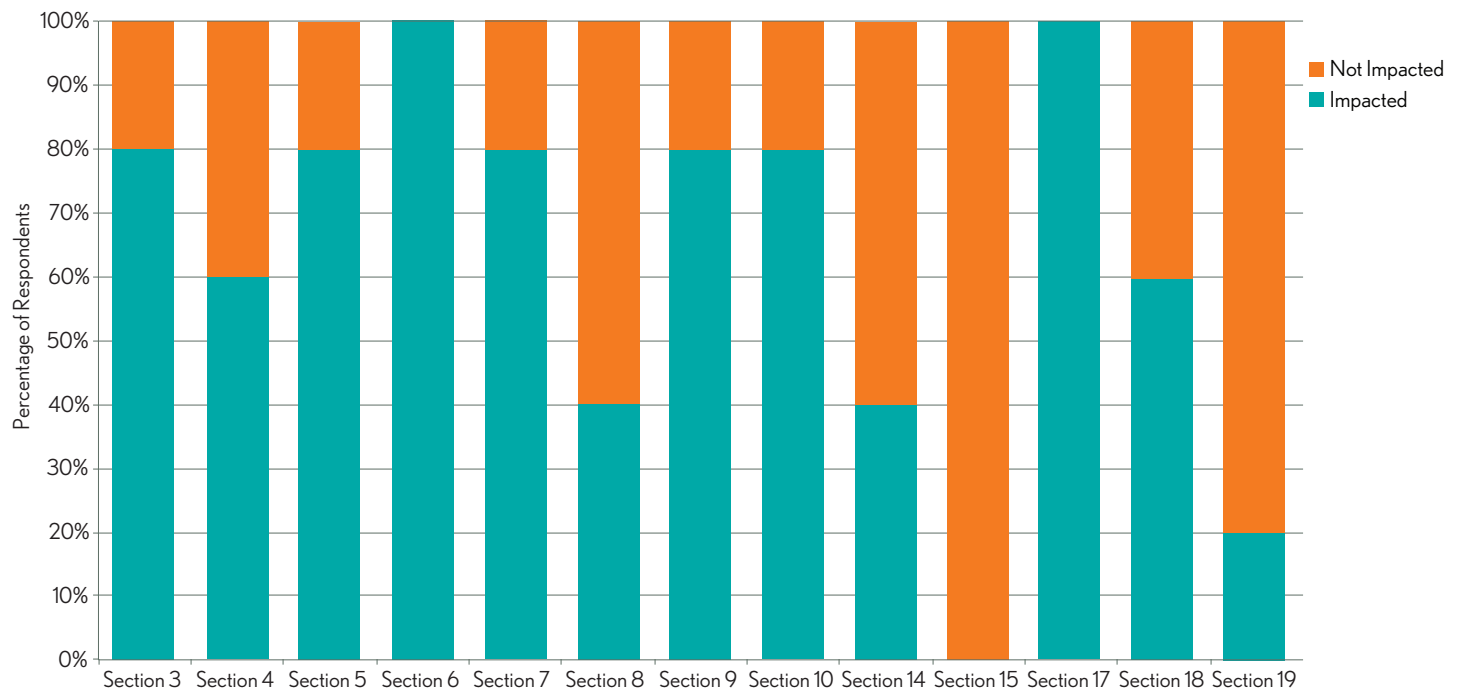
n = 3

LHIN 7 – Toronto Central



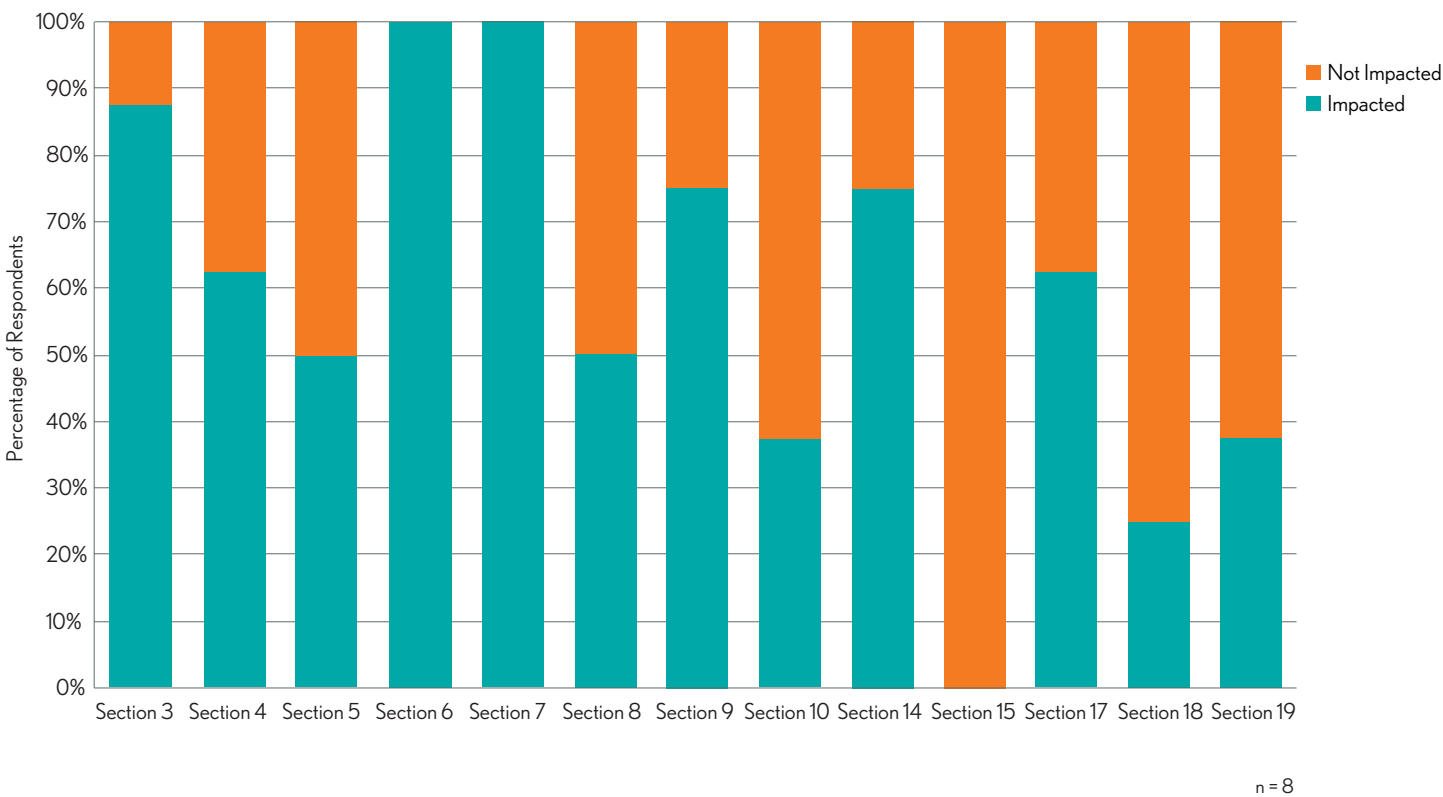
n = 13

LHIN 8 – Central

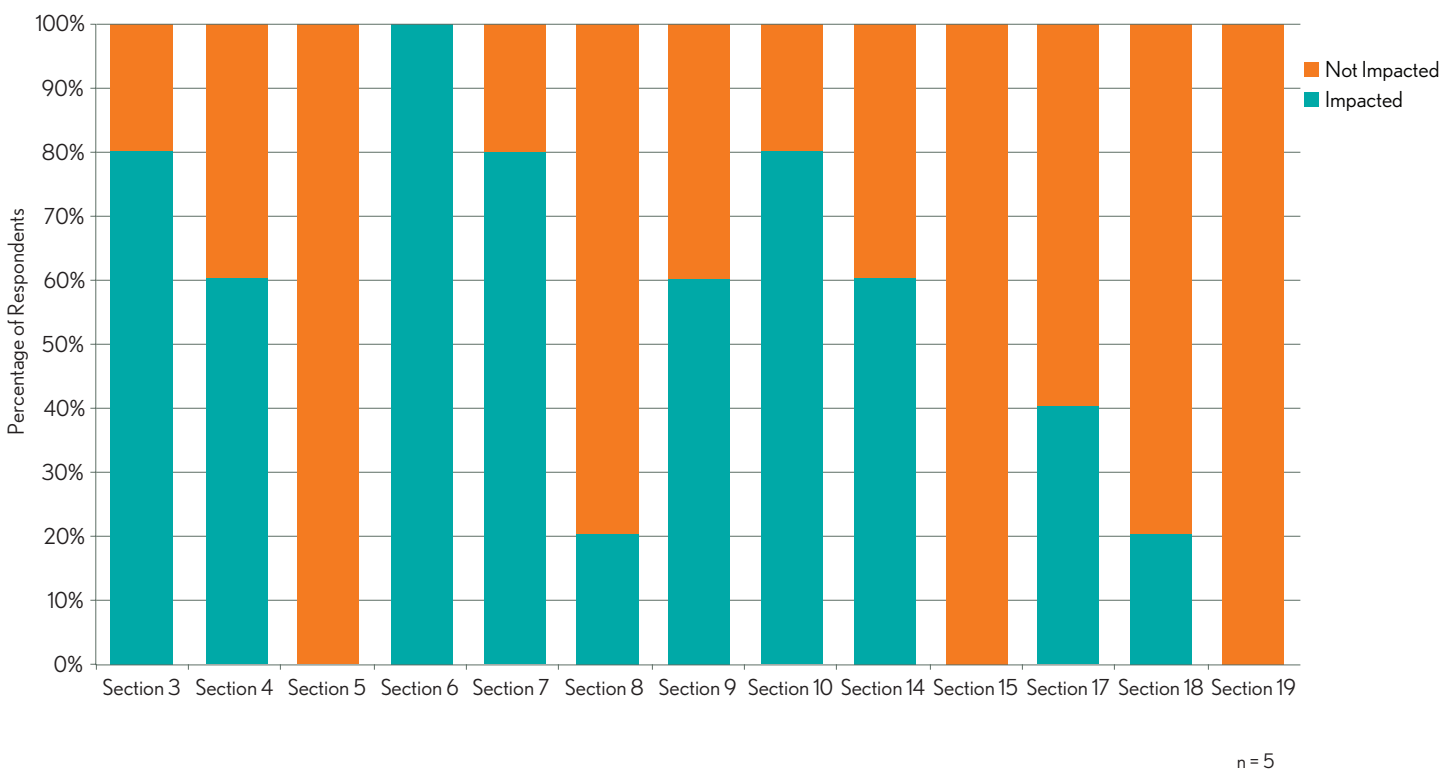


n = 5

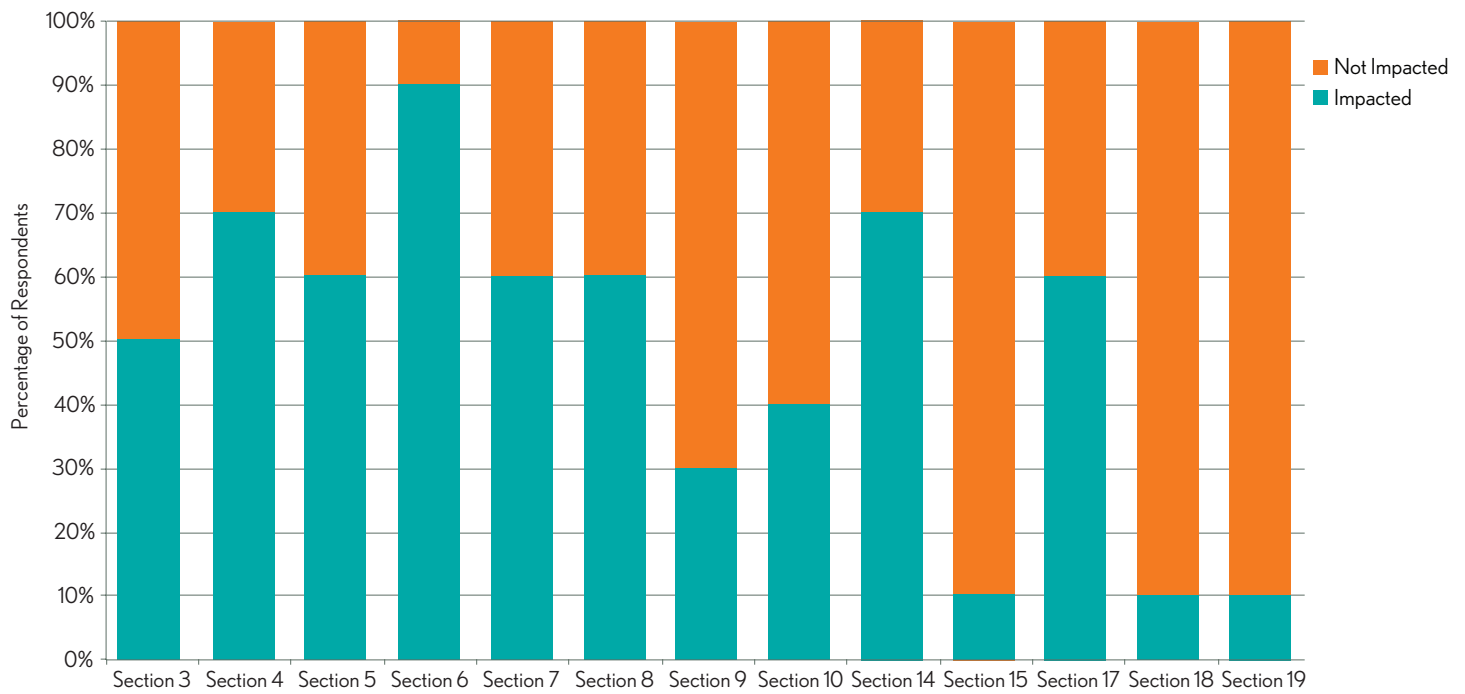
LHIN 9 – Central East



LHIN 10 – South East

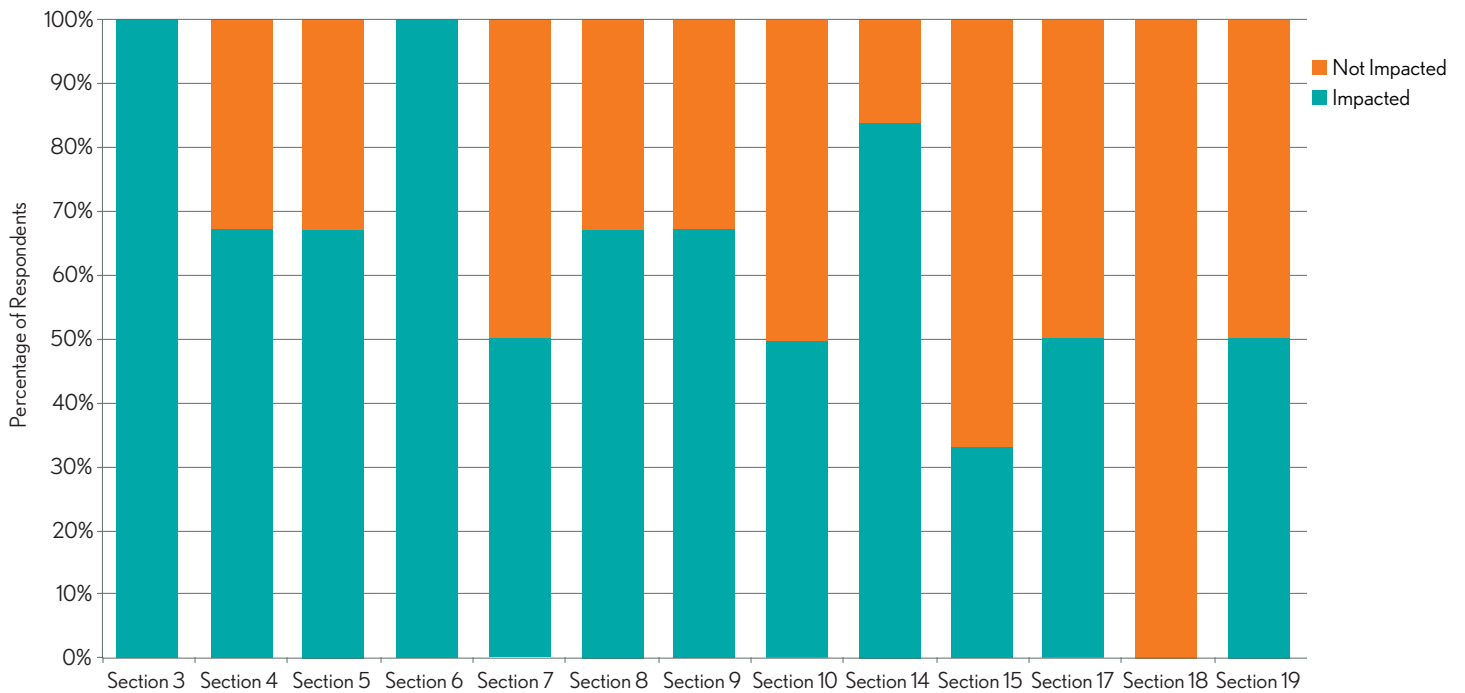


LHIN 11 – Champlain



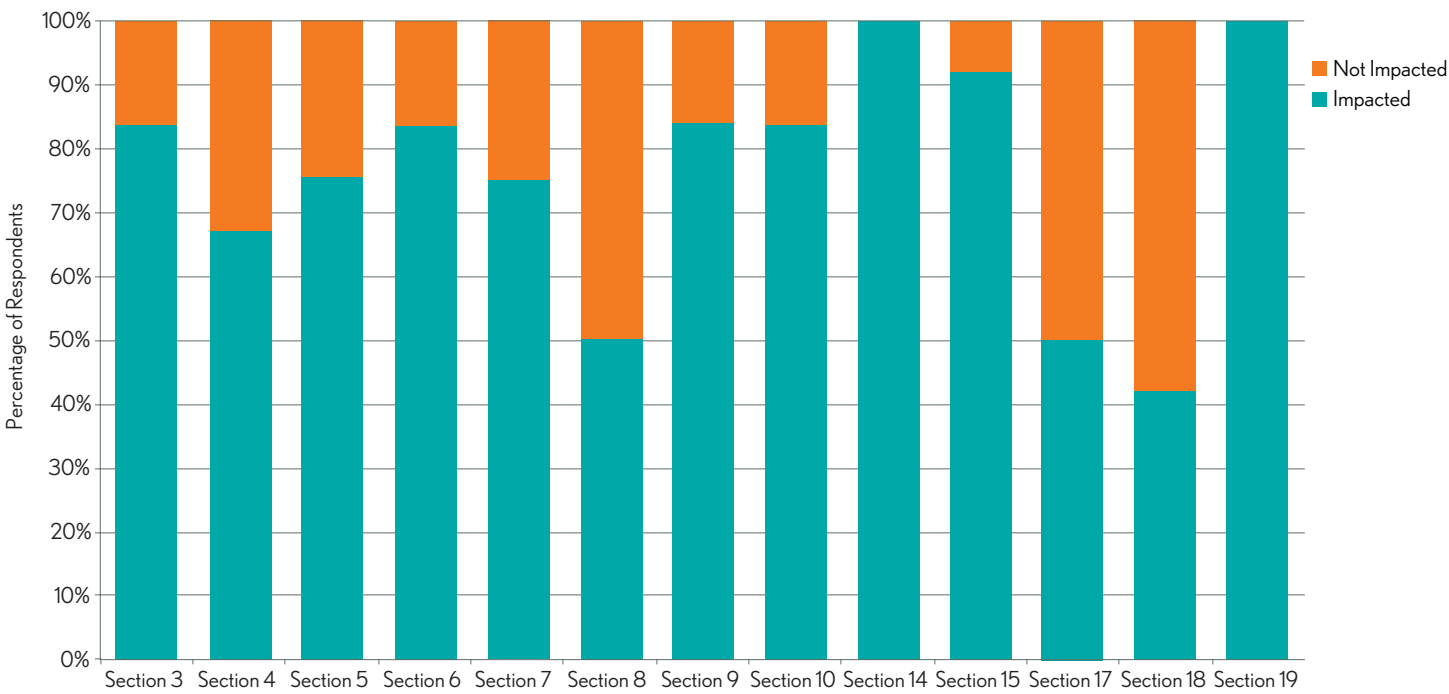
n = 10

LHIN 12 – North Simcoe Muskoka



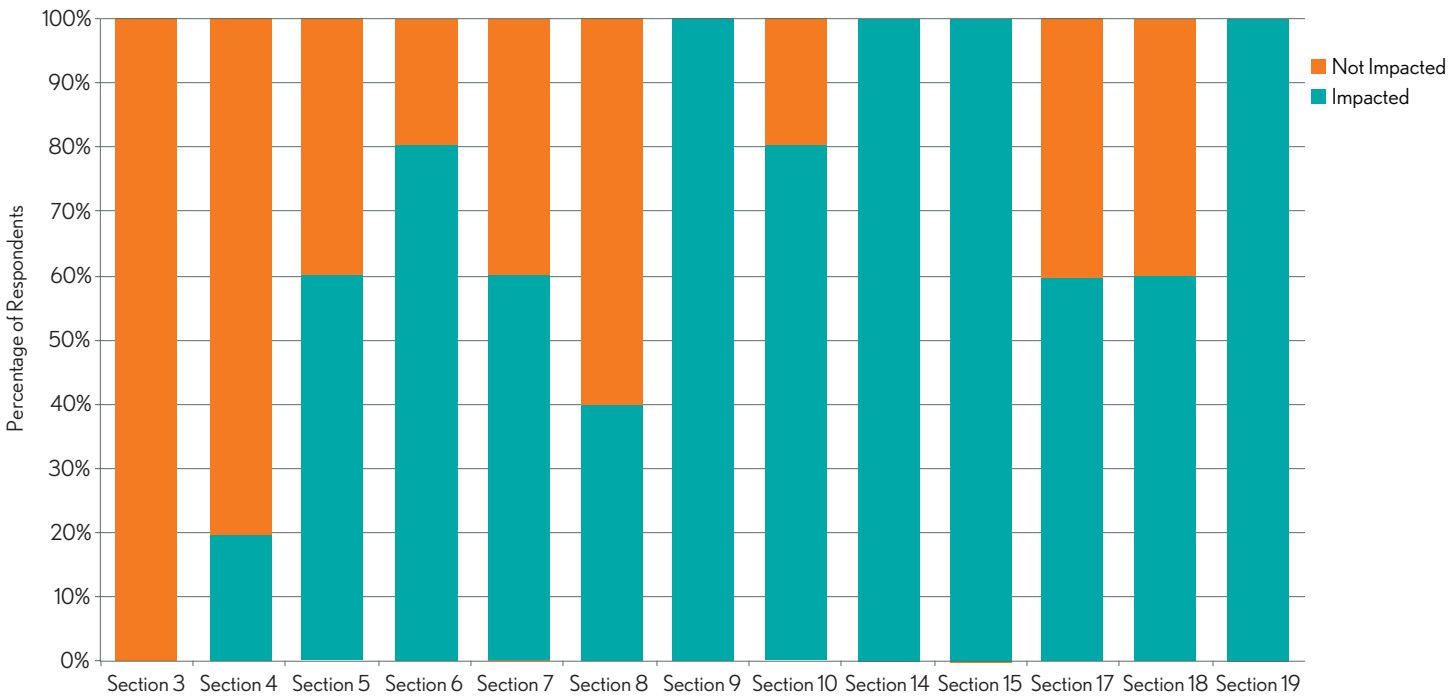
n = 6

LHIN 13 – North East



n = 12

LHIN 14 – North West



n = 5

Appendix F

OHA Physician Provincial Leadership Council

Physician Provincial Leadership Council 2011 – 2012 (as of June 9, 2011)

Name	Organization	Position
Dr. Jack Kitts (Chair)	The Ottawa Hospital	President & CEO
Dr. Charlie Chan (Vice Chair)	University Health Network	VP Medical Affairs & Quality
Dr. Donald Atkinson	Orillia Soldiers' Memorial Hospital	Chief of Staff & VP Medical Affairs
Ms. Carolyn Baker	St. Joseph's Health Centre Toronto	President & CEO
Dr. Stephen Brown	William Osler Health System	Corporate Chief Anaesthesia & Co-Medical Director, Surgical Program
Ms. Michelle DiEmanuele	Credit Valley Hospital	President & CEO
Dr. Pamela Eisener-Parsche	Bruyere Continuing Care	Chief of Staff
Mr. Paul Heinrich	Georgian Bay General Hospital	CEO
Dr. Emmalee Marshall	Sault Area Hospital	VP Medical Affairs
Dr. Benoît Mulsant	Centre for Addictions & Mental Health	Physician-in-Chief
Mr. Paul Paradis	McCausland Hospital & Wilson Memorial General Hospital	CEO
Dr. Dwight Prodger	Joseph Brant Memorial Hospital	VP Medical Affairs
Dr. Keith Rose	Sunnybrook Health Sciences Centre	EVP & Chief Medical Executive
Dr. Ashok Sharma	Grand River Hospital & St. Mary's General Hospital	Chief of Staff
Dr. Thomas Stewart	Mount Sinai Hospital	Physician-in-Chief, Chief Clinical Officer
Dr. Nancy Whitmore	St. Thomas Elgin General Hospital	VP Medical Affairs & Chief of Staff

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