PRELIMINARY RECOMMENDATIONS OF THE ACADEMIC PHYSICIAN HUMAN RESOURCES EXPERT PANEL TO THE ACADEMIC HEALTH SCIENCE CENTRES ALTERNATE FUNDING PLAN TASK FORCE

JANUARY 2007
ACKNOWLEDGEMENTS AND MEMBERSHIP

As Chair of the Academic Physician Human Resources Expert Panel, I would like to extend my gratitude and appreciation to the members of the Expert Panel who dedicated their time to this ambitious project. Through leveraging their knowledge and expertise the Expert Panel was able to develop a series of recommendations that will advance HR planning strategies and processes across all provincial AHSCs.

It is with respect that I submit this report to the Task Force on behalf of the Academic Physician Human Resources Expert Panel.

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Sincerely,

Dr. John Brown
Chair, Academic Physician Human Resources Expert Panel
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INTRODUCTION

Under the 2004 Physician Services Agreement, between the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care (MOHLTC), $150M in new funding was made available to complete the Academic Health Science Centres Alternate Funding Plan (AHSC AFP) initiative, which began under the 2000 Physician Services Agreement. Appendix G of the 2004 Physician Services Agreement called for the establishment of an AHSC AFP Task Force to advise on the development of a common AHSC AFP template agreement and a methodology for the allocation and distribution of the new investment.

Recognizing that changes in complement may be required at Academic Health Science Centres (AHSCs) as a result of changing needs, services and programs, the Parties to the 2004 Physician Services Agreement also mandated, through Appendix G, the development of a provincial academic physician human resource strategy that would also take local AHSC human resource plans into account. To this end, the AHSC AFP Task Force appointed the Academic Physician Human Resources Expert Panel (APHREP) to consult widely and make recommendations on a provincial human resource strategy for AHSCs.

The APHREP, Chaired by Dr. John Brown, engaged in a thorough review of HR planning practices in Ontario, including interviewing Vice Presidents of Academic Affairs at 16 AHSC sites, a detailed informational survey and an exhaustive data collection and analysis process. As a result, the APHREP has develop a series of recommendations intended to strengthen and align hospital HR planning processes; including establishing common planning principles, impact analyses and tri-partite agreement on human resource priorities.
Summary of Expert Panel Recommendations

Recommendation 1
The principals should establish an Academic Physician Human Resource (AHSC) Reference Group with expert representation from the OMA, MOHLTC, CAHO, COFM, CPSO and the Academic Physician Governance organizations.

Recommendation 2
The allocation of funds to individual AHSCs to support recruitment must meet the Appendix G requirement of transparency among the participating AHSCs.

Recommendation 3
Recruitment priorities should be established for the allocation and use of recruitment funds from the New Investment fund to participating AHSCs. That information should be provided to the AHSC Reference Group for planning purposes.

Recommendation 4
A defined and common amount of funding for each recruit should be established.

Recommendation 5
The Principals to the agreement should allocate a defined portion of the New Investment funds annually specifically for the purposes of recruitment. The amount of the New Investment fund allocated annually for that purpose should be determined in part by an annual provincial AHSC recruitment planning exercise that would be facilitated by the Reference Group.

Recommendation 6
The allocation of funds at each AHSC would be the responsibility of the local Governing Committees and would accommodate local priorities and needs.

Recommendation 7
AHSCs should be allowed to use local resources and funds for recruitment rather than depending on an allocation from the New Investment fund.

Recommendation 8
AHSCs should be allowed to use AFP funds currently allocated to participating physicians who retire or leave the AHSC for other reasons for the purpose of recruiting replacements.
Summary of Expert Panel Recommendations (cont’d)

Recommendation 9

If the retiring physician is to leave the province or practice then there should be consideration for the AHSC to use the full financial package attached to the retiring physician for recruitment purposes. If a departing physician is leaving the province then the AHSC should be allowed to use the full financial package of that physician for recruitment purposes.

Recommendation 10

A common template should be adopted by the AHSCs to secure and collate information regarding recruitment taking into account service demand, academic obligations and hospital operating capacity. There should be an impact analysis and tripartite agreement among the University, the Hospital and the local Governing Committee before funds are released for the appointment.

Recommendation 11

Establish an inclusive academic physician definition that would accommodate part-time and, in some instances, primarily clinical support positions where the latter meet some of the accountability requirements at certain centres. The level of support for full-time, part-time and support physician positions will be determined by the application of the FTE definition.

Recommendation 12

Develop common provincial eligibility criteria for participation in the full AFP. These criteria will be used when considering recruitment and the use of New Investment funds allocated for recruitment.

Recommendation 13

Academic Physician recruits will be required to become members of the AFP as a condition to receive New Investment Funds. Funding will cease when that academic physician leaves the AFP. Part-time members will have to join the AFP if they wish to receive recruitment or other AFP related funds.
1.0 Background

1.2 The Panel’s Mandate

Appendix G of the 2004 Physician Services Agreement mandated the appointed an Academic Human Resources Expert Panel (APHREP) to advise the AHSC AFP Task Force and make recommendations on a provincial human resource strategy for Academic Health Science Centres (AHSCs). More specifically the Expert Panel was charged with developing the following:

- A standard process, approach and methodology for the addition of new complement that takes into account service demand, academic obligations and hospital operating capacity; and
- A standard method and process to integrate planning activities for academic physician human resources across all AHSC sites.

Background research performed by the Expert Panel revealed that, at the present time, human resource (HR) planning for academic physicians varies across the institutions from a somewhat informal, ad hoc process to a rigorous, formal ongoing process tied to the institution’s strategic plan. There appears to be no relationship between the size of the institution and the existence of a robust HR planning process.

1.3 HR Planning Challenges

Interviews with Vice-Presidents of Academic Affairs at several AHSCs identified two principle challenges for HR planning in AHSCs; recruitment and retention.

Recruitment issues identified included:

- Shortages in particular specialties;
- Pressures on growing clinical need due to an aging population or government priorities;
- Increasing teaching load due to enrollment increases and requirements;
- Competition amongst AHSCs, between AHSCs and community hospitals and private practice;
- Lack of hospital resources (space, operating room time); and
- Lifestyle changes in both the aging physician population and newly graduating physicians.

Retention issues cited:

- Stars: Excellent physicians, no matter where they are, are always being recruited by other institutions. Remuneration is not always the competitive edge other institutions have. They may have state of the art equipment, more space, more operating time, or other resources that are attractive to these eminent physicians.
- Physicians in high demand specialties, e.g., anesthesia, occasionally leave for community hospital settings where the workload is less onerous without the academic responsibilities or to other AHSCs where remuneration is higher. Similarly, physicians in laboratory medicine, where positions are salaried by the hospital and in the context of increased workload due to the wait list strategy, have been cited as leaving for community hospitals where workloads are lighter.
1.3 HR Planning Challenges (cont’d)

Retention issues cited (cont’d):

- Uncompetitive salaries have resulted in poor retention in some specialties (geriatrics, neurosurgery, anaesthesia).
- Differences in OHIP premiums: Some specialties receive larger billing amounts than others. This was cited as an issue in practice plans (angioplasty) in a few hospitals where physicians pool their incomes. Physicians doing the procedures bring in higher earnings than those who provide the clinical care on the wards. Although both types of physicians are necessary, the higher earners resent subsidizing the income of the lower earners. These discrepancies are becoming larger and the higher earners are threatening to leave the partnership and to form a parallel partnership within the same hospital, or to go into private practice.
- Nature of the practice: Physicians in specialties which do not require a patient roster (e.g. emergency medicine, anesthesia) are more easily able to relocate.
- Age of physicians: younger physicians are seen as more mobile.
- Burn out of physicians can be the cause of turnover (e.g., dual diagnosis psychiatry).
- Organizational change: The amalgamation of hospitals has highlighted, in some instances, the inequity of physician incomes across the sites. Without redress, the institution is concerned that physicians will leave for the community. In one instance the de-merger of two institutions created a short term crisis as departments chose to go to one site over the other.

The recommendations detailed in this report are intended to strengthen hospital HR planning processes; including establishing common planning principles, impact analyses and tri-partite agreement on human resource priorities.

1.4 Approach to the Work

The Expert Panel’s work has been informed by the following:

- Extensive data analysis of existing AHSC AFP participants and eligible academic physicians, by site and specialty, including full and part-time physicians and non-phase I eligible AFPs and AFPs.
- Review of existing provincial AHSC Human Resource plans.
- One-on-one interviews with Vice-Presidents of Academic Affairs of AHSCs regarding HR planning processes (16 of 17 AHSCs approached participated in the interviews).
- Informational surveys regarding physician human resource recruitment, retention, and vacancies (82% response rate).
- Consultation with the AFP Task Force, the AFP Governance chairs from across the Province, the Provincial Human Resources Committee, medical leaders and hospital administrators.
1.5 Data Analysis

The Expert Panel undertook an extensive data collection and analysis exercise to provide background information on existing academic physicians including:

- Total number of existing academic physicians;
- Number of academic physician by specialty and location; and
- Number of academic physicians eligible for participation in the phase III AHSC AFP

The information was used by the Panel to help identify, where possible, recruitment patterns and to act as starting points for discussion around HR planning and recruitment.

AFP APP Consolidated Data Tables created by the Expert Panel contain the number (not the full-time equivalent number) of academic physicians by specialty and sub-specialty at each AHSC (note data was collected between April and September 2006 and therefore numbers may have changed since that time period). The validity of the Phase 1 eligible physician data is compromised for the following reasons: Eligibility definitions vary among centres. Some departments, divisions or individuals did not participate in Phase 1. Some centres identified full and part time academic physicians and some institutions provided FTE counts using local definitions and while they are included in the data tables they are not identified as such.

Total Academic Physician Count: 5137
Total New Investment Fund eligible Academic Physician Count: 4152
Total Phase 1 AHSC AFP Academic Physician Count: 3119

The most complete and accurate count of academic physicians in Ontario with planning utility will emerge when the AHSC AFP Task Force FTE definition is applied uniformly across all academic centres. This count will be the starting point from which a standard process, approach and methodology for determining new complement can proceed. It will also be useful in the integration of planning activities for academic physician resources at all the AHSC sites.

Recruitment Data:

Interviews were conducted with Vice-Presidents of Academic Affairs of AHSC hospitals and surveys regarding physician human resource recruitment, retention, and vacancies were sent to each of these hospitals. The validity of the information received is compromised by some incomplete responses, by differences in terminology used by hospitals and in their interpretation of the questions. Because there is no commonly accepted definition of full-time-equivalent, all numbers reported are head counts. The findings from the interviews and survey, however, can inform the discussions regarding academic physician resource issues and the concerns facing AHSCs.
1.5 Data Analysis (cont’d)

Recruitment Data (cont’d):

Following is a summary of the data received.

1. Requested and approved new (not replacement) appointments 2005-06 453

2. Turnover in 2005-06 292

3. Retirements next 5 years Ontario AHSCs (head counts) 259

4. Retirements in 2006-07 Ontario AHSCs (head counts) 69

5. Unfilled, vacant positions (new and existing as of 1 June 2006 for Ontario 267

6. Positions likely requested in 2006-07 235

Note: SEAMO and most other full AFPs and APPs are included in the estimates. Mount Sinai and UHN AFP organizations did not provide recruitment data so the above data was extrapolated to provide an overall estimate of recruitment positions likely requested for 2006-07 as follows:

According to the consolidated data tables Mount Sinai/UHN account for approximately 18.7% of the physicians eligible to participate in New Investment funds from all AFPs and APPs. If item 6 identifies the number of recruitment requests expected in the Ontario AHSCs exclusive of Mount Sinai/UHN and assuming Mount Sinai/UHN recruitment needs are similar to the provincial need then multiplying 235 by 1.187 should give an approximate total need for the province in 2006 of 279 new positions.

If it is assumed that each recruit would receive on average $50,000 in recruitment funds then it would require approximately $14 Million of New Investment funds to meet all recruitment requirements. If each recruit were to receive on average $100,000 in recruitment funds then it would require approximately $28.2 Million to meet all recruitment requirements for 2006-07.
2.0 Defining Academic Physicians

Through interviews conducted with VP Medical Affairs, respondents were asked to provide the definition of and criteria for, an academic physician in their institution. Definitions varied from a general understanding to one that was specified in a tripartite agreement between the university, the hospital and the physician. One generally accepted principle required that academic physicians have an academic appointment at the affiliated university. However, in a couple of exceptions, specific AHSCs considered all physicians contributing to the academic mission of the hospital whether or not they hold an academic appointment as academic physicians and therefore eligible for participation in the AHSC AFP. In some hospitals, physicians without academic appointments at the time of the AFP agreement have been grandfathered and allowed to continue their clinical work with the understanding that all future appointments at these institutions would require academic appointments.

In almost all provincial AHSCs, Academic physicians are involved, at a minimum, in clinical teaching or research (aside from the aforementioned exceptions). AHSCs use various terms to describe the academic nature of the physician’s profile; e.g. clinician teacher, clinician educator, clinician researcher/investigator, clinician scientist (bench research), clinician administrator. At some centres, distinction was also made, between academics who progress through the University ranks, i.e., senate stream (Geographic Full Time physicians) and those which progress through the provostial stream (Virtual Part Time physicians).

A recommendation of the Expert Panel, detailed later in this report, supports the development of a standardized, inclusive definition of an academic physician to align HR planning and recruitment processes and requirements across AHSC sites.

3.0 Impact of Hospital Accountability Agreements on Academic Physician Human Resources

In 2005/06, the MOHLTC introduced Hospital Annual Planning Submissions (HAPS) and Hospital Accountability Agreements (HAAs) to provide hospitals with a streamlined business planning process. The intent of the HAPS and HAAs were to support and advance the government’s priority of increasing stability and efficiency across the health care system. Hospital Accountability Agreements are a collaborative effort between the ministry and the hospital sector and once negotiated both the ministry and the hospital have a role in ensuring that accountability agreements are successfully implemented. As part of the HAA process, hospitals must sign an agreement that commits to the following deliverables:

- Deliver accessible, appropriate services;
- Maximize service levels and outcomes within a needs based context;
- Meets planned and agreed upon performance targets;
- Establishes agreed upon mechanisms for consequences for falling short of agreed upon performance targets; and
- Manages within resources available.
3.0 Impact of Hospital Accountability Agreements on Academic Physician Human Resources (cont’d)

AHSCs have noted that Hospital Accountability Agreements and more specifically the balanced budget requirement and managing within available resources can impede a hospital’s ability to recruit physicians. Some felt that it may be necessary to cut some non-essential services or staff to meet this requirement. It was also highlighted that Hospital Accountability Agreements tie hospitals to certain volumes of care and a population base; however, AHSCs have no control over the referral patterns of community physicians, which makes it difficult to negotiate and maintain performance and volume targets. Furthermore, AHSCs have expressed concern that the Phase III AHSC AFP may create additional challenges in achieving target volumes as academic physicians will no longer be tied fee-for-service billing. There is a perception that AHSCs will see services and volumes decline under the proposed AHSC AFP conversion level of 60-70%.

4.0 Process for Recruitment of New and Replacement Positions in AHSC Hospitals

Either the hospital or the university department can identify the need to create a new position. In AHSCs where the university department Chair and hospital department Chief is the same person, the question of who raises the need is largely irrelevant. Nevertheless, in most instances, the hospital takes the initiative because the need is typically clinical in nature and it is the hospital that has the resources to support the position. The timing and extent of the university’s involvement tends to relate to whether the position is largely academic (e.g. a clinical scientist), a senior rank is being recruited, or an international search is being conducted. Regardless of where the process starts, the university validates the academic need and determines whether a candidate has the experience/credentials to be granted an academic appointment.

The criteria or credentials required for an academic appointment vary according to the nature of the appointment. Typically, at a minimum, academic physicians will have a fellowship with some evidence of teaching and clinical expertise. They may be required to have a post-fellowship degree such as a Masters in Public Administration, Public Health, Business Administration or a PhD in a related field especially for research appointments.

The need for a new appointment is typically identified by the length of the waiting list; the availability of a new technology/procedure that the hospital wishes to adopt; the necessity of a minimum critical mass of physicians to ensure on-call coverage and to ensure clinical coverage while enabling physicians with a greater academic portfolio to do their work; or in some cases the number of medical graduates who want to do residencies in a particular specialty.
4.0 Process for Recruitment of New and Replacement Positions in AHSC Hospitals (cont’d)

Impact analyses on positions are conducted for different purposes. Most hospitals have some form of analysis of the impact on resources that each new position must undergo. 1 An impact analysis is often done for replacement positions as well due to the probability that the incoming physician will not have the same profile as the exiting physician, and thereby, different resources would be required. Additionally, many hospitals will do some form of physician impact on an annual basis, commonly when physicians reapply for privileges, as career paths of physicians can often change and hospitals want to ensure the physician profile still meet its clinical service requirements and priorities.

The rigor in which the impact analysis is applied varies across hospitals. Hospitals that are chronically short-staffed may forego an impact analysis. Similarly, for specialties/subspecialties in short supply, hospitals will often recruit a candidate in training in anticipation of future requirements regardless of current need.

5.0 Impact of LHINs on AHSCs

In October, 2004, the Ministry of Health and Long-Term Care announced the creation of Local Health Integration Networks (LHINs) as part of the government’s strategy to transform health care in Ontario from a collection of services that are often un-coordinated to a true health care system. LHINs are not-for-profit corporations that will be responsible for planning, integrating and funding local health services in 14 different geographic areas of the province. LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities.

LHINs are still evolving and therefore only speculation can be offered in assessing what impact LHINs may have on HR planning and recruitment at AHSCs. As previously noted, LHINs are based on the principle that community-based care is best planned and coordinated within the local community, however, AHSCs are unique in that their role and mission extends beyond the community to the provincial, national and even international level. Additionally, in some instances, one AHSC crosses more than one LHIN. AHSCs have noted some concern about whether LHINs recognize and understand the unique mission of AHSCs which extends beyond secondary, tertiary and quaternary care to include research enterprises and centres of Excellence. There is also a general lack of understanding among AHSCs of how LHINs will plan and respond to AHSCs’ provincial roles, and whether money will flow across LHIN boundaries when patients are treated in an AHSC outside their regional LHIN boundary.

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1 A Canadian survey of academic health facilities across Canada found that virtually all facilities use some form of physician impact analysis, but few have documented policies to support the analysis. While adopting impact analysis process, they have done so without fully developing their physician resource planning structure or aligning it with a corporate strategic plan. There was evidence that many experienced difficulty with the effective use of the impact analysis, revising them a number of times. Lastly, few conducted assessments of their impact analysis process. Smith S, J Kazimirski, R Audas, “Impact Assessment: An Essential Component of Physician Resource Planning. Draft Manuscript.
5.0 Impact of LHINs on AHSCs

There was belief that LHIN planning would allow for a more efficient flow of patients through the system, i.e., the ability of academic hospitals to repatriate patients more quickly to either the local community hospital or discharge to their home.

6.0 Key Considerations Impacting Future Needs for Academic Physicians

Several factors have been identified as influencing the need for future academic physicians. These factors can be associated to changes in the following categories: demographics, training, and work life and practice patterns.

Demographics
- Changes in demographics that will determine the need for growth in some specialties (geriatrics, chronic diseases, joint replacement, psychiatry)
- The aging of the physician workforce that leads to increased retirements and the need to introduce flexibility in employment to keep “retired” physicians on part-time
- An overall decrease in the general population

Training
- Need to develop academic priorities for the future to address changing needs and a process for developing them;
- The need to make academic medicine more attractive to trainees;
- Changes in specialty requirements (e.g. the requirement that generalists be trained in community hospitals, making it more difficult for teaching hospitals to recruit generalists for care provision thereby impacting clinical volumes);
- The need for more advanced specialized tertiary/quartenary physicians to train for the future;
- The workload impact of increased enrollments and training of international medical graduates;
- The move to decentralized training, which leaves the hardest part of training (curriculum development, didactic teaching, and management of students) to fall to the academic hospitals;
- The need for increased support for research
6.0 Key Considerations Impacting Future Needs for Academic Physicians (cont’d)

Work Life and Practice Patterns

- the inequity of income and workload of physicians in AHSC hospitals versus community hospitals or private practice;
- the changing values of both younger and older physicians (i.e., the desire for a more balanced work/life, and changing practice patterns);
- the inequities in compensation across specialties, i.e., low incentive structure for choosing specialties of need;
- increasing specialization of physicians reducing the flexibility of types of care that can be provided;
- new technology/drugs that will change the nature of interventions and therefore the type of physician needed in the future;
- the need to explore alternative models of providers and of delivering care to meet increasing demands and financial sustainability;
- the need for collaboration across hospitals to meet the demands of service and on-call (seems to be a Toronto phenomenon); and
- the need for flexibility in fee-for-service conversion to balance a limited ability to generate income in some specialties (therefore favouring more conversion), specialties that can generate high volumes (therefore favouring more fee-for-service), and maintaining volumes.
7.0 Academic Physician Human Resources Expert Panel Recommendations

RECOMMENDATION 1

The principals should establish an Academic Physician Human Resource Reference Group with expert representation from the OMA, MOHLTC, CAHO, COFM, CPSO and the Academic Physician Governance organizations.

To maintain the principles of transparency and consistency of funding levels, a provincial body (composition and mandate to be determined) will be required to monitor the distribution and use of recruitment funds and to liaise with the provincial body responsible for physician resource planning that will take into account planning priorities. The proposed Reference Group should be a subcommittee of the Physician Human Resources Committee (PHRC) of the PSC.

Functions of the AHSC Reference Group:

1. Assist in establishing academic physician resource planning principles that would take into account AHSC and provincial physician resource plans and local and provincial academic and community needs

2. Assist in policy development regarding academic physician needs and priorities. This Group acting through the PHRC could liaise with the larger provincial health human resources strategy body and thus avoid conflict in policy or duplication of effort.

3. Maintain the consolidated AHSC AFP physician data base. The Reference Group would collect and review local AHSC planning and physician resource data annually that had been confirmed using the agreed FTE methodology to develop a picture of how local and provincial academic physician planning priorities are being met.

Academic physician resource planning principles

1. Recognition of the importance for support for centres of excellence at AHSCs

2. Recognition of the importance for a critical mass of specialists in core disciplines at AHSCs

3. Collaboration with the provincial and national physician human resources planning process

4. Collaboration with the regional LHINs Health Human Resources planning process
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 2

The allocation of funds to individual AHSCs to support recruitment should meet the Appendix G requirement of transparency among the participating AHSCs. Appendix G requires:

1 d) the funding and allocation of funds to AHSCs, including the allocation calculation, will be transparent between AHSCs and within the AHSCs to the level of specialty groups and will take into account retention and recruitment;

9. Complement:

Complement increases funded through this initiative (as set out in paragraph 7) will be approved by the Parties with advice from the AHSC AFP Task Force and taking into consideration the provincial Academic Physician Human Resource Strategy. Funding for the clinical service portion of such complement increases will be derived from conversion or new utilization as the case may be.

RECOMMENDATION 3

Recruitment priorities should be established for the allocation and use of recruitment funds from the New Investment fund by participating AHSCs. That information should be provided to the AHSC Reference Group for future reference and to facilitate planning.

RECOMMENDATION 4

A defined and common amount of funding for each recruit should be established.

To preserve the principles of transparency and fairness of the allocations for recruitment from the New Investment fund would have to be the same for each specialty at each AHSC and if an AHSC wishes to enhance the compensation for a recruit then the additional funds will have to come from a source other than the New Investment fund.

As with previous contracts, funds that are assigned to an AHSC for recruitment would continue to be assigned to the AHSC to support the recruit for the term of the contract.
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 5

The Principals to the agreement should allocate a defined portion of the New Investment funds annually specifically for the purposes of recruitment. The amount of the New Investment fund allocated annually for that purpose should be determined in part by an annual provincial AHSC recruitment planning exercise that would be facilitated by the Reference Group.

The Reference Group (see recommendation 1) would monitor the recruitment numbers and types of recruitment to ensure that recruitment practices were consistent with the provincial academic physician human resources plan. Reporting lines will be established to allow for maintenance of the academic physician data base and to ensure that provincial priorities are being met.

The amount allocated to each AHSC for the purpose of recruitment could be dependent on several factors. It could be a function of their specific recruitment needs, a function of their previous recruitment profile, a function of the number of current participants, and/or a reflection of the AHSC recruitment priorities and how coherent they are with the provincial AHSC physician resource plans.

RECOMMENDATION 6

The allocation of recruitment funds at each AHSC would be the responsibility of the local Governing Committees and would accommodate local priorities and needs.

RECOMMENDATION 7

AHSCs should be allowed to use local resources and funds for recruitment rather than depending on an allocation from the New Investment fund.

If the recruits in this situation join the AFP then they would be eligible for New Investment funding based on their ultimate FTE status but the local AHSC would be responsible for the maintenance of the recruit.

RECOMMENDATION 8

AHSCs should be allowed to use AFP funds currently allocated to participating physicians who retire or leave the AHSC for other reasons for the purpose of recruiting replacements.

The exception would be if a Program was to move to another AHSC in Ontario in which case, and according to Appendix G, the funds would move with the Program.
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 9

If the retiring physician is to leave the province or practice then there should be consideration for the AHSC to use the full financial package attached to the retiring physician for recruitment purposes. If a departing physician is leaving the province then the AHSC should be allowed to use the full financial package of that physician for recruitment purposes.

This option would be valuable where a retiring or departing physician was in a leadership position and the recruited replacement was to assume those leadership duties.

Consideration should be given to the use of these funds for recruitment triggered by retirement, resignation, expansion of existing programs or new programs and other reasons including leave of absence, maternity and paternity leave, and sabbaticals where replacement may be temporarily necessary.

RECOMMENDATION 10

A common template should be adopted by the AHSCs to secure and collate information regarding recruitment taking into account service demand, academic obligations and hospital operating capacity. There should be an impact analysis and tripartite agreement among the University, the Hospital and the local Governing Committee before funds are released for the appointment.

Model Template:

The following table collates and summarizes the information and impact analysis requirements of CHEO, HHSC, SJHC/LHSC, Ottawa Hospital, SEAMO, St. Michael’s, and Sunnybrook. It can serve as the model of a template for required information that will enable access to the Recruitment portion of New Investment Fund. Exceptions based on how the medical schools and teaching hospitals define their need for new complement could be accommodated and should include consideration for part-time and for primarily clinical support faculty.

1. Position Profile

- Department and Division of position
- Replacement/ New Position
- Date of Appointment
- Specialty/ Sub Specialty
- Medical Staff Status (full-time/part-time, active/courtesy, provisional)
- University Rank (lecturer, assistant/associate/full professor or adjunct)
- Relationship to University (GFT, part-time)
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 10 (cont’d)

2. Justification for Recruitment
   - Fit with Strategic Objectives for teaching, research and/or clinical service
   - Fit with Department and Hospital Staffing Plan
   - Need – teaching, research, clinical, administrative

3. Practice Profile
   - Nature of Contribution and Percent of Time devoted to
     a) Teaching (clinical, didactic, undergraduate, post graduate, CME)
     b) Research (basic, clinical, applied)
     c) Clinical Service
     d) Administration (clinical, academic)
   - Nature of Practice
     a) Clinical Focus
     b) Type of Procedures
     c) Type of Treatments
   - Estimation of Clinical Volumes – patient volumes, admissions, outpatient visits, number of beds, number of patient days, OR time, etc.

4. Funding of Position (use of outgoing or existing physician with similar profile and clinical workload as proxy)
   - Level of Remuneration
   - Availability and Source of Funds for income for practice and research needs including university, hospital, department, practice plan, and OHIP
   - Revenue Generation (generation of offsetting revenues for hospital by physician’s activities)

5. Impact on Hospital Resources (use of outgoing or existing physician with similar profile and clinical workload as proxy)
   - Nursing Services (impact on critical care beds and required monitoring, discharge planning)
   - Allied Health Services (OT, PT, SLP, Social Services, Nutrition) and demands on existing allied services in program area, need for additional services
   - Operating Room/Anesthetic Recovery (required OR time, anesthetic requirements, impact on recovery room, ICU, IV teams, day surgery)
   - New Procedures (requirement for new procedures currently not undertaken)
   - Diagnostic Imaging (MRI, CT, ultrasound, nuclear medicine, angiography)
   - Laboratory Services (biochemistry, hematology, microbiology, pathology, cytology)
   - Pharmaceuticals
   - Inpatient Beds
   - Outpatient Clinic (impact on existing clinics, need for new clinics)
   - Research/Office Space (existing, new, renovated space)
   - Office/Research Support (secretarial/other support, equipment, furniture, supplies)
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 10 (cont’d)

7. Sign Offs

- Chief of Department and/or Division
- Directors of Departments potentially impacted by position
- Candidate

8. Approvals

- Hospital Administrative Committee/ Chief of Staff/ CEO
- Medical Advisory Committee
- Faculty of Health Sciences (Associate Dean (Research), Associate Dean (Academic Affairs), Chair of Department)

RECOMMENDATION 11

Establish an inclusive academic physician definition that would accommodate part-time and, in some instances, primarily clinical support positions where the latter meet some of the accountability requirements at certain centres. The level of support for full-time, part-time and support physician positions will be determined by the application of the FTE definition.

Criteria to aid in the definition of an academic physician can be drawn from the document “Valuing our Future” from the University Of Ottawa Department Of Medicine Task Force. The two objectives of this document were to develop new career path names and career path structures for clinical faculty members and to develop principles of evaluation and recognition of faculty career paths. These criteria and designations could be used for planning purposes and identification of recruits when requests are made for recruitment funds from the New Investment fund.

An alternative definition of an Academic Physician may be drawn from the criteria used to determine eligibility for participation in the next phase of the AFP and access to the New Investment funds (see Recommendation 12 below).
7.0 Academic Physician Human Resources Expert Panel Recommendations (cont’d)

RECOMMENDATION 12

Develop common provincial eligibility criteria for participation in the full AFP. These criteria will be used when considering recruitment and the use of New Investment funds allocated for recruitment.

Currently, eligibility criteria vary among the Phase 1 AFPs and the other full AFPs or APPs. While a common set of eligibility criteria would be desirable it may be difficult to establish such criteria without allowing for some local variability to meet special circumstances. The Expert Panel has asked the Governing Chairs of Phase 1 AFP organizations to provide the criteria for eligibility or participation that they currently use.

Criteria:

1. Has a University appointment at a participating AHSC
2. Has an appointment at an AHSC participating teaching hospital or a participating clinical department of the university.
3. Has a defined relationship with a participating Clinical Department or Division Practice Plan or Divisional Group Practice Plan
4. Provides some In-Scope Clinical Services on a Fee-For-Service basis or is salaried or is approved to receive AFP funding; and signs a Declaration and Consent for the purpose
5. Has agreed to convert a designated portion of Fee-For-Service income for the purposes of the AFP
6. Provides support to the Academic Department or Division by assisting it to meet the agreed accountabilities of the contract, or;
7. Is a member of an alternative payment plan or alternative funding plan that is eligible to receive New Investment funds, has met the participation criteria of the Governing Committee of that AFP and has signed a current “Declaration and Consent”.

RECOMMENDATION 13

Academic Physician recruits will be required to become members of the AFP as a condition to receive New Investment Funds. Funding will cease when that academic physician leaves the AFP. Part-time members will have to join the AFP if they wish to receive recruitment or other AFP related funds.
APPENDIX A

Academic Physician Human Resources Expert Panel Terms of Reference

1. The AHSC AFP Task Force in consultation with the PSC shall appoint the APHREP. Its membership shall consist of (TBD).

2. The AHSC AFP Task Force will establish the work plan, set the priorities and direct the activities of the APHREP.

3. The AHHREP shall cooperate and, where possible, coordinate its work with the Physician Human Resources Committee and other HR initiatives of the PSC and the MOHLTC.

4. The APHREP will be guided in its work by the principles laid out in Appendix G of the 2004 Framework Agreement.

5. The APHREP shall follow a basic work plan focused on the development of a single, integrated human resource plan across the AHSC AFP sites that includes but is not limited to the following areas:

   a. Beginning with existing complement and local physician HR plans, recommend a standard process, approach and methodology for determining the addition of new complement that takes into account service demand, academic obligations and hospital operating capacity.

   b. Advise on a standard method and process to integrate planning activities for academic physician human resources across all AHSC sites
APPENDIX B

Key Considerations Impacting the Future Needs for Academic Physicians:

Factors impacting the future need for academic physicians identified by respondents to the Survey include: demographics - the aging of the population requiring an increase in particular specialties, the aging physician workforce and an overall decrease in the general population; training issues – need to develop academic priorities, increasing enrollments, changes in training requirements, impact of decentralized training, and the relative lack of appeal for an academic career; work life and practice patterns – inequity of income for physicians across AHSC, community hospitals and private practice, across specialties, changing technologies/drugs, need for greater collaboration across hospitals, between physicians and allied health providers, and greater flexibility in fee-for-service conversion.

Scope and Content of a Provincial Academic Physician Human Resource Strategy: Suggestions from Survey respondents included clarity in roles, terms and definitions; a provincial body that has responsibility for making recommendations on academic physician human resource issues (specialty shortages, training pressures, income inequity, impact of changing technology); the development of a provincial strategic plan and a provincial human resource plan for AHSCs; the need to link the various accountabilities (physicians, Alternate Funding Plans, hospitals and universities); and greater coordination, flexibility, fairness, and transparency in the process. Many expressed concern about the size of the task and the need to maintain flexibility across AHSCs to meet future changes.

Suggestions include:

Role: a determination of the role of AHSCs in teaching, the creation of new knowledge, and the provision of tertiary/ quaternary care; the determination of the critical mass of academic physicians and the types of patients and volumes required to support them.

Definitions: the need for the development of common definitions for commonly-used terms to ensure comparability, e.g., AHSC, academic physician, full-time-equivalence, full-time/part-time, determination of teaching/research/clinical output.

Strategic plan: a determination of provincial and regional health care needs now and in the near future, the physician human resource required, and the way in which each AHSCs can prepare future physicians to meet those needs – in other words, a provincial AHSC strategic plan.

Planning Body: a provincial academic physician human resource plan should be formulated by a provincial body with representation from the stakeholders and principals including the OMA, MOHLTC, hospitals and universities.
APPENDIX B (cont’d)

Provincial physician human resource plan: The need for each AHSC to produce a human resource plan and an aggregation of these plans to produce a provincial plan. This exercise will identify the “hot spots” in terms of recruitment and retention needs, and assist in targeting funds appropriately to address them. (NB: However, some respondents doubted the ability to produce a meaningful provincial HR plan. Even with the recognition of specialties in shortage, hospitals will differ in the type of subspecialty needed (e.g. cardiac anesthesia), and the teaching, research and clinical care profile needed for the position. Some felt that HR planning is too complex, with the assumptions too numerous and largely undeterminable to produce a valid plan. Others held the view that HR planning is only meaningful at the local level and must be done “at the rock face.” While others believed that academic physician human resource planning cannot be divorced from physicians human resource planning.)

Goals of a Provincial Academic Physician Human Resource Planning Body

Identification of Shortages: the development for proposals for addressing immediate shortages, e.g., providing greater incentives for physicians in short supply throughout their career span; training more International Medical Graduates; using existing resources from vacant physician positions to fund alternate providers, and using them more effectively (team approach).

Technology: The anticipation and planning for the impact of changing technology on practice and the diminishing or increasing need for particular specialists (e.g. cardiac surgery)

Income issues: addressing income disparity between teaching and community hospitals and across teaching hospitals, and between fee-for-service and AFP physicians; exploration of the feasibility of putting academic physicians on salary so that income generation does not get in the way of teaching and research

Coordination: the need for more coordination and the determination of system-wide impacts of Ministry priorities, new programs, and decisions.

Accountability: the need to link physician, AFP and hospital accountability agreements to provide clarity in what is required, who is accountable, and the collaboration necessary.

Flexibility: if a provincial human resource plan is developed, it should allow sufficient flexibility for AHSCs, hospitals, and practice plans to shape their own processes and futures.

Fairness: ensuring transparency and fairness in AFP process of allocating dollars.