OMA Ontario Medical Association

General Assembly Prioritization 2022 Cycle

Shortlist Idea review and summary

Governance, May 6, 2022

Member Proposals Preamble

This document is designed to assist Priority and Leadership Group (PLG) delegates by providing a summary of shortlisted ideas for discussion and prioritization at the May 14-15 General Assembly meeting. This document not only outlines the shortlist of ideas for each panel, but includes all member comments as well as the delegate rankings of each idea.

Process
All OMA members were encouraged to submit their ideas throughout February and March 2022. Members submitted their ideas aligned to the OMA's strategic plan, while identifying which of the respective compensation, advocacy or issues and policy panel the idea was most aligned to. A total of 65 ideas were presented to PLG for consideration, including 13 compensation ideas that were deferred from the 2021 ideas intake in consideration of the newly ratified Physician Services Agreement.

Throughout April and early May, PLG delegates were asked to rank these ideas based on cost, feasibility, subset impact, and overall impact on the profession. As of result of this ranking process, the top six ideas have been shortlisted according to panels for discussion at the upcoming meeting.

Shortlisted ideas
Although there are common themes that intersect across panels, including health human resources, virtual care, mental health, unpaid work, and data and practice supports, the nuances of each idea merit its assignment to a specific panel based on the approach and actions suggested in each member proposal. In the past, delegates have elevated ideas to a more strategic level for prioritization based on the proposals presented to them. This has included proposals to merge ideas from those shortlisted. At the current time, no new ideas are brought forth to the PLG meeting out of respect for the submissions and ranking process of members.

(Please note that this document replicates the information available on the IdeaNote platform. Comments are always open and visible on IdeaNote and may have changed since the production of this document. This information is current as of May 6, 2022. For the most current information go to the IdeaNote platform).

Contents

Compensation Prioritization

1. Restructure negotiations to optimize constituency groups involvement

Idea Submitted by: David Schieck

Idea Outline:
Restructure negotiations so that constituency groups are more directly involved in those aspects of negotiations that affect those particular constituency groups.

Idea:
The current OMA approach to negotiations involves constituting a Negotiations Task Force (NTF) that is made up of five physicians from across the spectrum of consultant and family medicine specialists. The NTF consults with specific areas of specialty as needed over the course of negotiations and takes that input and feedback into consideration as it engages with the MOH over the course of negotiations. This approach often results in various constituency groups feeling that they have not had the opportunity to be appropriately and adequately engaged in negotiations that directly impact on their specific membership.

A different approach to negotiations might involve a small group of physician leaders from a particular constituency group being brought directly in to participate with the NTF in those aspects of negotiations that specifically relate to their area of focus. There are different approaches to negotiations in other provinces that might give some direction to how specific groups of physicians might be more directly involved in those aspects of negotiations that affect them.

Desired outcome:
The desired outcome would be that specific physician groups would be more directly involved in those aspects of negotiations that affect them.

Which of the OMA Strategic Outcomes does this most address?
The OMA strives to have the best governance structure and processes in place, with a lens of diversity and inclusiveness, that work together in a way that best represents members and delivers on the mandate of the organization. Management takes responsibility and is accountable for guiding and supporting Board, General Assembly and the Constituency groups.

Physician Impact:
Medical student, resident, early career, established, late career

Groups Affected:
Patient impact, population impact, regional impact, rural regional impact, Northern regional impact, urban/inner-city

Please select the panel most related to this idea:
Compensation

Role:
OMA Negotiations, OMA EPR, OMA constituency groups (ie. Sections, MIGs, ect.)

Resources:
Increased physician leaders directly involved in negotiations will result in some increase in costs to fund the time and commitment for those additional physicians. More robust selection process to determine the expanded members participating in negotiations.

Risk:
N/A

Has this work been done before? Or being addressed by others?
Not aware of this approach currently being considered within OMA.

OMA Added: Other Comments:
When required, the Negotiations Committee does involve relevant physician groups on specific topics. This includes involvement of section representatives in discussions with the ministry or the arbitration panel. Opening up negotiations discussions to larger group risks confidential information being leaked.

OMA Added: Has this been done before?
Yes, approach to negotiations including consultation strategy and mandate development is approved by the Board.

Member comments on idea:

Sharadindu Rai
It would be easier for OMA Sections to be involved if the OMA NTF would release Section Chairs from non-disclosure agreements that prohibit discussion with others. Or perhaps OMA legal could facilitate NDA's with Section Executive that facilitate these discussions with the Chair and the NTF. This would have the effect of providing more fulsome and timely feedback to NTF. I note the following from the fall 2016 minutes of OMA Council:

"4.3 Motion #3

Moved by Dr. Virginia Walley and seconded by Dr. Gail Beck,

BE IT RESOLVED THAT in all future negotiations between the Association and the Ministry every OMA Section Chair should be kept fully apprised throughout the negotiations of the ongoing discussions including the issues, the proposed terms and the status and that each should be given timely and meaningful opportunities to provide input on such issues and terms as the discussions evolve, and again before the Association agrees to a form of Agreement.

CARRIED

The Chair gave members a reasonable period of time, approximately 30 minutes, to vote. At the end of that time, after hearing no objection, he declared the poll closed."

Rohit Kumar
I understand the risk of confidentiality. Do the different sections feel adequately proactively consulted before or during negotiations so that their context is felt to be represented? Most of the distribution comes during the implementation phase.

Joy Hataley
Would take some vigor but could be a much more effective way of negotiating for ourselves and our patients with The Ministry.

Alykhan Abdulla
We spend time and energy with each section to bring ideas forward to NTF specific to each section's needs which is traditional (and leads to ongoing concerns of transparency and true motivation of NTF to represent each section's needs). What if? What if we allowed the NTF to continue it's work but allow 1 representative from each section to participate in negotiations DIRECTLY related to their interests. So there is a consistent NTF and a "limited" member related to items pertaining to their section. That is the future of value based negotiations.

Robert Dinniwell
Agree with the intent of this proposal. The NDA process and section chair updates have worked well. Briefing and engaging the section chair leadership when specialty specific interests are being discussed would likely be appreciated by members and demonstrate that individual section interests have been brought to the negotiation table. The coordination and logistics of this would need to be understood as it may impact on the structure/process of negotiations.

Member Ranking:
Subset of impact 4.15/5
Cost 3.9/5
Overall Impact 4.08/5
Feasibility: 3.93/5
Average of 4.01 in 158 ratings

2. EMR providers provide all EMR custom forms

Idea Submitted by: Cathy Mastrogiacomo

Idea Outline:
OMA to advocate that EMR providers create and upload (for free) all necessary EMR custom forms physicians need to provide care to their patients.

Idea:
As a busy community family physician, I spend a great deal of time searching for updated custom forms for diagnostic tests, diagnostic radiology, and outpatient community and hospital clinics. In this age of everything digital, physicians should not have to print up, fill out, scan in and fax forms in order to get care for their patients. These custom forms should all be available and uploaded (for free) to our EMRs by the EMR providers. For the amount of money we all pay to these powerful EMR providers, physicians should have this work completed for them for free. And yet, there is a huge gap in what is available in practice.

Desired outcome
1. Improve ease of referral for patients to diagnostic tests, diagnostic imaging and outpatient and hospital clinics.
2. Decrease valuable admin time for the physician and their staff.
3. Decrease physician burnout.
4. Improve value for money for our rising EMR costs.

Which of the OMA Strategic Outcomes does this most address?
Improve membership engagement by aligning OMA efforts around Negotiations, Advocacy, Practice Support, Advantages & Association Governance with a focus on helping members navigate the healthcare system and support them with their health and wellness.

Physician Impact:
Resident, Early Career, Established, Late Careers

Groups Affected:
Patient impact, Regional impact, Urban/inner-city

Please select the panel most related to this idea:
Compensation

Role: Idea Lead

Resources
This would require IT support from EMR vendors and the hospital sector to prepare all of their custom forms. EMRs have the budget to work on this from all the fees we pay them. The OMA would lead and ensure this important work is completed for the benefit of its physicians.

Risk:
No risk. Just time, money and collaboration.

Has this work been done before? Or being addressed by others?

Some EMR providers will say they have many custom forms already available. What is available in reality is lacking and needs improvement, especially from the hospital sector.

OMA Added: Other Comments:

OMA Added: Has this been done before?

Member comments on idea:

Alykhan Abdulla
Excellent idea Dr. Mastrogiacomo!
EMR's were supposed to make physician's lives easier by speeding up interactions but we struggle with LU codes, inability to email prescriptions to pharmacies, no central intake for patient care, multiple "individualized" forms to fill out, non connectivity between WSIB requests, insurance companies' requests, provincial forms for exceptional use or disability tax credits or hearing aid coverage. Why are there so many EMR providers? Why are we having to pay out of our pocket for EMR services that is critical to patient care? Why are certain regions struggling with hospital downloads (like EPIC in Ottawa)?

Diana Kljenak
Agree and would add that the OMA and the government should work to have one EMR system for the entire province. Even though this would be costly (the government should bear the cost) it would greatly improve the system. I would go even a step further and advocate one EMR system for Canada.

Karima Khamisa
How can we leverage Ontario MD to research and institute a plan ?

Sharadindu Rai
Great idea Dr. Mastrogiacomo! We should also point out that Ontario's OHTs need a common EMR for the optimal provision of patient care, and that the government of Ontario should be providing the appropriate logistical and funding supports to make this happen. Far beyond our ask for the free upload of forms, why not ask the government of Ontario to provide the proper funding supports for EMRs that enhance patient care? Why is this responsibility downloaded onto Ontario's already over-burdened physicians without appropriate fiscal and logistical supports? It's high time these issues were addressed.

Christine E Seidler
Completely agree!! The government should be funding and supporting one EMR for all doctors!

Theodore Wallace Mitchell
Really like this. Requisitions, and referral forms(!) should never be punitive administrative burdens. But there is room to individualize a form to specific locations which could bold/grey out tests that are/aren't available.

Julie Anne Josephine Kovacs

Wonderful idea! Administrative tasks are extremely arduous on physicians who are already stressed and overworked with a high burnout rate. Burnout is pervasive in the profession and administrative tasks are one of the top reasons cited by physicians. Physicians are busy and pay high premiums for their EMR's! The onus should not be on health care providers to ensure they have the correct upgraded digital forms, it should instead be on innovation and EMR technology to develop and implement the necessary tools and infrastructure. EMR vendors should be tasked with implementing the tools designed to assist and optimize the physician's digital experience. Strategies to cut down on the administrative burden to physicians should be encouraged.

Dannica Switzer
Build this into the province wide EMR viewer. We all need the same info, let's make it the same system.

Akram Arab
Great idea. I second that OMD can mandate the creation of forms for these purposes in order for the EMRs to receive the OMD certification/designation.

Matthew J Schurter
Great concept and likely more cost effective than each clinic paying someone to do this themselves...however, the (for free) is not realistic in my opinion. The bill always comes, EMRs aren't going to do it for free.

Christine E Seidler
Great idea! And let's go a step further, and simplify for everyone. Rather than every hospital having different forms - get them to work together and standardize them - so there's only one form for the entire province.

Albert Ng
Need to find a set of standardized custom forms that are acceptable across various agencies/providers. The concern is that there could be thousands of custom forms from various stakeholders/providers that would make it impossible to use efficiently

Joy Hataley
Agree this would be a time saver!

Neil Isaac
I think a centralized, generic form may be easier. Or perhaps an online tool like Oceans.

Eric Goldszmidt
Suggest combining all EMR suggestions into one idea for PLG to consider

Elisheva H Chernick
One EMR for the Province.

Angela Laughton
Rather than EMRs having to make an infinite number of forms there should be a single common form for each type of test that all labs/providers/hospitals should use - there is no need for every

diagnostic imaging place to have their own forms! OMA should also be advocating for LESS use of separate custom forms for referrals rather than more that we need to use.

Member Ranking:
Subset of impact 4.24/5
Cost 3.98/5
Overall Impact 4.11/5
Feasibility: 3.71/5
Average of 4.01 in 180 ratings

3. Bolster team-based mental health resources

Idea Submitted by: Angela O Ho

Idea Outline:
Ontario needs to bolster mental health resources, namely team-based co-located care with psychiatrists, Family MDs, social workers.

Idea:
Idea: Poor support for mental health impacts physical health and health system usage (more money managing outcomes when money should be spent upfront to prevent outcomes).

- i.e., disrupted attachment style contributes to no shows and unnecessary ER visits
- i.e., poor coping leading to self harm, swallowing dangerous materials — require ER, internal medicine, ICU, surgery, dermatology
- i.e., intergenerational trauma requiring extensive resources to treat network of impacted persons; similar to family supports of persons with psychiatric illness who also become traumatized or burned out by impact of mental illness (e.g., psychosis, substance use, spending and indiscretions while manic).

Desired outcome:
More robust team based community care with appropriate infrastructures (physical co-location, multi disciplinary, funding model to facilitate work such as home outreach, advocacy, care coordination)

Which of the OMA Strategic Outcomes does this most address?
The OMA drives provincial policy as a leader in advocacy, policy and thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical student, resident, early career, established career, late career, retired

Groups Affected:
Patient impact, population impact, rural regional impact, northern regional impact, urban/inner impact

Please select the panel most related to this idea:
Compensation Panel
Role:
The OMA would need to work with other stakeholders to develop these models of interdisciplinary care.

Resources:
The OMA would need to work with other stakeholders to develop these models of interdisciplinary care.

Risk:
Political, economical

Has this work been done before? Or being addressed by others?

OMA Added: Other Comments:
To minimize any disruption, co-location should be clearly defined to include innovative models of collaboration (e.g., virtual connectivity) and not be exclusive to physical co-location (although physical co-location may be advantageous in certain situations).

Ontario Health Teams are aiming to foster connectivity between primary care and mental health/addiction service providers.

OMA Added: Has this been done before?
Yes, the OMA has called for the embedding of mental health resources within primary care in our recent paper: Responding to a Mental Health and Addiction Tsunami.

We have also been involved in ongoing discussions regarding priority alignment with the Primary Care Collaborative, who are involved in ongoing advocacy for stronger cross-sectoral integration between primary care and community based mental health and addiction services.

Member comments on idea:

Joy Hataley
A very good idea and should be developed through OHTs. As team based care is gaining uptake and momentum, this is likely where we will end up in the next decade. OMA should intentionally advocate for this

Christine E Seidler
This already exists in some family medicine group practices, where a psychiatrist works on site a day or two a week. These group practices already have counsellors onsite as well. I'm not sure what limits more group practices from having psychiatrists work with them ... perhaps this needs to be studied if it hasn't already. Is it a funding issue?? Lack of psychiatrists? Lack of space in group practices?? Also would ideally have a compensation mechanism for consultations between family docs and psychiatrists .... though not necessarily needed if capitated practice.

Diana Kljenak
It is possible that this is a funding issue - psychiatrists may assume (?correctly) that they would be asked to pay a high overhead cost.

Akram Arab
Look at integrating this work into established OHTs

Sharadindu Rai
Agree with the above comments: this is another area in which we need to work closely with Ontario Health.

Sarangan Uthayalingam
The impact of social media has also increased the volume of paediatric mental health concerns. This has been amplified with the effects of the pandemic. The void on Pediatric Mental health expertise, guidelines and resources is evident in every region of Ontario. This needs to be addressed ranging from addressing the gaps in Pediatric residency mental health training to lack of community supports focused in wrap around therapy and trauma based therapy, community hospital ED and school

mental health services and regionally focused spoke and hub model of pediatric mental health care (ranging from guidelines, education and patient flow).

James Whyte
Continuing to utilize, integrate and partner with Family Physicians who have existing focused practices in psychotherapy and primary care mental health (preserving the focused practice role, recruiting additional physicians to this role, and connecting these practices to these larger teams)

Lysa Lomax
This idea is key. I am not a psychiatrist, but I recognize an undercurrent of mental health issues that exacerbate medical conditions in almost every patient I manage. Psychiatry and access to counsellors and CBT etc. are vital to improving physical and mental health in our population.

Larry Erlick
community based care is more important, not just ALC

Shehnaz Pabani
Team based care for all models of care

Alykhan Abdulla
This requires a BIG INVESTMENT

Alykhan Abdulla
Psychiatry should be provided sessional payments (and trained in this model from PGY1 in residency) to work in primary care as a consultant, support person, see patients, provide advice/guidance, and conduct group sessions. Investments in such services will LOWER the overall health care burden. All patients end up with mental health challenges will almost any medical condition. We need to be proactive.

Joy Hataley
Agree, ideally psychiatry is embedded in Family Practice settings to facilitate shared mental health care.

Jill Trinacty
I agree that more support services are required and I see comments about aligning this with family health practices. I agree family practice needs to be better supported but as there are many patients without a family physician, we need these types of programs and services to be available through non traditional referral streams.

Jane Purvis
Tying this into virtual care would be a good idea if having local mental health workers is not feasible

Robert Dinniwell
The timing to bring this idea forward is ideal as the need has been identified by the relevant stakeholders and the demand for services is expected to increase. Pre-pandemic the need to improve the system and expand support was known and building a better system now would help to ensure optimal use of limited resources.

Previous research (Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario - Open Med. 2014; 8(3): e87–e99.
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4242254/) identified issues around access to care and psychiatrist supply by LHIN. Similar work (https://eopa.ca/opa-groups/opa-initiatives/about-us) has also flagged a growing need. It may be useful to revisit this work to have a clearer understanding as to physician (psychiatrist) supply now and going forward so that the near term expansion can be undertaken with a clear understanding of existing capacity and potentially leveraging virtual care if/where needed and longer-term workforce planning engaged to support a sustainable solution.

Heather Noelle Weir
In general, mental health treatment needs to be team based. Treating psychiatric disorders is complex and expensive. Primary Care needs to be involved, but a team needs other professionals as well. Embedding with just primary care is not enough. Social work, community psychiatric nurses and occupational therapy also need to be involved.

Joy Hataley
Agree team based care including Mental Health should be mandated by The Ministry and setup/overseen by OHTs. Should include embedded MHW in all EDs

Jennifer Ingram
At the core of this is the correct premise that 1. Medicine is a team based endeavor, 2. that current funding in health care is very focused on institutional based practice models making community based practice a forgotten cousin. Broaden this to be more inclusive to all community based care and all issues of complexity and chronic illness being funded to co-locate with supports including community service providers and specialists and Primary care into hubs or pods (not unlike a Community Health Centre on steroids.

Theodore Wallace Mitchell
I'm probably not alone in primary care not knowing how psychiatric services work or how to access them appropriately, especially across arbitrary geographic borders. That seems intentional as a way to limit their workload. Teamwork, not only between psychiatry and primary care but within FHTs, is probably as beneficial to provider's mental health as it is to patients.

Maryna Mammoliti
very needed

Member Ranking:
Subset of impact 4.21/5
Cost 3.86/5
Overall Impact 3.79/5
Feasibility: 3.14/5
Average of 3.75 in 171 ratings.

4. Revamp the system for registration of newborn health cards

Idea Submitted by: Jane Healey

Idea Outline:
Revamp the system for registration of newborn health cards to avoid frequent rejections and non-payment of services to OHIP-eligible newborns

Idea:
The current system where a newborn is given a "Pre-Assigned Health Number" (PHAN) requires that multiple steps, out of physicians' control, need to take place for the number to be registered correctly with the Ministry. This includes the parents completing the form, the hospital collecting the form and then sending it to the Ministry. There is an unacceptable number of rejections when this process fails and the number is not formally registered. The only way to be paid for services provided to the newborn is to contact the family and for the family to disclose the new health card number. There are several ways this process fractures on the way. The family often doesn't answer the phone, sometimes there is a language barrier, or the physician doesn't have the correct contact information for them - all they have to go by is the information that is on their demographic page when they registered in the hospital. This creates an unacceptable administrative burden for those who provide episodic care for newborns. Often, a family is never reached and the claims are never paid. In cases where there is a neonatal death, the PHAN often rejects and most pediatricians are unwilling to contact a grieving family and ask them to register their deceased infant with Service Ontario.

Desired outcome:
1. As with other provinces, OHIP-eligible newborns are billed under a parent's health card number for the first 3 months.
2. If above too difficult to implement, there needs to be a reliable and consistent way to flag these VH9 rejected claims for manual review and to be paid without having to contact the family.

Which of the OMA Strategic Outcomes does this most address?
Membership satisfaction continues to increase based on value members receive from the OMA including: engagement in the transformation of the healthcare system; solutions and programs to support physicians with their practice and business to effectively navigate the healthcare system; and support with their personal health and wellness.

Physician Impact:
Early career, established career, late career

Groups Affected:
Patient impact, rural regional impact, northern regional impact, urban/inner impact

Please select the panel most related to this idea:
Compensation Panel

Role:
OHIP registration system is purview of MOH, not OMA.

Resources:
The Claims Adjudication Sub-Committee (CASC) is aware of this issue and it is part of their workplan.

Risk:
Political, economical, legal

Has this work been done before? Or being addressed by others?

OMA Added: Other Comments:
This issue has been on the OMA's radar since 2019. The issue was raised at PSC and was directed to the CASC. CASC discussed the matter in June 2021 with staff from the Ministry's OHIP eligibility staff and it was part of the Claims Adjudication Sub-Committee (CASC) workplan.

In August 2021 changes were made to the PAHN registration process:

• Prior to August 30, 2021, Infant Registration forms with incomplete, illegible, or missing addresses/surnames could not be registered if the missing information was not received by ServiceOntario within the 90-day window for PAHN registrations.
• A 2019 Ministry review of the PAHN registration process found that in the 12-month period between December 1, 2018 and November 30, 2019, approximately 99% of PAHNs (134,221 of the 135,720 total births registered using PAHNs) were successfully registered.
• To reduce the ~1% of PAHNs that are not successfully registered, an MOH policy change was implemented on August 30, 2021 to permit registration using approved placeholders in situations where registration forms are incomplete, illegible, or missing addresses/surnames.
• The new policy enables payment of claims while issues around newborn information are clarified.
• The ability to register PAHNs with missing information is expected to result in less claims for newborn/infant services being rejected due to unregistered PAHNs.

OMA Added: Has this been done before?
This issue has been raised on multiple occasions with the Ministry.

Member comments on idea:

Alykhan Abdulla
OHIP needs to ensure a newborn has a health card that is VALID immediately and billable for all services until 1 year old. This is completely inexcusable

Joy Hataley
To generalize the concept, the OMA should set up a system to identify all unpaid physician work in order to ensure physicians are adequately compensated for services.

Albert Ng
Expand to include all patients where there are issues with health cards, not just newborns - eg refugees, out of province issues, etc

Jill Trinacty
OMA has commented that this has been raised with the Ministry but please provide more details on what the response has been, where the issue stands and plans to move forward.

Elisheva Chernick
The MOH seems quite capable of rapidly de-registering OHIP numbers of the deceased with no required input from the deceased or their family, often before those involved in late-in-life care are paid for these services. I have never had these claims honoured by OHIP in spite of vigorously

pursuing and submitting requested documentation (ie Gave anesthetic for "surgery x" on "date y"....pt was alive at the time"). Given this level of capability, it is inexcusable that the MOH cannot perform the same service in reverse for the newly born. It should be automatically triggered by hospital documentation of live birth, and valid for 1 ye

Eric Goldszmidt
Like many issues, this keeps coming up and has been raised many times with MOH yet remains unresolved. What's the path forward when this happens? That is the answer that is needed here.

Member Ranking:
Subset of impact 3.98/5
Cost 3.92/5
Overall Impact 2.91/5
Feasibility: 3.84/5
Average of 3.66 in 172 ratings

5. Find solutions for the locum crisis in Ontario

Idea Submitted by: Cathy Mastrogiacomo

Idea Outline:
OMA to find solutions for the locum crisis in Ontario. It has become increasingly difficult to find locum coverage for our practices when a physician gets sick, needs a maternity/paternity leave, or simply needs a holiday. Our responsibilities to our patients and our practices have become more important than caring for ourselves (our own physical health, mental health and life cycle issues). Physicians should not have to worry about losing their license to practice or losing their income while dealing with a critical life event because they cannot find a locum. Solutions for office coverage need to be found. This is a human rights crisis. It is contributing to physician burnout and to the loss of comprehensive family doctors.

Idea:
Create a task force to address the increasing Locum crisis in Ontario with an aim to finding viable solutions. This could include a collaboration of various stakeholders including the OMA, the CPSO, the Ontario Primary Care Collaborative, a patient advisory group, the ONA (including nurse practitioners), and the Ministry of Health.

Desired outcome:
To find viable solutions so that physicians are able to readily find locums to cover their practices when they are ill, when they have babies, and when they simply need an (extended) holiday.

Which of the OMA Strategic Outcomes does this most address?
Improve membership engagement by aligning OMA efforts around Negotiations, Advocacy, Practice Support, Advantages & Association Governance with a focus on helping members navigate the healthcare system and support them with their health and wellness.

Physician Impact:
Resident, Early Career. Established, Late careers

Groups Affected:
Patient impact, Population impact, Regional impact, Rural regional impact, Northern regional impact, Urban/inner-city

Please select the panel most related to this idea:
Compensation

Role:
Idea Lead. The OMA represents physicians. Who best to advocate and lead this work than our OMA?

Resources:
This would include collaboration among various stakeholders starting from the patient level right up to the CPSO and Ministry of Health.

Risk:
Of course there will be risks with this idea. Risk of not finding a solution. Risk of increased liability from the CPSO perhaps. Risk of legislation changes and those ramifications. But the benefit to physicians--to their physical and mental health--outweighs all of this.

Has this work been done before? Or being addressed by others?
The OMA does have a working group called "Practice Support for Locums" and they have created a resource page on the OMA website, but it did not address the crisis of actually finding a locum. There is a Facebook page that is available for advertising for a locum as well as HealthForce Ontario, but this does not address the crisis that members are still experiencing trying to find adequate locum coverage.

OMA Added: Other Comments:
Healthforce Ontario is responsible for assisting physicians with securing locum coverage. If HFO is not meeting this obligation effectively, or is insufficiently resourced to meet its obligation, it is a matter to be brought to PSC or Negotiations for resolution.

This idea could take resources away from other programs or initiatives; especially if there is no new funding available to implement.
The idea could result in duplication of work of the bilateral PHRWG, and confusing communications and results.

OMA Added: Has this been done before?
The OMA & MOH have committed to a collaborative process for identifying and responding to urgent physician human resources issues in the province, and have established a bilateral Physician Human Resources Working Group of the PSC. Accordingly, there is not a need to establish an additional separate Task Force. The PHRWG's work in the immediate term will be focused on HHR planning for short-term crises, especially ED coverage as the summer approaches. However the WG's next focus will be on developing more enduring solutions to the challenge of securing adequate, qualified locum coverage.

Member comments on idea:

Sharadindu Rai
Thank you Dr. Mastrogiacomo. We should point out that this idea aligns with OMA's five-point plan to have a comprehensive human health resources strategy for Ontario - ensuring an adequate locum coverage strategy is surely part of any effective HHR strategy and serves both the patients of Ontario as well as Ontario's physicians. And as you've pointed out, an effective locum coverage strategy is needed to reduce physician Burnout. We should be cautious that the CPSO does not take this as an opportunity to MANDATE locum coverage by Ontario's physicians - what happens if CPSO decides that every physician should take turns covering the practices of colleagues in their respective communities? Will CPSO start policing physicians who "over-use" locum coverage (imagine what will happen if a patient files a CPSO complaint in this regard)? And who at the OMA is going to ensure that any CPSO policy is fair in this regard? Is there any effective oversight of the CPSO by the OMA? These are all important questions that will need to be addressed in any comprehensive locum coverage strategy.

Shehnaz Pabani
Could other team family physician members in the PEM models cover each other for their colleagues on holidays, like we did in the past in call groups? This is possible with appropriate roster size for each physician and the new requirement (PPSA)for each PEM physicians to be in close proximity(5KM) would make this possible.

Pamela Liao
I would agree. There are some extremely distasteful comments from patients when physicians are away from their practices. This is a challenge in community but also hospital practices where it's even more complex to find coverage due to the need for privileges to be organized. I find the registrar's notice in BC to have a contingency plan for coverage particularly concerning. This absolutely links to the work of the gender pay gap and parental leave benefits.

Alykhan Abdulla
This can be combined with idea from Dr. Habermehl above.

Dannica Switzer
Maybe part of the solution is MOH funded permanent locums who are salaried and 'assigned' to fill in the most urgent gaps. Having other physicians in your group cover for you works only to a point; once your local physician pool shrinks too much you are barely able to cover your own practices and the unattached patients, let alone your colleague's absence. In these situations - critically underserved rural towns - an unexpected absence is impossible.

Denise Wexler
The OMA needs to work to the CPSO to develop reasonable guidelines for practice coverage for all physicians during critical life events when practice cannot be continued for a period of time.

Joy Hataley
HFO already has this objective and service. The care providers to make this functional simply do not exist. We need to transition to comprehensive team based care to allow all team members to practice to the upper limits of their expertise thus reducing the numbers of physicians needed to service the populous. All patients should have access to a team lead by physicians with guaranteed cross coverage of each others practices

Christine E Seidler
Agree we don't have enough doctors. And, agree with comprehensive teams for large communities. But small towns in the north will never have large teams to provide care. And, we will likely always need locums to cover our absences. Not having them just increases burnout for the remaining physician(s) .. if there even is a remaining physician.

Albert Ng
Work this into the broader HHR strategy for Ontario

Elisheva Chernick
As an Anesthesiologist in a small rural hospital, this is critical to our day to day operations. We are too far south, and too close to major centres to benefit from any of the locum programs, but with

less than 3 FTE's, we are having days with no Anesthesia on call coverage for the hospital, and this is expected to worsen in the coming months. Having said this, I fully agree with concerns that more extensive locum programs could actually worsen the situation as people opt for more lucrative locum work with fewer responsibilities to a given institution or practice. I also would not like to see the CPSO involved!! Changes which would be helpful (in the South) are ways to "regionalize" privileges so that it is easy to "borrow a doc" for a day, and mechanisms for smooth rerouting of patients to referal centres when local resources are inadequate.

I recognize that ultimately, the answers lie in human resources which has been well addressed elsewhere, as have issues of physician compensation models which avoid financial penalty to physicians working in smaller centres, but we need locum service access to get us over the hump!

Theodore Wallace Mitchell
I think it's important to note that HFO is way over its head in attempting to fill the locum need, administrate it properly, target the neediest areas, and even know which way is up. For example, the REP asked HFO several years ago, with a couple or reminders, to pass along its data for locum utilization of the RFMLP. We are still waiting!

Member Ranking:
Subset of impact 4.08/5
Cost 3.41/5
Overall Impact 3.82/5
Feasibility: 3.2/5
Average of 3.63 in 160 ratings

6. Compensation for emergent/non-deferrable care to uninsured patients

Idea Submitted by: Angela Marrocco

Idea Outline:
The OMA should prioritize negotiations of compensation for physicians who provide emergent/non-deferrable care to uninsured patients.

Idea:
During the pandemic, a funding stream became available for care provided to uninsured patient. In the Emergency Department it became evident how much care we provide to patients without OHIP coverage. In many cases in the past this care was never remunerated as the patients had no capacity to pay. Other specialties are also likely heavily burdened with this type of work. Examples of care include - resuscitation from drug overdoses, psychiatric assessment, Form 1, admission, newborn resuscitation (previous idea brought to this group), complicated infectious disease presentations in patients who often leave against medical advice, medical care provided to patients without stable housing and primary care.
Patients who require this care fall into several categories:
1. Those who are clearly entitled to OHIP (often they have ODSB and other supports, they definitely live in Ontario, but they are not able to keep their OHIP cards current for social, personal, substance-use or psychiatric reasons.
2. Those who need care but would not be able to afford to pay - for example refugees whose IFH is not current or has expired.
3. Visitors with either money or insurance who are capable of paying privately for emergency and hospital care.

The OMA should use the data from the last 2 years, to cost out uninsured care and make extension of this program a top priority for negotiations going forward.

The first group -- need to be insured and physicians should be easily able to bill for these visits (mechanism to be determined).

The third group - does not need to be included - and hospitals and physicians should go back to collecting money and insurance information.

Desired outcome:
That specialties such as Emergency medicine, paediatrics, psychiatry and general internal medicine who are heavily burdened caring for uninsured patients, as well as all other specialties who provide emergent/necessary care for those who are uninsured, have a mechanism to receive remuneration for this important work -- especially for the group of patients who are OHIP eligible, but simply are not able to keep their OHIP cards current, due to medical/social reasons.

Which of the OMA Strategic Outcomes does this most address?
The 2021 agreement is in place with an implementation plan that includes member education, and OMA has a plan to address relativity.

Physician Impact:
Early career, established, late career

Groups Affected:
Patient impact, population impact, regional impact, urban/inner-city

Please select the panel most related to this idea:
Compensation

Role:
The OMA would need to cost this ask and prioritize it within the NTF.

Resources:
N/A

Risk:
N/A

Has this work been done before? Or being addressed by others?
N/A

OMA Added: Other Comments:
The proposal calls for different payment structures for uninsured patients, those that are entitled to OHIP coverage (but do not have a valid OHIP card) vs those that might not. It is unclear how one could distinguish between the two groups

Risks of patients not entitled to OHIP coverage could be receiving free care in Ontario.

The OMA can advocate to the government to continue fund medically necessary care for uninsured patents, however a decision as to whether to fund such services falls within the purview of the government.

OMA Added: Has this been done before?
Yes, short term program to fund care provided to uninsured patients is currently in place. The OMA is not aware of any plans to cancel this program in the near future.

Member comments on idea:

Jane Healey
Absolutely agree. It is incredibly unfair to burden physicians with the administrative chasing of valid health card numbers when patients present for emergent, non-elective care. In a non-urgent/elective setting, payment can be requested up front if a health card is not valid, however in urgent situations, physicians are legally (and obviously ethically) required to provide care. I understand that healthcard fraud is a concern, but the follow-up of expired/non-valid health cards should fall to the Ministry, not to inidividual physicians. Patients are reluctant to provide personal information over the phone and are not as motivated to renew their health cards when contacted by a physician after the "free" care has been provided.
As a separate, but related issue, emergent care provided by physicians to non-insured, non-OHIP eligible patients should also be funded and not penalize the physician providing this care as they have no choice in declining providing this service and yet take on medico-legal risk. An example of such a population are pregnant patients and their newborns who travel to Canada specifically to deliver their baby to obtain Canadian citizenship. This issue was widespread prior to the pandemic and is beginning to re-establish itself as international travel is becoming more common. I am glad to hear that the OMA is not aware of any Ministry plans to discontinue the current program for

remuneration for services provided to non-insured patients through hospitals, but there should be a long-term plan to address this issue which disproportionately affects lower-earning specialties and thus exacerbates the relativity problem and gender pay gap.

Jane Purvis
excellent idea

Jennifer Ingram
This is again a Band-aid solution for a problem of access to health care which should be addressed through many additional methods 1. develop more Community Health Centres province wide with staffing funded and NPs or GPs on salary Every community should have CHCs with the capacity to address their population need

Theodore Wallace Mitchell
I was unaware there is a program for uninsured patients. Who administrates it and what is the process?

Member Ranking:
Subset of impact 3.95/5
Cost 3.16/5
Overall Impact 3.27/5
Feasibility: 3.2/5
Average of 3.4 out of 176 ratings

Issues and Policy Prioritization

1. Distribution of newly announced residency capacity

Idea Submitted by: Nancy Merrow

Idea Outline:
OMA input to medical schools for the priority distribution of newly announced residency capacity to most needed specialties - Fam Med, ED., Hospitalists (FM AND GIM), Geriatrics and Psychiatry

Idea:
We have a once in a generation expansion of med school seats and residency spots recently announced. Would like to see more enhancements to ROMP, distributed learning placements, scholarships, loan forgiveness programs and return of service agreements to get learners out of the urban centres early and often to promote the lifestyle and professional opportunities available where they are in such need.

Desired outcome:
Population based planning for medical Human Resources leveraging trainee experience to create a win win. Support for burned out preceptors

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical student, resident early career, established, late career

Groups Affected:
Patient impact, population impact, regional impact, rural regional impact, Norther regional impact

Please select the panel most related to this idea:
Issues and Policy

Role:
Host a OMA, HFO, ROMP summit with the med schools before decisions are made about the allocation of residency spots occurs.

Resources:
Don't know

Risk:
Don't know

Has this work been done before? Or being addressed by others?
Don't know

OMA Added: Other Comments:
The Idea seems to be focused on practical relief and incentives to encourage placements in particular areas/programs of need, which is a helpful adjunct to physician resources planning

The allocation of medical education positions across Ontario's six medical schools is negotiated by the Deans/Universities with government. There is very little information known about this process,

and the allocations may actually already have been decided. Although the Universities & government may be receptive to OMA input, it is not likely that decisions already made will be changed because of it.

OMA Added: Has this been done before?
The OMA's Physician Human Resources Committee (OHRC) has reviewed available proposals for medical education expansion (i.e. not all proposals were available to the OMA) and recommends any expansion be developed and implemented according to a comprehensive evidence-based plan that accounts for current and future population health needs in addition to viable future practice opportunities.

The OMA is currently developing a physician supply and demand model which will help identify current supply gaps based on population health needs, and will facilitate scenario analysis to forecast projected future needs. Thus work in support of this idea is already underway.

Member comments on idea:

Alykhan Abdulla
Health Care Human Resources decisions should be co-designed by those with knowledge (PTMA's, Royal College, CCFP) and those with the resources (governments). Then issues of true needs for a population, barriers to practicing in various jurisdictions, and further understanding of EDI, racism, gender pay gaps and Indigenous needs are understood thoughtfully.

Ushma Purohit
It is definitely important to distribute the residency spots based on a model that reflects current supply and demand. In this model, the OHRC should ensure that medical student interest in various specialists is taken into account if we are to avoid the ongoing trend of unmatched medical graduates + unfilled generalist spots. For this reason, working alongside the primary stakeholders - OMA Section of Medical Students and OMA Section of Residents is incredibly important. They should be involved at every step of the planning and decision-making process.

Eric Goldszmidt
Fully support need for more work and data in the area of human resources. Sounds like OMA already working on it. Need to ensure work gets done.

Ali Damji
Should we consider that payment for the specialities in high demand should increase to attract medical students to those fields? It is highly telling that all of those specialties listed are traditionally on the lowest level for compensation when we look at relativity…

Member Ranking:
Subset of impact 3.95/5
Cost 3.79/5
Overall Impact 3.78/5
Feasibility: 3.42/5
Average of 3.74 in 151 ratings

2. Expand eConsult to seamless full virtual or in-person consult when needed

Idea Submitted by: Dannica Switzer

Idea Outline:
Expand eConsult to seamless full virtual or in-person consult when needed

Idea:
eConsult has been a practice changing tool facilitating access to specialists for clinic questions. However, many times the specialist response is that a more in-depth assessment is required and they recommend referral to said speciality. Often said speciality is not readily available in the area, hence why the eConsult was done in the first place. So facilitation of a full virtual or in-person assessment by the eConsult specialist already familiar with the patient/case would be beneficial, and we could call it HereConsult.
OMA could liaise with CFPC, RCPSC and Ontario Health to expand and streamline the current (and clunky) eConsult platform, and allow the transition to full consultation at the request of the primary care referee or specialist. These detailed assessments could be offered via OTN or in-person, as required.

Desired outcome:
Expansion of limited advice online eConsult into full virtual and in-person consults (HereConsult), saving time wasted on a second referral, and improving timely access to specialists for patients.

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical student, resident, early career, established, late career

Groups Affected:
Patient impact, regional impact, rural regional impact, Northern regional impact

Please select the panel most related to this idea:
Issues and Policy

Role:
Idea lead

Resources:
IT development of improved eConsult platform; I have no idea of the cost because this if far outside the scope of a rural GP

Risk:
More efficient healthcare delivery
Has this work been done before? Or being addressed by others?
Not that I know of

OMA Added: Other Comments:
Note that an existing priority for Ontario this year is the seamless integration of eReferral and eConsult pathways, with the immediate priority being to facilitate a referral request being converted

to an eConsult when appropriate. This is opposite to what the writer is asking. The conversion of an eConsult to an in-person/virtual referral still rests with the clinician as they may choose a regional consultant or someone who specializes further in the condition at hand. In addition, not all eReferral specialists are taking on patients. This is something we can bring up to eServices who is charged with this issue overall.

OMA Added: Has this been done before?
Note that an existing priority for Ontario this year is the seamless integration of eReferral and eConsult pathways, with the immediate priority being to facilitate a referral request being converted to an eConsult when appropriate. This is opposite to what the writer is asking. The conversion of an eConsult to an in-person/virtual referral still rests with the clinician as they may choose a regional consultant or someone who specializes further in the condition at hand. In addition, not all eReferral specialists are taking on patients. This is something we can bring up to eService s who is charged with this issue overall.

Member comments on idea:

Karima Khamisa
I am part of a system called Ocean eReferral that apparently does this. Need further training on how to use it but its out there.

Matthew J Schurter
on the topic of administrative burden, typing the patient's HCN and DOB into this system is painful.

Joy Hataley
What a terrific idea! fully support

Jennifer Ingram
Many of my colleagues are using e consults. They are a better tool in my estimation than more funding for phone calls but still the emphasis on the intake of data by others and the veracity of the data accumulated can produce problematic decisions or results. I am therefore pleased to see the consideration of this tool e consults as one of a spectrum of modalities with emphasis on an in-person virtual referral and consultation would empower the requestor provide needed education and guidance useful in the future and create better decisions. I would suggest that this option is a good start but we need a hierarchy or plan that makes it easy to get the quick answer to the easier questions but also allow and predispose us to use a more fulsome contact mechanism for certain issues involving complexity cognition abuse substance abuse. as an example.

Maryna Mammoliti
very detailed and organized

Member Ranking:
Subset of impact 3.87/5
Cost 3.75/5
Overall Impact 3.72/5
Feasibility: 3.48/5
Average of 3.78 in 158 ratings

3. Create access to a central provincial vaccine database

Idea Submitted by: Lisa Marie Habermehl

Idea Outline:
Create access to a central provincial vaccine database

Idea:
Physicians, pharmacies, hospital and public health all give vaccines and all have a different mechanism to document them, sometimes requiring one agency to fax over lists of vaccines they've given to have them transferred by hand into another database.
In the absence of a province wide EMR*, facilitate easy access to a central vaccine database that can be used by existing office and hospital EMRs. It should have no additional login requirements aside from physician's "usual" electronic record keeping and should not be specific to one type of vaccine, like the Covaxon system for covid vaccination.

*I think we likely all agree a province wide EMR would solve significant numbers of problems of intercommunicability.

Desired outcome:
The pandemic has underlined the disjointedness of vaccination records--duplication of work, incomplete patient records and a relative inability to identify those in need of a vaccination have been magnified. Facilitating easy access to a central vaccine database could
1) Improve patient care. A quick electronic window to determine vaccine status when clinically indicated would ensure patients got best care. Imagine how much easier it would be to decide "Does she need a tetanus shot in the ER?" "Is this immunocompromised patient fulling vaccinated against Covid?" "Did this kiddo already get her third Hep B shot?" with a one-click acces point.
2) Reduce redundant administrative work. Reducing phone calls between agencies to try and sort out whether the patient got their flu shot or not would allow efforts to be redirected to clinical care.
3) Central access for information for patients. Patients could do away with the "yellow immunization cards" for good if the portal also included a patient/family facing point of access.

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical Student, Resident, Early Career, Established, Late Careers

Groups Affected:
Patient impact, Population impact, Regional impact, Rural Regional impact, Northern regional impact, Urban/inner-city

Please select the panel most related to this idea:
Issues and Policy

Role:
OPA, PHO, MOH, OMA, SGFP, AFHTO would all have a role to play in this, as would office/hospital EMR IT/vendors

Resources:
It would require IT platform development (that I know nothing about) and may or may not be expandable from Panorama that Public Health Units use. (In the North, public health does much of the childhood vaccination. This may not be the case elsewhere in the province). It would require the usual privacy agreements we're all accustomed to.

Risk:
A complex log in system or stand alone silo, separate from EMR's, will not enhance utility for physicians or patients.

Has this work been done before? Or being addressed by others?

OMA Added: Other Comments:

OMA Added: Has this been done before?
Great issue! This work is currently underway by OntarioMD through the provincially-sponsored, EMR-integrated Digital Health Immunization Repository (DHIR). The DHIR project will provide seamless access from EMRs to patient vaccines (initial scope: required vaccines for school-age children as well as COVID vaccines) without navigating to a portal, re-entering patient details for search, etc.

DHIR was underway prior to the COVID pandemic, and pilot EMR vendors had substantially progressed development work. Certain aspects of DHIR were paused at the onset of the pandemic due to competing demands on Public Health, and so a current provincial priority is to determine when this work with Public Health can resume.

For clarity, the current scope of the DHIR would not address the example herein relating to tetanus shots. Once implemented, DHIR will have a product roadmap which will contemplate expansion to additional vaccines (in addition to school age and COVID) and other new functionality.

Member comments on idea:

Angela O Ho
Yes...would also be helpful to facilitate distribution to other institutions requiring vaccination info eg. schools, hospital occupational health

Julie Anne Josephine Kovacs
Excellent idea! Although health care in Canada is under provincial jurisdiction, I would encourage the development of not a provincial but rather a national immunization registry to better track and make it easier to retrieve immunization records should families move out of province. A national immunization registry may prove more financially efficient and a more effective method than multiple individual provincial programs.

Alykhan Abdulla
support. We should build on the Ontario PANORAMA portal to have a national registry of vaccinations.

https://www.ehealthontario.ca/wps/portal/eHealthPortal/Applications/PanoramaInfo/!ut/p/z1/hc9NC4JAEAbg39LBqzOpiXRbLCT7WCFN20tobKugrqjl30-

RDkbS3GZ4XmYGGETAyviVibjNZBnnfX9l5g0921juLe1IA3uDxD0YtnWmOlKEcAQzRRDYvzybEod624HQ3SU4aYirb0B93RwA-o5J-h3mB8zf4AITuUzGf0iZ6JYAVvMHr3mtPut-nLZt1awVVLDrOlVIKXKu3mWh4K9IKpsWoqmEqogw84rQasjiDYFDcDc!/dz/d5/L2dBISEvZ0FBIS9nQSEh/

Lee Donohue
OMA to supply to PLG the background documentation on work done to date on immunization (and drug) registries DHDR, and DHIR.

OMA to also supply to PLG the proposed timelines for these products and the implementation supports that physicians will have.

With this information PLG members can inform OMA on what else is required.

Jane Healey
Looking forward to learning more about the work already done. Agree that this is a critically important issue and one that should ideally be instituted on a national level.

Joy Hataley
I like this idea. It would save care providers in multiple settings a significant amount of time as well as tightening up the system to increase our capacity to ensure vaccine uptake is maximized

Angela Laughton
I agree that this is a great idea and long overdue like much coordinate information however I think the OMA should spend its limited time/focus/energy/budget mainly on things that primarily help physicians as opposed to using our resources to do the Ministry's job...

Member Ranking:
Subset of impact 3.98/5
Cost 3.64/5
Overall Impact 3.57/5
Feasibility: 3.58/5
Average of 3.69 in 179 ratings

4. Centralized Lab Requisitions for Imaging and Bloodwork

Idea Submitted by: Mariam Hanna

Idea:
Physician's time is increasingly being utilized to fill and find the 'right form' in the patient's 'correct/preferred region'. Even having to upload these forms and automate them into an EMR is a time consuming endeavor and utilizes administrative resources. Those forms go through revisions, and the cycle starts again. Patients can also at times go to the 'wrong lab' and get declined for a test or have inappropriate tests completed as the requisition was 'illegible'.

If we are able to centralize the process of putting in lab orders, and or imaging requests utilizing the patients OHIP#, the patient can then go through the process of booking this at a convenient location to them.

This would save physician/admin time and would improve patient access. It would ensure that the required information is available to complete the test and that the correct investigations are done.

Desired outcome:
Decrease time spent on finding/completing requisitions. Improve access for patients to get tests done at their desired locations.

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Resident, Early Career. Established

Groups Affected:
Patient impact, Population impact

Please select the panel most related to this idea:
Advocacy

Role:
Idea lead

Resources:
Present this as a cost saving measure to improve patient satisfaction and approach industry to collaborate on the creation of a centralized process. Patients will be able to access lab sites that normally may not get utilized perhaps because the physician did not have their site specific requisition.
Risk: N/A

Has this work been done before? Or being addressed by others?
This is an extension of - "Give every patient a team of health-care providers, and link them digitally" - now we can consider linking the process of ordering investigations digitally!

OMA Added: Other Comments:
There has been an historic challenge with getting multiple DI organizations to align to a single DI referral form (e.g., hospitals largely maintain their own forms); this challenge pre-dates electronic forms.

This proposal focuses on centralizing the process to enter orders, without contemplating the mechanisms to align critical stakeholders to a common requisition. Such alignment work – independent of the technology – would be substantial.

OMA Added: Has this been done before?
Ontario Health has extended OLIS (labs) functionality to include electronic ordering (implementation is in very early stages) seamlessly available through a provider's EMR. For labs this is coming.

The Mobile Order and Results Entry (MORE) service is being deployed by OH for limited use at this stage (e.g., COVID test requisitions), with broader functionality expected within the year. Ultimately, MORE is anticipated to support a broad array of lab requisitions.

Electronic DI (imaging) r equisitions are supported through a variety of systems (e.g., Ocean, Novari) and are being extended under the auspices of Ontario's eServices program.

Member comments on idea:

Cathy Mastrogiacomo
This idea can be combined with my idea for all custom forms to be uploaded into our EMRs. Blood requisitions and Imaging forms should be available to all physicians and inputted into our EMRs by the providers to which we pay ++ sums of money.

Alykhan Abdulla
Wasted time and unnecessary burdens associated with various forms for laboratory, diagnostic imaging, referral for specialist consultations and so on needs to stop. One for for each of the above, in each and every EMR, accepted by all facilities, sent electronically (PDF or direct) not by paper fax has to be the future.

https://www.nejm.org/doi/full/10.1056/NEJMp1809698

Jane Purvis
forms committee working on this

Elisheva Chernick
Single EMR for the province.

Member Ranking:
Subset of impact 3.83/5
Cost 3.56/5
Overall Impact 3.72/5
Feasibility: 3.29/5
Average of 3.6 in 162 ratings

5. Address outside usage fees

Idea Submitted by: Nicole Ranger

Idea Outline:
As a rural family physician, I am charged outside usage fees for patients who attend OATC appointments for opioid agonist therapy. I have also noticed that I am being charged for outside use for patients that are being followed up by specialists using virtual platforms.

Idea:
Need to modify reasons family physicians are charged for outside use. Patients with an opioid addiction or patients needing specialized care should not be considered as using an outside service. Family physicians are the individuals providing the bulk of care required by these patients

Desired outcome:
As above - modification of funding stipulations for outside use

Which of the OMA Strategic Outcomes does this most address?
Improve membership engagement by aligning OMA efforts around Negotiations, Advocacy, Practice Support, Advantages & Association Governance with a focus on helping members navigate the healthcare system and support them with their health and wellness.

Physician Impact:
Early Career

Groups Affected:
N/A

Please select the panel most related to this idea:
N/A

Role: N/A

Resources:
N/A

Risk: N/A

Has this work been done before? Or being addressed by others?
N/A

OMA Added: Other Comments:
Changes to access bonus may lead to adjustments of capitation rates.

Services provided by specialists should not impact access bonus. Please submit specific examples of how access bonus is impacted by specialists to negotiations@oma.org

OMA Added: Has this been done before?
Yes, outside use has been brought to OMA's attention in the past. The GP Focus Practice WG has been working on approving GP Focus applications to reduce impact on access

Member comments on idea:

Lisa Nichole Currie
Completely agree. Addition to this, in the northern rural community that I work we aim to keep care close to home and minimize travel especially in the winter months due to poor and unsafe road conditions. Some of the local physicians have their "niche" area to which we can refer to each other (i.e. gyne concerns, endometrial biopsies, IUD insertions, dermoscopy/special excisions, allergy clinic, etc). Family docs in the FHO contract locally will lose $ if they refer their patients to another family doc. Some will intentionally refer their patients out of the district to an urban centre so they don't get charged for outside use. We should continue to aim to provide full-service family medicine when the resources and abilities are available locally.

Alykhan Abdulla
Such services should be out of basket even though the supporting doctor may not be Focused Designation. Otherwise such chicanery will lead to "derostering" patients on OATC. Please flag this for repair.

Eric Goldszmidt
There are a number of submissions related to GP focused practice. They should be combined and brought to PLG together.

Member Ranking:
Subset of impact 3.86/5
Cost 3.49/5
Overall Impact 3.08/5
Feasibility: 3.38/5
Average of 3.45 in 148

6. Growing a Physician Resilience Network

Idea Submitted by: Alykhan Abdullah

Idea Outline:
Growing a Physician Resilience Network

Idea:
Burnout is torrential.
The OMA regularly invests in Physician Health Program (but that tends to be when the situation is dire). The OMA invested in the Burnout Taskforce and its work is done. The OMA invested in Doc to Doc Physician Resilience Facilitator Training (which trained 20 MD experts to be Resilience Trainers in their communities) and its potential has not been realized.

However we are all struggling and burning out. Physicians in Ontario are suffering and there is a simple solution and process to improve their situation.

Why not take the Doc to Doc Physician Resilience Trainees and invest in them to train a new cohort? This would take the group of 20 trained facilitators and turn them into 400 "new" Physician Resilience trainees. This second tier of physician resilience experts would support 400 "physician communities" across Ontario.

This plan uses resources we already have and focus on preventative care. Why wait until doctors are sick or burnt out? Why not create healing communities of care?

I know the OMA cares for its members. In fact that is the raison d'etre of the OMA. And this investment on building out the true vision of a Doc to Doc properly trained Physician Resilience Facilitators (maybe 2000) in each and every community in Ontario will show that the OMA is focused on Membership.

Desired outcome:
Each community has a trained Physician Resilience Facilitator/Champion

Which of the OMA Strategic Outcomes does this most address?
Improve membership engagement by aligning OMA efforts around Negotiations, Advocacy, Practice Support, Advantages & Association Governance with a focus on helping members navigate the healthcare system and support them with their health and wellness.

Physician Impact:
Medical Student, Resident, Early Career, Established, Late Career

Groups Affected:
Patient impact, Population impact, Regional impact, Rural regional impact, Northern regional impact, Urban/inncer-city

Please select the panel most related to this idea:
Issues and Policy

Role:
Builders of OMA Doc to Doc Physician Wellness project

Resources:

Investment of resources on OMA PHP and the OMA Doc to Doc Physician Wellness project co planned with SGFP and OMA Women.

Risk:
Our members will be healthy and less stressed. Happy doctors may have more ideas leading to more work for the OMA.

Has this work been done before? Or being addressed by others?
PHP, OMA Burnout Taskforce and Doc to Doc Wellness Enhanced. The foundational work is done. We just need to scale up.

OMA Added: Other Comments:
We agree with the author that this is a challenge and needs to be addressed.

OMA Added: Has this been done before?
OMA PHP, SGFP and the chair of the OMA burnout task force conducted a pilot of Doc 2 Doc Wellness Enhanced. The program was set up to launch and be scalable, but through the delivery and evaluation the planning committee decided to pause in order to modify the program so that it could be scaled.

The burnout task force is still convening, and is now focusing on the implementation of the recommendations from the white paper.

Member comments on idea:

Diana Kljenak
A physician burnout is a problem that absolutely needs to be addressed. I would add that the primary focus should be on root causes of burnout.
When the focus is on the building of physician resilience it gives a message that physician lack of resilience is the issue.
To give an example in a fictional corporation:
There is an expectation that an employee works overtime and on weekends without any additional compensation and under threat of losing their job if they raise this as an issue.
Eventually the employee will burn out.
It would be very demoralizing and frankly insulting if the corporation sent the employee to a resilience coach.

Sharadindu Rai
Thank you Dr. Abdulla for this excellent idea. In our OMA branch society (the London and District Academy of Medicine) we are working on building a peer-to-peer support network that sounds very much in alignment with what you have proposed. We should make a point of developing partnerships with our branch societies to create similar support networks throughout Ontario. We have already been in touch with the OMA Physician Health Program regarding appropriate educational and logistical supports in this regard, however the PHP's educational program is still under development and logistical supports (e.g. how should the program be structured/implemented, what would the staffing look like, what sort of liability coverage is required) are unavailable. It would be wonderful to have the OMA provide our branch societies the supports that they need to properly address physician Burnout.

Heather Noelle Weir
Heather Weir. This is a very important issue but a difficult one to solve. As a psychiatrist I have many physicians in my practice. There are many factors that lead to burnout but lack of support, devaluation by the MOH and unreasonable expectations of working hours for physicians is a major problem. A troubling trend is mid career physicians needing to reduce or leave their practices. This is a huge waste of talent . Systemic changes in how we practice medicine needs to looked at. Resilience and self care help but are band aid solutions.

Shehnaz Pabani
We are self employed and comparing us with an employee of a company expected to work overtime leading to burnout is not a good analogy. As self employed physicians, we can all control how much we work.(Except in rural remote areas where human health resources are scant) For family physicians, self reflecting on how much we are able to work without impacting our families and well being is doable: limiting roster sizes(the cap at 2400 roster size in PEM models is double what makes sense as far as the ability to provide comprehensive care to such a large roster-especially if the patients are complex) Taking on extra work outside of a comprehensive practice is another activity that can be divulged. Sure, we will earn less but be happier and not burnt out! We also have to learn to say "No"

Alykhan Abdulla
This is one of the best programs developed by multiple stakeholders, with proven evidence, with an eager group of facilitators and easily scaled up. It would be a shame to let this program collect "electronic dust".

Jane Healey
There is good evidence for peer support (i.e. physician to physician interactions). Some hospitals have implemented a Peer Support network via the Physician Staff Association - with training provided by a similar, successful program from the Harvard Medical School. These peer support physicians are volunteering their time to help their colleagues. Support for such programs would be beneficial as part of practical solutions to the physician burnout epidemic.

Matthew J Schurter
Great, forward thinking idea. I'm interested to learn more about what's involved in the resilience training.

Joy Hataley
I like this idea and such a resource would certainly help temporize until the system, which is the driver of burnout, restructures to protect its workforce or implodes and is rebuilt better.

Member Ranking:
Subset of impact 3.61/5
Cost 3.26/5
Overall Impact 3.54/5
Feasibility: 3.24/5
Average of 3.41 in 151 ratings.

Advocacy Prioritization

1. Develop a comprehensive Health Human Resources strategy

Idea Submitted by: Sharadindu Rai

Idea Outline:
The OMA has advocated to the government of Ontario for the development of a comprehensive Human Health Resources strategy, but we need to go one step beyond that: we need to have the OMA actively work with the government of Ontario to properly address this problem (details below).

Idea:
In its 5-point platform, the OMA has enjoined the government of Ontario to develop a comprehensive Human Health Resources Strategy. The reality is that the government of Ontario has had decades to fill this void and has not done so. Accordingly, it behooves the OMA to lead this work in partnership with the government of Ontario.

The lack of a comprehensive HHR strategy has manifested itself in many ideas on this IdeaNote platform alone: the lack of a comprehensive locum strategy, untenable privileging requirements in Northern communities, shortages of Family Physicians in rural communities, lack of healthcare system capacity, lack of comprehensive supports for physicians such as a centralized EMR, as well as the ongoing, and untenable, negation of Ontario's Family Physicians for "outside use." I respectfully submit that these are all symptoms of an underlying disease: lack of proper planning by the government of Ontario itself.

If the government of Ontario cannot, or will not, take the initiative to address these problems then it is time for the OMA to lead that effort in concert with the government of Ontario. This is also a great opportunity for the OMA to build new partnerships with the government of Ontario.

To the extent that the OMA will say that this work is already underway by OMA staff, it is clear that the Physician Leadership in this forum need to be as involved in this process as our hard-working staff to ensure that the changes we're looking for are enacted. Colleagues: It is time for us to be personally involved in enacting the changes that both we, and our patients, need to see in our healthcare system.

Desired outcome:
That the government of Ontario enacts a comprehensive Human Health Resources strategy.

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical Student, Resident, Early Career, Established, Late Careers

Groups Affected:
Patient impact, Population impact, Regional impact, Rural Regional impact, Northern Regional impact, Urban/inner-city.

Please select the panel most related to this idea:
Advocacy

Role:
OMA Advocacy to reach out to key government contacts (e.g. Nadia Surani) to effect a comprehensive HHR strategy.

Resources:
OMA EPR will need to provide the data needed to guide the development of the HHR strategy.

Risk:
There are substantial risks to both our profession as well as the patients of Ontario if we do NOT effect a comprehensive HHR strategy.

Has this work been done before? Or being addressed by others?
N/A

OMA Added: Other Comments:
Other stakeholders would want to be involved since the strategy would not be limited to physicians only.

Would OMA also need to undertake data collection capacity?

OMA Added: Has this been done before?
The Ministry of Health currently has a Capacity Planning and Analytics Department with Health human resources planning in its mandate. So, it is possible this work is already underway by the Ministry.

OMA currently has a Ontario Health Human Resources Committee providing advice on health human resources matters, but they are not officially partnered with the government.

The Policy and Issues Panel currently is looking into health human resources data and may overlap

with this idea,

As mentioned by the member, OMA's Prescription for Ontario contains recommendations for health human resources and physician supply including:

• Creating a detailed analysis, based on high-quality data, that accounts for the types and distribution of doctors to meet population needs
• Establishing a set of best practices around physician supports to help ensure Ontario has the right doctors in the right places at the right times
• Using best evidence regarding forecasted population need, increasing the number of medical student and residency positions
• Supporting students from remote, rural and racialized communities to go to medical school aligned with populations in need
• "Letting doctors be doctors" whereby they spend more time with patients doing the things that only doctors can do and less time on paperwork or other tasks
• Helping doctors trained in other jurisdictions become qualified to practise here
• Investing in more training and educational supports for practising doctors
However, the Prescription does not contain any suggestions of creating a Health Human Resources strategy jointly with the government.

Member comments on idea:

Angela O Ho
I think this speaks to need for more consideration of what attracts/retains individuals to underserved areas. Sign-on bonuses are not enough. Many need personal and professional resources -- how would one raise a family in an underserved or more remote area when one's partner may not be able to get a job there; easy access to childcare, community programs, library etc; lack of easy opportunities for collegial interactions w physicians in same specialty...

Theodore Wallace Mitchell
This idea is excellent. How to implement it? Maybe start by asking what does a new doc want or need to have a fulfilling life and career in an underserviced area. NOSM was created to help fill this need, but has so far failed to recruit to the remote northern communities of greatest need. Why not ask their students and residents why such practice is unappealing, and what they would need to sign on? I suspect it has something to do with backup or lack of same, locum supply, specialist/consult availability, patient transfer barriers, inability to take time off, and inadequate skills for the great responsibility of providing care all on your own. I suspect that not only government and the OMA need to be involved but the CPSO and CFPC need to rewrite their standards of care because urban standards are currently unattainable in these communities. But again, don't ask me, ask the reluctant learners, and the physicians who have left or retired prematurely from these communities.

Angela O Ho
I would like this also to my previous suggestion re needing organized systems of care, with mental health prioritized. Even for OHTs to work well, there needs to be more physical + alternative funding structures to promote community-based, team-based, colocation with multidisciplinary collaboration; alternative funding to allow for all the non-patient facing work and care coordination

Ushma Purohit

This HHR strategy should incorporate a plan for distributing the newly promised medical student and resident spots

Joy Hataley
Would also be helpful to have a synchronous assessment of system capacity (eg OR and Hospital beds resources existing vs required) to address the back log of services

Albert Ng
I think the OMA should develop the plan with the use of some government data and own it rather than sharing with government. Government does not know our work and needs but rather relies on raw numbers - hence the high needs/low needs in a city like Windsor is divided by a single street in the middle of the city

Alykhan Abdulla
HHR is complicated and cannot fall within doctors per population. Each region has its own needs. We need economists and population experts to work directly with OMA (regional directors, community groups, hospitals, and medical leaders in communities) to find what is needed in a particular community. For example, communities with vulnerable populations and low social determinants of health need more doctors for their populations than affluent areas.

Eric Goldszmidt
Suggest combining all HHR submissions for PLG consideration of the issues they raise

Member Ranking:
Subset of impact 4.33/5
Cost 4.2/5
Overall Impact 4.33/5
Feasibility: 3.73/5
Average of 4.14 in 160 ratings

2. Patient coverage and assisting in the locum/HHR shortage

Idea Submitted by: Pamela Liao

Idea Outline:
This idea was raised previously at PLG, and there are 2 ideas raised in this cycle that relate to this - patient coverage and assisting in the locum/HHR shortage.

Idea:
National licensing would allow physicians to provide care to areas in high need, locum coverage, allow for easier transitions for trainees who wish to learn in other provinces (at present, there are significant administrative costs and burden placed on learners for this), and allow for support to patients who are moving within the country while they identify new care providers.

Desired outcome:
Take this proposal to CMA, work with other PTMAs to develop a policy. Ultimately colleges will need to be involved. This is an opportunity for OMA to be a leader in

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical Student, Resident, Early Career, Established, Late Careers

Groups Affected:
Patient impact, Rural Regional impact, Northern regional impact

Please select the panel most related to this idea:
Advocacy

Role:
Collaborator

Resources:
Human resources, staff time to do background research and connect with relevant parties.

Risk:
Detract from other priorities/work.

Has this work been done before? Or being addressed by others?
Raised at PLG previously.

OMA Added: Other Comments:

OMA Added: Has this been done before?

Member comments on idea:

Alykhan Abdulla
support

Andrea Guerin
All the locum asks should be grouped together

Sharadindu Rai
This is a proposal that OMA could raise with CPSO. Properly, the CPSO should be working with other regulatory authorities to enact a national licensure standard.

Joy Hataley
Lawyers have already figured out short term national licensure such that they can work in any province in a temporary position across Canada despite the fact that lawyers are provincially licensed and regulated. We need to understand the legal process by which this was made possible for lawyers to see if it informs the route to a National Locum licensure program for physicians

Member Ranking:
Subset of impact 3.91/5
Cost 3.77/5
Overall Impact 3.72/5
Feasibility: 3/5
Average of 3.6 in 172 ratings

3. 24/7 Physician Crisis Line

Idea Submitted by: Maryna Mammoliti

Idea Outline:
Creation of Physician for Physician Crisis line

Idea:
Creation of physician led crisis line where the phones are answered by fellow physicians to provide support, resources or redirection to the ER as needed.

Physician burnout rate has been at its highest and physicians in crisis need a resource 24/7 they can privately call for even a few minutes of support and validation. I have strongly advocated for a physician led Crisis line that can be accessible 24/7 for Ontario physicians. No one understands the trauma and burnout of medical system like another physician. Many physicians who have urged the existing line supported by non-physicians were more frustrated and turned off and invalidated rather than supported. In the US, a psychiatrist started Physician Support line that is in its second year and highly successful - Ontario physicians deserve the same. If we want to provide support to our colleagues - we need physician for physician Crisis line as this in the USA https://www.physiciansupportline.com/.

Desired outcome:
Increased support for Ontario physicians' mental health and crisis support by fellow physicians.

Which of the OMA Strategic Outcomes does this most address?
The OMA is an agile and resilient organization that has embedded learning and continuous improvement in its process to anticipate and mitigate risk

Physician Impact:
Medical student, resident, early career, established, late career

Groups Affected:
Patient impact, population impact, regional impact, rural regional impact, Norther regional impact, urban/inner-city

Please select the panel most related to this idea:
Advocacy

Role:
Collaborators

Resources:
Funding for training, technology support and retention of physicians who would answer the crisis line for fellow Ontario physicians

Risk:
Legal, medical

Has this work been done before? Or being addressed by others?
yes in the US https://www.physiciansupportline.com/

OMA Added: Other Comments:
The addition of this service can potentially create additional crisis and burnout to physicians and other healthcare providers engaged in this type of service.

OMA Added: Has this been done before?
The PHP operates 8:45-5:00 Monday to Friday
The CMA Wellness Line (in pilot phase) is available to Ontario physicians 24/7

Member comments on idea:

Bryan R A MacLeod
I am complete agreement . physicians commit suicide at rates greatly higher than those of the general public and I would hope they would access such a line. in turn this intervention can only be part of a larger goal to improve MD wellbeing across the board. from the CMA we have received early data from this year's Physician health survey showing substantial increases in burnout, stress, and plans to reduce or leave practice. the OMA PHP despite having great people, currently has a narrow focus and limited resources. it needs to be greatly expanded in its scope and more than just "bolstering our resilience" and funding to fully address the wellness challenges we all face. to the previous posting about accommodating return to work for MDs struggling w/ disability; this is a great example of how OMA's previous focus on addiction and or suicide = health intervention; does not meet the needs of our population as humans, with human challenges... when I was paralyzed and reeling after cauda equina, the PHP had nothing to offer me.. "are you addicted? suicidal? no? do you want to do a talk?"... not enough... Great people but we need MORE PHP...

Alykhan Abdulla
In addition to this crisis line (which may be part of the PHP program), we need to activate the Doc to Doc Wellness program to build resiliency networks throughout Ontario.

Sharadindu Rai
Great idea. I should point out that I was able to successfully pass a motion to this effect at the former OMA Council, it's just a matter of getting OMA PHP to act upon an idea that was passed by a majority of OMA Council years ago:

"2017-11-25/26
Council Meeting

Motion # 20

Moved by Dr. Rai, seconded by Dr. Dalby

“That the OMA create a hotline to support physicians who are experiencing workplace violence.”

Carried

Response from OMA:

PHP will look into this as part of its EAP feasability work, scheduled for later this year. In the meantime, PHP staff are trained to deal with such calls. Assigned to PHP."

Jane Purvis
great idea

Member Ranking:
Subset of impact 3.61/5
Cost 3.29/5
Overall Impact 3.32/5
Feasibility: 3.34/5
Average of 3.39 in 164 rankings

4. To not forget mental health in priorities

Idea Submitted by: Louis Girard

Idea Outline:
To not forget mental health in priorities

Idea:
As the pandemic has greatly affected the mental health of the population, is still greatly affecting and will affect the population, people of ALL AGES, for a long time after hopefully finding « a new normal », I want to remind the OMA of the importance of finding proper funding and of developing more resources to help the population recover mentally from the pandemic. I think that this is one of the priorities In the OMA Prescription For Ontario. But I don't see it mentioned in Friday's OMA email News.

Desired outcome:
To develop more mental health care resources to deal with the significant increase of mental illness in the population, physicians included, caused by the pandemic.

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
N/A

Groups Affected:
N/A

Please select the panel most related to this idea:
N/A

Role: N/A

Resources:
N/A

Risk:
N/A

Has this work been done before? Or being addressed by others?
N/A

OMA Added: Other Comments:
A focus on mental health may detract from other pillars in the Prescription for Ontario.

OMA Added: Has this been done before?
On October 26, 2021, as a result of the largest consultation in the OMA's 140-year history, Ontario's doctors launched Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care. It is a roadmap that leads toward a better health-care system. One of its pillars is to expand mental health

and addiction services in the community.

The Prescription for Ontario offers the following recommendations that are consistent with the member's submission:

• Province-wide standards for equitable, connected, timely and high-quality mental health and addiction services to improve the consistency of care
• Expanding access to mental health and addiction resources in primary care
• Specific mental health supports for front-line health-care providers
• Ensuring that appropriate resources are in place to provide virtual mental health services where clinically appropriate
• Increased funding for community-based mental health and addiction teams where psychiatrists, addiction medicine specialists, family doctors, nurses, psychologists, psychotherapists and social workers work together
• More mental health and substance awareness initiatives in schools and in communities
• Make access to care easier by defining pathways to care, navigation and enable smother transitions with the system
• Build service capacity for young patients moving into the adult system
• Reducing the stigma around mental health and addiction through public education
• More resources to fight the opioid crisis, particularly in northern Ontario where the crisis is having a significant impact and resources are limited
• Increasing the number of supervised consumption sites

We are mobilizing the public and members to urge all political parties to adopt Prescription for Ontario recommendations into their election platforms.

Member comments on idea:

Angela O Ho
This speaks to need for ongoing support for OHIP-covered psychotherapy, with flexibility to use virtual/phone to increase reach geographically.

Renata Villela
I agree with the comment about how this connects with OHIP-covered, physician-delivered psychotherapy and virtual care services. There is momentum to expand on these resources now.
Alykhan Abdulla

Mental health issues are burgeoning and they require considerable time and supports. IF these resources are not invested they will overwhelm all other medical conditions. Invest early.

Theodore Wallace Mitchell
We need much more investment in mental health provision within medicine, but also acknowledge that the recent explosion in mental distress has to do with socioeconomic disruption and societal disintegration, and is well beyond the capacity of health care providers to put bandaids on it.

Maryna Mammoliti
more specific targets

Member Ranking:
Subset of impact 3.62/5
Cost 3.18/5
Overall Impact 3.56/5
Feasibility: 3/5
Average of 3.34 in 156 ratings

5. Influencing change in government policies by building relationships

Idea Submitted by: Alykhan Abdulla

Idea Outline:
Influencing change in government policies by building relationships

Idea:
The OMA has a small MD-MPP coterie. It has its pros and cons. Its intent is to build relationships with MD's and MPP's with each of the 124 MPP ridings and numerous MD's for each riding.

In the past we had Queen's Park Day where MD's came to Queen's Park and networked with various MPP's. It is in abeyance.

But it takes time, talent, energy, organization, and resources.

How successful are we here?

We need regular training, regular touch points, regular support (financially and administratively) to ensure this coterie truly becomes an army of advocates, subject experts and the first phone number on each and every MPP's speed dial list.

The OMA should invest in multiplying this advocacy arm under MRAC by a magnitude between, during and after election years.

Our success is more linked to this work than after the fact lobbying.

Desired outcome:
Each of the 124 MPP ridings have 10 doctors connected the MPP (and candidates in waiting)

Which of the OMA Strategic Outcomes does this most address?
The OMA is a trusted and credible influencer to, and has enhanced credibility with, government and system stakeholders. The OMA drives provincial policy as a leader in advocacy, policy, thought leadership and positions physicians as leaders in healthcare system transformation.

Physician Impact:
Medical student, Resident, Early Career. Established, Late career

Groups Affected:
Patient impact, Population impact, Regional impact, Rural regional impact, Northern regional impact, Urban/inner-city

Please select the panel most related to this idea:
Advocacy

Role:
Extenders of present priorities
Resources:
Double or Triple investments in finding interested MD's, training/mentoring them, building a regular schedule of interfacing with a tracking of interactions software, building networks of influence at all steps and all parties.

Risk:
Lobbying accusation which can be mitigated by being non partisan and focusing on Knowledge Translation

Has this work been done before? Or being addressed by others?
Being done now feebly

OMA Added: Other Comments:
Other ideas focused on advocacy objectives (wait times, mental health resources). This idea relates to building OMA capacity to develop a program to advance any advocacy objective.

OMA Added: Has this been done before?
OMA currently has a Health Care Advocates program with over 3,000 members currently signed up. The program currently offers training sessions, communication through a monthly newsletter and resources such as MPP meeting kits available through OMA.org. At this point, our goal is to identify one key contact per riding to serve as a conduit to local MPPs and candidates. The current focus is promoting Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care.

Member comments on idea:

Rohit Kumar
This is an excellent idea. I would further target this by subdividing the sessions into the different Networks. Two main benefits of this is greater engagement of Networks and an opportunity to have targeted initiatives that are more specific to certain areas of practice.

Sharadindu Rai
Thank you Dr. Abdulla for this excellent idea. In recent months, OMA Healthcare Advocate training sessions have been attended by roughly 20 physicians per session. The roll-out of the OMA 5-point Better Healthcare Platform at MPP offices last fall occurred at a handful of MPP offices in Ontario. There is a very strong need to build a robust Healthcare Advocate network along the lines of what you have described and I look forward to working with yourself and OMA Advocacy in that regard.

Alykhan Abdulla
The SGFP and OCFP is already working on this type of direct outreach. It is time that the OMA started working with eager sections instead of developing their own central approach.

Matthew Schurter
Great idea. Make advocacy more personal.

Joy Hataley
Work could be done through the District chairs with admin support of the District managers. Managers would facilitate by communicating the MPP/MPP candidates and physician advocates to set up meetings, attend meetings and take care of the "niceties" such as coffee and a follow card. We are stumbling in this effort because it lacks admin support

Neil Isaac
Hire a lobbyist

Jennifer Ingram
Access to both the politicians and the bureaucrats is a mysterious pathway or club. This is why the OMA staffers have good access to their necessary counterparts in the Ministries of importance to us. However at the root of this request is, I believe a request for topic specific practitioners to have a way to meet the politicians and bureaucrats in the Lobby of Queens Park as a meet and greet.

I am informed this is available but setting this up requires the help of organizations of respect. Giving the issues a passionate or a human face is what drives politicians to think creatively about policy and what gives them the inner strength to stand up to an entrenched bureaucrat or a party leader who is not listening.

I would suggest four possible meet and greets would be
1. Community Based Health Care for the future - Beyond Bricks and Mortar - to support people at home.
2. Mental Health & Addictions in both the public, our patients and physician colleagues.
3. Aging Impacts on all Health Care : Preparations needed in 1980s now cant wait!
4. Recruitment and Human Resources Planning for communities for Health Care Professionals (EMR /education/ Immigration quotas/ wage parity)

Member Ranking:
Subset of impact 3.26/5
Cost 3.32/5
Overall Impact 3.32/5
Feasibility: 3.21/5
Average of 3.28 in 151 ratings

6. Support physician contracts for Indigenous organizations managing their own physician services

Idea Submitted by: Claudette Chase

Idea Outline:
The OMA work to support attractive md contracts for Indigenous organizations wishing to manage their own physician services.

Idea:
Matawa First Nations approached the OMA for help over 2 years ago as they were expected to hire grads of a family medicine residency program with a return of service. There is still no contract. Pressure needs to be placed on the Ministry to move on this before these much needed doctors move on.

Desired outcome:
A contract that is attractive enough to recruit and retain doctors to work for the Matawa Health Coop within 2 months.

Which of the OMA Strategic Outcomes does this most address?
The OMA strives to have the best governance structure and processes in place, with a lens of diversity and inclusiveness, that work together in a way that best represents members and delivers on the mandate of the organization. Management takes responsibility and is accountable for guiding and supporting Board, General Assembly and the Constituency groups.

Physician Impact:
Resident, Early Career

Groups Affected:
Patient impact, Population impact, Regional impact, Northern regional impact

Please select the panel most related to this idea:
Advocacy

Role:
NOSM has tried to support moving this forward as they recruit residents for a ROS without knowing what that ROS will look like.

Resources:
The negotiators could priories this and get it done in a week.

Risk:
N/A

Has this work been done before? Or being addressed by others?
N/A

OMA Added: Other Comments:
OMA staff has worked with the physician group and the ministry and will continue to assist in developing an APP for Matawa Health Co-Operative. The 2021 Physician Services Agreement includes funding allocation to establish new APPs. It is possible that portion of that funding could be used to fund the APP.

OMA Added: Has this been done before?
In general, OMA assists groups wishing to establish an Alternative Payment Plan that provides government payments for areas not well-funded through Fee-For-Service arrangements. The OMA has worked with the Matawa group in developing a proposal to the ministry and an approval for 2.0FTEs has been granted to provide employment for 2.0 FTE resident physicians graduating from the Northern Ontario School of Medicine in the Remote First Nations Residency Program (RFNRP). Additional work is underway for a permanent APP.

Member comments on idea:

Shehnaz Pabani
Partnering with NOSM which has a 'Social accountability' mandate to pressure the ministry on this important initiative. Recently, the OMA President and CEO visited the Northern Ontario Region, making it one of the most important priority to improve Human health resources in the North, which is short 400 doctors. This initiative will expedite getting physicians to where they are needed the most: Rural Indigenous Communities. In fact this scheme should be expanded to other such rural communities.

Karima Khamisa
Did the OMA assist in creating an APP using a template used by other organizations? OMA Economics does assist groups working on APPs.

Pamela Liao
IPAC - Indigenous Physician Association of Canada could be a helpful ally in this work.

Alykhan Abdulla
Providing guidance and support to aid these vulnerable populations is helpful to the OMA brand.

Elisheva H Chernick
Conceptually important, but far too focused on a single problem in a single area. It seems as if the OMA is already involved in this particular issue.

Member Ranking:
Subset of impact 3.34/5
Cost 3.17/5
Overall Impact 2.8/5
Feasibility: 3.44/5
Average of 3.19 in 163 ratings