

**In the Matter of an Arbitration**

**BETWEEN:**

**ONTARIO MEDICAL ASSOCIATION**

(the “OMA”)

**- AND -**

**MINISTRY OF HEALTH**

(the “MOH”)

(together, “the PARTIES”)

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**BOOK OF DOCUMENTS OF THE  
ONTARIO MEDICAL ASSOCIATION  
VOLUME 8 of 8**

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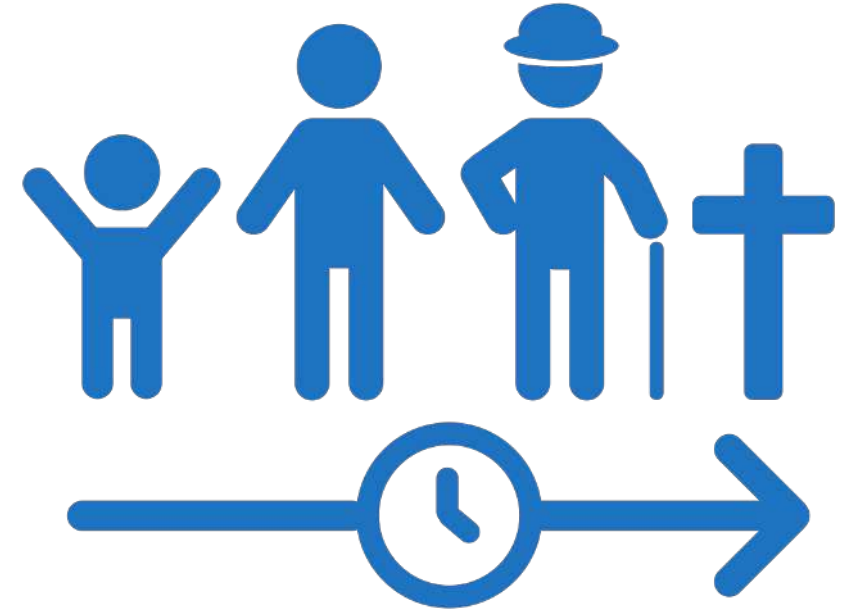
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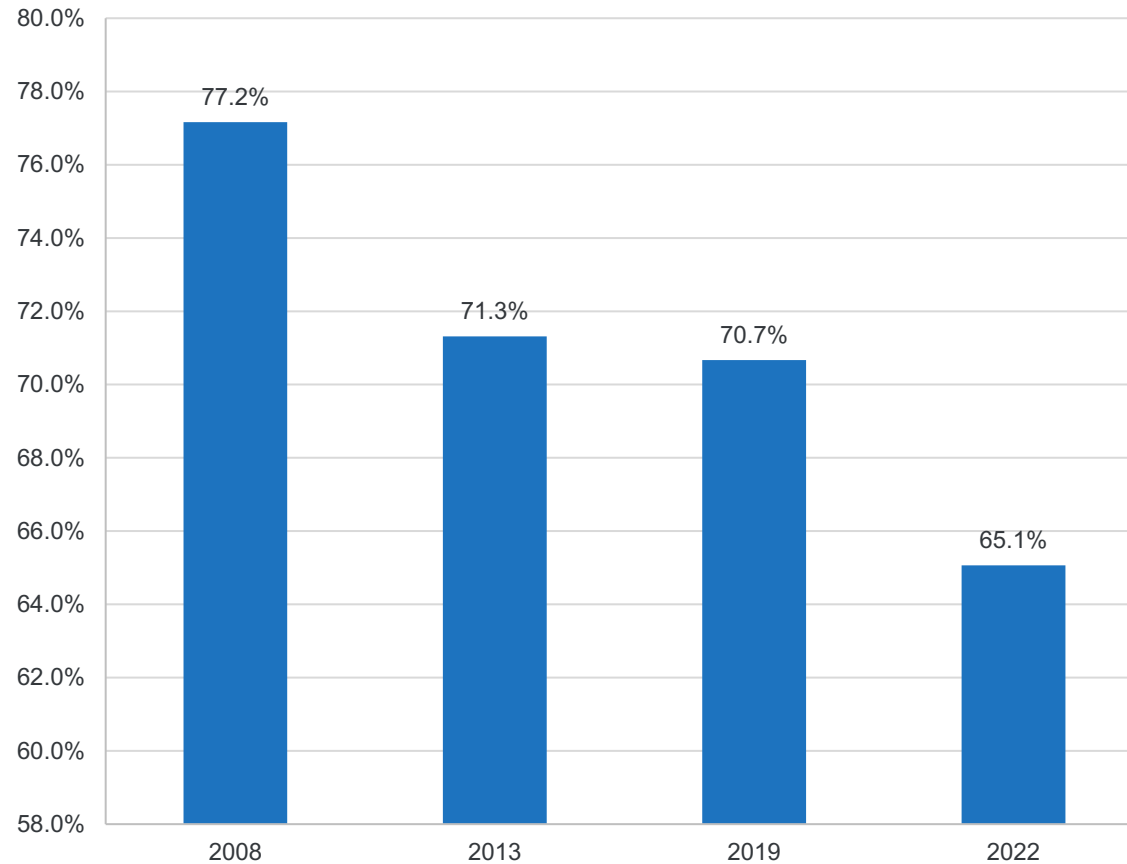
# Family Physician Workforce

- Comprehensive family medicine = family physicians providing “cradle to grave” primary care
- The delivery of a broad range of primary care services to a defined population (“panel”/“roster”) on a continuous basis
  - ✓ Associated with improved health equity, health outcomes, and health system costs
- Distinct from:
  - Episodic primary care (e.g., walk-in clinic)
  - Focused scopes of family physician practice (e.g., sports medicine, ER, hospitalist, etc.)
  - Other primary care practitioners (e.g., primary care NPs, PAs)



# Declining Practice of Comprehensiveness

Proportion of Ontario Family Physicians Practicing Comprehensive Family Medicine Over Time



The shift away from comprehensive FM is occurring across *all* FP ages/career stages.

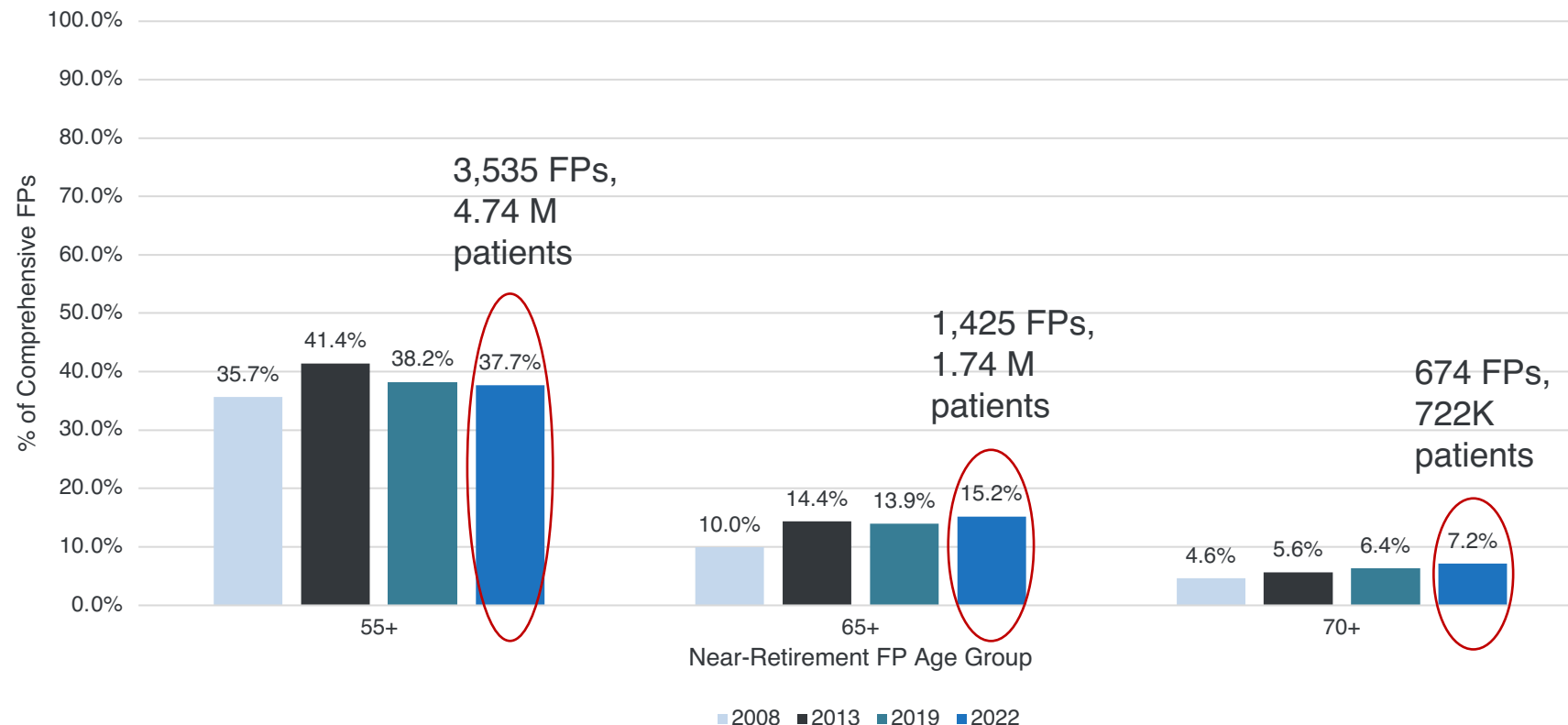
Due to the pandemic and changes in services for in-person visits family physicians were billing for, we note the number of current family doctors practicing family medicine may be a slight underestimation, however, we believe this to be the most accurate number possible. It is clear we are seeing a steady decline in family doctors choosing comprehensive family medicine since 2008.

Source: Premji K, Green ME, Glazier RH, Khan S, Schultz SE, Mathews M, Nastos S, Frymire E, Ryan BL. (2023)



# An Aging Comprehensive FP Workforce Poised to Retire

- 3 near-retirement FP age groups: 55+, 65+, 70+



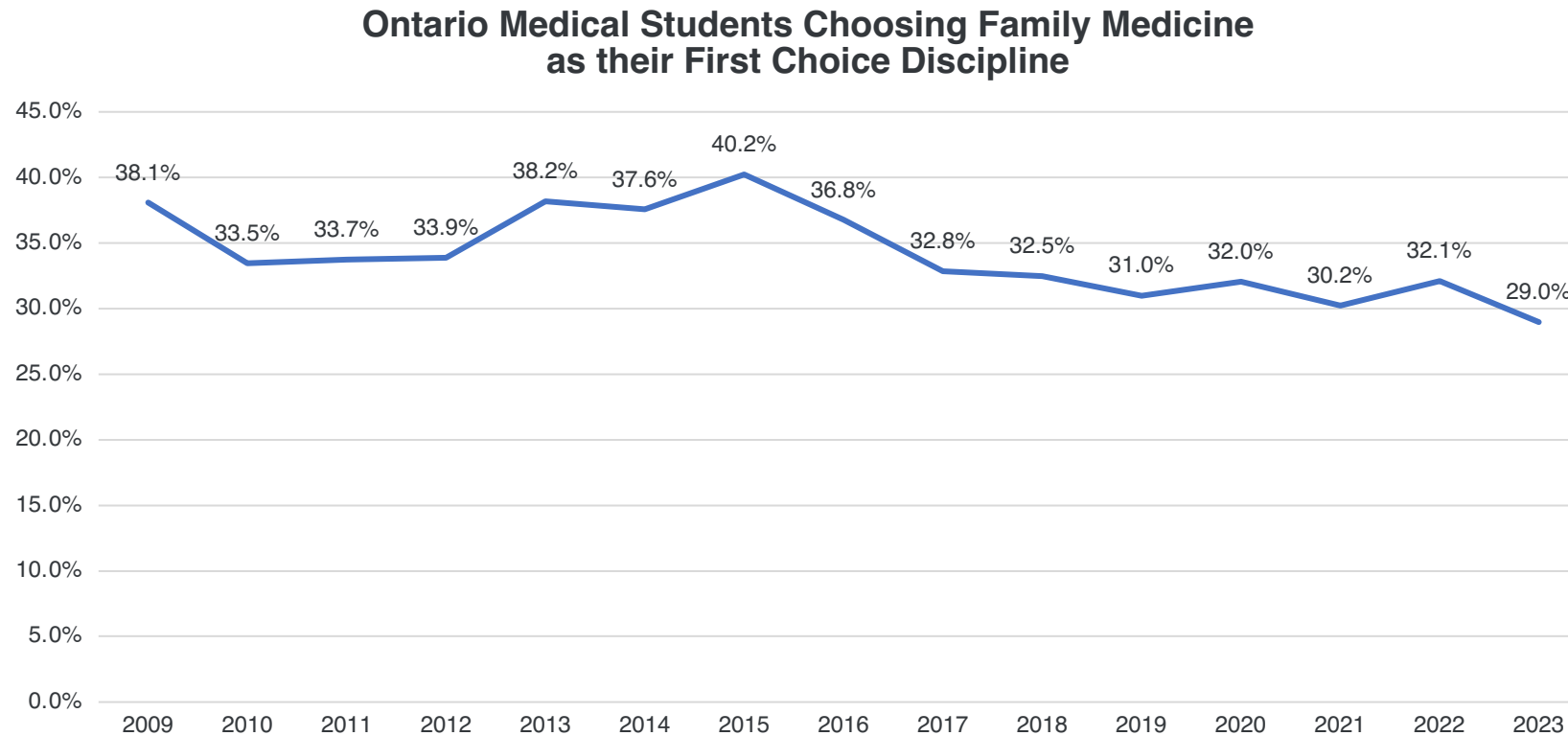
Source: Premji K, Green ME, Glazier RH, Khan S, Schultz SE, Mathews M, Nastos S, Frymire E, Ryan BL. (2023)





# Declining Interest Among Medical School Graduates in Family Medicine

- Lowest in 15 years



Source: CaRMS R-1 Data & Reports (2009-2023)



**TAB 169**

# Contribution of Primary Care to Health Systems and Health

BARBARA STARFIELD, LEIYU SHI,  
and JAMES MACINKO

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Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.

**Key Words:** Primary care, health outcomes, population health.

THE TERM *PRIMARY CARE* IS THOUGHT TO DATE BACK TO ABOUT 1920, when the Dawson Report was released in the United Kingdom. That report, an official “white paper,” mentioned “primary health care centres,” intended to become the hub of regionalized services in that country. Although primary care came to be the cornerstone of the health services system in the United Kingdom as well as in many other countries, no comparable focus developed in the United States. Indeed, the formation of one after another specialty board

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in the early decades of the 20th century signaled the increasing specialization of the U.S. physician workforce (Stevens 1971). The GI Bill of Rights, which supported the further training of physicians returning from service in World War II, helped increase the specialization of many who had been general practitioners (generalists) before the war. At that time, general practitioners were physicians who lacked additional training after graduation from medical school, apart from a short clinical internship.

Concerned that the survival of generalist physicians would be threatened by the disproportionate increase in the supply of specialists in the United States—to the detriment of generalist practice—family physicians, working with international colleagues, established standards for credentialing the new “specialty” of family practice. Thus, in the 1960s and 1970s, longer postgraduate training became part of generalist physicians’ preparation for practice. This recognition of a “specialty” of primary care, which, in the United States, covered general internal medicine as well as general pediatrics, resulted in two reports from the Institute of Medicine (IOM) (Donaldson et al. 1996; IOM 1978). These reports defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” This definition is consistent with at least two international reports (WONCA 1991; World Health Organization 1978) and has been used to measure the four main features of primary care services: first-contact access for each new need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere. Primary care is assessed as “good” according to how well these four features are fulfilled. For some purposes, an orientation toward family and community is included as well (Starfield 1998).

Despite the greater recognition of the importance of primary care to health services systems (World Health Organization 1978, 2003), professionals have recently called for increasing even further the supply of specialist physicians in the United States (Cooper et al. 2002). Compared with other industrialized nations, the United States already has a surplus of specialists, but not of primary care physicians. On the basis of the studies reviewed in this article, we believe that health of the U.S. population will improve if this maldistribution is corrected. Specifically, a greater emphasis on primary care can be expected to lower the costs

of care, improve health through access to more appropriate services, and reduce the inequities in the population's health.

We first review the evidence concerning the relationship between primary care and health, using three different measures of primary care. The effect of health policy on primary care and health can also be determined by between-country comparisons, which we summarize next. We then consider the impact of primary care in reducing disparities in health across population groups. After a section on cost considerations, we discuss why primary care would be expected to have a beneficial effect on health. We then look at the analyses' limitations and discuss the likely nature of primary care in the future in accordance with the policy implications of this evidence.

## Reviewing the Evidence

We used research on the effects of primary care on health from studies of the supply of primary care physicians, studies of people who identified a primary care physician as their regular source of care, and studies linking the receipt of high-quality primary care services with health status. These three lines of evidence represent a progressively stronger demonstration that primary care improves health by showing, first, that health is better in areas with more primary care physicians; second, that people who receive care from primary care physicians are healthier; and, third, that the characteristics of primary care are associated with better health. We used three systematic literature reviews of primary care (Atun 2004; Engstrom, Foldevi, and Borgquist 2001; Health Council of the Netherlands 2004), supplemented by our own compilation of articles in major national and international general medical journals. We concentrated on publications written in English and mainly on studies from the United States (which accounted for most of them). We did, however, include studies from other countries if they addressed primary care, as measured by at least one of the three types of studies. A study's inclusion or exclusion did not depend on its findings. Rather, the only criterion for inclusion was a clear conceptualization of primary care, systematic data collection and analysis, and comparison populations. Several studies in the systematic literature reviews, although uniformly favorable to primary care, did not meet these criteria and therefore were excluded.

## Primary Care and Health

### *Health Outcomes and the Supply of Primary Care Physicians*

As a group, these studies covered a variety of health outcomes: total and cause-specific mortality, low birth weight, and self-reported health. They examined the relationship between the supply of primary care physicians and health at different levels of geographic aggregation (state, county, metropolitan, and nonmetropolitan regions); controlled for various population characteristics (such as income, education, and racial distribution); and used several different analytic approaches (standard regressions, path analyses) in individual years (cross-sectional) as well as over time (longitudinal).

The number of primary care physicians per 10,000 population is the measure of "supply." Primary care physicians include family and general practitioners, general internists, and general pediatricians. These three types of physicians constitute the primary care physician workforce and have been shown to provide the highest levels of primary care characteristics in their practices (Weiner and Starfield 1983).

Studies in the early 1990s (Shi 1992, 1994) showed that those U.S. states with higher ratios of primary care physicians to population had better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health, even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking). Vogel and Ackerman (1998) subsequently showed that the supply of primary care physicians was associated with an increase in life span and with reduced low birth-weight rates.

Other studies added sophistication to these early studies by examining the relationship between primary care and health after considering other potentially confounding characteristics. One of these confounders was income inequality, or the extent to which income is concentrated in certain social groups rather than being equitably distributed. In 1999, Shi and colleagues reported that both primary care and income inequality had a strong and significant influence on life expectancy, total mortality, stroke mortality, and postneonatal mortality at the state level. They also found smoking rates to be related to these outcomes, but the effect

of the primary care physician supply persisted after they controlled for smoking (Shi et al. 1999). A later study confirmed these findings, this time using self-assessed health as the health outcome (Shi and Starfield 2000). These relationships remained significant after controlling for age, sex, race/ethnicity, education, paid work (employment and type of employment), hourly wage, family income, health insurance, physical health (SF-12), and smoking.

Additional studies examined the influence of the supply of primary care physicians at the state level while also taking into account the supply of specialist physicians. These analyses found, in the same year as well as in time-lagged (between 1985 and 1995) analyses, that the supply of primary care physicians was significantly associated with lower all-cause mortality, whereas a greater supply of specialty physicians was associated with higher mortality. When the supply of primary care physicians was disaggregated into family physicians, general internists, and pediatricians, only the supply of family physicians showed a significant relationship to lower mortality (Shi et al. 2003a).

Mortality attributed to cerebrovascular stroke also was found to be influenced by the supply of primary care physicians. Using 11 years of state-level data and adjusting for income inequality, educational level, unemployment, racial/ethnic composition, and percentage of urban residents, the supply of primary care physicians remained significantly associated with reduced mortality and even wiped out the adverse effect of income inequality (Shi et al. 2003b).

Consistent with these findings for total and cause-specific mortality, the reduction in low birth weight at the state level was significantly associated with the supply of primary care physicians in the concurrent year as well as after one-, three-, and five-year lag periods (Shi et al. 2004). A greater supply of primary care physicians was associated with lower infant mortality as well and persisted after controlling for various socioeconomic characteristics and income inequality.

County-level analyses confirmed the positive influence of an adequate supply of primary care physicians by showing that all-cause mortality, heart disease mortality, and cancer mortality were lower where the supply of primary care physicians was greater. When urban areas (counties including a city with at least 50,000 people) and nonurban areas were examined separately (Shi et al. 2005b), nonurban counties with a greater number of primary care physicians experienced 2 percent lower all-cause mortality, 4 percent lower heart disease mortality, and 3 percent lower

cancer mortality than did nonurban counties with a smaller number of primary care physicians. In urban areas, however, the relationship appeared more complex, possibly resulting from the lesser degree of income inequality and the greater racial differences in urban areas. A study of premature mortality (mortality before age 75) in U.S. metropolitan, urban, and rural areas found inconsistent relationships to the supply of primary care physicians, possibly owing to a statistical instability in the way in which the supply of physicians was categorized, which was inappropriate for areas with great variability in both the supply and the population size (Mansfield et al. 1999).

Analyses conducted in counties in the state of Florida used cervical cancer mortality as the health outcome. Controlling for a variety of county-level characteristics (percentage of whites, low educational level, median household income, percentage of married females, and urban/nonurban), each one per 10,000 population increase in the supply of family physicians was associated with a decrease in mortality of 0.65 per 100,000 population. That is, a one-third increase in the supply of family physicians was associated with a 20 percent lower mortality rate from cervical cancer. The positive effect of primary care was also found in the significant relationship between reduced mortality and the supply of general internists, but not the supply of obstetrician-gynecologists (Campbell et al. 2003).

The relationship between primary care physician supply and better health is not limited to studies in the United States. In England, the standardized mortality ratio for all-cause mortality at 15 to 64 years of age is lower in areas with a greater supply of general practitioners. (In England, pediatricians and internists are not considered, and do not function as, primary care physicians.) Each additional general practitioner per 10,000 population (a 15 to 20 percent increase) is associated with about a 6 percent decrease in mortality (Gulliford 2002). A later study (Gulliford et al. 2004) found that the ratio of general practitioners to population was significantly associated with lower all-cause mortality, acute myocardial infarction mortality, avoidable mortality, acute hospital admissions (both chronic and acute), and teenage pregnancies, but the statistical significance disappeared after controlling for socioeconomic deprivation and for partnership size, which the authors interpreted as suggesting that the structural characteristics of primary care practices may have had a greater impact on health outcomes than did the mere presence of primary care physicians.



The supply of general practitioners also has high salience for in-hospital mortality; that is, it is more closely associated with lower in-hospital standardized mortality than is the total number of physicians per 100 hospital beds (Jarman et al. 1999).

In summary, the studies consistently show a relationship between more or better primary care and most of the health outcomes studied. Primary care was associated with improved health outcomes, regardless of the year (1980–1995), after variable lag periods between the assessment of primary care and of health outcomes, level of analysis (state, county, or local area), or type of outcome as measured by all-cause mortality, heart disease mortality, stroke mortality, infant mortality, low birth weight, life expectancy, and self-rated health. All but a few studies found this effect for cancer mortality. The magnitude of improvement associated with an increase of one primary care physician per 10,000 population (a 12.6 percent increase over the current average supply) averaged 5.3 percent. The results of these studies suggest that as many as 127,617 deaths per year in the United States could be averted through such an increase in the number of primary care physicians (Macinko, Starfield, and Shi 2005).

### *Patients' Relationship to Primary Care Facilities and Providers*

Because a greater number of primary care physicians does not necessarily mean that all people in the area have greater access to or receipt of primary care services, analyses considering people's relationships to or experiences with a primary care practitioner are helpful to determining the association between primary care and health outcome. Thus the second line of evidence for the positive impact of primary care on health comes from comparing the health of people who do or do not have a primary care physician as their regular source of care.

A nationally representative survey showed that adult U.S. respondents who reported having a primary care physician rather than a specialist as their regular source of care had lower subsequent five-year mortality rates after controlling for initial differences in health status, demographic characteristics, health insurance status, health perceptions, reported diagnoses, and smoking status (Franks and Fiscella 1998). That is, people who identify a primary care physician as their usual source of

care are healthier, regardless of their initial health or various demographic characteristics.

U.S. populations served by community health centers, which are required to emphasize primary care as a condition for federal funding, are healthier than populations with comparable levels of social deprivation receiving care in other types of physicians' offices or clinics (O'Malley et al. 2005). People receiving care in community health centers receive more of the indicated preventive services than does the general population (Agency for Healthcare Research and Quality 2004). A comparison of rural patients receiving care in these community health centers with patients receiving care in other types of facilities showed that despite being sicker, they are significantly more likely to have received a Pap smear in the previous three years and to have been vaccinated against pneumococcal infection and less likely to have low-birth-weight babies (Regan et al. 2003).

In some health systems, both in the United States and abroad, people normally go to their primary care physician before seeking care elsewhere (such as from another type of physician). Spain passed a law in the mid-1980s that strengthened primary care by reorganizing services to better achieve the main features of primary care, which led to the establishment of a national program of primary health care centers. The impact of this reform on health was evaluated after ten years by examining mortality rates for some major causes of death (Villalbi et al. 1999). Death rates associated with hypertension and stroke fell most in those areas in which the reform was first implemented. There even were fewer deaths from lung cancer in those areas with primary care reform than in other areas. Health outcomes that would not be expected to be influenced by primary care, for example, perinatal mortality, did not differ across the areas.

Outcomes of care after surgery in Canada also were shown to be better when care was sought from a primary care physician who then referred children to specialists for recurrent tonsillitis or otitis media, compared with self-referral to a specialist (Roos 1979). The referred children had fewer postoperative complications, fewer respiratory episodes following surgery, and fewer episodes of otitis media after surgery, thus implying that specialist interventions were more appropriate when patients were referred from primary care.

Finally, we note that Cuba and Costa Rica, which reformed their health systems to provide people with a source of primary care, now have much lower infant mortality rates than do other countries in Latin America. In

Cuba, infant mortality rates now are on a par with those in the United States (PAHO 2005; Riveron Corteguera 2000; Waitzkin et al. 1997).

The findings from studies of the impact of actually receiving care from a primary care source consistently show benefits for a variety of health and health-related outcomes.

### *How Well the Characteristics of Primary Care Are Achieved*

As we noted earlier, until recently primary care could be assessed only by determining the type of physician who provided it: family physicians, general internists, and general pediatricians in the United States; and family physicians or general practitioners in most other industrialized countries. The intensive examination of criteria for the designation of “primary care” in the most recent half century encouraged the development of tools to assess the adequacy of those health delivery characteristics that together define the practice of primary care. This development then enabled us to examine the extent to which the receipt of better primary care is associated with better health.

Using these new methods, several studies have demonstrated a positive association between the adequacy of the features of primary care and the provision of preventive services. A cross-sectional study using a representative sample of 2,889 patients in Ohio evaluated the aforementioned four attributes of primary care for their relationship to the delivery of preventive services. After controlling for the patients’ age, race, health, and insurance in the hierarchical linear regression model (HLM), each of the measured primary care attributes was significantly associated with patients’ being up to date on screening, immunization, and health habit–counseling services (Flocke, Stange, and Zyzanski 1998). According to another study, adolescents with the same regular source of care for preventive and illness care (one indication that the source is focused on providing primary care) were much more likely to receive the indicated preventive care and less likely to seek care in emergency rooms (Ryan et al. 2001).

The positive impact of primary care also was shown by comparing the self-assessed health of those who received better primary care (as assessed by the health delivery characteristics of primary care) with those who reported less adequate primary care. Among those who reported better

primary care, more than 5 percent fewer people reported poor health and 6 percent fewer reported depression than did people experiencing less adequate primary care. Considering only those who reported the *best* primary care experiences, 8 percent fewer reported poor health, and more than 10 percent fewer reported feeling depressed, compared with those who received less adequate primary care (Shi et al. 2002).

Studies in two different areas of Brazil confirmed the relationship between the adequacy of primary care delivery characteristics and self-reported health. In a study in Petropolis, Macinko, Almeida, and Sa (2005) showed that patients who had better primary care experiences were more likely to report better health, even after adjusting for other salient characteristics such as their age, whether or not they had a chronic illness or a recent illness, household wealth, educational level, and the type of facility in which they received their care. Using parents' reports of their children's primary care, Erno Harzheim and colleagues confirmed these findings in a study conducted in Porto Alegre (Harzheim 2005, personal communication).

## International Comparisons

International comparisons extended our examination of the impact of primary care according to the achievement of its characteristics. Studies of the characteristics of different health systems were particularly useful because they enabled us to assess the impact of various policy characteristics on the practice and outcomes of primary care. Three studies, one using data from the mid-1980s and two from a decade later, demonstrated not only that countries with stronger primary care generally had a healthier population but also that certain aspects of policy were important to establishing strong primary care practice.

The first study examined the association of primary care with health outcomes through an international comparison conducted in 11 industrialized countries (Starfield 1991, 1994). Each country's primary care was rated according to the four main characteristics of primary care practice: first-contact care, person-focused care over time, comprehensive care, and coordinated care, as well as family orientation and community orientation. Policy characteristics were the attempts to distribute health services resources equitably (according to the extent of health needs in different areas of the country); universal or near-universal financial coverage

guaranteed by a publicly accountable body (government or government-regulated insurance carriers); low or no copayments for health services; percentage of physicians who were not primary care physicians; and professional earnings of primary care physicians relative to those of other specialists. (Operational definitions of these indicators and the method of scoring them are described in Starfield 1998.) The first important finding is that the score for the practice characteristics was highly correlated with the score for the policy characteristics. That is, the adequate delivery of primary care services was associated with supportive governmental policies. The second finding is that those countries with low primary care scores as a group had poorer health outcomes, most notably for indicators in early childhood, particularly low birth weight and postneonatal mortality.

A more recent comparison, with 13 countries and an expanded set of indicators of both primary care policy characteristics and health outcomes, also showed better health outcomes for the primary care-oriented countries even after controlling for income inequality and smoking rates, most significantly for postneonatal mortality ( $r = .74, p < .001$ ) and rates of low birth weight ( $r = .38, p < .001$ ). Countries with weak primary care also performed less well on most major aspects of health, including mental health, such as years of potential life lost because of suicide (Starfield and Shi 2002). The positive impact of primary care orientation on low birth-weight rates may reflect a beneficial effect of primary care on mothers' health *before* pregnancy (Davey Smith and Lynch 2004; Starfield and Shi 2002). The characteristics of primary care practice present in countries with high primary care scores and absent in countries with low primary care scores were the degree of comprehensiveness of primary care (i.e., the extent to which primary care practitioners provided a broader range of services rather than making referrals to specialists for those services) and a family orientation (the degree to which services were provided to all family members by the same practitioner). The most consistent policy characteristics were the government's attempts to distribute resources equitably, universal financial coverage that was either under the aegis of the government or regulated by the government, and low or no patient cost sharing for primary care services (Starfield and Shi 2002). The latter two were studied and confirmed by Or (2001).

The positive contributions of primary care to health also were found in a much more extensive time-series analysis of 18 industrialized

countries, including the United States (Macinko, Starfield, and Shi 2003). The stronger the country's primary care orientation (as measured by the same scoring system as in the earlier international comparison) was, the lower the rates were of all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease, and heart disease. This relationship held even after controlling for various system characteristics (GDP per capita, total physicians per 1,000 population, percentage of elderly people) and population characteristics, including the average number of ambulatory care visits, per capita income, alcohol consumption, and tobacco consumption. The analyses estimated that increasing a country's primary care score by five points (on a 20-point scale) would be expected to reduce premature deaths from asthma and bronchitis by as much as 6.5 percent and that the reduction in premature mortality for heart disease could be as high as 15 percent.

Data from this study were analyzed as well to ascertain the robustness of primary care scores over time. The average primary care score increased by nearly one point from the 1970s to the 1990s. Countries that performed well in the 1970s remained high performers in each succeeding decade. When countries were divided into high and low performers (above or below the mean for each decade), no country crossed the threshold from low to high or from high to low, but the score of some countries changed. One country's score fell over time; Germany lowered access to ambulatory care services by imposing higher copayments, thus lowering its overall primary care score (OECD 2001). In general, policy changes over time paralleled improvements in primary care practice. For example, in the late 1980s and early 1990s, Spain strengthened its primary care by moving to a tax-based financing system, improving its geographic allocation of funds, and increasing the supply of family physicians as well as developing primary health care centers that improved integration, family orientation, coordination of care, and health promotion services (Larizgoitia and Starfield 1997). The United States' score rose slightly over time, almost entirely resulting from the greater participation of Americans in health maintenance organizations (HMOs), which tend, on average, to use a higher percentage of primary care practitioners (Weiner 2004) and have (at least among the not-for-profit HMOs) a tradition of community involvement (Stevens and Shi 2003).

## Primary Care and Disparities in Health Outcomes

Both the World Health Organization and many countries (including the United States) have recognized the existence of marked disparities (inequities) in health across population subgroups and have identified reductions (and, for the United States, even elimination) of these as a priority (Sachs and McArthur 2005; U.S. Department of Health and Human Services 2000). In reviewing the impact of primary care on reductions in disparities in health, we looked at studies of physician supply, studies of the association with a primary care physician, and studies of the receipt of services that fulfilled the criteria for primary care delivery.

Higher ratios of primary care physicians to population are associated with relatively greater effects on various aspects of health in more socially deprived areas (as measured by high levels of income inequality). Areas with abundant primary care resources and high income inequality have a 17 percent *lower* postneonatal mortality rate (compared with the population mean), whereas the postneonatal mortality rate in areas of high income inequality and few primary care resources was 7 percent *higher*. For stroke mortality, the comparable figures were 2 percent *lower* mortality where the primary care resources were abundant and 1 percent *higher* where the primary care resources were scarce (calculated from data in Shi et al. 1999). These findings are even more striking in the case of self-reported health. Income inequality and primary care were significantly associated with self-rated health, but the supply of primary care physicians significantly reduced the effects of income inequality on self-reported health status (Shi and Starfield 2000). People in high-income-inequality areas were 33 percent more likely to report fair or poor health if the primary care resources were few (calculated from data in Shi and Starfield 2000).

As in state-level analyses, the adverse impact of income inequality on all-cause mortality, heart disease mortality, and cancer mortality was considerably diminished where the number of primary care physicians in county-level analyses was high (Shi et al. 2005a).

The supply of primary care physicians in the U.S. states has a larger positive impact on low birth weight and infant mortality in areas with high social inequality than it does in areas with less social inequality (Shi et al. 2004).

Eleven years of state-level data found the supply of primary care physicians to be significantly related to lower all-cause mortality rates in both African American and white populations, after controlling for income inequality and socioeconomic characteristics (metropolitan area, percentage of unemployed, and educational levels). In these state-level analyses, the supply of primary care physicians had a greater positive impact on mortality among African Americans than among whites. The inclusions of both the supply of primary care physicians and sociodemographic characteristics eliminated the negative impact of income inequality. The association between a greater supply of primary care physicians and lower total mortality was found to be four times greater in the African American population than in the white majority population, indicating a reduction in racial disparities in mortality in the U.S. states (Shi et al. 2005c). But when exploring further the relationship between the supply of primary care physicians and health outcomes in African American and white populations in metropolitan areas of the United States, both the supply of primary care and income inequality were significantly associated with total mortality rates in the white population, whereas only income inequality maintained its significant relationships in African American populations (Shi and Starfield 2001). The authors interpreted this finding as suggesting that in many urban areas, a great supply of primary care physicians does not ensure certain population subgroups' access to primary care; they may receive their care in places such as hospital clinics and emergency rooms, which do not emphasize primary care.

The equity-related effect of having a good primary care source also was found in the study that examined the degree of primary care-oriented services that people received. Good primary care experiences were associated with reductions in the adverse effects of income inequality on health, with fewer differences in self-rated health between higher and lower income-inequality areas where primary care experiences were stronger (Shi et al. 2002). Although similar in the direction of effect, the relationship to "feeling depressed" was not statistically significant.

In county-level analyses that stratified urban areas by race, the supply of primary care physicians had a strong and significant influence on white mortality in both low- and high-income-inequality areas, but only a weak association with African American mortality in low-income-inequality areas and no significant association in high-income-inequality areas (Shi et al. 2005b).



Thus, the U.S. studies showed that an adequate supply of primary care physicians reduced disparities in health across racial and socioeconomic groups. Multivariate analyses controlling for individual, community, and state-level characteristics provided strong evidence for the association of primary care with fewer disparities in several aspects of health.

These conclusions are buttressed by a study comparing the type of place where care is received. Disparities in low-birth-weight percentages between the majority white and African American infants are fewer in infants of mothers receiving care in primary care-oriented community health centers, compared with the population as a whole. In both white and African American populations in both urban and rural areas in the United States, the rates of low birth weight were lower, in both absolute numbers and ratios of rates, where the source of care was a community health center (Politzer et al. 2001).

A study of civil servants in the United Kingdom, where access to primary care physicians is universal, found that socioeconomic differences in coronary heart disease mortality were *not* a result of differences in cardiac care (Britton et al. 2004). Another exploration of the effect of primary care found that blacks in London did not have greater rates of diabetes-related lower-extremity amputation than whites did (Leggetter et al. 2002), whereas blacks in the United States had rates two to three times higher than that in the white population. In the United Kingdom, the rates were lower in black men than in the white population, a difference wholly accounted for by lower rates of smoking, neuropathy, and peripheral vascular disease. The findings persisted even after controlling for socioeconomic differences, thus confirming other findings (van Doorslaer, Koolman, and Jones 2004) that a health system oriented toward primary care services (such as in the United Kingdom) reduced the disparities in health care so prominent in the United States (Agency for Healthcare Research and Quality 2004).

Primary care programs aimed at improving health in deprived populations in less developed countries succeeded in narrowing the gaps in health between socially deprived and more socially advantaged populations. A matched case-control study in Mexico (Reyes et al. 1997) found that some aspects of primary care delivery had an important independent effect on reducing the odds of children dying in socially deprived areas. These processes included adequate referral mechanisms, continuity of care (being seen by the same provider at each visit), and being attended

in a public facility designed to provide primary care. A study in Bolivia (Perry et al. 1998) found that a community-based approach to planning primary health care services in socially deprived areas lowered the mortality of children under age five compared with adjacent similar areas or the country as a whole.

The Costa Rican primary care reforms, which were instituted first in the most socially deprived areas, illustrate the importance of primary care in reducing health disparities. These reforms included transferring the responsibility for providing health care from the Ministry of Health to the Costa Rican Social Security Fund (CCSS), expanding the number of primary care facilities—particularly in underserved areas—and reorganizing primary care into “integrated primary care teams” or EBAIS (*equipos básicos de atención integral en salud*), which consist of teams of health professionals assigned to a geographic region covering about 1,000 households (Rosero-Bixby 2004b). By 1985, Costa Rica’s life expectancy reached 74 years, and infant mortality rates fell from 60 per 1,000 live births in 1970 to 19 per 1,000 live births, levels comparable to those in more developed countries. The improvements in primary health care were estimated to have reduced infant mortality by between 40 percent and 75 percent, depending on the particular study (Haines and Avery 1982; Klijsing and Taylor 1982; Rosero-Bixby 1986). For every five additional years after primary health care (PHC) reform, child mortality fell by 13 percent, and adult mortality fell by 4 percent. The study’s quasi-experimental nature provided evidence of the power of PHC policies and provision of services to improve health, above and beyond improvements in social and economic indicators (which the longitudinal analyses controlled for) (Rosero-Bixby 2004a).

Studies in other developing countries show the considerable potential of primary care to reduce the large disparities associated with socioeconomic deprivation. In seven African countries, the wealthiest 20 percent of the population receives well over three times as much financial benefit from overall government spending as does the poorest 20 percent of the population (40 percent versus 12 percent). For primary care services, the ratio of rich to poor in the distribution of government expenditures was notably lower (23 percent to the top group versus 15 percent to the lowest group) (Castro-Leal et al. 2000), leading one international expert to conclude that “from an equity perspective, the move toward primary care represents a clear step in the right direction” (Gwatkin 2001,720). An analysis of preventable deaths in children concluded that

in the 42 countries accounting for 90 percent of child deaths worldwide, 63 percent could have been prevented by the full implementation of primary care. The primary care interventions included integrated care addressing the very common problems of diarrhea, pneumonia, measles, malaria, HIV/AIDS, preterm delivery, neonatal tetanus, and neonatal sepsis (Jones et al. 2003).

Except in metropolitan areas, where a greater supply of primary care physicians alone may not be associated with reductions in disparities between African Americans and whites, the findings of fewer disparities by primary care were consistent across all types of studies and were particularly marked in studies examining the actual receipt of primary care services.

## Costs of Care

In addition to its relationship to better health outcomes, the supply of primary care physicians was associated with lower total costs of health services. Areas with higher ratios of primary care physicians to population had much lower total health care costs than did other areas, possibly partly because of better preventive care and lower hospitalization rates. This was demonstrated to be the case for the total U.S. adult population (Franks and Fiscella 1998), as well as among U.S. elderly living in metropolitan areas (Mark et al. 1996; Welch et al. 1993). Baicker and Chandra's (2004) analysis showed a linear decrease in Medicare spending along with an increase in the supply of primary care physicians, as well as better quality of care (as measured by 24 indicators concerning the treatment of six common medical conditions). In contrast, the supply of specialists was associated with more spending and poorer care.

Care for illnesses common in the population, for example, community-acquired pneumonia, was more expensive if provided by specialists than if provided by generalists, with no difference in outcomes (Rosser 1996; Whittle et al. 1998).

Consistent with the findings within countries, international comparisons of primary care showed that those countries with weaker primary care had significantly higher costs ( $r = .61, p < .001$ ) (Starfield and Shi 2002).

## Rationale for the Benefits of Primary Care for Health

Six mechanisms, alone and in combination, may account for the beneficial impact of primary care on population health. They are (1) greater access to needed services, (2) better quality of care, (3) a greater focus on prevention, (4) early management of health problems, (5) the cumulative effect of the main primary care delivery characteristics, and (6) the role of primary care in reducing unnecessary and potentially harmful specialist care.

1. *Primary care increases access to health services for relatively deprived population groups.* Primary care, as the point of first contact with health services, facilitates entry to the rest of the health system. With the exception of the United States, most industrialized countries have achieved universal and equitable access to primary health services, some of them directly provided and others through the assurance of financial coverage for visits (van Doorslaer, Koolman, and Jones 2004). In the United States, however, socially deprived population subgroups are more likely than more advantaged people to lack a regular source of care. The evidence is striking with regard to family income, for which there are marked gradients in having a regular source of care, hovering around 80 percent for the poor and near-poor to nearly 90 percent for those in the middle income range, approaching 95 percent for those with high incomes, and increasing over time from 1999 to 2001 for mainly those with high incomes (Agency for Healthcare Research and Quality 2004).

The principal benefit of health insurance in the United States is facilitating access to primary care (Lillie-Blanton and Hoffman 2005; Starfield and Shi 2004). Socially deprived population groups that do not have health insurance are less likely to have a source of primary care and thus have less access to the entire health system. Over the past several decades, attempts to improve access have been mainly the expansion of eligibility for reimbursement by public funds through Medicare, Medicaid, and related programs like the State Child Health Insurance Program. Some, but not all, of these efforts have been accompanied by incentives or

even mandated enrollment with a regular source of care, and disparities in identification with a regular source of care have been reduced. However, differences in the receipt of good primary care services persist (Seid, Stevens, and Varni 2003; Shi 1999; Stevens and Shi 2002; Taira et al. 1997). Shi's national study of adults (1999) demonstrated not only differences in the likelihood of having a regular source but also (and more marked) differences in the type of that regular source, with minorities more likely to report a place rather than a person as their regular source of care; to have a specialist (other than a primary care physician) if they reported a physician as their source of care; and to experience longer delays in obtaining needed services after controlling for having a regular source of care. The same was found for children (Newacheck, Hughes, and Stoddard 1996). Other studies show that minority children are more likely to use an emergency room as their source of care (Weitzman, Byrd, and Auinger 1999). After controlling for having a regular source of care, there were few if any differences in reporting difficulty in obtaining needed services.

Analyses reported by Weinick and Krauss (2000) and Lieu, Newacheck, and McManus (1993) confirmed the finding of fewer or no difficulties in access to care when the source is a primary care source. Once they do have access to adequate primary care services, deprived minority groups often report better experiences with their care than the majority white population does, particularly when the studies were conducted in organized health care settings that, by design, eliminated many of the access barriers to primary care services (Morales et al. 2001; Murray-Garcia et al. 2000; Taira et al. 1997).

In sum, one of the main functions of a primary care source is reducing or eliminating difficulty with access to needed health services.

2. *The contribution of primary care to the quality of clinical care.* Studies designed by specialists to compare the quality of care of specialty and generalist practices often find that specialists are better at adhering to guidelines. For example, adhering to guidelines for asthma management was better in practices of specialists dealing with asthma (Bartter and Pratter 1996), and gastroenterologists used antibiotic therapy for *helicobacter pylori* earlier than

generalists did (unless the generalists were in a group practice with gastroenterologists) (Hirth, Fendrick, and Chernew 1996). Most studies comparing generalists and specialists concluded that the condition-specific quality of care provided by specialists was better when the condition was in the specialist's area of special interest, using indicators of quality of care such as the performance of disease-specific preventive procedures, the performance of indicated laboratory tests for monitoring disease status, and the prescription of relevant medications (Harrold, Field, and Gurwitz 1999).

The findings concerning the superior quality of care by specialists were not, however, confirmed by other studies. In demonstrating the effectiveness of primary care for diabetes, general practitioner (GP) diabetic clinics in the United Kingdom were found to do as well as hospital specialists in monitoring for diabetic complications (Parnell, Zalin, and Clarke 1993). In addition, in systems in which the GPs were given additional educational support and had an organized system for recall, GPs' care of diabetic patients was better than that of specialists in hospitals. In such situations, patients of GPs had lower mortality rates and better glycemic control than did patients treated by specialists (Griffin and Kinmonth 1998). Rates of complications, readmission to the hospital, and length of convalescence were the same after early discharge from the hospital after minor surgery, regardless of whether the care was provided by the hospital's outpatient department or general practitioners (Kaag, Wijkel, and de Jong 1996). Moreover, the few studies planned and executed by generalists (Donohoe 1998; Grumbach et al. 1999) concluded that the quality of care was the same or that primary care was better. These differences suggest differences in the conceptualization of appropriate "outcomes" by the two types of physicians, with specialists more concerned with specific disease-related measures and adherence to guidelines for these diseases and primary care physicians more targeted to multiple aspects of health, that is, "generic" health. Assessing generic outcomes, or quality of care *other* than for the particular conditions under study, is important because comorbidity is common and causes more visits to both generalists and specialists than do most specific conditions (Starfield et al. 2003; Starfield et al. 2005a). If the interest is in patients' health

(rather than disease processes or outcomes) as the proper focus of health services, primary care provides superior care, especially for conditions commonly seen in primary care, by focusing not primarily on the condition but on the condition in the context of the patient's other health problems or concerns.

In short, primary care physicians do at least as well as specialists in caring for specific common diseases, and they do better overall when the measures of quality are generic. For less common conditions, the care provided by primary care physicians with appropriate backup from specialists may be the best; for rare conditions, appropriate specialist care is undoubtedly important, as primary care physicians would not see such conditions frequently enough to maintain competence in managing them.

3. *The impact of primary care on prevention.* The evidence strongly shows that it is in primary care that preventive interventions are best when they are not related to any one disease or organ system. Examples of these "generic" (i.e., not limited to a particular disease or type of disease) measures are breast-feeding, not smoking, using seat belts, using smoke detectors, being physically active, and eating a healthy diet. Those U.S. states with higher ratios of primary care physicians to population have lower smoking rates, less obesity, and higher seatbelt use than do states with lower ratios of primary care physicians to population (Shi 1994; Shi and Starfield 2000). Good primary care, as determined by peoples' ratings of its main characteristics, is positively associated with smoking cessation and influenza immunization, as shown in an ongoing 60-community study in the United States (Saver 2002). The likelihood of disadvantaged children's making any preventive visits is much greater when their source of care is a good primary care practitioner (Gadomski, Jenkins, and Nichols 1998).

To the extent that many preventive activities stress the early detection of specific diseases (secondary prevention), the quality of primary care (compared with specialty care) would not necessarily be expected to be better. However, the evidence suggests otherwise for common conditions that are in the purview of primary care. A greater supply of family physicians (although not necessarily internists) is associated with an earlier detection of breast cancer, colon cancer, cervical cancer, and melanoma (Campbell et al. 2003; Ferrante et al. 2000; Roetzheim et al. 1999, 2000). Ferrante and

colleagues (2000) found that each tenth-percentile increase in the supply of primary care physicians was associated with a statistically significant 4 percent increase in the odds of a diagnosis in an early (rather than late) stage. Most mammograms (87 percent) are ordered by primary care physicians (Schappert 1994); moreover, a physician's advice to have mammograms enhances their receipt (Breen and Kessler 1994; Campbell et al. 2003; Fox, Siu, and Stein 1994; NCI Breast Cancer Screening Consortium 1990; Roetzheim et al. 1999, 2000). Another study of differences between primary care physicians and specialists caring for patients with hypertension, non-insulin-dependent diabetes, recent myocardial infarction, or depression showed that the only preventive care procedures better performed by specialists were checks for foot ulcers and infection status in endocrinologists' diabetic patients (Greenfield et al. 1992). Moreover, approaches to prevention in primary care practice were more generic and resulted in more improvement in patients' health status than was the case in specialty-oriented practices (Bertakis et al. 1998). When the data were from the general community rather than from practices, having a good primary care source was the major determinant of receiving even disease-focused preventive care, consisting of blood pressure screening, clinical breast exams, mammograms, and Pap smears (Bindman et al. 1996).

4. *The impact of primary care on the early management of health problems.* Another indication of the benefit of primary care is its demonstrated impact on managing health problems before they are serious enough to require hospitalization or emergency services. Several studies support this conclusion.

Shea and colleagues (1992) examined the relationship between having a primary care physician as the source of care and hospitalization for reasons that should be preventable by good primary care. Men with hypertension who were admitted to the hospital from the emergency room in a large metropolitan area were divided into two groups. One group was composed of those who were admitted for a preventable complication of hypertension; the other group was admitted for a condition unrelated to hypertension. The study found that those admitted for the preventable complication were four times more likely to lack a primary care provider than were those admitted for a condition unrelated to



hypertension, even after considering other factors such as absence of health insurance, level of compliance with antihypertensive regimens, and alcohol or drug use—related problems, thus indicating that those men with a primary care provider were relatively better protected against hospitalization for a preventable complication of a common medical problem.

In the United Kingdom, each 15 to 20 percent increase in GP supply per 10,000 population was significantly associated with a decrease in hospital admission rates of about 14 per 100,000 for acute illnesses and about 11 per 100,000 for chronic illnesses, even after controlling for the degree of social deprivation in the area in which people live, their social class, ethnicity, and limiting long-term illness (Gulliford 2002).

In the United States, rates of hospitalization for conditions that should be preventable by exposure to good primary care (ambulatory care—sensitive conditions, or ACSC) are strongly associated with socioeconomic deprivation, at least in part because socially disadvantaged populations are less likely to have a good source of primary care (Agency for Healthcare Research and Quality 2004; Hansell 1991; Stevens and Shi 2002). In contrast, in Spain, the rates of hospitalization for these conditions were *not* associated with socioeconomic characteristics, indicating that the Spanish health system's primary care orientation reduced the hospitalization rates for these conditions despite social disadvantage (Casanova, Colomer, and Starfield 1996; Casanova and Starfield 1995).

In a large multispecialty comparison of hospitalization rates, Greenfield and colleagues found that the rates of hospitalization were 100 percent higher when, compared with family physicians, the ongoing care was provided by cardiologists and 50 percent higher when it was provided by endocrinologists (Greenfield et al. 1992).

The literature is consistent in showing that lower rates of hospitalization for ACSC are strongly associated with the receipt of primary care. Geographic areas with more family and general practitioners have lower hospitalization rates for these types of conditions, including diabetes mellitus, hypertension, and pneumonia (Parchman and Culler 1994). Children receiving their care from a primary care source that fulfills the criteria for its main

characteristics have lower hospitalization rates for these conditions as well as lower hospitalization rates overall. These findings are associated with the greater receipt of preventive care from primary care providers (Gadomski, Jenkins, and Nichols 1998). Rates of hospital admissions of children are lower in those U.S. communities in which primary care physicians are more involved in caring for children both before and during hospitalization (Perrin et al. 1996). Adolescents with the same regular source of care for preventive and illness care are less likely to seek care in emergency rooms (Ryan et al. 2001). An analysis of national Medicare data showed that the elderly in the United States who are in fair or poor health are more likely to experience a potentially preventable hospitalization if they live in a county designated as a primary care shortage area (Parchman and Culler 1999).

Only two studies failed to find a positive impact for the supply of primary care physicians and hospitalizations for conditions sensitive to primary care management. Each of the studies was conducted in only one state, New York or North Carolina (Ricketts et al. 2001; Schreiber and Zielinski 1997). In both studies, socioeconomic characteristics were more salient, and so it is possible that in some places, the availability of more primary care physicians did not necessarily mean that deprived populations had access to them. A later study in one of those states (New York) showed that the ratio of primary care physicians to population was one of the more salient factors associated with lower levels of hospitalizations for ACSC (Friedman and Basu 2001).

5. *The accumulated contribution of primary care characteristics to more appropriate care.* As noted in regard to quality of care, the beneficial effects of primary care on mortality and morbidity can be attributed, at least in part, to the focus of primary care on the person rather than on the management of particular diseases. Care focuses on the person when practitioners attend to overall aspects of the patient's health rather than to the care of his or her specific diseases; it focuses on achieving better outcomes for health in all its aspects rather than on the procedures directed at improving the processes or outcomes of care for particular conditions. Other aspects of health services delivery that are characteristic of primary care also have been associated with better health outcomes. Although an extensive review of the positive contribution of each

of these characteristics is outside the scope of this review (which concerns primary care as an entity within health service systems) and has been covered elsewhere (Starfield 1998), a brief summary of these contributions explains why primary care as a whole might have positive effects.

We noted earlier that an important element of primary care is its role as the first contact for patients when a problem develops. In a seminal article entitled "Gatekeeping Revisited—Protecting Patients from Overtreatment," Franks, Clancy, and Nutting (1992) made the case for seeing a primary care physician before seeking care from another type of physician. Having a relationship with a primary care practitioner who can serve as an initial point of contact is strongly and statistically significantly associated with less use of specialists and emergency rooms (Hurley, Freund, and Taylor 1989; Martin et al. 1989). *Continuity* of care, which implies that individuals use their primary source of care over time for most of their health care needs, is associated with greater satisfaction, better compliance, and lower hospitalization and emergency room use (Freeman and Hjortdahl 1997; Mainous and Gill 1998; Rosenblatt et al. 2000; Weiss and Blustein 1996). Previous knowledge of a patient, which reflects good continuity of care, increases the doctor's odds of recognizing psychosocial problems influencing the patient's health (Gulbrandsen, Hjortdahl, and Fugelli 1997). Both continuity and first-contact attributes of primary care ensure greater efficiency of services in the time saved in the consultation, less use of laboratory tests, and fewer health care expenditures (Forrest and Starfield 1996, 1998; Hjortdahl and Borchgrevink 1991; Raddish, Horn, and Sharkey 1999; Roos, Carriere, and Friesen 1998). Very short-term relationships with physicians are associated with poor outcomes. For example, veterans with a chronic disease who did not have a previous relationship with a primary care physician were randomized to receive an intervention of increased follow-up by a newly assigned nurse and a primary care physician after they were discharged from the hospital. Rehospitalization rates six months later were higher in this intervention group (Weinberger, Oddone, and Henderson 1996), thus indicating that relationships over time are an important component of primary care. (The study did not assess rehospitalization rates for veterans who already had a primary care provider,

and it may be that the assignment of such a provider to people without an existing relationship led to the discovery of new conditions not previously recognized and requiring hospitalization.) At least two years of a relationship (and as many as five) are generally required for patients and practitioners to get to know each other well enough to provide optimal person-focused care (Starfield 1998, 175). A freely chosen primary care practitioner provides better assurance of a good relationship than does assigning a practitioner (Starfield 1998, 151). The evidence is strong regarding the benefits of an ongoing relationship with a particular provider rather than with a particular place or no place at all. People with no source of primary care are more likely to be hospitalized, to delay seeking needed and timely preventive care, to receive care in emergency departments, and to have higher subsequent mortality and higher health care costs, and they are less likely to see a physician in the presence of symptoms. People with just a place (such as a particular hospital clinic) are somewhat better off than those without a regular source of care, in that they are more likely to keep their appointments, have fewer hospitalizations and lower costs, and receive generally better preventive care. In addition, people who report a particular doctor as their regular source of care receive more appropriate preventive care, are more likely to have their problems recognized, have fewer diagnostic tests and fewer prescriptions, have fewer hospitalizations and visits to emergency departments, and are more likely to have more accurate diagnoses and lower costs of care than are either people having a particular place or people having no place at all as their regular source of care (Starfield 1998, chap. 8).

The benefits of the other two main attributes of good primary care (comprehensiveness and coordination) are less well documented, but the existing evidence was summarized by Starfield (1998, chaps. 10 and 11).

6. *The role of primary care in reducing unnecessary or inappropriate specialty care.* Nearly all studies of specialist services concluded that there is either no effect or an adverse effect on major health outcomes from increasing the supply of specialists in the United States, which already has a much greater supply of such physicians than do other industrialized countries (Starfield et al. 2005b). This

evidence addresses a wide variety of population health outcomes, including all-cause (total) mortality; heart and cerebrovascular disease mortality; cancer mortality; postneonatal, neonatal, and total infant mortality; and low birth weight; as well as the early detection of various cancers, including cervical cancer, colorectal cancers, breast cancer, and melanoma (the evidence was reviewed by Starfield et al. 2005b). The evidence is also consistent that first contact with a primary care physician (before seeking care from a specialist) is associated with more appropriate, more effective, and less costly care (Starfield 1998, chap. 7).

Other countries, most notably the United Kingdom and the Netherlands, have led the way with primary care innovations to reduce the inappropriate use of specialist services. These include making better use of information systems and video communications as well as consulting with specialists in primary care settings.

The adverse effects of seeking care directly from nonprimary care specialists have a strong theoretical basis. Since these specialists are trained in the hospital, the patients seen by specialists are not representative of the way in which patients present symptoms in community settings, because the latter have a much lower prior probability of serious illness requiring the services of a specialist. The properties of diagnostic tests (sensitivity, specificity, predictive power of a positive test) are much different in populations with a high prevalence of serious illness than they are in community settings and thus much different in specialty care than in primary care settings. The result is that specialists practicing in the community overestimate the likelihood of illness in the patients they see, with the consequently inappropriate use of diagnostic and therapeutic modalities, both of which raise the likelihood of adverse effects (Franks, Clancy, and Nutting 1992; Hashem, Chi, and Friedman 2003; Sox 1996). Compared with other Anglophone countries, people in the United States experience more adverse effects and medical errors (Schoen et al. 2004). This, combined with evidence concerning the adverse effects of greater supplies of specialists and estimates of the likelihood of adverse effects of medical care, may at least partly explain the United States' low ranking on health status relative to that of similarly industrialized countries.

## Potential Limitations of Interpretations of Effectiveness of Primary Care

Despite the consistency of the findings from various types of studies, areas, and populations and the theoretical rationale for benefit of primary care on population health, it is possible that the results may be overinterpreted. Those countries and areas in which primary care is strongest (however measured) may be areas in which other social interventions (such as income supports and welfare policies that influence health) also are strongest. So far, the effort to identify the social policies that have a great influence on health has not been successful (Graham and Kelly 2004).

Moreover, the mere presence of primary care physicians may not reflect the availability of primary care services to certain population groups. At least two of the reviewed analyses in urban counties showed that the supply of primary care physicians is less closely related to the health of urban African Americans than it is for urban whites or for African Americans in rural areas. This is likely due to the poorer distribution of primary care physicians in more deprived urban areas, with the consequently greater need to seek care in such places as hospital outpatient units and emergency rooms. Supporting this hypothesis are two lines of evidence. First, African Americans are more likely than whites to report having their regular source of care in a facility (such as a hospital) and to report a specialist as their regular source of care (Shi 1999). That is, primary care physicians in urban areas tend to locate in more socially advantaged areas (Weiner et al. 1982). As a result, hospital clinics with predominantly hospital-based physicians not trained to provide the important features of primary care become the “default” regular source of care. Second, even in the presence of adequate primary care resources, African Americans may be less likely than other racial and ethnic groups to use primary care when other resources (such as hospital clinics) are available; this has been demonstrated to be the case for the medical care of inner-city infants (Hoffmann, Broyles, and Tyson 1997). State-level analyses are not as susceptible to this type of possible error because primary care is more evenly distributed than is specialty care (Shi and Starfield 2001).

If the supply of primary care physicians is less closely associated with health outcomes in urban African Americans than in whites because of difficulties in access to them, the demonstrated association between supply and health outcomes may actually underestimate the potential impact

of primary care services, particularly for deprived populations. Moreover, the studies that use alternative measures of primary care, including relationships with a primary care physician and studies considering the adequacy of primary care health services delivery characteristics, all confirm the conclusion that care meeting the criteria for primary care is associated with the better health of those populations receiving it, with a greater impact in more deprived populations.

## Primary Care in the Future

What issues remain to be addressed in primary care to improve its contribution to the health of populations and equity in distribution of health? A pervasive U.S. focus on “access” to health services rather than on the type of health services has detracted from the need to ensure that services are provided in the most appropriate places. The existing national data health interview surveys combine various safety net providers into one group so that people receiving their care from hospital outpatient clinics are not distinguishable from those receiving care from primary care-oriented clinics. Combining primary care-focused community health centers with hospital emergency and outpatient departments as “safety net providers” masks the high positive contributions to the health of the former with the lesser primary care focus of the latter. Apart from the Community Health Center program of the federal Health Resources and Services Administration and the commitment of certain not-for-profit health care organizations to strong primary care (Weiner 2004), little or nothing has been done to ensure that other “regular sources of care” fulfill the criteria for good primary care. In most other industrialized countries, primary care physicians are clearly distinguished from other physicians, and where people receive care is easily identified as primary care or specialty care. Greater appreciation that it is primary care that plays a major role in ensuring access to appropriate health services should provide the rationale for better distinguishing primary care from specialty care in data on the use of health services in the United States.

At the very least, primary care must be recognized as a distinct aspect of a health services system. There now are well-validated methods (e.g., see Shi, Starfield, and Xu 2001; Starfield et al. 1998) to assess both the presence and the characteristics of primary care, and all sources of data on use of health services should include at least a few of these

measures. Understanding people's primary care experiences (rather than or in addition to their satisfaction), including the extent to which they receive the range of services appropriate to their needs and have the care they receive elsewhere coordinated and integrated, are important to evaluating the adequacy of health services.

In contrast to the situation in primary care, for which intensive conceptual and methodologic study over the past several decades has clarified its most important aspects, professional specialty groups in the United States have made little if any attempt to define the practice of "specialism" or the circumstances that should lead to seeking care from specialists. Referrals to specialists apparently have three functions: short-term consultation for diagnosis or management, referral for long-term management of specific illnesses, and recurrent consultation for periodic management. A study of referrals from 80 office-based family practices showed that by far the most referrals for common conditions (over 50 percent of all referrals to most types of specialists) were expected to be for a short term (less than 12 months) and that for more than 50 percent, they were for consultation only (no direct intervention) (Starfield et al. 2002). Very little is known, however, about the relative frequency of these functions from the viewpoint of specialty practice. One report (Hewlett et al. 2005) indicated that about 75 percent of visits to a pulmonary specialty clinic were just for "checkups," even though the patients' primary care physicians, once they had access to the specialists' reports, could just as easily perform this function and report the findings to the specialists. Such an approach to reducing the number of visits to specialists could lower the demand for a greater supply of specialists; it at least deserves to be tested. There is an urgent need for information about the indications for specialty care and about the impact on outcomes of excessive use of specialists.

Major challenges to primary care practice concern (1) recognizing and managing comorbidity, (2) preventing the adverse effects of medical interventions, (3) maintaining a high quality of the important characteristics of primary care practice, and (4) improving equity in health services and in the health of populations (Starfield 2001).

1. Historically, principles of delivery of medical care have been based on preventing and managing specific diseases. In the current climate of evidence-based medicine, guidelines for the management of diseases are proliferating and increasingly used. The



development of guidelines is generally based on evidence from the literature that certain modes of management achieve better outcomes than others do. The “gold standard” for evidence is the randomized controlled clinical trial, which generally excludes, as a requirement for participation in the trial, individuals with comorbid conditions. Comorbidity (the simultaneous presence of apparently unrelated conditions) is common in the population and is not randomly distributed. Although comorbidity becomes more common with age, it is in the young that comorbidity occurs much more frequently than expected by the chance occurrence of two or more conditions (van den Akker et al. 1998). (That is, the frequency of illness is much greater in the old than in the young, so there is much greater likelihood that two unrelated illnesses will be found together. In the young, illness is much less common, so that it is statistically much less likely that two or more will be found together, although in fact this is the case.) Data systems should be developed that provide a much better basis for examining the distribution and nature of comorbidity in primary care; ascertainment of the impact of baseline risks on comorbidity; likelihood of responsiveness to treatment in the presence of comorbidity; and susceptibility to adverse effects of medical interventions. Moreover, the applicability to primary care of guidelines developed from randomized controlled clinical trials may be more limited than is generally thought, even apart from the issue of comorbidity (Kravitz, Duan, and Braslow 2004; Rothwell 2005), particularly when considering the issue of disease-specific versus overall clinical end points (Fleming 2005).

2. Primary care practitioners are in the best position to detect the occurrence of potentially adverse effects of medical interventions, particularly those stemming from drug reactions and interactions. In systems of care oriented to primary care (including some HMOs in the United States), the primary care practitioner is, by far, the most commonly seen physician, for patients with *all* degrees of comorbidity and for both single common conditions and comorbid conditions. Only when individual conditions are uncommon are specialists the type of physician most frequently seen, and only for that condition (*not* for comorbid conditions) (Starfield et al. 2003; Starfield et al. 2005a). Thus, primary care physicians are more likely to see the adverse events that result from their own

care as well as the care of others whom the patient may see. The challenge for primary care is to establish systems to code unexpected symptoms or signs and to create information systems that could serve as early warnings of the occurrence of adverse events in persons previously subjected to particular types of interventions. It is possible that the International Classification of Primary Care (ICPC) (Lamberts, Wood, and Hofmans-Okkes 1993), which provides a straightforward classification of problems encountered in primary care while maintaining comparability with the better known International Classification of Diseases (originally developed to code causes of death), could serve as the basis for recording and classifying these symptoms and signs in the United States, as it is already being used in several other countries.

3. Improvement in clinical quality and in performance with respect to the main features of primary care practice is a challenge for primary care practice. Although each of these features is known to confer benefits on health, the remaining issues require consideration.
  - To what extent can teams of practitioners provide first-contact care without interfering with the benefits of continuing interpersonal relationships between particular practitioners and patients?
  - Ongoing person-focused care means that care should be focused on the person rather than on the disease. Can teams of practitioners fulfill this function?
  - Comprehensiveness means that all problems in the population should be cared for in primary care (with short-term referral as needed), except those that are too unusual (generally a frequency of less than one or two per thousand in the population served) for the primary care practitioner or team to treat competently. How can data systems provide the information needed to decide when problems are best met in primary care, when they can be best dealt with in primary care with appropriate specialty backup, and when patients need to be seen by a specialist?
  - Coordination of care means that the primary care practice must integrate all aspects of care when patients must be seen elsewhere. Because 13 to 20 percent (depending on various assumptions) of an average practice population requires a referral each year, this burden is considerable. Very few health systems, even

those that rate high on primary care, achieve high coordination of care, at least as measured by transfer of information from primary care physicians to specialists and vice versa. Systems to facilitate coordinating efforts are urgently needed. Lessons might be gleaned from the experiences of some health systems. For example, and despite the design limitations (Talbot-Smith et al. 2004) of the study comparing the Kaiser-Permanente health care plan in the United States with the National Health Service in the United Kingdom (Feachem, Sekhri, and White 2002), the lower hospitalization rates and lower resource use in the United States may well be a result of a system specifically designed to enhance coordination between primary care physicians and specialists.

4. The achievement of equity in health services and health is an imperative everywhere. Primary care is inherently a more equitable level of care than other levels of care. It is less costly (hence sparing resources that could be devoted to providing better services to more disadvantaged populations), and through its key features, it narrows disparities in health between more and less socially deprived population groups. The extent to which primary care in fact does result in more equity depends on the availability of information about the needs in the various areas in which primary care practices are located. Better information systems, at both the area and practice levels, would enhance the already-strong benefits of primary care to the health of individuals, population subgroups, and populations (National Committee for Vital and Health Statistics 2001).

## The Relevance of Policy

The relatively poor performance of the United States on major health indicators, despite per capita health care expenditures that are much higher than those of any other country, is a pressing concern for policy-makers, the business community (which has, historically, paid for much of the health insurance in the country), and, ultimately, taxpayers. Efforts to improve the system to achieve better health at lower cost are rapidly becoming imperative. Primary care offers an effective and efficient approach to achieve that goal. Evidence of the benefits of a health

system with a strong primary care base is abundant and consistent. These benefits are not limited to one or only a few aspects of health but, rather, extend to the major causes of death and disorders as well as to reducing disparities in health across major population subgroups, including racial and ethnic minorities as well as socially deprived adults and children.

Federally qualified community health centers (CHCs) currently serve more than 3,600 urban and rural communities, which are typically low-income inner-city or resource-poor rural communities. But they serve only one-quarter of all people living below the poverty level, one in seven people living under 200 percent of poverty level, and one of eight uninsured Americans (Proser, Shin, and Hawkins 2005). Expansion of the CHC network well beyond the current supply is one appropriate strategy.

Other policy strategies would strengthen primary care on a broader level (Starfield and Simpson 1993). These include (but are not limited to) changes in the method of reimbursing primary care physicians and, particularly, better reimbursement rates for primary care services for both common conditions and for the important primary care delivery characteristics. Establishing a more rational basis for referrals and improving the coordination between primary care and specialist physicians would make primary care practice more challenging and intellectually rewarding. States could encourage a better distribution of physicians (both primary care and specialists) by tailoring their licensing policies to health needs in different areas or by providing financial incentives for practicing in underserved areas, as is done in some other countries. Incentives for training primary care practitioners could be improved by reorienting federal support for graduate medical education toward training primary care physicians. Similarly, loan forgiveness for primary care practitioners could be expanded. Reducing the amount of paperwork needed to file claims and encouraging the creation of electronic medical records would greatly reduce the tedium of record keeping in practice and, at the same time, make time to improve the self-monitoring of the quality of care. Bonus payments for team practice could enhance the comprehensiveness of primary care. Special recognition of best primary care practices could enhance public recognition of the importance of primary care and its characteristics. Finally, offering more funds for research on primary care, including the support of collaborative practice-based networks (Lanier 2005; Wasserman, Slora, and Bocian 2003), would help meet the intellectual challenges of expanding our knowledge base for the practice of both primary care and specialty care.

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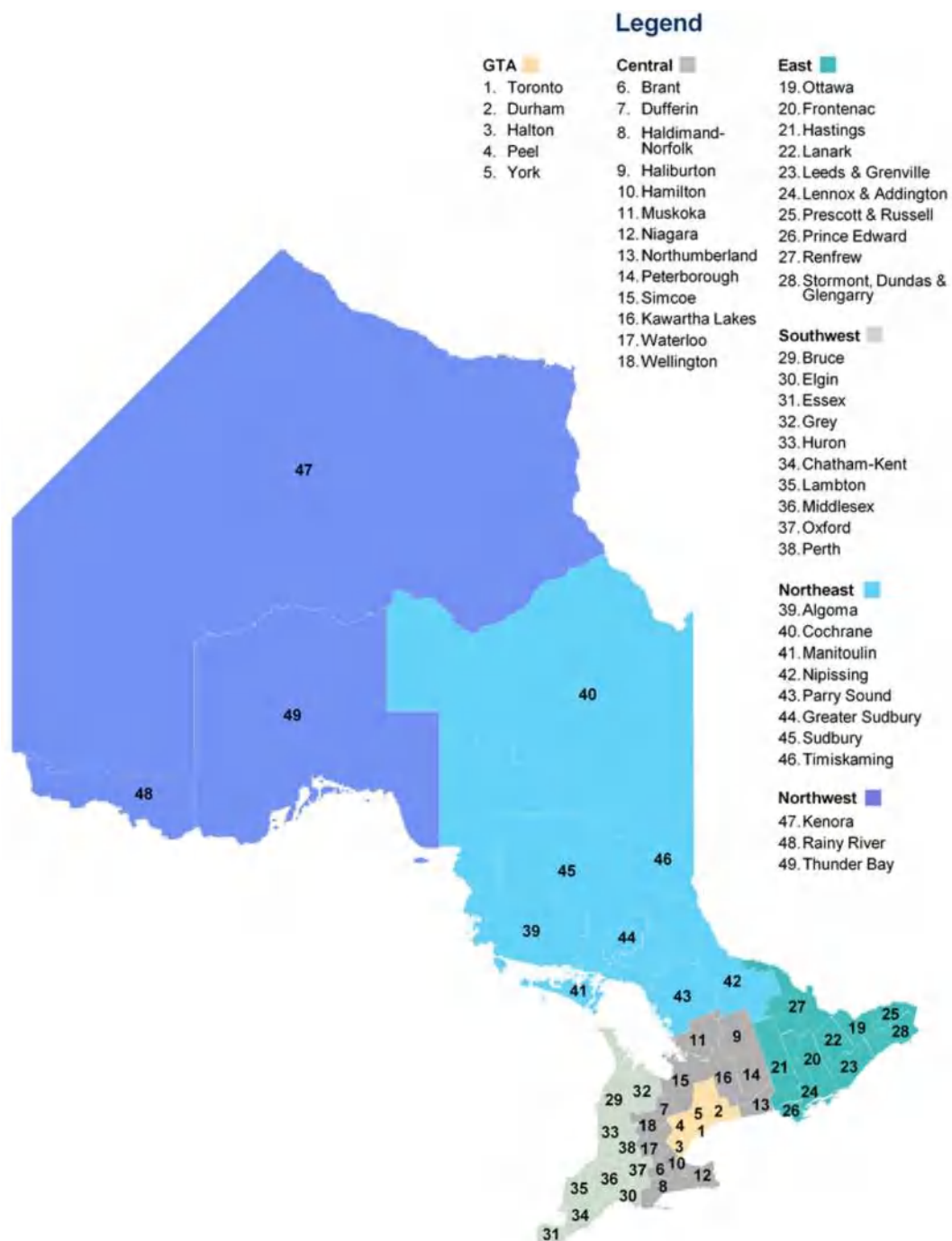
**TAB 170**

## Ontario population projections

Learn about the 2022-2046 population projections for Ontario and its 49 census divisions.

978-1-4868-7192-6 English HTML - Ontario Population Projections Update, 2022-2046

### Map of Ontario census divisions



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## Introduction

This report presents population projections for Ontario and each of its 49 census divisions, by age and gender, from the base year of 2022 to 2046. These projections were published by the Ontario Ministry of Finance in the summer of 2023.

The Ministry of Finance produces an updated set of population projections every year to reflect the most up-to-date trends and historical data. This update uses as a base the 2022 population estimates from Statistics Canada (released in January 2023 and based on the 2016 Census) and includes changes in the projections to reflect the most recent trends in fertility, mortality and migration.

The new projections include three scenarios for Ontario. The medium, or reference scenario, is considered most likely to occur if recent trends continue. The low- and high-growth scenarios provide a reasonable forecast range based on plausible changes in the components of growth. Projections for each of the 49 census divisions are for the reference scenario only.

The projections do not represent Ontario government policy targets or desired population outcomes, nor do they incorporate explicit economic or planning assumptions. They are developed using a standard demographic methodology in which assumptions for population growth reflect recent trends in all streams of migration and the continuing evolution of long-term fertility and mortality patterns in each census division. Census division projections are summed to obtain the Ontario total.

The report includes a set of detailed statistical tables on the new projections. Key demographic terms are defined in a glossary.

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## Highlights

Highlights of the new 2022–2046<sup>[1]</sup> projections for the reference scenario:

- Ontario's population is projected to increase by 43.6 per cent, or almost 6.6 million, over the next 24 years, from an estimated 15.1 million on July 1, 2022 to almost 21.7 million by July 1, 2046.
- The provincial population is projected to grow rapidly in the short term, increasing at an annual rate of 3.2 per cent in 2022–23, 2.7 per cent in 2023–24, and 2.1 per cent in 2024–25. Thereafter, the rate of growth is projected to ease over time, reaching 1.3 per cent by 2045–46.
- Net migration is projected to account for 85 per cent of all population growth in the province over the 2022–2046 period, with natural increase accounting for the remaining 15 per cent.
- The number of seniors aged 65 and over is projected to increase significantly, from 2.8 million or 18.4 per cent of population in 2022, to 4.4 million, or 20.3 per cent by 2046. Rapid growth in the share and number of seniors will continue over the 2022–2031 period as the last cohorts of baby boomers turn age 65. After 2031, the growth in the number of seniors will slow significantly. The share of seniors is projected to peak at 20.9 per cent in 2036.
- The number of children aged 0–14 is projected to increase moderately over the projection period, from 2.3 million in 2022 to 3.3 million by 2046. The children's share of population is projected to decrease initially from 15.1 per cent in 2022 to 14.4 per cent by 2026, followed by a slow increase to 15.4 per cent by 2046.
- The number of Ontarians aged 15–64 is projected to increase from 10.0 million in 2022 to 14.0 million by 2046. This age group is projected to decline as a share of total population for most of the projection period, from a peak of 66.9 per cent in 2024 to 64.0 per cent by 2038, and to increase slowly thereafter to reach 64.4 per cent by 2046.
- Each of the six regions of the province are projected to see growing populations over the projection period. Central Ontario is projected to be the fastest growing region, with its population increasing by 1.6 million, or 48.1 per cent, from 3.3 million in 2022 to 4.9 million by 2046. The Greater Toronto Area (GTA) will see the largest increase in population, adding 3.3 million residents to 2046, with growth of 45.9 per cent, from 7.2 million in 2022 to over 10.5 million by 2046. The GTA's share of provincial population is projected to rise from 47.8 per cent in 2022 to 48.6 per cent in 2046.
- All regions will see a shift to an older age structure. The GTA is expected to remain the region with the youngest age structure as a result of strong international migration and positive natural increase.

# Projection Results

## Reference, low and high-growth scenarios

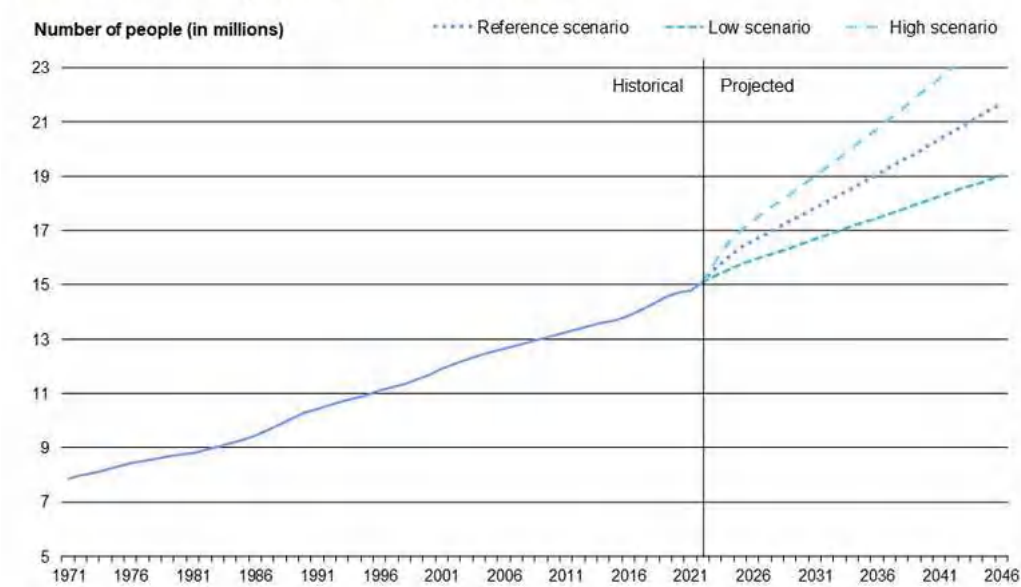
The Ministry of Finance projections provide three growth scenarios for the population of Ontario to 2046. The medium-growth or reference scenario is considered most likely to occur if recent trends continue. The low- and high-growth scenarios provide a forecast range based on plausible changes in the components of growth. Population is projected for each of the 49 census divisions for the reference scenario only. Charts and tables in this report are for the reference scenario, unless otherwise stated.

Under all three scenarios, Ontario's population is projected to experience growth over the 2022–2046 period. In the reference scenario, population is projected to grow 43.6 per cent, or almost 6.6 million, over the next 24 years, from an estimated 15.1 million on July 1, 2022, to almost 21.7 million on July 1, 2046.

The provincial population is projected to grow rapidly in the short term, increasing at an annual rate of 3.2 per cent in 2022–23, 2.7 per cent in 2023–24, and 2.1 per cent in 2024–25. Thereafter, the rate of growth is projected to ease over time, reaching 1.3 per cent by 2045–46.

In the low-growth scenario, population increases 26.0 per cent, or 3.9 million, to reach over 19.0 million people by 2046. In the high-growth scenario, population grows 62.4 per cent, or 9.4 million, to over 24.5 million people by the end of the projection period.

Chart 1: Ontario population, 1971 to 2046

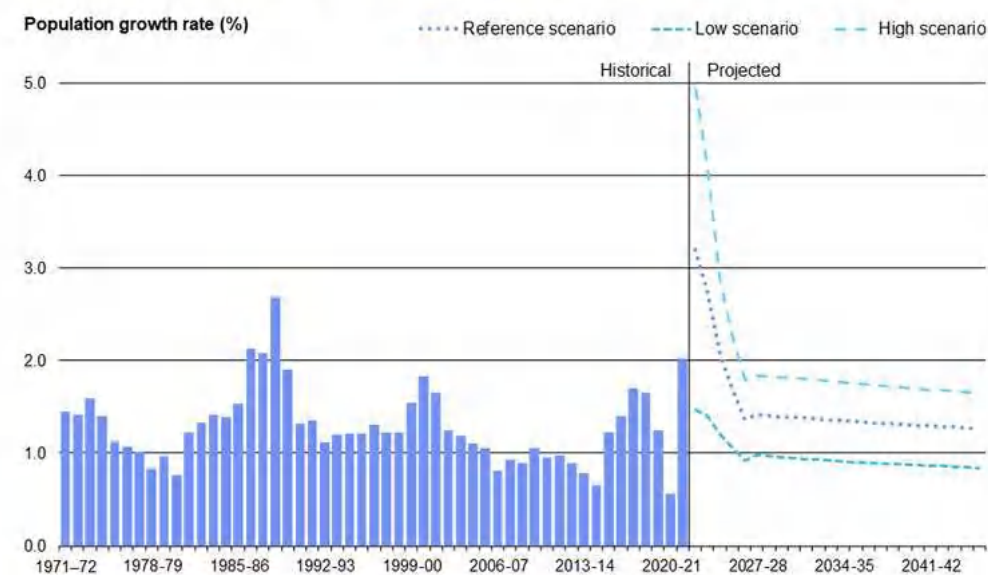


Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections

### Accessible description of Chart 1: Ontario population, 1971 to 2046

In the low-growth scenario, the annual rate of population growth is projected to decline rapidly over the first five years of the projections, from 1.5 to 0.9 per cent by 2026–27, and then to slowly reach 0.8 per cent by 2046. In the high-growth scenario, the annual population growth rate is also projected to fall quickly over the first five projected years, from 4.9 to 1.8 per cent by 2026–27, and then to reach 1.6 per cent by 2046.

Chart 2: Annual rate of population growth in Ontario, 1971 to 2046



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.

Accessible description of Chart 2: Annual rate of population growth in Ontario, 1971 to 2046

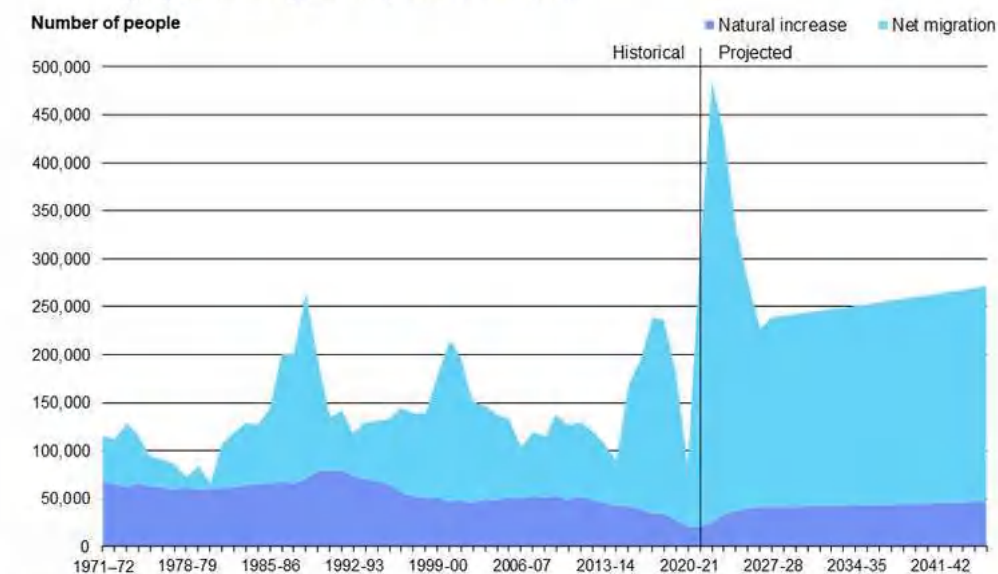
The components of Ontario population change

The contributions of natural increase and net migration to population growth vary from year to year. While natural increase trends evolve slowly, net migration can be more volatile, mostly due to swings in interprovincial migration and variations in international migration. For example, over the past 10 years, the share of population growth coming from net migration has been as high as 93 per cent in 2021–22 and as low as 53 per cent in 2014–15.

Net migration levels to Ontario have averaged about 136,000 per year in the past decade, with a low of 47,000 in 2014–15 and a high of 280,000 in 2021–22. The number of births has been fairly stable, and deaths have been rising, resulting in natural increase declining from 52,000 to 20,000 over the last decade.

Net migration has been affected by COVID-19 pandemic-related disruptions. Net migration to Ontario slowed from 202,000 in 2018–19 to 63,000 in 2020–21 but rebounded to 280,000 in 2021–22. In the medium-term, as the net change in non-permanent residents goes from its current elevated levels to its long-term track, net migration will decline from 458,000 in 2022–23 to 186,000 by 2026–27. Subsequently, net migration is projected to increase gradually, reaching 224,000 by 2045–46. The share of population growth accounted for by net migration is projected to decline from 95 per cent in 2022–23 to 82 per cent in 2026–27, and to slowly rise thereafter to reach 83 per cent by 2046.

**Chart 3: Contribution of natural increase & net migration to Ontario's population growth, 1971 to 2046**



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.

Accessible description of Chart 3: Contribution of natural increase & net migration to Ontario's population growth, 1971 to 2046

Partly due to higher-than-normal mortality in 2022–23, natural increase is projected to jump from 26,000 to 34,000 in 2023–24. Beyond 2024, future levels of natural increase are projected to increase slowly to reach 47,000 by 2045–46. The share of population growth accounted for by natural increase is projected to increase initially from 5 per cent in 2022–32 to 18 per cent in 2026–27, and to slowly decline thereafter to reach 17 per cent by 2045–46.

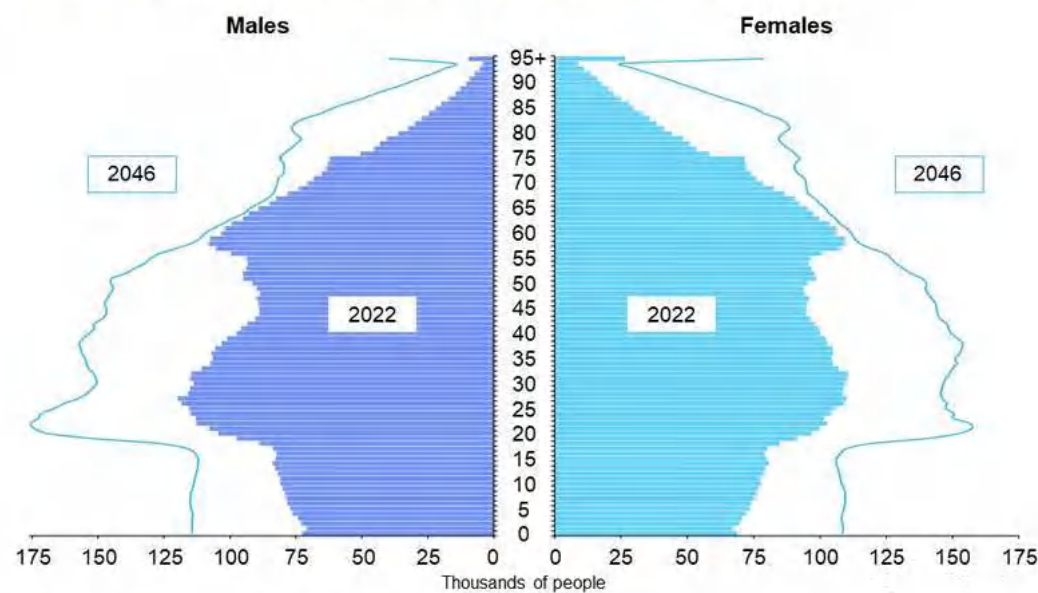
The number of deaths is projected to increase over time, as the large cohorts of baby boomers continue to age. By 2031, all baby boomers will be 65 or older. The annual number of deaths is projected to rise from 123,000 in 2022–23 to 175,000 by 2045–46.

Births are also projected to increase over the projection period, fuelled in the short term by the passage of the baby boom echo (children of baby boomers) through peak fertility years, and subsequently by continued population growth driven by young international migrants. The annual number of births is projected to rise from 148,000 in 2022–23 to 223,000 by 2045–46.

### Age structure

By 2046, there will be more people in every single year of age in Ontario compared to 2022, with a sharp increase in the number of seniors. Baby boomers will have significantly increased the number of seniors; children of the baby boom echo generation will be of school-age; and the baby boom echo cohorts, along with a new generation of immigrants, will have boosted the population aged 15–64.

**Chart 4: Age pyramid of Ontario's population, 2022 and 2046**



Sources: Statistics Canada for 2022, and Ontario Ministry of Finance projections.

Accessible description of Chart 4: Age pyramid of Ontario's population, 2022 and 2046

The median age of Ontario's population is projected to continue its current decline in the short term, falling from 40.4 years in 2022 to 39.2 years by 2026, and will rise slowly thereafter to reach 40.3 years in 2046. The median age for women falls slightly from 41.8 to 41.5 years over the projection period, while for men it is projected to increase marginally from 39.1 to 39.2 years.

The number of seniors aged 65 and over is projected to increase significantly, from 2.8 million or 18.4 per cent of population in 2022, to 4.4 million, or 20.3 per cent by 2046. In 2016, for the first time, seniors accounted for a larger share of population than children aged 0–14.

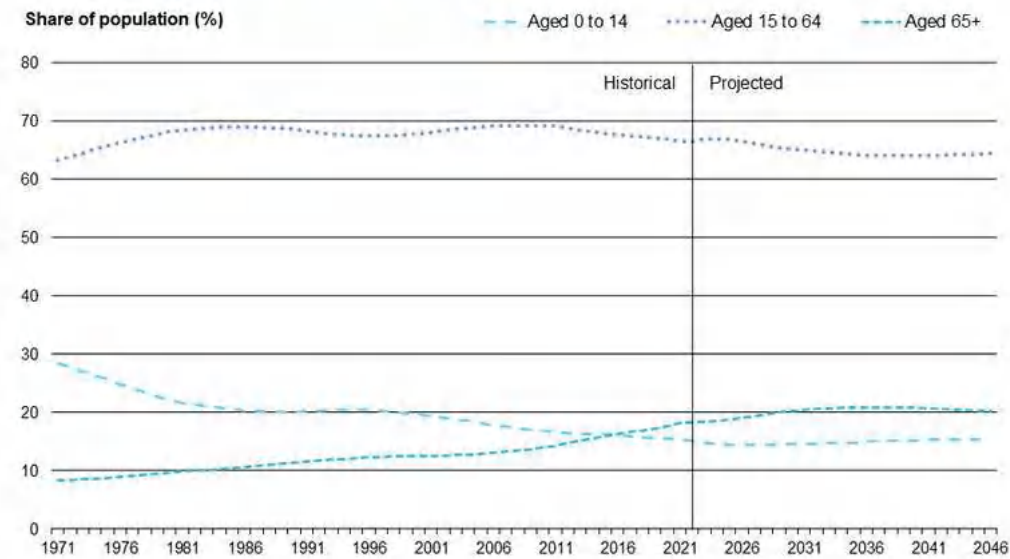
By the early 2030s, once all baby boomers have reached age 65, the growth in the number of seniors will slow significantly. The share of seniors is projected to peak at 20.9 per cent in 2036. The annual growth rate of the senior age group is projected to slow from an average of 3.1 per cent over 2022–31 to 1.0 per cent by the end of the projection period.

The older age groups will experience the fastest growth among seniors. The number of people aged 75 and over is projected to more than double in size, from 1.2 million in 2022 to almost 2.6 million by 2046. The number of people in the 90+ group will triple, from 139,000 to 417,000.

A substantial imbalance exists in the proportions of women and men in older age groups, as a result of men's lower life expectancy. The proportion of women among the oldest seniors is projected to remain higher than that of men but will decline slightly as male life expectancy is projected to increase relatively faster. In 2022, there were 33 per cent more women than men in the 75+ age group. By 2046, it is projected that there will be 25 per cent more women than men in the 75+ age group.



Chart 5: Proportion of population aged 0–14, 15–64 and 65+ in Ontario, 1971 to 2046



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.

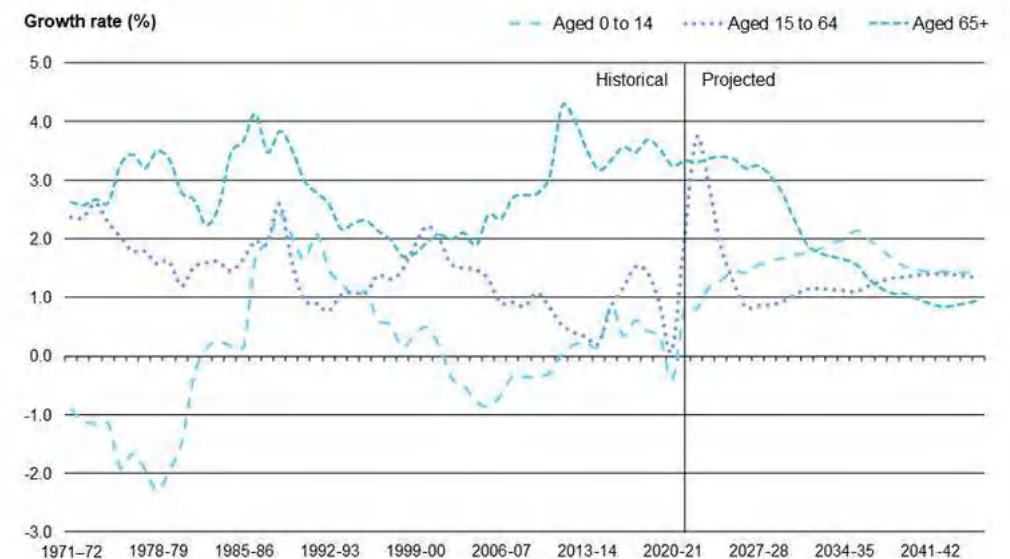
Accessible description of Chart 5: Proportion of population aged 0–14, 15–64 and 65+ in Ontario, 1971 to 2046

The number of children aged 0–14 is projected to increase moderately over the projection period, from 2.3 million in 2022 to 3.3 million by 2046. The children’s share of population is projected to decrease initially from 15.1 per cent in 2022 to 14.4 per cent by 2026, followed by a slow increase to 15.4 per cent by 2046.

The number of Ontarians aged 15–64 is projected to increase from 10.0 million in 2022 to 14.0 million by 2046. This age group is projected to decline as a share of total population for most of the projection period, from a peak of 66.9 per cent in 2024 to 64.0 per cent by 2038, and to increase slowly thereafter to reach 64.4 per cent by 2046.

The growth rate of the population aged 15–64 is projected to quickly trend lower initially to an average of 0.8 per cent annually over the late 2020s, a pace of change similar to that observed over the 2010s. Thereafter, as the children of the baby boom echo begin to reach age 15 and strong international migration continues, the pace of annual growth of the 15–64 age group is projected to accelerate, reaching 1.3 per cent in 2045–46.

Chart 6: Pace of growth of population age groups 0–14, 15–64 and 65+ in Ontario, 1971 to 2046



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.



## Accessible description of Chart 6: Pace of growth of population age groups 0–14, 15–64 and 65+ in Ontario, 1971 to 2046

Within the 15–64 age group, the number of youth (those aged 15–24) is projected to increase throughout the projection period, from 1.9 million in 2022 to 2.8 million by 2046. The youth share of total population is projected to increase initially from 12.6 per cent in 2022 to 13.8 per cent by 2026, followed by a gradual decline to 13.1 per cent by 2046.

The number of people aged 25–44 is projected to increase during the projection period, from 4.2 million in 2022 to 6.1 million by 2046, while their share of population is projected to initially increase from 28.0 to 29.6 per cent by 2033, followed by a decline to 27.9 per cent by 2046.

The number of people aged 45–64 is projected to be fairly stable at 3.9 million until 2029. Growth of this age group is projected to pick up in the early 2030s, to reach 5.1 million by 2046. Its share of population is projected to initially decline from 25.9 in 2022 to 21.7 per cent by 2034, and to resume growing to reach 23.4 per cent by 2046.

### Demographic determinants of regional population change

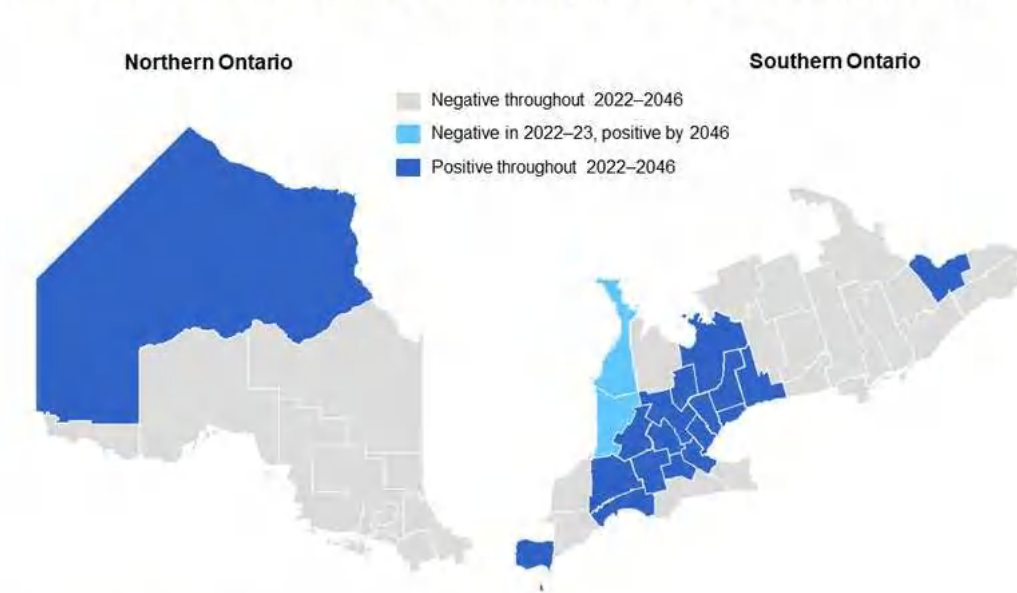
The main demographic determinants of regional population trends are the current age structure of the population, the pace of natural increase, and the migratory movements in and out of each of Ontario's regions. These determinants vary substantially among the 49 census divisions that comprise the six geographical regions of Ontario and drive significant differences in demographic projections.

The current age structure of each region has a strong influence on projected regional births and deaths. A region with a higher share of its current population in older age groups will likely experience more deaths in the future than a region of comparable size with a younger population. Similarly, a region with a large share of young adults in its population is expected to see more births than a region of similar size with an older age structure. Also, since migration rates vary by age, the age structure of a region or census division will have an impact on the migration of its population.

Due to the general aging of the population, most census divisions in Ontario were experiencing negative natural increase, where deaths exceed births, even period before the pandemic. This is projected to continue over the projection period. Although they represent a majority, the combined population of the 29 census divisions with negative natural increase by 2046 will account for only 18 per cent of Ontario's.

Many census divisions in Ontario where natural increase previously was the main or even sole contributor to population growth have already started to see their population growth slow. This trend is projected to continue as the population ages further.

## Chart 7: Evolution of natural increase by census division, 2022 to 2046



Source: Ontario Ministry of Finance projections.

### Accessible description of Chart 7: Evolution of natural increase by census division, 2022 to 2046

Migration is the most important factor contributing to population growth for Ontario and for most of its regions. Net migration gains, whether from international sources, other parts of Canada or other regions of Ontario, are projected to continue to be the major source of

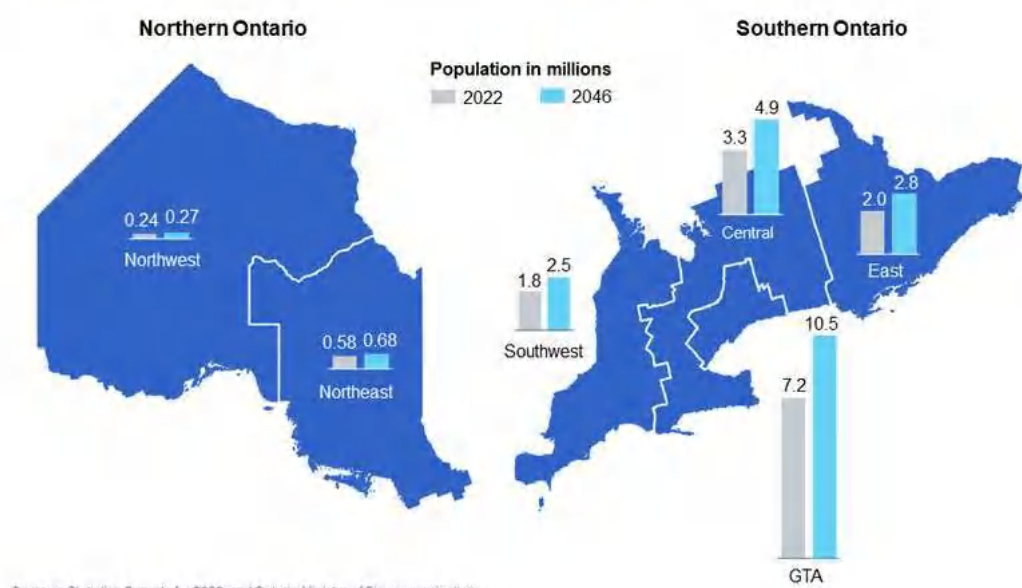
population growth for almost all census divisions.

Large urban areas, especially the Greater Toronto Area (GTA), which receive most of the international migration to Ontario, are projected to experience the strongest population growth. For other regions such as Central Ontario, the continuation of migration gains from other parts of the province will be a key source of population increase. Some census divisions of Northern Ontario tend to receive only a small share of international migration while experiencing net out-migration, mostly among young adults, which reduces projected population growth.

Regional population growth

The GTA is projected to see the largest increase in population among regions, accounting for just over 50 per cent of Ontario's net population growth to 2046. The GTA's population is projected to increase from 7.2 million in 2022 to over 10.5 million in 2046. The region's share of total Ontario population is projected to rise from 47.8 per cent in 2022 to 48.6 per cent in 2046.

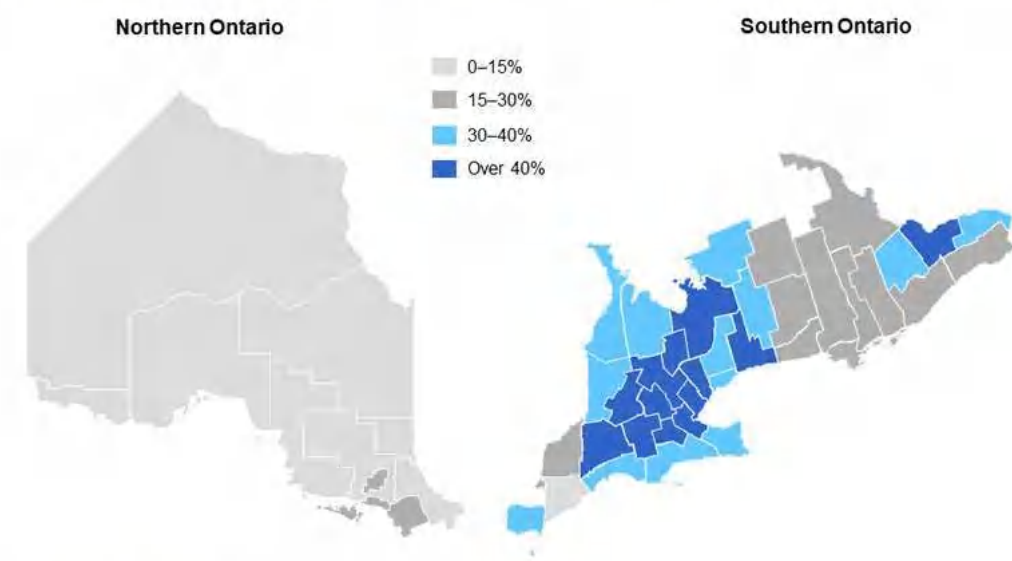
Chart 8: Population of Ontario regions, 2022 and 2046



Accessible description of Chart 8: Population of Ontario regions, 2022 and 2046

Within the GTA, Toronto's population is projected to rise from 3.03 million in 2022 to 4.20 million in 2046, adding 1,171,000 people, the largest population gain projected among census divisions. Nevertheless, Toronto's projected population growth rate of 38.7 per cent to 2046 is slightly slower than the provincial rate of 43.6 per cent. The four census divisions of the suburban GTA are projected to add a total of over 2.1 million people over the period. Peel (62.6%), Halton (59.5%) and Durham (43.8%) are projected to grow faster than the average for Ontario, while York's population is projected to grow at a pace (36.4%) slower than the province as a whole.

Chart 9: Population growth by census division over 2022 to 2046



Source: Ontario Ministry of Finance projections.

Accessible description of Chart 9: Population growth by census division over 2022 to 2046

Central Ontario is projected to be the fastest growing region of the province, adding 1.59 million residents for growth of 48.1 per cent, from 3.31 million in 2022 to 4.91 million in 2046. The region’s share of provincial population is projected to rise slightly from 21.9 to 22.6 per cent during the same period. Four census divisions of Central Ontario are projected to continue experiencing population growth significantly above the provincial average over the projection period: Waterloo, the fastest growing census division in Ontario at 67.6 per cent, Dufferin at 59.5 per cent, Wellington at 57.2 per cent, and Simcoe at 49.7 per cent. Hamilton is also projected to grow slightly faster than the provincial average at 44.1 per cent.

The population of Eastern Ontario is projected to grow 41.7 per cent over the projection period, from 1.98 million to 2.80 million. Ottawa is projected to grow fastest (54.5 per cent) from 1.07 million in 2022 to 1.66 million in 2046. All other Eastern Ontario census divisions are also projected to grow, but below the provincial average, with growth ranging from 15.1 per cent in Prince Edward to 38.7 per cent in Lanark.

The population of Southwestern Ontario is projected to grow from 1.77 million in 2022 to 2.50 million in 2046, an increase of 40.9 per cent. Growth rates within Southwestern Ontario vary, with Middlesex and Oxford growing fastest (53.7 and 53.6 per cent respectively), and Chatham-Kent and Lambton growing at the slowest pace (14.9 and 18.6 per cent respectively).

The population of Northern Ontario is projected to grow slowly over the projection horizon, with an increase of 14.6 per cent, from 821,000 in 2022 to 941,000 by 2046. Within the North, the Northeast is projected to see population growth of 96,000 or 16.7 per cent, from 579,000 to 676,000. The Northwest is projected to experience growth of 23,000 or 9.7 per cent, from 242,000 to 265,000.

In the past, Northern Ontario’s positive natural increase offset part of the losses it experienced through net migration. However, while the North has recently seen modest net migration gains, its natural increase has turned negative.

Table A: Population Shares of Ontario Regions, 1986 to 2046

Share of Ontario Population (%)	1986	1996	2006	2016	2026	2036	2046
GTA	41 . 4	43 . 0	45 . 8	47 . 8	48 . 2	48 . 5	48 . 6
Central	21 . 8	22 . 1	22 . 0	21 . 6	22 . 0	22 . 3	22 . 6
East	14 . 0	13 . 8	13 . 2	13 . 1	12 . 8	12 . 8	12 . 9

Share of Ontario Population (%)	1986	1996	2006	2016	2026	2036	2046
Southwest	14 . 1	13 . 4	12 . 6	11 . 7	11 . 8	11 . 6	11 . 5
Northeast	6 . 2	5 . 4	4 . 5	4 . 1	3 . 7	3 . 4	3 . 1
Northwest	2 . 6	2 . 3	1 . 9	1 . 7	1 . 5	1 . 3	1 . 2

Sources: Statistics Canada, 1986–2016, and Ontario Ministry of Finance projections.

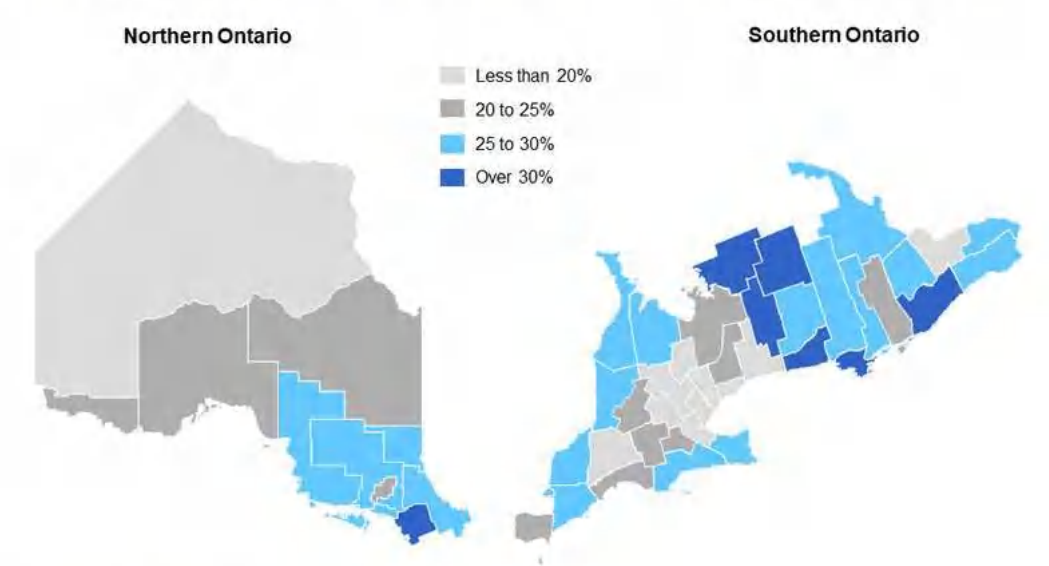
### Regional age structure

All regions are projected to see a continuing shift to an older age composition of their population. The largest shifts in age structure are projected to take place in census divisions, many in northern and rural areas, where natural increase and net migration are projected to remain or become negative. The GTA is expected to remain the region with the youngest age structure, a result of strong international migration and positive natural increase. The Northeast is projected to remain the region with the oldest age structure.

In 2022, the share of seniors aged 65 and over in regional population ranged from a low of 16.2 per cent in the GTA to a high of 23.3 per cent in the Northeast. Among census divisions, it ranged from 14.4 per cent in Peel to 36.1 per cent in Haliburton.

By 2046, the share of seniors in regions is projected to range from 18.3 per cent in the GTA to 25.4 per cent in the Northeast. Among census divisions, it is projected to range from 15.4 per cent in Peel to 38.5 per cent in Haliburton.

Chart 10: Share of seniors in population by census division in 2046

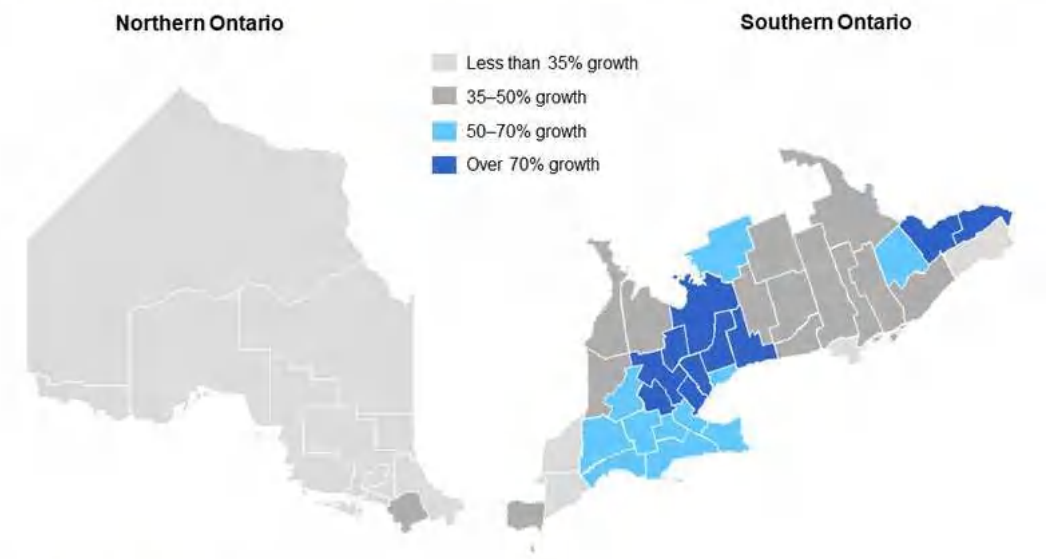


Source: Ontario Ministry of Finance projections.

Accessible description of Chart 10: Share of seniors in population by census division in 2046

Even as the share of seniors in census divisions located in and around the suburban GTA is projected to remain lower than the provincial average, the increase in the number of seniors will be highest in this area.

Chart 11: Growth in number of seniors by census division, 2022 to 2046



Source: Ontario Ministry of Finance projections.

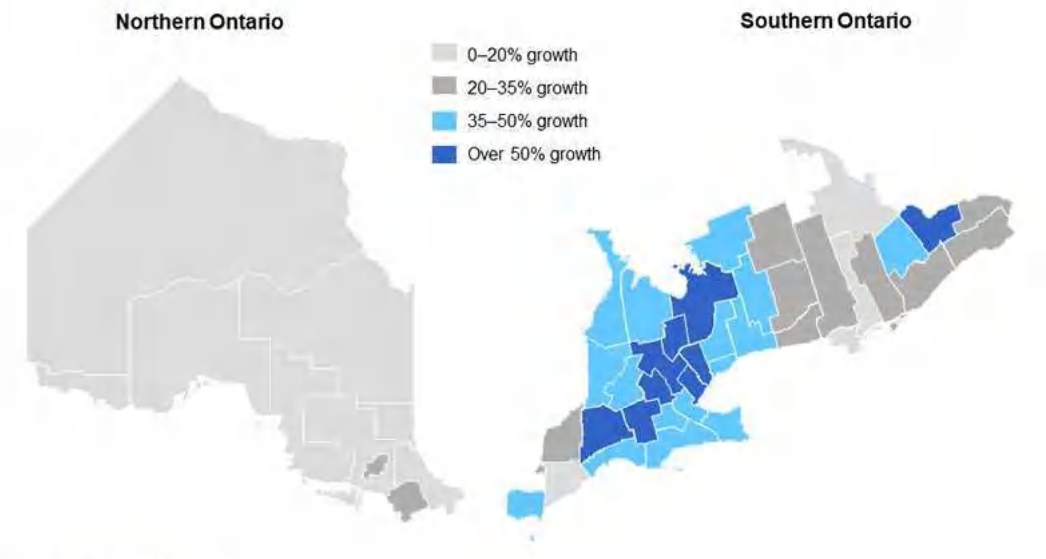
Accessible description of Chart 11: Growth in number of seniors by census division, 2022 to 2046

The number of seniors is projected grow by 75 per cent in the suburban GTA. Conversely, the number of seniors grows most slowly (less than 20 per cent) in Timiskaming and Thunder Bay.

The number of children aged 0–14 is projected to increase in all 6 regions over the projection period. However, the share of children in every region is projected to remain fairly stable throughout the projections. In 2022, the highest share of children among regions was in the Northwest at 16.6 per cent; the Northeast had the lowest share at 14.3 per cent. By 2046, the Northeast is projected to remain the region with the lowest share of children at 14.7 per cent while the highest share is projected to be found in the Southwest at 16.3 per cent.

Waterloo, Peel, Dufferin, and Halton are projected to record growth of over 60 per cent in the number of children aged 0–14 over the 2022–2046 period. Conversely, Kenora, Cochrane, Thunder Bay, and Rainy River are projected to see less than 10 per cent growth in the number of children aged 0–14 over that period. In 2022, the highest share of children was found in Kenora at 21.2 per cent and the lowest share in Haliburton at 9.5 per cent. By 2046, Kenora is projected to still have the highest share of children at 19.6 per cent, while Haliburton is projected to continue to have the lowest at 9.2 per cent.

Chart 12: Growth in number of children aged 0–14 by census division, 2022 to 2046



Source: Ontario Ministry of Finance projections.

Accessible description of Chart 12: Growth in number of children aged 0–14 by census division, 2022 to 2046

The share of population aged 15–64, which ranged from 62.4 per cent in the Northeast to 69.0 per cent in the GTA in 2022, is projected to decline to 2046 in every region. The share of this age group is projected to range from 60.0 per cent of population in the Northeast to 66.6 per cent in the GTA by 2046.

While the share of population aged 15–64 is projected to decrease in every census division of the province except for Bruce (+0.1 percentage point), the number of people in this age group is projected to increase in all 49 census divisions. The highest share of people aged 15–64 in 2022 was in Toronto (70.6 per cent) while the lowest was in Haliburton (54.4 per cent). By 2046, Toronto is projected to remain the region with the highest share of population in this age group (69.1 per cent), followed by Peel, Waterloo, and Ottawa. Prince Edward (50.7 per cent) and Haliburton (52.2 per cent) are projected to have the lowest shares by 2046.

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## Methodology and Assumptions

### Projections methodology

The methodology used in the Ministry of Finance's long-term population projections is the cohort-component method, essentially a demographic accounting system. The calculation starts with the base-year population (2022) distributed by age and sex.

A separate analysis and projection of each component of population growth is made for each year, starting with births. Then, projections of deaths and the five migration components (immigration, emigration, net change in non-permanent residents, interprovincial in- and out-migration, and intraprovincial in- and out-migration) are also generated and added to the population cohorts to obtain the population of the subsequent year, by age and sex.

This methodology is followed for each of the 49 census divisions. The Ontario-level population is obtained by summing the projected census division populations.

It should be noted that the population projections are demographic, founded on assumptions about births, deaths and migration over the projection period. Assumptions are based on the analysis of the long-term and the most recent trends of these components, as well as expectations of future direction. For Ontario, the degree of uncertainty inherent in projections is represented by the range between the low- and high-growth scenarios, with the reference scenario representing the most likely outcome.

### Base population

This report includes demographic projections released by the Ministry of Finance that use the latest population estimates based on the 2016 Census adjusted for net under-coverage. Specifically, the projections use Statistics Canada's preliminary postcensal population estimates for July 1, 2022 as a base.

As well as providing a new starting point for total population by age and sex, updating the projections to a new base alters the projected age structure and population growth in each census division. It also has an impact on many components of population growth that are projected by using age-specific rates, such as births, deaths, and several of the migration streams.

### Fertility

The projected number of births for any given year is obtained by applying age-specific fertility rates to cohorts of women in the reproductive age group, ages 15 to 49. The projection model relies on four parameters<sup>[2]</sup> to generate the annual number of births. The first of these parameters, the total fertility rate (TFR), reflects the level of fertility while the other three parameters (the mean age at maternity, the skewness and the variance of the distribution) reflect the timing, or age, at which women give birth. These parameters are calibrated to generate age-specific fertility rates that closely follow recent trends.

Assumptions are based on a careful analysis of past age-specific fertility trends in Ontario and a review of fertility trends elsewhere in Canada and in other countries. A general and common trend is that a growing proportion of women are giving birth in their 30s and early 40s. The overall decline in the fertility rate among young women is accompanied by a rise in fertility rates among older women. Over the past 20 years, teenagers and women in their early 20s have experienced the sharpest declines in fertility rates. Fertility rates of women in their 30s and older, which were rising moderately over the 1990s and more rapidly over most of the 2000s, have shown a slower pace of increase in



more recent years. These are the same cohorts of women who postponed births during their 20s and are now having children in their 30s and early 40s.

Ontario's total fertility rate (TFR), which stood at 3.8 children per woman around 1960, fell below the replacement level of 2.1 children per woman in 1972. Over the rest of the 1970s, the TFR fell rapidly toward the 1.40 to 1.70 range where it was hovering until recently. The latest data available for Ontario (2021) show a TFR of 1.37. Fertility rates are unlikely to return to the highs observed in the 1950s and early 1960s. Rather, it is believed that relatively small fluctuations around values below the replacement level are more likely.

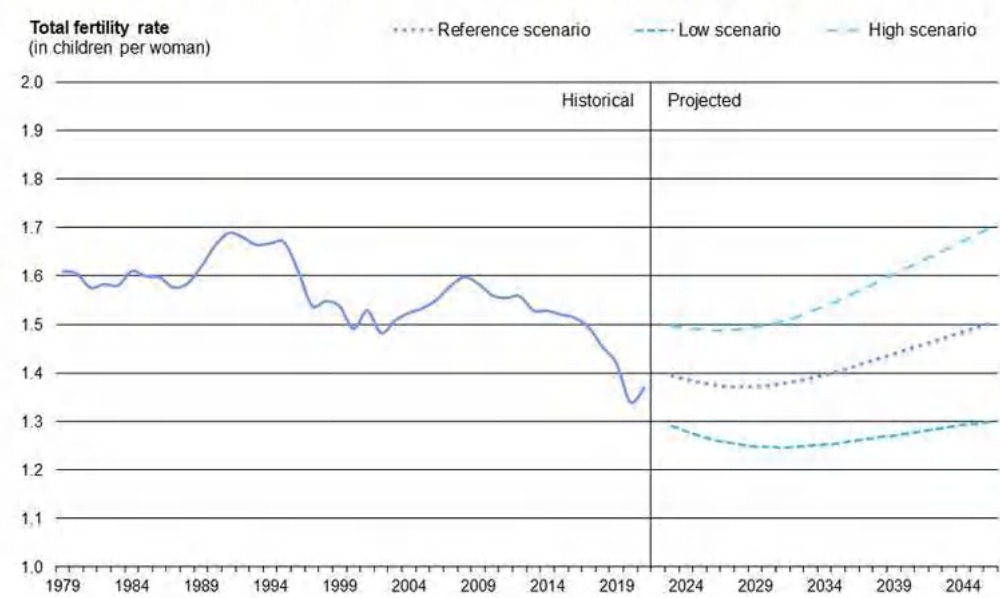
In the reference scenario, the TFR is assumed to decline initially from 1.39 in 2022–23 to 1.37 by 2027–28, and to subsequently rise slowly as younger women's fertility rates stabilize while those of older women continue to gradually increase, reaching 1.50 children per woman in 2046.

In the low- and high-growth scenarios, fertility is assumed to follow a similar pattern of initial decline followed by a slight increase. By 2046, the TFR reaches 1.30 children per woman in the low-growth scenario and 1.70 in the high-growth scenario.

Fertility assumptions at the census division level

The most recent complete data for census divisions (2019) shows that TFRs range from a high of 2.09 in Kenora to a low of 1.17 in Toronto. The projected parameters for fertility at the census division level are modelled to maintain regional differences. The census division-to-province ratio for mean age at fertility in the most recent period is assumed to remain constant. The variance and skewness of fertility distributions for census divisions evolve over the projection period following the same absolute changes of these parameters at the Ontario level.

Chart 13: Total fertility rate of Ontario women, 1979 to 2046



Source: Ontario Ministry of Finance.

Accessible description of Chart 13: Total fertility rate of Ontario women, 1979 to 2046

Mortality

The population of Ontario has one of the highest life expectancies in Canada and the developed world. The latest data shows that life expectancy at birth in Ontario was 84.4 years for females and 79.9 years for males in 2020. Deaths related to opioid use and the COVID-19 pandemic are having negative impacts on the pace of life expectancy improvements in the short term. However, the generally accepted view is that life expectancy will continue to rise over the long term in Canada and around the world.

Up to the mid-1990s, annual gains in life expectancy were becoming smaller and it was expected that future improvements would continue at this slowing speed. The pace of annual gains in life expectancy then picked up over the next two decades, and the progression of life expectancy became more linear. Until the mid-2010s, average gains in life expectancy were in the order of 0.16 years per year for females and 0.23 years for males. However, in recent years and even before the pandemic, average life expectancy was not rising in Ontario, partly due to an increase in opioid-related deaths, but mostly as a result of a slowdown in the improvement of survival rates from heart diseases,

which was the main cause of increases in life expectancy over the past decades. It is assumed that other factors, such as continued progress in fighting cancer, will drive increases in the average lifespan at a gradual pace over the projection period.

The projected number of deaths each year is obtained by applying projected age-specific mortality rates to population cohorts of corresponding ages. Projections of age-specific death rates are derived<sup>[3]</sup> from trends related to the pace of improvement in overall life expectancy and the age patterns of mortality.

All three projection scenarios for Ontario reflect a continuation of the gains recorded in average life expectancy. Male life expectancy is expected to progress at a faster pace than that of females under the long-term mortality assumptions for each of the three scenarios. This is consistent with recent trends where males have recorded larger gains in life expectancy than females. This has resulted in a shrinking of the gap in life expectancy between males and females, a trend that is projected to continue. Furthermore, reflecting current trends, future gains in life expectancy are modelled to be concentrated at older ages and to be smaller for infants.

In the reference scenario, life expectancy in Ontario is projected to continue increasing, but slower than the average observed over the last two decades, with the pace of increase gradually diminishing over the projection period. By 2046, life expectancy is projected to reach 84.3 years for males and 87.6 years for females. This represents total life expectancy gains of 4.4 years for males and 3.3 years for females between 2020 and 2046.

In the low-growth scenario, life expectancy increases at a slower pace, to 82.8 years for males and 86.4 years for females by 2046. In the high-growth scenario, life expectancy reaches 86.0 and 89.1 years in 2046 for males and females respectively.

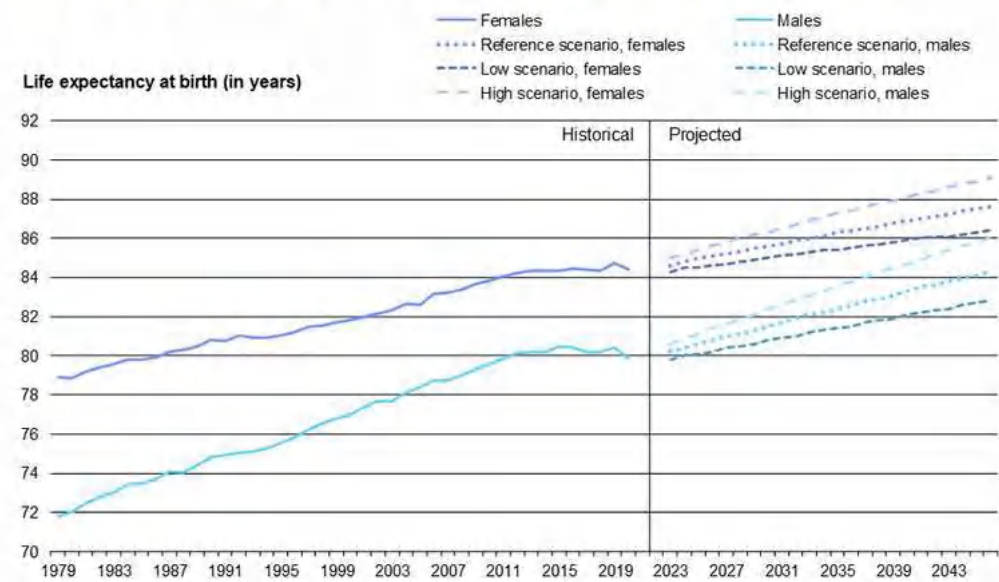
**Table B: Life expectancy in Ontario, 1986 to 2046**

Item	1986	1996	2006	2016	2026	2036	2046
Males at birth	73.7	75.8	78.7	80.4	80.8	82.6	84.3
Males at age 65	14.9	16.1	18.2	19.6	20.3	21.6	22.9
Females at birth	79.9	81.2	83.2	84.4	85.1	86.4	87.6
Females at age 65	19.1	19.8	21.3	22.4	23.0	24.0	25.0

Sources: Statistics Canada, 1986–2016, and Ontario Ministry of Finance projections.



Chart 14: Life expectancy at birth by sex in Ontario, 1979 to 2046



Sources: Statistics Canada for 1971–2020, and Ontario Ministry of Finance projections.

Accessible description of Chart 14: Life expectancy at birth by sex in Ontario, 1979 to 2046

Mortality assumptions at the census division level

At the census division level, the mortality assumptions were developed using a ratio methodology. The Ontario-level mortality structure was applied to each census division’s age structure over the most recent six years of comparable data and the expected number of deaths was computed. This was then compared to the actual annual number of deaths for each census division over this period to create ratios of actual-to-expected number of deaths. These ratios were then multiplied by provincial age-specific death rates to create death rates for each census division. These were then applied to the corresponding census division population to derive the number of deaths for each census division.

An analysis of the ratio of actual-to-expected deaths for each census division did not reveal a consistent pattern or movement toward a convergence or divergence among regions over time. For this reason, the most recent six-year average ratio for each census division was held constant over the projection period.

Components of net migration

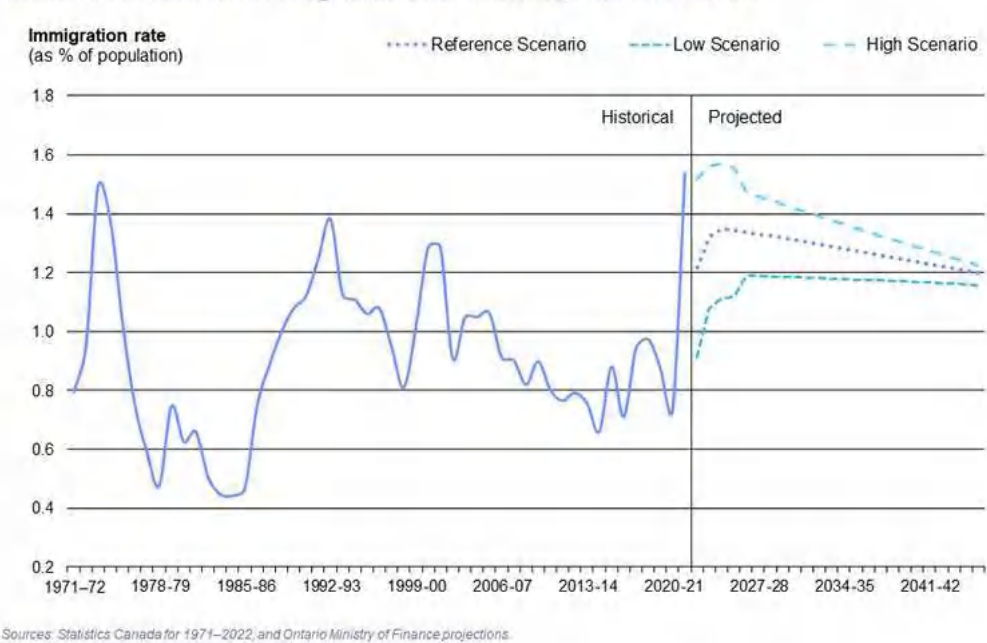
The following sections discuss assumptions and methodology for the components of net migration, including immigration, emigration, non-permanent residents, interprovincial migration and intraprovincial migration.

Immigration

Immigration levels in Canada are determined by federal government policy. The federal Minister of Immigration, Refugees and Citizenship Canada (IRCC) sets the national target and target-range for the level of immigration to be achieved over the following year(s). For calendar year 2023, the target is set at 465,000, with a plan for 485,000 in 2024 and 500,000 in 2025. These represent a significant increase from the targets set in recent years. The share of immigrants to Canada settling in Ontario declined in calendar year 2022, from 49.1 per cent in 2021 to 42.3 per cent. These lower shares are projected to continue in the short-term, before increasing lightly in the medium-term.

In the reference scenario, immigration levels are projected to reach about 220,000 in Ontario by 2025–26, resulting in an immigration rate of 1.35 per cent. Over the rest of the projection period, the number of immigrants increases slowly over time as population grows, such that annual immigration is projected to reach 257,000 by 2045–46. The immigration rate will gradually decline after 2025–26 to reach 1.2 per cent by the end of the projection period.

Chart 15: Rate of immigration to Ontario, 1971 to 2046



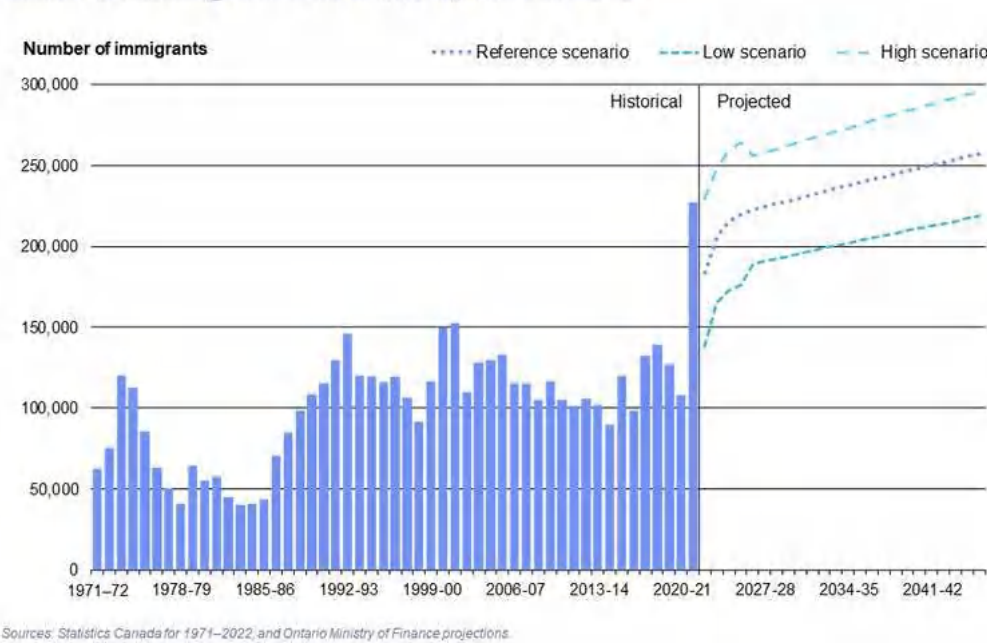
Accessible description of Chart 15: Rate of immigration to Ontario, 1971 to 2046

Immigration levels in the low-growth scenario are set at 85 per cent of reference scenario levels in the long term, resulting in immigration levels rising to 218,000 by 2045–46. In the high-growth scenario, immigration levels are set at 115 per cent of reference scenario levels in the long term, resulting in immigration rising strongly to reach 296,000 by 2045–46.

Immigration assumptions at the census division level

Projected immigration shares for each census division are based on the trends observed in the distribution of immigrants by census division over the recent past. These shares evolve throughout the projection period following established trends. The average age-sex distribution pattern for immigrants observed over the past five years is assumed to remain constant over the entire projection period. Nearly 90 per cent of immigrants coming to Ontario in 2021–22 were aged 0 to 44.

Chart 16: Immigration to Ontario, 1971 to 2046



Accessible description of Chart 16: Immigration to Ontario, 1971 to 2046

Emigration

Total emigration is defined as the gross flow of international emigration, minus returning emigrants, plus the net variation in the number of temporarily emigrants. The level of total emigration from Ontario was 17,600 in 2021–22, slightly higher than the average of 15,600 over the two years before the pandemic.

The number of emigrants is difficult to estimate with a high degree of accuracy because of limited information. Statistics Canada publishes annual estimates of these flows based on a variety of sources, such as tax data and statistics from the American Community Survey and the Department of Homeland Security. However, these estimates are believed to be lower than the actual number of people who emigrate from Ontario each year. This under-estimation can help explain the difference between population growth as measured by Census enumerations adjusted for net under-coverage and estimated population growth by Statistics Canada over the same period.

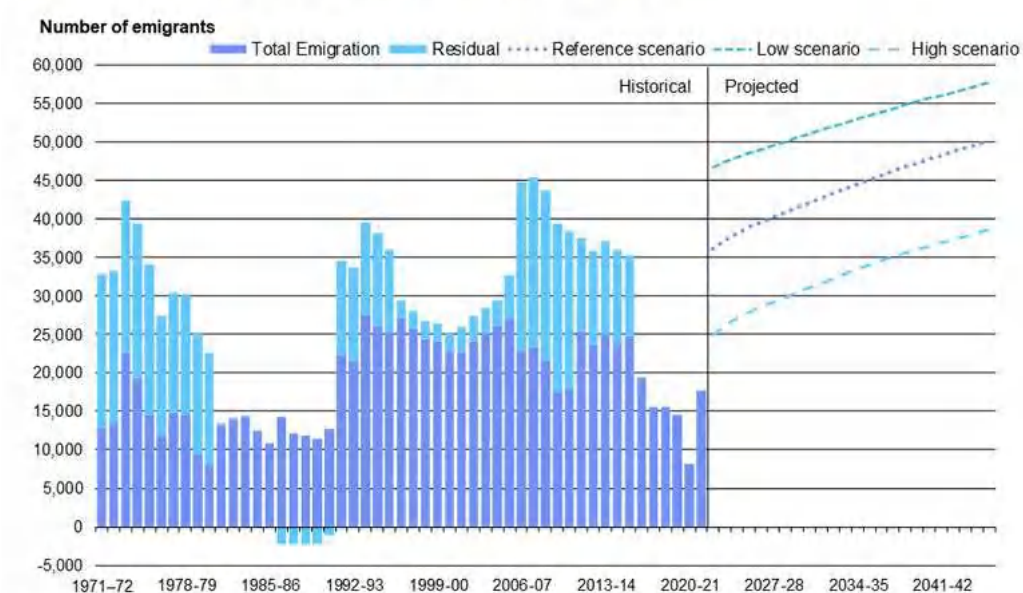
Over the last intercensal period from 2011 to 2016, population estimates from Statistics Canada overestimated population growth in Ontario by about 11,800 people each year on average. It is thought that under-estimation of emigration is part of the explanation. In order to account for this unexplained element of Ontario's estimated population growth trends, the projections assume that emigration fully accounted for the overestimation. Therefore, an annual adjustment of about 11,800 to emigration is applied for each year of the projections.

In the reference scenario, the average emigration rates by age and sex for each census division over the past five years are used to model the projected number of people emigrating annually from each census division. These rates are then adjusted to factor in the noted adjustment for the overestimation in the postcensal estimates of population. The modelling is dynamic, taking into account the annual changes in age structure within census divisions. For Ontario as a whole, this results in the number of emigrants increasing gradually over the projection period to reach 50,100 by 2045–46.

In the low-growth scenario, emigration rates by age and sex used in the reference scenario are increased by 30 per cent, making them 130 per cent of recently-observed rates. This results in emigration levels reaching 57,600 by 2045–46.

In the high-growth scenario, emigration rates by age and sex used in the reference scenario are reduced by 30 per cent, making them equivalent to 70 per cent of recently-observed rates. This results in the number of emigrants reaching 38,500 by 2045–46.

**Chart 17: Emigration from Ontario, 1971 to 2046**



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.

Accessible description of Chart 17: Emigration from Ontario, 1971 to 2046

## Non-permanent residents

There were almost 700,000 non-permanent residents (NPRs: e.g., foreign students, temporary foreign workers, refugee claimants) living in Ontario on July 1, 2022. These foreign residents are part of the base population since they are counted in the Census and are included in the components of population change. The year-to-year change in the total number of NPRs is accounted for as a component of population growth in the projections. Determining assumptions for this component is complicated by the significant annual fluctuations in this group.

The increase in the number NPRs in Ontario averaged 77,000 annually over the three calendar years before the pandemic. During 2020 and 2021, travel restrictions and immigration initiatives targeting candidates already in Canada under temporary residence permits slowed the increase in the number of non-permanent residents in Ontario. However, 2022 saw a record increase of 306,000 non-permanent residents in the province. Over the past 30 years, Ontario gained on average 16,100 non-permanent residents annually. As a proportion of total population, the corresponding rate was 0.13 per cent on average each year.

Over the next few months, net gains in NPRs will continue to be affected by the special measures put in place by the federal government in response to the Russian invasion of Ukraine. In particular, the Canada-Ukraine authorization for emergency travel (CUAET) was created to help Ukrainians and their family members come to Canada as quickly as possible and to provide them with the ability to work and study while in Canada under multi-year temporary residence permits. The number of CUAET permits has not been capped. Over one million Ukrainians have applied, 700,000 have been approved to date, and 153,000 have already arrived in Canada. Based on the latest information and despite the high level of uncertainty, assumptions have been made to include the arrival of 80,000 CUAET permit holders in Ontario in 2022–23, with an additional 110,000 during 2023–24. It is assumed that they will leave Canada as their permits expire or be gradually absorbed into the permanent resident population through immigration.

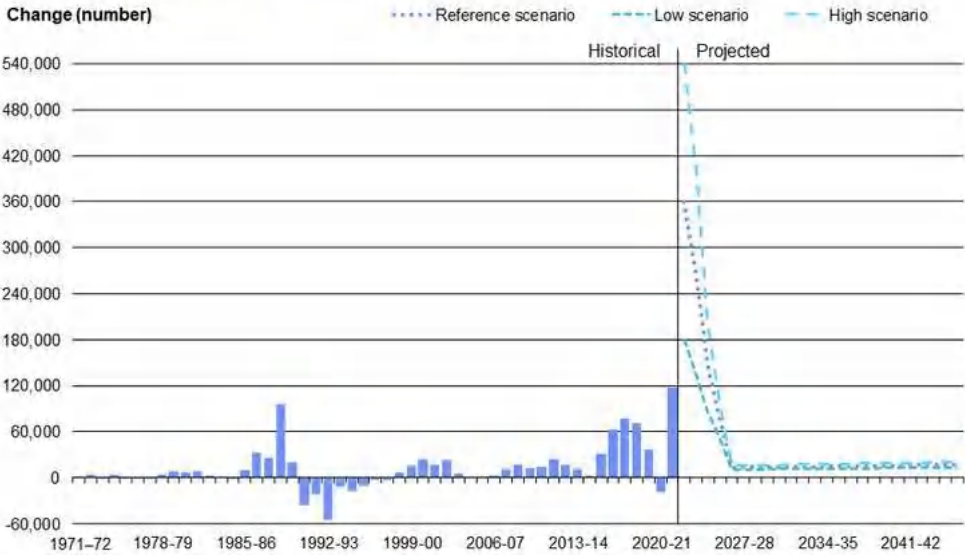
The reference scenario reflects long-term trends in the annual change in the number of NPRs by setting the long-term yearly gain at 0.08 per cent of population. The long-term assumptions for each projection scenario are reached after a transition period to reflect the higher net gains expected in the short term, including CUAET permit holders.

For 2022–23, the reference scenario net gain is set at 360,000, followed by net gains of 265,000 in 2023–24, 145,000 in 2024–25, 75,000 in 2025–26, and 13,000 in 2026–27. The low- and high-growth scenarios are set as a range of 50 per cent below and above the reference scenario net gain in 2022–23 and 2023–24, 40 per cent in 2024–25, 30 per cent in 2025–26, and 20 per cent over the rest of the projection period.

**Non-permanent resident assumptions at the census division level**

Projected shares of the net change in non-permanent residents for each census division, as well as their distributions by age and sex, are based on the shares observed over the last five years. The distribution pattern is assumed to remain constant over the projection period.

**Chart 18: Annual change in the number of non-permanent residents living in Ontario, 1971 to 2046**



Sources: Statistics Canada for 1971–2022, and Ontario Ministry of Finance projections.

Accessible description of Chart 18: Annual change in the number of non-permanent residents living in Ontario, 1971 to 2046

Sources: Statistics Canada, 1971–2022, and Ontario Ministry of Finance projections

**Interprovincial migration**

Interprovincial migration is a component of population growth that fluctuates significantly from year to year. Although Ontario remains a major province of attraction for migrants from some other provinces, trend analysis of the last three decades reveals a mixed pattern of



several years of gains followed by several years of losses. This pattern is usually closely tied to economic cycles.

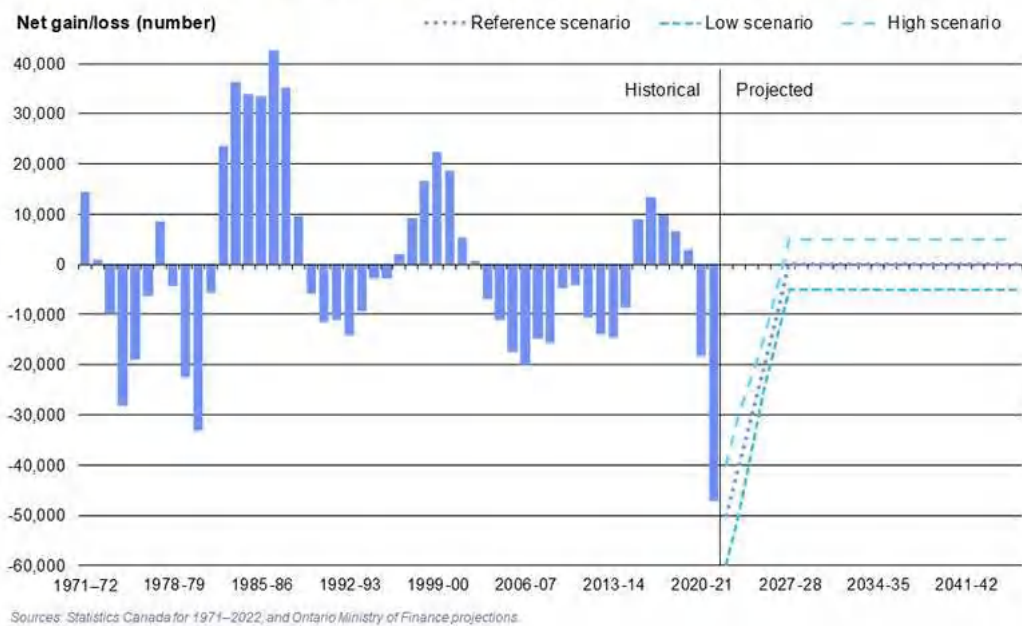
Over the past 30 years, net interprovincial migration has not contributed to Ontario's population growth, with net losses averaging about 4,000 people per year. Between 2015 and 2020, net interprovincial migration to Ontario had been positive. However, the most recent data shows a reversal of this trend, with net losses of 18,000 in 2020–21 and 47,000 in 2021–22.

In the reference scenario, annual net interprovincial migration to Ontario is set at -50,000 for 2022–23, reflecting the most recent data, followed by net losses of 40,000 in 2023–24, 30,000 in 2024–25, 20,000 in 2025–26, and 10,000 in 2026–27. The long-term assumption of a net gain of zero is then reached by 2027–28, remaining at that level for the rest of the projection period.

The low- and high-growth scenarios are set as a range of 10,000 above and below the reference scenario net loss in 2022–23 and 2023–24. This range is narrowed to 7,500 in 2024–25, and to 5,000 over the rest of the projection period.

The annual in-flows corresponding to the long-term net migration levels in the low-growth, reference and high-growth scenarios are 62,500, 65,000 and 67,500 respectively. The corresponding annual out-flows are 67,500, 65,000 and 62,500.

**Chart 19: Net interprovincial migration in Ontario, 1971 to 2046**



Accessible description of Chart 19: Net interprovincial migration in Ontario, 1971 to 2046

**Interprovincial migration assumptions at the census division level**

For each census division, interprovincial migration flows reflect migration rates by age and sex observed during the last five years and vary over the projection period following Ontario-level fluctuations. Each census division's share of Ontario inflow and outflow of interprovincial migrants over the last five years is applied to projected flows for the province and held constant throughout the projection period.

**Intraprovincial migration**

At the census division level, intraprovincial migration, or the movement of population from one census division to another within the province, is a significant component of population growth. This component directly affects population growth only at the census division and regional levels.

The annual number of intraprovincial migrants in Ontario has fluctuated within the 350,000 to 460,000 range over the past 20 years. Over the projection period, the annual number of intraprovincial migrants is projected to increase from 451,000 in 2022–23 to 506,000 in 2045–46. The resulting rate of intraprovincial migration in Ontario declines slightly over the projection period, from 3.0 per cent in 2022–23 to 2.4 per cent by 2045–46.

**Intraprovincial migration assumptions at the census division level**

The projected number of people by age, leaving each census division for each year of the projections, as well as their destination within the province, is modelled using origin-destination migration rates by age and census division over the past five years. Because migration rates are different for each census division and because age groups have different origin-destination behaviours, the methodology provides an approach to project movers based on observed age and origin-destination migration patterns. The modelling is dynamic, taking into account the annual changes in age structure within census divisions.

The evolution of intraprovincial migration patterns in each census division was studied to identify specific trends and the intraprovincial migration rate assumptions were adjusted to account for these trends.

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## Glossary

### **Baby boom generation**

People born during the period following World War II, from 1946 to 1965, marked by a significant increase in fertility rates and in the number of births.

### **Baby boom echo**

People born during the period 1972 to 1992. Children of baby boomers.

### **Cohort**

Represents a group of persons who have experienced a specific demographic event during a given period, which can be a year. For example, the birth cohort of 1966 consists of the number of persons who were born in 1966.

### **GTA**

The Greater Toronto Area, comprised of the census divisions of Toronto, Durham, Halton, Peel and York.

### **International migration**

Movement of population between Ontario and a foreign country. International migration includes immigrants, emigrants and non-permanent residents. Net international migration is the difference between the number of people entering and the number of people leaving the province from foreign countries.

### **Interprovincial migration**

Movement of population between Ontario and the rest of Canada. Net interprovincial migration is the difference between the number of people entering Ontario from the rest of Canada and the number of people leaving Ontario for elsewhere in Canada.

### **Intraprovincial migration**

Movement of population between the 49 census divisions within Ontario. Net intraprovincial migration for a given census division is the difference between the number of people moving from the rest of Ontario to this census division and the number of people leaving it for elsewhere in the province.

### **Life expectancy**

A statistical measure reflecting the average number of years of life remaining for members of a particular population at a specific age if they were to experience during their lives the age-specific mortality rates observed in a given year.

### **Median age**

The median age is the age at which exactly one half of the population is older, and the other half is younger. This measure is often used to compare age structures between jurisdictions.

### **Natural increase**

The number of births minus the number of deaths.

### **Net migration**

Difference between the number of people entering and the number of people leaving a given area. This includes all the migration components included in net international migration, net interprovincial migration and net intraprovincial migration (for sub-provincial jurisdictions).

### **Non-permanent residents**

Foreign citizens living in Ontario (e.g., international students, foreign workers, and refugee claimants).

### **Population aging**

An expression used to describe shifts in the age distribution of the population toward more people of older ages. One indicator of population aging is an increasing share of seniors (ages 65+) in the population.

## Population estimates

Measures of current and historical resident population derived using Census and administrative data.

## Total fertility rate

The sum of age-specific fertility rates during a given year. Indicates the average number of children that a generation of women would have if, over the course of their reproductive life, they had fertility rates identical to those of the year considered.

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## Statistical tables

View the related statistical tables at Ontario's Open Data Catalogue (<https://data.ontario.ca/dataset/population-projections>)

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## Accessible chart descriptions

### Chart 1: Ontario population, 1971 to 2046

This line chart shows the estimated total population of Ontario from 1971 to 2022, and the projection to 2046 for the three scenarios (reference, high and low). Over the historical period, Ontario's population increased from 7.8 million in 1971 to 15.1 million in 2022. Over the projections period 2022-2046, the three scenarios gradually diverge. In the reference scenario, total population reaches 21.7 million in 2046. Ontario's population reaches 24.5 million in the high scenario and 19.0 million in the low scenario at the end of the projection period.

[Return to chart 1](#)

### Chart 2: Annual rate of population growth in Ontario, 1971 to 2046

This chart shows historical annual growth rates of Ontario's population as bars from 1971 to 2022, and projected growth rates as lines for the three scenarios (reference, high and low). Over the historical period, annual growth rates start at 1.5% in 1971-72, and then decline to reach 0.8% in 1980-81. This is followed by higher growth rates culminating at 2.7% in 1988-89, with a lower peak of 1.8% in 2000-01, trending lower to 0.7% in 2014-15, and finally reaching 2.0% in 2021-22. The projected annual growth rate of Ontario's population in the reference scenario is 3.2% in 2022-23, trending down thereafter to reach 1.3% in 2045-46. In the high scenario, annual population growth goes from 4.9% in 2022-23 to 1.6% over the projection period. In the low scenario, population growth goes from 1.5% in 2022-23 to 0.8% in 2045-46.

[Return to chart 2](#)

### Chart 3: Contribution of natural increase & net migration to Ontario's population growth, 1971 to 2046

This area chart shows the annual contribution of natural increase and net migration to Ontario's population growth from 1971 to 2046. Over the historical period, natural increase was more stable than net migration, starting at about 69,000 in 1971-72, with an intermediate high point of 79,000 in 1990-91, and a declining trend to 20,000 by 2021-22. Over the projection period, natural increase is projected to increase gradually, reaching 47,000 by 2045-46. Net Migration was more volatile over the historical period, starting at about 45,000 in 1971-72, with a low point of 10,000 in 1978-79, peaks of 194,000 in 1988-89, 168,000 in 2000-01, and 280,000 in 2021-22. Annual net migration is projected to decrease initially from 458,000 in 2022-23 to 186,000 in 2026-27 and rise gradually for the rest of the projection period to reach 224,000 by 2045-46.

[Return to chart 3](#)

### Chart 4: Age pyramid of Ontario's population, 2022 and 2046

This population pyramid shows the number of people of each age in Ontario in 2022 and 2046 separately for males and females. In 2022, the pyramid starts at the bottom with about 70,000 each for males and females aged zero, and gradually widens to over 110,000 people per cohort in their late 20s. This is followed by a slight narrowing of the pyramid to about 90,000 at late 40s ages, and a peak around 110,000 at late-50s ages. The pyramid subsequently narrows to only a few thousand people per cohort at ages 95+. The 2046 line starts at around 110,000 each for both males and females at age zero with steep peak above 150,000 after age 20, followed by a gradual decrease to around 150,000 near age 45, and a further decline to age 95+.

[Return to chart 4](#)

**Chart 5: Proportion of population aged 0–14, 15–64 and 65+ in Ontario, 1971 to 2046**

This chart has three lines showing the evolution of the share of Ontario’s population in age groups 0-14, 15-64 and 65+ over the 1971-2046 period. The highest proportion is aged 15-64 and is fairly stable over the historical period between 60% and 70%, with a declining trend starting around 2010. Over the projection period, the share of people aged 15-64 is projected to fall from 66.5% to 64.4%. The share of population aged 0-14 is seen falling gradually from 28.4% in 1971 to 15.1% in 2022, with a further decline to 14.4% by 2066, and an increase to 15.4% by 2046. The share of seniors increases slowly from 8.3% in 1971 to 18.4% in 2022, and more rapidly over the first half of the projection period to reach 20.9% in 2036 and subsequently declining to 20.3% by 2046. The share of seniors surpassed that of children in 2016.

[Return to chart 5](#)

**Chart 6: Pace of growth of population age groups 0–14, 15–64 and 65+ in Ontario, 1971 to 2046**

This line chart shows the pace of annual growth of population age groups 0-14, 15-64 and 65+ in Ontario from 1971 to 2046. The 65+ age group grows faster than the other two groups for most of the historical and the first half of the projection period, with a peak of 4.3% in 2011-12 and a low close to 0.8% in the early 2040s. The annual pace of growth of the 15-64 age group is seen trending gradually lower from 2.4% in 1971-72 to 0.2% in 2014-15, followed by a peak of 3.7% in 2022-23, a decline to 0.8% by 2026-27 and then rising to 1.3% by 2045-46. The annual growth rate of the 0-14 age group is the most volatile, recoding declines from 1971 to 1982 with a trough of -2.3% in 1978-79, and then again from 2002 to 2011. Over the projection period, growth in the number of children is projected to peak at 2.1% in the mid-2030s, ending at 1.4% by 2045-46.

[Return to chart 6](#)

**Chart 7: Evolution of natural increase by census division, 2022 to 2046**

This map shows the evolution of natural increase by census division in Ontario over the projection period 2021-46. The census divisions are split in three categories.

Census divisions where natural increase is projected to be negative throughout 2022-2046 include: Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Greater Sudbury, Timiskaming, Manitoulin, Parry Sound, Nipissing, Lambton, Chatham-Kent, Grey, Haldimand-Norfolk, Niagara, Muskoka, Haliburton, Kawartha Lakes, Peterborough, Northumberland, Hastings, Prince Edward, Lennox & Addington, Frontenac, Renfrew, Lanark, Leeds & Grenville, Prescott & Russell, and Stormont, Dundas & Glengarry.

Two census division where natural increase is projected to be negative in 2021-22, but positive by 2045-46: Huron and Bruce.

Census divisions where natural increase is projected to be positive throughout 2022-2046 include: Kenora, Essex, Middlesex, Elgin, Perth, Oxford, Brant, Waterloo, Wellington, Hamilton, Dufferin, Halton, Peel, York, Simcoe, Toronto, Durham, Ottawa.

[Return to chart 7](#)

**Chart 8: Population of Ontario regions, 2022 and 2046**

This chart shows a map of Ontario’s 6 regions with bars showing their total populations in 2022 and 2046.

For 2022, the chart shows total population in millions for each of the regions as:

Northwest 0.24, Northeast 0.58, Southwest 1.8, Central 3.3, GTA 7.2, East 2.0.

For 2046, the chart shows total population in millions for each of the regions as:

Northwest 0.27, Northeast 0.68, Southwest 2.5, Central 4.9, GTA 10.5, East 2.8.

[Return to chart 8](#)

**Chart 9: Population growth by census division over 2022 to 2046**



This map shows the population growth by census division in Ontario over the projection period 2022-46. The census divisions are split in four categories.

Census divisions where population is projected to grow between zero and 15% include: Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Chatham-Kent.

Census divisions where population is projected to increase between 15% and 30% include: Manitoulin, Greater Sudbury, Parry Sound, Lambton, Haliburton, Peterborough, Northumberland, Hastings, Prince Edward, Renfrew, Lennox & Addington, Frontenac, Leeds & Grenville, Stormont, Dundas & Glengarry.

Census divisions where population is projected to increase between 30% and 40% include: Essex, Elgin, Huron, Bruce, Grey, Haldimand-Norfolk, Niagara, Toronto, York, Kawartha Lakes, Muskoka, Lanark, Prescott & Russell.

Census divisions where population is projected to increase by over 40% include: Middlesex, Oxford, Perth, Wellington, Brant, Dufferin, Simcoe, Waterloo, Halton, Peel, Hamilton, Durham, Ottawa.

[Return to chart 9](#)

#### **Chart 10: Share of seniors in population by census division in 2046**

This map shows the projected share of seniors in the population of Ontario census divisions in 2046. The census divisions are split in four categories.

Census divisions with less than 20% seniors in 2046 include: Kenora, Middlesex, Waterloo, Wellington, Dufferin, Hamilton, Halton, Peel, Toronto, Durham, Ottawa.

Census divisions with between 20% and 25% seniors in 2046 include: Rainy River, Thunder Bay, Cochrane, Greater Sudbury, Essex, Elgin, Perth, Oxford, Brant, Simcoe, York, Frontenac.

Census divisions with between 25% and 30% seniors in 2046 include: Algoma, Sudbury, Manitoulin, Timiskaming, Nipissing, Lambton, Chatham-Kent, Bruce, Huron, Grey, Haldimand-Norfolk, Niagara, Peterborough, Hastings, Renfrew, Lennox & Addington, Lanark, Prescott & Russell, Stormont, Dundas & Glengarry.

Census divisions with over 30% seniors in 2046 include: Parry Sound, Muskoka, Haliburton, Kawartha Lakes, Northumberland, Prince Edward, Leeds & Grenville.

[Return to chart 10](#)

#### **Chart 11: Growth in number of seniors by census division, 2022 to 2046**

This map shows the growth in number of seniors in the population of Ontario census divisions between 2022 and 2046. The census divisions are split in four categories.

Census divisions with less than 35% projected growth in number of seniors over 2022-2046 include: Kenora, Rainy River, Thunder Bay, Cochrane, Timiskaming, Algoma, Manitoulin, Sudbury, Greater Sudbury, Nipissing, Lambton, Chatham-Kent, Prince Edward, Stormont, Dundas & Glengarry.

Census divisions with between 35% and 50% projected growth in number of seniors over 2022-2046 include: Parry Sound, Essex, Grey, Huron, Bruce, Haliburton, Peterborough, Northumberland, Kawartha Lakes, Hastings, Renfrew, Lennox & Addington, Frontenac, Leeds & Grenville.

Census divisions with between 50% and 70% projected growth in number of seniors over 2022-2046 include: Middlesex, Elgin, Perth, Oxford, Haldimand-Norfolk, Brant, Hamilton, Niagara, Toronto, Muskoka, Lanark.

Census divisions with over 70% projected growth in number of seniors over 2022-2046 include: Waterloo, Wellington, Dufferin, Simcoe, Halton, Peel, York, Durham, Ottawa, Prescott & Russell.

[Return to chart 11](#)

#### **Chart 12: Growth in number of children aged 0–14 by census division, 2022 to 2046**

This map shows the growth in number of children aged 0-14 in the population of Ontario census divisions between 2022 and 2046. The census divisions are split in four categories.

Census divisions with between 0% and 20% projected growth in number of children aged 0-14 over 2022-2046 include: Kenora, Thunder Bay, Cochrane, Nipissing, Rainy River, Algoma, Sudbury, Timiskaming, Manitoulin, Chatham-Kent, Prince Edward, Renfrew, Lennox & Addington.

Census divisions with between 20% and 35% projected growth in number of children aged 0-14 over 2022-2046 include: Greater Sudbury, Parry Sound, Essex, Lambton, Perth, Elgin, Brant, Haldimand-Norfolk, Niagara, York, Toronto, Durham, Kawartha Lakes, Haliburton, Peterborough, Hastings, Muskoka, Northumberland, Lanark, Frontenac, Leeds & Grenville, Prescott & Russell, Stormont, Dundas & Glengarry.

Census divisions with between 35% and 50% projected growth in number of children aged 0-14 over 2022-2046 include: Essex, Perth, Huron, Bruce, Grey, Elgin, Brant, Haldimand-Norfolk, Niagara, Hamilton, York, Toronto, Durham, Kawartha Lakes, Muskoka, Lanark.

Census divisions with over 50% projected growth in number of children aged 0-14 over 2022-2046 include: Middlesex, Oxford, Waterloo, Wellington, Halton, Dufferin, Peel, Simcoe, Ottawa.

[Return to chart 12](#)

#### **Chart 13: Total fertility rate of Ontario women, 1979 to 2046**

This line chart shows the historical total fertility rate of Ontario women from 1979 to 2021, and projections under the three scenarios for 2023-2046. Over the historical period, the total fertility rate in Ontario has been hovering within a narrow range, going from 1.61 in 1979 to 1.37 in 2021. Under the reference scenario, the total fertility rate is projected to increase from 1.39 in 2022-23 to 1.50 in 2045-46. Under the high scenario, the total fertility rate is projected to increase from 1.50 in 2022-23 to 1.70 in 2045-46. Under the low scenario, the total fertility rate is projected to decline initially from 1.29 in 2022-23, but to reach 1.30 again in 2045-46.

[Return to chart 13](#)

#### **Chart 14: Life expectancy at birth by sex in Ontario, 1979 to 2046**

This line chart shows the historical life expectancy at birth by gender in Ontario from 1979 to 2020, and projections under three scenarios for 2023-2046.

For females, life expectancy at birth rose from 78.9 years in 1979 to 84.4 years in 2020. Over the projection period to 2046, life expectancy of females is projected to increase gradually to reach 87.6 years under the reference scenario, 89.1 years under the high scenario, and 86.4 years under the low scenario.

For males, life expectancy at birth rose from 71.8 years in 1979 to 79.9 years in 2020. Over the projection period to 2046, life expectancy of males is projected to increase gradually to reach 84.3 years under the reference scenario, 86.0 years under the high scenario, and 82.8 years under the low scenario.

[Return to chart 14](#)

#### **Chart 15: Rate of immigration to Ontario, 1971 to 2046**

This line chart shows the historical immigration rate to Ontario from 1971 to 2022 and projections under three scenarios to 2046. Over the historical period, the immigration rate was very volatile, starting at 0.79% in 1971-72, rising to 1.49% by 1973-74, declining to a low of 0.44% by the mid-1980, rising again to 1.38% by 1992-93, then falling gradually to reach 0.66% in 2014-15, and rebounding 1.53% to in 2021-22.

Over the projections period 2022-2046, the immigration rate to Ontario is projected initially reach 1.35% in 2024-25 in the reference scenario, 1.57% in the high scenario, and 1.11% in the low scenario. This is followed by gradual changes to 2045-46 in all scenarios to reach 1.20% in the reference scenario, 1.22% in the high scenario, and 1.16% in the low scenario.

[Return to chart 15](#)

#### **Chart 16: Immigration to Ontario, 1971 to 2046**

This chart shows historical annual immigration levels to Ontario from 1971 to 2022 and projections under three scenarios to 2046. Over the historical period, immigration was very volatile, starting at about 62,000 in 1971-72, rising to 120,000 by 1973-74, falling to 40,000 in the mid-1980s, rising to peak at 153,000 in 2001-02, gradually declining thereafter to reach 90,000 in 2014-15, and rebounding to 227,000 in 2021-22.

Immigration to Ontario is projected to increase from 184,000 in 2022-23 to 257,000 in 2045-46 in the reference scenario, from 230,000 to 296,000 in the high-growth scenario, and from 138,000 to 218,000 in the low-growth scenario.

[Return to chart 16](#)

#### **Chart 17: Emigration from Ontario, 1971 to 2046**

This chart shows historical annual emigration levels from Ontario and residual deviations in Statistics Canada's estimates from 1971 to 2022, as well as projections of emigration under three scenarios to 2046. Over the historical period, emigration was very volatile, starting at about 13,000 in 1971-72, rising to 22,000 by 1973-74, falling to 8,000 in 1980-81, rising to peak at 27,000 in 1993-94 and hovering below 20,000 since 2016.

During the historical period, the residual deviation ranged from -2,000 in 1987-88 to 22,000 in 2007-08.

Emigration from Ontario is projected to increase from 36,000 in 2022-23 to 50,000 in 2045-46 in the reference scenario, from 25,000 to 39,000 in the high scenario, and from 47,000 to 58,000 in the low scenario.

[Return to chart 17](#)

#### **Chart 18: Annual change in the number of non-permanent residents living in Ontario, 1971 to 2046**

This chart shows historical annual net gains in non-permanent residents in Ontario from 1971 to 2022 and projections under three scenarios to 2046. Over the historical period, the net gain was very volatile, starting with values close to zero in the early 1970s, with a peak of 95,000 in 1988-89, a deep through of -54,000 in 1992-93, and another high level in 2021-22 at 117,000.

The projected annual net gain of non-permanent residents in Ontario in the reference scenario is projected to fall from 360,000 in 2022-23 to 13,000 in 2026-27 and reach 17,000 by 2045-46. In the high scenario, the net gain is projected at 540,000 in 2022-23, 16,000 in 2026-27, reaching 21,000 by 2045-46. In the low scenario a net gain of 180,000 is projected for 2022-23, a gain of 11,000 in 2026-27, with an endpoint of 14,000 for 2045-46.

[Return to chart 18](#)

#### **Chart 19: Net interprovincial migration in Ontario, 1971 to 2046**

This chart shows the historical net interprovincial migration gain in Ontario from 1971 to 2022 and projections under three scenarios to 2046.

Over the historical period, net interprovincial migration followed cycles of net gains followed by net losses. Net interprovincial migration was generally negative during the 1970s, the late 1980s and early 1990s, and from 2003 to 2015. Positive cycles occurred during the early 1980s, the late 1990s, and from 2015 to 2020. In 2021-22, net interprovincial migration to Ontario was -47,000.

In the reference scenario, annual net interprovincial migration is set at -50,000 for 2022-23, rising to zero by 2027-28, and remaining at zero for the rest of the projections. In the high scenario, a net annual interprovincial migration is set at -40,000 for 2022-23, rising to 5,000 by 2027-28, and remaining at that level for the rest of the projections. In the low scenario, net interprovincial migration is set at -60,000 for 2022-23, rising to -5,000 by 2027-28, and remaining at that level for the rest of the projections.

[Return to chart 19](#)

#### **Map of Ontario census divisions**

This map includes the following census divisions:

GTA:  
\*\*\*\*\*

1. Toronto

2. Durham
3. Halton
4. Peel
5. York

Central:

6. Brant
7. Dufferin
8. Haldimand–Norfolk
9. Haliburton
10. Hamilton
11. Muskoka
12. Niagara
13. Northumberland
14. Peterborough
15. Simcoe
16. Kawartha Lakes
17. Waterloo
18. Wellington

East:

19. Ottawa
20. Frontenac
21. Hastings
22. Lanark
23. Leeds and Grenville
24. Lennox and Addington
25. Prescott and Russell
26. Prince Edward
27. Renfrew
28. Stormont, Dundas and Glengarry

Southwest:

29. Bruce
30. Elgin
31. Essex
32. Grey
33. Huron
34. Chatham–Kent
35. Lambton
36. Middlesex

37. Oxford

38. Perth

Northeast:

39. Algoma

40. Cochrane

41. Manitoulin

42. Nipissing

43. Parry Sound

44. Greater Sudbury

45. Sudbury

46. Timiskaming

Northwest:

47. Kenora

48. Rainy River

49. Thunder Bay

[Return to map of Ontario census divisions](#)

## Related

[Ontario Demographics \(https://www.ontario.ca/page/ontario-demographics\)](https://www.ontario.ca/page/ontario-demographics)

Updated: July 19, 2023

Published: June 23, 2021

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## Footnotes

- [1] ^ Results are presented for Census years, which run from July 1 to June 30.
- [2] ^ Based on the Pearsonian approach, a parametric model used to distribute estimated fertility rates by age of mothers.
- [3] ^ Following the Lee-Carter method of mortality projection used to generate annual age-sex specific mortality rates. See Lee, Ronald D., and Carter, Lawrence, 1992. "Modeling and Forecasting the Time Series of U.S. Mortality," *Journal of the American Statistical Association* 87, no 419 (September):659-71.

**TAB 171**



# LONGITUDINAL FAMILY PHYSICIAN PAYMENT MODEL

---

Dr. Renee Fernandez  
Chief Medical Officer, BC Family Doctors

Presentation for OMA Negotiations  
April 5, 2024

**YOUR SPECIALISTS  
IN PRIMARY CARE.**





# Negotiating Environment





## Family Doctors Told Us

- Value spending time with patients
- Recognize the complexity of care
- Increase family physician compensation
- Address rising overhead costs
- Pay for time spent on indirect care/administration
- Ensure physician autonomy and choice

## How does the Payment Model work?

- A blended payment model that combines three elements
- Rural retention premium continues to apply
- No involvement of health authorities
- Physicians sign up through a zero-dollar enrollment code
- Claims are submitted and paid via MSP/Teleplan (same mechanism as FFS)

# Included Services

## Now:

- In-office care
- Home visits

## Coming June 2024:

- In-patient care
- Maternity care in hospital
- Long Term Care
- Palliative Care

## What are physicians agreeing to do?

- Provide longitudinal family physician services to a known panel of patients for a minimum of one day per week
- Have a minimum panel of 250 patients
- Submit and maintain a list of their empanelled patients to the Provincial Attachment System
- Provide both in-person and virtual care, consistent with guidance from the College of Physicians and Surgeons of BC

## What are physicians agreeing to do?

- Work with other physicians and healthcare providers in your community to provide care
- Encourage patients to participate in a provincially administered primary care survey
- Bill using simplified time and encounter billing codes
- Provide a list of empanelled patients to a provincial system on an annual basis.

# Daily Billing

**TIME**  
**+**  
**INTERACTIONS**



## Daily Billing - Time

- Bill daily for the total time spent providing care
- Three time codes:
  - Direct patient care
  - Indirect patient care
  - Clinical administration





## Direct patient care

- In-person care
- Synchronous virtual care (phone, video)
- Concurrent provision of clinically related teaching

## Indirect patient care

- Charting, review of results, referrals and requisitions
- Care coordination & planning
- Conferencing and team meetings
- Completion of forms and reports
- Clinical teaching
- Asynchronous virtual care (email, text)

## Clinical Administration

- Time spent creating and providing your list of patients
- Proactive panel management and review
- EMR updating and management requiring physician expertise
- Medical director responsibilities as required by the College
- Privacy officer responsibilities as required by legislation

# Daily Billing – Patient Interactions

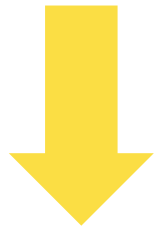
- Bill for each physician-patient interaction
- Eight interaction codes
  - In-person visit
  - Virtual visit
  - Minor procedure or diagnostic test
  - Standard procedure
  - Advanced procedure
  - Consultation
  - Home visit
  - Group medical visit



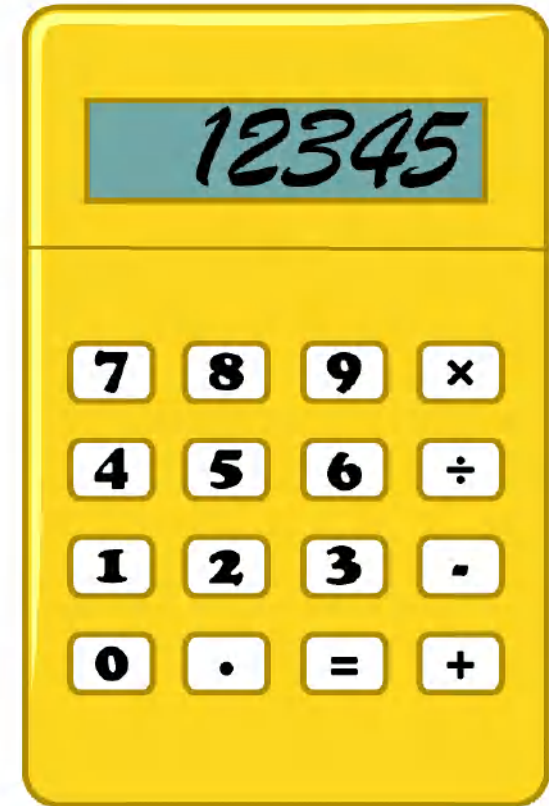
# Let's talk money

**Time:** \$130/hour

**Interactions:** \$25-\$110/interaction



**\$230/hour**



## Panel Payment

- A payment based on the size and complexity of a physician's patient panel
  - Minimum payment: \$13,380
  - Maximum payment: \$133,800
- A physician with 1250 empanelled patients of average complexity would receive \$66,900

# Creating Choice

**AUTONOMY**  
+  
**FLEXIBILITY**



## Let's do the math for Dr. X

- Sees 4 patients per hour
- 25 hours per week seeing patients
- 12 hours per week of indirect patient care (labs/paperwork)
- Panel of 1250 patients of average complexity
- 5 weeks of vacation

**\$386,070**



# A massive shift in billing in BC

## Simplified LFP Guide

The Simplified LFP Guide provides clear and concise information regarding the LFP Payment Model.

We encourage you to refer to our searchable Billing Question Library to find answers to commonly asked billing questions. If you cannot find the answer you need, please send us a billing question using our online form.

Recently Updated Fees

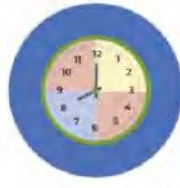
Search Fees



Overview



Eligibility & Enrollment



Time Codes



Patient Interaction Codes



Panel Payment



Uninsured Services

## Billing Question Library

### LFP Payment Model

Search



Home Question Library LFP Payment Model

Back

### LFP Payment Model

Eligibility, Enrollment & Withdrawal

Included & Excluded Services

Locums

Virtual Care

Team Based Care

ICBC & WorkSafeBC

Time Codes

Interaction Codes

Panel Payment



**TAB 172**

## B.C. launches new payment model for family doctors

CBC News | Posted: Wednesday, February 1st, 2023 3:04 PM | Last Updated: February 2nd, 2023

Officials tout change as 'transformational' to struggling health-care system

Image | B.C. Health Minister Adrian Dix

Caption: B.C. Health Minister Adrian Dix pauses while speaking during an announcement in Burnaby, B.C., on May 30, 2022. (Darryl Dyck/The Canadian Press)

Load Image

B.C.'s new payment model for family physicians came into effect on Wednesday, giving doctors the option to do away with the old fee system reported to have driven new recruits and veterans alike away from the job.

The new framework allows physicians to scrap the current fee-for-service system that saw them paid a flat rate per patient visit and be paid instead for a range of duties that come with the job.

"I believe it's the most significant reform to primary care in my lifetime in the history of the public health-care system," Health Minister Adrian Dix said at a news conference outlining the changes.

"It addresses inequities in compensation, helping to attract and retain family physicians and therefore increase the number of physicians able to provide care to people in B.C."

- [Fee-for-service model is deterring aspiring family doctors from setting up practice: report](#)
- [In 1991, B.C. had more family doctors than it needed. So why are so many residents unable to find one now?](#)

Through the fee-for-service system, doctors are paid around \$30 per patient visit — no matter whether they're treating a simple common cold or a complex chronic health condition.

B.C.'s new model, called the longitudinal family physician (LFP) payment model, sees doctors compensated the number of patients they see daily and the complexity of their needs.

The province said it means family physicians will be paid for extra time with patients, especially those who need more support — like seniors or patients with mental health conditions.

They'll also be paid for time spent on other necessary tasks like reviewing lab results, consulting with other medical professionals, updating patient lists and clinical administrative work.

"Today is a new day for family physicians to have choice to provide the care that they have always wanted to do and have not been able to," said Doctors of B.C. president Dr. Joshua Greggain, calling the model "transformational."

### Image | DOCTOR SHORTAGE

Caption: People wait outside a walk-in medical clinic in Surrey, B.C., on May 24. The shortage of family doctors in the province has left a burden on other areas of health-care, like urgent care centres and emergency rooms. (Ben Nelms/CBC)

Load Image

Dix said 1,043 of roughly 4,000 eligible doctors from all five health authorities signed up for the new model on the first day. He expected the number to grow "significantly" in coming days and weeks.

Most family doctors in B.C. are independent contractors and run their practices as businesses, paying for overhead costs such as office space and staff and medical equipment. The price of operating a practice has driven many prospective physicians to choose other areas of medicine.

The College of Family Physicians of Canada called in 2020 for alternative funding models to replace the fee-for-service method to better support continuity of care and stop family doctors from leaving their jobs.

Under the new framework, the average family physician in B.C. will see a raise from roughly \$250,000 to around \$385,000.

The number of people without a family doctor in B.C. more than doubled from 2003 to 2017. The shortage of family doctors in the province has left a burden on other areas of health care, like urgent care centres and emergency rooms.

One in five residents didn't have a general practitioner in the latter year, though Dix expected the number would rise.

---

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PEI | 4 hours ago

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North | April 3rd

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[Children and families in crisis have a new place to turn in Calgary](#)

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## Family doctor in North Bay, Ont., says family medicine is in crisis



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**TAB 173**



**MINISTRY OF HEALTH**

**MEDICAL SERVICES COMMISSION**  
**LONGITUDINAL FAMILY PHYSICIAN**  
**PAYMENT SCHEDULE**  
**MARCH 11, 2024**



**MEDICAL SERVICES COMMISSION  
LONGITUDINAL FAMILY PHYSICIAN PAYMENT SCHEDULE**

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## **PART I: INTRODUCTION**

### **1. Purpose**

This is a Payment Schedule under Section 26 of the *Medicare Protection Act*. A physician who meets the eligibility criteria for the Longitudinal Family Physician (LFP) Payment Model can enrol and be compensated in accordance with this LFP Payment Schedule. This document sets out the eligibility criteria, enrolment steps and billing rules for this payment model, acting as a roadmap for its application and interpretation.

### **2. Definitions**

Capitalized terms have the meaning given to them in the Definitions at Appendix A, unless otherwise provided in this Payment Schedule. Unless context requires otherwise, definitions expressed in the singular include the plural and *vice versa*.

### **3. Description of the LFP Payment Model**

The LFP Payment Model is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is an alternative to Fee-For-Service and the Alternative Payments Program. The LFP Payment Model is a blended payment model which compensates a physician for:

- (a) physician time;
- (b) physician-patient interactions; and
- (c) the size and complexity of a physician's patient panel.

Appendix B outlines how physician time, physician-patient interactions, and the patient panel together generate the total compensation for a physician enrolled in the LFP Payment Model. It also describes the background and principles for the LFP Payment Model, including the Patient Medical Home.

Rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) community are eligible to receive rural premiums on LFP Payment Model payments, in accordance with the RSA. These rural premiums can be found in the RSA Guide under the [Rural Retention Program](#).

## **PART II: ELIGIBILITY, REQUIRED SERVICES, ENROLMENT AND WITHDRAWAL**

### **4. Initial Eligibility for the LFP Payment Model**

To be eligible for the LFP Payment Model, a physician must:

- (a) commit to provide all of the Required Services, except the physician is not required to meet the requirement in Section 6(g) [ensure that Non-panel Services are no more than 30% of the total LFP Practice Services and Non-panel Services];

- (i) until ~~March 31~~ **September 30**, 2024, if the physician is actively transitioning their practice to meet the requirement in Section 6(g) and submits the Transition Code; or
  - (ii) ~~until March 31, 2024, or such time as the LFP Payment Model is amended for rural communities~~, if the physician is practicing at an LFP Clinic in a rural community that was receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002.
- (b) contribute either directly or indirectly to the rent, lease, or ownership costs, as well as other operating costs (such as staffing, equipment and supplies) of the clinic(s) that will be their LFP Clinic;
  - (c) have not withdrawn from the LFP Payment Model within the past 12 months, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol; and
  - (d) not be Deemed Ineligible by the Medical Services Commission, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol.

**(“Initial Eligibility Criteria”)**

Notwithstanding the Initial Eligibility Criteria, a physician may be eligible for the LFP Payment Model as an LFP Locum if they meet the criteria in Section 10.

## **5. Ongoing Eligibility in the LFP Payment Model**

Once a physician is enrolled in the LFP Payment Model, the physician must do the following to maintain eligibility:

- (a) meet the Initial Eligibility Criteria on an ongoing basis;
- (b) submit the Registration Code annually to Health Insurance BC (HIBC) via Teleplan between January 1 and March 31 of each calendar year, to confirm that they meet the Initial Eligibility Criteria; and
- (c) confirm their list of Empanelled Patients each calendar year, as required.

**(“Ongoing Eligibility Criteria”)**

## **6. Required Services**

A physician enrolled in the LFP Payment Model must:

- (a) provide Longitudinal Family Physician Services, aligned with the attributes of a Patient Medical Home;
- (b) provide timely, accessible, comprehensive, and relationship-based care to patients by working and collaborating with other physicians and healthcare providers when appropriate;
- (c) develop and submit an accurate list of Empanelled Patients within three months of enrolling in the LFP Payment Model;

- (d) participate in the Provincial Attachment System by providing information in the Panel Registry and working with clinic medical directors/delegates to update information in the Clinic and Provider Registry as directed;
  - (e) have at least 250 Empanelled Patients within four months of enrolling in the LFP Payment Model;
  - (f) provide LFP Practice Services for a minimum of one day per week, distributed equitably over the course of a year. This minimum is based on the physician's usual work arrangement. It does not include temporary absences or decreases in days worked related to illness, vacation, parental leave, caregiving, military deployment or other reasons;
  - (g) ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services provided in one calendar year;
  - (h) provide patient care consistent with any interim or permanent guidance on the appropriate use of virtual care in physician practices endorsed and/or issued by the College of Physicians and Surgeons of BC. Unless CPSBC guidance on the appropriate use of virtual care states otherwise, the physician must provide both in-person and virtual visits to patients in their LFP Clinic;
  - (i) encourage patients to participate in a provincially administered patient survey about primary care experiences;
  - (j) create and maintain Adequate Medical Records; and
  - (k) agree to the audit and assessment authority of the Medical Services Commission as set out in the *Medicare Protection Act*.
- (the “**Required Services**”)

## 7. Enrolment and Annual Registration

- (a) **How to Enrol** – A physician who meets **all** the Initial Eligibility Criteria enrolls in the LFP Payment Model by submitting the Registration Code to HIBC via Teleplan, ~~unless the physician does not yet meet Section 6(g) [ensure that Non-panel Services are no more than 30% of the total LFP Practice Services and Non-panel Services].~~

A physician who meets the Initial Eligibility Criteria but does not yet meet Section 6(g) **[ensure that Non-panel Services are no more than 30% of the total LFP Practice Services and Non-panel Services]** enrolls for the LFP Payment Model by submitting both the Registration Code and the Transition Code.

For clarity, a physician practicing in a rural community that was receiving NIA premiums as of December 15, 2002 does not need to submit the Transition Code in addition to the Registration Code.

- (b) **Enrolment Effective Date** – A physician's enrolment is effective on the first day that the physician bills a Time Code. After this day, the physician cannot claim under Fee-for-Service for services covered under the LFP Payment Schedule. Physicians cannot bill for services under the LFP Payment Model for dates of service prior to this date. A physician's enrolment effective date cannot be earlier than the day they submitted the Registration Code.

- (c) **How to Continue Enrolment** – To continue enrolment, a physician who meets the Ongoing Eligibility Criteria must submit the Registration Code annually between January 1 and March 31. If the Registration Code is not submitted by March 31 of a given calendar year, no subsequent payments will occur under the LFP Payment Model until the Registration Code is submitted.

A physician who wishes to withdraw from the LFP Payment Model must submit a withdrawal form as noted in Section 8(a).

- (d) **Registration Code** – The “Registration Code” is as follows:

**98000                    Longitudinal Family Physician Payment Model Registration Code.....0.00**

A longitudinal family physician who meets the Eligibility Criteria submits this code to enrol or continue enrolment in the LFP Payment Model.

By submitting 98000, the physician confirms that they meet the Eligibility Criteria as outlined in this Longitudinal Family Physician Payment Schedule. The physician agrees to only claim for payment in relation to services in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for services covered under the LFP Payment Schedule. Enrolment is effective on the first day that the physician bills a Time Code following submission of 98000.

- a) Submit once per calendar year per physician.
- b) For physicians who meet the Eligibility Criteria, submission provides access to the LFP Panel Payment and the following Time Codes and Patient Interaction Codes until the end of the calendar year:
  - 98010 LFP Direct Patient Care Time
  - 98011 LFP Indirect Patient Care Time
  - 98012 LFP Clinical Administration Time
  - 98020 LFP In-person Interaction with an Advanced Procedure
  - 98021 LFP In-person Interaction with a Standard Procedure
  - 98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction
  - 98030 LFP Consultation
  - 98031 LFP In-person Interaction in a Clinic
  - 98032 LFP Virtual Interaction by Phone or Video
  - 98033 LFP In-person Interaction in the Patient’s Home
  - 98034 LFP In-person or Video Group Interaction

- (e) **How to submit the Registration Code** – A physician submits the Registration Code using their MSP Practitioner Number and the following “patient” demographic information:

- PHN: 9694105066
- Patient Surname: Portal
- First name: LFP
- Date of Birth: January 1, 2023
- ICD-9 code: L23

- (f) **Transition Code** – The “Transition Code” is as follows:

**98001                    Longitudinal Family Physician Payment Model Transition Code..... 0.00**

A longitudinal family physician submits this code after the Registration Code to indicate that they do not yet meet Section 6(g) [ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services].

By submitting this code, the physician confirms that they are actively transitioning their practice to meet the requirement in Section 6(g) by ~~March 31~~ **September 30**, 2024.

- (g) **How to submit the Transition Code** – A physician submits the Transition Code after the Registration Code using their MSP Practitioner Number and the following “patient” demographic information:

- PHN: 9753035697
- Patient Surname: Portal
- First name: GPSC
- Date of Birth: January 1, 2013
- ICD-9 code: L23

The Transition Code must be submitted using the MSP Facility Number associated with the LFP Clinic. If a physician practices at multiple LFP Clinic locations, submit a separate Transition Code with the associated MSP Facility Number of each LFP Clinic location where they meet the eligibility criteria and provide the Required Services.

## 8. Withdrawal and Removal from the LFP Payment Model

- (a) ~~**Voluntary Withdrawal**~~ – ~~A physician can voluntarily withdraw from the LFP Payment Model and transition to another payment model at any time, but a physician who withdraws may not re-enrol in the LFP Payment Model for a period of 12 months unless approved in writing by the Medical Services Commission.~~
- (b) ~~**Withdrawal due to Ineligibility**~~ – ~~A physician who does not meet the Ongoing Eligibility Criteria must promptly withdraw from the LFP Payment Model.~~
- (a) **Withdrawal** – A physician must withdraw from the LFP Payment Model by submitting the withdrawal form [2981 LFP Payment Model – Withdrawal](#) to the Ministry of Health when:

- they no longer meet the Ongoing Eligibility Requirements
- they choose to voluntarily withdraw from the LFP Payment Model

Not completing the annual requirement to resubmit the Registration Code by March 31 will not result in automatic withdrawal from the payment model. Submission of a withdrawal form is required when a physician transitions to another payment model, leaves practice in BC, or other circumstance where there is no longer an intention to bill for services under the LFP Payment Model.

A physician who withdraws may not re-enrol in the LFP Payment Model for a period of 12 months unless approved in writing by the Medical Services Commission.

- (b) **Method of Withdrawal** – A physician withdraws from the LFP Payment Model by providing written notice to the Ministry of Health. To do so, complete and submit form 2981 [LFP Payment Model – Withdrawal](#) to:

Mailing Address: LFP Payment Schedule  
PO Box 9649 Stn Prov Govt  
Victoria, B.C. V8W 9P4

Fax: (250) 952-1417

- (c) **Deemed Ineligible** – Notwithstanding any other provision in this LFP Payment Schedule, the Medical Services Commission may determine that a physician is ineligible for the LFP Payment Model on the basis that:
- (i) the physician is not providing the Required Services;
  - (ii) the physician is claiming for payment contrary to this LFP Payment Schedule, or in an unjustifiable departure from the patterns of practice or billing of other physicians in this category; or
  - (iii) it would be in the public interest that the physician not be entitled to participate in the LFP Payment Model.

(“**Deemed Ineligible**”).

Prior to determining that a physician is Deemed Ineligible for the LFP Payment Model, the Medical Services Commission will provide:

- (i) written notice to the physician identifying the reason(s) why the Medical Services Commission is considering making the physician ineligible;
- (ii) the records the Medical Services Commission intends to consider in determining the physician’s eligibility (if any); and
- (iii) an opportunity for the physician to provide a written response for consideration within 21 days from delivery of the written response.

For clarity, a finding by the Medical Services Commission that a physician is Deemed Ineligible does not otherwise impact the physician’s enrolment in MSP. As such, the physician may continue to provide services and make claims for payment under Fee-for-Service, subject to the other requirements and processes of the *Medicare Protection Act*.

Please see Appendix F in relation to billing Fee-for-Service after withdrawing from the LFP Payment Model.

## **PART III: LOCUMS**

### **9. Locum Services in the LFP Payment Model**

The LFP Payment Model is a compensation option for locum physicians who provide care on behalf of longitudinal family physicians. An “**LFP Locum**” means a physician who meets the Locum Eligibility Criteria and provides LFP Locum Services on behalf of a Host Physician.

An LFP Locum must only bill under the LFP Payment Model when providing LFP Locum Services for one or more Host Physicians at a Host Physician’s longitudinal family medicine clinic or Host



Physician's Maternity Clinic. An LFP Locum may provide LFP Locum Services at the same time as a Host Physician is providing care or while they are away from practice.

An LFP Locum must bill Locum Time Codes and Locum Patient Interaction Codes for LFP Locum Services at a Host Physician's longitudinal family medicine clinic or Host Physician's Maternity Clinic. LFP Locums are not eligible to receive a panel payment directly from the Medical Services Commission.

The terms "**Host Physician**" and "**LFP Locum Services**" are defined in Appendix A [Definitions]. For reference:

- "**Host Physician**" means a physician who provides Longitudinal Family Physician Services, is having an LFP Locum provide services on their behalf, and is:
  - i) enrolled in the LFP Payment Model;
  - ii) remunerated under Fee-for-Service and has submitted 14070 in the same calendar year;
  - iii) remunerated under the Group Contract for Practicing Full-Service Family Physicians or the Individual Contract for New-to-Practice Family Physicians; or
  - iv) remunerated under Alternative Payments Subsidiary Agreement (APSA) contracts under the following practice categories until October 31, 2024:
    - General Practice – Full Scope (Rural) – Area A, B, C
    - General Practice – Full Scope (Non-JSC Community)
    - General Practice – Defined Scope B (Student Health Centres)
- "**LFP Locum Services**" means LFP Practice Services, Non-panel Services, Maternity Services, and Complex Contraception Services provided by an LFP Locum on behalf of a Host Physician.

For clarity, a physician who is enrolled under the LFP Payment Model and providing Longitudinal Family Physician Services may also provide LFP Locum Services. When they provide LFP Locum Services, they must bill Locum Time Codes and Locum Patient Interaction Codes.

## 10. Locum Eligibility

To be eligible as an LFP Locum under the LFP Payment Model, a physician must:

- (a) commit to provide LFP Locum Services on behalf of one or more Host Physicians;
- (b) commit to provide all Required Locum Services;
- (c) submit 98005 Locum Registration Code;
- (d) submit an [LFP Locum registration form](#) each calendar year; and
- (e) not be Deemed Ineligible by the Medical Services Commission, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol.

(**"Locum Eligibility Criteria"**)

## 11. Required Locum Services

An LFP Locum enrolled in the LFP Payment Model must:

- (a) provide LFP Practice Services, Maternity Services, and/or Complex Contraception Services, with or without Non-panel Services, when providing LFP Locum Services for a Host Physician;
- (b) provide timely, accessible, comprehensive, and relationship-based care to patients by working and collaborating with other physicians and healthcare providers when appropriate;
- (c) ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services provided in one calendar year at each clinic where LFP Locum Services are provided. The physician is not required to meet this requirement ~~until March 31, 2024 or such time as the LFP Payment Model is amended for rural communities~~, when the physician is practicing at an LFP Clinic in a rural community that was receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002;
- (d) provide patient care consistent with any interim or permanent guidance on the appropriate use of virtual care in physician practices endorsed and/or issued by the College of Physicians and Surgeons of BC. An LFP Locum must not provide exclusively virtual care;
- (e) create and maintain Adequate Medical Records; and
- (f) agree to the audit and assessment authority of the Medical Services Commission as set out in the Medicare Protection Act.

**(“Required Locum Services”)**

## 12. Locum Enrolment and Annual Registration

- (a) **How to Enrol** – A physician who meets the Locum Eligibility Criteria may enrol in the LFP Payment Model as an LFP Locum by submitting:
  - i) 98005 Locum Registration Code to HIBC via Teleplan; and
  - ii) an [LFP Locum registration form](#).
- (b) **Enrolment Effective Date** – A physician’s enrolment is effective on the first day that the physician bills a Locum Time Code. After this day, the physician cannot claim under Fee-for-Service when they provide LFP Locum Services. Physicians cannot bill for services under the LFP Payment Model for dates of service prior to this date. A physician’s enrolment effective date cannot be earlier than the day they submitted the Locum Registration Code.
- (c) **How to Continue Enrolment** – To continue enrolment, an LFP Locum who meets the Locum Eligibility Criteria must submit the following between January 1 and March 31 in each calendar year they provide LFP Locum Services:
  - i) 98005 Locum Registration Code to HIBC via Teleplan; and
  - ii) an [LFP Locum registration form](#).

If the Locum Registration Code and [LFP Locum registration form](#) are not submitted by March 31 of a given calendar year, no subsequent payments will occur under the LFP Payment Model until they are submitted.

(d) **LFP Locum Registration Code** – The “Locum Registration Code” is as follows:

**98005 Longitudinal Family Physician Payment Model Locum Registration Code.....0.00**

A family physician who meets the Locum Eligibility Criteria submits this code to enrol or continue enrolment in the LFP Payment Model to provide LFP Locum Services. By submitting 98005, the physician confirms that they meet the Locum Eligibility Criteria.

The physician agrees to only claim for payment in relation to services in accordance with the terms contained in this LFP Payment Schedule, including that they can only bill Locum Time Codes and Locum Patient Interaction Codes when they provide LFP Locum Services. Enrolment is effective on the first day that the physician bills a Locum Time Code following submission of 98005.

a) Submit once per calendar year

b) Submission provides access to the following Locum Time Codes and Locum Patient Interaction Codes until the end of the calendar year:

- 98040 LFP Locum Direct Patient Care Time
- 98041 LFP Locum Indirect Patient Care Time
- 98042 LFP Locum Clinical Administration Time
- 98050 LFP Locum In-person Interaction with an Advanced Procedure
- 98051 LFP Locum In-person Interaction with a Standard Procedure
- 98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98060 LFP Locum Consultation
- 98061 LFP Locum In-person Interaction in a Clinic
- 98062 LFP Locum Virtual Interaction by Phone or Video
- 98063 LFP Locum In-person Interaction in the Patient's Home
- 98064 LFP Locum In-person or Video Group Interaction

(e) **How to submit the Locum Registration Code** – A physician submits the Locum Registration Code using their MSP Practitioner Number and the following “patient” demographic information:

- PHN: 9694105066
- Patient Surname: Portal
- First name: LFP
- Date of Birth: January 1, 2023
- ICD-9 code: L23

## **PART IV: INCLUDED AND EXCLUDED SERVICES**

### **13. Included Services**

The following services are included under the LFP Payment Model, except for services that fall under Section 14:

(a) **LFP Practice Services**

**“LFP Practice Service”** means Direct Patient Care and Indirect Patient Care that a physician provides to a patient on: (i) the physician’s panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:

- (i) at the physician’s LFP Clinic;
- (ii) at a Maternity Clinic
- (iii) as a virtual care service associated with the physician’s LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
- (iv) to a patient in their Home Setting (but not in a Facility)

#### **(b) Non-panel Services**

**“Non-panel Service”** means Direct Patient Care and Indirect Patient Care that a physician provides to a patient who is not: (i) on the physician’s panel; or (ii) on the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:

- (i) at the physician’s LFP Clinic;
- (ii) at a Maternity Clinic
- (iii) as a virtual care service associated with the LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
- (iv) to a patient in their Home Setting (but not in a Facility)

For clarity, Non-panel Services are part of the LFP Payment Model; therefore, they cannot be billed under Fee-for-Service and must be claimed under the LFP Payment Model. Non-panel Services can be no more than 30% of the total of LFP Practice Services and Non-panel Services.

#### **(c) Maternity Services and Complex Contraception Services for Non-panel Patients**

A physician cannot claim more than 30% of their Patient Interaction Codes or Locum Patient Interaction Codes for Non-panel Services in one calendar year. This limit does not apply to Maternity Services and Complex Contraception Services for non-panel patients if the service is:

- (i) provided at the physician’s LFP Clinic, at a Maternity Clinic, as a virtual care service associated with the physician’s LFP Clinic or Maternity Clinic (except if the physician provides successive services to patients located in a Facility), or to a patient in their Home Setting (but not in a Facility); and
- (ii) identified with one of the specified ICD-9 codes.

To identify a Patient Interaction Code or Locum Patient Interaction Code as a Maternity Service, a physician must submit one of the following ICD-9 codes:

- V20 Health Supervision of Infant or Child – for care of newborns up to six weeks of age
- V22 Normal Pregnancy – for care during a pregnancy, including medical abortion
- V24 Postpartum Care and Examination – for postnatal care and lactation support

To identify a Patient Interaction Code or Locum Patient Interaction Code as a Complex Contraception Service, a physician must submit the following ICD-9 code:

- V25 Contraceptive Management

**“Maternity Service”** means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.

**“Complex Contraception Service”** means ~~contraceptive~~ care related to **contraceptive** procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), **as well as the use of contraceptive methods for** medically and socially complex patients, **care resulting from a referral or recommendation from** ~~patients referred by~~ a physician or allied care provider, and gender-affirming care.

If the patient care provided is not fully reflected by one of the specified ICD-9 codes, use one of the specified ICD-9 codes to identify the interaction code as a Maternity Service or Complex Contraception Service and up to two additional ICD-9 codes to describe the care provided during the patient interaction.

Please see Appendix E for detailed information about using ICD-9 codes when billing under the LFP Payment Model.

Services provided at a Maternity Clinic must be billed using the MSP Facility Number of the Maternity Clinic. This includes Time Codes, Locum Time Codes, Patient Interaction Codes, and Locum Patient Interaction Codes.

## 14. Excluded Services

The following services are excluded and not payable under the LFP Payment Model:

### (a) Services at a Facility

Services which the patient is located at a Facility are excluded from the LFP Payment Model. This does not apply to Maternity Clinics located in a Facility. The term “Facility” is defined in Appendix A [Definitions]. For reference, it means an acute care, hospice, palliative care or long-term care facility, including but not limited to hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.

Physicians must claim for these services under a different compensation model, including using fees contained in Fee-for-Service or an alternative payment model, as applicable.

For clarity, if a physician provides Indirect Patient Care for a patient located at a Facility while the physician is between patient interactions in the course of their workday at an LFP Clinic or Maternity Clinic, this Indirect Patient Care time is payable under the LFP Payment Model.

### (b) Surgical Procedures Not Listed at Appendix D

Surgical procedures not listed in Appendix D are excluded from the LFP Payment Model. Physicians must claim for surgical procedures not listed in Appendix D under a different compensation model, including fees contained in Fee-for-Service or an alternative payment model, as applicable. If Fee-for-Service or the applicable alternative payment model includes services associated with the surgical procedure, that service or time is excluded under the LFP Payment Model.

When a physician provides a consultation and surgical procedure not listed in Appendix D to the same patient on the same day:

- Direct Patient Care time is payable for the time spent on the consultation, but not the surgical procedure.
- An LFP Consultation (98030) or LFP Locum Consultation (98060) Patient Interaction Code is payable in addition to the surgical procedure.
- No other Patient Interaction Codes are payable for the same patient on the same day.

**(c) Medical Assistance in Dying**

Medical assistance in dying services are excluded from the LFP Payment Model. Physicians must claim for services related to assessment and provision of medical assistance in dying (any location) under a different compensation model, including fees contained in Fee-for-Service or an alternative payment model as applicable.

**(d) Services to Residents of Other Provinces and Territories**

Services to residents of other provinces and territories are excluded from the LFP Payment Model. MSP-insured services for out-of-province patients are claimed under Fee-for-Service, except for residents of Quebec. All Provinces and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid provincial health card. Physicians charge services for Quebec residents directly to the patient.

C. 11 (Reciprocal Claims) of the General Preamble to the Fee-for-Service Payment Schedule lists services that are excluded from the inter-provincial agreements. Physicians charge these services directly to the patient.

**(e) Services to Residents of Other Countries and Non-beneficiaries**

Services provided to patients who are not beneficiaries under the *Medicare Protection Act* are excluded from the LFP Payment Model, including out-of-country patients and patients who do not meet minimum residency requirements (but excluding patients who fall under Section 14(d)). These services are not insured under MSP and can be charged to the patient or third-party insurance.

**(f) Motor Vehicle Accidents and WorkSafeBC Services**

Patient care relating to motor vehicle accidents and WorkSafeBC services cannot be claimed under the LFP Payment Model.

All patient care directly relating to a motor vehicle accident (ICBC services) must be billed in accordance with C. 17 (Motor Vehicle Accident Billing Guidelines) of the General Preamble to the Fee-for-Service Payment Schedule.

All patient care directly relating to WorkSafeBC services must be billed to WorkSafeBC. A detailed description of WorkSafeBC fees, preamble, and policies is contained in the Physicians and Surgeons WorkSafeBC Services Agreement.

When a physician provides both MSP-insured services and WorkSafeBC/ICBC-related care during a single patient interaction:

- Time Codes and Locum Time Codes are not payable under the LFP Payment Schedule for any of the time during the patient interaction.
- A Patient Interaction Code or Locum Patient Interaction Code is payable in full for the MSP-insured service under the LFP Payment Model.

- Start and end times for the patient interaction must be entered on the codes billed for WorkSafeBC/ICBC-related care.

**(g) Services Not Insured by MSP**

Services that are not insured by MSP are not payable under the LFP Payment Model:

- Services that are not benefits under the *Medicare Protection Act*.
- Services requested or required by a third party for reasons other than medical requirements.
- Services provided solely in association with other services not insured under MSP, including patient consultations, pre-operative examinations, and laboratory investigations.
- Medical services which are provided solely for the purposes of research or experimentation.
- Cosmetic procedures solely to alter or restore appearance.
- Charges for missed appointments.
- Services provided by a physician to their family and household members as follows:
  - spouse,
  - child or stepchild,
  - parent or stepparent,
  - parent of a spouse,
  - grandparent,
  - grandchild,
  - sibling,
  - person living in their household, or
  - spouse of a person referred to in the above list

**(“Services Not Insured by MSP”)**

Physicians can charge these services to the third party or directly to the patient as appropriate.

**(h) Services Provided under Health Authority Contract**

Services provided under a contract (e.g., service contract, sessional contract and salary agreement) between a physician and a health authority (including Provincial Health Services Authority, Providence Health Care Society and First Nations Health Authority) are excluded from the LFP Payment Model.

**(i) Services Insured by Legislation other than the Medicare Protection Act**

Services are not payable under the LFP Payment Model if the patient is eligible for and entitled to them under the following legislation:

- the *Aeronautics Act* (Canada),
- the *Civilian War-related Benefits Act*,
- the *Government Employees Compensation Act* (Canada),
- the *Merchant Seaman Compensation Act* (Canada),

- the *National Defence Act* (Canada),
- the *Pension Act* (Canada),
- the *Royal Canadian Mounted Police Pension Continuation Act* (Canada),
- the *Royal Canadian Mounted Police Superannuation Act* (Canada),
- the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*,
- the *Department of Veterans Affairs Act*,
- the *Corrections and Conditional Release Act* (Canada),
- the *Workers Compensation Act*, or
- the *Hospital Insurance Act*.

## **PART V: BILLING FOR TIME**

### **15. Included and Excluded Time**

A physician may claim for their work time on a daily basis using Time Codes or Locum Time Codes for Direct Patient Care, Indirect Patient Care, and Clinical Administration.

Patient care provided by non-physicians (e.g., nurses, nurse practitioners, allied care providers, nonclinical staff) is not payable under the LFP Payment Model. A physician may claim Indirect Patient Care for time spent communicating, care planning, and conferencing about a specific patient or patients.

The amount of time a physician may claim per calendar day is equal to the amount of time the physician spends providing Direct Patient Care, Indirect Patient Care, and Clinical Administration services that are included under the LFP Payment Model, subject to Section 16.

Physicians must not claim for time spent on Excluded Services. This includes:

- WorkSafeBC and ICBC-related services
- Services for patients who are not BC residents
- After-hours coverage (on call) time when not providing patient care
- Breaks

Physicians must ensure that medical records and other documentation support time claimed under the Time Codes or Locum Time Codes (Direct Patient Care, Indirect Patient Care, and Clinical Administration). In the event of an audit, a medical inspector (who will ordinarily be a family physician) must be able to independently determine the services provided in any given block of time.

Documentation of time claimed must be made available upon request, in accordance with the terms of the *Medicare Protection Act*.

Time spent on care provided under other payment models (e.g., Fee-for-Service, Alternate Payment Program) must be clearly documented and demonstrate there is no overlap with time claimed under the LFP Payment Model.



## 16. Limits on Payment for Time

Time codes are subject to the following limits:

- (a) **Maximum Daily Time** – The maximum amount of time payable under the LFP Payment Model is 14 hours in a single calendar day.
- (b) **Maximum Two-Week Time** – The maximum amount of time payable under the LFP Payment Model is 120 hours in any 14-day period.
- (c) **Maximum Clinical Administration Time** – The maximum amount of time billable as Clinical Administration time (98012, 98042) is 10% of the total amount of time claimed by the physician in a calendar year for Direct Patient Care (98010, 98040) and Indirect Patient Care (98011, 98041) and Clinical Administration (98012, 98042). It is anticipated that Clinical Administration time for most physicians will be in the range of 5% of the time claimed under the Time Codes and Locum Time Codes.

Claims for Time Codes and Locum Time Codes that exceed typical hours by peer family physicians are more likely to result in a review and/or audit.

## 17. How to Bill Time Codes and Locum Time Codes

Claims for Time Codes and Locum Time Codes are submitted on a daily basis for Direct Patient Care, Indirect Patient Care, and Clinical Administration. One or more claims may be submitted for each Time Code each day. There is no requirement to separately claim for the time spent with each individual patient.

Start and end times on each block of time must be entered on the billing claim. Only one Time Code or Locum Time Code at a time is payable. This means that start and end times for each code must not overlap.

Time Codes and Locum Time Codes are billed in 15-minute increments. The number of 15-minute units of time providing Clinic-based Services is totaled over the whole day and entered as the number of services on the claim. A physician must work the full 15 minutes to bill for that 15-minute increment. For example, if a physician provides 50 minutes of Direct Patient Care, they are entitled to claim 3 units of “98010 LFP Direct Patient Care Time – per 15 minutes”.

Time Codes and Locum Time Codes are submitted using the personal health number (PHN) and demographic information of the first or last patient of the day for whom Direct Patient Care or Indirect Patient Care is provided under the LFP Payment Model. On a day when only Clinical Administration is provided, use the information of the last LFP patient for whom Direct Patient Care or Indirect Patient Care was provided.

The following fields are required for each Time Code and Locum Time Code submitted to HIBC via Teleplan (items in *italics* are required for Locum Time Codes only):

- MSP Payee Number,
- Practitioner Number,
- Date of service

- Time Code or Locum Time Code (using the fee item field in Teleplan)
- Start time (for each block of time),
- End time (for each block of time),
- Time units – the number of 15-minute time units
- ICD-9 diagnostic code: L23
- Location Code, and
- MSP Facility Number
- *Referred by (The MSP Practitioner number of the Host Physician is required on all Locum Time Codes. When an LFP Locum is providing care on behalf of more than one Host Physician at the same longitudinal clinic, use the MSP practitioner number of one of the Host Physicians.)*

## 18. Time Codes

The “**Time Codes**”, as explained in detail below, are the following:

- 98010 LFP Direct Patient Care Time – per 15 minutes
- 98011 LFP Indirect Patient Care Time – per 15 minutes
- 98012 LFP Clinical Administration Time – per 15 minutes

Each type of patient care must be billed using the appropriate Time Code. An LFP Locum can only bill Locum Time Codes (98040, 98041, 98042) and must not bill the Time Codes (98010, 98011, 98012).

The Time Codes are as follows:

<b>98010</b>	<b>LFP Direct Patient Care Time – per 15 minutes.....\$32.50</b>
	<b>Notes:</b>
	a) Payable only to physicians who have billed 98000 Registration Code.
	b) Payable for time spent providing Direct Patient Care, which means the following Clinic-based Services with a patient present: <ul style="list-style-type: none"> <li>• In-person care, including home visits</li> <li>• Synchronous virtual care (phone, video)</li> <li>• Clinical teaching provided concurrently with patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students, and midwives/midwifery students.</li> </ul>
	c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is included under 98010.
	d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
	e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include time spent on: <ul style="list-style-type: none"> <li>• Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)</li> <li>• After-hours coverage (on call) time when not providing patient care</li> <li>• Breaks</li> </ul>
	f) Start and end times must be entered on the billing claim.
<b>98011</b>	<b>LFP Indirect Patient Care Time – per 15 minutes .....\$32.50</b>

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for time spent on Indirect Patient Care, which is patient-specific services provided when the patient is not present. This means:
  - Documentation of patient interactions and charting
  - Review of results: labs, imaging, consultations, and other reports
  - Preparing referrals and requisitions
  - Chart review
  - Asynchronous virtual care (email, text, messaging via EMR)
  - Care coordination, care planning, and prescription refills done without the patient present
  - Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients
  - Conferencing and meeting with family members, caregivers, and/or patient medical representatives
  - Travel time required to see a patient in their Home Setting
  - Clinical teaching arising from direct patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students
  - Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g., investigating particular diagnostic and therapeutic interventions)
  - Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp.
- c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is excluded, as it is included under 98010.
- d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
- e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
  - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
  - After-hours coverage (on call) time when not providing patient care
  - Breaks
- f) Start and end times must be entered on the billing claim.

**98012 LFP Clinical Administration Time – per 15 minutes .....\$32.50**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for time spent on clinical administration, which are activities that may not be patient-specific but require the professional expertise of a physician for management of the patient panel and practice. Examples include the following services:
  - Proactive patient panel management and review for screening interventions, disease management, and provision of data-informed care (e.g., mammograms, colon cancer screening, immunizations, diabetes management).
  - Electronic Medical Record (EMR) updating and management that requires physician expertise.
  - [Medical director responsibilities](#) to ensure standards of medical care in the primary care practice as required by the College of Physicians and Surgeons of British Columbia.
  - [Privacy officer responsibilities](#) for establishing and maintaining a privacy management program as required by privacy and other legislation, including the *Personal Information*

*Protection Act, the Freedom of Information and Protection of Privacy Act and E-Health Act.*

- c) Not payable for non-clinical administration related to clinic management that does not require the professional expertise of a physician for management of the patient panel and practice. This includes, but is not limited to, management of employees, finance and accounting responsibilities, ordering supplies and equipment, and clinic infrastructure services such as leasing and insurance.
- d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
- e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
  - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
  - After-hours coverage (on call) time when not providing patient care
  - Breaks
- f) Start and end times must be entered on the billing claim.
- g) The maximum amount of time payable as clinical administration is 10% of the total hours paid as 98010, 98011, and 98012 per calendar year.

## 19. Locum Time Codes

The Locum Time Codes, as explained in detail below, are the following:

- 98040 LFP Locum Direct Patient Care Time – per 15 minutes
- 98041 LFP Locum Indirect Patient Care Time – per 15 minutes
- 98042 LFP Locum Clinical Administration Time – per 15 minutes

Each type of patient care provided by an LFP Locum must be billed using the appropriate Locum Time Code.

The Locum Time Codes are as follows:

**98040 LFP Locum Direct Patient Care Time– per 15 minutes.....\$32.50**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for time spent providing Direct Patient Care, which means the following Clinic-based Services with a patient present:
  - In-person care, including home visits
  - Synchronous virtual care (phone, video)
  - Clinical teaching provided concurrently with patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students, and midwives/midwifery students.
- c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is included under 98040.
- d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
- e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include time spent on:
  - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)

- After-hours coverage (on call) time when not providing patient care
- Breaks
- f) Start and end times must be entered on the billing claim.
- g) The MSP practitioner number of the Host Physician must be entered in the “Referred by” field on the billing claim.

**98041 LFP Locum Indirect Patient Care Time – per 15 minutes .....\$32.50**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for time spent on Indirect Patient Care, which is patient-specific services provided when the patient is not present. This means:
  - Documentation of patient interactions and charting
  - Review of results: labs, imaging, consultations, and other reports
  - Preparing referrals and requisitions
  - Chart review
  - Asynchronous virtual care (email, text, messaging via EMR)
  - Care coordination, care planning, and prescription refills done without the patient present
  - Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients
  - Conferencing and meeting with family members, caregivers, and/or patient medical representatives
  - Travel time required to see a patient in their Home Setting
  - Clinical teaching arising from direct patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students
  - Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g., investigating particular diagnostic and therapeutic interventions)
  - Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp.
- c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is excluded, as it is included under 98040.
- d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
- e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
  - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
  - After-hours coverage (on call) time when not providing patient care
  - Breaks
- f) Start and end times must be entered on the billing claim.
- g) The MSP practitioner number of the Host Physician must be entered in the “Referred by” field on the billing claim.

**98042 LFP Locum Clinical Administration Time – per 15 minutes .....\$32.50**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.

- b) Payable for time spent on clinical administration, which are activities that may not be patient-specific but require the professional expertise of a physician for management of the patient panel and practice. Examples include the following services:
  - Proactive patient panel management and review for screening interventions, disease management, and provision of data-informed care (e.g., mammograms, colon cancer screening, immunizations, diabetes management).
  - Electronic Medical Record (EMR) updating and management that requires physician expertise.
  - [Medical director responsibilities](#) to ensure standards of medical care in the primary care practice as required by the College of Physicians and Surgeons of British Columbia.
  - [Privacy officer responsibilities](#) for establishing and maintaining a privacy management program as required by privacy and other legislation, including the *Personal Information Protection Act*, the *Freedom of Information and Protection of Privacy Act* and *E-Health Act*.
- c) Not payable for non-clinical administration related to clinic management that does not require the professional expertise of a physician for management of the patient panel and practice. This includes, but is not limited to, management of employees, finance and accounting responsibilities, ordering supplies and equipment, and clinic infrastructure services such as leasing and insurance.
- d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
- e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
  - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
  - After-hours coverage (on call) time when not providing patient care
  - Breaks
- f) Start and end times must be entered on the billing claim.
- g) The maximum amount of time payable as clinical administration is 10% of the total hours paid as 98040, 98041, and 98042 per calendar year.
- h) The MSP practitioner number of the Host Physician must be entered in the “Referred by” field on the billing claim.

## PART VI: BILLING FOR PHYSICIAN-PATIENT INTERACTIONS

### 20. Physician-Patient Interaction Codes

In addition to billing Time Codes or Locum Time Codes, a physician also bills for physician-patient interactions included in the LFP Payment Model using a Patient Interaction Code or Locum Patient Interaction Code.

Fee-For-Service codes, such as tray fees and diagnostic tests, are not payable in addition to Patient Interaction Codes or Locum Patient Interaction Codes in relation to services included in the LFP Payment Model.

### 21. Limits on Payment for Physician-Patient Interactions

Patient Interaction Codes and Locum Patient Interaction Codes are subject to the following limits:

- (a) **Maximum Interactions Paid Daily** – The maximum number of Patient Interaction Codes and Locum Patient Interaction Codes payable in a single calendar day is 50. This maximum applies to all Patient Interaction Codes and Locum Patient Interaction Codes, except 98022 and 98052. This maximum does not apply to services provided in communities that were receiving NIA premiums as of December 15, 2002.
- (b) **Maximum Payment for Services to Patients not on Panel** – A physician cannot claim more than 30% of their Patient Interaction Codes for Non-panel Services in one calendar year, unless they meet the exception criteria in Section 4(a)(i) or (ii). A physician is not entitled to payments in excess of the 30% limit. If a physician exceeds this 30% limit, they cannot bill Fee-for-Service for additional Clinic-based Services.

An LFP Locum cannot claim more than 30% of their Locum Patient Interaction Codes for Non-panel Services in one calendar year at each clinic where LFP Locum Services are provided.

For the purposes of Section 21(b), the terms “Patient Interaction Codes,” “Locum Patient Interaction Codes,” and “Clinic-based Services” exclude Maternity Services that are identified with the following ICD-9 codes: V20, V22, V24, and Complex Contraception Services that are identified with the following ICD-9 code: V25. Please see Appendix E for detailed information about using ICD-9 codes to identify Maternity Services and Complex Contraception Services.

Claims for Patient Interaction Codes and Locum Patient Interaction Codes that exceed typical numbers by peer family physicians are more likely to result in a review and/or audit.

## 22. How to Bill Patient Interaction Codes and Locum Patient Interaction Codes

The following fields are required for each Patient Interaction Code and Locum Patient Interaction Codes submitted to HIBC via Teleplan (items in *italics* are required for referrals and consultations only):

- MSP Payee Number
- Practitioner Number
- Patient Personal Health Number (PHN)
- Patient Name
- Patient Date of Birth
- Date of service
- Patient Interaction Code or Locum Patient Interaction Code (fee item)
- ICD-9 Diagnostic Codes (1 code mandatory, 3 maximum)
- Location Code
- MSP Facility Number
- *Referred by (Notify MSP that a referral has been made to you by including the MSP practitioner number of the referring physician in the “Referred by Field.”)*
- *Referred to (Notify MSP of a referral by including the MSP practitioner number of the physician being referred to in the “Referred to Field.” If no Patient Interaction Code or Locum Patient Interaction Code is being submitted, a claim record for a “no charge referral” may be submitted to MSP under fee item 03333 with a zero-dollar amount.)*

## 23. Patient Interaction Codes

The “**Patient Interaction Codes**”, as explained in detail below, are the following:

- 98031 LFP In-person Interaction in a Clinic
- 98032 LFP Virtual Interaction by Phone or Video
- 98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98021 LFP In-person Interaction with a Standard Procedure
- 98020 LFP In-person Interaction with an Advanced Procedure
- 98033 LFP In-person Interaction in the Patient’s Home
- 98030 LFP Consultation
- 98034 LFP In-person or Video Group Interaction

Seven Patient Interaction Codes are stand-alone fee codes, inclusive of all services provided during the physician-patient interaction. For these services, only one Patient Interaction Code is billable for each patient interaction. When the patient is seen for multiple issues during the same patient interaction, the applicable Patient Interaction Code with the highest value should be billed and additional Patient Interaction Codes are not payable.

The eighth Patient Interaction Code is “98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction.” When minor procedures or diagnostic tests are provided during an in-person interaction, these are billed via an add-on code that can be billed in addition to other in-person interaction codes.

Appendix D outlines the procedures and diagnostic tests that are payable under the three procedure Patient Interaction Codes (98020, 98021, 98022). Procedures and diagnostic tests not outlined in Appendix D cannot be claimed under these Patient Interaction Codes and are included in the appropriate in-person Patient Interaction Code (98030, 98031, 98033, 98034). They cannot be claimed under Fee-For-Service or by any alternative payment model, unless it is an Excluded Service.

The Patient Interaction Codes are as follows:

**98031 LFP In-person Interaction in Clinic.....\$25**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for an in-person interaction provided in an LFP Clinic or Maternity Clinic.
- d) Not payable in addition to 98020, 98021, 98030, 98032, 98033, or 98034.

**98032 LFP Virtual Interaction by Phone or Video ..... \$25**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for a virtual interaction provided by phone or video.
- d) Not payable in addition to 98020, 98021, 98022, 98030, 98031, 98033, or 98034.



**98022 LFP Minor Procedure or Diagnostic Test Provided in addition to an In-person Interaction.....\$10**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of a minor procedure or diagnostic test to the patient.
- c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
- d) Payable for a maximum of two of the services from the following list. Only one of each type of minor procedure or diagnostic test listed below is payable per patient per day.
  - Cryotherapy to any or multiple parts of the body
  - Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)
  - Urinalysis by dipstick
  - Urine pregnancy test
  - Urine screening for opioid agonist treatment
  - Urine screening for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone
  - Peak flow testing
  - Venipuncture
- e) Payable on the same day in addition to 98020, 98021, 98030, 98031, or 98033.
- f) Not payable in addition to 98032 and 98034.

**98021 LFP In-person Interaction with a Standard Procedure .....\$60**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
- d) Payable for the following procedures:
  - Gynecologic examination and cervix screening that includes the use of a speculum
  - IUD removal
  - Cervical polypectomy
  - Anoscopy
  - Trigger point injection
  - Injection or aspiration of tendon or bursa
  - Intra-articular injection or aspiration
  - Varicose vein injection
- e) Not payable in addition to 98020, 98030, 98031, 98032, 98033, or 98034.

**98020 LFP In-person Interaction with an Advanced Procedure ..... \$110**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.

- c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
- d) Only payable for procedures named in Appendix D.
- e) Not payable for procedural pain management that is required to be performed in a facility accredited by the Non-Hospital Medical and Surgical Facilities Accreditation Program Committee of the College of Physicians and Surgeons of BC.
- f) Not payable in addition to 98021, 98030, 98031, 98032, 98033, or 98034.

**98033 LFP In-person Interaction in the Patient's Home .....\$100**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for an in-person interaction provided to a patient in their Home Setting as deemed appropriate by the physician. This excludes patients in acute care facilities and long-term care facilities such as hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.
- d) Not payable in addition to 98020, 98021, 98030, 98031, 98032, or 98034.
- e) Time spent during the in-person interaction in the patient's home is payable as 98010. Travel time required to see a patient in their Home Setting is payable as 98011.

**98030 LFP Consultation..... \$60**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for consultations provided in-person or virtually as is clinically appropriate for the presenting concern.
- d) A consultation applies when a physician, nurse practitioner, or other health care practitioner requests the opinion of a family physician who has specialized expertise to provide consultative services. "Health care practitioner" in this context is limited to a:
  - midwife for maternity care or pediatric care,
  - registered nurse or registered psychiatric nurse for substance use care.
- e) A consultation must not be billed without a written request for consultation and the provision of a written report to the referring practitioner. It is expected that a written report will be generated by the physician providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.
- f) The consultation service includes the initial services necessary to enable the consultant to prepare a written report to the referring practitioner, including their findings, opinions and recommendations.
- g) A consultation for the same diagnosis is not payable as an LFP Consultation unless an interval of at least six months has passed since the consultant has last billed an LFP Consultation for the patient. A new and unrelated diagnosis can be billed as an LFP Consultation without a six-month interval.
- h) Not payable for transfer of care within a group of physicians who work together to provide care and coverage to patients.
- i) Not payable in addition to 98020, 98021, 98031, 98032, 98033, or 98034.

**98034 LFP In-person or Video Group Interaction ..... \$25/patient**

**Notes:**

- a) Payable only to physicians who have billed 98000 Registration Code.
- b) Payable for a documented interaction between a group of patients and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for an in-person or video group medical visit or group counselling visit for groups of two or more patients that provides 1:1 interaction between each patient and the physician.
- d) A minimum of thirty minutes must be spent for the group interaction.
- e) While the length of the group interaction and the number of patients in the group interaction may vary, this is only payable for a maximum of:
  - 3 patients for a 30 minute In-person or Video Group Interaction
  - 5 patients for a 45 minute In-person or Video Group Interaction
  - 6 patients for a 60 minute In-person or Video Group Interaction
  - 8 patients for a 75 minute In-person or Video Group Interaction
  - 9 patients for a 90 minute or longer In-person or Video Group Interaction
- f) Start and end times for the group interaction must be entered on the billing claim.
- g) Not payable in addition to 98020, 98021, 98022, 98030, 98031, 98032, or 98033.

## **24. Locum Patient Interaction Codes**

The “Locum Patient Interaction Codes”, as explained in detail below, are the following:

- 98061 LFP Locum In-person Interaction in a Clinic
- 98062 LFP Locum Virtual Interaction by Phone or Video
- 98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98051 LFP Locum In-person Interaction with a Standard Procedure
- 98050 LFP Locum In-person Interaction with an Advanced Procedure
- 98063 LFP Locum In-person Interaction in the Patient’s Home
- 98060 LFP Locum Consultation
- 98064 LFP Locum In-person or Video Group Interaction

An LFP Locum can only bill Locum Patient Interaction Codes listed in this section of the LFP Payment Schedule. They must not bill the Patient Interaction Codes in Section 23.

Seven Locum Patient Interaction Codes are stand-alone fee codes, inclusive of all services provided during the physician-patient interaction. For these services, only one Locum Patient Interaction Code is billable for each patient interaction. When the patient is seen for multiple issues during the same patient interaction, the applicable Locum Patient Interaction Code with the highest value should be billed and additional Locum Patient Interaction Codes are not payable.

The eighth Locum Patient Interaction Code is “98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction.” When minor procedures or diagnostic tests are provided during an in-person interaction, these are billed via an add-on code that can be billed in addition to other in-person interaction codes.

Appendix D outlines the procedures and diagnostic tests that are payable under the three procedure Locum Patient Interaction Codes (98050, 98051, 98052). Procedures and diagnostic tests not outlined in Appendix D cannot be claimed under these Locum Patient Interaction Codes and are included in the appropriate in-person Locum Patient Interaction Code (98060, 98061, 98063, 98064). They cannot be claimed under Fee-For-Service or by any alternative payment model, unless it is an Excluded Service.

<b>98061</b>	<b>LFP Locum In-person Interaction in Clinic.....</b>	<b>\$25</b>
	<b>Notes:</b>	
	a) Payable only to physicians who have billed 98005 Locum Registration Code.	
	b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.	
	c) Payable for an in-person interaction provided in an LFP Clinic or Maternity Clinic.	
	d) Not payable in addition to 98050, 98051, 98060, 98062, 98063, or 98064.	
<b>98062</b>	<b>LFP Locum Virtual Interaction by Phone or Video .....</b>	<b>\$25</b>
	<b>Notes:</b>	
	a) Payable only to physicians who have billed 98005 Locum Registration Code.	
	b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.	
	c) Payable for a virtual interaction provided by phone or video.	
	d) Not payable in addition to 98050, 98051, 98052, 98060, 98061, 98063, or 98064.	
<b>98052</b>	<b>LFP Locum Minor Procedure or Diagnostic Test Provided in addition to an In-person Interaction.....</b>	<b>\$10</b>
	<b>Notes:</b>	
	a) Payable only to physicians who have billed 98005 Locum Registration Code.	
	b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of a minor procedure or diagnostic test to the patient.	
	c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.	
	d) Payable for a maximum of two of the services from the following list. Only one of each type of minor procedure or diagnostic test listed below is payable per patient per day.	
	<ul style="list-style-type: none"> <li>• Cryotherapy to any or multiple parts of the body</li> <li>• Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)</li> <li>• Urinalysis by dipstick</li> <li>• Urine pregnancy test</li> <li>• Urine screening for opioid agonist treatment</li> <li>• Urine screening for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone</li> <li>• Peak flow testing</li> <li>• Venipuncture</li> </ul>	
	e) Payable on the same day in addition to 98050, 98051, 98060, 98061, or 98063.	
	f) Not payable in addition to 98062 and 98064.	
<b>98051</b>	<b>LFP Locum In-person Interaction with a Standard Procedure .....</b>	<b>\$60</b>
	<b>Notes:</b>	
	a) Payable only to physicians who have billed 98005 Locum Registration Code.	
	b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.	

- c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
- d) Payable for the following procedures:
  - Gynecologic examination and cervix screening that includes the use of a speculum
  - IUD removal
  - Cervical polypectomy
  - Anoscopy
  - Trigger point injection
  - Injection or aspiration of tendon or bursa
  - Intra-articular injection or aspiration
  - Varicose vein injection
- e) Not payable in addition to 98050, 98060, 98061, 98062, 98063, or 98064.

**98050 LFP Locum In-person Interaction with an Advanced Procedure ..... \$110**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
- d) Only payable for procedures named in Appendix D.
- e) Not payable for procedural pain management that is required to be performed in a facility accredited by the Non-Hospital Medical and Surgical Facilities Accreditation Program Committee of the College of Physicians and Surgeons of BC.
- f) Not payable in addition to 98051, 98060, 98061, 98062, 98063, or 98064.

**98063 LFP Locum In-person Interaction in the Patient's Home .....\$100**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for an in-person interaction provided to a patient in their Home Setting as deemed appropriate by the physician. This excludes patients in acute care facilities and long-term care facilities such as hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.
- d) Not payable in addition to 98050, 98051, 98060, 98061, 98062, or 98064.
- e) Time spent during the in-person interaction in the patient's home is payable as 98040. Travel time required to see a patient in their Home Setting is payable as 98041.

**98060 LFP Locum Consultation..... \$60**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the

following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.

- c) Payable for consultations provided in-person or virtually as is clinically appropriate for the presenting concern.
- d) A consultation applies when a physician, nurse practitioner, or other health care practitioner requests the opinion of a family physician who has specialized expertise to provide consultative services. "Health care practitioner" in this context is limited to a:
  - midwife for maternity care or pediatric care,
  - registered nurse or registered psychiatric nurse for substance use care.
- e) A consultation must not be billed without a written request for consultation and the provision of a written report to the referring practitioner. It is expected that a written report will be generated by the physician providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.
- f) The consultation service includes the initial services necessary to enable the consultant to prepare a written report to the referring practitioner, including their findings, opinions and recommendations.
- g) A consultation for the same diagnosis is not payable as an LFP Consultation unless an interval of at least six months has passed since the consultant has last billed an LFP Consultation for the patient. A new and unrelated diagnosis can be billed as an LFP Consultation without a six-month interval.
- h) Not payable for transfer of care within a group of physicians who work together to provide care and coverage to patients.
- i) Not payable in addition to 98050, 98051, 98061, 98062, 98063, or 98064.

#### **98064 LFP Locum In-person or Video Group Interaction ..... \$25/patient**

**Notes:**

- a) Payable only to physicians who have billed 98005 Locum Registration Code.
- b) Payable for a documented interaction between a group of patients and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
- c) Payable for an in-person or video group medical visit or group counselling visit for groups of two or more patients that provides 1:1 interaction between each patient and the physician.
- d) A minimum of thirty minutes must be spent for the group interaction.
- e) While the length of the group interaction and the number of patients in the group interaction may vary, this is only payable for a maximum of:
  - 3 patients for a 30 minute In-person or Video Group Interaction
  - 5 patients for a 45 minute In-person or Video Group Interaction
  - 6 patients for a 60 minute In-person or Video Group Interaction
  - 8 patients for a 75 minute In-person or Video Group Interaction
  - 9 patients for a 90 minute or longer In-person or Video Group Interaction
- f) Start and end times for the group interaction must be entered on the billing claim.
- g) Not payable in addition to 98050, 98051, 98052, 98060, 98061, 98062, or 98063.

## **PART VII: THE PANEL PAYMENT**

### **25. Panel Payment**

In addition to billing for time and patient interactions, a physician enrolled in the LFP Payment Model who is not an LFP Locum receives a panel payment based on the size and complexity of their patient panel. The panel payment is the component of the LFP Payment Model that recognizes relational

continuity – the ongoing, trusting, therapeutic relationship between a patient and their family physician.

Currently, the panel payment is based on an interim methodology adapted from the Community Longitudinal Family Physician (CLFP) Payment to estimate the size and complexity of a longitudinal family physician's patient panel. In this interim methodology, the number of patients is estimated using the Majority Source of Care (MSOC) methodology and complexity is measured using the Adjusted Clinical Group (ACG) system.

Once the Provincial Attachment System is fully established for identifying physicians' Empanelled Patients, the panel payment will be calculated based on the number of Empanelled Patients and the complexity of those patients.

The panel payment is designed to be paid out four times per year on a quarterly installment schedule. An eligible physician must submit a claim form once per calendar year to claim the panel payment instalments for the calendar year. Submitting the claim form will confirm the physician's eligibility for the panel payment and their MSP Payee Number.

## **PART VIII: SPECIAL SITUATIONS**

### **26. Multiple Visits by the Same Patient in One Day**

Occasionally, a patient will visit a physician more than once on the same day. When this occurs:

- (a) Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040) is billable; and
- (b) a second Patient Interaction Code or Locum Patient Interaction Code is not billable, unless the second visit is:
  - (i) for a new condition; or
  - (ii) because the condition has worsened significantly and requires a new assessment.

To bill more than one Patient Interaction Code or Locum Patient Interaction Code for the same patient on the same calendar day:

- provide the time for each interaction in the time field for each Patient Interaction Code or Locum Patient Interaction Code;
- provide a note record indicating the reason for the second interaction; and
- use submission code "D" for the second Patient Interaction Code or Locum Patient Interaction Code.

### **27. Clinical Teaching**

For the purposes of payment for clinical teaching, "**Clinical Learners**" are medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students.

Time Codes and Locum Time Codes are payable to physicians providing clinical teaching to Clinical Learners in relation to Clinic-Based Services as follows:

**a) Direct Patient Care time**

- Time spent providing clinical teaching concurrent with patient care is payable as Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040).
- The physician must be present in-person in order for the Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040) to be payable for clinical teaching concurrent with in-person patient care.
- For clinical teaching concurrent with virtual patient care, the physician can be present in-person, by telephone, or by videoconference.

**b) Indirect Patient Care time**

- Time spent providing clinical teaching arising from Direct Patient Care is payable as Indirect Patient Care Time (98011) or Locum Indirect Patient Care Time (98041).

Time Codes and Locum Time Codes are not payable for the Clinical Learner's time.

## **28. Services provided by Students, Residents and Trainees**

Patient Interaction Codes and Locum Patient Interaction Codes for Clinic-based Services are payable to supervising physicians for patient interactions provided by students, residents, and trainees as follows:

- When patient care is provided in-person, the supervising physician must be present in-person at the LFP Clinic or Maternity Clinic.
- When patient care is provided virtually by phone or video, the supervising physician must be available in-person, by telephone, or by videoconference in a timely manner appropriate to the acuity of the service being supervised.
- The maximum number of Patient Interaction Codes and Locum Patient Interaction Codes payable in a single calendar day is 50. This maximum applies to all Patient Interaction Codes and Locum Patient Interaction Codes except 98022 and 98052.
- The physician must review the patient interaction and sign off the medical record or other auditable document by the end of the next workday.

## **PART IX: ADMINISTRATION AND CLAIMS SUBMISSION**

### **29. Audit Authority**

Physicians receiving payment through the LFP Payment Model are subject to the auditing authority of the Medical Services Commission under the *Medicare Protection Act*.

Physicians are responsible for all claims submitted under their MSP practitioner number, even if they receive support from others.

### **30. Adequate Medical Records**



All claims must be supported by an Adequate Medical Record. An “**Adequate Medical Record**” is a record that contains sufficient information to enable a family physician, without being familiar with the patient or the physician, to readily determine the following:

- (a) Date and location of the service.
- (b) Identification of the patient and the physician.
- (c) Presenting concern(s) and presenting symptoms and signs, including their history.
- (d) All pertinent previous history including pertinent family history.
- (e) The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient’s problem(s).
- (f) Identification of the extent of the physical examination including pertinent positive and negative findings.
- (g) Results of any investigations carried out during the interaction.
- (h) Summation of the problem and plan of management.

A service for which an Adequate Medical Record has not been recorded and retained is not a benefit under MSP.

### **31. MSP Facility Number**

An MSP Facility Number is required to submit claims under the LFP Payment Model. A physician can obtain the MSP Facility Number from the physician responsible for administration of the clinic.

If a clinic does not have an MSP Facility Number, the physician responsible for administration of the clinic (the “**Facility Administrator**”) must apply for a number by submitting an *Application for MSP Facility Number* via [online application](#) or [printable form](#).

If there are any changes to the information for the facility after the application for MSP Facility Number has been submitted, the Facility Administrator must submit an *Application to Cancel or Change Details for Facilities with an MSP Facility Number* via [online application](#) or [printable form](#).

Each clinic location must obtain a unique MSP Facility Number. Only one MSP Facility Number is required per clinic.

### **32. Billing the LFP Payment Model on the Same Day as Fee-for-Service, ICBC Services, or WorkSafeBC Services**

If a physician provides Clinic-based Services and Fee-for-Service services on the same day, start and end times must be entered on each Fee-for-Service claim. This is required for all Fee-for-Service claims, regardless of whether the service is provided at the LFP Clinic, Maternity Clinic, in a Facility, or at another location.

For an individual service, a physician must enter the actual start and end time on the Fee-for-Service claim. For multiple services provided back-to-back under Fee-for-Service (a block of services), a physician must enter the start and end times of the block of services on each Fee-for-Service claim. Actual start and end times for each service provided during a continuous block of services are not required.

In addition, if a physician provides Clinic-based Services and WorkSafeBC/ICBC-related services on the same day, start and end times must be entered on the codes billed for WorkSafeBC/ICBC-related care.

### **33. Claim Submission**

Physicians billing under the LFP Payment Model must submit claims for Time Codes, Locum Time Codes, Patient Interaction Codes, and Locum Patient Interaction Codes to HIBC via Teleplan within 90 days of the date of service, subject to limited exceptions.

Please see Appendix C for detailed information about submitting claims more than 90 days after the date of service and submitting claims for newborns.

### **34. Reviewing and Resubmitting Claims**

A physician should carefully review their remittance statements issued by MSP to reconcile all claims and payments made.

In certain circumstances, MSP may hold, reduce, or refuse claims submitted by a physician. In each case, [explanatory codes](#) explain the reason for the claim not being paid in full.

If a physician does not agree with MSP's payment of a claim, the physician should resubmit the claim to MSP with a note record explaining the circumstances.

### **35. Contact Information**

Health Insurance BC (HIBC) Practitioner & Professional Resources

#### **Phone**

Vancouver: (604) 456-6950

Elsewhere in B.C.: 1-866-456-6950

#### **Fax**

##### Billing Support

Fax: (250) 405-3593

- Assists with Practitioner billing; payment schedule/fee item questions; handles adjudication disputes and overage claims.

##### Provider Services

Fax: (250) 405-3592

- Responsible for practitioner registration, opting-in/out, assignment of payment, electronic claims submission, direct bank deposit, locum programs, northern and rural programs.

#### **Mail**

Medical Services Plan  
PO Box 9480 Stn Prov Govt  
Victoria, B.C. V8W 9E7

## **APPENDICES**

**Appendix A:** Definitions

**Appendix B:** Background and Principles of the LFP Payment Model

**Appendix C:** Claim Submission and Payment

**Appendix D:** Procedures and Diagnostic Tests Payable Under 98020, 98021, 98022, 98050, 98051, and 98052

**Appendix E:** Using ICD-9 Codes when Billing Under the LFP Payment Model

**Appendix F:** Billing Fee-for-Service After Withdrawing from the LFP Payment Model

## Appendix A – Definitions

In this Payment Schedule, unless the context otherwise requires:

- (a) **“Adequate Medical Record”** has the meaning given to it in Section 30 [*Adequate Medical Records*].
- (b) **“Clinic-based Services”** means LFP Practice Services, Non-panel Services, Maternity Services, and Complex Contraception Services.
- (c) **“Clinical Administration”** means Clinical Administration as described in Time Code 98012 LFP Clinical Administration – per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code and excluding time described in item (c).
- (d) **“Complex Contraception Service”** means ~~contraceptive~~ care related to **contraceptive** procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), **as well as the use of contraceptive methods for** medically and socially complex patients, **care resulting from a referral or recommendation from** ~~patients referred by~~ a physician or allied care provider, and gender-affirming care.
- (e) **“CPSBC”** means the College of Physicians and Surgeons of BC.
- (f) **“Deemed Ineligible”** has the meaning given to it in Section 8(c) [*Deemed Ineligible*].
- (g) **“Direct Patient Care”** means direct patient care as described in Time Code 98010 LFP Direct Patient Care Time– per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code.
- (h) **“Eligibility Criteria”** means, for a physician not currently enrolled in the LFP Payment Model, the Initial Eligibility Criteria; for a physician enrolled in the LFP Payment Model, the Ongoing Eligibility Criteria.
- (i) **“Empanelled Patient”** means an individual for whom a family physician has accepted responsibility to provide and coordinate longitudinal, relationship-based, comprehensive, family medicine care.
- (j) **“Excluded Services”** means all of the services and circumstances described in Section 14 [*Excluded Services*] as being excluded from the LFP Payment Model.
- (k) **“Facility”** means an acute care, palliative care, or long-term care facility, including but not limited to hospitals, hospice, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.
- (l) **“Fee-for-Service”** means a Payment Schedule titled the “Medical Services Commission Payment Schedule” that contains a “General Preamble” and separate schedules for different sections of physicians, as amended from time-to-time, which is sometimes referred to as “fee-for-service”. For clarity, it is a Payment Schedule that is not this LFP Payment Schedule.
- (m) **“Home Setting”** means a setting where a patient lives – including a home, assisted living or another setting where a person lives – but excluding a Facility.

- (n) **“Host Physician”** means a physician who provides Longitudinal Family Physician Services, is having an LFP Locum provide services on their behalf, and is:
- i) enrolled in the LFP Payment Model;
  - ii) remunerated under Fee-for-Service and has submitted 14070 in the same calendar year;
  - iii) remunerated under the Group Contract for Practicing Full-Service Family Physicians or the Individual Contract for New-to-Practice Family Physicians; or
  - iv) Remunerated under Alternative Payments Subsidiary Agreement (APSA) contracts under the following practice categories until October 31, 2024:
    - General Practice – Full Scope (Rural) – Area A, B, C
    - General Practice – Full Scope (Non-JSC Community)
    - General Practice – Defined Scope B (Student Health Centres)
- (o) **“Indirect Patient Care”** means indirect patient care as described in Time Code 98011 LFP Indirect Patient Care Time– per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code.
- (p) **“Initial Eligibility Criteria”** means the initial eligibility criteria for the LFP Payment Model defined in Section 4 [*Initial Eligibility for the LFP Payment Model*].
- (q) **“LFP Clinic”** means a medical clinic in which a physician enrolled in the LFP Payment Model provides Longitudinal Family Physician Services.
- (r) **“LFP Locum”** means a physician who meets the Locum Eligibility Criteria and provides LFP Locum Services on behalf of a Host Physician.
- (s) **“Locum Patient Interaction Codes”** has the meaning given to it in Section 24 [*Locum Patient Interaction Codes*].
- (t) **“LFP Locum Services”** means LFP Practice Services, Non-panel Services, Maternity Services, and Complex Contraception Services provided by an LFP Locum on behalf of a Host Physician.
- (u) **“Locum Time Code”** or **“Locum Time Codes”** means, as context requires, one or more of: LFP Locum Direct Patient Care Time (98040), LFP Locum Indirect Patient Care Time (98041), and LFP Locum Clinical Administration Time (98042).
- (v) **“LFP Payment Schedule”** means this Payment Schedule.
- (w) **“LFP Practice Service”** means Direct Patient Care and Indirect Patient Care that a physician provides to a patient on: (i) the physician’s panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:
- i) at the physician’s LFP Clinic;
  - ii) at a Maternity Clinic;
  - iii) as a virtual care service associated with the physician’s LFP Clinic, except if the physician provides successive services to patients located in a Facility; or

- iv) to a patient in their Home Setting (but not in a Facility).
- (x) **“Locum Eligibility Criteria”** means the eligibility criteria for the LFP Payment Model defined in Section 10 [*Locum Eligibility*].
  - (y) **“Locum Registration Code”** means 98005 Longitudinal Family Physician Payment Model Locum Registration Code, as defined in Section 12 [*Locum Enrolment and Annual Registration*].
  - (z) **“Longitudinal Family Physician Payment Model”** or **“LFP Payment Model”** means the compensation model set out in this LFP Payment Schedule.
  - (aa) **“Longitudinal Family Physician Services”** means the types of services typically provided by a family physician who provides longitudinal, relationship-based, comprehensive, family medicine care in a community-based setting (including medically required services to beneficiaries), aligned with the attributes of a Patient Medical Home.
  - (bb) **“Maternity Clinic”** means a medical clinic in which a physician enrolled in the LFP Payment Model provides Maternity Services.
  - (cc) **“Maternity Service”** means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.
  - (dd) **“MSP”** means the Medical Services Plan, which is continued under the Medicare Protection Act.
  - (ee) **“Non-panel Service”** means Direct Patient Care and Indirect Patient Care that a physician provides to a patient who is not: (i) on the physician’s panel; or (ii) on the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:
    - i) at the physician’s LFP Clinic;
    - ii) at a Maternity Clinic;
    - iii) as a virtual care service associated with the LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
    - iv) to a patient in their Home Setting (but not in a Facility).
  - (ff) **“Ongoing Eligibility Criteria”** has the meaning given to it in Section 5 [*Ongoing Eligibility in the LFP Payment Model*].
  - (gg) **“Patient”** means an individual who is a beneficiary under the Medical Services Plan.
  - (hh) **“Patient Interaction Code”** has the meaning given to it in Section 23 [*Patient Interaction Codes*].
  - (ii) **“Patient Medical Home”** or **“PMH”** means the description of Patient Medical Home specified in Appendix B.
  - (jj) **“Payment Schedule”** means a payment schedule established by the Medical Services Commission under Section 26 of the Medicare Protection Act.

- (kk) **“Provincial Attachment System”** means British Columbia’s IT-enabled attachment system that connects patients who do not have a family doctor with physicians who are able to take on new patients. The system also provides data to measure system progress and capacity.
- (ll) **“Registration Code”** means 98000 Longitudinal Family Physician Payment Model Registration Code, as defined in Section 7(d) [*Registration Code*].
- (mm) **“Required Locum Services”** means the services specified in Section 11 [*Required Locum Services*].
- (nn) **“Required Services”** means the services specified in Section 6 [*Required Services*].
- (oo) **“Time Code”** or **“Time Codes”** means, as context requires, one or more of: LFP Direct Patient Care Time (98010), LFP Indirect Patient Care Time (98011), and LFP Clinical Administration Time (98012).
- (pp) **“Transition Code”** means 98001 Longitudinal Family Physician Payment Model Transition Code, as defined in Section 7(f) [*Transition Code*].



## Appendix B – Background and Principles of the LFP Payment Model

The Longitudinal Family Physician (LFP) Payment Model was developed by the BC Ministry of Health in consultation with BC Family Doctors and Doctors of BC. It is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is grounded in a commitment to increase patient access to community-based, longitudinal family medicine care, and expand primary care capacity across British Columbia.

To reflect the comprehensive and continuous nature of family medicine, it is a blended payment model that compensates physicians for time, patient interactions, and their overall patient panel. It was developed to:

- Recognize the complexity of longitudinal care
- Value the time spent with patients
- Resource family medicine clinics as critical healthcare infrastructure
- Acknowledge the value of indirect care and clinical administrative services
- Support physician agency and flexibility in practice

### 1. LFP PAYMENT MODEL PRINCIPLES

The LFP Payment Model is guided by a set of principles that govern the payment model and this payment guide. These principles outline what the payment model seeks to support and achieve for patients, physicians, and the healthcare system:

1. **Quality and Safety:** Supporting the provision of safe, high-quality care as defined in the [BC Health Quality Matrix](#).
2. **Health Equity:** Facilitating the provision of care that supports health equity and provides all British Columbians with fair opportunity to reach their fullest health potential.
3. **Patient Medical Home:** Strengthening the ability of family physicians and family medicine clinics to act as Patient Medical Homes, enabling team-based care delivery for clinics who choose.
4. **Physician Health and Well-being:** Promoting family medicine clinics and care environments that support physicians' needs as health care providers and as human beings.
5. **Equitable Payment:** Providing equitable payment for family physician services, with an emphasis on valuing the critical role of longitudinal family medicine as the foundation of our healthcare system.
6. **Professional Agency:** Recognizing the professional agency and clinical judgement of family physicians as an enabler of patient care while maintaining accountability to the health system.
7. **Simplicity of Administration:** Offering a payment mechanism that is simple to access and administer for both physicians and the healthcare system.

The LFP Payment Model is structured to empower family physicians to provide accessible, high-quality, comprehensive, and continuous care that is adaptive to the needs of their patients and communities. It recognizes family medicine as the cornerstone of an integrated system of care and family practice clinics as hubs of access and coordination. It recognizes the important role of family medicine in an integrated system of care, and that family practice clinics are hubs of access and coordination.

## 2. LFP PAYMENT MODEL COMPONENTS

The LFP Payment Model is a blended payment model which compensates a physician for:

- (a) physician time;
- (b) physician-patient interactions; and
- (c) the size and complexity of a physician's patient panel.

In the development of this payment model, the concept of a “full-time equivalent” physician was considered, while acknowledging that there is significant variation in how family physicians work. This concept was used to determine how the above payment mechanisms together generate the total compensation for a physician being paid under the LFP Payment Schedule.

A “full-time equivalent” is described as a family physician who, as part of the LFP Payment Model, provides:

- 1680 hours of patient care per year, inclusive of time spent on Direct Patient Care, Indirect Patient Care, and Clinical Administration;
- 5000 physician-patient interactions per year; and
- care to a patient panel that is the equivalent of 1250 Empanelled Patients of average complexity.

A family physician must work a minimum of 0.2 of a full-time equivalent in order to be eligible for the LFP Payment Model. This requires a family physician, as part of the LFP Payment Model, to:

- provide LFP Practice Services a minimum of one day per week, distributed equitably over the course of the year; and
- have a minimum patient panel of at least 250 Empanelled Patients.

## 3. FAMILY MEDICINE ATTRIBUTES

Family physicians embody within their professional practice the [Four Principles of Family Medicine](#) articulated by the College of Family Physicians of Canada:

- The family physician is a skilled clinician
- Family medicine is a community-based discipline
- The patient-physician relationship is central to the family physician's role
- The family physician is a resource to a defined practice population

Through these principles and a broad [professional profile](#), family physicians collectively provide a system of front-line health care that is accessible, comprehensive, and continuous. Individually, they take responsibility for the coordinated medical care of patients, by providing relational continuity and a commitment to responsive and proactive patient care.

Care provided by family physicians may include, but is not limited to, the following primary care services:

- Health promotion and illness prevention services
- Primary care for minor or episodic illnesses

- Chronic disease management
- Reproductive and sexual care, including maternity care
- Mental health and substance use care
- Palliative care
- Care coordination and planning of patient care across the spectrum of primary, secondary and tertiary care
- Advocacy and outreach to ensure patients have timely and appropriate access to care
- Clinical teaching

#### 4. PATIENT MEDICAL HOME

The Patient Medical Home (PMH) is the foundation and cornerstone of an integrated system of care in BC. As such, it is fundamental to the LFP Payment Model. The PMH is a family medicine clinic that provides longitudinal family medicine services, operating as a central hub for patients' healthcare needs. The goal is patient-centred, whole person-care in which care is easily navigated and centered on the needs of the patient, family, and community.

A PMH has a number of [key attributes](#) that define how the clinic supports patients:

##### a) Service Attributes

- Commitment:** Patients are attached to a defined practice and primary care provider who will be the most responsible provider of their medical care. Family physicians accept responsibility for a panel of longitudinal patients.
- Contact:** Patients are able to access timely care through the PMH, including linking to after-hours services.
- Comprehensive:** Care is provided within the PMH throughout the patients' lifecycle, supplemented by services in care settings or through providers outside the PMH as needed.
- Continuity of care:** Longitudinal relationships between patients, the physician, and the team within the PMH are the foundation of care, supported through informational continuity and clinical networks of care outside the practice.
- Coordination:** The PMH is the hub for coordination of care with simple and clear pathways to support patients as they transition to and from acute care, specialized services, or other community health services.

##### b) Relational enablers of care

- Team-based care:** The PMH is supported by an inter-professional team within and/or linked to the practice.
- Family physician networks supporting practice:** Family physicians and associated teams are part of a clinical network of providers responding to the comprehensive care needs of the patients, including access to after hours care and cross coverage with other PMHs.
- PMH networks supporting communities:** Family physicians and associated teams are supported through partnerships as part of a broader network of care encompassing Divisions of Family Practice, health authority services, consultant specialist care, and other health care services.

##### c) Structural enablers of care

- Information technology enabled:** Physicians and staff in the PMH are IT-enabled, including optimized EMR use, virtual care, and data collection methods to inform quality improvements in patient care and practice workflow.

- (ii) **Education, training and research:** Physicians within the PMH are active participants in medical student and resident education, mentoring of new-to-practice physicians, primary care research, and/or interprofessional education.
- (iii) **Evaluation and quality improvements:** Robust data and information sharing safeguards allow for active participation in quality improvement activities and evaluation of patient experience, contributing to regional and provincial understanding of the value and quality of primary care services.
- (iv) **Internal and external supports:** The PMH has a business model supporting longitudinal team-based primary care, with linkages with the broader health care system.

## **Appendix C – Claim Submission and Payment**

### **1. Claims Submission Period**

Physicians billing under the LFP Payment Model must submit claims for Time Codes, Locum Time Codes, Patient Interaction Codes, and Locum Patient Interaction Codes to HIBC via Teleplan within 90 days of the date of service, which is the period of time for submission of claims under Section 27 of the *Medicare Protection Act* as prescribed by Section 33 of the Medical and Health Care Services Regulation

Notwithstanding the claims period above, the Medical Services Commission will pay claims submitted more than 90 days after the date of service in special circumstances. The following information provides an overview of how to bill claims more than 90 days after the date of service using submission codes C, X, I, W, and A:

#### **SUBMISSION CODE C**

- The patient did not have active coverage at the time the service was rendered.
- Coverage has been reinstated, but the claim is now over 90 days from the date of service.
- Note record required: “coverage reinstated”

#### **SUBMISSION CODE X**

- The physician disagrees with the adjudication of the claim. It is now over 90 days from the date of service.
- A note record with additional information is required to assist in re-adjudication of the claim.
- The claim must be resubmitted within 90 days from the remittance date of the original claim.
- See below for information about resubmitting claims for reassessment of payment.

#### **SUBMISSION CODE I**

- The claim has been either refused or accepted by ICBC since originally submitted. It is now over 90 days from the date of service.
- The claim must be submitted within 90 days of being advised of ICBC decision.

#### **SUBMISSION CODE W**

- The claim has been either refused or accepted by WorkSafe BC (WSBC) since originally submitted. It is now over 90 days from the date of service.
- The claim must be submitted within 90 days of being advised of WSBC decision.

#### **SUBMISSION CODE A**

- If the claim does not meet the criteria for the other submission codes (C, X, I and W), a physician can submit a written request to use submission code A to submit or resubmit claims more than 90 days after the date of service.
- Fax a *Practitioner Request for Approval of Over-age Claims* [form](#) to MSP billing support to (250) 405-3593.
- Requests must include the date range of the claims, number of claims, value of claims and the fee items involved.

- Requests must include detailed explanation for late submission. Administrative issues such as staffing problems, clerical errors, lost or forgotten claims, system or service bureau problems do not qualify for exemption.
- If the written request for use of submission code A is approved, the approval applies only to the exemption to the 90-day submission limit and does not guarantee payment. All claims billed are subject to the usual processing and adjudication rules and regulations.

## **2. Submitting Claims for Newborns**

Services for newborns can be billed under the mother's personal health number (PHN), if the mother has valid MSP coverage. The maximum period that MSP will cover an unregistered baby under the mother's PHN is the month of birth plus the following two calendar months. After that, all services must be billed under the baby's own PHN.

When a baby has been provided with a PHN by the hospital, the family must still register the baby with MSP before that PHN can be used to submit claims.

To submit a claim for a newborn, use the mother's PHN with a dependent number of '66'. Some electronic medical record (EMR) systems have a different mechanism for billing a newborn patient.

**Appendix D – Procedures and Diagnostic Tests**  
**Payable Under 98020, 98021, 98022, 98050, 98051, 98052**

The following Patient Interaction Codes and Locum Patient Interaction Codes are payable only for the listed procedures and diagnostic tests.

Associated Fee-for-Service codes are provided for reference to assist physicians transitioning from Fee-for-Service. The General Preamble, billing rules, and fee notes of the listed Fee-for-Service codes do not apply to procedures and diagnostic tests billed under the LFP Payment Model, unless specifically noted in the LFP Payment Schedule.

**98022 – LFP Minor Procedure or Diagnostic Test in addition to an In-person Interaction**

**98052 – LFP Locum Minor Procedure or Diagnostic Test in addition to an In-person Interaction**

<b>Procedures and Diagnostic Tests Payable as 98022 and 98052</b>	<b>Fee-for-Service Code</b>
Cryotherapy	00190
Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)	00010 00011 00013 00016 00030 00034 10010 to 10030 10040 10041
Urinalysis by dipstick	15130
Urine pregnancy test	15120
Urine screening for opioid agonist treatment	15039
Urine screening for amphetamines, benzodiazepines, etc.	15040
Peak flow testing	00930
Venipuncture	00012

**98021 – LFP In-person Interaction with a Standard Procedure**

**98051 – LFP Locum In-person Interaction with a Standard Procedure**

<b>Procedures Payable as 98021 and 98051</b>	<b>Fee-for-Service Code</b>
Gynecologic examination and cervix screening that includes the use of a speculum	14562
IUD removal	14562
Cervical polypectomy	04509
Anoscopy	10710
Trigger point injection	01156 01157
Injection or aspiration of tendon or bursa	00014 00015 51039 51040
Intra-articular injection or aspiration	00811 52405 52410 53405 53410 54405

**98021 – LFP In-person Interaction with a Standard Procedure****98051 – LFP Locum In-person Interaction with a Standard Procedure**

<b>Procedures Payable as 98021 and 98051</b>	<b>Fee-for-Service Code</b>
Intra-articular injection or aspiration	00811 52405 52410 53405 53410 54405 54410 55405 55410 56405 56410 57405 57410
Varicose vein injection	77045

**98020 – LFP In-person Interaction with an Advanced Procedure****98050 – LFP Locum In-person Interaction with an Advanced Procedure**

<b>COMMONLY PERFORMED IN FAMILY MEDICINE CLINICS</b>	
<b>Procedures Payable as 98020 and 98050</b>	<b>Fee-for-Service Code</b>
Biopsy of skin or mucosa	13600 13601
Abscess, superficial opening	13605
Laceration or foreign body, Minor	13610 13611 13612
Excision of tumour of skin, subcutaneous tissue or scar	13620 13621 13622 13623 13624
Paronychia	13630
Nail removal	13631 13632
Wedge excision or Vandenbos procedure of one nail	13633
Hemorrhoid Thrombotic, Enucleation	13650
Insertion of IUD	14540
Insertion or removal of subdermal contraceptive implant	14542 14543
Cautery or excision of genital wart(s)	04305
Cervix punch biopsy	00784
Endometrial biopsy	00785
Proctosigmoidoscopy, rigid, diagnostic	10714
Abscess – perianal, I & D, superficial	07678



<b>LESS COMMONLY PERFORMED IN FAMILY MEDICINE CLINICS</b>	
<b>Procedures Payable as 98020 and 98050</b>	<b>Fee-for-Service Code</b>
Venesection for polycythaemia or phlebotomy	00019
Curettage and electrosurgery of skin carcinoma	00218 00219
Direct laryngoscopy	00701
Sigmoidoscopy with or without biopsy	00715 00716 00718
Chest Aspiration Paracentesis	00759
Paracentesis Abdominal	00760
Scratch test, per antigen Note: Only applicable if a minimum of 15 antigens are used.	00762 00763 00765
Endoscopic Examination of the Nose and Nasopharynx	00907
Nerve block paravertebral sympathetic	01042
Peripheral nerve block, single or double	01124 01125
Chalazion Excision	02150
Aural polyp removal or debridement, foreign body removal	02221
Myringotomy unilateral or bilateral - with insertion of aerating tube	02254 02274
Cauterization of septum, electric	02303
Posterior nasal packing	02341 02346
Nasal fracture - simple reduction or with reduction and splinting	02364 02365
Direct or indirect laryngoscopy with foreign body removal	02419
Incision of peritonsillar abscess – under local anesthetic	02447
Muscle Biopsy	03211
Biopsy of vulva, excisional lesion	04032 04317
Bartholin's cyst excision	04301
Amputation, Finger	06219
Aspiration: abdomen or chest	07041
Vasectomy – bilateral	08345
Esophagogastroduodenoscopy, including collection of specimens	10761
Application of Cast	51016 to 51025
Fine Needle aspiration of solid or cystic lesion	70041 70042
Removal of tumour (including intraoral) or scar revision – 2 to 5 cm	70116
Hemorrhoid(s); (e.g., band ligation) to include proctoscopy	71689
Compression sclerotherapy initial or repeat	77050 77060
Removal of totally implantable access device (e.g., portacath),	77142

## Appendix E – Using ICD-9 Codes when Billing Under the LFP Payment Model

All claims submitted by physicians to the Medical Services Plan (MSP) must include an ICD-9 code. Each claim submitted to Teleplan can accommodate up to three ICD-9 codes. The ICD-9 codes submitted should reflect the care provided during the patient interaction.

The ICD-9 field in Teleplan only accepts alphanumeric characters. As special characters like decimal points are invalid, ICD-9 codes should be entered without decimal points (e.g., V10.4 is entered as V104, 102.51 is entered as 10251).

The diagnostic codes used by MSP are based on the ninth revision of the International Classification of Diseases developed by the World Health Organization, commonly referred to as ICD-9. MSP's [Index and Guide to 3-Digit and 4-Digit Diagnostic Code Descriptions](#) provides a list of ICD-9 codes listed by topic area.

### Maternity Services and Complex Contraception Services for Non-panel Patients

A physician cannot claim more than 30% of their Patient Interaction Codes or Locum Patient Interaction Codes for Non-panel Services in one calendar year. This limit does not apply to Maternity Services and Complex Contraception Services for non-panel patients if the service is:

- (i) provided at the physician's LFP Clinic, at a Maternity Clinic, as a virtual care service associated with the physician's LFP Clinic or Maternity Clinic (except if the physician provides successive services to patients located in a Facility), or to a patient in their Home Setting (but not in a Facility); and
- (ii) identified with one of the specified ICD-9 codes.

To identify a Patient Interaction Code or Locum Patient Interaction Code as a Maternity Service, a physician must submit one of the following ICD-9 codes:

- V20 Health Supervision of Infant or Child – for care of newborns up to six weeks of age
- V22 Normal Pregnancy – for care during a pregnancy, including medical abortion
- V24 Postpartum Care and Examination – for postnatal care and lactation support

To identify a Patient Interaction Code or Locum Patient Interaction Code as a Complex Contraception Service, a physician must submit the following ICD-9 code:

- V25 Contraceptive Management

**“Maternity Service”** means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.

**“Complex Contraception Service”** means ~~contraceptive~~ care related to **contraceptive** procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), **as well as the use of contraceptive methods for** medically and socially complex patients, **care resulting from a referral or recommendation from** ~~patients referred by~~ a physician or allied care provider, and gender-affirming care.

If the patient care provided is not fully reflected by one of the specified ICD-9 codes, use one of the specified ICD-9 codes to identify the interaction code as a Maternity Service or Complex Contraception Service, and up to two additional ICD-9 codes to describe the care provided during the patient interaction.

**Registration Code, Locum Registration Code, and Transition Code**

The Registration Code, Locum Registration Code, and Transition Code must be submitted using ICD-9 code L23.

**Time Codes**

Time Codes and Locum Time Codes are submitted on a daily basis for Direct Patient Care, Indirect Patient Care, and Clinical Administration. Each Time Code and Locum Time Code is submitted using ICD-9 code L23.

**Panel Payment**

Currently, the panel payment is based on an interim methodology adapted from the Community Longitudinal Family Physician (CLFP) Payment to estimate the size and complexity of a longitudinal family physician's patient panel. In this interim methodology, the number of patients is estimated using the Majority Source of Care (MSOC) methodology and complexity is measured using the Adjusted Clinical Group (ACG) system. All ICD-9 codes submitted to Teleplan are considered by the ACG system to estimate patient complexity.

## **Appendix F – Billing Fee-For-Service After Withdrawing from the LFP Payment Model**

Longitudinal family physicians transitioning from the LFP Payment Model to Fee-for-Service are reminded to submit the Community Longitudinal Family Physician Portal Code (14070) if they will be continuing to provide care as a longitudinal family physician and meet the criteria for the portal code.

14070 provides access to the following Fee-for-Service codes if individual fee criteria are met:

- *PG14075 FP Frailty Complex Care Planning and Management Fee*
- *PG14076 FP Patient Telephone Management Fee*
- *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
- *PG14033 Complex Care Planning & Management Fee – 2 Diagnoses*
- *PG14043 Mental Health Planning fee*
- *PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management Fees*
- *PG14063 Palliative Care Planning Fee*
- *PG14066 Personal Health Risk Assessment (Prevention) Fee*
- *PH14041 CLFP New Patient Intake Fee*
- *PH14002 Maternity Care Risk Assessment*

Fee codes that will be affected by the transition from the LFP Payment Model are as follows:

- **Chronic Disease Management (CDM) fees (14050, 14051, 14052, 14053)**
  - These fees compensate for the additional work, beyond the office visit, of providing guideline-informed care to patients with eligible conditions over a full twelve-month period.
  - These fees are not payable for eligible patients who are living in their home or assisted living for 12 months after a physician transitions from the LFP Payment Model to Fee-for-Service.
  - There must be at least 2 visits billed via Fee-for-Service in the 12 months prior to billing a CDM fee. Further details about the two visits can be found in the fee details.
- **Complex Care Planning and Management Fees (14033, 14075)**
  - These fees are payment for the creation of a care plan (as defined in the FPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions (14033) or frailty (14075) who are living in their home or assisted living.
  - These fees are payable for eligible patients after a physician transitions from the LFP Payment Model to Fee-for-Service, if the care meets the requirements of the fee notes. However, if a physician switches back to the LFP Payment Model within the calendar year of billing Complex Care Planning and Management Fees, payments for those fees will be recovered for that calendar year.

**TAB 174**

## ARTICLE

# FM+ Remuneration Overview

Under Family Medicine Plus, family physicians will continue to claim fee-for-service remuneration for volume-based activities, such as visits and procedures, as you always have. Now, you will have additional non-volume-based funding, which will be more predictable and available more frequently to support your practice.

There are three broad components under FM+ for family physician remuneration and funding:

Volume-based: existing fee-for-service payments for visits and procedures.

Panel-based: quarterly funding based on the size, age and complexity of your patient panel.

Indirect clinic time: weekly payments to recognize up to three hours of indirect clinical services.

## Volume-Based Fee-for-Service

Unlike other jurisdictions with longitudinal family practice models, in Manitoba volume-based fee-for-service funding is not reduced in any way. It is maintained at 100%. This means you can continue to make use of existing and new fee tariffs, including [virtual visits](#), [extended visits with two or more issues](#), [community-based practice support](#), and [collaboration with other providers](#).

## Panel Payments

Panel payments will replace Continuing Care Management tariffs and will now ensure every patient in your panel is counted.

The Home Clinic Panel Payment recognizes the skill, expertise, and continuity of care provided by family physicians providing care to their patients. This new stream of funding is not volume-based, and will offer more predictability for family practice clinics. Physicians will be able to access this funding quarterly, rather than annually under CCM.

The annual rate will vary based on age and complexity, with a range of \$15 for a healthy adult to \$445 for an elderly patient over 75 with multiple chronic diseases. A new premium will also be developed for socially-complex patients by 2026/27.

The new model will:

Provide a payment for patients of all ages.

Add more diseases to the list of eligible diagnoses.

Expand the maximum number of chronic conditions included from three to four.

Adding a separate add-on tariff for mental health diagnoses.

Provide quarterly payments instead of just annually.

Plus, there will be a one-time \$100 payment for accepting a newborn or infant (under age 2) onto your panel.

## Learn more

FM+ Panel Payment Billing Guide →

Newborn Enrollment →

## Indirect Clinical Services

Family Medicine Plus will include a time-based stipend of up to 3 hours to recognize indirect clinical time services for enrolled patients on your panel.

A new tariff will allow physicians to claim:

Up to 30 minutes of time per working week for every 250 patients on your panel

At an hourly rate of \$171.04, prorated to \$42.76 per 15-minute increment.

The tariff will pay a maximum of \$513.12 per week for a physician with a panel of 1,500+ patients.

Indirect clinical services are activities that are medically relevant and specific to an individual patient. They can include charting, reviewing labs and diagnostic imaging, preparing referrals etc. Indirect clinical services should not be claimed for administrative exercises such as clinic administration.

Indirect clinical services can be claimed for weeks you have worked providing primary care to your panel. In other words, you cannot bill for indirect clinical services on weeks you were off work.

## Learn more

Indirect Clinical Services →

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### Last updated

March 20, 2024

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)



**TAB 175**

Home › Managing Your Practice › Remuneration › Billing & Fees › Visits › Virtual Visit Tariffs

## GUIDE

# Virtual Visit Tariffs

Doctors Manitoba has negotiated a permanent suite of virtual visit tariffs, effective October 1, 2023.

This largely extends the existing temporary practice for virtual visits started during the pandemic.

Key features include:

Virtual visit tariffs will be paid at 100% of in-person visit rates.

Start & stop times no longer need to be documented, which should reduce a frequent administrative burden. (Note: start and stop times will be required for the new provisional virtual extended visit tariff).

This page is designed to offer advice and guidance on virtual visit tariffs and related rules. We encourage physicians to carefully review the rules and tariffs, as significant changes and enhancements take effect October 1, 2023.

## Common Requirements and Guidance

Generally, the following common rules guide the use of all virtual visit tariffs:

You may continue to bill for services provided by a Resident under your supervision in accordance with past practice.

Services must be provided personally by the physician. No claim may be made for a virtual visit in which only a physician proxy participates, such as a nurse or clerk.

After hours premiums may not be claimed in addition, except for established patients for urgent or emergency communications.

Rural/Northern/Brandon Fee differentials apply.

Both the patient and the physician must be in Manitoba for the virtual visit. Exceptions have been approved by Manitoba Health for patients residing in Nunavut, Saskatchewan and Northwestern Ontario.

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## Family Practice Virtual Visit Tariffs



The table and notes below summarize the most common virtual visit tariffs for family medicine. Please ensure you also review the sections related to continuing patient relationships and episodic care, if applicable to your practice. You may also find tariffs under the general schedule as well.

<b>Tariff</b>	<b>Description</b>	<b>Rate or Equivalent Tariff</b>
8340	Episodic virtual visit by phone (NEW effective October 1, 2023)	\$20.00
8345	Basic virtual visit by telephone or video (NEW effective October 1, 2023)	8509
8321	Intermediate virtual visit by telephone or video	8529
8535	Virtual consultation by telephone or video	8550
8442	Comprehensive Virtual Assessment by telephone or video.	8540
~8350	Extended virtual visit by video (PROVISIONAL) (NEW effective October 1, 2023)	\$70 + age premiums*

\* As of February 15, 2024, age premiums will be automatically applied to eligible visits. For visits before February 15, the age premium add on tariffs must be applied (8465 at 10% for age 65–69 and 8463 at 20% for age 70+).

1. When 8345, 8321 is provided by telephone the service must be part of a continuing patient relationship as described in Rule of Application (see below).
2. 8442 may only be provided as part of a continuing patient relationship as described in Rule of Application (see below).
3. Age premium rates are eligible for tariffs 8321, 8442 and ~8350.
4. An extended visit (8350) is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:
  - a. A history of the presenting two or more complaints;
  - b. An examination of the parts or systems related to the presenting complaints;
  - c. A review of all pertinent investigations;
  - d. A complete written record and advice to the patient;
  - e. The visit shall be a minimum of twenty (20) minutes of physician time.

For tariff 8350 (extended virtual visit by video), start and stop times must be noted because this is a provisional tariff. You can [read more about this provisional tariff here](#).

## General Schedule Virtual Visit Tariffs



Tariff	Description	Equivalent Rate
8527	Chronic Care virtual visit by telephone or video	8511
8655	Virtual psychotherapy by telephone or video by non-psychiatrist	8580
8575	Virtual Group Psychotherapy two or more patients by telephone or video by non-psychiatrist	8589

Note: Requirements are generally similar to the in-person equivalent tariffs.

## Pediatrics Virtual Visit Tariffs



The table and notes below summarize the most common virtual visit tariffs for pediatrics. Please ensure you also review the sections related to continuing patient relationships and episodic care, if applicable to your practice. You may also find tariffs under the general schedule as well.

Tariff	Description	Rate or Equivalent Tariff
8340	Episodic virtual visit by phone (NEW effective October 1, 2023)	\$20.00
8345	Basic virtual visit by telephone or video (NEW effective October 1, 2023)	8509
8321	Intermediate virtual visit by telephone or video	8529
8535	Virtual consultation by telephone or video	8550

Tariff	Description	Rate or Equivalent Tariff
8447	Comprehensive Virtual Assessment by telephone or video.	8540
8350	Extended virtual visit by video (PROVISIONAL) (NEW effective October 1, 2023)	\$80

## NOTES

1. When 8345 or 8321 is provided by telephone the service must be part of a continuing patient relationship as described in Rule of Application
2. 8447 may only be provided as part of a continuing patient relationship as described in Rule of Application
3. An extended visit (8350) is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:

- a. A history of the presenting two or more complaints;
- b. An examination of the parts or systems related to the presenting complaints;
- c. A review of all pertinent investigations;
- d. A complete written record and advice to the patient;
- e. The visit shall be a minimum of twenty (20) minutes of physician time.

For tariff 8350 (extended virtual visit by video), start and stop times must be noted because this is a provisional tariff. You can [read more about this provisional tariff here](#).

## Psychiatry Virtual Visit Tariffs



The table and notes below summarize the most common virtual visit tariffs for psychiatrists.

Tariff	Description	Equivalent Tariff
8533	Psychotherapy	8581
8786	Psychiatric Care	8584
8668	Group (2–4) Psychotherapy	8444

Tariff	Description	Equivalent Tariff
8669	Group (5+) Psychotherapy	8446
8521	Consultation by psychiatrist involving a child (	8554 or 8622

Note: Requirements are generally similar to the in-person equivalent tariffs.

## Specialist Virtual Visit Tariffs



The table and notes below summarize the most common virtual visit tariffs for specialists. Please ensure you also review the sections related to continuing patient relationships and episodic care, if applicable to your practice. You may also find tariffs under the general schedule as well.

Tariff	Description	Equivalent Tariff
8340	Episodic virtual visit by phone (NEW effective October 1, 2023)	\$20.00
8321	Virtual Visit	Regional history or exam (e.g. 8529)
8447	Comprehensive Virtual Assessment	In-person complete exam (eg. 8540)
8535	Consultation	Consultation (e.g. 8550)

Note: Requirements are generally similar to the in-person equivalent tariffs.

## Continuing Patient Relationship vs. Episodic Care



A new rule of application will limit some virtual tariffs to *continuing patient relationships* only, which is defined below.

### Definition of Continuing Patient Relationship

1. The physician has provided at least one insured service for the patient in the preceding 24 months; or
2. The patient is on the panel of another physician within the same practice group who has seen the patient within the preceding 24 months and the physician has access to the patient's electronic medical record; or
3. The physician is providing services through a contractual arrangement with Manitoba Health, an SDO or under the Physician Services Agreement including but not limited to Specialist On-Call coverage or coverage of a Rural ED; or
4. The patient has been referred from another health care provider or health care service in Manitoba; or
5. The virtual medicine visit is for the purpose of psychiatric care or psychotherapy.

## Episodic Visits

For visits not considered part of a continuing patient relationship, or in other words episodic in nature:

Most virtual visits are available for episodic care if conducted by video.

For phone-only episodic visits, tariff 8340 is available.

A new extended video visit is available for family physicians and pediatricians for visits that [meet the criteria](#), which helps to replace comprehensive virtual assessments which is no longer available outside of continuing patient relationships.

Here is a summary of what is available:

Tariff	Description	Phone or Video
8340	Episodic virtual phone visit—\$20	Phone only
8345	Basic virtual visit (equivalent to 8509)	Video only
8321 8284 8285	Intermediate virtual visit, including with age 65–69 and 70+	Video only
8350	Extended Video Visit (20+ minutes, 2+ patient complaints)	Video only

# New Rule of Application for Virtual Medicine

1. A Virtual Medicine Visit is a medical service provided to a patient by a physician by telephone or video. Telephone means synchronous audio-only communication (no visualization); and video means 2-way synchronous video-conference (audio and video visualization)

2. For the purposes of claiming Virtual Medicine Visits, continuing patient relationship means:

i) The physician has provided at least one insured service for the patient in the preceding 24 months; or;

ii) The patient is on the panel of another physician within the same practice group who has provided at least one insured service to the patient in the preceding 24 months and the physician has access to the patient's electronic medical record; or;

iii) The physician is providing services through a contractual arrangement with Manitoba, a Health Authority or under the Physician Services Agreement including but not limited to Specialist On-Call coverage or coverage of a Rural or Northern ED; or;

iv) The patient has been referred to the physician from another health care provider or health care service in Manitoba; or;

v) The virtual medicine visit is for the purpose of psychiatric care or psychotherapy.

3. Virtual Medicine Visits may be claimed subject to the following:

a) Services must be personally rendered by the physician, i.e., no claim may be made for a virtual medicine visit in which only a physician proxy, e.g., nurse or clerk, participates.

b) Maximum of one virtual visit per patient per day may be claimed.

c) The patient and the physician must both be located in Manitoba at the time of service, except where otherwise authorized by the Provincial CMO or designate.

d) After Hours Premiums may only be claimed when there is a continuing patient relationship as described above and the visit is an urgent or emergent service,

e) Medical services provided must be documented and such documentation may be requested by Manitoba, to support the claim submitted.

f) Geographical fee differentials shall apply in addition. The geographical fee differential shall be determined by the average of the fee differential applicable to the patient's location and applicable to the physician's location.



g) Where, during the course of the virtual visit, it is determined an in-patient assessment is necessary, the physician may bill a Basic or Intermediate virtual visit as appropriate. The subsequent in person visit may be billed at the appropriate in-person examination tariff in addition.

## Other Important Notes

It is important to ensure you are following both Manitoba Health and CPSM rules governing virtual visits.

We recommend reviewing CPSM's information to ensure your approach to virtual medicine follows their standards.

The Standard of Practice for Virtual Medicine, [available through this page](#). You will notice CPSM emphasizes that “each member’s practice of medicine must include timely in-person care when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. A blended model of care balancing in-person and virtual medicine is required if providing virtual medicine.”

An [information sheet](#) on practicing virtual medicine across provincial or international borders. This includes Manitoba physicians looking to offer virtual visits to patients outside of the province, and out-of-province physicians.

Like any other care physicians deliver, CPSM may receive complaints and investigate concerns about the provision of virtual medicine.

### DO

### DON'T

DO conduct the visit yourself. Virtual visits by non-physicians are not covered. Where a Physician Assistant carries out part of the visit the physician must also see/speak with the patient.

DON'T use the new tariff for phone advice you would normally have provided following an in-person visit, such as sharing normal test results.

DO continue to provide PCH care in person, unless you are ill or required to self-isolate. You can continue to use tariff 8000 for calls from PCH staff.

DON'T claim comprehensive virtual assessments (8442 or 8447) unless part of a continuing patient relationship.

DO claim interpretations of any diagnostic tests (e.g., Audiograms, EKG, EEGs...) that are usually billed in addition to visits under the applicable tariff in addition

DON'T claim a virtual visit on the same day as an in-person visit

**DO****DON'T**

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DO claim rural and northern premiums if both you and your patient are outside of Winnipeg

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DON'T claim office/home visit tariffs for services provided virtually.

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DON'T claim after hours premiums except for established patients for urgent or emergency communications.

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**Last updated**

February 9, 2024

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)

**TAB 176**

## GUIDE

# Extended Visit

A new Extended Visit tariff will be available for family medicine physicians and pediatricians starting October 1, 2023. This new tariff offers an option for more complicated visits, something between an intermediate and complete exam. This is being introduced as a provincial tariff for 18 months and will be evaluated.

Extended visits must involve two or more complaints from the patient and last at least 20 minutes. These complaints must be distinct from one another and should be well documented, including history, advice to the patient, investigations, and plans for future treatment.

The extended visit tariff is like other visit tariffs for family physicians: age modifiers and additional exams can be added on if appropriate. Read more about the simplified visit schedule here ([link to be added](#)).

The new tariff is provisional up to and including September 30, 2024. During this period, Doctors Manitoba and Manitoba Health will review the tariff and consider steps to make it a permanent option for physicians and your patients.

**8640**     **Extended Visit - Family Medicine**  
\$70.00



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**Note:** An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:

- i) A history of the presenting two or more complaints;
- ii) An examination of the parts or systems related to the presenting complaints;
- iii) A review of all pertinent investigations;
- iv) A complete written record and advice to the patient.

**8644**     **Extended Visit - Pediatrics**  
\$80.00



---

**Note:** An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:

- i) A history of the presenting two or more complaints;
- ii) An examination of the parts or systems related to the presenting complaints;
- iii) A review of all pertinent investigations;
- iv) A complete written record and advice to the patient.

As this is a provincial tariff, Doctors Manitoba will be closely monitoring the tariff to support its evaluation. We would welcome your feedback on whether this tariff is helpful to providing patients with the care they need, and any opportunities to improve it based on our experience. Send your feedback to [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca).

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#### **Last updated**

September 28, 2023

## **Questions?**

If you have questions about helping at the vaccine super sites?

[Click here](#)

**TAB 177**

## GUIDE

# Community-Based Practice Supplement

A new community-based practice support supplement will provide a payment per in-person patient encounter starting October 1, 2023. This new tariff is being introduced to recognize the escalating clinic costs that can be associated with in-person visits in a community setting. The nature of providing in-person hands-on care and associated costs were considered in the creation of this tariff.

**8380**     **Community Based Practice Supplement**  
\$3.50



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Tariff 8380 Community based practice supplement may be claimed in addition to an office/home visit where practice expenses are incurred. Like any community-based tariff, 8380 shall be claimed by individual physicians. A maximum of fifty (50) claims for tariff 8380 may be claimed per physician in any twenty-four period.

---

**Billing Note**

Tariff 8380 is available only to community-based practices where the practice expenses are incurred by the physician. It may not be claimed in addition to services performed at a hospital, personal care home or other publicly-funded facility or a facility on contract with a Health Authority to perform insured services.

Doctors Manitoba understands that whenever new tariffs or enhancements are introduced, there are often conversations about whether or not adjustments are needed for the overhead arrangements for physicians in community-based clinics. Doctors Manitoba encourages all physicians and clinic owners to approach this dialogue with mutual respect and fairness in mind.

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**Last updated**

September 28, 2023

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)



**TAB 178**

# Communication Between Providers

Doctors Manitoba has negotiated remuneration to facilitate communication and collaboration about patient care between physicians and with other health care providers. With the new Physician Services Agreement, existing tariffs have been enhanced and new tariffs have been introduced to promote more collaboration to support caring for your patients.

You will find billing guides for each tariff in this section, near the bottom of the page. The following table lists the new and existing tariffs in a hierarchy to help you find and optimize your use of these tariffs.

## At-a-Glance Guide to Communication Tariffs

Type	Requirements	Initiating MD	Responding MD
<b>eConsult</b>	Must be conducted on a recognized provincial eConsultation platform (Store & Forward or BASE).	\$27.33 (8628)	\$60/15 min (8627)
<b>Phone/Video</b>	For physician to physician and for calls from other designated providers. This includes: GP to GP, GP to Specialist, Specialist to Specialist, NP/PA/CA to physician, and some other specified providers.	\$25 (8356)	\$50 (8355)
<b>Email/Fax</b>	Only applicable to physicians responding to email/fax. This includes email/fax from another physician, NP, and some other specified providers.	N/A	\$25 (8001)
<b>Phone/Email/Fax-Other Providers</b>	From other health providers such as home care, nurses, mental health workers, pharmacists, etc.	N/A	\$16.25 (8000 or 8005)

Type	Requirements	Initiating MD	Responding MD
Cortext (secure messaging)		N/A	Part of on-call premium

## Common Requirements

All communication tariffs are about seeking advice about and/or providing guidance or direction about patient care.

All tariffs have further notes and restrictions. Please refer to our billing guide (see below) and the Physician's Manual. General requirements include:

Documenting the name of the other physician or provider involved in the communication.

Maximums on the number of claims per patient, per physician, per day or week.

No claim can be made until the physician responds to the communication.

No claim can be made when conducted by a physician proxy (e.g. nurse, clerk) participates instead of the physician.

May not be claimed for arranging for lab or diagnostic testing or informing the referring provider of the results.

## Practical Guidance and Advice

When communicating, consider the best platform or communication tools to allow for efficient and effective sharing of information, and what remuneration it may qualify for. For example:

If contacted on Cortext (secure messaging), consider whether or not the nature of the communication is simple enough to text back and resolve quickly? If so, use Cortext but note that no remuneration claim is available. However, if the situation is more complicated, consider escalating to email or phone to improve the exchange of information to support patient care.

If you were contacted by fax or email, consider if a phone or video call would be more effective to support a dialogue about the patient. If so, consider escalating to a phone/video communication.

Take the time to explain the process for non-physician providers, especially new groups such as optometrists and audiologists that may be unfamiliar with the tariff requirements. Explain why obtaining the name of the provider to support the claim enables better support for inquiries to be returned in a timely manner.

## Q&A

## What happens if the mode of communication is mixed (e.g. email sent but response is by phone)?

Generally, try to use the responding mode of communication as this will offer remuneration that best supports and reflects the interaction. The email, or even a secure message via Cortext, could be considered planning a phone call. This means both the initiating and responding physician should claim a phone call.

## What are the documentation requirements?

As some of these are new tariffs, it's best to carefully document the interaction. Generally, include the patient and provider information in your documentation including name and PHIN / billing number. Please note that as the consultant physician you are not required to establish a new chart for the patient discussed. You should include the required information in your claim, and ensure that you could recall a record of the claim using your billing software.

## How do I sign up for eConsultation?

Digital Shared Services manages two different platforms for eConsults: BASE and Store and Forward:

See this [one-pager](#) to learn more about eConsultation.

You can learn more about these platforms on [this Digital Shared Services eConsult page](#). You can also access training [here](#).

To apply for access, go to [this Digital Shared Services page](#), and click on BASE eConsult to apply for access to that platform, and/or click on iScheduler to gain access to the Store & Forward platform.

## How do I sign up for Cortext Secure Messaging?

All physicians now have free access to secure provider messaging through Manitoba Telehealth's MyMBT Messaging (Cortext).

You can sign up by [completing this intake form](#) (link to attached file), and emailing it to [servicedesk@sharedhealthmb.ca](mailto:servicedesk@sharedhealthmb.ca) using the Subject Line: **New MyMBT**. This form can be used for individual or bulk registrations.

Quick Reference Guides are available on the [MBTelehealth website](#) under the MyMBT section.

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### Last updated

January 18, 2024

## Resources

**Guide (4)****eConsultation**

Communication Between Providers

**Phone & Video Communications Between Physicians**

Communication Between Providers

**Email/Fax/Phone Communication from Physicians or Nurse Practitioners**

Communication Between Providers

**Communication with Health Care Providers**

Communication Between Providers

**Topics you may be interested in****Practice Opportunities**

See opportunities available in clinics, hospitals and other settings across Manitoba.

View Topic →

**Billing & Fees**

Our team can help you with billing and contract questions, as well as offer guidance as you establish your practice.

View Topic →

## CME Rebates

Reimburses Continuing Medical Education expenses such as CME registration fees, medical educational materials, accommodation and meals

View Topic →

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)

**TAB 179**

## ARTICLE

# FM+ Panel Payment Billing Guide

An important component of Family Medicine Plus, the panel payment recognizes the skill, expertise, and continuity of care provided by family physicians delivering longitudinal care to their patients.

Panel payments are a new stream of non-volume-based funding based on the age and complexity of each patient. Panel payments will replace Comprehensive Care Management (CCM) tariffs and will now ensure every patient enrolled in your panel is included.

The new FM+ panel payments will:

- Provide a payment for patients of all ages.

- Add more diseases to the list of eligible diagnoses compared to CCM.

- Expand the maximum number of chronic conditions included from three to four.

- Add a separate add-on tariff for mental health diagnoses.

- Provide quarterly payments instead of annual payments.

## Claiming FM+ Panel Payments

While not volume-based, FM+ panel payments will be claimed using fee-for-service tariffs, in a similar way to CCM, providing a familiar billing process for physicians. There are three components to panel payments for which each patient may qualify:

1. Patient Age
2. Comprehensive Chronic Disease Care
3. Mental Health Care

Unlike CCM payments, which were claimed at the end of every year retrospectively, we recommend claiming FM+ payments at the beginning of each quarter, prospectively. However, they can be claimed anytime during each quarter.

Guidance will be provided soon on how to transition billing from CCM to FM+.

### Patient Age



The first component of the panel payment is the age of each patient. Every patient enrolled in your panel counts, even those without a recent (<24 months) visit. We anticipate vendors will automate billing using the age for each enrolled patient from your EMR.

### ***FM+ Age-Based Panel Tariffs***

The following tariffs should be used to claim FM+ panel funding based on patient age. Expand the box below to see billing notes.

#### **8181 0-16 years**

\$7.50

#### **8182 17-49 years**

\$3.75

#### **8183 50-64 years**

\$12.50

#### **8184 65-74 years**

\$18.75

#### **8185 75+ years**

\$25.00



1. Tariffs 8181 – 8185 are claimable once per three-month time period for a patient enrolled on the physician's panel. The three-month time periods are defined as:

- a. April 1 to June 30
- b. July 1 to September 30
- c. October 1 to December 31
- d. January 1 to March 31.

2. A physician may claim one of the following tariffs: 8181, 8182, 8183, 8184, or 8185 per enrolled patient.

#### **Billing Note**

1. There is no recent visit requirement to claim the age-based portion of the panel payment. Any enrolled patient on your panel qualifies.
2. Newborns are also eligible for the panel payments even if you claimed the newborn enrollment in the same quarter.
3. Age-based tariffs do not require an ICD code.
4. PCH patients are also eligible for the panel payment. Ensure you enroll your PCH patients in your Home Clinic and document the visit and care in the Home Clinic EMR, for inclusion in the monthly submission of the Primary Care Data Extract (PCDE).

## Comprehensive Chronic Disease Care

The second and third components of FM+ panel payments involve patient complexity, specifically disease diagnoses that require ongoing care, monitoring, and follow-up. This portion will replace CCM tariffs. The FM+ suite of diagnoses is broader than CCM and can now be claimed quarterly rather than annually. FM+ moves to disease “clusters” rather than individual diagnoses, so patients with multiple diagnoses from one cluster would be counted as diagnoses from one cluster group. A list of the diagnoses included in FM+ follows below.

A visit or service must have occurred within the last 24 months to claim a medical or mental health cluster.

It will be important to plan your FM+ disease claims to follow your last CCM claim. Guidance on this will be provided soon.

We anticipate vendors will link eligible ICD codes from the EMR for each patient enrolled in your panel to simplify and automate the billing process.

### *Medical Clusters and Disease Diagnoses*

Cluster	Disease
Cardiac Disease	Hypertension; Coronary Artery Disease; Chronic Heart Failure
Endocrine Disease	Diabetes
Respiratory	Asthma; COPD
STBBI	HIV Active*; HIV Prevention*; Hepatitis*; Syphilis*
Substance Use Disorder	Excludes caffeine and tobacco. FM+ includes cannabis.*

NOTE: the expanded list of diagnoses under FM+ are marked with an asterisk (\*)

### *Mental Health Cluster and Disease Diagnoses*

Cluster	Disease
Mental Health Diagnosis	Anxiety; Depression; Bipolar Disorder*; Schizophrenia*; Borderline Personality Disorder*; ADHD/ADD*.

Note: the expanded list of diagnoses under FM+ are marked with an asterisk (\*)

# FM+ Medical and Mental Health Disease Cluster Tariffs

The following tariffs should be used to claim FM+ panel funding based on included medical and mental health conditions. Expand the box below to see billing notes.

## 8186 Diagnosis from 1 Medical Cluster Group

\$32.50

## 8187 Diagnoses from 2 Medical Cluster Groups

\$43.75

## 8188 Diagnoses from 3 Medical Cluster Groups

\$51.25

## 8189 Diagnoses from 4 Medical Cluster Groups

\$56.25

## 8190 Diagnosis from the Mental Health Cluster

\$30.00



Tariffs 8186 – 8190 are claimable once per three-month time period for a patient enrolled on the physician's panel. The three-month time periods are defined as: April 1 to June 30, July 1 to September 30, October 1 to December 31 and January 1 to March 31.

A physician may claim one of the following tariffs: 8186, 8187, 8188, or 8189 where applicable and additionally may claim tariff 8190 where applicable

For the purpose of claiming tariffs 8186, 8187, 8188, 8189 or 8190, the chronic disease clusters and disease groupings are included in the Chronic Disease Clusters table. [Applicable ICD codes for the Chronic Diseases are available for review here](#).

In order to claim tariff 8186, 8187, 8188, 8189 or 8190 the physician, an allied health member of their clinic, or another physician providing coverage to the physician must provide a medical service to the patient in the preceding twenty-four (24) months.

The physician or member of their team must provide:

1. Medical services consistent with the applicable indicators in the [Manitoba Primary Care Quality Indicators Guide](#) (version 4.0 or such other version(s) as agreed to by the parties).
2. Ongoing coordination with other health care providers respecting management of patient condition(s) and patient care plan; and
3. Ongoing communication with patient, monitoring of patient condition(s) and patient care plan.

Family Medicine Plus tariffs may not be claimed in combination with Chronic Disease Management Tariffs: 8431, 8432, 8433, 8434, or 8435.

Claims for additional services rendered to a patient on the physician's enrolled panel (e.g., visits) may be made in addition. The services must be documented in the EMR and communicated to Manitoba Health via data extracts compatible with Manitoba Health's information system and delivered securely, either (a) through a secure electronic interface (EMR extract) on a monthly basis, or (b) on an encrypted electronic device (e.g. CD or flash drive), on a quarterly basis (commencing on April 1 of each year), within 15 calendar days of the end of each quarter.

The physician shall provide care based on current standards and shall maintain competency to manage these patients, or shall be practicing in a multi-disciplinary team based care environment that develops common care plans and collectively cares for a patient population in a primary care setting.

In addition to medication management, the physician, or a member of their team, where required, must:

1. Provide ongoing screening and monitoring of the patient's condition using validated screening/diagnostic tools including identifying risk status;
2. Make brief interventions, as required, helping patient identify goals and treatment readiness, and identify risky behaviours. Such interventions may require additional visit or services as applicable;
3. Develop, review and manage patient care plans including management of co-morbidities, on an on-going basis;
4. Make appropriate referrals/consultations.

## Key Resources

[Access complete list of eligible diagnoses and ICD codes here](#)

[Preparing and Maintaining Your Panel for FM+](#)

[View the full Family Medicine Plus Package 2024 Rate Table here](#)

## CCM and FM+ Examples

Under CCM, payments were calculated based on the number of eligible disease diagnoses. FM+ moves to disease clusters, with payments calculated based on the number of applicable clusters of diagnoses. The list of diagnoses has also expanded under FM+

Below you will find some common patient examples under CCM and FM+ Panel Payments. For comparison, all amounts are presented annually.

Patient Example	Under CCM	Under FM+
41-year old with schizophrenia	\$0	\$135/yr (Includes \$15 for age and \$120 for diagnosis)
30-year old with anxiety disorder	\$60.75/yr	\$135/yr (Includes \$15 for age and \$120 for diagnosis)

Patient Example	Under CCM	Under FM+
77-year old with hypertension and coronary artery disease	\$106.32/yr	\$230/yr (Includes \$100 for age and \$130 for diagnosis)
61-year old with diabetes, COPD, HIV and depression	\$151.89/yr	\$375/yr (Includes \$50 for age and \$325 for diagnosis)
45-year old with hypertension, coronary artery disease, congestive heart failure	\$151.89/yr	\$145/yr (Includes \$15 for age and \$130 for diagnosis) Note: The slight decrease for this patient is due to all diagnoses falling within one disease cluster under FM+.
66-year old with no applicable diagnoses	\$0	\$75/yr (Includes \$75 for age and \$0 for diagnosis)

**Last updated**

March 7, 2024

## Key Takeaways

Learn how to claim FM+ Panel Payments including the age- and disease-based components.

Access the tariff numbers, billing notes and rate table.

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)

**TAB 180**

## ARTICLE

# Newborn Enrollment

Manitoba Health is encouraging family physicians to enroll newborns and infants into the panel. Under FM+, a newborn and infant enrollment payment has been created to recognize the additional and detailed work involved with assuming care for a patient under the age of two.

You can expand the tariff box below to see the full billing notes and advice.

**8180**      **Newborn and infant enrollment - Newborn and infance acceptance of ongoing care, under age 2**   
\$100.00 One-time payment

1. Tariff 8180 may be claimed once per patient (lifetime maximum), upon enrollment into the physician's panel.
2. To claim tariff 8180, the physician must provide a medical service to the patient in the preceding twenty-four (24) months.
3. 8180 may be claimed in addition to a visit.

**Billing Note**

This tariff is available once per lifetime per patient.

You may bill the one-time payment for any newborn you take on under your practice after the first visit.

To claim 8180, **the patient must be enrolled on your panel**. This is confirmed by the Home Clinic Portal after the overnight enrolment process occurs. If you successfully enroll a newborn on your panel April 1<sup>st</sup>, you may bill tariff 8180 on April 2<sup>nd</sup> as this ensures Manitoba Health has the patient in your enrolment panel.

An ICD code is not required as there is no clinical diagnosis needed to support the claim.

The newborn enrolment is a one-time fee. However, ensure you claim the quarterly FM+ panel age payment when eligible.

This tariff will allow payment for patients that are *still* under the age of 2 that were enrolled prior to April 1<sup>st</sup>, 2024. Upon Implementation, physicians may run a query of all their patients under 24 months of age and bill for the one-time payment. Thereafter, all additional newborn patients may be billed as noted above.

**Last updated**

March 11, 2024

## Key Takeaways

Family physicians are encouraged to accept newborns and infants into their practice.

Under FM+, family physicians will receive a one-time enrollment payment when adding a newborn/infant into their practice.

## Compensation Questions?

We're always here to help. Contact our team at [practiceadvice@doctorsmanitoba.ca](mailto:practiceadvice@doctorsmanitoba.ca)

[Click here](#)



**TAB 181**

## ARTICLE

# Indirect Clinical Services

In addition to [panel payments](#), Family Medicine Plus also offers family physicians remuneration for up to three hours of indirect clinical services per week. This recognizes the various indirect tasks physicians provide to support patient care, such as documentation, reviewing results, preparing referrals and requisitions, and care coordination among others.

Rather than adding a new administrative burden of tracking your indirect clinical time, the billing claim for indirect clinical services is a simple multiplier based on your panel size:

Physicians receive up to 30 minutes per week for every 250 patients enrolled in their panel.

Indirect clinical service is claimed in 15-minute units.

Physicians can claim up to three hours, or up to 12 15-minute units, with a panel of 1,500 patients or more.

Indirect clinical services should be claimed weekly. It can only be claimed during weeks the physician has provided primary care services to their panel.

The following table summarizes what can be claimed based on panel size.

Enrolled Panel Size	Maximum Units (15 minutes each)	Maximum Hours Per Week	Maximum Payment Per Week
less than 250		0 hours	
250 to 499	2	0.5 hours	\$85.52
500 to 749	4	1.0 hours	\$171.04
750 to 999	6	1.5 hours	\$256.56
1,000 to 1,249	8	2.0 hours	\$342.08
1,250 to 1,499	10	2.5 hours	\$427.60
1,500+	12	3.0 hours	\$513.12

# Claiming Indirect Clinical Services

A single tariff is used with a generic PHIN to claim indirect clinical services. Review the tariff below. You can expand the box for billing notes.

8191

**Indirect clinical services provided to the physician's enrolled panel of patients, to a maximum of 12 units per week, subject to the below maximum.**



\$42.76 Per 15 Minutes Per Week

## Notes:

1. The physician may claim up to 30 minutes per calendar week, for each 250 patients on their panel. A calendar week is defined as Sunday to Saturday

*Example, a physician with an enrolled panel of 1,300 patients shall be eligible for:  
 $1,300 / 250 = 5.2 = 5$  30-minute blocks, or 10 units of 8191 per calendar week.*

2. The physician shall be limited to a maximum of three (3) hours (or 12 units) of indirect clinical service per calendar week.

3. The physician shall have provided primary care services to their enrolled panel of patients during the calendar week that they are claiming indirect clinical services.

4. The physician may claim for time spent on indirect clinical services, which are patient-specific services provided when the patient is not present. This includes:

i) Documentation of patient interactions and charting.

ii) Review of results: labs, imaging, consultations, and other reports.

iii) Preparing referrals and requisitions, excluding e-consultation.

iv) Chart review.

v) Care coordination, and care planning.

vi) Clinical teaching arising from direct patient care for the following learners: medical students, residents, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students

vii) Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g. investigating particular diagnostic and therapeutic interventions)

viii) Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial

## Billing Note

The claim will have to reference the week of service but does not have to be claimed in that week. For example:

Week ending April 6<sup>th</sup>

Week ending April 13<sup>th</sup>

Week ending April 20<sup>th</sup>

Week ending April 27<sup>th</sup>

These services could all be claimed at the end of the month on single claim denoting tariff 8191 the number of units each week and the weeks on 4 separate claim lines.

There must be a record of the number of patients on your enrolled panel, and a brief description of the types of services provided for indirect clinical services. This does not need to be documented at a patient specific level of detail.

## Claim Instructions

When billing, use the following GENERIC patient demographics to ensure your billings are not rejected:

Field	Input
Registration Number	A40905
PHIN	126869933
First Name	Indirect
Surname	Services
DOB	April 1, 2000
Gender	F

An ICD code is not required as there is no clinical diagnosis needed to support the claim.

### When can't you claim indirect clinical services?

Indirect clinical services are payable provided that the claiming physician provided medical services to their enrolled panel of patients in that given week. This means the following weeks are not eligible for indirect clinical services, unless you provided a visit or procedure to patients on your panel during the week: vacation/holiday weeks, exclusively on a service that is not primary care (Hospital or walk in), were on CME leave, etc.

Indirect Clinical Services cannot be transferred between physicians in group practices, which means if you are covering a colleague's panel during their time away, you cannot claim additional indirect

clinical services.

### **Do I need to track my indirect clinical time?**

No. As we focus on reducing administrative burdens for physicians, Manitoba Health agreed to a model that is based on panel size. It is understood some physicians save indirect clinical work for the end of the day or a paperwork afternoon, while others complete tasks throughout the day.

### **What if I spend more than the maximum three hours per week on indirect clinical time?**

Manitoba Health would likely suggest some indirect clinical services are remunerated as part of the visit or procedure tariff. Doctors Manitoba advocated for remuneration for clinical time because administrative tasks have become more complex and demanding. Our research shows physicians spend over 10 hours per week on administrative tasks. Manitoba Health set the maximum time claimable under FM+ at three hours per week. Doctors Manitoba will monitor physicians' experiences under FM+ closely.

---

#### **Last updated**

March 13, 2024

## **Key Takeaways**

Under FM+, family physicians can claim up to three hours per week of indirect clinical services.

Indirect clinical services are claimed based on panel size, and does not require new or additional tracking of your administrative time.

**TAB 182**



# A New Path Forward

Making the Longitudinal Family  
Medicine payment model work for you

Doctors Nova Scotia | March 2024

## Contents

**2** A letter from the authors

**3** Where to start: Is the LFM for you?

- What is the LFM payment model?
- How do I know it's right for me?
- How to apply
- Getting started

**6** Billing: What's in, what's out, how to optimize and how to get paid

- What is included and excluded?
- Reporting requirements – hours, fees, time away
- Everything you need to know about panels and rosters
- Understanding and optimizing service encounters
- Understanding business arrangement numbers

**12** Need help? Who to call



# A letter from the authors

**W**e hope this letter finds you well as we navigate the evolving landscape of family medicine in Nova Scotia. Many changes have been introduced by the Longitudinal Family Medicine (LFM) payment model and the recent introduction of numerous new fee codes. We understand the challenges these transformations may bring to community family physicians. We understand because, as community family physicians ourselves, we're jumping these same hurdles right alongside you!

The LFM payment model was designed to strengthen family medicine in our province. It aims to provide stable, equitable funding for physicians dedicated to offering longitudinal family medicine, with a specific focus on improving access and fostering attachment.

Key to the LFM is its commitment to providing competitive compensation and increased accountability. Physicians will be remunerated based on the hours they work, the services they deliver and their panel size, resulting in a multi-pronged remuneration structure. This approach

not only serves our patients by supporting improved access and attachment, but also contributes to recruiting and retaining community family practice physicians, which will further stabilize primary care in our province.

Doctors Nova Scotia (DNS) asked us to leverage our experience across various payment models and our knowledge of billing procedures, practice optimization and electronic medical records (EMRs), to

support your journey with the LFM. We hope this publication will be a starting point for sharing our collective knowledge as a physician community.

We hope you use this resource to help you evaluate the suitability of the LFM model for your practice, to guide you through the application process, and to ensure smooth integration. Look for more information on how to optimize your billing processes with a focus on the newer fee codes in the future.

Like any significant change, adopting the LFM has not been without its challenges. Let's come together to learn from each other by asking questions, holding space and creating dialogue.

We invite you to engage with us and your peers on this journey. Share your knowledge and let us work together in the pursuit of delivering exceptional patient care.

Wishing you continued success and resilience in the face of change.



**Alison Wellwood, MD**  
Family physician, Wolfville, N.S.



**Ben Sabine, MD**  
Family physician, Wolfville, N.S.

## LFM by the numbers

- 493 family physicians are under LFM, 96 of whom converted from fee for service
- 6 new fee codes
- 3 major fee code revisions





# Where to Start

Is this new payment model right for you?

**F**amily medicine is the foundation of our health-care system. The Longitudinal Family Medicine (LFM) payment model was designed to strengthen family medicine in our province.

## What is the Longitudinal Family Medicine payment model?

*The Longitudinal Family Medicine (LFM) payment model offers competitive compensation and enhanced accountability, through a blended payment that is calculated based on hours worked, panel size and services delivered.*

### How do I know if it's right for me?

The LFM is right for you if you:

Bill ME=CARE (comprehensive, continuous, cradle-to-grave care) for patients you would consider attached to you, with the patients considering you their family doctor

Work 46 weeks per year in office-based clinical practice (exceptions include weeks doing other clinical work approved by Nova Scotia Health (NSH), such as hospitalist work)

Provide most direct clinical services in face-to-face patient encounters

Provide an average of 2.8 or more service encounters per hour

Use an EMR

Take a maximum of six weeks away from your practice each year for educational leave, sick time, holidays and vacation time

## How to apply for the LFM payment model

Family physicians interested in converting to or starting a practice under the LFM remuneration model will complete the following steps.

### 1. Contact your DNS physician advisor:

Reach out to the DNS physician advisor for your zone; they will address any queries or concerns you may have regarding the LFM.

### 2. Determine your ME=CARE panel size:

Email the Department of Health and Wellness (DHW) at [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca) to request your ME=CARE panel size. This is based on past billings. Physicians may wish to verify their ME=CARE panel size through a panel validation exercise. To initiate this process, email [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca) and indicate your interest in a panel validation. The DHW will provide further instructions, including your ME=CARE panel size, which you should compare to your EMR panel.

### 3. Review your information, then propose a start date:

Once you decide to proceed with the LFM, email [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca) with a proposed start date that is at least four weeks in the future.

### 4. Download and complete the contract:

Upon receiving confirmation of your start date, download and complete the [contract and contracted activities template](#). Physicians have one week from the confirmation of their start date (see Step 3) to return a signed contract.

### 5. Email documents:

Email your electronically completed and signed contract and contracted activities template to your DNS physician advisor, with a copy (cc) to the DHW at [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca).

MSI has [lots of resources available online](#), including the LFM Contract Filling Instructions, LFM Contract template and others.

## Short and sweet

Here's the short version of how to apply to the LFM model:

1. Contact your physician advisor
2. Email the DHW for your ME=CARE panel size

*Note: If you are concerned about your ME=CARE panel size, request a panel validation from the DHW before you proceed to Step 3.*

3. Review, then email the DHW with your start date
4. Complete the contract and contracted activities template
5. Email your signed documents to your physician advisor and copy the DHW

## Setting up your contract

*The following tips will support you in completing your contract and schedule. Read everything before beginning.*

MSI provides instructions on how to complete the [LFM Contract and Schedule A online](#). Open the MSI document [LFM Contract Filling Instructions](#) and consider these notes as you go.

## Populating and signing the contract

1. Your start date must be approved by the DHW before you fill out the contract. Do not start filling out the contract until you have received this approval.

## Populating the Schedule A: Contracted Activities template

1. Under "Practice Profile," enter your office/clinic manager or administrator as the primary contact.
2. Before you fill in your projected hours in the "Clinical Working Time" section, calculate the number of clinical hours you'll contract to work each week (see "Be smart about projected hours of work," below, for tips). Multiply this number by 46 weeks to input into Schedule A for your clinical working time per annum.
3. The sample practice schedule is intended to reflect a typical work week when you are seeing patients either face-to-face or virtually, particularly if/when you are offering access to patients outside of daytime hours. If you do paperwork in the evenings or on weekends with no patient contact at all, you can enter those hours in the appropriate time block, but you would claim these at the daytime (non-premium) hourly rate.

## Be smart about projected hours of work

The number of annual hours you submit in the "Clinical Working Time" section will determine the hourly portion of your biweekly payments. You will be asked to project how many clinical hours you will work annually. Once you sign this document, that number becomes your contracted hours. Every two weeks, the DHW will pay you for those hours, plus another 10% for your clinical support service time and any complexity modifier for your place of practice.

You will submit your actual hours worked on a regular basis (see page 8) and your submitted (actual) hours will be reconciled with your contracted hours annually, after the end of the fiscal year (March 31). If your submitted hours exceed your contracted hours, you will be paid the difference, but if your submitted hours are less than your contracted hours, you will have to pay back the difference.

To avoid facing a claw back at the end of the year, consider submitting a slightly lower number of projected hours than you intend to work when filling out Schedule A. Here are some additional ideas to consider.

### Projected hours considerations

- Statutory holidays
- Time of day
- Practice management
- Hospitalist work

### CONTACT DHW

To learn more and sign up, or as an LFM physician, [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca)



**NEED HELP?**  
Contact your  
[Physician Advisor.](#)

## Accounting for statutory holidays

### TYPICAL WORK WEEK

$$\begin{array}{rcl} 40 & \times & 46 \\ \text{hours} & & \text{weeks} \end{array} = 1,840$$

*minus*

### RECOGNIZED HOLIDAYS

$$\begin{array}{rcl} 40 & \times & 14 \\ \text{hours} & & (\text{stat holidays}) \end{array} = 112$$

**1,728**

**total contracted  
annual hours**

If you work on a statutory holiday, submit premium hours for that time.

If a statutory holiday falls on a day you wouldn't typically work, you will submit more hours worked than you will be paid for that week.

In both cases **the hours will be reconciled at the end of the year** so you will not need to consider them part of your six weeks vacation time or need to make up the hours.

### Statutory holidays

If you do not typically work statutory holidays, consider deducting those hours from your annual contracted hours up front. You won't be paid for them; therefore, they won't have to be part of your six weeks of uncontracted time and you will not have to make up the hours elsewhere.

For example: If you typically work 40 hours per week over 46 weeks, you would be contracted to work 1,840 hours annually. MSI recognizes [14 statutory holidays in 2024](#). If you typically work an eight-hour day, subtract 112 hours from 1,840 to get 1,728 hours for your contracted annual hours. This is the equivalent of "banking" another 14 days of uncontracted time. You will still work your 40-hour work week on the weeks there are no statutory holidays. If you were to work a statutory holiday, you would submit premium hours for that time and be paid for those hours at the end of the year following the annual hours reconciliation. Similarly, if the stat holiday falls on a weekend or a day you wouldn't typically work, you will have submitted more hours worked than you were paid for that week and it will be reconciled at the end of the year. This ensures you are not paid upfront for the statutory holidays so you will not need to consider them part of your six weeks uncontracted time or need to make up the hours.

### Time of day

#### Daytime (regular, non GPEW premium eligible)

**hours** are Monday to Friday between 8 a.m. and 5 p.m. To calculate your yearly daytime non GPEW premium eligible hours, multiply the number of daytime hours you work per week by 46 (if your weekly hours vary, use the average).

**Premium (GPEW premium eligible) hours** are Monday to Friday, from 6 to 8 a.m. and 5 to 10 p.m., plus Saturdays, Sundays and statutory holidays (as recognized by MSI). These hours are paid at a higher rate than daytime hours. You can only claim GPEW hours if you are seeing patients (in person or virtually) during that time. You cannot claim GPEW hours if you are doing indirect patient care only (such as charting, writing referrals, reviewing lab/DI reports). To capture indirect hours worked during premium time, add them to your daytime (non GPEW premium) hours calculation of annual contracted hours. To determine your annual contracted GPEW hours, use the same methodology used to calculate your daytime (non-GPEW) hours above.

### Practice management doesn't count

When projecting your contracted hours, only count the time you will be doing direct and indirect clinical work. Do not include the time you spend managing your practice or providing clinical support services. Your 10% clinical support service payment is intended to cover some of this work. Do not track or bill hours for this kind of work. These hours are automatically added to your biweekly payments and to your annual adjustment should you work more hours than you were contracted to work. *Note: Physicians may choose how they direct their time within this 10%.*

### Hospitalist work

If you do hospitalist work and you know how many weeks per year you'll be working, you can deduct that number from the 46-week requirement – just be sure to include your hospitalist work in the notes section below the practice schedule. When projecting your annual contracted hours of work you multiply your weekly average by 46 weeks minus the number of weeks you'll be doing hospitalist work; for example, if you're going to do six weeks of hospitalist work per year, you'd use 40 weeks as your multiplier to determine annual contracted (projected) hours of work.

**PROJECTING  
CONTRACTED HOURS?**  
Only count time spent  
on direct and indirect  
clinical work.



# Making it work

## What's in, what's out, how to optimize and how to get paid

**T**he work involved in longitudinal family medicine can vary widely, considering that your patients may range in age from newborn to 100 years old (or more!). Be aware of what work is covered so that you can bill appropriately.

## What services are included in and excluded from the LFM payment model?

*It's important to know what is included in the Longitudinal Family Medicine (LFM) payment model as well as what is excluded and what's optional. Services that are not included in the LFM can be billed separately, outside of your LFM hours.*



### Included

- Most insured services for patients in your panel
- Services for out-of-province patients (DHW pays the physician and recovers the fee code amount from the relevant province)
- Chronic Disease Management (CDM), paid at 30%
- EMR envelopes B and C are included in the LFM, so there is no longer a need to apply for these incentives
- *Note: It is anticipated that the Collaborative Practice Incentive Program (CPIP) will be paid at 30% once it's converted to fees, but details are being finalized with Fee Committee*



### Excluded

- Non-insured services (including third-party, medico-legal, insurance, out-of-country services), including work for Workers Compensation Board of Nova Scotia, Community Services, Province of Quebec
- Hospital-based work with an established payment model (including hospitalist, surgical assists, primary maternity care and emergency department shifts)
- Hospice
- Medical Assistance in Dying (MAID)
- Obstetrical deliveries for both attached and unattached patients
- Honoraria/external committee work
- EMR grant A (new adopters) is payable on top of the LFM
- NSH Committee work and/or meeting time



### Optional

Physicians can determine whether they want to bill the following services as part of their LFM agreement or outside it:

- **Long-term care/nursing home work**
    - **Under LFM:** Can bill hours worked plus 30% FFS and nursing home patients will be included in your panel calculation.
    - **Not under LFM:** Bill 100% FFS; no LFM hours to be submitted for this work. Patients not included in panel.
  - **Unattached patient work (non ME=CARE)**
    - **Under LFM:** Bill hours worked plus 30% FFS. No panel payment.
    - **Not under LFM:** Bill 100% FFS; no LFM hours to be submitted for this work. Reminder: ME=CARE cannot be billed for unattached patients, with the exception of prenatal codes.
- Physicians may dedicate some of their 10% clinical support service time to NSH committee and quality improvement work should they have capacity to do so.

## Reporting requirements – hours, fees and time away from practice

*The LFM payment model is flexible and allows family physicians to work part- or full time. It's important to think carefully about how many patients you see each day, how many hours you want to work each week and how much time you'd like to take away from your practice each year before you commit to the LFM payment model.*

### Contracted hours worked

Physicians project the number of hours they will work each year, spread over 46 weeks, as part of their LFM contract. This projection is called "clinical working time" and these are your "contracted hours." The hourly component of your biweekly paycheck for the next year is based on this projection.

Contracted hours include all work with panel patients, except the following: uninsured services, MAID, third-party services including WCB, and when providing services that are paid under other provincial funding models, such as hospitalist work, CHIP, Primary Maternity Care and emergency department coverage.

Do not claim hours for clinical support services that are not patient-specific but provide benefit to the patient population and the health system, such as meeting with your admin team to rearrange your schedule or spending time ordering new equipment. These hours are paid as a 10% top-up to your weekly contracted hours.

When calculating your contracted hours, remember to exclude a daily lunch break if you typically take a non-working lunch. If you don't take a lunch, or if you do paperwork or provide indirect patient care while you eat your lunch, you can include that time in your contracted hours.

### Actual hours worked

Submitted (actual) hours worked are claimed daily and include clinical work that is both direct and indirect patient care.

- **Direct:** Any visit with a patient (face-to-face or virtual) that is insured by MSI.
- **Indirect:** Specific patient care where the patient isn't engaged in an encounter with you, for example, any necessary discussion with or advice to a patient's family/caregivers; charting; prescribing medication or therapy; arranging diagnostic services; writing or arranging referrals; reviewing labs, diagnostic images, consult or OR reports; and updating the patient's chart, as appropriate. This time also includes consulting with other physicians or allied health-care providers regarding the management of your patient.

Physicians should claim actual clinical working hours daily, 365 days per year – while always being mindful of the need to bill an average of at least 2.8 service encounters per hour. Depending on your practice efficiency (service encounter ratio), you may or may not be able to bill all working hours.

### Annual reconciliation of hours

Once a year, around July 1 (90 days after March 31, the end of the DHW's fiscal year) the DHW will reconcile LFM physicians' submitted (actual) hours worked with their contracted hours as per the Schedule A – Contracted Activities form they submitted with their contract.

The hourly component of each biweekly LFM payment is based on the contracted working hours in each physician's contract. The reconciliation will use billing data to assess whether the submitted (actual) working hours claimed align with the hours paid based on the contracted hours. If the physician has worked more than their contracted hours, they will be paid for the extra hours after the reconciliation. If they've worked less, the money must be repaid; repayment terms will be arranged with the DHW on an individual basis.

### Expected hours per year

Physicians are expected to work 46 weeks per year, but payments will be smoothed over 52 weeks (or 26 pay periods). The DHW expects physicians who are planning to be away from clinical work for more than two weeks to make every reasonable effort to ensure necessary medical coverage for their patients.

## Clinical working time – eligible activities



Office visit



Virtual visit



Flu shot



PAP smear



Paperwork for panel patients



## Uncontracted time

Six weeks per year are deemed uncontracted time. This time includes unpaid days for sick time, bereavement leave, educational leave, statutory holidays and vacation days.

## Billing LFM hours

To enable billing of submitted (actual) LFM hours, two health service codes (HSCs) have been created:

- HDAY1 – This is the hourly fee code for clinical daytime hours worked, billed at the daytime rate, that is, not eligible for the GPEW premium. This is also the appropriate code to bill for paperwork done during evenings or weekends when there are no concurrent visits.
- HEVW1 – This is the hourly fee code for clinical evening/weekend/holiday hours worked, billed at the premium rate, that is, eligible for the GPEW premium.

To facilitate billing submitted (actual) hours as a fee code, MSI has created a “mock patient.”

The mock patient demographics and diagnosis are:

- Health Card Number 0015800568
- DOB April 1, 1969
- Diagnostic code V689

To bill your submitted (actual) hours worked, enter the number in the “units” box of the claim (for example, 8.5 daytime hours = 8.5 units). Each provider can only bill one HDAY1 and one HEVW1 claim per day. Round submitted (actual) hours to the nearest 15-minute increment.

Physicians must bill their submitted (actual) hours under their LFM Hourly Business Arrangement (BA) Number.

Because these claims are strictly for tracking purposes, the LFM hourly HSC pays \$0. Reporting the hours you worked under this HSC enables reconciliation at the end of the year. For more complete billing guidelines, refer to the [\*MSI Physician’s Bulletin from Oct. 27, 2023\*](#).

### DON'T FORGET

#### Physicians are paid

biweekly according to the contracted hours they entered in their contract. Submitted (actual) hours are not reflected in the biweekly pay. Contracted vs. submitted hours will be reconciled at the end of the fiscal year.

### TIP

Many physicians find it useful to book this mock patient at the end of their daily schedule as a reminder to bill their submitted (actual) LFM hours when the work day is complete.

## Billing premium rates

Physicians will bill HSCs GPEW and HEVW1 for premium rates for early morning, evening, weekend and holiday visits (direct clinical services) with patients. These visits can be face-to-face or virtual. The premium available under the LFM for this after-hours work is two-fold:

1. You can bill the GP Enhanced Hours Premium (TI=GPEW) for all eligible services you provide, which adds a 25% premium to the MSU value for the visit billed, and
2. You can claim your submitted (actual) LFM hours at the premium rate of \$139.05 (HEVW1) instead of the daytime rate of \$92.70 per hour (HDAY1).

The premium rates (GPEW and HEVW1) can be billed for work conducted Monday to Friday between 6 and 8 a.m. and 5 and 10 p.m., and on Saturdays, Sundays and holidays. Remember that after-hours paperwork (that is, indirect patient care) cannot be claimed at the premium rate (HEVW1) unless direct patient services (visits) are provided during that hour. If no direct patient care is provided, the hour should be billed at the daytime rate (HDAY1).

### TIP

Consider adding early morning, evening and weekend appointments to your clinic hours – scheduling more patients during GPEW and LFM premium hours boosts compensation and creates better access for patients. For example, choose one day per week to book six patients for 10-minute appointments from 7 to 8 a.m. or 5:30 to 6:30 p.m.

## Part-time work and unexpected leaves

Under the LFM payment model, physicians are contracted to work 46 weeks per year. Physicians may work part time or extended hours each week, however, they must be accessible to their practice and patients (virtually and in-person) for 46 weeks of the year. The LFM is not an appropriate model for physicians who intend to take extended time away from their office-based family practice.

Exceptions will be made for physicians who are unable to be in their office practices for 46 weeks due to other approved clinical work, such as hospitalist work, Primary Maternity Care (PMC) or emergency department coverage. These specific arrangements will be determined on a case-by-case basis as part of your contract discussion.

If a physician will be absent for more than six weeks in a year, 30 days’ notice must be given to the DHW and NSH by emailing [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca). Parental leaves and extended absences due to unforeseen circumstances (that is, medical leave) will be approved. Your LFM model will be paused or terminated depending on your unique circumstances.

## Everything you need to know about panels or rosters

*Your panel or roster is made up of patients who would consider you their family doctor. The size of your panel affects the amount of your panel payment. Learn about how panel sizes are calculated and other considerations.*

### How is the panel/roster size calculated?

When calculating physician panels, the DHW considers the New Patient Intake Visit (NPIV1) code and the ME=CARE modifier.

- Use of the NPIV1 code will immediately roster a patient to your panel.
- In the absence of a NPIV1 code, use of the ME=CARE service modifier will be used to determine rostering. The DHW considers:
  - o the number of ME=CARE encounters with each provider
  - o the most recent ME=CARE encounter date with each provider, with more recent visits weighted more heavily

In the absence of a billed NPIV1 code, the patient is counted in the panel of the physician with whom they have had the most ME=CARE encounters. If tied, the patient is counted in the panel of the physician with whom they have had the most recent ME=CARE encounter.

Panel size is calculated dynamically and smoothed for payment every quarter.

#### TIP

Don't forget to use the NPIV1 code for newborn babies.

### Your panel payment

You will receive \$103 per year for each patient rostered to your panel. (The panel payment will increase by 3% on April 1, 2024.) Panel payments are smoothed into your biweekly paycheck. Bill the NPIV1 code when accepting a new patient into your practice, including for newborn babies.

### How are my "healthy unseen" patients counted?

The DHW understands that physicians have a number of "healthy and unseen" patients in their practice. To account for this, an additional 10% is added to your calculated panel size. Currently, if a patient has been added to your panel by billing NPIV1, they will only be removed from your panel when another physician bills NPIV1 for that patient. If a patient has been added to your panel based on the ME=CARE algorithm, they will be removed from your panel if another physician bills ME=CARE for that patient more often than you or if a physician claims the NPIV1 code for that patient. Nurse

practitioners do not shadow bill ME=CARE, so seeing a nurse practitioner will not result in a patient being removed from your panel. ME=CARE is also not billable by walk-in clinics, local emergency departments or primary care access clinics (PCCs). Accessing services in these locations will also not result in a patient being removed from your panel. *Note: The LFM attachment methodology is evolving and being refined on an ongoing basis. Changes will be made with approval of all stakeholders and members will be notified accordingly. The above information is true as of the date of publication.*

### What is ME=CARE?

ME=CARE is a fee code modifier established in 2019. Physicians receive a premium on most office-based billing codes when seeing a rostered/attached patient. Physicians must commit to providing ongoing comprehensive primary health care to that attached patient to claim ME=CARE. ME=CARE can be billed for a patient of another provider within your collaborative practice group.

#### TIP

Be sure to bill ME=CARE codes for your rostered patients. If you are in a collaborative practice, bill ME=CARE for all patients within your collaborative group.



### More tips for billing success

- Bill submitted (actual) hours worked, including paperwork time, but **keep an eye on your service encounter ratio**. Make sure to distinguish between daytime (non-premium) (HDAY1) hours and premium (HEVW1) hours.
- **Billing hours daily (or when you bill your FFS billings) is best practice**. Do not delay billing your submitted (actual) hours worked. Use calendar reminders to make sure you don't forget and consider using an app to help track your submitted (actual) hours worked.
- **Consider using your EMR to help you log times**. In Med Access, use the "Memo" feature at the top of your daily schedule to log your start/end times for every work session.
- Remember that EMR data can be easily accessed to see every click you make and when you made it. This information can help you track your submitted (actual) LFM hours if needed. **Refer to your cell phone call log for phone call durations.**
- **Get in the habit of time-stamping all encounters** – for example, if you realize you had a patient encounter that will be billed to Veteran's Affairs or WCB NS, you'll need to subtract it from your actual hours worked. Find the times by checking the time stamps on the visits straddling that encounter. When the visits on either side of it were time-stamped, the calculation is easy to do.

## What about patients who receive prenatal care outside of my practice?

Prenatal care codes are not accounted for in the ME=CARE attachment algorithm, so the patient will remain on your panel.

## Community complexity modifier

The LFM payment model includes a community complexity modifier to account for variations in socio-economic status factors in different communities. This calculation is currently based on your community of practice, but work is being done to provide a more accurate calculation that would reflect the actual medical complexity of your specific patient panel. This is still under development. Currently, the complexity modifier is applied automatically to your panel and hourly payments and smoothed into your biweekly payments. The community complexity modifier is paid as a quarterly premium on your 30% FFS claims.

## How to request a panel validation

Physicians may participate in a panel validation exercise to receive a report comparing their panel size as calculated by their EMR patient count and the panel size as calculated by the ME=CARE/NPIV1 algorithm. Email [psaccountability@novascotia.ca](mailto:psaccountability@novascotia.ca) to request a panel validation.

## Physicians are responsible for all claims

You are responsible even when claims are entered by someone else, such as billing staff. MSI is the ultimate authority on physician billing. If you have questions about billing under the LFM, [email MSI](#) and save the response for audit purposes.

## Understanding and optimizing service encounters

*The LFM payment model requires physicians to perform a minimum of 2.8 service encounters per hour. Service encounters will be averaged quarterly.*

It's important that physicians bill all insured services and accurately track their hours.

## What is a service encounter?

In the LFM payment model, service encounters track qualifying medical services. Every patient appointment counts as at least one service encounter. Most MSI-insured, community-based medical services are valued as one or more service encounters.

### What qualifies as a service encounter:

- All patient appointments
- Pap smear and vaginal/pelvic exams with speculum each count as an extra service encounter, in addition to the service encounter earned for any associated appointment
- Services with time-based multiples (such as prolonged office visits, counselling, psychotherapy, palliative care support) are valued at 1 SE per multiple
- Procedures count as one or two service encounters (refer to the [LFM Service Encounter Cheat Sheet](#))
- Surgical and fracture services
- Most complex visits are valued as two service encounters, including:
  - NPIV1
  - Palliative care support visits (03.03C)
  - Comprehensive visits (03.04)
  - Gender readiness assessments (03.04K GAC)
  - Initial opioid agonist treatment (OAT) codes (03.03J, 03.03K, 03.03L)
  - Comprehensive GP consultations (03.08)

### TIP

Check the MSI website for an [LFM service encounters cheat sheet](#) that lists common billing codes and combinations of codes, plus their related service encounter value.

### What does not qualify as an extra service encounter:

- Insured injections and immunizations do not qualify as an extra service encounter when billed with an office visit
- NSH interpreter (ADON OFI1)
- Yearly CDM incentive fees
- Indirect patient care codes, such as Allied Health Care Provider to Physician Discussion (AHCPI), Prescription Renewal (TPR1) and the Teaching Stipend for Medical Student
- Workers Compensation Board services (paid outside LFM contract)

The definition of LFM service encounters is new and will continue to evolve as data is gathered and physicians provide feedback.

## Make the most of each service encounter

- Delegate work mindfully so that you can achieve the service encounter ratio. For example, delegate some indirect care tasks and components of more time-consuming tasks (such as first prenatal visit history, CDMs, Rourke's), but retain some straightforward service encounters in your own schedule (such as insured stand-alone injection/immunizations and suture removals).
- Bill all insured services.
  - **Know your fees** – especially the codes for prolonged office visits (03.03, 03.03A, NPIV1)
  - **Check out the billing education** information available on the [MSI website](#)
  - **Bill for all face-to-face and non-face-to-face visits**, and indirect services like Allied Health Care Provider to Physician Discussion (AHCPI), Prescription Renewal (TPR1) and Physician to Physician Advice (03.09L)





## Understanding business arrangement numbers

*Physicians who are remunerated under the LFM payment model receive a paycheque biweekly (every two weeks).*

This payment consists of three components: an hourly component, a payment based on panel size and a payment for 30% of their FFS billings. The hourly component is static and reflects the annual hourly commitment the physician made in their contract (that is, their contracted hours) and Schedule A (reconciliations happen annually; see page 7). The panel payment may vary depending on fluctuations in panel size; changes are tracked and adjustments made quarterly. The FFS billing payment will fluctuate with each cheque, depending on what/how many FFS services were provided during the pay period.

Each of these payments is tracked through a different business arrangement (BA) number. These numbers are automatically provided to LFM physicians by MSI.

### Business arrangement numbers

Each LFM physician will receive three BA numbers – and a fourth, for 100% FFS work, if applicable.

- 1. LFM Annual Hours BA** – For submitting actual hours worked. Nothing should be billed to this BA except for the new hourly health service fee codes HDAY1 and HEVW1. This is necessary for annual reconciliation of your submitted (actual) hours worked with your contracted hours outlined in Schedule A of your LFM contract. (See page 7 for more about the annual reconciliation.)
- 2. LFM Attachment BA** – This BA is for the patient attachment (panel) component of the LFM model. Physicians should not bill any codes to this BA – it exists so that the panel payment is easy to see as a separate payment component, rather than getting combined with one of the other BAs.
- 3. LFM 30% BA** – For billing FFS health service claims, which are paid at 30% under the LFM payment model. Payments under this BA will fluctuate because they reflect 30% of actual FFS billings. If you are on vacation for a few weeks, you'll notice this payment decrease accordingly.
- 4. 100% FFS BA** – This BA is for services provided outside the LFM if applicable. This number is for FFS-eligible claims (such as WCB, MAID, Community Services).

You may see payments to additional BA numbers on your account. These numbers include:

- **CMPA BA** – For issuing CMPA rebates and/or incentives – no billing occurs on this BA.
- **Locum BA** – A temporary or long-term BA set up for physician locum payments.

### Understanding payments

Go to [www.msielink.ca](http://www.msielink.ca) and log in using the six digits of your provider number as your username. You will then be able to reconcile your payments with your billings by looking at what is listed under your business arrangement numbers.

#### TIP

Consider setting your LFM 30% BA as your default billing number in your LFM but remember to toggle to the hourly BA when submitting hours. It is recommended all hours be billed at the same time as daily encounters.



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# Need help?

## Who to call

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*Whether you're considering adopting the LFM payment model, in the process of converting or already using the LFM but in need of support, we're here for you. The DNS Physician Advisory Team is ready to answer your questions and guide you through the LFM application process. Call or email the advisor in your zone any time.*

### **DNS Physician Advisory Team**

#### **Noelle Moulaison**

Physician advisor (Western Zone)

902-740-5240 | [noelle.moulaison@doctorsns.com](mailto:noelle.moulaison@doctorsns.com)

#### **Ryan Brown**

Physician advisor (Northern and Eastern zones)

902-304-6569 | [ryan.brown@doctorsns.com](mailto:ryan.brown@doctorsns.com)

#### **Jennifer Girard**

Physician advisor (Central Zone)

902-240-6301 | [jennifer.girard@doctorsns.com](mailto:jennifer.girard@doctorsns.com)

### **Connect with colleagues**

Doctors Nova Scotia has created an [LFM hub on the Doctors Lounge](#) – check it out to pose your questions, share tips with your colleagues and find reliable information.

### **How to reach the DHW**

To learn more and sign up, or as an LFM physician with questions, email [lfmfunding@novascotia.ca](mailto:lfmfunding@novascotia.ca)

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> [Longitudinal Family Medicine payment model](#)

# Longitudinal Family Medicine payment model

The Longitudinal Family Medicine (LFM) payment model offers competitive compensation and enhanced accountability, through a blended payment that is calculated based on hours worked, panel size and services delivered.

## About the LFM payment model

It's projected that family physicians working full-time to provide longitudinal family medicine will earn, on average, about \$365,000 annually under the new Longitudinal Family Medicine (LFM) model (up from about \$300,000 under the previous APP – an increase of about 20%). Adding hours to your schedule and patients to your roster, providing additional services or becoming a preceptor all deliver the opportunity to earn even more.

The best part? You're paid for the hours worked, services delivered and patients rostered to your practice.

## Compensation

Physicians under the LFM model will be paid a blended payment that is calculated based on hours worked, services delivered and panel size.

- Hours worked: \$95.48 per hour (weekdays); \$143.22 per hour (evenings/weekends)
- Services delivered: 30% of fee-for-service billings, with enhanced fee codes in place
- Panel size: \$106.09 per patient

*Note: these fees will increase by 2% on April 1, 2025*

In this model, a physician may earn more or less by working more/fewer hours, delivering more/fewer services and/or growing/shrinking their panel size. The model is also flexible – a physician could work full-time or part-time and still participate in this model. They could also work part-time within a longitudinal family practice and part-time providing care in other areas of the system, such as providing hospitalist or emergency services or working in a sexual health clinic.

## Income smoothing

Having a stable and reliable income is vitally important. Having payments accurately reflect the hours worked, services billed and panel size is also essential. Physicians paid under the LFM model will be paid biweekly (every two weeks) and their income will be smoothed. We expect smoothing to look like this:

- Hours – Smoothed annually based on contracted hours as outlined in your Contracted Activities (Schedule A to the LFM Contract); reconciled at the end of the year to ensure hours paid matched hours worked. If a physician worked more hours, they will then be paid for the extra hours.
- Billing – Based on actual billing claims submitted (no smoothing)
- Panel – Smoothed quarterly (payment based on panel size at the beginning of each quarter)

## How do I know if it's right for me?

The LFM is right for you if you:

- Bill ME=CARE (comprehensive, continuous, cradle-to-grave care) for patients you would consider attached to you, with the patients considering you their family doctor
- Work 46 weeks per year in office-based clinical practice (exceptions include weeks doing other clinical work approved by Nova Scotia Health (NSH), such as hospitalist work)
- Provide most direct clinical services in face-to-face patient encounters
- Provide an average of 2.8 or more service encounters per hour
- Use an EMR
- Take a maximum of six weeks away from your practice each year for educational leave, sick time, holidays and vacation time

## Next steps

Physician Agreement 2023-2027 ([https://doctorsns.com/sites/default/files/2023-2027\\_PhysicianAgreement.pdf](https://doctorsns.com/sites/default/files/2023-2027_PhysicianAgreement.pdf))

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A New Path Forward: Making the Longitudinal Family Medicine payment model work ...

(<https://doctorsns.com/sites/default/files/2024-03/LFM-SIP-2024.pdf>)

LFM Payment Model FAQ – October 2023 (<https://doctorsns.com/sites/default/files/2023-10/LFM-FAQ-Oct2023.pdf>)

## Related content

Add Start and End Times to Visit Records in Your EMR

([https://doctorsns.com/sites/default/files/2023-08/next-steps/EMRs\\_adding-time-stamps.pdf](https://doctorsns.com/sites/default/files/2023-08/next-steps/EMRs_adding-time-stamps.pdf))

### Physician Agreement

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#### Physician Agreement programs and funding (2023)

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#### Longitudinal Family Medicine payment model

-

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[Contract and Practice Support \(/contract-and-support\)](/contract-and-support/) > Reducing physician administrative burden

## Reducing physician administrative burden

Doctors Nova Scotia, with the support of the Department of Health and Wellness (<https://novascotia.ca/dhw/>), has partnered with the Office of Regulatory Affairs and Service Effectiveness (<https://novascotia.ca/regulatoryopportunity/>) to identify and implement concrete actions to reduce unnecessary physician administrative burden.

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Doctors in Nova Scotia collectively spend 1.36 million hours a year on administrative tasks. While much of that work is important, doctors report 500,000 hours of this work is considered unnecessary.

More than 45 initiatives have been identified, many completed, others underway, to reduce physician red tape by 400,000 hours per year, the equivalent of 1.2 million patient visits, by the end of 2024.

### Completed work

As of Dec. 31, 2023 more than 251,000 hours have been saved:

- Legislation passed to significantly limit the use of medical notes (<https://doctorsns.com/contract-and-support/medical-sick-notes>) for employee absences
- Enabling the use of physician assistants in our healthcare system to augment various care teams, and allowing registered nurses to onboard patients at some collaborative care practices and admit patients into hospital

- With help from Canada Life and Health Insurance Association, the number of different short term disability forms has been reduced from 28 to one standard form, which has been added in the EMR
- Improving high volume forms by making them easier to understand and faster to complete
- Making it easier and faster for physicians from other parts of Atlantic Canada to practice in Nova Scotia
- Providing more options to Nova Scotians to receive treatment for common illnesses at mobile clinics and pharmacies
- Making common-sense modifications to processes and policies, like moving the maternal serum screening process to a single comprehensive test and introducing technological capabilities where possible

Find the full list of red tape reducing actions here

(<https://beta.novascotia.ca/sites/default/files/documents/1-3625/patients-paperwork-reducing-red-tape-physicians-february-2024-en.pdf>).

## Forms and processes

**Click here (/contract-and-support/admin-burden/forms)** for a round up of changes to forms (and where to find them) and process to the end of 2023.

## Administrative burden physician advisors hired

Drs. Amanda MacDonald-Green, family physician, and Osama Loubani, ER/ICU physician, are working with ORASE to help determine the impact of administrative burden reduction initiatives. The work of the advisors is generously supported by funding from the CMA, MD Financial Management Inc. and Scotiabank. Contact them (<mailto:adminburden@doctorsns.com>)

## Physician involvement

Physicians are encouraged to submit their ideas to reduce administrative burden via the physician portal (<https://forms-beta.novascotia.ca/NewSubmission/d5e89d42-258d-43ae-ac89-6969b446d49e>).

## Measuring physician administrative burden

Physicians have raised unnecessary administrative burden as an issue impacting patient care, professional practice and the effectiveness of the health-care system.

Since 2019, Doctors Nova Scotia (DNS), with the support of the Department of Health and Wellness, has worked with the provincial Office of Regulatory Affairs and Service Effectiveness (ORASE) to reduce physician administrative burden.

Measuring regulatory or administrative burden is critical to understanding and communicating its significance.

To better understand the size and scope of physician administrative burden, the office worked with DNS and other key stakeholders on a survey to quantify physician administrative burden and its impact. With this work, Nova Scotia becomes this first province in Canada to measure physician administrative burden.

Key findings from the survey include:

- On average, Nova Scotia physicians spend more than one full day per week (10.6 hours) on administrative tasks
- Physicians reported that 38% of this time was spent on unnecessary administrative tasks: 24% was work that could be done by another role and 14% was work that could be eliminated entirely
- The top contributors to unnecessary administrative burden were completing medical forms, doctor's notes, business operations, billing (including shadow billing), licensing and privileging
- The health system itself, including the complexity of the governing and oversight bodies, also contributed to physician administrative burden
- Physicians reported administrative burden was a significant contributor to burnout and that they could use the freed-up time to achieve better work/life balance and patient care

Read a full analysis of the survey results here (<https://www.doctorsns.com/sites/default/files/2020-11/admin-burden-survey-results.pdf>).

\*With special thanks to:

The Canadian Medical Association, MD Financial Management Inc. and Scotiabank together proudly support work on physician administrative burden, one of several initiatives that comprise our 10-year, \$115 million commitment to supporting the medical profession and advancing health in Canada.



## Contact

### Samantha Graham

Policy advisor

902-830-6592

1-800-563-3427

[samantha.graham@doctorsns.com](mailto:samantha.graham@doctorsns.com) (mailto:samantha.graham@doctorsns.com)

## Next steps

Master Agreement 2019-2023 (/sites/default/files/2019-12/MA-Execution-Copy-SIGNED-Dec\_9\_2019.pdf)

## Related content

Reducing physician administrative burden workplan (/sites/default/files/2020-11/admin-burden-workplan.pdf)

Reducing physician administrative burden survey results (summary) (/sites/default/files/2020-11/admin-burden-survey-summary.pdf)

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> [Overhead/attachment support \(2023\)](#)

## Overhead/attachment support (2023)

The 2023 contract includes overhead support for family physicians who run longitudinal practices and for rural specialists who bear the costs of overhead (rent) for their offices.

### Family medicine

The rostering grant is an annual payment to fee-for-service family physicians who provide longitudinal family medicine (i.e., bill ME=CARE) to help them with overhead costs. The payment is \$20 per rostered patient, up to 2,000 patients (\$40,000). For example, a physician who has a roster of 1,310 patients will receive \$26,200 annually. The payment is available as long as the physician has worked any portion of the previous fiscal year and is still working in a ME=CARE practice as of March 31 of each year. For the first year (2023–24), the grant will be paid out in two instalments, with the first payment coming in fall 2023.

#### Survey for additional information

An email was sent from the president, Dr. Colin Audain, to all fee-for-service family physicians on Nov. 20, 2023 with a survey to collect additional information to ensure they receive the rostering grant. Physicians who complete the survey by Nov. 27, 2023, will receive their rostering grant payment by the end of December 2023. If they complete the survey after Nov. 27 but before Dec. 31, 2023, they will receive their

rostering grant payment in early 2024. If they have not completed the survey by Dec. 31, 2023, they will not receive a rostering grant for this period. The next rostering grant will be issued based on their panel size on March 31, 2024.

The grant is also available to APP family physicians for the first six months of this year (at the rate of \$10 per patient), to bridge the transition to the LFM payment model. The enhanced compensation in the LFM payment model includes funding for overhead support.

The contract also includes new funding to help rural specialists manage the costs associated with running their practice.

## Specialists

See the new Rural Practice Support Program (<https://doctorsns.com/contract-and-support/master-agreement/programs-funding/rural-specialist-retention-practice-support-2023>) will help cover their overhead costs.

## Related content

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> [Funding for allied health-care providers \(2023\)](#)

## Funding for allied health-care providers (2023)

The 2023 contract includes funding for a new pilot project available to LFM and fee-for-service family physicians who hire an allied health-care provider (AHCP).

In this pilot, family physicians can bill for the services provided by the AHCP to help offset the costs associated with employing them, to a maximum of \$110,000 per year. All services delivered by the AHCP must be within their scope.

The new codes will include:

- AHCP Service (simple) – \$25
- AHCP Service (complex) – \$52 (approx. 1 hour)

Family physicians cannot bill these fees if the salary of the AHCP is paid by the NSH or another third party. Only family physicians in their own practice (not in an NSH-operated facility) may apply to be part of the pilot project.

Applicants must explain how an AHCP will benefit the system in terms of access and attachment, related to either stabilization or service expansion.



If hiring an AHCP into your practice enables you to attach additional patients, those patients will become part of your roster. This will either increase base compensation for LFM payment model physicians or increase the rostering grant (overhead) for fee-for- service physicians providing longitudinal family medicine services.

Proposals must be submitted between Jan. 1 and Feb. 29, 2024, for implementation in 2024, or between Jan. 1 and Feb. 28, 2025, for implementation in 2025. Details on the application process will be provided as soon as they are available.

Specialists

For other specialists requests for additional resources – including both new physician FTE needs and requests for allied health-care providers (AHCPs) or other resources – should be advanced by the Department Head through the annual NSH and IWK Health business case process.

Contact

Jessica Moore  
Compensation manager, Physician Agreement and Fee Schedule  
902-225-1533  
1-800-563-3427  
jessica.moore@doctorsns.com (mailto:jessica.moore@doctorsns.com)

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> [New fee codes for invisible unpaid work \(2023\)](#)

## New fee codes for invisible unpaid work (2023)

This contract includes new fee codes that will mean family physicians will be paid for some of their “invisible unpaid work” – important work they do that takes time but hasn’t always been recognized by the system.

New fee codes take effect upon signing of the new Physician Agreement, however, MSI will not be ready to receive claims for the new codes until Sept. 15, 2023. It is recommended that physicians hold billing claims until Sept. 15 so they can claim these new codes. The new fee codes are:

1. New patient intake visits
2. Prolonged office visit for ME=CARE patients
3. Prolonged nursing home visits
4. Telephone prescription renewals
5. Allied health-care provider to physician
6. 03.09 K and L specialist advice codes (expanded to include in-person and secure messaging exchanges between consulting and referring physicians)
7. GPEW (25% premium) for after-hours service – family physicians are now able to bill the GPEW regardless of whether they have billed ME=CARE for the service. This includes physicians delivering services in walk-in clinics.

## An important note about multiples

Details on the new fee codes are outlined on pages 29 to 34 of the Physician Agreement, however, the language on the Prolonged Office Visits does not fully reflect our final agreement with the DHW. We have agreed that the multiple is billable at 24 minutes. For a physician to claim multiples, they would need to spend 80% of the total time in direct patient care (during a 30-minute visit, 24 minutes must be in direct patient care). If the 24-minute mark was not reached with the patient, the physician would claim a regular visit (with no multiples). The government has, in turn, agreed that 03.03A geriatric visits will now be able to be billed with multiples at the same enhanced rate as the 03.03A base visit (despite language in the Physician Agreement that says multiples on 03.03A can only be billed at the regular 03.03 rate).

## Fee Committee to-do list

Under the 2023 Physician Agreement, the Fee Committee will explore several fee codes that better compensate physicians for the work they are doing or recognize work that is currently not compensated appropriately, including:

- Physician-to-physician capacity building, mentoring, maintenance of competency
- NSH/IWK Health-requested quality/safety work
- Collaboration time
- Team development
- Family physician consults
- Group medical visits
- Multiples on specialist telephone advice
- Triage
- Shared care/co-management of patients (for example, high-risk obstetrics rounds, organ transplant rounds)
- General internal medicine visit and consult codes (including complex discharge, follow-up office visit and subsequent hospital visit)
- Care of the elderly
- Long-term care
- End-of-life care

## Related content

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## Continuing Professional Development (CPD) stipends

Physicians practising in Nova Scotia may be eligible to receive stipends in support of their continuing professional development, or CPD – formerly known as continuing medical education, or CME. Eligibility for this payment is based on calendar year (Jan. 1-Dec. 31) billings from the previous year and is determined automatically each year by the Department of Health and Wellness (DHW).

To qualify for the stipend, you must be actively practising in Nova Scotia (have billings during the period of March 1 prior to the payment up to the time of the payment) and meet the other program eligibility criteria outlined below.

### General practitioners – \$2,000 per year

- Eligibility as a general practitioner (GP) is established by license.
- To be eligible for a CME support payment, you must maintain a license and have billings or contract-based funding of \$100,000 or more in the previous year.

### Non-C/AFP specialists – \$4,000 per year

- To be eligible for a CPD support payment, you must be a non-C/AFP specialist, maintain a license and have actual fee-for-service billings of \$150,000 or equivalent payments through a rural specialty

contract in the previous year.

## CME verification

The DHW may randomly withhold annual payments from select physicians pending submission of supporting documentation of CPD activities.

## Contact

### Jessica Moore

Compensation manager, Physician Agreement and Fee Schedule

902-225-1533

1-800-563-3427

[jessica.moore@doctorsns.com](mailto:jessica.moore@doctorsns.com) (mailto:jessica.moore@doctorsns.com)

## Next steps

Master Agreement 2019-2023 ([https://doctorsns.com/sites/default/files/2019-12/MA-Execution-Copy-SIGNED-Dec\\_9\\_2019.pdf](https://doctorsns.com/sites/default/files/2019-12/MA-Execution-Copy-SIGNED-Dec_9_2019.pdf))

## Related content

COVID-19 Roster Agreement (<https://doctorsns.com/sites/default/files/2020-04/COVID-19-roster-agreement.pdf>)

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Master Agreement 2015-2019 (/sites/default/files/2018-08/2016-09-09-Master\_Agreement-Execution\_Copy.pdf)

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Master Agreement 2008-2013 (/sites/default/files/2018-06/Master-Agreement-2008-12.pdf)

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Physicians Services Master Agreement: Program evaluation (Deloitte) (/sites/default/files/2018-06/Physician-Services-Master-Agreement-Program-Evaluation-Deloitte.pdf)

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**TAB 189**

## **Locum Program Guidelines**

Effective July 24<sup>th</sup>, 2023

### **Physician Eligibility**

- Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia and privileged by a health authority.

### **Coverage Guidelines**

- For family physicians and specialists, the locum program will fund coverage for: Scheduled leave of physician for vacation, CME, parental, or unplanned leave due to illness.
- Specialist services covered: general internal medicine, general surgery, orthopedic surgery, anaesthesia, obstetrics/gynecology, psychiatry, pediatrics, radiology, pathology and urology.
- For daily/hourly paid physicians such as (Hospitalists, Emergency Departments, Psychiatry, CHIP, PMC, etc.). These physicians may be able to claim the travel elements of the locum program and not the daily income guarantees.
- A full locum day is defined as providing a minimum of 7.5 hours of clinical coverage, a half locum day is defined as minimum of 3.75 hours of clinical coverage.

The Locum Program is available:

- To provide coverage for vacancies but only if they are actively being recruited for by a health authority.
- For a maximum coverage period of 30 days per fiscal year, per physician.

The Locum Program is not available:

- For providing service coverage at your regular work sites.
- For providing service coverage in a regional hospital where physician groups have an approved facility on-call call rotation of 5 or more physicians.
- To C/AFP Departments, although individual AFP Physicians may be eligible for work outside of the C/AFP Department with their Department Head approval.

## Services to be provided

### Family Physicians

- Family practice coverage (may include inpatient and nursing home if part of FP normal practice).

### Royal College Specialists

- Specialist hospital coverage including on-call.
- Office coverage where indicated, as requested on application form.

## Payment Rates

### Daily Rates

- The minimum daily income guarantee for a locum Physician is:
  - \$1,200 for FP's providing full day coverage; \$600 for half day coverage.
  - \$1,600 for Specialists providing full day coverage; \$800 for half day coverage.

### Shadow Billing Above Daily Rates

- If shadow billings for Insured Medical Services are higher than the applicable minimum daily rate on a given day, including for Insured Medical Services delivered after hours, the locum physician will receive the amount of shadow billings greater than the applicable minimum daily rate.

### Travel

- If required to travel for the locum assignment, travel will be reimbursed as follows:
  - Kilometrage from the Physician's residence or regular work site (whichever is closer to the required non-regular work site) to the required locum work site, and return, at the then-prevailing Nova Scotia Government kilometrage rate (unless NSH has provided a rental car for physician's use).
  - Per diem of \$100 per day for full day coverage; \$50 for half day coverage.
  - Accommodations at 100% to a maximum of \$300 per night, receipts of which must be provided to be eligible for reimbursement.
  - Airfare to and from Nova Scotia, where required, 100% covered at regular economy fare up to a maximum of \$1,500, receipts must be provided for reimbursement.
  - Travel time at \$100 per hour up to a maximum of 10 hours return (5 hours each way) per week.
  - No travel time or expenses are payable for travel that is less than one hour total travel time roundtrip.

## Licensing Fees

- For Atlantic Registry physicians the CPSNS Atlantic Registry license fee is reimbursed.
- For locum physicians outside the Atlantic Registry, the CPSNS locum license fee is reimbursed.

## Facility On Call

- Facility On Call Rotas may be claimed through the applicable Facility On Call fee code. Locum physicians are not entitled to receive payment for any services while on call unless the total daily shadow billings exceed the minimum daily income guarantee.

## Additional Payment

- The host physician is eligible for \$250 per day for the duration of the locum if covering for leaves.

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[Contract and Practice Support \(/contract-and-support\)](/contract-and-support) > [Provincial locum program \(2023\)](#)

## Provincial locum program (2023)

The Physician Agreement funds a provincial locum program, administered by the Department of Health and Wellness through MSI, with specific program guidelines and payment rates for general practitioners and specialists. Specific eligibility criteria and some restrictions apply.

The 2023 contract offers enhancements to the existing locum program to support timely access to locum resources. New investments include a significant increase in rates, better coverage for travel expenses and support for licensing fees. Perhaps most importantly, the locum program will now be available to family physicians working in Zone 4 – Central.

The daily income guarantee for family physicians will increase from \$800/day to \$1,200/day. Rural specialists will see improved locum payments, with a guaranteed daily minimum income of \$1,600/day, up from \$1,200/day.

The contract also includes a commitment to review the following in the coming months:

1. Application of locum program for practices implementing advanced access and parental and other leaves.
2. General review and updating of the program guidelines to align with the above changes, including access to comprehensive medicine incentives.
3. The Physician Agreement Management Group will also explore the benefits and risks of establishing a pool of locum family physicians in the future.



This enhanced program can be accessed only with NSHA support and provides additional funding for hard-to-recruit areas and specialties.

## Program details

Under this program, physicians are contracted to provide locum services for:

- a set period of time
- a minimum payment guarantee
- a per diem payment
- some travel expenses
- office overhead (if applicable)

## Locum applications

Physicians can apply for a locum for:

- a scheduled vacation leave
- CME
- maternity leave
- medical leave
- unplanned leave due to illness

## Eligibility criteria and guidelines

Specific eligibility criteria, guidelines, application forms and claim forms can be found on the MSI Locum Registration webpage (<http://msi.medavie.bluecross.ca/locum-registration/>).

## Travel within Nova Scotia

In the 2023 contract, when a N.S. physician is asked by a health authority to travel to another hospital in the province more than one hour away, the physician will have their expenses reimbursed. See rates in table below.

## Funding rates for Provincial Locum Program

(Effective July 24, 2023)

	GP	Specialist	Psychiatrists
Income guarantee	\$1,200/day	\$1,600/day	District Psychiatry Program hourly rate

### Travel requested by a health authority

Per diem	\$100/day	\$100/day	\$100/day
----------	-----------	-----------	-----------

Accommodations	100% to a maximum of \$300/night	100% to a maximum of \$300/night	100% to a maximum of \$300/night
Airfare	100% at regular economy rate to a maximum of \$1,500	100% at regular economy rate to a maximum of \$1,500	100% at regular economy rate to a maximum of \$1,500
Mileage in N.S.	Provincial government rate		
Travel time	\$100/hour to maximum of 10 hours return (5 hours each way)/week		

In addition to the rates above, the following also apply:

- **Licensing:** College licensing fees will be paid for out-of-province locum physicians. For Atlantic physicians, the cost of the Atlantic registry will be paid; for other out-of-province physicians, the cost of a locum license will be paid.
- **Overhead:** Paid at \$250 per day.
- **Call stipend:** Paid on top of other payments when locum physician is covering call.
- **Minimum income guarantee:** If the locum physician shadow bills above the minimum daily rate, the excess is paid to the locum physician at 100%. (No payment for services delivered after-hours, unless billings exceed the daily guarantee.)

The locum program eligibility has been extended to family physicians in Zone 4 – Central.

Emergency medicine, hospitalists, primary maternity care, and other hourly or sessionally paid physicians are entitled to all aspects of the locum program except the daily income guarantee, as they will be paid based on the hourly or sessional rate applicable to the work.

## Contact

### MSI locum coordinator

Medavie Blue Cross

902-496-7011

Fax: 902-496-3060 or toll-free 1-855-350-3060

locumprogram@medavie.ca (mailto:locumprogram@medavie.ca)

## Next steps

Physician Agreement 2023-2027 ([https://doctorsns.com/sites/default/files/2023-2027\\_PhysicianAgreement.pdf](https://doctorsns.com/sites/default/files/2023-2027_PhysicianAgreement.pdf))

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### Physician Agreement

-

#### Physician Agreement programs and funding (2023)

-

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## Electronic medical record grants (2023)

Financial assistance for physicians who set up and maintain an electronic medical record (EMR) in their practices is part of the existing Master Agreement between Doctors Nova Scotia and the Department of Health and Wellness.

Funding incentives make it possible for Doctors Nova Scotia members to move to an EMR system while minimizing out-of-pocket expenses and providing resources for a smooth transition from paper records. Under the terms of the 2019 Master Agreement contract, the EMR participation and utilization grants (Envelopes B and C) are still slated to convert to fees. The program remains unchanged until new fees are established, except for family physicians who convert to the new longitudinal family medicine (LFM) payment model.

Under the terms of the 2023 Physician Agreement, EMR grants B and C are included in the base salary of family physicians under the new LFM payment model.

### EMR grants

There are three grants are available.

#### **One-time EMR investment grant (A) – \$10,000**

This one-time grant is to assist physicians in the adoption of an EMR system and will be paid upon implementation.



**Annual EMR participation grant (B) – \$2,000**

This grant will help offset the investments of time and effort by you and your staff in educational and peer-support activities. If you implement an EMR or sign a license agreement with one of the two recommended EMR vendors on or before March 31, and implement prior to Sept. 30, you will be eligible for this grant. As well, you will continue to receive it in any year in which you have invested at least four hours in EMR participation events and activities, up to March 31 (a self-assessment is required). The grant is available as long as you continue to use the EMR through education or participation in an EMR group.

**Annual EMR utilization grant (C) – Varied amount based on usage**

This grant is to encourage and reward you financially for the extent of your efforts in the use of the EMR in your practice. The funding available depends on the usage of the EMR system and the pool of funding available.

To receive this grant, you must complete a self-assessment application; your individual score is compared to the rest of the applicants' scores. To be eligible, you must have implemented an EMR by March 31, and have billed (or shadow billed) a minimum of \$30,000 in MSI billings within an EMR in the 12 months up to March 31.

**More information and a link to the EMR grants application (when active), can be found here (<https://doctorsns.com/contract-and-support/electronic-medical-records/funding>).**

## Next steps

Find out more about EMRs (<https://doctorsns.com/contract-and-support/electronic-medical-records>)

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> [Preceptor support](#)

## Preceptor support

The 2023 contract includes increased remuneration for physicians prepared to serve as preceptors and assessors for the physicians of tomorrow.

Family physicians (including those who work as hospitalists, within a Primary Maternity Care service, within hourly and sessional arrangements and emergency departments), regional and community specialists who serve as preceptors or assessors will earn an annual retainer of \$5,000, plus a 5% premium on fee-for-service billings. In addition, the current daily teaching stipends (\$90 per day) may be billed when working with a learner. Here are the details:

- \$5,000 in annual funding, now payable to Dalhousie-approved preceptors (logistics and timing of this payment are still being sorted out).
- Note that the 5% on billings when working with a learner does not take effect until Sept. 15, 2023.
- Physicians working in the fee-for-service academic departments and divisions are now eligible to bill the \$90/day stipends as outlined in the March 19, 2021, MSI bulletin (page 5) (<https://msi.medavie.bluecross.ca/wp-content/uploads/sites/3/2021/04/MSI-Physicians-Bulletin-March-19-2021.pdf>)

System partners have committed to work with DNS in fall 2023 to review those stipend values.

## Related content

Add Start and End Times to Visit Records in Your EMR

([https://doctorsns.com/sites/default/files/2023-08/next-steps/EMRs\\_adding-time-stamps.pdf](https://doctorsns.com/sites/default/files/2023-08/next-steps/EMRs_adding-time-stamps.pdf))

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**TAB 193**

# President's Letter

April 14, 2023



Kris Luscombe  
MD, FRCPC

## Blended Capitation Advisory Service

Dear Colleagues:

The NLMA is pleased to announce the launch of a Blended Capitation Advisory Service to support physicians who wish to explore what moving to the [Blended Capitation Model](#) means for their individual practices.

The NLMA and provincial government have reached an agreement on a new Blended Capitation payment model for family physicians. Blended Capitation is a voluntary, alternate payment model designed for independent community family practice. The model blends a capitation payment per each rostered patient with a partial fee-for-service payment for direct patient encounters. The new model supports comprehensive family medicine, improved access for patients, team-based care, and improved recruitment and retention of physicians who want to practise under this model. For more information, please visit [the NLMA webpage](#).

We have contracted a consultant with whom you can book a meeting to explore how you can use your EMR data to define your panel of patients, and to predict your future income. This information can help inform your decision on whether to move to Blended Capitation.

The advisory service will also bring in support from a peer group of physicians who have been involved in the project over the past year, and who can share their perspectives on the benefits and realities of blended capitation.

The first block of appointments is available now, please visit our [booking webpage](#) for meeting times.

More appointment availability will be added in the coming weeks as we gauge demand. If there is no current availability for an appointment, we invite you to express your interest by emailing [nlma@nlma.nl.ca](mailto:nlma@nlma.nl.ca).

Sincerely,



Kris Luscombe  
President



Newfoundland &  
Labrador Medical  
Association  
164 MacDonald Dr.  
St. John's, NL  
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[president@nlma.nl.ca](mailto:president@nlma.nl.ca)

**TAB 194**



Blended Capitation

# Blended Capitation

The [Family Practice Renewal Program \(FPRP\)](#) is responsible for administration of the Blended Capitation Program, including project management, physician engagement, enrolling physician practices, entering into agreements with physician practices, and practice improvement initiatives to support successful practices. For more information about the Blended Capitation Program, including how to submit an expression of interest, advisory services and answers to frequently asked questions, please click [here](#).

The Memorandum of Agreement (MOA) signed on May 3, 2022, included a commitment from the NLMA and the provincial government to establish Blended Capitation as a new payment schedule of the MOA. The final agreement was arrived at with the assistance of a mediator and officially released on April 3, 2023.

with a partial fee-for-service payment for direct patient encounters based on 25% of the MCP Fee Schedule rate. All codes that are “Out of Basket Services” are billed at 100% of the MCP rate. There is no negation if a rostered patient receives care elsewhere. If a physician sees a non-rostered patient, they will receive 100% for “[In Basket Services](#)” up to \$56,000 per year, and 100% for all “Out of Basket Services”.

The new model represents a 21.8% increase in clinical compensation based on average family physician MCP billing rates, on top of the 13.3% increase last year. Those who choose to enroll in the new payment model will also receive income guarantees to facilitate the transition. This includes a guaranteed income floor in the first two years based on an individual's previous two-representative years billing average, plus a 10.9% premium payment applied in the first year. In addition, physicians will receive a one-time Transition Grant of \$11,250 and a one-time Start-up Grant of \$10,000 in recognition of start-up costs. Physicians who choose to enroll in the Blended Capitation Model can also qualify for an annual \$7,500 Quality of Care Bonus and an annual Procedures Bonus of \$2,500 for physicians who bill more than \$1,200 in procedures annually. The Capitation Rate has also been boosted in value to help pay for two-weeks of locum coverage. If a physician does not use locums in a year, the locum funding stays with the physician. Monthly EMR subscription costs will be paid by the provincial government. Physicians who agree to join the Blended Capitation Model will group together (minimum of three) to provide after-hours care and act as a team in the provision of care.

The agreement is appended as *Schedule R of the Memorandum of Agreement (MOA)* and is available in its entirety [here](#).



NEWFOUNDLAND AND LABRADOR  
MEDICAL ASSOCIATIONA CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA  
UNE SECTION DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

# BLENDED CAPITATION MODEL

## WHAT IS BLENDED CAPITATION?

- Voluntary alternate payment model
- Designed for independent community family practice

### HOW DOES IT WORK?

Each physician decides how many patients will be in their practice and rosters them (patients agree to belong). The physician receives an annual payment to provide comprehensive primary care to each patient, regardless of the number of patient encounters. When a patient is seen by the physician, a percentage of the appropriate FFS code is also paid to the physician.

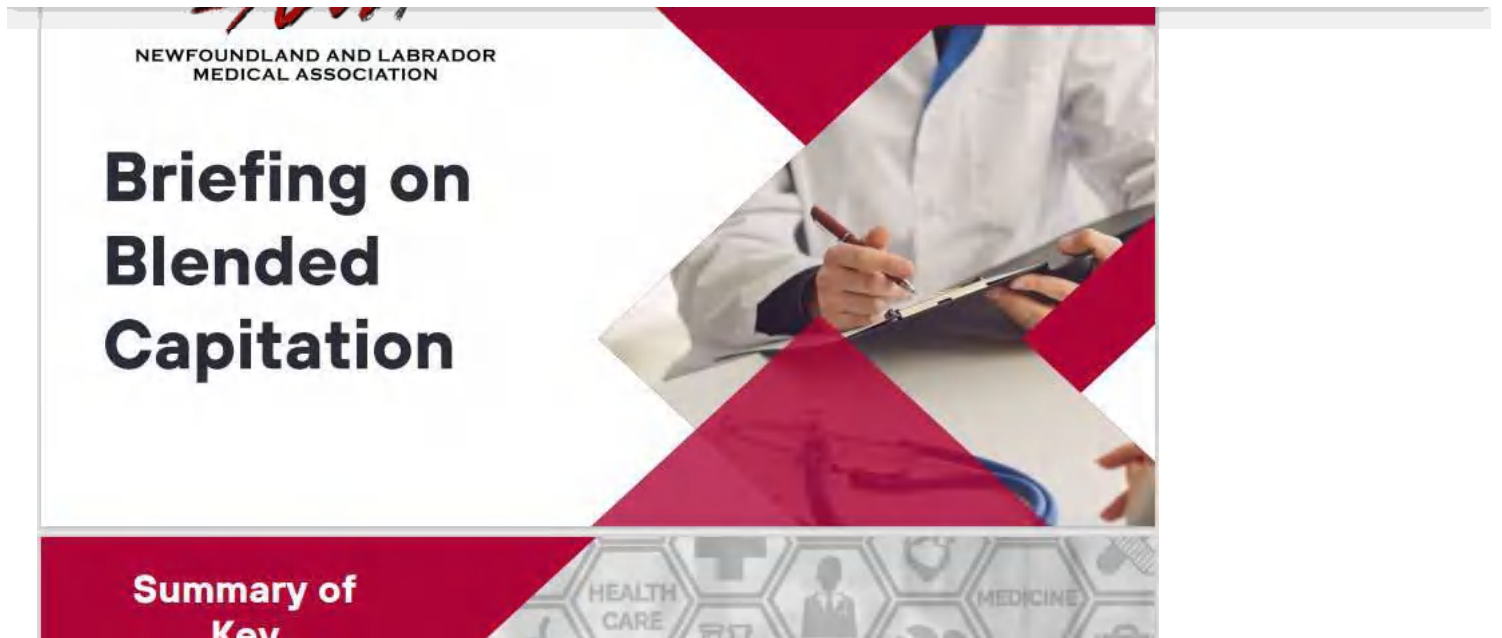
### COMPONENTS:

1. Bi-weekly Capitation Payment
2. Fee for service Payment: 25%

[2023.06.02 NLMA CFPC Blended Cap Document](#)

DOWNLOAD

## Member Consultations Presentation



[2023.03.09-Briefing-on-Blended-Cap-Reduced\\_FINAL](#)

DOWNLOAD

## Member Consultations Video



## Previous President's Letters

- [April 14, 2023 – Blended Capitation Advisory Service](#)
- [April 3, 2023 – New Blended Capitation Agreement finalized](#)
- [March 22, 2023 – Consultations on tentative Blended Capitation Payment Model](#)
- [February 3, 2022 – NLMA Members Ratify New Agreement](#)

## Recent News

April 19, 2024

**EOI for EMR Clinical Advisory Committee**

**Nominations Deadline April 22 - NLMA Board Election**

[Continue Reading](#)

**[View All News →](#)**

**Upcoming Events**

May 10, 2024

**Thriving in Practice: Re-imagining Your Relationship with Medicine with Dr. Rebecca King**

[Continue Reading](#)

May 16, 2024

**CME: Advancing Migraine Management**

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Physician Wellness

- Physician & Family Assistance Program
- MD Link
- Peer Support Network
- Physician Care Network
- NLMA Research
- Contacts
- Self-Help Resources

Digital Health

- Virtual Care
- EMR
- eConsult
- Other Digital Initiatives

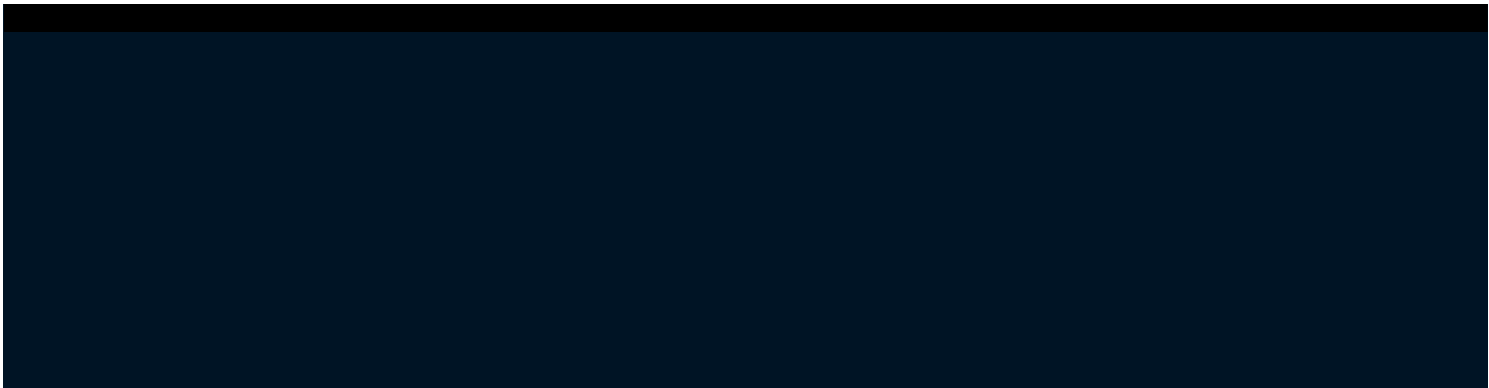
About

- Who We Are
- Governance
- President
- Corporate Services

Contact

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Building Hours: 9:00 a.m. -  
4:00 p.m. | Monday - Friday  
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St. John's, NL A1A 4B3  
  
(709) 726-7424  
  
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**TAB 195**



NEWFOUNDLAND AND LABRADOR  
MEDICAL ASSOCIATION

March 2023

# Briefing on Blended Capitation



# Summary of Key Components

<b>a.</b>	Blended Capitation Model (BCM) established in MOA (80/20)
<b>b.</b>	21.8% increase in clinical compensation for in-basket services
<b>c.</b>	One-time Signing Bonuses
<b>d.</b>	Income to pay two-weeks of locum coverage
<b>e.</b>	Annual bonuses for quality of care and volume of procedures
<b>f.</b>	EMR to be paid by Government



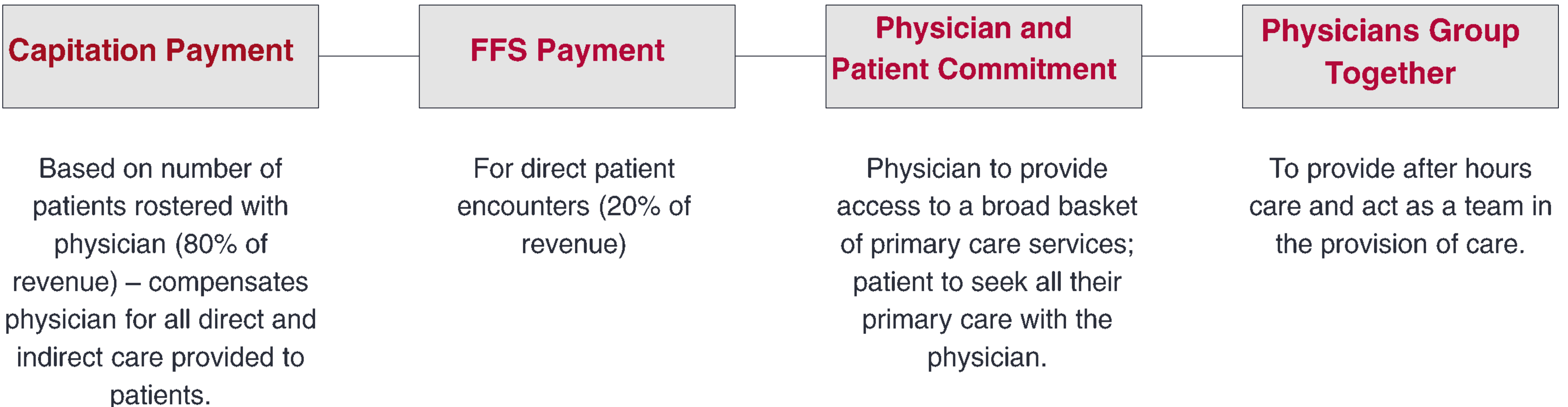
# Summary of Key Components

<b>g.</b>	Two-year income guarantee while transitioning to new model, plus 10.9% premium in the first year
<b>h.</b>	No negation
<b>i.</b>	Revenue for practices who wish to hire/contract with NPs or RNs
<b>j.</b>	Family Practice Renewal Program is main implementation arm
<b>k.</b>	Maintain practice autonomy

# What is Blended Capitation?

- Alternate payment model
- Designed for independent community practice

## Components:



# Rostering

Physicians will roster their patients through the EMR

---

Each patient in the province can only be attached to one physician

---

Patients de-rostered when entering LTC (Nursing Homes)

---

New billing system will extract roster size from the EMR





# Maximum Roster Size

Mediator's recommendation – 2400 patients
Consistent with Ontario
Less than 10 physicians exceed this level





# Capitation Rate

\$180.97 per rostered patient (adjusted by complexity modifier)

Rate is derived from:

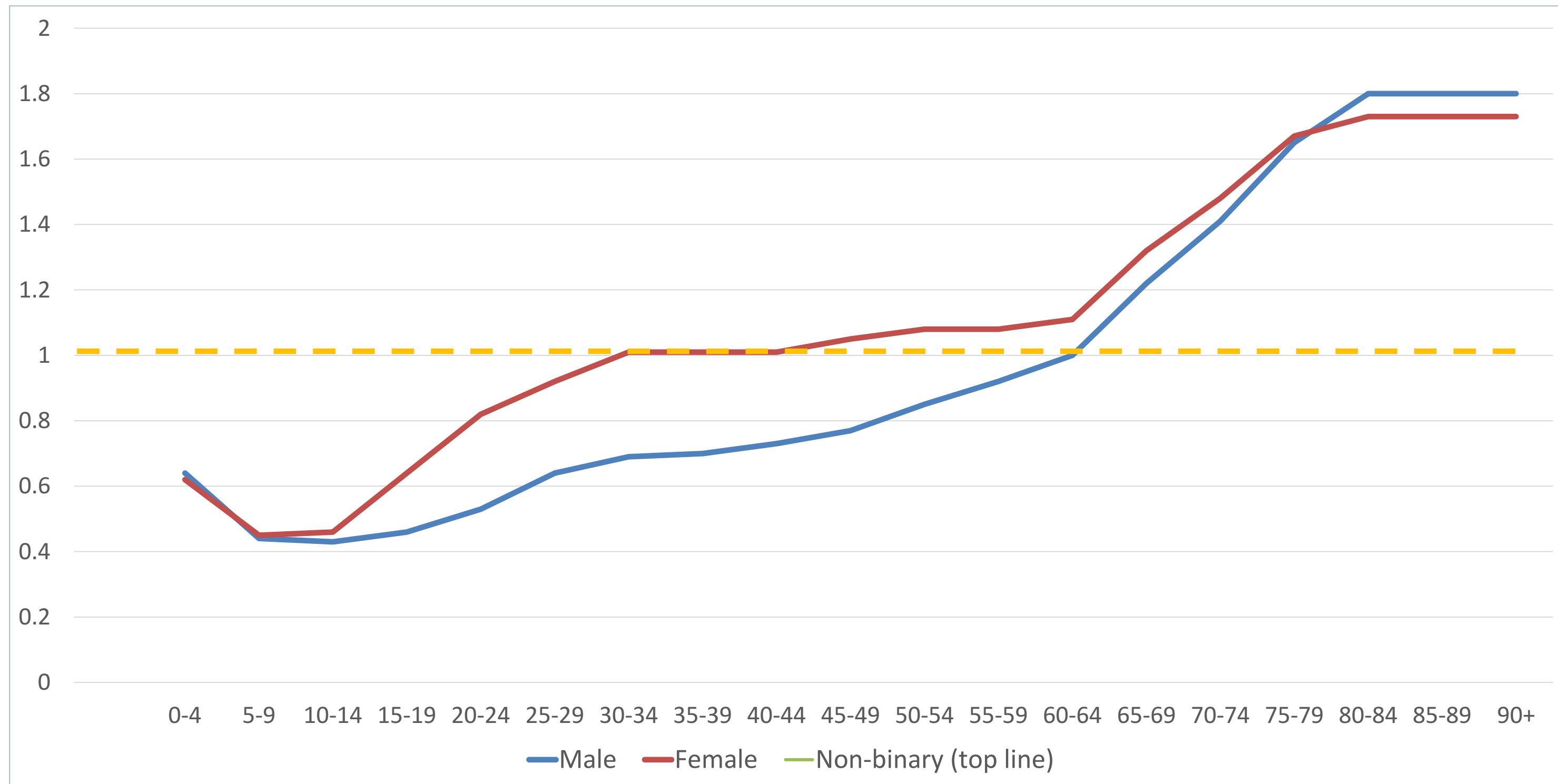
- 80% of the 3 year average earnings, of the average physician, for in-basket services
- Plus MOA increase – 13.31%
- Plus value of 2 weeks of locum support
- Plus Mediator's recommendation – 21% increase

In-basket Services

- 62 codes (does not include home visits/personal care homes; flu/covid shots; Methadone/Suboxone monthly monitoring)
- A new “procedures” bonus adds \$2500 for physicians who bill more than \$1200 annually

No negation if your patient seeks services elsewhere

# Complexity Modifier (Age/Gender)





# FFS Billing

	Rostered Patients	Non-Rostered Patients
In Basket-Services	25%	100% up to \$56k
Out of Basket Services	100%	100%

NOTE: All compensation provided by RHAs, non-insured patients, WorkplaceNL, private insurance, etc. is outside the BCM

# Bonus and Grants

## **Annual \$7500 Quality of Care Bonus**

In recognition of the physician's participation in FPRP or practice-initiated quality programs, practice improvement and related professional development. Policy to be developed by FPRC.

---

## **One-time \$10,000 Start-Up Grant**

- In recognition of start-up costs... such as renovations, technology, training, and legal services.
  - Payable from FPRP Surplus
- 

## **One-time \$11,250 Transition Grant**

- Upon acceptance into the BCM
- Payable from Government







# Locum Revenue

Capitation Rate has been boosted by value of two weeks capitation revenue

Designed to provide revenue to hire locums

Blended capitation groups will pay locums from the capitation revenue and the FFS MCP claims

If a doctor does not use locums in a year, the revenue stays with the doctor

# Income Floor

Once accepted into the program, there is a two-year Income Floor, plus a 10.9% premium in the first year

Floor is calculated as average of two recent representative years of the physician

New billing system will be available near end of 2023...  
...but doctors should start rostering and changing practice style from the outset

The Income Floor ensures that incomes will not suffer if doctors allocate time to practice improvement, rostering, meetings, etc. to get ready for the new system

Reconciliation will be done twice yearly



# EMR

Provincial EMR subscription costs will be paid by GNL

Mediator's recommendation was that all BCM physicians use the provincial EMR

Practices using alternate EMR will receive \$30,000 to transition to the provincial EMR

GNL position was based on security and functionality



# Future Annual Income of a Physician

Source	Comment
Capitation Revenue	\$180.97 per patient (as modified)
FFS In-basket	25% of FFS
Out of Basket and Non-Rostered	100% of FFS
Quality of Care Bonus	\$7500
Procedures Bonus	\$2500
MOA Bonuses (e.g., Retention; OBS)	As per MOA
EMR In-kind	\$2400
RHA-based Work (e.g., ER, Hospitalist, Surgical Assist, sessional work, on-call payments)	Varies by physician
Private (e.g., non-insured services; Workplace NL; private insurance; etc.)	Varies by physician





# Other Providers

## NPs and RNs

a. Revenue from Capitation Rate (no FFS)

b. Maximum Additional Roster

- NP – 900 patients
- RN – 600 patients

c. Attached to physicians for billing purposes, but NPs can carry out MRP roles

d. Flexibility within practice to design team roles

# Obligations

## General

- Minimum Group Size – 3 physicians
- Rostering Agreement – commitment to patient
- Access – to encourage continuous improvement and/or maintenance of accessibility
- EMR – to adopt province EMR
- Data Sharing -data accessible to NLCHI for purposes of this Schedule

## Performance Indicators

- Access Only
  - % of same day or next day appts for attached patients
  - After hours access provided to attached patients
  - Proportion of total visits by attached patients to their Blended Cap physician group
- Monitoring and oversight

Visits Per week – aspirational goal

# Access and After-hours Care

- ▶ Use best practice for scheduling (same day/next day)
- ▶ Coordinate within group to ensure primary care during daytime hours
- ▶ Minimum afterhours expectations (outside 9-5, M-F)
  - 2.2 hours per 100 patients, per Group, per 3-month period
  - Approximately 6 hours every 3 weeks for a full-time doctor
  - Minimum of 3 hours per week per group

## Examples:

Number of Attached Patients	Hours per Quarter	<u>Average</u> Hours per week	<u>Minimum</u> Hours per week
3600	79	6.1	3
4000	88	6.8	3
6000	132	10.1	3
7200	158	12.2	3



# Governance & Administration



**a.**

Department administers payment system

**b.**

FPRP governs and administers BCM Program

**c.**

Dispute Resolution

- Consensus model of Decision-making
- Dispute resolution on “termination from model” may go to Minister
- NLMA can send Minister’s decision to arbitration

**d.**

Administration and Bonuses funded over 5 years from:

- FPRP Surplus
- \$2m from GNL
- Annual FPRP surplus (\$2.7m)
- Negotiate funding levels in MOA for after 5 years.



# Schedule



**April 3, 2023**

Open for applications

**Sept. 1, 2023**

Start to issue notices of acceptance; thereafter 3 month processing time

**April 1, 2024**

Billing system ready for testing – 75 physicians

**July 1, 2024**

Billing system open to all

# Change Management

## NLMA advisory service

- Meetings with individual practices
- Calculation of possible future incomes
- Answer questions

## NLMA Website

- All documents, plus FAQs

## FPRP Program Support

- To be designed and managed by FPRP
- Goal – successful transition and practice optimization

**TAB 196**



## Transitional Payment Model (TPM) Information

The Transitional Payment Model (TPM) is a new payment model for eligible Saskatchewan family physicians that combines the existing fee-for-service (FFS) structure with a new capitation payment (based on patient contacts and panel size).

TPM recognizes and supports the delivery of longitudinal community-based family medicine by:

- promoting longitudinal care within family medicine.
- acknowledging patient complexity and the additional time required to provide care; and
- increasing patient access to primary care.

The new model is a transitional step between the current fee-for-service model and the future goal of establishing a blended capitation model as recommended by the Primary Care Compensation Working Group (PCCWG), a collaborative working group formed between the Saskatchewan Medical Association (SMA), Saskatchewan Health Authority (SHA) and the Ministry of Health (MoH).

**TPM is available to physicians as of April 1, 2024.**

1. [Eligibility](#)
2. [Registration](#)
3. [Payments](#)
4. [Accountabilities and Deliverables](#)
5. [Frequently Asked Questions](#)

---

### Contact Us

TPM Program Support Services

[tpm@health.gov.sk.ca](mailto:tpm@health.gov.sk.ca)

[Register Now](#)

## 1. Eligibility

To be eligible for the program, fee-for-service family physicians must:

- Be licensed to practice and currently reside in Saskatchewan.
  - Provide longitudinal family medicine as the majority of their practice in a Saskatchewan community.
  - Hold SHA appointment/privileges.
  - Commit to being the “Most Responsible Provider” (MRP) to a panel of patients and document patient understanding of the relationship.
  - Commit to providing chronic disease management including submitting CDM-QIP flow sheets.
  - Provide comprehensive care and on-call services.
  - Participate as part of a group (a clinic group or multiple clinic groups for solo physicians) to ensure adequate service and call coverage; and
  - Assign a family physician as the physician group lead.
- 

## 2. Registration

Registration is open on April 19, 2024, and there is no deadline to apply. To qualify for payment for any given quarter you must register within 60 days from the start of each quarter (i.e., May 30 for Q1 or July 30 for Q2).

**Register Now**



---

## 3. Payments

Eligible physicians will receive a payment of up to \$144,000 based on the following formula:

$$\text{Capitation Payment} = \$144K * \frac{(\text{Patient Contact Ratio} + \text{Patient Panel Ratio})}{2}$$

## Patient Contact Ratio

A patient contact represents each time a physician provides primary care (in-person or via virtual care) to a patient. The visit is considered one contact based on date regardless of the number of services provided during the visit (contact count is limited to one contact per patient per day).

Physician billing data is used to determine the number of patient contacts. The contact ratio is calculated using a threshold of 6,500 contacts.

$$\text{Patient Contact Ratio} = \frac{\# \text{ Contacts}}{\text{Contacts Threshold (6,500)}}$$

## Patient Panel Ratio

A patient panel is a group of patients assigned to one specific physician.

Patient panel size is calculated using a four-cut methodology that matches patients to one physician. The four-cut matching methodology uses a three-year data analysis period to match Saskatchewan patients to a Family Physician or Nurse Practitioner where most of their primary care services were billed to the Medical Services Branch (MSB).

The Patient Panel Ratio is calculated using a threshold panel size of 1,600.

$$\text{Patient Panel Ratio} = \frac{\# \text{ Matched Patients}}{\text{Panel Size Threshold (1,600)}}$$

**NOTE:** An individual physician must have a minimum of 250 patients matched to be eligible for the program.

**NOTE:** Although the calculations of the ratios use thresholds (6,500 contacts and 1,600 patients), there is no limit on the number of contacts or matched patients a physician may have.

## Establishing A Patient Panel

Family physicians are expected to engage in a conversation with their patients about physician-patient empanelment and what a "Most Responsible Physician" (MRP) relationship between physician and patient entails. An empanelment process will be developed by Ministry of Health and the Saskatchewan Medical Association.

- The empanelment process represents a physician's commitment to delivering patient-centred care by communicating and collaborating with patients regarding the management of their condition(s) and care plan(s) on an on-going basis.
- The empanelment process means the patient commits to seeking all their primary care from that physician, or that physician's colleague(s) whenever possible.

Physicians will be required to maintain an up-to-date list of empaneled patients as well as to retain copies of all physician-patient documentation. The empaneled patient list will inform the next phases of the Saskatchewan made blended capitation model.

**NOTE: For the purposes of calculating TPM payments, the four-cut methodology described in the payment section is used to determine patient panel size, not the number of patients the physician empanels through an established empanelment process.**

---

## 4. Accountabilities and Deliverables

Physicians participating in TPM are expected to provide the following four deliverables:

1. Establish a longitudinal relationship with patients, by providing ongoing community-based family medicine services to a dedicated patient panel, which includes screening, prevention activities, chronic disease management, and comprehensive care.

- When the empanelment process is developed, physicians will be expected to document patient understanding and consent to the Most Responsible Physician (MRP) relationship with each empaneled patient.
- Physicians are expected to adhere to best practices in Chronic Disease Management.
- Physicians are expected to provide comprehensive care to their empaneled patients shared by a TPM clinic/group, including hospital and supportive care, nursing home care, pre- and post-natal and infant care, complete physicals including PAP smears, and phone calls from Allied Health Care Providers (AHCP), where applicable.
- Physicians are expected to adhere to a set of Primary Care Quality Indicators once jointly developed by the SMA and Ministry.

- Physicians are expected to adhere to common work standards for EMR/eHR patient- centered information exchange.

## 2. Commitment to transition towards the Patient's Medical Home (PMH) framework:

- Physicians are expected to be part of a group with more than one Most Responsible Physician (MRP) participating in TPM.
- For solo clinics, joining a group of physicians (minimum of two family physicians) in the same community or catchment area is encouraged, with all physicians willing to share patient information for coverage and comprehensive care.
- Appointment of at least one family physician lead from the clinic or group to be a point of contact, attend learning events, and liaison with SHA. This role is paid.
- Providing on-call coverage for the group's patients.

## 3. Commitment to address multiple relevant patient issues/concerns during one visit.

## 4. Commitment to any necessary data tracking, sharing, and reporting that demonstrates improvements to primary care delivery and patient outcomes as jointly developed by the SMA and Ministry.

Further details on each deliverable are [available](#).

## Related Items

[Detailed Transitional Payment Model \(TPM\) Deliverables](#)



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## 5. Frequently Asked Questions

### 1. Enrolment and Changes to Enrolment

#### Who can enrol in TPM?

Licensed fee-for-service physicians providing longitudinal community-based family medicine in Saskatchewan.

#### How do I enrol in TPM?



Eligible physicians [must register to participate in TPM](#).

## How do I make changes, updates or withdraw from TPM registration?

Changes to your registration can be made by sending an email to: [tpm@health.gov.sk.ca](mailto:tpm@health.gov.sk.ca).

## Is TPM mandatory? If I join, can I leave it?

The TPM is voluntary. Family physicians are free to join or withdraw from the program. If you wish to withdraw from the program, please send an email detailing the following information to [tpm@health.gov.sk.ca](mailto:tpm@health.gov.sk.ca):

- Physician Number
- Physician Name
- Date of Withdrawal

Please note that payment will not occur if your request for withdrawal takes place within the first quarter of the program.

## 2. Patient Contact

### What type of primary care services count towards patient contacts?

Services associated with the delivery of longitudinal community-based family medicine count as patient contacts including GP visit services, prenatal and infant services, some minor procedures (e.g., suturing, other minor treatments not billed with a visit code), and some in-office diagnostics (e.g., ECG, spirometry).

### If I see the same patient more than once in a day, does it count as more than one contact?

No, contacts counts are limited to one per day per patient.

## 3. Patient Panel

### Where can I get my Health Quality Council (HQC) patient panel report?

Your panel report is available at [Physicians Practice Report](#).

### Why does my panel noted in the HQC patient panel report differ from the panel used to determine my TPM payment?

The panel methodology used to determine the TPM payment includes Nurse Practitioners and excludes clinics that do not primarily practice longitudinal family medicine. Information specific to payment drivers, deliverables and clinic activities will be available through your TPM report (currently in development).

### How often is my patient panel calculated?

Patient panels are calculated semi-annually in April and October of each year.

### Is there a limit on the number of empaneled patients a physician may have?

There is no limit on the number of empaneled patients a physician may have; however, to be eligible for TPM, a physician must have a minimum panel size of 250.

### How will panel sizes be determined for family physicians new to practice and/or new to Saskatchewan?

As an incentive for new family physicians choosing to practice in Saskatchewan, the below panel sizes will be used to inform payment for family physicians in the first two years of practice.

Range of Contacts	Year 1	Year 2
0-749	0	0
750-1999	640	715
2000-2999	745	830
3000-3999	850	950
4000-4999	980	1095
5000+	1065	1190

The panel size used is directly correlated with the physician's activity level (as measured by patient contacts).

## 4. Payment

## **When will I receive my first payment?**

TPM payment calculations occur quarterly; payments will be provided to participating physicians within 30 days of the end of the quarter.

## **How often will payments occur?**

Payments will occur quarterly beginning in July 2024.

## **Is there a maximum amount paid in each quarter?**

The maximum annual payment a family physician can receive through TPM is \$144,000 per fiscal year. To support the administrative process and provide timely payments to physicians, the maximum annual eligible amount will be divided into four quarters (\$36K each quarter).

To account for fluctuations in the volume of services between quarters and to ensure all billing services are included, a reconciliation process will occur six months after the end of each fiscal year. An additional payment not to exceed \$144,000 may result from the reconciliation process.

## **Will the TPM calculation include patient complexity modifiers?**

Patient complexity modifiers are not used to calculate payments in the current methodology. However, the Ministry and SMA intend to jointly review and develop patient complexity modifiers for future payment calculations.

## **5. Patient Matching**

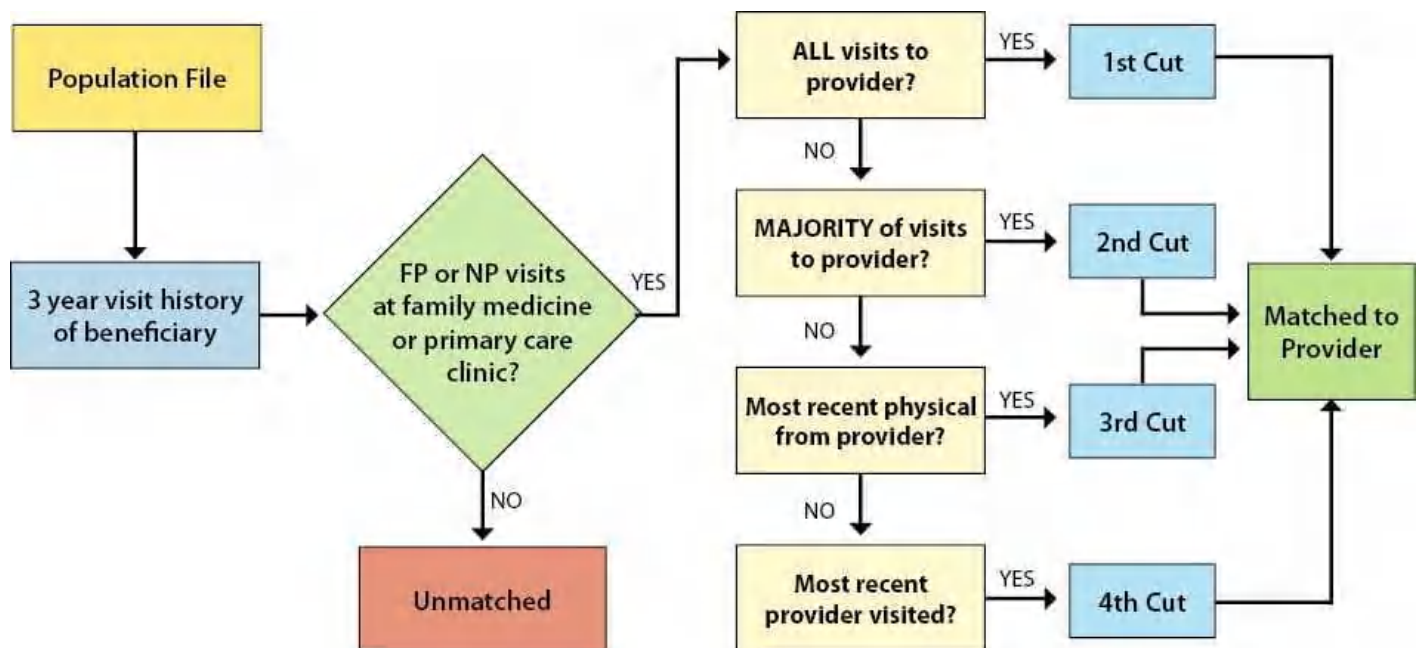
### **How are Saskatchewan residents matched to a family physician using a four-cut method?**

Residents are matched to one provider using a four-cut method:

- Cut 1: Saw only you. If an individual only saw you during the three years, they are matched to you. Otherwise, go to cut 2.
- Cut 2: Saw you the majority of the time. If an individual saw you and other providers, but visited you the majority of the time, they are matched to you. Otherwise, go to cut 3.
- Cut 3: Had their last physical examination with you. If an individual saw you and other providers the same number of times, they are matched to you if you did the last physical exam (fee codes: 3B, 4B, 52B, 64B). Otherwise, go to cut 4.

- Cut 4: Saw you last. If an individual saw you and other providers the same number of times and has not had a physical, they are matched to you if they saw you last.

**Note: Providers in the four-cut method include family physicians and nurse practitioners. Patients who match to an NP will not be matched to a FP.**



### What are the other inclusion and exclusion criteria for the patient matching?

Every Saskatchewan beneficiary with a billed service to an in-province Family Physician or a Nurse Practitioner (NP) practicing at a Family Medicine or Primary Health Clinic (PHC) is matched to one provider. Patients matched to providers are added to create the total panel size.

#### Inclusion Criteria

- Patients are matched to a provider working at a clinic that was determined to offer full-service primary care services by an FP or NP.
- A full-service family medicine or primary care clinic is defined as a clinic that offers routine care, care for urgent but minor or common health problems, minor mental health care, maternity and childcare, liaison with home care, health promotion and disease prevention, nutrition counselling and end-of-life care.
- Patients are defined as Saskatchewan beneficiaries for which a billable service was submitted to MS by a Family Physician (FP) or Nurse Practitioner (NP) at a primary care clinic during the three-year analysis period.

## 6. Other

## **I currently receive CDM-QIP and FPCCP payments. Will these payments continue?**

Physicians enrolled in the TPM will no longer receive payments for FPCCP, Metro On-Call, and the CDM-QIP payment (specifically, the \$75 payment for all indicators met per patient and per chronic condition in a 12-month period flow sheet). Fee for services payments for these services will continue.

## **Why do I have to consent to share my data?**

Participation in TPM requires that a physician commits to necessary data tracking, sharing and reporting that demonstrates improvements to longitudinal community-based family medicine delivery and patient outcomes as jointly developed by the MoH and the SMA.

**Download FAQs**

We need your feedback to improve saskatchewan.ca. [Help us improve](#)

**TAB 197**

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# \$100 million in stabilization family and rural generalist care

December 21, 2023



Dear Members,

This afternoon I joined Minister of Health Adriana LaGrange and Premier Danielle Smith at a news conference to announce that government will **apply \$100 million to immediate stabilization** of family and rural generalist physician practices.

After months of ceaseless, intense advocacy, this is great news and a critical first of three steps that the **AMA's Strike Team** has called for in 2024, including a **new payment model option**:

1. **Stabilize:** \$100 million paid in early 2024 for up front stabilization of family and rural generalist practices that are failing. Government also commits to an additional \$100 million installment of stabilization funding to be paid in early 2025. This is an unprecedented \$200 million solely to stabilize family physician and rural generalist practices, while the following steps are achieved.
2. **Transition:** Payments to physicians so they can afford to remain in comprehensive care until the new payment model is established.
3. **Transform:** Implement the Physician Comprehensive Care Model – an option away from fee-for-service that recognizes the special demands of comprehensive, cradle-to-grave care. It includes payment for:
  - visits and related activity
  - hours worked
  - responsibility for managing a panel of patients

I thank the minister and premier for honouring the commitment to prioritize immediate stabilization of family and rural generalist practices with this significant down payment. The minister has also promised to consider the other steps that need to be taken in the context of Budget 2024.

This is a momentous achievement, reached with your support. We all hope this is the beginning of the road back from the edge of disaster.

For today, I take the opportunity to wish you the best of what this time of year has to offer, including time and celebration with family and friends. You have all given so much, alongside with your health care team colleagues. If you have not seen it yet, please view the **special holiday greeting** that I signed with the leaders of Alberta's health associations and unions to honour your contributions and those of all health care workers in Alberta.

Regards,

Paul Parks  
President, Alberta Medical Association

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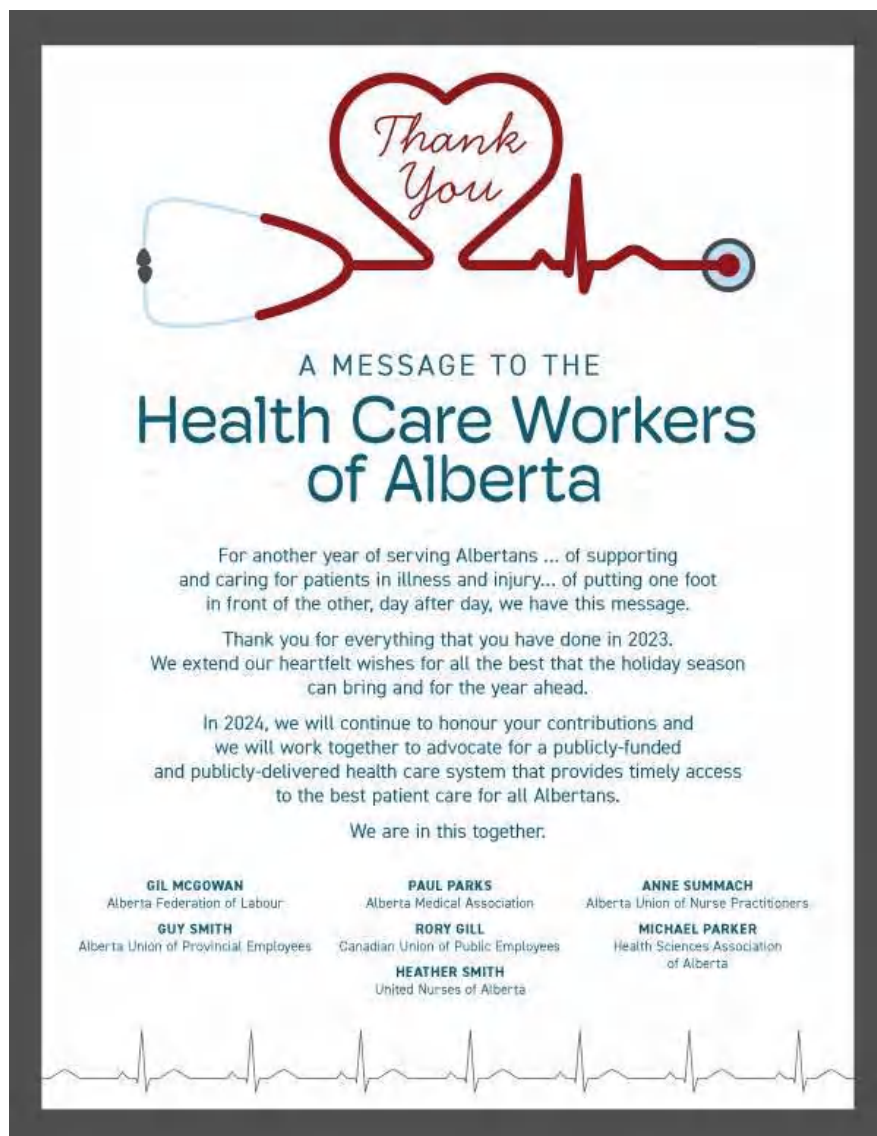
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**TAB 198**

Panel Management Support Program

April 5, 2024

The Panel Management Support Program (PMSP) is a temporary program, funded by Alberta Health, which provides eligible physicians financial support for costs related to panel management and practice improvement activities. This funding was announced in October 2023 when the [Modernizing Alberta's Primary Health Care System \(MAPS\)](#) final panel reports were released.

In the recommendations coming out of the MAPS final reports, the government laid out immediate actions to address urgent issues in primary care and to provide Albertans more access to family physicians. Part of these actions included financial incentives for physicians participating in panel management:

*"...allocating \$57 million over 3 years to provide family doctors and nurse practitioners with support to help manage costs related to their increasing number of patients. Each provider has the potential to receive up to \$10,000 annually"*

The PMSP provides family physicians and rural generalists with financial support to help manage the costs related to caring for an increasing number of patients. Funding through the PMSP is intended to be an immediate action to address urgent issues in primary care.

Panel management and practice improvement activities support the Patient's Medical Home and strengthens continuity of care for Albertans. Alberta Health requires that PMSP funds be used to fund staff, technology and/or other practice resources in order to reduce the time, cost and effort spent on administrative tasks involved in providing comprehensive, longitudinal primary care.

Quick links:

- [Eligibility requirements](#)
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Eligibility Requirements

Eligible primary care physicians can now begin receiving funding in quarterly installments. The PMSP is anticipated to provide ongoing funding until March 31, 2026.

Eligible family physicians and rural generalists who meet the following requirements are eligible to receive funding through the PMSP:

- Must be entitled to receive payment of benefits under the Alberta Health Care Insurance Plan AHCIP.
- Must be a general practitioner, family practitioner, or family medicine specialist practicing in a community-based primary care clinic. This includes physicians practicing at Primary Care Network clinics and Alberta Health Services-operated family medicine clinics.
- Must be registered and in good standing with the College of Physicians and Surgeons of Alberta (CPSA).

Payment conditions and amounts

Alberta Health sets out the conditions for payment and requires family physicians and rural generalists to sign a declaration in order to receive payment. The declaration is an agreement that PMSP funding will be used to support panel management and practice improvement activities.

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Eligible costs must have been incurred when the physician was eligible for the PMSP.

Primary care physicians will be allocated funding based on panel size. Family physicians and rural generalists with a minimum panel size of 500 will receive funding as follows:

Location	Panel Size	Funding/Year	Funding/Quarter
Urban	500 - 899	\$4,000	\$1,000
Urban	900 - 1299	\$8,000	\$2,000
Rural	500 - 1299	\$8,000	\$2,000
Rural and Urban	1300+	\$10,000	\$2,500

Alberta Health calculates panel sizes by allocating patients to eligible physicians according to CPAR and/or the patient's visit history.

Physicians live on CPAR are allocated patients from their CPAR panel and "topped up" through the remaining allocations 2-5.

Physicians not on CPAR are allocated patients through billing in allocations 2-5.

Allocation	Grant Agreement
Allocation 1	<p>Patients who are on one CPAR panel are allocated to that panel's primary eligible physician.</p> <ul style="list-style-type: none"> <li>■ CPAR panel information is reviewed three months retrospectively and the panel size is taken from the last submitted record.</li> <li>■ Patients that are listed on two or more CPAR panels are allocated according to subsequent cuts based on fee-for-service or shadow billing.</li> <li>■ Eligible physicians that share a CPAR panel will receive an equal portion of the payment based on their shared panel size.</li> </ul>
Allocation 2	Patients who have seen only one eligible physician are allocated to that eligible physician.
Allocation 3	Patients who have seen more than one eligible physician are allocated to the physician with the majority of visits.
Allocation 4	Patients who have seen multiple physicians the same number of times are allocated to who did the last physical exam.
Allocation 5	Patients who have seen multiple eligible physicians the same number of times and have not had a physical exam are allocated to eligible physician who last saw the patient.

- Allocations 2-5 are based on the past 18 months of billing data. Patients who have not been seen in the last 18 months will not be allocated unless they are on a single CPAR panel.

## Receiving payments

### Step 1

All eligible members will receive an email the week of February 12, 2023 with a link to the declaration page in their [member dashboard](#). Eligible members must click the link, login to the dashboard and sign the declaration. Members should ensure that all personal and banking information is up-to-date.

### Step 2

AMA members who are 1) on Alberta Health's list of eligible physicians and 2) have completed the declaration

in their [member dashboard](#) and updated their banking information, can expect to receive funding through direct deposit.

**NOTE:** If you are a non-AMA member, please email [programpayments@albertadoctors.org](mailto:programpayments@albertadoctors.org). You will be provided with an email copy of the declaration to be signed and returned along with confirmation of your mailing address to receive payment.

**Questions?**

If you have questions or require assistance, please reach out to [programpayments@albertadoctors.org](mailto:programpayments@albertadoctors.org).

Read the [Frequently Asked Questions document](#).

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**TAB 199**

## **Background: INSPIRE-PHC Research Findings for Ontario**

New research conducted by INSPIRE-PHC<sup>1</sup> shows that as of March 2022, 2.2 million Ontarians were without a regular family doctor, an increase from the 1.8 million in March 2020.

In Toronto, at least 415,000 are without a family doctor, and those with the lowest income are especially impacted. The latest number of Toronto patients without a family doctor is an underestimate as data is unavailable for patients who were born in or who moved to Toronto after 2019.

On average, a family doctor [takes on 1200 patients](#) (many take on far more). In this case, Toronto would need at least 385 new family doctors who solely focus on family medicine to meet the current demand. It isn't possible to reach this target due to the current shortage, as well as the limited number of family doctors coming in and the large number who are nearing retirement.

Based on [2019 data](#) that showed 1.7 million Ontarians have a family doctor poised to retire, along with the current data, over 3 million Ontarians may be without a family doctor by 2025.

Many family doctors are ageing and [set to retire](#): As of 2019, 4.9 million Ontarians had a family physician over the age of 55. Additionally, more family physicians stopped work during the first six months of the pandemic than in previous years. [Findings suggest](#) many of these doctors likely chose to retire early due to the pandemic.

Family doctors may also leave family practice before retirement age to practice other, more specialized types of medicine that are perceived to be less stressful or more flexible. Overall, the [proportion of family physicians in family practice](#) went from 77.2 per cent in 2008 to 70.7 per cent in 2019, with an increasing proportion of physicians in every age group shifting away from family practice.

Forecasting over 3 million without a family doctor by 2025 does not account for the number of new graduates from family medicine. However, [research shows that fewer students are choosing careers as family doctors](#). It is expected that there will not be enough new doctors to cover all patients who lose their doctor to retirement.

While the family doctor shortage is impacting all Ontarians, the data shows those most vulnerable, including newcomers and those in poorer communities, have higher rates of being without a family doctor. [The data shows](#) that across Ontario 32.6 per cent of newcomers do not have a regular family doctor, compared to 22.5 per cent in 2020 while 19.4 per cent of the lowest income Ontarians do not have access to a regular family doctor, up from 16.1 per cent in 2020.

Unfortunately, children are also impacted by the family doctor shortage. More than 360,000 children across the province do not have a family doctor, including 48,628 are under age 5. That is equivalent to

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<sup>1</sup> [Due to a lag in the update date on OHT attribution](#) there are 3 caveats for all users of the OHT-specific data:

1. The N for under 5 years of age is low – this does not reflect children born or moving to the region after the last attribution date. Estimate is 30-40% of the actual numbers are missing. This estimate is based on the size of the 5 year paediatric age cohorts (<5, 5-9, and 10-14) being approximately equal.
2. All OHTs should see their total attributed numbers fall due to removal of people who have died or no longer have OHIP numbers/no longer meet inclusion criteria ie. based on max age, years since last OHIP billed service etc.
3. All users of this data should look closely and the % attached/unattached rather than just the N.

*This does not apply to all Ontario numbers as we include everyone even those not attributed to a specific OHT.*

13 per cent of Ontario children under the age of 5, or more than 1 in every 10, without a family doctor. The situation is even more dire for youth - among pediatric patients without a family doctor or primary care pediatrician, 189,978, or 52.8 per cent, are adolescents or teens.

Regional data examining pediatric populations and newcomer is forthcoming.

However, data from Toronto shows that there has been an increase in the number of the lowest income residents without a family doctor from 101,903 in 2020 to 120,700 in 2022. The latest (2022) number is an underestimate as data is unavailable for patients who are new to this region since 2019.

As of 2022, compared to those in the highest income group, a higher proportion of residents in the lowest income group are without a family doctor (14.9 per cent in the lowest income group, compared with 11.7 per cent in the highest income group). This pattern regarding income-based disparities is seen in all 8 OHTs within Toronto and may be an underestimate as data is unavailable for patients who are new to each OHT since 2019. The disparities are most pronounced in the West Toronto OHT (20.9 per cent in the lowest income group without a family doctor, compared with 14.8 per cent in the highest income group), Northwest Toronto OHT (16.5 per cent vs 11.3 per cent), North Toronto OHT (13.7 per cent vs 9.1 per cent), and Scarborough OHT (13.2 per cent vs 8.8 per cent).

The population in Ontario is expected to exceed 15 million by 2025. As Ontario's population ages and as advances in medicine are made, patients need more complex health supports.

A [new report from CFIB](#) found that physicians in Ontario spent approximately 18 million hours on administrative work per year in 2021, with unnecessary administrative work making up 38 per cent, or approximately 6.9 million hours, of the annual total. That is equivalent to over 20 million patient visits per year spent by physicians on unnecessary administrative work that can be done by someone else or eliminated altogether.

The pandemic and the administrative burden increase have left Ontario in a position where there will not be enough new doctors to cover all patients who lose their doctor to retirement. The CFPC found that the [burnout rate among family physicians tripled in 2021](#) compared to the previous year, with 51 percent of family physicians indicated they were working beyond capacity. A [National Physician Health Survey conducted in 2021](#) by the Canadian Medical Association found that workload is the top factor affecting family physician mental health. Research shows 2-in-3 family doctors are experiencing moderate to severe burnout, and 1-in-4 family doctors are experiencing high or severe burnout.

-30-

#### References:

1. Primary care attachment data for 2020: INSPIRE PHC Primary Care Data Reports. Publicly available at <https://www.ontariohealthprofiles.ca/ontarioHealthTeam.php>
2. Trends in patient attachment to an aging primary care workforce: a population-based serial cross-sectional study in Ontario, Canada. Kamila Premji, Michael E Green, Richard H Glazier, Shahriar Khan, Susan E Schultz, Maria Mathews, Steve Nastos, Eliot Frymire, Bridget L Ryan. medRxiv 2023.01.19.23284729; <https://www.medrxiv.org/content/10.1101/2023.01.19.23284729v1>



3. Data sources: The research cited above uses centralized health services databases and includes all Ontario residents who have OHIP coverage and all registered Ontario primary care physicians from 2008 to 2022.

\* Previously, the OCFP reported a Stats Can survey estimating that 1.3M were without a regular doctor in 2019. Stats Can and INSPIRE data have been collected differently.

**TAB 200**

# Trends in attachment to a primary care provider in Ontario, 2008–2018: an interrupted time-series analysis

Imaan Bayoumi MD MSc, Richard H. Glazier MD MPH, Liisa Jaakkimainen MD MSc, Kamila Premji MD MSc, Tara Kiran MD MSc, Eliot Frymire BA MA, Shahriar Khan MSc MA, Michael E. Green MD MPH

## Abstract

**Background:** Attachment to a regular primary care provider is associated with better health outcomes, but 15% of people in Canada lack a consistent source of ongoing primary care. We sought to evaluate trends in attachment to a primary care provider in Ontario in 2008–2018, through an equity lens and in relation to policy changes in implementation of payment reforms and team-based care.

**Methods:** Using linked, population-level administrative data, we conducted a retrospective observational study to calculate rates of patients attached to a regular primary care provider from Apr. 1, 2008, to Mar. 31, 2019. We evaluated the association of patient characteristics and attachment in 2018 using sex-stratified, adjusted, multivariable logistic regression models and used segmented piecewise regression to evaluate changing trends before and after implementation of a policy that restricted physician entry to alternate models.

**Results:** Attachment increased from 80.5% ( $n = 10\,352\,385$ ) in 2008 to 88.9% of the population ( $n = 12\,537\,172$ ) in 2018, but was lower among people with low comorbidity, high residential instability, material deprivation, rural residence and recent immigrants. Inequities narrowed for recent immigrants, males and people with lower incomes over the study period, but disparities persisted for these groups. Attachment grew by 1.47% annually until 2014 ( $p < 0.0001$ ), but was stagnant thereafter (annual percent change of 0.13,  $p = 0.16$ ).

**Interpretation:** Lack of sustained progress in attachment followed reduced levels of physician entry to alternate funding models. Although disparities narrowed for many groups over the study period, persistent gaps remained for immigrants and people with lower incomes; targeted interventions and policy changes are needed to address these persistent gaps.

Strong primary care is fundamental to effective, efficient and equitable health care systems.<sup>1,2</sup> Attachment to a regular primary care provider, defined as formal or informal patient access to the same individual primary care provider or group of providers,<sup>3</sup> is associated with delivery of more preventive care, better chronic disease management and lower rates of hospital admission.<sup>4–7</sup> Lack of attachment to a primary care provider is associated with higher mortality; higher rates of emergency department visits, hospital admissions and readmissions; presentation to care with more advanced disease; and poor patient experiences.<sup>8–10</sup> Some groups are less likely to be attached (e.g., people who are new immigrants, have low income, were previously incarcerated, were prescribed opioid agonist treatment or have serious mental illness).<sup>11–17</sup>

Despite the importance of consistent primary care access, 14.5% of Canadians aged 12 years and older (about 4.6 million people) reported not having a regular primary care provider in 2019.<sup>18</sup> High numbers of unattached patients have important health systems impacts, such as high use emergency department and walk-in clinic use, poor follow-up after hospital discharge and high morbidity.<sup>8,9</sup>

Understanding trends in primary care attachment is a key policy priority<sup>19</sup> and is critical for ensuring effective health system planning that reduces inequities for structurally marginalized

**Competing interests:** Kamila Premji reports research funding from the University of Ottawa Faculty of Medicine and Institut du Savoir Montfort; consulting fees from the Ontario College of Family Physicians and the Ontario Medical Association; honoraria from the Centre for Effective Practice and the Ontario College of Family Physicians; travel support from INSPIRE-PHC-2 and the University of Ottawa Department of Family Medicine; and roles as chair of the board of directors with the Canadian Women in Medicine and as member of the Ontario Provincial Primary Care Advisory Table. Michael Green reports research funding from the Canadian Institutes of Health Research, Ontario Health, the Ontario College of Family Physicians and the College of Family Physicians of Canada; honoraria from the University of Toronto and The Ottawa Hospital; and travel support from the Frederick National Laboratory. He is president-elect of the College of Family Physicians of Canada, a board member with AMS Healthcare and a medical advisor with the Lawson Foundation. No other competing interests were declared.

This article has been peer reviewed.

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groups. Some drivers of attachment include recruitment and retention of family physicians. Professional organizations have called for alternate payment models and expansion of team-based care as factors that can incentivize physicians to practise family medicine.<sup>20</sup> Policy changes between 2012 and 2015 to restrict access to alternate payment models may have negatively affected patient attachment, and trends may have differed for some groups. Thus, we sought to evaluate trends in attachment to a primary care provider in Ontario in 2008–2018, through an equity lens and in relation to policy changes in implementation of payment reforms and team-based care.

## Methods

### Study setting

The study was set in Ontario (population of more than 15 million<sup>21</sup>), in which family physician and nurse practitioner visits are insured and free at the point of care. In 2002, Ontario increased investment and implemented voluntary reforms in the delivery and payment of primary care aimed at improving access, quality of care and physician retention.<sup>22</sup> Under the reforms, most physicians shifted from exclusive fee-for-service remuneration to one of several models that incorporated blended capitation payments, patient enrolment and, in some cases, access to interdisciplinary teams. Several models require patient enrolment (collectively described as patient enrolment models), including those in which physicians are paid by blended capitation (monthly age- and sex-adjusted payments and a small proportion of fee-for-service payments), and those paid by fee for service. Beginning in 2012, the Ontario government began to limit new physicians entering capitation-based models, culminating in 2015, when the government restricted new positions in some patient-enrolment models to 20 per month in areas of high physician need, or to replacement of physicians in existing teams.<sup>23</sup>

### Study design

We conducted a repeated cross-sectional study using population-level administrative data. Study participants included all Ontario residents with a health card number in each year from Apr. 1, 2008, to Mar. 31, 2019.

### Data sources and linkages

We used linked administrative data sets to evaluate trends in attachment at the patient level. Using a confidential and secure proprietary algorithm, health card numbers are converted to unique encoded identifiers, and are linked and analyzed at ICES.<sup>24</sup> ICES is an independent, nonprofit research institute whose legal status under Ontario's health information privacy law allows it to collect and analyze health care and demographic data, without consent, for health system evaluation and improvement.

We used the Primary Care Population data set (PCPOP), an ICES-derived, population-level data set that includes all eligible people in Ontario. An eligible person would be an Ontario resident who is alive at the index, has had contact with the health care system within 9 years of index and has

Ontario Health Insurance Plan (OHIP) eligibility. We linked PCPOP with the Registered Persons Database (a health insurance registry), the Corporate Provider Database (a registry of providers and groups eligible to bill OHIP for their services), the Client Agency Program Enrolment database (which identifies patients enrolled in different primary care models over time) and the Community Health Centre (CHC) database (which lists patients receiving health services at CHCs, nonprofit health centres that provide primary care and health promotion to priority populations in which primary care providers are salaried). We assessed emergency department visits using the National Ambulatory Care Reporting System and hospital admissions using the Discharge Abstracts Database.

### Outcome

The dependent variable was the percentage of eligible Ontario residents attached to a primary care provider, identified in administrative data using an algorithm developed and validated by our group against survey responses, with excellent sensitivity (90.5%) and modest specificity (46.1%).<sup>25</sup> The algorithm involved hierarchical assignment of attachment. First, patients enrolled to a patient enrolment model were considered attached. Next, patients receiving clinical care at a community health centre were included as attached. Next, patients were included as attached if they were virtually rostered to a primary care provider with the highest billings for that patient, with higher physician-level continuity of care. We sought to limit categorizing virtually rostered patients who received a substantial proportion of their care from physicians with low continuity of care for their patients, such as those practising in walk-in clinics. Therefore, virtually rostered patients were considered attached only if they received most of their primary care over the preceding 2-year period from a primary care provider with greater than 10% physician-level continuity of care. Physician-level continuity of care is a visit-based measure of the proportion of patients receiving ongoing care with the same provider and was determined with a numerator of patients virtually rostered to a primary care provider divided by the denominator of all unique patients the same primary care provider has seen over 2 years. Finally, and consistent with a previously validated algorithm used to evaluate access to pediatric health services,<sup>26</sup> children who were virtually attached to a primary care pediatrician were also considered attached.<sup>25</sup> All others were considered uncertainly attached (described in additional detail in Appendix 1, available at [www.cmajopen.ca/content/11/5/E809/suppl/DC1](http://www.cmajopen.ca/content/11/5/E809/suppl/DC1)).

### Covariates

We derived age, sex, rurality and immigration status from the Registered Persons Database. We measured rurality using the postal code and the Rurality Index for Ontario, categorized as urban (score 0–9), suburban (score 10–39) and rural (score ≥ 40).<sup>27</sup> We used postal codes and the Ontario Marginalization Index to derive participants' Material Deprivation and Residential Instability quintiles. The Ontario Marginalization Index is an area-based index derived using variables

from the Census that seeks to understand differences in health between population groups or between geographical areas.<sup>28</sup> Material deprivation includes indicators such as the proportion of the adult population who are lone-parent families, are receiving government transfer payments, are low income, are unemployed or have no high school diploma. Residential instability is a measure of area-level concentration of people who experience high rates of family or housing instability and includes indicators of the proportion of people living alone, the proportion of dwellings that are apartment buildings and the proportion of the population who have moved in the previous 5 years. We identified people with first-time health care coverage in Ontario within the previous 10 years, most of whom are recent immigrants to Canada.<sup>29</sup> We used the Johns Hopkins Adjusted Clinical Groups System Version 10 to capture comorbidity according to Aggregated Diagnostic Groups (ADGs), in which the diagnostic codes describing each person's health conditions are assigned to 1 or more of 32 diagnostic groups based on clinical and expected health services use.<sup>30</sup> We used hospital admissions and OHIP claims from the preceding 2 years to determine the ADGs and Resource Utilization Bands, which are robust and validated measures of comorbidity and expected resource use. We categorized ADGs as low (0–4 ADGs), moderate (5–9 ADGs) or high comorbidity ( $\geq 10$  ADGs). We categorized Resource Utilization Bands as nonuser or healthy user (0–1), low (2), moderate (3) or high expected resource use ( $\geq 4$ ).

### Statistical analysis

We identified attached and uncertainly attached populations for each year between 2008/09 and 2018/19, their characteristics and annual rates of emergency department visits and hospital admissions. We evaluated changes in attachment over time, stratified by demographic group. Next, we used logistic regression models using complete case analysis to evaluate the association between patient characteristics and attachment in 2018/19, adjusting for sex, age, rurality, comorbidity, resource utilization, recent immigration ( $\leq 10$  yr v. those who had immigrated  $> 10$  yr previously or those who were born in Canada), material deprivation and residential instability. We tested for and identified an interaction between age and sex, and developed stratified multivariable models for males and females of factors associated with attachment in 2018, using prespecified variables selected a priori from published literature. We did not use a model selection process. Tolerance and variance inflation factors were consistent with lack of multicollinearity in the multivariable models.

To assess the association with restricted entry to alternate funding models in 2015, we used segmented piecewise linear regression models with correlated residuals, including year, policy change in 2015 and time after policy change as predictors. We tested for and found no evidence of autocorrelation ( $\beta$  for AR(1) = 0.57,  $p = 0.39$ , AR(2) = 0.59,  $p = 0.19$ ). Therefore, we dropped the autoregressive terms from the regression model and included only time before and time after the policy change in the model.

We completed all analyses with SAS Enterprise Edition.

### Ethics approval

The use of the data in this project is authorized under section 45 of Ontario's *Personal Health Information Protection Act* and does not require review by a Research Ethics Board.

### Results

In 2008, 10 352 385 (80.5%) of 12 863 036 eligible Ontario residents were attached to a primary care provider (Appendix 2, available at [www.cmajopen.ca/content/11/5/E809/suppl/DC1](http://www.cmajopen.ca/content/11/5/E809/suppl/DC1)). Attachment increased over the study period to 12 537 172 (88.9%) of the 14 096 100 population in 2018. The characteristics of the attached and general population are summarized in 2008, 2014 and 2018 (Table 1). Proportionately fewer males were attached at baseline (77.4% v. 83.5% females) and in 2018 (86.9% v. 90.9% females). Young adults (aged 19–34 yr) had lower rates of attachment compared with all other age groups at baseline (71.5%) and study end (83.6%). Children and youth had the highest rates of attachment, followed by older adults. Attachment was lower among those who lived in rural areas, those with low comorbidity, those with the highest residential instability, those with the highest material deprivation and recent immigrants throughout the study period. About 25% of uncertainly attached people visited the emergency department, which remained stable throughout the study period. Rates of hospital admission for uncertainly attached patients decreased from 12.1% in 2008 to 9.8% in 2018. Health system use was higher for attached patients, of whom about 37% visited the emergency department and 20%–22% were admitted to hospital in a given year.

Attachment increased over the study period overall and for all demographic groups, with the largest relative gains seen among new immigrants, patients aged 19–34 years and patients with low comorbidity. Overall, we observed gains between 2008 and 2014, after which attachment plateaued (Figure 1). Gaps between some groups narrowed from 2008 to 2014, after which the rate of change slowed overall (Figure 2). The disparity for recent immigrants continued to close after 2014, though more slowly than before 2014. We observed rapid gains in the proportion of attached patients among those with low comorbidity until 2014, after which the rate was essentially unchanged. We observed limited reduction in disparities by material deprivation between 2008 and 2014, but the gap continued to close throughout the study period.

We used sex-stratified, unadjusted, single variable (Table 2) and multivariable models of 2018 data to further evaluate predictors of attachment (Table 3). Compared with adults aged 50–64 years, children and youth were most likely to be attached (males: adjusted odds ratio [OR] 2.70, 95% confidence interval [CI] 2.67–2.73; females: adjusted OR 2.40, 95% CI 2.37–2.43). Adults aged 19–34 years were least likely to be attached (males: adjusted OR 0.86, 95% CI 0.86–0.87; females: 0.83, 95% CI 0.83–0.84). Older adult males were more likely to be attached to a provider, but not older females.

Males and females with moderate-to-high comorbidity had higher odds of attachment, as did those with moderate-to-high

health care use. Urban and small-town residents had higher odds of attachment than those living in rural areas.

**Table 1 (part 1 of 2): Patient demographic characteristics**

Variable	2008		2014		2018		Difference 2018–2008, %	
	No. (%) of attached patients	Total population	No. (%) of attached patients	Total population	No. (%) of attached patients	Total population	Absolute difference	Relative difference
Overall	10 352 385 (80.5)	12 863 036	11 972 070 (88.1)	13 371 946	12 537 172 (88.9)	14 096 100	8.4	10.4
Sex								
Male	4 902 611 (77.4)	6 336 768	5 731 257 (86.3)	6 641 622	6 021 636 (86.9)	6 928 191	9.5	12.3
Female	5 449 774 (83.5)	6 526 268	6 240 813 (90.6)	6 886 323	6 515 536 (90.9)	7 167 909	7.4	8.9
Age category, yr								
< 19	2 731 580 (91.6)	2 983 281	2 707 855 (93.7)	2 889 839	2 688 182 (93.6)	2 872 967	2	2.2
19–34	1 941 613 (71.5)	2 713 735	2 387 721 (82.8)	2 883 509	2 491 779 (83.6)	2 979 286	12.1	16.9
35–49	2 345 430 (76.3)	3 073 175	2 468 965 (86.4)	2 856 163	2 471 632 (86.7)	2 850 490	10.4	13.6
50–64	1 947 237 (80.2)	2 429 426	2 536 267 (89.0)	2 849 501	2 708 959 (89.6)	3 024 685	9.4	11.7
65–79	1 038 837 (83.3)	1 246 586	1 402 343 (91.3)	1 536 482	1 646 130 (91.9)	1 791 552	8.6	10.3
≥ 80	347 688 (83.4)	416 833	468 919 (91.5)	512 451	530 490 (91.9)	577 120	8.5	10.2
Rurality Index for Ontario								
Urban (0–9)	7 397 897 (79.8)	9 275 239	8 692 101 (88.2)	9 855 613	9 144 956 (88.8)	10 302 737	9	11.3
Small town (10–39)	2 116 215 (84.8)	2 496 232	2 345 182 (90.9)	2 579 570	2 434 140 (90.9)	2 676 741	6.1	7.2
Rural (≥ 40)	765 279 (78.2)	978 283	857 518 (87.4)	980 713	874 527 (87.9)	994 441	9.7	12.4
Missing	72 994 (64.4)	113 282	77 269 (69.0)	112 049	83 549 (68.4)	122 181	4	6.2
Comorbidity (ADG)								
No or low comorbidity (0–4)	4 977 558 (73.3)	6 791 348	6 068 182 (83.8)	7 245 411	6 237 180 (84.0)	7 427 923	10.7	14.6
Moderate comorbidity (5–9)	4 272 094 (88.7)	4 816 930	4 625 684 (94.0)	4 920 446	4 859 500 (94.5)	5 142 000	5.8	6.5
High comorbidity (≥ 10)	1 102 733 (87.9)	1 254 758	1 278 204 (93.8)	1 362 088	1 440 492 (94.4)	1 526 177	6.5	7.4
Resource Utilization Band								
Nonuser or healthy user (0–1)	1 026 238 (48.4)	2 118 830	1 472 205 (67.5)	2 182 561	1 539 471 (67.3)	2 286 918	18.9	39.1
Low morbidity (2)	2 218 280 (84.8)	2 616 422	2 457 443 (90.6)	2 711 249	2 454 723 (91.0)	2 696 051	6.2	7.3
Moderate morbidity (3)	5 248 159 (87.5)	5 999 986	5 818 534 (93.0)	6 254 661	6 042 110 (93.6)	6 452 615	6.1	7.0
High morbidity (≥ 4)	1 859 708 (87.4)	2 127 798	2 223 888 (93.5)	2 379 474	2 500 868 (94.0)	2 660 516	6.6	7.6

However, we also identified lower odds of attachment for people who had recently immigrated to Ontario (males: adjusted OR 0.63, 95% CI 0.63–0.64; females: adjusted OR 0.60, 95% CI 0.59–0.60). In addition, we observed lower odds of attachment for those with higher residential instability (highest instability males: adjusted OR 0.67, 95% CI 0.67–0.68; highest instability females: adjusted OR 0.72, 95% CI 0.71–0.73) and higher material deprivation (adjusted OR highest deprivation

males 0.75 [0.75–0.76], females 0.80 [0.79–0.80]). Both marginalization measures followed a gradient by quintile, with lower odds of attachment for more vulnerable males than females.

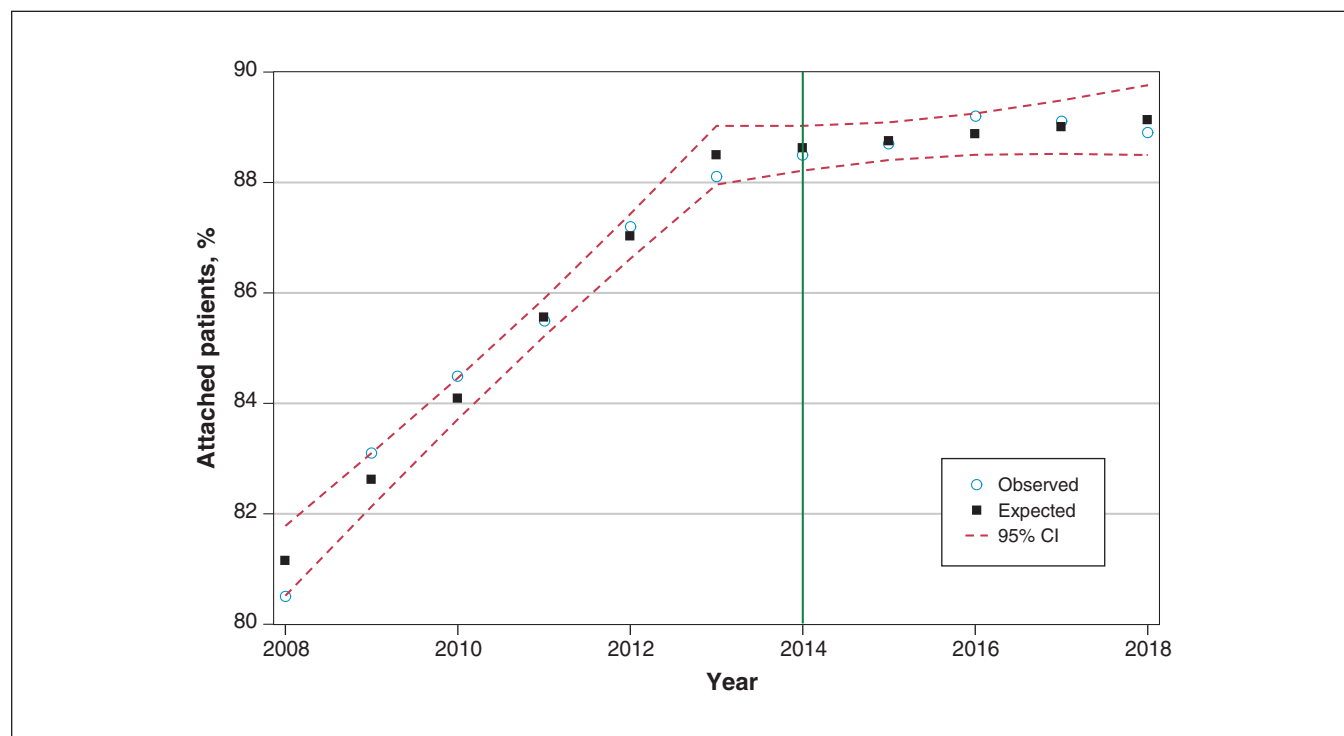
We modelled change in the percentage of attached patients using segmented regression models, including initial slope, intercept and a paravermis at 2014 as variables, with correlated residuals. Given the lack of evidence of either first- or second-order autocorrelation, we assumed the residuals to

**Table 1 (part 2 of 2): Patient demographic characteristics**

Variable	2008		2014		2018		Difference 2018–2008, %	
	No. (%) of attached patients	Total population	No. (%) of attached patients	Total population	No. (%) of attached patients	Total population	Absolute difference	Relative difference
Recent immigrant								
No	7 920 620 (80.1)	9 882 644	9 466 538 (88.6)	10 682 618	10 045 967 (89.0)	11 287 661	8.9	11.1
Yes	924 122 (67.8)	1 363 337	970 576 (79.8)	1 216 706	975 069 (81.4)	1 198 483	13.6	20.1
Residential instability quintile								
1 (lowest instability)	2 245 592 (83.8)	2 678 771	2 746 156 (90.9)	3 019 913	2 858 167 (91.3)	3 130 363	7.5	9.0
2	2 091 120 (83.3)	2 511 738	2 311 451 (90.4)	2 556 842	2 412 349 (90.6)	2 661 479	7.3	8.8
3	1 917 243 (82.1)	2 335 277	2 142 267 (89.5)	2 393 882	2 280 527 (89.9)	2 535 978	7.8	9.5
4	1 893 272 (79.6)	2 377 687	2 136 073 (88.1)	2 425 107	2 213 598 (88.5)	2 500 126	8.9	11.2
5 (highest instability)	2 087 599 (75.1)	2 780 816	2 524 839 (84.9)	2 972 369	2 671 039 (85.5)	3 123 843	10.4	13.9
Material deprivation quintile								
1 (lowest deprivation)	2 381 696 (83.4)	2 857 306	2 623 982 (90.2)	2 910 272	2 893 438 (90.4)	3 201 555	7.0	8.4
2	2 099 290 (82.5)	2 545 256	2 518 205 (90.2)	2 791 259	2 663 134 (90.5)	2 942 539	8	9.7
3	1 982 173 (81.0)	2 447 798	2 297 416 (89.1)	2 577 049	2 382 518 (89.6)	2 659 189	8.6	10.6
4	1 863 131 (79.4)	2 346 986	2 199 123 (87.9)	2 503 068	2 244 028 (88.3)	2 540 744	8.9	11.2
5 (highest deprivation)	1 908 536 (76.7)	2 486 943	2 222 060 (85.9)	2 586 465	2 252 562 (86.4)	2 607 762	9.7	12.7
ED visit in previous 2 years								
Yes	3 760 038 (85.4)	4 403 177	4 397 211 (91.5)	4 805 605	4 708 543 (92.1)	5 113 652	6.7	7.5
No	6 592 347 (77.9)	8 459 859						
Hospital admission in previous 2 years								
Yes	2 338 830 (88.5)	2 642 562	2 551 439 (93.8)	2 719 265	4 708 543 (92.1)	2 761 144	3.6	4.1
No	8 013 555 (78.4)	10 220 474						

Note: ADG = Aggregated Diagnostic Group, ED = emergency department.





**Figure 1:** Proportion of patients attached to a primary care provider, 2008–2018. Note: CI = confidence interval.

be independent and thus dropped the autoregressive terms. We observed a significant trend before 2014 (slope = 1.47% increase in attachment rate per year,  $p < 0.0001$ ), which flattened after 2014 (slope = 0.13%,  $p = 0.16$ ).

## Interpretation

The crude number of attached patients increased by 21.1% over the study period, a rate in excess of population growth (9.6%), but plateaued after 2014, when it matched but no longer exceeded population growth.

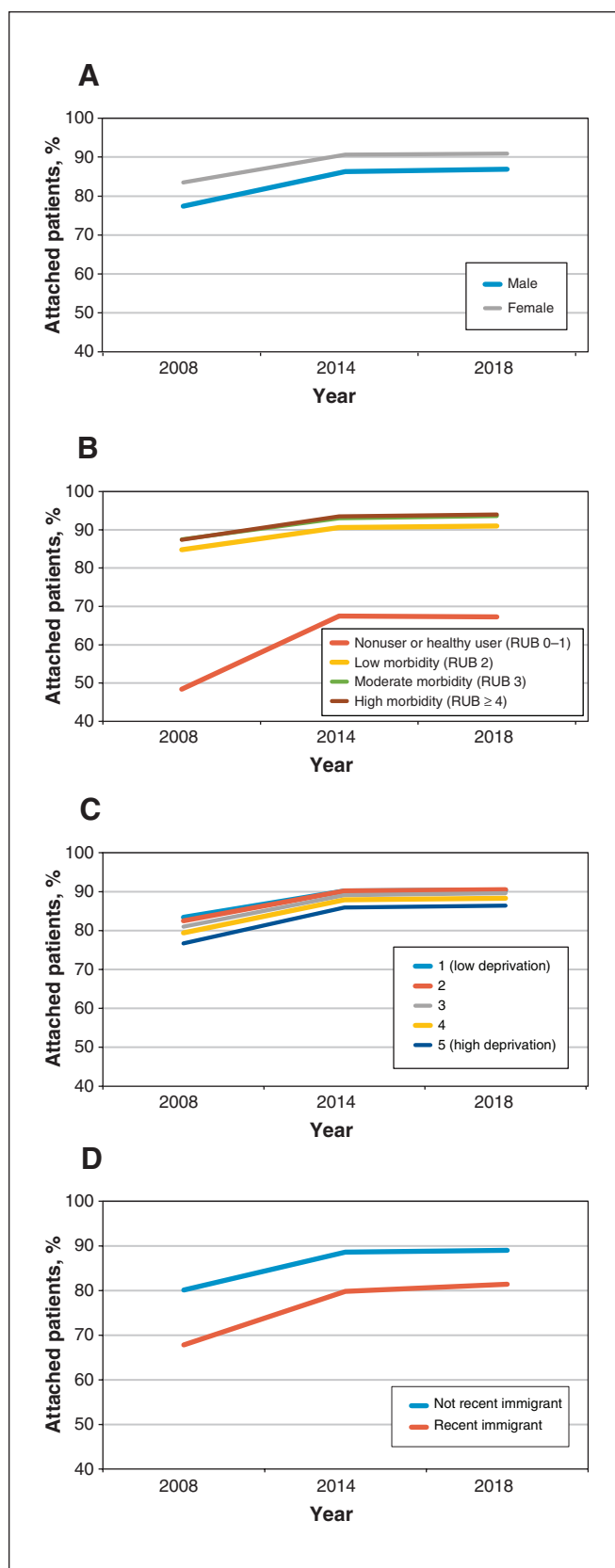
Rapid growth in attachment occurred during the period of growth policy reforms, including new models of primary care based on patient enrolment and blended capitation payment. Attachment plateaued around the time that the Ontario government restricted entry to blended capitation models, many of which were also interprofessional teams.<sup>31</sup> From 2012 to 2015, primary care was affected by a series of policy changes aimed at containing costs, including restricted access to new family health teams, government-imposed fee cuts and discontinuation of a new patient fee code. Finally, expansion of alternate models was limited to physicians practising in underserved areas or addressing attrition within existing teams. In 2015, 122 physicians entered these new models, compared with 489 in 2014. Our results support a strong rationale for investment in funding reform and expansion of interdisciplinary teams in primary care. Expansion of patient enrolment models was included in the recently approved Ontario Physician Services Agreement, although specific implementation details remain unclear.<sup>32</sup>

A substantial proportion of uncertainly attached people had frequent contact with the health system, including about 25% with an emergency department visit and 10%–12% who were admitted to hospital in a given year. Although these proportions were lower than those seen for attached people (38% with an emergency department visit and 21%–23% admitted to hospital), each of these encounters represents an opportunity for attachment, which will require appropriate policy innovations.

Overall equity in attachment improved. In contrast to other jurisdictions, we found higher attachment among people with higher comorbidity, likely because those with lower comorbidity were less likely to seek care, and therefore had fewer enrolment opportunities. However, important gaps in attachment remained for specific groups, particularly new immigrants and people living with economic and residential insecurity. Targeted interventions are needed to reach these communities, who have not benefited as much from policy reforms.<sup>33</sup>

In other jurisdictions, attachment has either decreased or remained fixed over time. In the United States, attachment among adults decreased from 77% (95% CI 76%–78%) in 2002 to 75% (95% CI 74%–76%) in 2015 (adjusted OR 0.90, 95% CI 0.82–0.98).<sup>34</sup> Another study reported reduced attachment of older adults from 94.2% in 2010 to 91.0% in 2016 ( $p < 0.0001$ ).<sup>35</sup> Both studies found lower attachment among males, people with lower incomes or those whose race or ethnicity was Black or Latino, even after controlling for insurance status. In New Zealand, 93%–95% of the population was enrolled in primary care from 2015 to 2019, with lower attachment among Maori people and those living with higher deprivation.<sup>13</sup>





**Figure 2:** Proportion of patients attached to a primary care provider, 2008–2018 by (A) sex, (B) Resource Utilization Band (RUB), (C) material deprivation quintile and (D) recent immigrant status.

Nationally, Ontario has the lowest proportion of residents who are unattached to a primary care provider.<sup>18</sup> Data from the Canadian Community Health Survey show that Quebec and the Western provinces fare considerably worse and, nationwide, more than 4.5 million people in Canada do not have access to a regular primary care provider.<sup>18</sup> Some provinces have established centralized wait lists to improve attachment.<sup>19</sup> Cross-sectional studies have shown increased attachment with this strategy; however, people with fewer comorbid conditions were preferentially enrolled and demand exceeded primary care capacity.<sup>36,37</sup> Longitudinal analyses of centralized waitlists are underway. Additional measures taken in Canada include payment reforms, implementation of interdisciplinary teams, specific fee codes for attachment of complex patients, expansion of nurse practitioner roles and geographic attachment.<sup>38</sup> Our work underscores the importance of payment reform and interdisciplinary team models for supporting attachment.<sup>39</sup>

Overall gains in attachment may be threatened by upcoming trends in health human resources. About 14.4% of Ontario family physicians are aged 65 years and older,<sup>40</sup> and the mean age of retirement is 70.5 years.<sup>41</sup> Increased pressures during the COVID-19 pandemic have accelerated retirement plans of older physicians,<sup>42</sup> and almost 20% of Toronto primary care providers report considering closing their practice in the next 5 years.<sup>43</sup> In addition, the comprehensiveness of practice has been decreasing.<sup>44</sup> Overall patient panel sizes are reduced in all career phases<sup>41</sup> and practice patterns are shifting away from comprehensive primary care practices to more focused practices and roles in hospital and emergency departments.<sup>45</sup> The combined impact of fewer medical students ranking family medicine as their first choice for residency training<sup>46</sup> and an aging family physician workforce<sup>47</sup> suggest upcoming problems in health human resources, which could substantially erode the gains observed in our study.

### Limitations

Administrative data cannot be used to track services provided by nurse practitioners, except in CHCs. In Ontario, 25 nurse practitioner–led clinics serve around 100 000 patients, largely located in rural and remote settings.<sup>48</sup> Although they play an important role in these communities, the volume of service is unlikely to change the overall trends. In addition, although the attachment algorithm showed high sensitivity, specificity was more modest, meaning that some uncertainly attached individuals may have been misclassified. In addition, measures of income and residential instability were all determined at a neighbourhood level using Census data. Area-level measures are economical and widely used to examine population-level differences, but are limited by their inability to capture variation within neighbourhoods.<sup>49</sup> Some young adults without clear primary care providers may have been temporarily living outside Ontario, which we could not identify in our data. We also could not assess the quality of attachment or whether unattached patients were seeking attachment. Finally, the associations found do not imply causation and additional unmeasured reasons may contribute to lack of attachment to a primary care provider.

**Table 2: Unadjusted, single-predictor logistic regression models for association between patient characteristics and patient attachment in 2018, stratified by sex**

Variable	OR (95% CI)	
	Male n = 6 009 381	Female n = 6 297 372
Age category, yr		
< 19	1.99 (1.97–2.01)	1.41 (1.40–1.42)
19–34	0.57 (0.57–0.57)	0.64 (0.63–0.64)
35–49	0.71 (0.70–0.71)	0.83 (0.82–0.84)
50–64	Ref.	Ref.
65–79	1.45 (1.44–1.47)	1.16 (1.15–1.17)
≥ 80	1.54 (1.52–1.57)	1.10 (1.08–1.11)
Rurality Index for Ontario		
Urban (0–9)	1.08 (1.07–1.09)	1.07 (1.06–1.08)
Small town (10–39)	1.33 (1.32–1.34)	1.44 (1.42–1.45)
Rural (≥ 40)	Ref.	Ref.
Comorbidity (ADG)		
No or low comorbidity (0–4) (Ref.)	Ref.	Ref.
Moderate comorbidity (5–9)	3.33 (3.31–3.35)	3.03 (3.01–3.05)
High comorbidity (≥ 10)	3.28 (3.24–3.32)	2.89 (2.86–2.92)
Morbidity (Resource Utilization Band)		
Nonuser or healthy user (0–1)	Ref.	Ref.
Low comorbidity (2)	4.38 (4.36–4.41)	5.85 (5.80–5.89)
Moderate morbidity (3)	6.51 (6.47–6.54)	7.67 (7.62–7.71)
High morbidity (≥ 4)	7.13 (7.07–7.19)	7.64 (7.58–7.71)
Recent immigrant		
No	Ref.	Ref.
Yes	0.56 (0.56–0.56)	0.50 (0.50–0.51)
Residential instability quintile		
1 (lowest instability)	Ref.	Ref.
2	0.90 (0.89–0.91)	0.95 (0.94–0.96)
3	0.82 (0.82–0.83)	0.89 (0.88–0.89)
4	0.70 (0.70–0.71)	0.77 (0.77–0.78)
5 (highest instability)	0.53 (0.53–0.54)	0.59 (0.58–0.59)
Material deprivation quintile		
1 (lowest deprivation)	Ref.	Ref.
2	1.01 (1.00–1.01)	1.03 (1.02–1.03)
3	0.90 (0.90–0.91)	0.94 (0.93–0.94)
4	0.78 (0.78–0.79)	0.83 (0.82–0.84)
5 (highest deprivation)	0.65 (0.64–0.65)	0.71 (0.71–0.72)

Note: ADG = Aggregated Diagnostic Group, CI = confidence interval, OR = odds ratio, Ref. = reference category.

## Conclusion

Attachment to a primary care provider in Ontario increased between 2008 and 2014, but was unchanged after 2014, following reduced physician entry to alternate funding and interdisciplinary team models. Targeted interventions are needed to address persistent gaps for

immigrants and people with low incomes. Upcoming trends in health human resources may erode the gains seen. Future research should use robust longitudinal designs to evaluate trends during the COVID-19 pandemic and health outcomes associated with attachment for different patient populations.

**Table 3: Multivariable logistic regression for association between patient characteristics and patient attachment in 2018, stratified by sex**

Variable	OR (95% CI)	
	Male n = 6 009 381	Female n = 6 297 372
Intercept	2.23 (2.20–2.26)	2.39 (2.35–2.43)
Age category, yr		
< 19 v. 50–64	2.70 (2.67–2.73)	2.40 (2.37–2.43)
19–34 v. 50–64	0.86 (0.86–0.87)	0.83 (0.83–0.84)
35–49 v. 50–64	0.92 (0.91–0.92)	1.01 (1.00–1.02)
65–79 v. 50–64	1.13 (1.12–1.14)	1.00 (0.99–1.01)
≥ 80 v. 50–64	1.14 (1.13–1.16)	0.91 (0.90–0.92)
Rurality Index for Ontario		
Urban v. rural	1.11 (1.10–1.12)	1.11 (1.09–1.12)
Small town v. rural	1.28 (1.27–1.30)	1.35 (1.33–1.37)
Comorbidity (ADG)		
Moderate v. low comorbidity	1.41 (1.40–1.42)	1.33 (1.31–1.34)
High v. low comorbidity	1.58 (1.56–1.61)	1.36 (1.34–1.38)
Resource Utilization Band		
Low user v. nonuser	3.90 (3.87–3.93)	5.43 (5.38–5.48)
Moderate user v. nonuser	5.32 (5.28–5.36)	6.95 (6.89–7.01)
High user v. nonuser	4.82 (4.76–4.89)	7.07 (6.98–7.16)
Recent immigrant		
Immigrant v. nonimmigrant	0.63 (0.63–0.64)	0.60 (0.59–0.60)
Residential instability quintile		
Q2 v. Q1 (lowest instability)	0.93 (0.92–0.94)	0.94 (0.93–0.95)
Q3 v. Q1 (lowest instability)	0.88 (0.88–0.89)	0.91 (0.90–0.92)
Q4 v. Q1 (lowest instability)	0.81 (0.81–0.82)	0.84 (0.83–0.85)
Q5 (highest) v. Q1 (lowest instability)	0.67 (0.67–0.68)	0.72 (0.71–0.73)
Material deprivation quintile		
Q1 v. Q1 (lowest deprivation)	0.98 (0.97–0.99)	0.98 (0.98–0.99)
Q3 v. Q1 (lowest deprivation)	0.92 (0.91–0.93)	0.93 (0.92–0.94)
Q4 v. Q1 (lowest deprivation)	0.85 (0.84–0.86)	0.87 (0.86–0.88)
Q5 (highest) v. Q1 (lowest deprivation)	0.75 (0.75–0.76)	0.80 (0.79–0.80)

Note: ADG = Aggregated Diagnostic Group, CI = confidence interval, OR = odds ratio.

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**Data sharing:** The data set from this study is held securely in coded form at ICES. Although legal data sharing agreements between ICES and data providers (e.g., health care organizations and government) prohibit ICES from making the data set publicly available, access may be granted to those who meet prespecified criteria for confidential access, available at <https://www.ices.on.ca/DAS> (email: [das@ices.on.ca](mailto:das@ices.on.ca)). The full data set creation plan and underlying analytic code are available from the authors upon request, understanding that the computer programs may rely upon coding templates or macros that are unique to ICES and are therefore either inaccessible or may require modification.

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**TAB 201**



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By Richard H. Glazier, Michael E. Green, Eliot Frymire, Alex Kopp, William Hogg, Kamila Premji, and Tara Kiran

# Do Incentive Payments Reward The Wrong Providers? A Study Of Primary Care Reform In Ontario, Canada

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**ABSTRACT** Primary care payment reform in the US and elsewhere usually involves capitation, often combined with bonuses and incentives. In capitation systems, providing care within the practice group is needed to contain costs and ensure continuity of care, yet this is challenging in settings that allow patient choice in access to services. We used linked population-based administrative databases in Ontario, Canada, to examine a substantial payment called the “access bonus” designed to incentivize primary care access and to minimize primary care visits outside of capitation practices. We found that the access bonus flowed disproportionately to physicians outside large cities and to those whose patients made fewer primary care visits, received less after-hours care, made more emergency department visits, and had higher adjusted ambulatory costs. Our findings indicate a lack of alignment between these payments and their intended purpose. Financial incentives should be prospectively evaluated and frequently revisited to ensure relevance, alignment with system goals, efficiency, and equity.

Physician payment reform is under way in high-income countries globally, most commonly focusing on primary care and taking the form of capitation, while sometimes also incorporating pay-for-performance, shared savings, and bundled payment.<sup>1</sup> In most cases these reforms are supplanting fee-for-service in part or in whole. Fee-for-service is increasingly seen as incentivizing unnecessary care, which results in care that is volume driven rather than value-driven and being wasteful.<sup>2,3</sup> A desire for value-based care that rewards higher quality and lower costs rather than volume is driving payment reforms—most prominently, the Medicare Access and CHIP Reauthorization Act of 2015—across the US in many markets and among numerous payers.<sup>4</sup> Other countries such as the UK, Australia, the Netherlands, Italy, and Canada are also engaged in major payment reforms.<sup>5–9</sup> Cen-

tral to most of these reforms is some form of risk-adjusted prospective capitation-based payment.

While its drawbacks are clear, fee-for-service payment is well understood, transparent in costs in some settings, modifiable to a degree through fee schedules, and largely predictable in terms of consequences. Capitation-based payment shifts risk to providers as they receive fixed amounts per person, and therefore providers' behavior may be less predictable and could vary depending on the setting and how capitation is structured. Known risks include the selection of healthy patients, who are expected to use fewer services, and underservicing through lack of follow-up or availability<sup>10</sup>—both of which contributed to a backlash against capitation-based managed care in the US in the 1990s.<sup>11</sup> Many current payment reforms include case-mix adjustment, episode-related care, bundled payment, shared savings, and other features designed to mitigate

these problems.

Capitation reimbursement in primary care usually features attribution of patients to physicians via formal enrollment, a defined basket of services covered by the capitated payment, and limitations on payment for in-basket services when provided outside of the patient's enrollment group. However, in single-payer systems such as in Canada, where patients are free to seek care with any provider, payers are at risk of paying twice for capitated patients—paying a monthly fee to the enrolling physician but also paying fee-for-service outside the capitation arrangement. To avoid paying twice and to incentivize timely access to care, some payers have sought to financially reduce capitation payments by the amounts billed by other physicians in fee-for-service, a practice sometimes called negation.<sup>12,13</sup> The government of Ontario, Canada, introduced widespread primary care reforms in the 2000s, including practice models in which physicians were paid largely by capitation. Instead of negation, which had previously been unpopular with Ontario physicians, the government and medical association negotiated a financial incentive called the “access bonus.” Practices received a bonus of up to 18.59 percent of capitation payments, which was reduced dollar for dollar if their patients sought care outside their group for in-basket services. Emergency department (ED) visits and specialist visits were not counted as outside care.

The ostensible policy objectives for implementing the access bonus were to incentivize access to care by the enrolling physician group and to control the costs of outside use of health services by patients enrolled in the capitated payment plan. Although this payment incentivizes providing care to patients within the physician group, it is also affected by patients' behavior, and we hypothesized that it could vary according to the services available in each community. For example, patients in rural areas typically rely on EDs as an access point for after-hours care and have few of the alternatives—such as walk-in clinics—available to patients in large urban centers.<sup>14,15</sup> The characteristics of physicians who received access bonus payments in Ontario are not known, nor is whether the payments were associated with the policy objectives of better access and lower costs. The impacts of negation or retention bonuses in other settings are also poorly understood. The purpose of this study was to examine the distribution of access bonus payments according to practice characteristics and to understand the relationship of these payments to primary care visits, after-hours care, ED use, and related costs.

## Ontario Setting

Ontario is Canada's most populous province, with a 2018 population of 14,411,424 people—accounting for almost 40 percent of the national population.<sup>16</sup> Ontario has universal health coverage of medically necessary physician and hospital services for permanent residents without copayments or deductibles, and it does not limit patients' choice of physician providers. Physician visits in family practice, walk-in clinics, and ED settings are fully insured. The single payer is the Ontario Ministry of Health and Long-Term Care. Health care is financed through income tax revenues, including federal transfers and an annual Ontario health premium, which ranges from \$60 to \$900 per person depending on income and is limited to people earning more than \$20,000 per year.<sup>17</sup>

## Ontario Primary Care Reform

Ontario's Ministry of Health and Long-Term Care introduced a number of voluntary alternative physician payment models starting in 2001. By 2012 about three-quarters of primary care physicians were included in these alternative models, and a similar proportion of Ontario's population was enrolled in these models for health care.<sup>18</sup> These models involve formal patient enrollment; a requirement that primary care physicians provide extended office hours on weekday evenings and on weekends; and blended payments to physicians that include capitation, incentives and bonuses, and fee-for-service payments. The access bonus was exclusive to two models: the Family Health Network and the Family Health Organization. Introduced in 2006, the Family Health Organization is the most popular alternative payment model, covering close to 40 percent of the Ontario population in 2012.<sup>18</sup> In Family Health Organizations, about 70 percent of payments to providers are from capitation adjusted for age and sex, 10 percent from incentives and bonuses, and the remaining 20 percent from fee-for-service limited to codes outside a defined basket of services and shadow billing for codes within the basket, valued at 15 percent of the total fee.<sup>18</sup> Shadow billings are partial fee-for-service payments for services included in the basket of services covered by capitation payments. Their purpose is to provide an incentive for patient visits and to track patient encounters. In 2015 only a few hundred physicians participated in Family Health Networks, and slightly more than half of Ontario primary care physicians practiced in an enrollment model based on fee-for-service or continued to practice in straight fee-for-service outside of a formal model.<sup>19</sup>

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## Study Data And Methods

**DATA SOURCES** The administrative data used in these analyses included data from Ontario's health care registry, physician claims, alternate payments, patient and physician enrollment records, physician characteristics, and ED visits (see online appendix 1).<sup>20</sup> These data sets were linked using unique, encoded identifiers and analyzed at ICES, formerly known as the Institute for Clinical Evaluative Sciences.

**ANALYSES** This study was a cross-sectional population-based analysis of Ontario's Family Health Organization model in 2012–13, which comprised 4,052 primary care physicians and 5.9 million patients. We attributed access bonus payments made to the group to physicians within the group equally. We divided physicians into quintiles of equal size according to the percentage of the maximum potential access bonus payment they received, with quintile 1 representing the lowest and quintile 5 the highest share. We examined the characteristics of patients and physicians in each quintile. We then assessed the association between the quintiles and primary care visits, after-hours care, ED use, and related costs.

**STUDY VARIABLES** Household income was measured using area-level census data linked to the patient's postal code of residence and expressed as quintiles. First-time registration for health care coverage within the past five years was used as a proxy for recent immigration, as close to 80 percent of new registrants in Ontario are international migrants.<sup>21</sup> Case-mix was measured using the Johns Hopkins Adjusted Clinical Groups System,<sup>22</sup> with at least five Aggregated Diagnosis Groups representing high comorbidity and Resource Utilization Bands 4 and 5 representing the highest quintiles of expected resource use. Rurality was measured using the Rurality Index of Ontario, with scores of 0–9 representing larger cities, 10–39 smaller cities, and 40 or more rural areas.<sup>23</sup> Analyses of health care use and costs were stratified by rurality to account for different patterns of care in rural areas, such as higher ED visit rates.<sup>14</sup>

Continuity of care was measured as the percentage of primary care visits over two years made to the enrolling physician and the enrolling group.<sup>24</sup> Visits after 5:00 p.m. on weekdays were assessed through a 30 percent after-hours premium (billing code Q012) and those on weekends and holidays through billing as an ED equivalent (billing code A888), which was paid in full as an out-of-basket service. The urgency of ED visits was assessed using the Canadian Triage and Acuity Scale (CTAS), with categories of 1–3 being considered more urgent and 4–5 considered less urgent.<sup>25</sup> Ambulatory visits were de-

## Primary care payment reform can be fraught with trade-offs, risks, and unintended consequences.

defined as the combined number of primary care visits and ED visits. Ambulatory costs included primary care fee-for-service, capitation, and shadow billing payments; ED hospital costs; and shadow billing costs for emergency physicians.<sup>26</sup> Ambulatory costs did not include bonus or incentive payments, the access bonus, or costs of specialist visits. Physician groups could apply to be exempt from the after-hours requirements if, for example, more than half of group physicians provided regular ED coverage, anesthesia, or obstetrical deliveries. We excluded groups with an after-hours exemption from analyses of health care use and costs.

**DATA ANALYSIS** Data were presented as means with standard deviations, medians with interquartile ranges, and proportions expressed as percentages. Significance was set at  $p < 0.05$  and assessed using chi-square tests for proportions, analysis-of-variance tests for means, and Mann-Whitney U tests for medians. Adjusted analyses were conducted using Poisson regression, controlling for age, sex, comorbidity, expected resource use, recent registration, income quintile, and rurality. Secondary analyses were conducted stratifying by rurality to examine whether associations were independent of setting.

**LIMITATIONS** This study had a number of limitations that are important for interpretation. First is the cross-sectional nature of the study, which limits causal inference. Longitudinal approaches could be highly recommended in the study of primary care reform and would be an appropriate next step for the current work. Lack of randomization means that important unobserved factors, such as provider and patient attitudes, could have affected the results. Residual confounding is also a possibility—for example, when controlling for rurality among groups with very different distributions. For these reasons, the study did not assess whether the access bonus scheme was achieving its objectives.

Second, administrative data contain only superficial information on patients' demographic

characteristics, socioeconomic status, or health care needs and are missing important information about the duration or complexity of visits and health attitudes and behaviors. These data also exclude nonbillable forms of access (such as telephone calls and email) and exclude people without provincial health care coverage (such as refugees, foreign students, and undocumented migrants). Active members of the military and the Royal Canadian Mounted Police, as well as indigenous populations living on reserve, may receive health services that are not included in these data.

Finally, it is possible that capitation practices that were paid 15 percent of fee-for-service claims might not have billed as completely as those in fee-for-service that were paid 100 percent. However, that limitation would be expected to apply equally to all of our study groups.

## Study Results

Each of the access bonus quintiles included approximately 800 primary care physicians (exhibit 1). The proportion of the maximum possible access bonus payment ranged from 0.0 percent in the lowest quintile to 82.9 percent in the highest, with corresponding mean payments of \$0 and \$36,570, respectively. Physicians in the highest quintile were of similar age and had practiced a similar number of years as those in the

lowest quintile but were more likely to be male and graduates of Canadian medical schools. They were far more likely to practice in smaller cities and rural areas (exhibit 2). Roster sizes (mean numbers of patients) were similar across quintiles (exhibit 1).

There were just over one million patients in each quintile, and patterns of age and sex were similar across quintiles (exhibit 3). The proportion of recent immigrants in the highest quintile was less than one-quarter that in the lowest quintile. The highest quintile also had the lowest proportion of people with high comorbidity, as measured by number of Aggregated Diagnosis Groups, and a low proportion of people with high expected resource use, as measured by Resource Utilization Bands.

Visits and costs were analyzed after excluding 450 physicians (11.1 percent) who were exempted from providing after-hours care (data not shown). Groups could request an exemption from after-hours care if at least half of their members provided inpatient, intrapartum, or ED care. The proportion of patients exempted was similar across quintiles except in the highest—in which a lower proportion was exempted (exhibit 4). Overall, patients had an annual average of 2.93 primary care visits, 2.09 of which were to their enrolling physician and 2.29 to that physician or someone else in their enrolling group. Patients of physicians in the highest quin-

### EXHIBIT 1

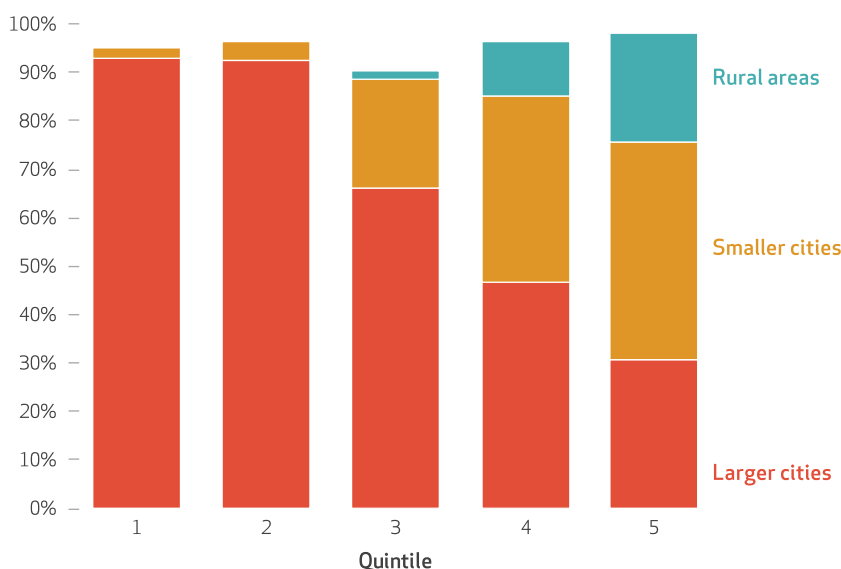
**Characteristics of Ontario physicians and their practices in blended capitation, by access bonus quintile, as of March 31, 2013**

	Quintile					
	1 (lowest)	2	3	4	5 (highest)	All
<b>PHYSICIAN CHARACTERISTICS</b>						
Number of physicians in quintile	806	814	810	817	805	4,052
Proportion of access bonus received (mean)	0.0%	22.2%	53.6%	73.5%	82.9%	41.5%
Access bonus per physician (mean)	\$0	\$9,275	\$22,766	\$31,250	\$36,570	\$17,646
Mean age (years)	51.58	51.10	50.54	50.26	51.02	50.90
Mean years in practice	24.13	23.42	22.76	22.12	22.75	23.04
Male	55.6%	50.2%	52.2%	56.3%	61.6%	55.2%
Graduate of Canadian medical school	74.9%	79.4%	81.4%	82.7%	82.6%	80.2%
<b>PRACTICE CHARACTERISTICS</b>						
Rurality						
Larger cities	92.9%	92.4%	66.2%	46.6%	30.6%	65.7%
Smaller cities	2.1	4.1	22.3	38.4	45.0	22.4
Rural areas	0.0	0.0	1.9	11.3	22.4	7.1
Missing data	5.0	3.6	9.6	3.7	2.1	4.8
Number of patients (mean)	1,537.64	1,445.90	1,455.87	1,429.60	1,429.07	1,459.51
Number of physicians in group (mean)	19.02	17.88	19.28	17.76	15.12	17.81

**SOURCE** Authors' analysis of the following data sets and analytic tools for 2013 at ICES (formerly known as the Institute for Clinical Evaluative Sciences): Generalized Alternate Payments, Architected Payments, Ontario Health Insurance Plan, Corporate Provider Database, ICES Provider Database, and Rurality Index of Ontario. **NOTE** Blended capitation is explained in the text.

## EXHIBIT 2

Physicians' access bonus quintiles, by rurality, 2013



**SOURCE** Authors' analysis of the following data sets for 2013 at ICES (formerly known as the Institute for Clinical Evaluative Sciences): Generalized Alternate Payments, Architected Payments, Ontario Health Insurance Plan, Corporate Provider Database, ICES Provider Database, and the Rurality Index of Ontario. **NOTES** Physicians in quintile 1 received the lowest percentage of the maximum potential access bonus payment, and physicians in quintile 5 received the highest percentage. The rurality measurement is explained in the text. There were no physicians in rural areas in quintile 1 or quintile 2. The percentages for the quintiles do not sum to 100 because of missing data.

tile had the lowest mean number of visits to the enrolling physician, enrolling group, and overall, while patients of physicians in the lowest quintile had the highest mean number of visits to the enrolling physician, enrolling group, and overall.

Continuity of care overall was moderately high, with 71.3 percent of primary care visits overall to the enrolling physician and 78.2 percent to the enrolling group. Patients of physicians in the highest quintile had the highest levels of continuity of care, and patients of physicians in the lowest quintile had the lowest levels. Overall, 6.5 percent of primary care visits had a billing code indicating service after 5:00 p.m. on a weekday, and 3.3 percent had a code for service on a weekend or holiday. Physicians in the highest quintile had the lowest proportion of all visits after hours, while physicians in the lowest quintile had the highest proportion. Overall, almost a quarter of the patients (23.0 percent) visited the ED each year, with the highest proportion in the highest quintile and the lowest proportion in the lowest quintile. When ED visits were categorized by urgency, the same pattern was seen, with higher rates of both high- and low-urgency visits found in the highest quintile.

When we considered primary care and ED visits together, we found that patients of physicians

in the highest quintile of access bonus payments had the lowest mean number of ambulatory visits, while those in the lowest quintile had the highest mean number. This pattern remained unchanged after adjustment. Mean and median ambulatory costs were similar across quintiles. Compared with the lowest quintile, in the highest quintile unadjusted ambulatory costs were slightly lower, but adjusted costs were higher.

For the secondary analyses stratified by rurality, the results for larger and smaller cities were largely consistent with the main findings (data not shown but available on request). Only 7.1 percent of physicians practiced in rural areas, and there were no rural physicians in quintiles 1 or 5. The patterns in rural quintiles 2–4 were inconsistent across measures, likely because of small numbers. For larger and smaller cities, the pattern of adjusted mean ambulatory visits was the same as in the overall findings, with the highest rates in quintile 1 and the lowest in quintile 5. The pattern of adjusted ambulatory costs was similar in smaller cities to the overall findings, with the highest costs in quintiles 4 and 5. For larger cities the adjusted ambulatory costs for quintile 5 were slightly lower than those in the other quintiles.

## Discussion

Primary care payment reform can be fraught with trade-offs, risks, and unintended consequences. Ontario's access bonus was ostensibly designed to incentivize access with the enrolling physician and contain ambulatory costs. It was substantial in amount, averaging over \$17,000 per physician and exceeding \$36,000 for physicians in the highest quintile. These funds flowed disproportionately to physicians outside large cities. Physicians receiving the access bonus served patients with less than average comorbidity and expected resource use. Although physicians receiving the greatest proportion of the access bonus had higher continuity of primary care visits, they also had the fewest primary care visits, provided the least after-hours care, and had the highest rates of ED visits. The adjusted cost of ambulatory visits, including primary care and ED visits, was highest among those receiving the greatest proportion of the access bonus. Had the costs of the access bonus itself been included, costs would have been even higher in the highest quintile.

Several considerations are taken into account when designing payment reform, including incentivizing desired provider and patient behavior. In the case of the access bonus, the government payer wished to avoid paying twice for the same service—once in capitation and again in

# EXHIBIT 3

Characteristics of Ontario patients in blended capitation, by access bonus quintile, as of March 31, 2013

	Quintile					
	1 (lowest)	2	3	4	5 (highest)	All
Number of patients in quintile	1,239,339	1,176,962	1,179,253	1,167,983	1,150,402	5,913,939
Mean age (years)	41.4	42.1	41.1	41.7	42.4	41.7
Male	47.5%	46.1%	47.6%	48.1%	48.0%	47.4%
Income quintile						
1 (lowest)	18.3%	14.6%	13.9%	17.5%	19.3%	16.7%
2	19.1	16.0	17.3	19.5	20.9	18.5
3	20.0	17.8	19.5	20.9	20.4	19.7
4	21.9	22.3	23.5	21.8	20.3	22.0
5 (highest)	20.5	29.0	25.5	19.9	18.7	22.7
Recent first-time health care registration <sup>a</sup>	9.6%	6.1%	4.0%	2.9%	2.3%	5.0%
High comorbidity <sup>b</sup>	49.5%	46.6%	42.3%	40.0%	38.8%	43.5%
High resource use <sup>c</sup>	17.3%	17.0%	15.8%	16.0%	16.1%	16.5%

**SOURCE** Authors' analysis of the following data sets and analytic tools for 2013 at ICES (formerly known as the Institute for Clinical Evaluative Sciences): Generalized Alternate Payments, Architected Payments, Ontario Health Insurance Plan, Registered Persons Database, Client Agency Provider Enrolment tables, and Johns Hopkins Adjusted Clinical Groups. **NOTES** Blended capitation is explained in the text. <sup>a</sup>Recent (within the past five years) first-time registration was used as a proxy for recent immigration. <sup>b</sup>Five or more Aggregated Diagnosis Groups. <sup>c</sup>Resource Utilization Band 4 or 5.

fee-for-service for use of services outside the enrollment group. In theory, a bonus payment for access would also reward physicians who were available to their patients, thereby reducing the need for outside care. In practice, however, incentives often flow to those already exhibiting the desired behaviors, sometimes with little evidence of change in outcomes.<sup>27–30</sup> The literature on the impact of financial incentives is mixed, with findings from the Quality and Outcomes Framework in the UK indicating improvement and better equity for some measures, but slowing of the changes over time as well as trade-offs in performance between measures such as timely access and continuity of care.<sup>30</sup> Other assessments of pay-for-performance have shown only very small improvements or no improvement overall.<sup>27,28,31,32</sup>

Physicians whose patients had the highest outside use of services also had the highest visit rates within their enrollment practices and groups. This pattern likely reflects greater complexity of care needs and the greater availability of primary care services such as walk-in clinics in larger cities, which demonstrates that health care services of all kinds are often driven by supply.<sup>33–35</sup> Conversely, smaller cities and rural areas have fewer alternative sources of care and therefore have less outside use, apart from that of EDs—which often serve as key points of primary care contact in many smaller communities. Our findings may also reflect different patterns of ED use<sup>14</sup> and cultural differences in health-seeking

behaviors between rural and urban patients.<sup>36</sup>

Payment reforms should align with health system goals to the extent possible. Contrary to this principle, physicians in this Ontario capitation-based model would be more likely to receive the access bonus if they encouraged their patients to visit the ED instead of a walk-in clinic. This is particularly problematic given that Canada has some of the highest rates of ED use among high-income countries.<sup>37</sup> A previous study in Ontario found that among reformed practices that adopted the new models of care, 60 percent of after-hours telephone messages directed patients to the ED, while only 32 percent informed patients of their own after-hours clinic.<sup>38</sup> Specialist care is also not penalized in the access bonus, which discourages collaboration among family physicians with specialized skills while incentivizing referral to more costly specialists. Although continuity of care has known benefits to both health outcomes and health system costs,<sup>39–41</sup> patients sometimes prioritize convenience over other considerations, and penalizing physicians for those choices may be ineffective and unfair.

## Policy Implications

There may be a need for different payment reform models in different settings such as small rural towns and large urban centers. Providers in rural settings, where almost all use of services and after-hours care outside of the enrollment

## EXHIBIT 4

## Ontario health care use in blended capitation, by access bonus quintile, 2013

	Quintile					
	1 (lowest)	2	3	4	5 (highest)	All
Patients of nonexempted physicians						
Number	1,099,390	992,212	1,035,235	1,019,170	1,094,454	5,240,461
Percent exempted	11.3%	15.7%	12.2%	12.7%	4.9%	11.4%
Mean primary care visits within 1 year to:						
Own physician	2.22	2.09	2.04	2.04	2.03	2.09
Own group	2.37	2.28	2.31	2.28	2.22	2.29
All physicians	3.45	3.12	2.88	2.69	2.51	2.93
Percent of all visits to:						
Own physician	64.3%	67.0%	70.8%	75.8%	80.9%	71.3%
Own group	68.7	73.1	80.2	84.8	88.4	78.2
Percent of all visits after hours						
Evenings	8.8%	6.2%	6.8%	5.5%	4.9%	6.5%
Weekends and holidays	4.6	3.9	4.2	1.7	1.6	3.3
ED visits within 1 year						
Any visit	19.9%	19.9%	22.1%	25.4%	27.3%	23.0%
No. of visits (mean)	0.33	0.33	0.38	0.45	0.48	0.39
No. of more urgent visits <sup>a</sup> (mean)	0.23	0.22	0.24	0.26	0.28	0.25
No. of less urgent visits <sup>b</sup> (mean)	0.10	0.11	0.14	0.19	0.20	0.15
Ambulatory visits within 1 year <sup>c</sup>						
Mean	3.78	3.44	3.25	3.14	2.99	3.32
Adjusted <sup>d</sup>	3.52	3.31	3.27	3.30	3.18	3.32
Ambulatory costs within 1 year						
Mean	\$401.10	\$392.13	\$386.71	\$393.78	\$397.81	\$394.45
Median	271	269	262	266	267	267
Adjusted <sup>d</sup>	386.35	383.10	392.42	405.01	405.98	394.45

**SOURCE** Authors' analysis of the following data sets and analytic tools for 2013 at ICES (formerly known as the Institute for Clinical Evaluative Sciences): Generalized Alternate Payments, Architected Payments, Ontario Health Insurance Plan, Registered Persons Database, Client Agency Provider Enrolment tables, National Ambulatory Care Reporting System, Rurality Index of Ontario, and Johns Hopkins Adjusted Clinical Groups (ACGs). **NOTES** Numbers of patients are in exhibit 3. Physicians exempted from providing after-hours care were excluded from the analysis of health care use. <sup>a</sup>Canadian Triage and Acuity Scale (CTAS) score of 1–3. <sup>b</sup>CTAS score of 4 or 5. <sup>c</sup>Primary visits and emergency department (ED) visits combined. <sup>d</sup>Variables used for adjustment included age, sex, comorbidity, and expected resource use from the Johns Hopkins ACGs; recent first-time health care registration (a proxy for recent immigration); income quintile; and rurality.

group is provided in EDs, should be neither rewarded nor penalized for that pattern of care when few viable alternatives for care are available. In major urban centers, where walk-in clinics are plentiful and many people commute to work, a different model may be needed. A model for large cities could allow dual enrollment of patients with a practice close to home and another practice close to work or provide access bonus payments to practices that could demonstrate timely access to care for urgent problems and after-hours care. A more radical approach would be to eliminate incentives or penalties for outside enrollment group use and instead make timely access and after-hours access requirements of the payment reform model, together with transparent reporting of patient experience in accessing care. Policy makers in other jurisdictions may also want to carefully consider the impact of primary care payment reform on other

sectors. For example, the Ontario access bonus was seen as desirable in primary care, but when examined across the whole health system, it inadvertently provided a financial incentive for physicians to advise their patients to use EDs in preference to lower-cost walk-in clinics. Finally, policy makers should consider prospective monitoring and evaluation of payment reforms to ensure that they are achieving their goals and to implement midcourse corrections as needed.

## Conclusion

Ontario's primary care access bonus was paid to the physicians who provided patients with the least after-hours care and whose patients had the highest ED visit rates and highest adjusted ambulatory costs. Payment reform may need to be designed and implemented differently for diverse settings such as small rural communities



and densely populated downtown cores. Financial incentives should be prospectively evaluated and frequently revisited to ensure relevance, alignment with system goals, efficiency, and equity. ■

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**TAB 202**



**Primary Care Use with Outside Providers: Multilevel Analysis of Family Health Organizations in Ontario, Canada**

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### **Contributions**

JK and SS conceived the study. SS analysed the data. SS and SW drafted the manuscript. All authors contributed to the interpretation of the data, revised the manuscript for important intellectual content, and approved the final version. SS is the guarantor.

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### **Competing Interests**

None of the authors report any competing interests in relation to this study.

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# **Primary Care Use with Outside Providers: Multilevel Analysis of Family Health Organizations in Ontario, Canada**

## **Abstract**

**Background and objectives:** Family Health Organizations in Ontario incentivize continuity of care through an access bonus. How patient and physician group factors impact outside use is not well understood. This study attempts to address the gap in policy-relevant evidence using a comprehensive set of patient and physician group variables to explain outside use as well as use multilevel modeling to quantify the relative variation in outside use at the patient, physician, physician group, and geographic levels.

**Approach:** Using administrative health data from April 1<sup>st</sup>, 2018 to March 31<sup>st</sup>, 2019, a multilevel logistic regression model was used to explain probability of outside use with a comprehensive set of observable factors at patient- and physician group-level. Multilevel modeling allowed us to explain relative variation in outside use attributable to patient, physician, group, and geographic levels.

**Results:** Patient-level variation explained 82.4% of outside use probability. Physician- and group-level variation each explained less than an additional 2% of outside use, with 14.2% explained at group geography level. Patient factors associated with outside use included age (odds ratio [OR] of oldest vs youngest cohort: 0.44, 95% confidence interval [CI] 0.42-0.45), female gender (OR: 1.21, 95% CI 1.19-1.23), complexity (most vs least complex quintile OR 3.58, 95% CI 3.45-3.71), distance from group (farthest vs nearest OR; 2.03, 95% CI 1.94-2.13), and FTE to population risk ratio (Highest quintile OR: 1.7, 95% CI 1.61-1.79). Group-level variables ( $p < 0.05$ ) included group rurality scores, group size, group years in existence, proportion of female MDs, average MD age, weekend/holidays worked per patient, and weekday after-hours per patient.

**Conclusion:** Effective policy options at the physician/group-level for reducing outside use may include promotion of group size greater than 5 and increased weekday/holiday and after-hours care. However, since outside use is primarily explained by variation at the patient level, more innovative policy options may be needed to improve care continuity.

**Keywords:** Primary care; continuity of care; access bonus; pay-for-performance; capitation; Ontario

## Introduction

Roughly one third of patients in Ontario, Canada are enrolled in a Family Health Organization (FHO) for primary care. FHOs are capitated payment models, with incentives to improve continuity of care through an “access bonus” payment. Continuity of care is internationally recognized as a key element of quality primary care provision and has been associated with improved patient outcomes and satisfaction.<sup>1</sup> The group’s access bonus can be earned for low levels of “outside use,” defined as enrolled patients receiving core primary care services from physicians outside the group. The tacit assumption is that physicians can influence patient behaviour, perhaps through increasing accessibility, or by otherwise encouraging patients to seek continuous care from their enrolling group. However, Ontario patients have universal first-dollar coverage for insured physician services at any Ontario practice and do not have direct financial incentives to seek out medical care from their enrolling physician group

Prior research has arrived at mixed conclusions on access bonus effectiveness. One longitudinal study found that when physicians switched from a model with no access bonus to one with it, there was lower patient-level outside use (i.e., improved continuity of care) compared to physicians who did not switch.<sup>2</sup> A cross-sectional study found that in urban settings, higher access bonus payments were associated with better patient self-reported telephone access, after-hours access, timeliness, and wait times in urban areas.<sup>3</sup> However, another cross-sectional study found that higher access bonus payments were associated with lower levels of after-hours visits and higher emergency department (ED) use and ambulatory costs.<sup>4</sup> The authors interpreted that this as due to differences in rural/urban practice patterns.

This study attempts to address the gap in policy-relevant evidence by using a comprehensive set of patient and physician group variables to explain outside use. This includes multiple measures of patient/physician group geography, which have been highlighted in the existing literature.<sup>3-4</sup> We used

multilevel modeling to quantify the relative variation in outside use at the patient, physician/physician group, and geographic levels.<sup>5-7</sup>

## **Methods**

### *Study population*

Deidentified administrative health care data were obtained from the Ontario Ministry of Health under an agreement with the Ontario Medical Association (OMA). The study population consisted of OHIP-eligible individuals residing in Ontario who were enrolled with a FHO physician during fiscal year (FY) 2018/19 (April 1<sup>st</sup>, 2018 to March 31<sup>st</sup>, 2019). We included only patients who were enrolled with their physician for the entire fiscal year. We excluded patients who were ineligible or died before the fiscal year ended and those with certain data anomalies (e.g., age > 130 years, death date preceding birth date).

### *Data sources and linkage*

The Client Agency Program Enrolment (CAPE) database provided information linking physicians with enrolled patients. The Corporate Provider Database (CPDB) provided information linking physicians to FHO groups. Group postal codes from the CPDB linked to an OMA data source on rurality. Ontario road network data obtained from publicly available OpenStreetMap services were used to determine travel time.<sup>8</sup>

Physician claims from the Ontario Health Insurance Plan (OHIP) database were used to estimate outside use. Patient complexity was summarized using the Canadian Institute for Health Information's Population Grouping Methodology. This relied on diagnostic data from patient encounters in OHIP claims as well as from the National Ambulatory Care Reporting System (NACRS) and the Discharge Abstract Database (DAD).<sup>9-11</sup>

### *Outcomes*

Our outcome measure was a binary indicator equal to 1 if the patient had outside use, and 0 otherwise. Outside use was based on utilization of OHIP fee codes in the FHO basket of core services (see Appendix A) when received from primary care physicians outside the enrolling group. This excluded services that were exempt when provided by a designated focused-practice GP.

### *Exposures*

We considered observable predictors at the level of patients, and physician groups, as well as geographic variables centred around both patients and groups. All continuous variables were specified as categorical variables to allow for non-linear relationships and ease of interpretation. These were based on prespecified cut-offs, where appropriate, and quintiles otherwise.

Patient-level variables included demographics (age and sex), complexity, patient-physician relationship metrics, and patient-geography centred contextual factors. Complexity was measured using the Population Grouping Methodology developed by the Canadian Institute for Health Information (CIHI). CIHI risk scores reflect an individual's relative total healthcare cost risk based on a comprehensive set of healthcare conditions diagnosed during the study period and prior 4 years. Patient-physician relationship metrics included years enrolled with the current group, count of past enrollments, and travel time to the enrolling group. The R package *osrm* was used to compute travel time between patients and physician groups based on a snapshot of road network data from Feb. 2019. Patient contextual factors included ratios of supply over demand calculated within a 50 km radius of a patient's postal code based on the Haversine distance calculation.<sup>12</sup> This included two factors: (1) the count of family physicians weighted by full-time equivalent (FTE) and (2) ED volume, normalized by the patient population in this radius weighted

by patient's CIHI risk scores. We refer to these, respectively, as FTE to population risk ratio and ED volume to population risk ratio.

Physician (MD) characteristics were defined at the group level as the Access Bonus is implemented as a group level incentive. Group variables included group years in existence, group size, average roster size, as well as physician demographics, access metrics, and rurality. Group size was defined as the number of affiliated physicians within a group, excluding locums. Group average roster size was calculated based on total patients enrolled with a group for the entire fiscal year, divided by group size. Physician demographics were aggregated to the group level as average MD age and proportion of female MDs. Access measures were based on days worked and after-hours services. These included weekdays worked per patient and weekend/holidays worked per patient, which were both based on the total relevant days worked by all physicians in a group divided by total group roster size. We also defined after-hours (AH) weekdays per patient, which was based on the count of after-hours blocks worked during weekdays summed over all physicians in a group and divided by the group roster size. An after-hours block was defined as a day in which at least one after-hours premium code (Q012) was billed by a physician. Group geography is defined by the Rurality Index of Ontario (RIO) scores.

### *Statistical Analysis*

Multivariable logistic regressions were performed on a 5% random sample of the data to assess the explanatory value of observable factors defined above (reported as adjusted odds ratios), and also assess the impact of unobservable factors at the level of patient, physician, physician group, and geography. These unobservable factors are captured in a *random effect* term. This allows us to estimate the relative magnitude of variation of outside use at each of these levels, by estimating the variance of each random effect at each level using likelihood methods. The ratio of variances at each level over the total variation in outside use, also called the intraclass correlation coefficient (ICC), gives us information about the

relative variation explained at the patient, physician, group, and geography level. The geography level random effect is defined by the group address' forward sortation area (i.e., FSA, defined as the 3-digit prefix of an Ontario postal code), which captures geography-level variation in outside use not accounted for by observable geography measures like the RIO.

We began with a four-level intercept-only model, nesting patients within physician, group, and geographic location. We used this approach for two purposes. First, this tells us how much variation is accounted for by each of these levels alone without accounting for any observable factors. Second, we use this for model selection purposes. That is, any levels in which there is variation below a 3% threshold, we exclude that level's random effect from the final multivariable model. This is done because: (1) unobservable factors at these levels have minimal impact; and (2) variation below these levels can cause difficulties for model estimation.

Database manipulation for this study was undertaken using SAS 9.4 (Cary, NC), and statistical analyses were conducted using STATA 16.0 (College Station, TX).

#### *Ethics Approval*

Formal ethics approval was not required because the analysis used deidentified, linked healthcare administrative data obtained from a data sharing agreement between the Ontario Medical Association and the Ontario Ministry of Health, and the research was initially carried out as part of Ontario Medical Association business operations.

## **Results**

We identified 5,713,877 patients enrolled to one of 4,905 FHO physicians for the study period. Observations dropped according to sample selection criteria are detailed in the supplementary material



(table S1). We found that 78.9% of patients had primary care use, and of these 25.6% had outside use (Figure 1).

All mean patient and enrolling group characteristics were significantly different for patients with and without outside use ( $P < 0.0001$ ). In unadjusted analyses, positive outside use was associated with younger patient age, female gender, higher risk score (complexity), higher travel time to enrolling group, less time enrolled with their physician, and more past enrolments. For patient contextual factors, positive outside use was associated with higher family physician FTE to population risk ratio, and lower ED volume to population risk ratio. Physician group characteristics associated with positive outside use included urban practice location, smaller physician group size, larger group average roster size, fewer group years in existence, a larger proportion of female MDs, higher MD average age, fewer weekdays worked per patient per year, fewer weekend/holidays worked per patient, and higher after-hours blocks during weekdays per patient (**Table 1**).

#### *Relative Importance by level*

Based on ICCs, in a four-level intercept-only model, the physician and group levels only explained an additional 1.5% and 1.9% of variation in outside use, respectively. Hence these levels were dropped in remaining regression analysis. Dropping these levels, the two-level intercept-only model, nesting patients in group geography, had an ICC of 15.8% of variation at the geography level, with the patient level accounting for the remaining 84.2% of variation in outside use.

#### *Regression Results*

Based on model selection results, multivariable regression analysis were reported for the preferred model nesting patient within group geography level random effects. After accounting for observable factors, the ICC ratio of proportion of variation in outside use explained by the group geography level dropped to 9.3%. Joint hypothesis tests for all dummy variable groupings found all patient-level observable variables

were statistically significant ( $P < 0.05$ ; **Table 2**). For group-level variables, statistically significant predictors at the 5% level included group rurality scores, group size, group years in existence, proportion of female MDs, average MD age, weekend/holidays worked per patient, and after-hours weekday blocks per patient.

Outside use was positively associated with female gender (odds ratio [OR] 1.21, 95% confidence interval [CI] 1.19-1.23), patient complexity (Q5 OR 3.58, 95% CI 3.45-3.71), distance from the enrolling group (OR of '60 + min' to '0 to <10 min' 2.03, 95% CI 1.94-2.13), past enrolments (OR of '2+ enrolments' to 'no past enrolments' 1.15, 95% CI 1.12-1.19), FTE to population risk ratio (Q5 OR 1.7, 95% CI 1.61-1.79). Outside use was negatively associated with patient age (OR of '65+ years' to '0 to 25 years' 0.44, 95% CI 0.42-0.45), group rurality (OR of 'RIO 45+' to 'RIO 0' 0.38, 95% CI 0.31-0.48), and weekend/holidays per patient (Q5 OR 0.88, 95% CI 0.83-0.94). For other dummy variables where joint hypothesis test confirmed significance, odds ratios had no consistent pattern, both increasing and decreasing across some quintiles/categories.

### Interpretation

We found 25.6% of patients with any PC use having outside use. Patient-level variation explained approximately 82.4% of the probability of outside use. The remaining variation was primarily at the group geography level. Physician and physician group contributions to the variation were small (relative variation <2% each). Thus, patient choice for outside use was primarily explained by idiosyncratic patient-level factors. All patient-level observable factors were statistically significant ( $P < 0.05$ ). In terms of group-level variables, the group physician demographic mix, years in existence, group size, and weekend/holiday and after-hours availability was associated with outside use levels ( $P < 0.05$ ).

Our results are consistent with prior research findings based on patient self-reported survey data suggesting that most variance in patient-reported access to primary care in Ontario was associated with

patient-level factors.<sup>3</sup> That study did not report variation in outside use directly. Other studies have highlighted the importance of rurality, especially the unavailability of outside primary care providers in rural areas, as a key factor in determining outside use.<sup>4</sup> While our analysis confirms the importance of geographic variation in explaining outside use, relative to physician- and group-level factors, this impact is overshadowed by patient-level factors. We did find that controlling for observable factors can explain a significant proportion of group variation which declined from 15.8% in the model with no observable variables to 9.3% in the model that controlled for all observable variables. This suggests some geographic differences in outside use and hence Access Bonus levels could be accounted for by these variables. However, patient factors determining outside use remains the dominant factor.

The primary objective of the access bonus is to promote continuity of care within the enrolling group. The importance to balance the necessity for continuity versus access across the care continuum may differ according to patient needs.<sup>13-14</sup> Thus, it may be useful to understand how specific health conditions translate to patient choices over access and continuity.

Policy options through physician group-level factors which may be effective include promotion of group size greater than 5, as well as incentives targeting increased weekday/holiday and after-hours care. However, since the majority of variation in outside use is at the patient level, it would likely be more impactful to consider policy options that promote continuity through means targeting patients, such as multi-language, culturally-appropriate public information campaigns, sharing of medical records, and addressing patient-level access barriers (e.g., transportation vouchers).

### *Limitations*

Caution should be taken with interpretation of this work in several respects. Estimates of variation at a level of the multilevel analysis were not necessarily a causal impact of that level.<sup>15</sup> Decomposition of variation in outside use depends on distributional and independence assumptions on unobservable error

components at each level. While we exclude designated focused practice GP billings in our definition of outside use, some physicians may effectively practice in this capacity but do not have formal designations recognized by the MOH. Our analysis also did not consider heterogeneous impact of after-hours on specific days or intensity of after-hours work per day.

### *Conclusion*

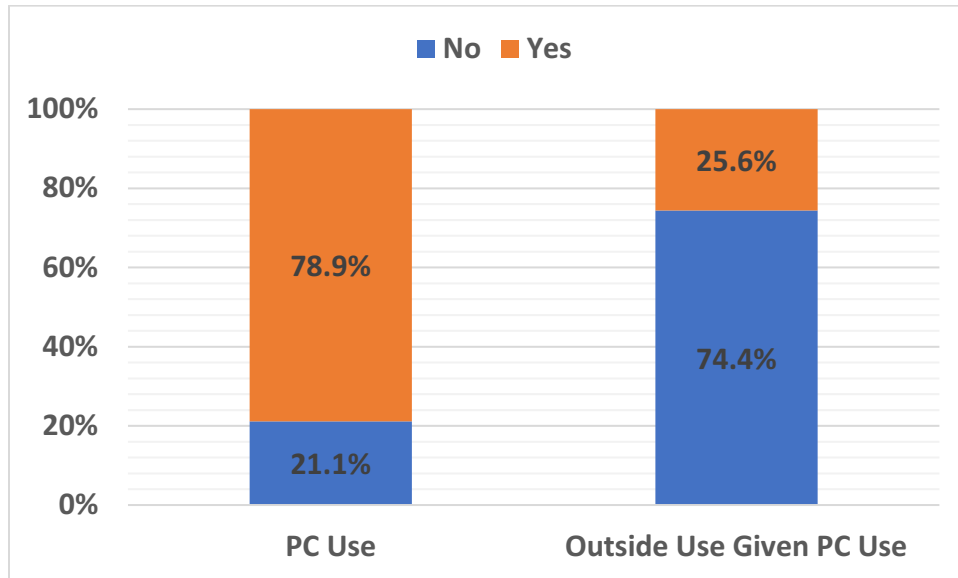
We used multilevel modeling to quantify the variation in outside use explained at the patient, physician, group, and geography levels. We also looked at how relative variation at the patient and geography levels was accounted for by observable factors. Although the importance of geography has been highlighted in past studies, we found that unexplained patient-level choice dominates geography-, group-, and physician-level factors. Our results highlight the need for careful consideration of factors influencing patient choices for continuous care of primary care services. Results suggest consideration of policy options that target patient choice through channels beyond enrolling physicians and groups.

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## Figures



**Figure 1.** Proportion of patients with outside use and any primary care utilization

## Tables

**Table 1.** Patient, patient geography, and physician group characteristics by outside use status

	Positive outside use					T-test
	Mean	SD	No	Yes	% Diff	P-value
Patient						
Patient age (years)	44.57	22.89	45.25	41.89	-7.4%	<0.0001
Patient female	0.53	0.50	0.51	0.58	12.3%	<0.0001
Patient risk score	1.00	1.91	0.94	1.25	32.8%	<0.0001
Travel time to MD (minutes)	21.60	41.19	20.73	25.02	20.7%	<0.0001
Years enrolled with MD	5.50	3.36	5.56	5.26	-5.4%	<0.0001
Number past MD enrollments	0.67	0.89	0.66	0.68	1.8%	<0.0001
FTE to population risk ratio	0.63	0.26	0.62	0.67	7.3%	<0.0001
ED volume to population risk ratio	13.55	15.30	13.95	11.98	-14.2%	<0.0001
Physician/group						
Group rurality index	9.41	15.00	10.44	5.31	-49.2%	<0.0001
Group size (no. MDs)	18.74	16.07	18.77	18.59	-1.0%	<0.0001
Group average roster size per MD	1186.99	322.87	1181.42	1209.09	2.3%	<0.0001
Group years in existence	8.73	3.13	8.85	8.23	-7.1%	<0.0001
Proportion female MDs	0.47	0.21	0.47	0.48	0.5%	<0.0001
Average md age	50.75	5.57	50.60	51.34	1.5%	<0.0001
Weekdays worked per patient	172.28	45.06	173.53	167.35	-3.6%	<0.0001
Weekend/holidays per patient	19.89	12.62	20.21	18.66	-7.6%	<0.0001
After-hours blocks per patient	22.88	15.83	21.96	26.54	20.9%	<0.0001

Notes: FTE to population risk ratio is measured per 1000 population members



**Table 2.** Multilevel multivariable logistic regression for outside use

	OR	95% CI	P-value, joint hypothesis tests
Patient level variables			
Age: 0 to <25	reference	.	<.0001
Age: 25 to <45	0.891	[0.866, 0.916]	
Age: 45 to <65	0.590	[0.574, 0.607]	
Age: 65 +	0.438	[0.424, 0.453]	
Patient gender: male	reference	.	<.0001
Patient gender: female	1.209	[1.185, 1.234]	
Risk score: q1 (lowest complexity)	reference	.	<.0001
Risk score: q2	1.808	[1.747, 1.872]	
Risk score: q3	2.281	[2.204, 2.361]	
Risk score: q4	2.720	[2.628, 2.816]	
Risk score: q5 (highest complexity)	3.577	[3.452, 3.706]	
Distance: 0 to <10 min	reference	.	<.0001
Distance: 10 to <20 min	1.199	[1.170, 1.229]	
Distance: 20 to <30 min	1.364	[1.322, 1.408]	
Distance: 30 to <60 min	1.583	[1.531, 1.635]	
Distance: 60 + min	2.030	[1.940, 2.125]	
Distance: missing	1.075	[0.925, 1.248]	
Years enrolled: 0 to <1	reference	.	<.0001
Years enrolled: 1 to <5	0.954	[0.922, 0.988]	
Years enrolled: 5 +	1.011	[0.976, 1.048]	
Past enrolments: 0	reference	.	<.0001
Past enrolments: 1	1.073	[1.048, 1.098]	
Past enrolments: 2 +	1.152	[1.116, 1.188]	
FTE to population risk ratio: q1 (lowest)	reference	.	<.0001
FTE to population risk ratio: q2	1.293	[1.231, 1.359]	
FTE to population risk ratio: q3	1.288	[1.223, 1.357]	
FTE to population risk ratio: q4	1.665	[1.580, 1.755]	
FTE to population risk ratio: q5 (highest)	1.698	[1.610, 1.792]	
Ed volume to population risk ratio: q1 (lowest)	reference	.	<.0001
ED volume to population risk ratio: q2	1.063	[1.028, 1.098]	
ED volume to population risk ratio: q3	1.068	[1.029, 1.109]	
ED volume to population risk ratio: q4	0.910	[0.866, 0.956]	
ED volume to population risk ratio: q5 (highest)	0.780	[0.738, 0.824]	
Physician group level variables			
Group rurality index: 0	reference	.	<.0001
Group rurality index: 1-44	0.808	[0.726, 0.900]	
Group rurality index: 45+	0.384	[0.309, 0.477]	
Group rurality index: missing	0.776	[0.695, 0.866]	
Group size: 1 to 5	reference	.	<.0001
Group size: 6 to 10	0.858	[0.814, 0.906]	
Group size: 11 to 20	0.909	[0.856, 0.966]	

Group size: 21 +	0.866	[0.812, 0.923]	
Average roster size: 1 to 999	reference	.	
Average roster size: 1000 to 1199	1.054	[0.991, 1.120]	
Average roster size: 1200 to 1799	1.046	[0.974, 1.124]	0.2080
Average roster size: 1800 to 2400	0.975	[0.857, 1.110]	
Group years in existence: q1 (lowest)	reference	.	
Group years in existence: q2	0.951	[0.900, 1.006]	
Group years in existence: q3	1.013	[0.953, 1.077]	<.0001
Group years in existence: q4	0.944	[0.885, 1.007]	
Group years in existence: q5 (highest)	0.845	[0.790, 0.904]	
Proportion female MDs: q1 (lowest)	reference	.	
Proportion female MDs: q2	1.068	[1.000, 1.142]	
Proportion female MDs: q3	0.971	[0.909, 1.036]	0.0002
Proportion female MDs: q4	1.029	[0.962, 1.102]	
Proportion female MDs: q5 (highest)	0.932	[0.873, 0.995]	
Average MD age: q1 (lowest)	reference	.	
Average MD age: q2	0.925	[0.873, 0.981]	
Average MD age: q3	0.938	[0.881, 0.999]	<.0001
Average MD age: q4	1.125	[1.058, 1.196]	
Average MD age: q5 (highest)	1.021	[0.954, 1.092]	
Weekdays worked per patient: q1 (lowest)	reference	.	
Weekdays worked per patient: q2	0.995	[0.929, 1.065]	
Weekdays worked per patient: q3	1.000	[0.930, 1.075]	0.8775
Weekdays worked per patient: q4	1.023	[0.944, 1.108]	
Weekdays worked per patient: q5 (highest)	0.994	[0.898, 1.100]	
Weekend/holidays per patient: q1 (lowest)	reference	.	
Weekend/holidays per patient: q2	0.988	[0.931, 1.048]	
Weekend/holidays per patient: q3	0.991	[0.934, 1.052]	0.0001
Weekend/holidays per patient: q4	0.919	[0.870, 0.971]	
Weekend/holidays per patient: q5 (highest)	0.884	[0.830, 0.942]	
After-hours weekdays per patient: q1 (lowest)	reference	.	
After-hours weekdays per patient: q2	0.885	[0.823, 0.951]	
After-hours weekdays per patient: q3	1.036	[0.968, 1.108]	<.0001
After-hours weekdays per patient: q4	0.937	[0.875, 1.003]	
After-hours weekdays per patient: q5 (highest)	0.932	[0.869, 0.999]	
Variance: Geography (group FSA) level	1.400	[1.317, 1.488]	
Intraclass correlation coefficient	9.3%		
N	280,013		

## Appendix A – FHO basket definition

**Table B1.** List of fee codes in FHO core services basket

Fee Code	Fee Code Descriptor
A001	Family Practice & Practice in General - minor assessment
A003	Family Practice & Practice in General - general assessment
A004	Family Practice & Practice in General - general re-assessment
A007	Family Practice & Practice in General - intermediate assessment/well baby care
A008	Family Practice & Practice in General - mini assessment
A110	Family Practice & Practice in General - periodic oculo-visual assessment - aged 19 years and below
A112	Family Practice & Practice in General - periodic oculo-visual assessment - aged 65 years and above
A777	Family Practice & Practice in General - intermediate assessment - pronouncement of death
A900	Family Practice & Practice in General - Complex house call assessment
A901	Family Practice & Practice in General - House call assessment
A903	Family Practice & Practice in General - pre-dental/pre-operative general assessment
A917	Family Practice & Practice in General-Focused Practice Assessment (FPA)-Sport medicine FPA
A927	Family Practice & Practice in General-Focused Practice Assessment (FPA) - Allergy FPA
A937	Family Practice & Practice in General-Focused Practice Assessment (FPA) - Pain management FPA
A947	Family Practice & Practice in General-Focused Practice Assessment (FPA) - Sleep medicine FPA
A957	Family Practice & Practice in General-Focused Practice Assessment (FPA)- Addiction medicine FPA
A967	Family Practice & Practice in General - Care of the elderly FPA
A990	SVP - Physician Office-Weekdays (07:00-17:00) - first patient seen
A994	SVP - Physician Office-(17:00-24:00) Mon-Fri - first patient seen
A996	SVP - Physician Office- (00:00-07:00) -first patient seen
A998	SVP - Physician Office - Sat., Sun. and Holidays (07:00-24:00)-first patient seen
B990	SVP - Patient's Home - Weekdays (07:00-17:00) Nonelective/Elective - first patient seen
B992	SVP - Patient's Home - Weekdays (07:00- 17:00) with Sacrifice of Office Hours - first patient seen
B994	SVP - Patient's Home - (17:00- 24:00) Mon-Fri Non-elective -first patient seen
B996	SVP - Patient's Home - (00:00-07:00) Non-elective -first patient seen
C882	Family Practice & Practice in General - non-emergency hospital in-patient services - Subsequent visits by the MRP following transfer from an Intensive Care Area - Palliative care
C903	Family Practice & Practice in General Nephrology - non-emergency hospital in-patient services - Pre-dental/pre-operative general assessment (maximum of 2 per 12 month period)
E542	When performed outside hospital, to G328, G378, G367, G370, R040, R041, R048, R049, R050, R094, R160, R161, R162, R163, R164, R165, S003, S006, Z080, Z081, Z082, Z083, Z084, Z085, Z096, Z101, Z103, Z104, Z106, Z114, Z116, Z122, Z123, Z124, Z125, Z126, Z127, Z128, Z129, Z173, Z174, Z130, Z131, Z141, Z154, Z156, Z157, Z158, Z162, Z163, Z164, Z175, Z176, Z177, Z179, Z190, Z191, Z192, Z331, Z332, Z477, Z501, Z502, Z503, Z504, Z545, Z702, Z714, Z722, Z757, Z763, Z770, Z874
G001	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Cholesterol, total
G002	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Glucose, quantitative or semi-quantitative
G004	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Occult blood
G005	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Pregnancy test
G009	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)
G010	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - One or more parts of above without microscopy
G011	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Fungus culture including KOH preparation and smear
G012	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Wet preparation (for fungus, trichomonas, parasites)
G014	Diagnostic & Therapeutic - Lab Medicine -Miscellaneous - Rapid streptococcal test

G123	Diagnostic & Therapeutic - Nerve Block S - Peripheral/Other Injections - Obturator nerve - for each additional one (to a maximum of 4) add
G197	Diagnostic & Therapeutic - Allergy - Skin testing - professional component, to a maximum of 50 per year per test
G202	Diagnostic & Therapeutic - Allergy -Hyposensitisation - each injection
G205	Diagnostic & Therapeutic - Allergy -Hyposensitisation -Insect venom desensitisation (immunotherapy) - per injection (maximum of 5 per day). In addition to G205, after the initial major assessment only, a minor or partial assessment may be claimed once per day if rendered
G209	Diagnostic & Therapeutic - Allergy - Skin testing - technical component, to a maximum of 50 per year per test
G212	Diagnostic & Therapeutic - Allergy -Hyposensitisation -when sole reason for visit (including first injection)
G223	Diagnostic & Therapeutic - Nerve Blocks - Peripheral/Other Injections - Somatic or peripheral nerves not specifically listed - additional nerve(s) or site(s) add
G227	Diagnostic & Therapeutic - Nerve Blocks - Peripheral/Other Injections - Obturator nerve - Other cranial nerve block
G228	Diagnostic & Therapeutic - Nerve Blocks - Peripheral/Other Injections - Obturator nerve - Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves
G231	Diagnostic & Therapeutic - Nerve Blocks - Peripheral/Other Injections - Somatic or peripheral nerves not specifically listed -one nerve or site
G235	Diagnostic & Therapeutic - Nerve Blocks- Peripheral/Other Injections - Somatic or peripheral nerves not specifically listed -Supraorbital
G271	Diagnostic & Therapeutic - Cardiovascular - Anticoagulant supervision - long-term, telephone advice per month
G310	Diagnostic & Therapeutic - ECG - Electrocardiogram - twelve lead - technical component
G313	Diagnostic & Therapeutic - ECG - Electrocardiogram - twelve lead - professional component - must include written interpretation
G365	Diagnostic & Therapeutic - Gynaecology - Papanicolaou Smear - periodic
G370	Diagnostic & Therapeutic - Injections or Infusions - Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath
G371	Diagnostic & Therapeutic - Injections or Infusions - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5
G372	Diagnostic & Therapeutic - Injections or Infusions - Intramuscular, Subcutaneous, or Intradermal - each additional injection/with visit (each injection)
G373	Diagnostic & Therapeutic - Injections or Infusions - Intramuscular, Subcutaneous, or Intradermal - sole reason (first injection)
G375	Diagnostic & Therapeutic - Injections or Infusions - Intralesional Infiltration - one or two lesions
G377	Diagnostic & Therapeutic - Injections or Infusions - Intralesional Infiltration - 3 or more lesions
G378	Diagnostic & Therapeutic - Gynaecology - Insertion of intrauterine contraceptive device
G379	Diagnostic & Therapeutic - Injections or Infusions - Intravenous - Child, adolescent or adult
G381	Diagnostic & Therapeutic - Injections or Infusions - Chemotherapy - Standard chemotherapy - agents with minor toxicity that require physician monitoring
G384	Diagnostic & Therapeutic - Injections or Infusions - Infiltration of tissues for trigger point
G385	Diagnostic & Therapeutic - Injections or Infusions - for each additional site (to a maximum of 2) add
G420	Diagnostic & Therapeutic - Otolaryngology - Ear syringing and/or extensive curetting or debridement unilateral or bilateral
G435	Diagnostic & Therapeutic - Ophthalmology - Radioactive phosphorus examination - Tonometry
G462	Diagnostic & Therapeutic - Injections or Infusions - Intralesional Infiltration - Administration of oral polio vaccine
G481	Diagnostic & Therapeutic - Lab Medicine - Miscellaneous - Haemoglobin screen and/or haematocrit (any method or instrument)
G482	Diagnostic & Therapeutic - Cardiovascular -Venipuncture - child
G489	Diagnostic & Therapeutic - Cardiovascular -Venipuncture - adolescent or adult
G525	Diagnostic & Therapeutic - Otolaryngology - Pure tone threshold audiometry with or without bone conduction - professional component
G538	Diagnostic & Therapeutic - Injections and Infusions - Immunization - Other immunizing agents not listed above
G840	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP/IPV) - paediatric
G841	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric
G842	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Hepatitis B (HB)
G843	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Human Papillomavirus (HPV)
G844	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Meningococcal C Conjugate (Men-C)

G845	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Measles, Mumps, Rubella (MMR)
G846	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Pneumococcal conjugate
G847	Diagnostic & Therapeutic - Injections and Infusions- Immunization -Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult
G848	Diagnostic & Therapeutic - Injections and Infusions- Immunization - Varicella (VAR)
J301	Pulmonary Function Studies - simple spirometry -Volume versus Time Study - must include Vital capacity, FEV1, FEV1 /FVC, and may include calculation of MMEFR(FEF25-75)
J304	Pulmonary Function Studies -Flow volume loop -Volume versus Flow Study - from which an expiratory limb, and inspiratory limb if indicated, are generated. A flow volume loop may include derivation of FEV1, VC, V50, V25
J324	Pulmonary Function Studies - simple spirometry -repeat after bronchodilator
J327	Pulmonary Function Studies - flow volume loop - repeat after bronchodilator
K001	General Preamble - Assessments - Detention – per full quarter hour
K002	Family Practice & Practice in General - Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act per unit
K003	Family Practice & Practice in General - Interviews with Children's Aid Society (CAS) or legal guardian on behalf of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent per unit
K004	Family Practice & Practice in General - psychotherapy - family -2 or more family members in attendance at the same time per unit
K005	Family Practice & Practice in General - primary mental health care -Individual care per unit
K006	Family Practice & Practice in General - hypnotherapy - Individual care per unit
K007	Family Practice & Practice in General - psychotherapy -Individual care per unit
K008	Family Practice & Practice in General - Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities per unit
K013	Family Practice & Practice in General-Counselling - Individual care - first three units of K013 and K040 combined per patient per provider per 12-month period per unit
K015	Family Practice & Practice in General- Group Counselling -Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons per unit
K017	Family Practice & Practice in General - Periodic health visit - child
K130	Family Practice & Practice in General- Periodic health visit - adolescent
K131	Family Practice & Practice in General- Periodic health visit - adult age 18 to 64 inclusive
K132	Family Practice & Practice in General- Periodic health visit - adult 65 years of age and older
K700	Family Practice & Practice in General- palliative care out-patient case conference per unit
K702	Family Practice & Practice in General-Bariatric out-patient case conference per unit
K703	Family Practice & Practice in General-Geriatric out-patient case conference per unit
K730	Family Practice & Practice in General-Physician to physician telephone consultation - Referring physician
K731	Family Practice & Practice in General-Physician to physician telephone consultation - Consultant physician
K732	Family Practice & Practice in General-Critical telephone consultation - Referring physician
K733	Family Practice & Practice in General-Critical telephone consultation - Consultant physician
Q990	SVP - Other (non-professional setting not listed) - Weekdays Daytime (07:00-17:00) First person seen
Q992	SVP - Other (non-professional setting not listed) - Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours - First person seen
Q994	SVP - Other (non-professional setting not listed) - Evenings (17:00-24:00) Mon - Fri - First person seen
Q996	SVP - Other (non-professional setting not listed) - Nights (00:00-07:00) - First person seen
Q998	SVP - Other (non-professional setting not listed) - Sat., Sun. and Holidays (07:00-24:00)- First person seen
R048	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - face or neck - simple excision - single lesion
R048C	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - face or neck - simple excision - single lesion - Anaesthetist rendering service, Professional component
R051	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - other Areas - Laser surgery on Group 1 - 4, pre-malignant and malignant lesions
R051C	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - other Areas - Laser surgery on Group 1 - 4, pre-malignant and malignant lesions - Anaesthetist rendering service, Professional component

R094	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - other areas - simple excision - single lesion
R094C	Integumentary - skin & subcutaneous tissue - malignant lesions including biopsy of each lesion - single or multiple sites - other areas - simple excision - single lesion - Anaesthetist rendering service, Professional component
Z101	Integumentary -Skin and Subcutaneous Tissue - Incision - Abscess or haematoma - Local anaesthetic - subcutaneous - one
Z110	Integumentary -Skin and Subcutaneous Tissue - Finger or Toe-Nail - Extensive debridement of onychogryphotic nail involving removal of multiple laminae
Z113	Integumentary - Skin and Subcutaneous Tissue - Incision -Biopsy(ies) - any method, when sutures are not used
Z114	Integumentary - Skin and Subcutaneous Tissue - Incision - Foreign body removal - local anaesthetic
Z116	Integumentary -Skin and Subcutaneous Tissue - Incision -Biopsy(ies) - any method, when sutures are used
Z117	Integumentary -Skin and Subcutaneous Tissue - Chemical and/or cryotherapy treatment of skin lesions - Chemical and/or cryotherapy treatment, one or more lesions
Z122	Integumentary -Skin and Subcutaneous Tissue - Group 3 - cyst, haemangioma, lipoma -Face or neck - Local anaesthetic - single lesion
Z125	Integumentary -Skin and Subcutaneous Tissue - Group 3 - cyst, haemangioma, lipoma - Other areas - Local anaesthetic - single lesion
Z128	Integumentary -Skin and Subcutaneous Tissue - Finger or Toe-Nail - Simple, partial or complete, nail plate excision requiring anaesthesia - one
Z128C	Integumentary -Skin and Subcutaneous Tissue - Finger or Toe-Nail - Simple, partial or complete, nail plate excision requiring anaesthesia - one - Anaesthetist rendering service, Professional component
Z129	Integumentary -Skin and Subcutaneous Tissue - Finger or Toe-Nail - Simple, partial or complete, nail plate excision requiring anaesthesia - multiple
Z129C	Integumentary -Skin and Subcutaneous Tissue - Finger or Toe-Nail - Simple, partial or complete, nail plate excision requiring anaesthesia - multiple - Anaesthetist rendering service, Professional component
Z154	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee -up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers
Z154C	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee -up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers - Anaesthetist rendering service, Professional component
Z156	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - single lesion
Z156C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - single lesion - Anaesthetist rendering service, Professional component
Z157	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - two lesions
Z157C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - two lesions - Anaesthetist rendering service, Professional component
Z158	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - three or more lesions
Z158C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by excision and suture - three or more lesions - Anaesthetist rendering service, Professional component
Z159	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - single lesion
Z159C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - single lesion - Anaesthetist rendering service, Professional component
Z160	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - two lesions
Z160C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - two lesions - Anaesthetist rendering service, Professional component
Z161	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - three or more lesions

Z161C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 1 - e.g. keratosis, pyogenic granuloma - Removal by electrocoagulation and/or curetting - three or more lesions - Anaesthetist rendering service, Professional component
Z162	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 2 - nevus - Removal by excision and suture - single lesion
Z162C	Integumentary -Skin and Subcutaneous Tissue - Excision (With or Without Biopsy) - Lesions - Single or Multiple Sites - Group 2 - nevus - Removal by excision and suture - single lesion - Anaesthetist rendering service, Professional component
Z175	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee - 5.1 to 10 cm
Z175C	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee - 5.1 to 10 cm - Anaesthetist rendering service, Professional component
Z176	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee - up to 5 cm
Z176C	Integumentary -Skin and Subcutaneous Tissue - Repair of lacerations - Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee - up to 5 cm - Anaesthetist rendering service, Professional component
Z314	Respiratory - nose - Treatment of Epistaxis (Nasal Haemorrhage) -Cauterization - unilateral
Z314C	Respiratory - nose - Treatment of Epistaxis (Nasal Haemorrhage) -Cauterization - unilateral - Anaesthetist rendering service, Professional component
Z315	Respiratory - nose - Treatment of Epistaxis (Nasal Haemorrhage) - Anterior packing - unilateral
Z535	Digestive - Rectum - Endoscopy - Sigmoidoscopy with or without anoscopy - with rigid scope
Z543	Digestive - Rectum - Endoscopy - Anoscopy (proctoscopy)
Z545	Digestive - Rectum - Incision - Thrombosed haemorrhoid(s)
Z611	Urogenital & Urinary - bladder - Introduction - Catheterization - hospital
Z847	Ocular and Aural Surgical Procedures - Cornea - Incision - Removal embedded foreign body - local anaesthetic - one foreign body

## Supplementary Tables and Figures

Table S1

Sample / exclusion condition	N
patients enrolled in a FHO as of fiscal year end	6,789,369
patients continuously enrolled for the fiscal year	5,949,037
dropping duplicate enrolments	5,889,965
dropping patients who were ineligible, or died before the fiscal year ended, or had data anomalies according to CIHI grouper criteria	5,713,877



**TAB 203**



November 19, 2013

HEALTHCARE POLICY

## Accountability and Access to Medical Care: Lessons from the Use of Capitation Payments in Ontario

by

Åke Blomqvist, Boris Kralj and Jasmin Kantarevic

- Over the last decade, the province of Ontario has reformed primary care to pay family doctors more on a capitated, or per patient, basis and less on a fee-for-service basis. This has been coupled with an emphasis on patient enrollment with a specific family doctor, or group of doctors, to improve both access and the relationships between family doctors and patients.
- While it is debatable whether Ontario has achieved good value-for-money with reforms, these efforts seem to have improved timely access to continuous primary care and created an incentive structure for providers that is more consistent with the system's access and cost-control objectives.
- However, even with greater access to family doctors in Ontario than in the past, there were over 1.7 million visits by enrolled patients to outside doctors in 2011/12. A cursory review of claims data suggests that visits outside of one's family doctor are largely due to patient choice based on convenience of care.
- Ontario's healthcare system could realize better value-for-money were fewer patients to seek such outside care. One area for reform would involve better designed incentives for patients that complement the existing incentives for providers.

An established relationship between individual patients and a regular family doctor, or other primary-care provider, is a valuable feature of a well-functioning healthcare system (Nabalamba and Millar 2007, Freundlich 2013). For providers, having familiarity with patients' medical

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histories improves their ability to treat patients appropriately, and can reduce the cost of care because it decreases the need for repeated diagnostic tests and for trying different treatment strategies. For patients, an implicit commitment from a familiar primary-care provider to see them quickly when they have health problems is also valuable. Some years ago, many patients in Ontario who did not have a regular family doctor complained of reduced access to timely care, since they had difficulty finding a doctor who was willing to see them on short notice.

In Ontario, the objective of improving patients' access to care from a regular family doctor has triggered comprehensive primary-care reform over the last decade that centers on: i) patient enrollment; and ii) a move away from fee-for-service toward per-patient, or so-called "capitation", physician payments.

In the new system, primary-care practices can establish a roster of regular patients, agreeing to supply them with care on a timely basis as needed. Patients join this roster by signing a written commitment to consider these practices as their regular providers, to whom they will turn in the first instance when they need care.

Payment by capitation, in turn, is used partially as an incentive for providers to take responsibility for many regular patients. Under capitation, the government pays providers a lump sum, which is a fixed, age-sex adjusted, annual amount based on the number and type of patients on the practice's roster. In return, the physicians provide a "basket" of services such as assessments, diagnosis, treatment, primary mental health, coordination and referral, and patient education and preventative care, at discounted rates.<sup>1</sup> This E-Brief examines the improvements in access achieved by reforms in Ontario and then discusses ways to better design incentives for patients and providers to ensure cost-effective primary care – the need to do so is an important lesson for other provinces considering similar reforms.

## Results of Ontario's Reforms

Primary-care reform in Ontario has introduced a variety of payment models, such as blended capitation models. A blended payment model sees most income earned on a capitated, or per patient, basis with a small share of income coming from fee-for-service payments. Physicians and care providers organized in so-called Family Health Organizations and Family Health Networks can take advantage of this model. There are also enhanced fee-for-service models, which combine the fee-for-service payment with additional performance incentives such as chronic disease management.<sup>2</sup>

Today, over 8,000 family physicians and about 10 million patients participate in these new models.<sup>3</sup> The most popular model for patient enrollment – Family Health Organizations (FHOs) – had 5.6 million patients and 4,200 family physicians participating in 2012. While a complete cost-benefit analysis of the reforms would

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- 1 In a pure capitation system, providers receive no additional payment for providing the services included in this basket. In a "blended" system, such as that in Ontario, doctors are paid additional amounts for each service provided, but at rates that are only a fraction of the regular fees paid for these services to doctors who practice purely on the basis of fee-for-service. Emergency Department services are not in the basket, and patients can access them without financially impacting the family doctor with whom they are enrolled.
  - 2 These fee-for-service payment models are known as Family Health Groups and the Comprehensive Care Model.
  - 3 The remaining family physicians (about 4,000) practice in Emergency Departments, Focused Practices, and traditional fee-for-service models.

have to include their fiscal costs, which have come under scrutiny (Ontario 2011), the reforms have likely led to other forms of cost savings, such as reduced referrals and hospital length of stay, among others.<sup>4</sup> There are also indicators they have had a significant positive impact on patient access to healthcare: Since 2004, for instance, there has been a major increase in the number of patients formally enrolled with family doctors (Kralj and Kantarevic 2012a).

Although Ontario's blended plans pay doctors partly by capitation, patients still are allowed to seek care from any provider, not only from the provider on whose list they appear, at no out-of-pocket cost. In similar enrollment models in other countries, patients are either restricted to seek care from their designated provider (e.g., in the Health Maintenance Organizations (HMOs) that are common in the US) or have to bear all or part of the cost if they receive services from an outside doctor (e.g., the United Kingdom). This is a common feature in primary-care systems abroad because it encourages a single access point to care, improving providers' familiarity with individual patients, and allowing for a more cost-effective use of public resources.

While patients in the Ontario model may value the ability to seek primary care from any provider without penalty, allowing them to do so weakens the rostering approach. Most obviously, it can be costly to the public purse since the provincial plan pays both the capitation amount to the regular provider and the full fees charged by outside providers. In addition, the outside use may cause some of the problems with fragmented care from multiple providers that the capitation approach was supposed to address in the first place.<sup>5</sup> To counter these problems, Ontario has introduced a number of incentives to limit outside use, such as financial penalties for providers when their patients seek care elsewhere,<sup>6</sup> formal requirements on capitated providers for scheduled after-hours operations, and disincentives to enroll too many patients.

However, these incentives focus on the providers only – there are currently no effective policies in place to limit outside use initiated by patients, even though the roster agreements they have signed oblige them to seek treatment first from their designated doctor or provider group. That is, patients are free to seek the most convenient source of care, even if their regular provider is available, because they are not financially sanctioned in any way for doing so.<sup>7</sup> As a result, many enrolled patients are still going to walk-in clinics or other outside providers to receive primary-care services. Under the FHO model, enrolled patients accounted for over 14 million family doctor visits in fiscal 2011/12, but over 1.7 million visits were with outside physicians for in-basket services (i.e., outside use), exposing their regular doctor (with whom they are enrolled) to a financial penalty.<sup>8</sup>

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4 See Kralj and Kantarevic (2012b) and Kralj and Kantarevic (2013) for more information on the additional impacts of reforms.

5 For example, in fiscal 2012/13, the value of outside use services was close to \$115 million, about 60 percent of the maximum possible access bonus (Source: Calculations by authors based on OHIP data).

6 A portion of the capitation payment to the regular providers is designated as an access bonus. If an enrolled patient seeks outside care, the access bonus is reduced by the full amount of the fee paid by the provincial plan to the outside provider. While this reduces the cost to the provincial plan, it does not completely eliminate the possibility of double payment since the access bonus cannot be reduced below zero.

7 There may be other, non-financial deterrents to outside use. For example, the physician may de-enroll patients with excessive outside use, but this is clearly not a preferred solution for either the physician or the patient.

8 The Auditor General of Ontario suggested that the level of outside use was even higher than the figure stated here (Ontario 2011). Outside use excludes Emergency Department services and certain other focused practice services and includes only comprehensive care services that could in principle have been provided by the enrolling physician rather than the alternative provider.

Allowing patients to seek care from outside providers may make sense if the ‘outside use’ is due to behaviors by the enrolling physician. However, a review of the Ontario Health Insurance claims data suggests that outside use is largely due to patient choice based on convenience of care.

## What Causes Outside Use of Primary Care in Ontario?

A number of factors can cause Ontarians enrolled in capitation plans to access outside providers. For instance, there may be a preference for receiving care on weekends or non-work hours, at a location near home or work, and there may also be limited office hours available in a patient’s primary-care group.<sup>9</sup> A cursory analysis of these factors in Ontario shows the following:

- The vast majority (about 93 percent) of outside use occurs during weekdays, not on weekends (see Figure 1a).<sup>10</sup>
- Younger patients have higher outside use than older patients (Figure 1b).<sup>11</sup>
- The travel time, from the patient’s home address, to providers where they received outside use service is longer than the travel time to their regular enrolling physician (Figure 1c).
- In at least one-half of the cases of outside use, the enrolling doctors’ group was available to provide services, as evidenced by the fact that doctors provided services to other patients during that day or evening (Figure 1d).
- Outside use visits are no different than other visits in terms of type of assessment and condition diagnosis. The vast majority of visits are minor or intermediate assessments associated with diagnosis such as the common cold, hypertension and anxiety.

The travel time finding noted above is interesting, and at first glance puzzling, since it is not clear why a patient would travel twice as far to seek outside care. After all, it is unlikely that these patients are unhappy with their enrolling physicians, given they still receive most of their care from them and given that they can change doctors twice a year. However, the puzzle disappears if it is recognized that many patients may seek care not from their home – from where travel time in our data is measured – but from places where they are spending most of their time, such as work or school. From these locations, the travel time for outside care is often faster than a trip to their regular doctor. Anecdotally, and consistent with the other data presented, the patients seek outside care near their employer and their children’s school.

## Conclusions and Recommendations

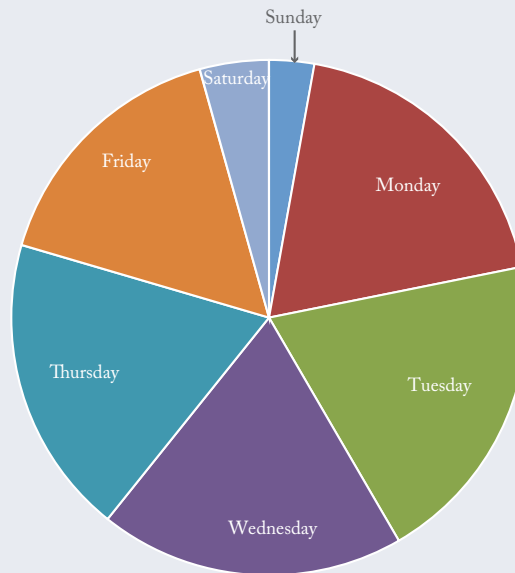
Ontario has made bold reforms to primary care. While debate on the cost-effectiveness of these reforms remains, these efforts seem to have improved timely access to continuous primary care, and created an incentive structure for providers that is more consistent with the system’s objectives in primary care than the traditional fee-for-

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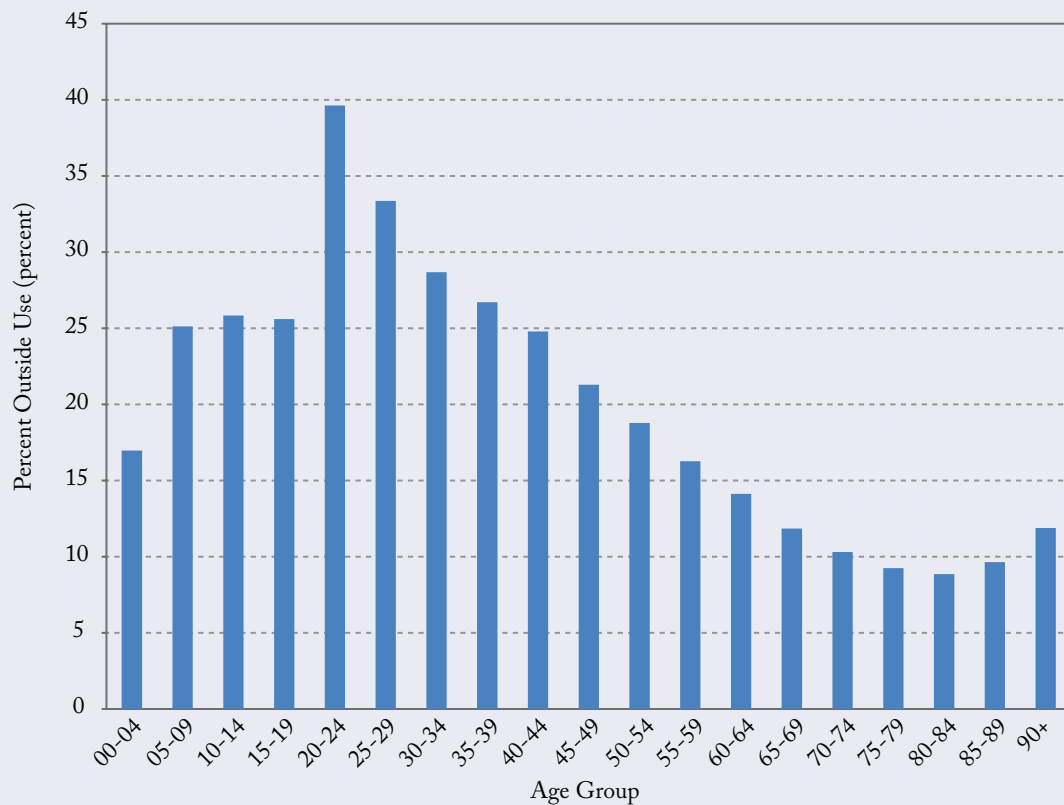
9 Clearly, there may be a myriad of other factors that influence patient choice that are beyond the scope of this paper, such as the proliferation of walk-in clinics, accessibility during regular hours, the type of medical condition, etc.

10 In interpreting the data, one limitation is that the data do not allow us to observe the hour when the outside use occurred.

11 The percent outside use in this Figure represents the visits for in-basket services provided by the non-enrolling physician as a percentage of the total number of visits for in-basket services that the patient received from both enrolling and non-enrolling providers.

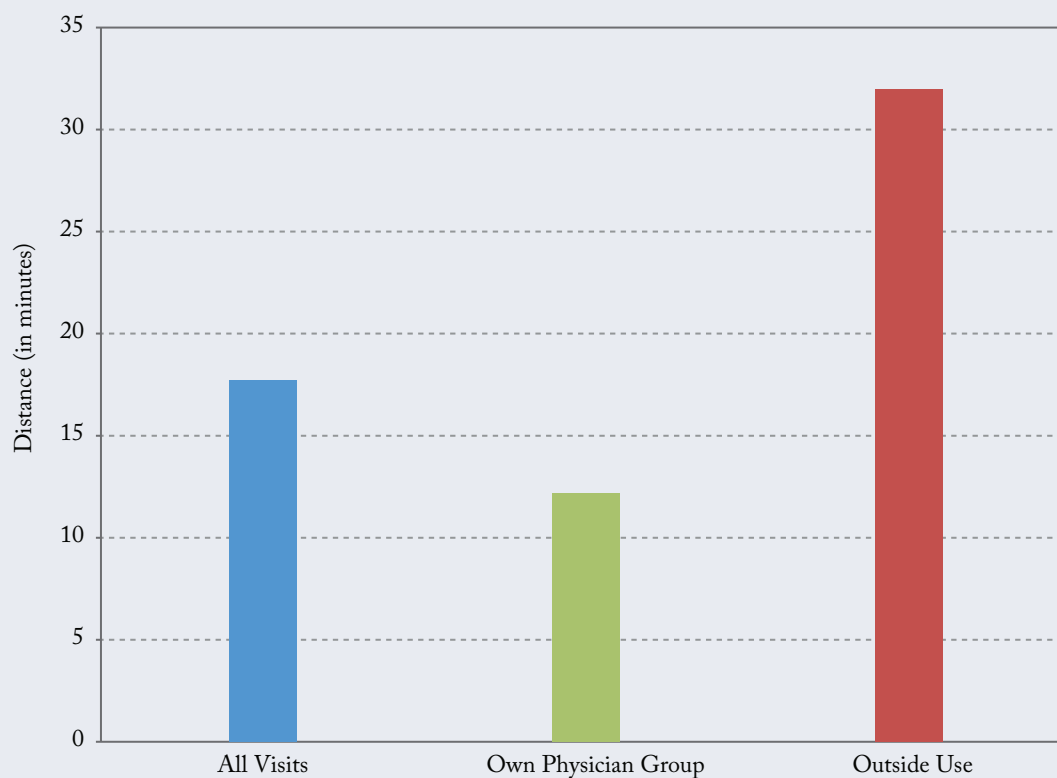
**Figure 1a: Outside Use by Day of Week, Fiscal 2011/12**

Sources: OMA Economics Department based on OHIP data.

**Figure 1b: Percent of Services Received Outside the Enrolling Physician Network, 2011/12, by Patient Age**

Sources: OMA Economics Department based on OHIP data.

Figure 1c: Mean Travel Time by Type of Visits, 2011/12



Sources: OMA Economics Department based on OHIP data.

service model (Blomqvist and Busby 2012). In our view, other provinces should consider adopting a similar model while learning from Ontario's challenges.

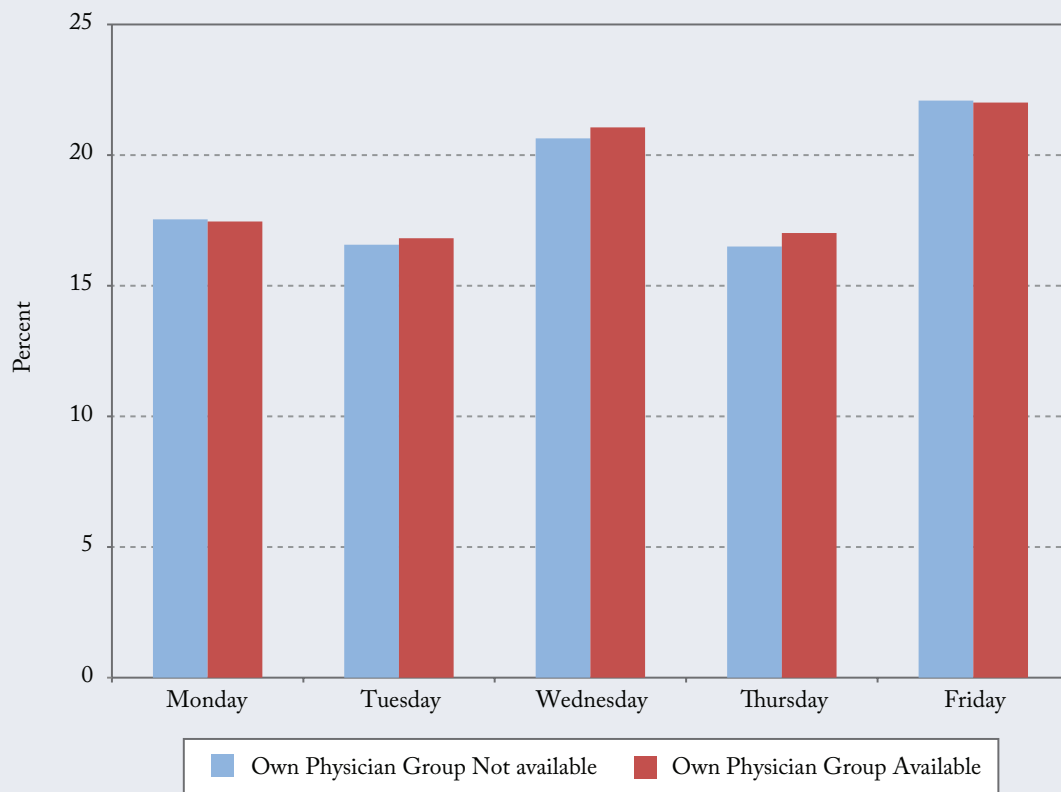
Better value-for-money for Ontario's health system could be achieved were fewer patients to seek care outside the doctor or family physician group that enrolls them. One area for reform would involve better designed incentives that target patients – complementing the existing incentives that target providers. If Ontarians – like citizens in many other advanced countries – value greater patient flexibility in seeking care from any provider then it should be recognized that this flexibility has a cost. Attempts to reduce this cost by targeting providers only will have limited success; ensuring that enrolled patients are similarly held accountable for their behavior seems a promising way forward.

As a start, we believe doctors should be encouraged to explain more clearly to patients that by signing the rostering agreement, they have agreed that they will only seek care from an outside provider when they have a good reason for doing so. As well, the Ministry of Health and Long-Term Care could expend more effort to explain the rationale for the rostering model, and that it does imply some obligations on patients as well as on providers.

Even though we recognize that it would be highly controversial, we also think it reasonable to ask patients to pay part of the cost of their care out-of-pocket if they chose to go to an outside provider purely for reasons of



**Figure 1d: Percent Outside Use by Day of Week and Whether Enrolling Physician Group was Available during After-Hours, 2011/12**



Sources: OMA Economics Department based on OHIP data.

convenience. Leeway could be given to patients who work long distances from home – all patients with a greater than one-hour commute to work could be permitted one or two outside visits per year before charges begin, for instance. Further flexibility could be given for patient visits during off-regular hours of care as well as for same-day needs or for repeat visits in a short time horizon.

If a pattern of outside use is common for a specific patient, he or she could be encouraged to choose a family physician closer to their place of work. Of course, any financial charge option would require amendments to the Physician Services Schedule of Benefits via regulation changes to the *Health Insurance Act* deeming such services uninsured. It would also require a thoughtful implementation approach, with caveats like those mentioned above, to achieve its objective of reducing unnecessary outside use without compromising access to quality care.

Better patient education and provider accountability on quality of care received are other avenues for improvement. Patients under the current system can choose to switch provider groups where they are enrolled – and thereby reduce the income of the group they are leaving and raise the income of the group they join. Greater effort to measure primary-care quality, including the availability of after-hours care for time-crunched patients, would put more incentives on physicians to improve service quality and keep their patients.



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**TAB 204**

Date: November 22, 2023

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**To:** CEOs, executive directors, and quality improvement leads in hospitals, long-term care homes, and interprofessional primary care organizations

**From:** Dr. David Kaplan, Vice President, Quality, Clinical Institutes and Quality Programs, Ontario Health

**Re:** Launch of the 2024/25 Quality Improvement Plan program cycle

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Dear colleagues,

I am writing to announce the launch of the Quality Improvement Plan (QIP) program cycle for 2024/25.

We recognize that it continues to be a challenging time for the health system. We continue to experience unprecedented health human resource challenges while striving to provide high-quality care and access to those who need it. We have taken these challenges into account when developing the program cycle for the upcoming year.

This year's QIP program requirements align with system priorities to support quality care in Ontario. Specifically, the priority issues and indicators were selected with Ontario Health, Ministry of Health, and Ministry of Long-Term Care priorities in mind and with input from partners in our consultation process. The QIP priorities align with those established in service accountability agreements (SAAs), and the two are complementary tools for accountability and quality improvement. SAAs establish the performance standard and set minimum expectations, while QIPs enable health service organizations to set stretch targets and test innovative changes while building a culture of continuous quality improvement. Where there are common indicators, the decision to include them for consideration in the QIP is to support alignment of system priorities, reduce indicator burden, and provide organizations with an opportunity to publicly share quality improvement activities and targets through the QIP, as a complement to ongoing work in fulfilling performance expectations.

The 2024/25 QIP priority issues are:

1. Access and flow
2. Equity
3. Experience
4. Safety

Important changes to the 2024/25 QIP program are a shift from priority indicators to a focus on four priority issues and a shift to a suite of optional indicators associated with those priority issues. Focusing on system-level priority issues rather than priority indicators supports health service organizations with more flexibility and options to align their quality improvement activities to high-priority areas where quality gaps exist. The indicators included in the matrix for

each priority issue are starting points – organizations may consider including these indicators in their QIP but are not required to do so. As always, organizations may also choose to add custom indicators aimed at improving issues that are important to their communities. Other changes to the QIP program are highlighted in the *Appendix*.

At Ontario Health, we are committed to driving improved and equitable outcomes across the province. We have included new equity indicators aimed at improving equity, diversity, and inclusion and addressing interpersonal and systemic racism, which contributes to disparities in services. In the narrative component of the QIP, we encourage organizations to share achievements and innovations in reducing disparities in services related to access, equity, experience, and safety.

[Ontario Health Teams](#) continue to drive improvement of population health outcomes across the full continuum of care, with an emphasis on equity-based and culturally appropriate approaches to improve outcomes and reduce health disparities. Organizations that submit a QIP may also consider highlighting collaborative work with other health service organizations or within Ontario Health Teams (for those who are part of an OHT) in the new narrative section **Population Health Approach** and including custom indicators in the workplan.

As we renew our collective commitment to quality, the QIP is an enabling tool for organizations to share quality improvement actions and targets with the people in Ontario. We encourage organizations to post their QIP on their websites, and we look forward to receiving your organization's 2024/25 QIP by April 1, 2024.

We are pleased to work with you once again to improve care for the people of Ontario. Please email [QIP@OntarioHealth.ca](mailto:QIP@OntarioHealth.ca) if you have any questions. As always, the team is here to support you.

Regards,



Dr. David M. Kaplan MD, MSc, CCFP, FCFP  
Vice-President, Quality  
Clinical Institutes and Quality Programs  
Ontario Health

c.c.: Renee Mahalanobis, Ministry of Health  
Susan deRyk, Ontario Health  
Brian Ktytor, Ontario Health  
Anna Greenberg, Ontario Health  
Judy Linton, Ontario Health  
Chris Simpson, Ontario Health

# Appendix

## Key Updates to the QIP Program for 2024/25

### Changes to the QIP Workplan

We have made several changes to the workplan and indicators since last year.

### Prepopulated current performance data

More fields will be prepopulated in *QIP Navigator*; current performance data will be prepopulated when administrative data are available.

### Optional indicators

Under each priority issue, there will be a suite of optional indicators, which health service organizations may consider including in their QIP. As always, organizations may also choose to add custom indicators that are aimed at improving issues that are important to their communities.

#### New for 2024/25 – Equity indicators

In alignment with Service Accountability Agreements, the Black Health Plan, and with Ontario Health's 2024/25 focus on Equity as a priority issue, organizations may consider including the optional indicator ***Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education.***

Additionally, in alignment with the newly released [Ontario Health Quality Standard – Sickle Cell Disease](#), hospitals may consider including optional indicators associated with improving care for individuals with sickle cell disease:

***Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2), Rate of emergency department 30-day repeat visits for individuals with sickle cell disease, and Percentage of emergency department visits for individuals with sickle cell disease triaged as high severity (CTAS 1 or 2).***

#### New for 2024/25 – For hospitals

Regions may prioritize an indicator(s) within one of the priority issues to encourage hospitals to consider in their QIP. In this case, the indicator(s) will appear as a priority indicator within the workplan. If an organization elects not to include the priority indicator(s) in the QIP, the reasons for this decision must be described in the Comments section of the workplan.

Below are indicators that are new for 2024/25 (refer to *2024/25 Quality Improvement Plan Indicator Matrix* or *2024/25 Quality Improvement Plan Indicator Technical Specifications* for the complete suite of optional indicators):

- For the **hospital** sector
  - 90th percentile ambulance offload time
  - 90th percentile emergency department length of stay
  - 90th percentile emergency department wait time to inpatient bed
  - Alternate level of care throughput ratio

- Percentage of patients who visited the emergency department and left without being seen by a physician
- Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
- Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2)
- Rate of emergency department 30-day repeat visits for individuals with sickle cell disease
- Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)
- Rate of delirium onset during hospitalization
- Rate of workplace violence incidents resulting in lost time injury
- For the **interprofessional primary care** sector
  - Patient/client perception of timely access to care
  - Number of new patients/clients/enrolment
  - Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
  - Completion of sociodemographic data collection
- For the **long-term care** sector
  - Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
  - Percentage of residents who fell in the last 30 days

## Changes to QIP Narrative Questions

QIP narrative questions enable organizations to provide context for the quality improvement work within the four priority issues. In 2024/25, there are three new sections:

- The section **Access and flow** allows organizations to describe initiatives that will support people in receiving care in the right place at the right time
- The section **Population health approach** allows organizations to describe how they are caring for the needs of their population in partnership with other health service providers and within Ontario Health Teams
- The section **Administrative burden** allows interprofessional primary care organizations to describe initiatives that support clinicians and the interprofessional team in being able to spend more time on direct patient care

## QIP Navigator Access

Access to *QIP Navigator*, Ontario Health's online platform for developing and submitting QIPs, is expected to open by January 2024.

## Information for Long-Term Care Homes

In addition to completing and submitting the QIP, the QIP Navigator platform may be used to prepare a continuous quality improvement initiative report, which is required under section 168 of O. Reg 246/22 of *the Fixing Long-Term Care Act, 2021*. This enables the completion of one report instead of two separate reports. QIP Navigator has been updated with prompts and hover help to suggest areas where information for continuous quality improvement initiatives may be included; however, the information can be included in any section. A copy of the report can be downloaded via QIP Navigator to publish on your home's website.

Please be advised if you are using QIP Navigator to complete the continuous quality improvement initiative report, it is the responsibility of the long-term care home licensee to ensure all legislative and regulatory requirements have been met. Using the Navigator tool does not presuppose compliance with other requirements. Please note that the QIP must be submitted through Navigator by April 1, 2024. Further information is available in the FAQ document posted on our website.

## Submission Deadline

The QIP submission is due by **April 1, 2024**.

## Contact Us

You can connect with a quality improvement specialist at Ontario Health by emailing [QIP@ontariohealth.ca](mailto:QIP@ontariohealth.ca).

**TAB 205**





Office of the Auditor General of Ontario

Value-for-Money Audit:  
Emergency  
Departments



*December 2023*

# Emergency Departments

## 1.0 Summary

Emergency departments are a crucial part of Ontario's health-care system, providing medical treatment for urgent and emergent illnesses and injuries 24 hours a day, 365 days a year. The facilities, sometimes referred to as emergency rooms, are largely overseen and funded by the Ministry of Health (Ministry) and Ontario Health, the Crown agency charged with integrating health-care services between organizations. Patients can seek care at any of Ontario's 163 emergency departments at any time by either entering by their own means or calling for an ambulance. The fully accessible nature of emergency departments can make it challenging for hospitals to anticipate patient inflows with any certainty. And while emergency departments are meant to treat urgent and emergent health-care issues, managing patient flows and planning appropriate staffing levels are made more complicated because patients also may choose to use them when they cannot access care in a timely manner at another setting, such as their primary care provider or a walk-in clinic. In addition to these inherent and constant challenges, funding issues and staffing shortages exacerbated by the COVID-19 pandemic have put further strain on Ontario's emergency-department system.

We found that while patients requiring immediate life-saving care are able to access the system in a timely manner, emergency departments have otherwise often struggled to provide timely and high-quality care, with patients having to wait on average two hours just to be

assessed by a physician. Some emergency department patients who require an inpatient bed have had to wait more than 24 hours, and many continue to be treated in emergency department hallways when space is not available. Strains in the system and long wait times have resulted in delayed or missed diagnoses, leading to patients returning to the emergency department in worse health.

Some of our significant findings include:

### Emergency Department Closures

- **There were over 200 temporary emergency department closures in the past year due in part to a lack of a comprehensive province-wide strategy to maintain staffing levels.** Unplanned closures of emergency departments were very rare before 2019/20. However, between July 2022 and June 2023 there were 203 temporary emergency department closures in Ontario, involving 23 hospitals primarily located in rural or remote areas, largely related to a nursing shortage and other staffing challenges. We found that there was no comprehensive province-wide and centralized strategy to help hospitals maintain nurse staffing levels to avoid closures or to reduce the duration of the closure. Instead, the Ministry and Ontario Health generally relied on hospitals to manage these situations independently, typically by closing their emergency department or using more-expensive agency staff where possible. These closures create risks to patients'

health that increase in proportion to the time needed to travel to the next nearest emergency department.

- **Rural and remote hospitals relied heavily on an emergency department locum program to avoid closures even though the program was intended to be used as a temporary solution.** In 2006, in an effort to avert highly disruptive emergency department closures due to the unavailability of physicians, the Ministry created the Emergency Department Locum Program (Locum Program), which aimed to provide urgent coverage as an interim measure of last resort to hospitals facing significant challenges filling emergency department shifts. While the Locum Program has been a strong resource for hospitals facing physician shortages, many hospitals have had to increase their reliance on the program to keep emergency departments open. In 2018/19, the Locum Program provided approximately 27,400 hours of coverage, which more than doubled to over 60,200 hours in 2022/23. During the same period, the cost of running the Locum Program increased by about 108%, from about \$5.7 million in 2018/19 to over \$11.8 million in 2022/23. Ontario Health estimates that the Locum Program helped to avert over 400 emergency department closures in 2022/23.

### Emergency Department Wait Times

- **Wait times to see a physician spiked and varied significantly from region to region.** While wait times to see a physician were relatively stable prior to 2020, there was a significant increase following the COVID-19 pandemic. Patients waited an average of 118 minutes after being triaged to receive their physician initial assessment in emergency departments in 2022/23, approximately 30 minutes longer than the wait time in 2013/14. Patients in the 90th percentile (the longest wait time after the top 10% of wait times are removed) waited up to 257 minutes (or more

than four hours) in 2022/23, up from 183 minutes in 2013/14. We also noted that the average wait time for a physician initial assessment varied widely by region and by hospital. For example, patients living in the Champlain region waited 169 minutes, or more than twice as long as patients living in the Central region, where average wait times were 79 minutes. As a result of long wait times for a physician initial assessment, we found that some patients chose to leave an emergency department without being seen by a doctor. In 2022/23, the average left-without-being-seen rate was 5.3%, although some hospitals had higher rates. For example, one hospital had about 14% of patients leave the emergency department without being seen. The wait time for a physician initial assessment at this hospital was approximately 175 minutes (or almost three hours), one of the longest wait times among emergency departments.

- **Unnecessary emergency department visits contributed to long wait times and high costs to the health-care system.** Lower-acuity patients, specifically less urgent or non-urgent cases, accounted for approximately 23% (or 1.29 million) of all emergency department visits in 2022/23. Some of these patients, such as those experiencing a sore throat or cold, did not require emergency care but chose to visit the emergency department because it was the only immediate option available or they had no primary care provider. A 2014 study by the Canadian Institute for Health Information (CIHI), an independent, not-for-profit national organization, noted that one in five emergency department visits could have been treated in a doctor's office or clinic. However, according to a 2019 health-care experience survey completed by the Ministry, only 41% of Ontarians were able to get an appointment with their primary care provider on the same or next day. Emergency department care comes at a significant cost to the health-care system as a whole—the direct cost of an emergency department visit in Ontario

was approximately \$165 per visit, almost three times higher than the cost of alternative options like primary care, which cost about \$56 per visit.

- **Medical directives, which help reduce the time patients spend in emergency departments, were not used consistently across hospitals.** Medical directives are orders that emergency department physicians have developed to help nurses and other hospital clinicians begin the process of assessing patients and performing certain procedures (such as ordering blood tests) before the physician initial assessment. Empowering nurses and other hospital clinicians to act before patients can be seen by a doctor allows certain basic emergency department testing and procedures to be completed more quickly and efficiently, leading to safer care and better patient flow. However, we noted significant variations in the use of medical directives at the hospital sites we visited. There also was no formal province-wide system for hospitals to share best practices on the use of medical directives.
- **Emergency department patients sometimes had to wait more than 24 hours for an inpatient bed.** In 2022/23, patients waited an average of 13 hours for an inpatient bed, a significant increase from the approximately eight hours they had to wait 10 years earlier. Patients in the 90th percentile waited as many as 35 hours for an inpatient bed, up from about 21 hours in 2013/14. We also noted significant differences across regions and hospitals. On average, patients waited at emergency departments for an inpatient bed for about nine to 19 hours in 2022/23 depending on which region they lived in, a significant increase from the five to 13 hours one year earlier. The long wait times were partly the result of the overall lack of inpatient beds in Ontario hospitals and the backlog of patients who did not require hospital-level care but were waiting for rooms elsewhere in the health-care system. Lengthy wait times have helped maintain high numbers of so-called

hallway patients, who have to be seen and treated in emergency department hallways until beds become available.

### Quality of Emergency Department Care

- **Strains in the system and long wait times at emergency departments resulted in delayed or missed diagnoses, leading to patients making return visits in poorer health.** To identify areas for quality improvement, in 2016 Ontario Health introduced the Emergency Department Return Visit Quality Program (Quality Program), which requires participating hospitals to report why Ontarians return to the emergency department shortly after their initial visit. We noted that there were 274 return visits with a sentinel (severe and significant) diagnosis in 2022; of these incidents, the hospitals identified a quality issue or adverse event had occurred in 104 cases. The most common causes of adverse events included patient mismanagement (for example, lack of reassessment of patients), a delayed or missed diagnosis, or an unsafe discharge decision. We also noted numerous examples of long wait times contributing to poor outcomes, including a case when a patient making a return visit to the emergency department required emergency surgery, and another when a returning patient was admitted to the critical care unit.

### Staffing Shortages

- **Significant staffing shortages reduced access to timely emergency care.** We noted multiple reasons for high staff turnover at emergency departments, especially among nurses. Factors included the higher pay and flexibility offered by private staffing agencies, as well as the introduction in 2019 of Bill 124, which limited annual wage increases for many employed professionals (including nurses) to 1% for three years. Since the Ministry and Ontario Health had never collected and tracked information on staffing shortages and vacancies across emergency



departments, we requested that information from a select number of emergency departments and noted that all of them experienced a significant increase in nursing vacancy rates between 2019/20 and 2022/23. For example, one emergency department's vacancy rate of full-time registered nurses increased from 6% to 26% in that time frame, and the rate for part-time registered nurses rose from 23% to 51%.

- **Worsening staffing shortages have forced hospitals to hire agency nurses at significantly higher hourly rates than permanent staff.** There has been no legislation that caps the amount for-profit staffing agencies can charge to hospitals. We noted that these agency nurses were paid significantly more than hospitals' full-time permanent nurses. For example, agency nurses that hold the position of registered nurse working in an emergency department could get paid more than \$75 an hour, compared with about \$35 to \$50 an hour for full-time permanent nurses employed by a hospital. The greater job flexibility and higher pay of agency nurses have resulted in some permanent nurses leaving hospitals. Furthermore, collective agreements with nursing staff limit the ability of hospitals to move nursing staff between units, forcing hospitals to rely on agency nurses even more to address their nursing shortages. The Ministry and Ontario Health did not track agency staff costs and instead relied on hospitals to manage their own budgets and make decisions related to agency staffing. We reviewed data on agency nurse spending across the hospitals we visited and found that in 2022/23, one hospital spent about \$8 million on agency nurses in the emergency department, compared with \$2.4 million in 2021/22, and less than \$1 million in 2019/20.
- **Inconsistencies and flaws in the physician payment structure could impact the timeliness and oversight of emergency department care.** The majority of emergency department physicians were compensated through an

alternative funding arrangement (AFA), while some used a fee-for-service (FFS) model to bill the Ontario Health Insurance Plan directly. Under the AFA, there is typically a base funding component, which is essentially a salary divided among the physicians. We found that there had been a lack of oversight of pay and performance of individual physicians who were part of an AFA and the Ministry does not review information on the funding provided to each physician or the volume of patients seen by each physician. We also noted that the FFS model appeared to incentivize physicians to see more patients in order to receive payment, which in turn resulted in shorter patient wait times. For example, even though only 15% of emergency departments used the FFS model, three of the top five hospitals with the shortest physician initial assessment wait times were using an FFS model while all five of the worst-performing hospitals were on an AFA. We also noted that one of the hospitals indicated it had relatively shorter wait times to see a physician as a result of process improvements, which were easier to implement under an FFS model.

### Oversight of Emergency Department Performance and Funding

- **Hospitals continued to get funding for a program that has had mixed results in improving patient flow through emergency departments.** The Ministry created the Pay for Results (P4R) program in 2008 to incentivize hospitals to improve patient flow through the emergency department. We reviewed historical data and found that in the early years of the P4R program, some key performance indicators showed a reduction in wait times, helping patients move more quickly through their emergency department visits. However, we found that performance deteriorated leading up to the December 2018–November 2019 period, the most recent full-year results before

the COVID-19 pandemic. Of the five indicators related to wait times that use historical performance as a benchmark, a significant number of hospitals had a worse performance in 2019 than when they first joined the P4R program. For example, in almost half of the 74 hospitals participating in the program as of 2019, admitted patients spent longer overall in the emergency department and there was a longer wait time for an inpatient bed. Despite this, hospitals with worsening performances continued to receive funding through the program.

### Emergency Department Diversion Practices and Virtual Urgent Care

- **Unique diversion practices that have helped some emergency departments handle patient flows more efficiently were often not shared with other hospitals.** We noted that some hospitals have developed practices to help divert patients away from the emergency department to a more appropriate setting within the hospital to receive care. These practices—which include using a rapid assessment zone for low-acuity patients that could be located outside of the emergency department—expedite and improve care for the patient involved while freeing up space and resources for others in the emergency department. While these practices have shown success, we noted that hospitals often did not share best practices province-wide. What's more, the Ministry and Ontario Health also did not have a framework in place to track, evaluate and encourage the use of these effective strategies.
- **A virtual urgent care pilot program has had some early successes, but subsequent changes to the program may result in worse outcomes if not managed effectively.** In 2020, the Ministry approved approximately \$4 million in one-time funding to support a regionally co-ordinated virtual urgent care program, sometimes referred to as virtual emergency department. The program was created

to support patients who had concerns about visiting an emergency department during the COVID-19 pandemic, as well as to divert lower-acuity patients away from the emergency department. In 2022/23, patients made over 50,000 virtual urgent care visits, compared with less than 20,000 visits in 2021/22. Ontario Health informed us that it planned to integrate some of the initiatives in the virtual urgent care pilot program into the provincial Health811 call services, through which patients are able to connect with a registered nurse 24 hours a day. However, we noted that some hospitals had concerns that this centralized model may not be as effective as virtual urgent care programs managed directly by hospitals. For instance, a virtual urgent care program managed by a hospital would be able to refer a patient directly for blood tests or diagnostic imaging in one of their facilities, while a patient using a centralized model who is advised to see an emergency physician might have to restart the triage process from the beginning upon arrival at the emergency department.

This report contains 14 recommendations, consisting of 23 action items, to address our audit findings.

### Overall Conclusion

Our audit concluded that the Ministry of Health and Ontario Health, in conjunction with hospitals, do not have fully effective systems and processes to oversee the delivery of care at emergency departments, or to manage resources efficiently, to help ensure emergency care that is timely and meets all patient needs. While the sickest patients are able to access and receive emergency department care on a timely basis, more needs to be done to address the risks associated with long wait times and increasing patient length of stay. Furthermore, while the Ministry and Ontario Health do measure areas of emergency department performance, more oversight and assessment are necessary to ensure

hospitals are meeting intended objectives of initiatives, such as those funded through the P4R program. We also concluded that while improvements have been made in the triaging of patients through the use and implementation of eCTAS, some emergency departments over-triage patients consistently, and hospitals need to do more to safely admit, discharge and/or transfer patients to other appropriate care settings in a timely manner.

While wait times to be assessed by a physician were relatively stable from 2013/14 to 2019/20, there has been a spike following the COVID-19 pandemic and patients face increasingly long wait times, sometimes in excess of four hours. This has prompted more patients to leave the emergency department without being seen, which may have contributed to worse health outcomes. In addition, some emergency department patients need to wait in hallways, sometimes for more than 24 hours, to be moved to an inpatient bed due to a shortage of beds and the presence of so-called alternate level of care patients, who cannot be moved out of hospital beds because spots in more appropriate alternative care settings are not available.

Further, we found that many small and rural hospitals have had to rely on the Province's Emergency Department Locum Program to stay open, helping to avoid more than 400 emergency department closures in 2022/23. Despite the program, which was only meant to provide hospitals with temporary relief, there were 203 temporary emergency departments closures due to staffing challenges, primarily because of a shortage of nurses. We also found that hospitals are spending millions of dollars on agency nurses at significantly higher hourly rates when they cannot address staffing shortages through internal resources.

While up to one in five emergency department patients treated and discharged in Ontario could have been treated in a doctor's office or clinic, we found that there have been insufficient efforts to try to divert or transfer patients to more appropriate care facilities. And in cases where hospitals did identify best practices to redirect patients, this information was not being effectively tracked by the Ministry and Ontario Health or shared with other hospitals across the province.

## OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) thanks the Office of the Auditor General of Ontario for their work and sharing the report on their value-for-money audit of Emergency Departments. Ontario hospitals and emergency departments were at the forefront of the health sector's response to COVID-19 and the COVID-19 pandemic, and its unprecedented challenges have had a lasting impact on the province's health-care system. Throughout the pandemic's waves, hospital emergency departments supported the COVID-19 response, stepping up to meet new and evolving demands amid historic health human resource shortages that impacted the entire health-care system.

The Ministry acknowledges the difficult position hospitals and emergency departments were in and appreciates the role they played in supporting the health-care system response, both locally and provincially. Hospitals provided high-quality patient care throughout the pandemic response, and the effect of the unprecedented global crisis continues to put strain on the delivery of care in emergency departments. The government remains steadfast in its commitment to protect the health and safety of all Ontarians and has worked closely with Ontario Health and hospitals to implement new programs and enhance existing supports to ensure the people of Ontario have access to high-quality emergency care, when and where it is needed. Initiatives like the Emergency Department Peer-to-Peer Program will ensure health-care providers across the province are supported and feel confident in delivering care to some of the most at-risk populations in Ontario's rural, remote and Northern communities. Enhancements to the Pay for Results program will ensure the busiest emergency departments are pushed to continually improve on their performance and that small-volume sites have access to supports that incentivize better performance and the continued delivery of high-quality care.

The Ministry remains engaged with Ontario Health on strategies to support Ontario's emergency departments and ensure that hospitals across the province are able to keep their emergency departments open and able to serve all those seeking emergency care. The Ministry is committed to continue working closely with Ontario Health and Ontario's hospitals to review the findings and recommendations within the report and drive improvements where able. The Ministry also will commit to applying learnings more broadly across the entire health-care system to inform and strengthen guidelines of current and future programs/strategies to support the delivery of high-quality care.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiation process between the parties set out in the Binding Arbitration Framework.

## OVERALL ONTARIO HEALTH RESPONSE

Ontario Health thanks the Office of the Auditor General of Ontario for sharing the value-for-money audit of Emergency Departments.

Ontario Health recognizes the enormous strain on emergency departments, observing increased challenges in patient complexity, and multifactorial impacts of health system capacity challenges that impact emergency department patient flow. High-quality and safe patient care is a priority.

In partnership with the Ministry of Health, Ontario Health works diligently with the emergency department community to ensure that

programs dedicated to improving quality and safety in the emergency departments are implemented and shared across the sector. Ontario Health's commitment to supporting patient care, the needs of our clinical teams/staff and access to resources is our priority.

Ontario Health commends recent new programs announced by the Ministry to support emergency departments, such as the Pay for Results (P4R) expansion, the Emergency Department Peer-to-Peer program, as well as a focus on emergency department nursing education and retention. These programs and resources ensure Ontario Health's ability to move forward with emergency department system strategy, capacity and access.

Ontario Health also has implemented innovative strategies to support patients in Ontario with initiatives such as Health811, expansion of P4R and the Peer-to-Peer program to provide system supports. Ontario Health remains committed to ensuring hospitals and regions are supported to reduce the risk of closures and impacts on communities.

Ontario Health is committed to working closely with the Ministry, hospitals and emergency department leaders to ensure that recommendations brought forward from the audit will be implemented, where feasible, to continually address the challenges emergency departments are facing in Ontario.

## 2.0 Background

### 2.1 Overview

The province's emergency departments provide medical treatment for illnesses and injuries 24 hours a day. Patients can seek care at any of Ontario's 163 emergency departments—sometimes referred to as emergency rooms—by arriving by their own means or calling an ambulance. While emergency departments are meant to treat urgent and emergency health-care issues, people also may choose to visit emergency



departments when they cannot access care in a timely manner at another setting, such as a primary care practitioner's office or a walk-in clinic.

**Figure 1** shows that the annual number of emergency department visits in Ontario over the last 10 years has been relatively stable at approximately 5 to 6 million visits. Because Ontario's population is projected to increase from approximately 15.1 million people in 2022 to over 17 million people within the next 10 years, the volume of emergency department visits is expected to continue to rise.

**Figure 2** shows the most common reasons for emergency department visits as well as the volume of visits for the top 10 diagnosis groupings. Of the approximately 5.6 million emergency department visits in 2022/23, these top 10 groupings accounted for 4.9 million visits (or about 88%).

## 2.2 Patient Flow in Emergency Department

Patient flow through an emergency department involves a number of steps. **Figure 3** shows the typical

patient journey when visiting an emergency department, while each step in the process is discussed in further detail below.

### 2.2.1 Triage

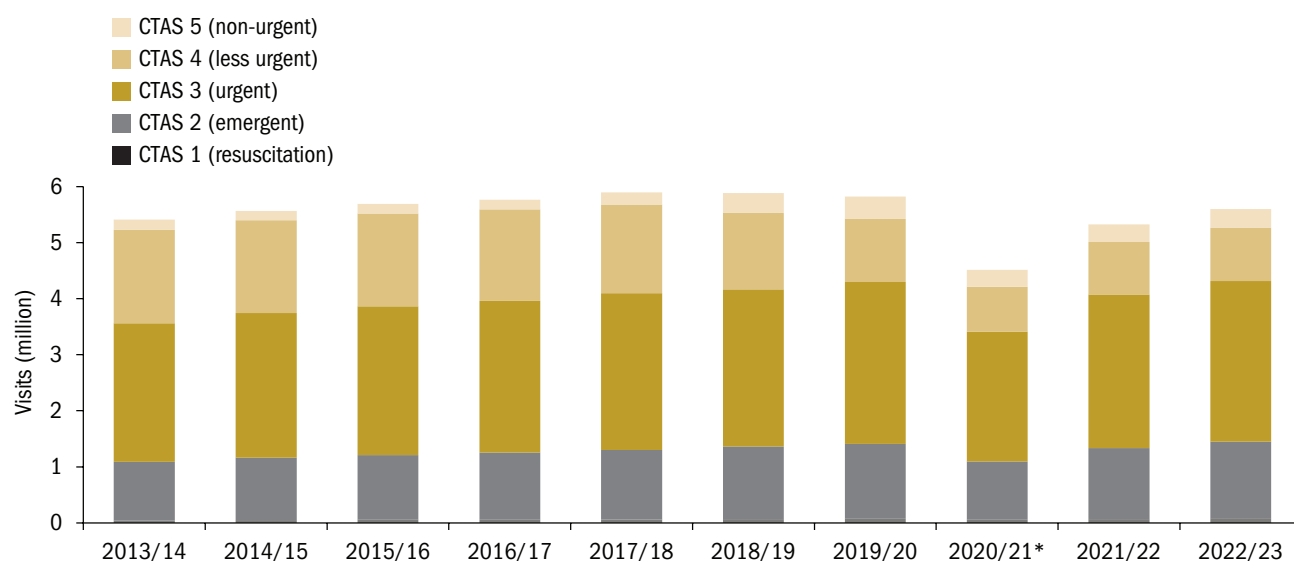
Upon arrival at the emergency department, patients are triaged, which is the process of assessing a patient's acuity level based on the five-level Canadian Triage and Acuity Scale (CTAS). The triage level assigned to a patient, typically by a nurse, determines their priority of being seen and treated. **Figure 4** shows the percentage of emergency department visits by CTAS level in 2022/23.

### 2.2.2 Physician Initial Assessment

After being triaged, all patients, except those assessed at CTAS 1 (requiring immediate resuscitation), have to wait for a physician assessment. Patients with a relatively higher-acuity level (CTAS 2 or 3) typically wait less time than those with a CTAS level of 4 or 5. Across Ontario, patients waited on average about two hours

**Figure 1: Number of Emergency Department Visits by Canadian Triage and Acuity Scale (CTAS), 2013/14–2022/23**

Source of data: Ontario Health



Note: This chart is based on data from emergency departments in Ontario that reported information centrally to databases or systems such as the National Ambulatory Care Reporting System.

\* In 2020/21, the number of emergency department visits temporarily dropped during the COVID-19 pandemic to about 4.5 million when fewer patients with less urgent needs sought emergency care. The number of visits rebounded to about 5.3 million in 2021/22.

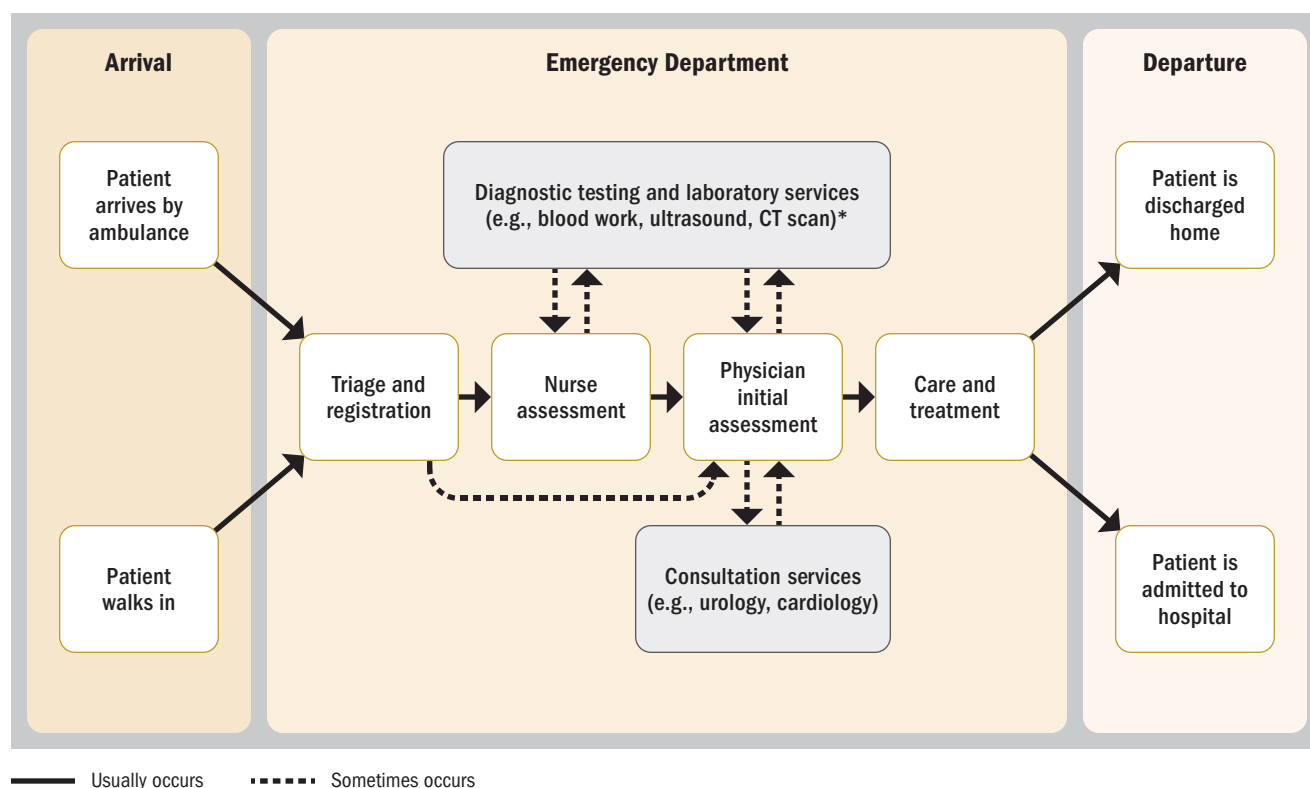
Figure 2: Top 10 Diagnosis Groupings of Emergency Department Visits, Ontario

Source of data: Canadian Institute for Health Information

Diagnosis Group	Examples	# of Emergency Department Visits, 2022/23
1. Symptoms, signs and abnormal clinical and laboratory findings	Abdominal and pelvic pain, pain in throat and chest, headache, nausea and vomiting	1,306,458
2. Injury, poisoning and other consequences of external factors	Open wounds, fractures, poisoning	1,200,126
3. Respiratory system	Asthma, pneumonia, bronchitis	532,338
4. Musculoskeletal system and connective tissue	Joint disorders, gout, arthritis	339,026
5. Digestive system	Intestinal disorders, appendicitis, hernias	315,110
6. Genitourinary system	Acute renal failure, urinary system disorders	284,829
7. Infectious and parasitic diseases	Diarrhea, herpes, warts	250,796
8. Mental, behavioural and neurodevelopmental disorders	Alcohol use, anxiety disorder, opioid use	239,564
9. Factors influencing health status and contact with health services	Surgical and orthopaedic follow-up care, counselling	221,316
10. Circulatory system	Hypertension, heart attack, cardiac arrest and stroke	211,063
<b>Total</b>		<b>4,900,626</b>

Figure 3: Patient Flow through an Emergency Department

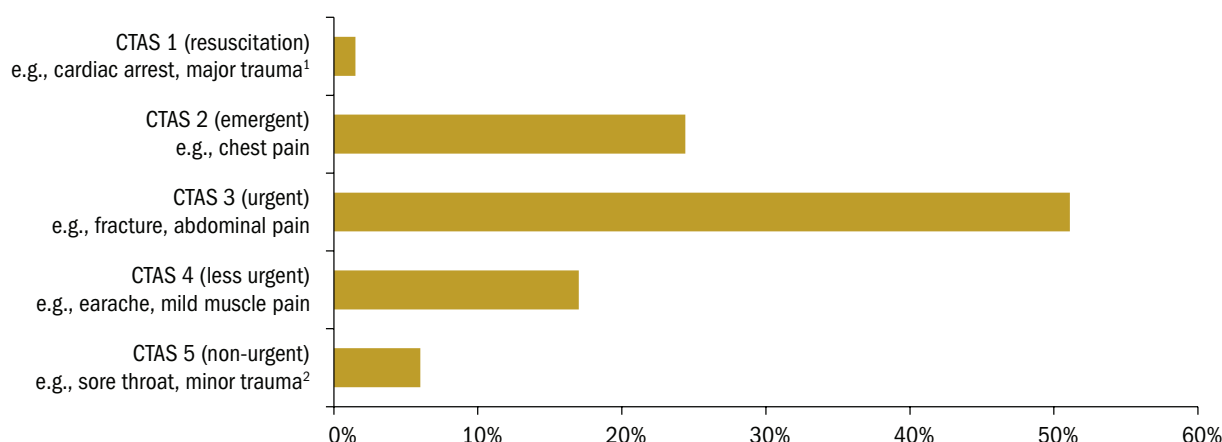
Prepared by Office of the Auditor General of Ontario



\* While waiting for a physician initial assessment, a nurse may request early testing (such as blood work) if the hospital utilizes medical directives, which allow nurses to initiate certain procedures for patients presenting specific symptoms, as discussed in **Section 4.2.3**.

**Figure 4: Percentage of Emergency Department Visits by Canadian Triage and Acuity Scale (CTAS), 2022/23**

Prepared by Office of the Auditor General of Ontario



1. Examples of major traumas include falls, motor vehicle accidents, head or spine injuries, and stabbings.

2. Examples of minor traumas include skin lacerations, sprains, muscle strains, scrapes and abrasions.

for an initial physician assessment, but wait times varied significantly between hospitals and regions, as discussed further in **Section 4.2.1**.

While patients wait for a physician initial assessment, nurses may begin treatment, such as prescribing medication and ordering diagnostic testing (such as blood tests), if the hospital uses medical directives that allow nurses to initiate certain procedures before a physician assessment, as discussed in **Section 4.2.3**. Wait times may be extended if patients require further testing (for example, an ultrasound or CT scan).

### 2.2.3 Inpatient Admission

After being assessed and treated by a physician in an emergency department, patients may be admitted to hospital for ongoing care and/or health monitoring. In Ontario, these patients typically have to wait in the emergency department for an average of nine to 19 hours until an inpatient bed is available, during which time they may become so-called hallway patients if the emergency department is overcrowded (see **Section 4.2.4**).

## 2.3 Emergency Department Funding and Spending

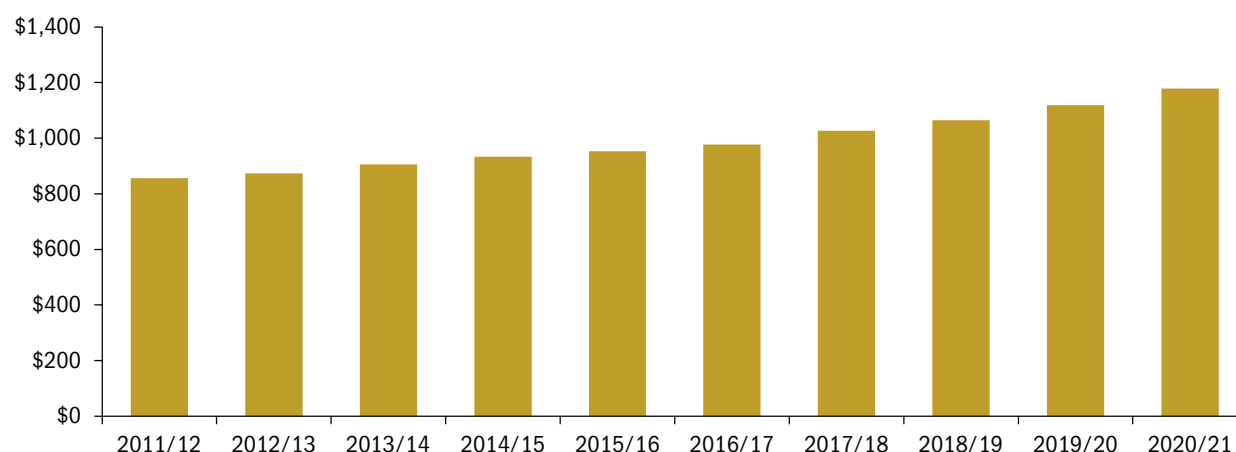
Approximately 60% of the Ministry's funding to hospitals is non-targeted global funding to support core programs and services, including the operation of emergency departments. Global funding is a base (or fixed) amount of annual funding for hospitals to deliver health-care services and cover operating expenses. Each hospital's management has discretion in how to use and allocate its global funding.

In addition to the global base funding, hospitals also may receive targeted funding by participating in performance- and activity-based initiatives or programs for emergency departments, for example, the Pay for Results, or P4R, program (see **Section 4.6**). Such targeted funding, which was approximately \$93 million in 2022/23, is minimal compared to the costs of running an emergency department. As of July 2023, 75 mid-sized and large hospitals received this funding. In July 2023, the Ministry announced changes to the P4R program that would expand eligibility, as discussed further in **Section 4.6.1**.

According to the Canadian Institute for Health Information (CIHI), which collects information directly from hospitals that report data into the National Ambulatory Care Reporting System (NACRS), emergency

**Figure 5: Emergency Department Spending in Ontario, 2011/12–2020/21 (\$ million)**

Source of data: Canadian Institute for Health Information



Note: 2020/21 is the latest data available.

department spending in Ontario has been consistently increasing since 2011/12, from \$857 million in that year to approximately \$1.18 billion in 2020/21 (the most recent year available), as seen in **Figure 5**.

The direct cost of an emergency department visit in Ontario was, on average, approximately \$165 per patient in 2019/20, a significant increase from \$107 reported in 2005/06. This amount excludes compensation for physicians working in emergency departments, most of whom are paid through alternative funding arrangements, or through a fee-for-service method.

- **Alternative Funding Arrangements:** These are contracts between the Ministry and physician groups that vary from one hospital to another and often involve the Ontario Medical Association, which represents the province's physicians. The contracts have provisions that specify the amount that physicians will receive and the related service levels (i.e., emergency department volumes) that need to be provided. In some cases, contracts can include key performance goals, such as improving patient access and satisfaction. We discuss alternative funding arrangements in **Section 4.5.4**.
- **Fee-for-Service (FFS):** In the FFS model, physicians do not receive compensation directly from the hospital for services provided to patients and instead bill the Ontario Health Insurance

Plan (OHIP) based on a set fee for each service provided to a patient. These fees are determined by a schedule of benefits that is part of the *Health Insurance Act*.

### 3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) and Ontario Health, in conjunction with hospitals, have effective systems and processes in place to:

- oversee that the delivery of care at emergency departments is timely and meets patient needs;
- manage resources for emergency departments efficiently to provide continuous availability of emergency care; and
- measure, assess and publicly report the performance and effectiveness of emergency departments on a regular basis.

In addition, our audit assessed whether emergency departments at selected hospitals have effective procedures and systems in place to:

- triage and assess patients appropriately based on their needs in a timely manner and in accordance with applicable standards and requirements; and

- safely admit, discharge, and/or transfer patients to the appropriate units for further care (such as a fracture clinic and for mental-health care) when necessary in a timely manner.

In planning for our work, we identified the audit criteria (see **Appendix 1**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry and Ontario Health reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between January 2023 and September 2023. We obtained written representation from the Ministry and Ontario Health senior management that, effective November 20, 2023, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

In arriving at the audit conclusion, we performed the following work at the Ministry and Ontario Health:

- interviewed management and staff responsible for managing and overseeing the delivery of emergency department services in Ontario;
- reviewed applicable policies, guidelines, legislation, reports and briefing notes related to emergency departments;
- reviewed strategic plans and related performance measure targets and results;
- reviewed funding structures and methodologies;
- obtained and analyzed various emergency department data, including number of visits, triage counts and levels, wait times and staffing counts; and
- reviewed initiatives and programs such as the Emergency Department Locum Program to help hospitals cover physician shortages, and the Pay for Results program to support innovation and practices that improve patient flow.

We also conducted site visits at the following hospital emergency departments, where we toured the emergency department, met with senior management and front-line staff responsible for the delivery of

emergency department care, including physicians and nurses, and reviewed information and files related to patient safety and critical events, patient satisfaction, health human resources, and performance measures:

- Children’s Hospital of Eastern Ontario (CHEO);
- Mount Sinai Hospital;
- The Hospital for Sick Children (SickKids);
- William Osler Health System (Brampton Civic Hospital and Etobicoke General Hospital); and
- Windsor Regional Hospital (Metropolitan campus and Ouellette campus)

Furthermore, we met with staff from the following hospitals to discuss specific initiatives and/or challenges faced in delivering emergency department care:

- Haliburton Highlands Health Services regarding their staffing challenges, use of the Emergency Department Locum Program and the permanent closure of their Minden Hospital emergency department on June 1, 2023;
- University Health Network and Sunnybrook Health Sciences Centre regarding their virtual emergency department initiative;
- William Osler Health System regarding its urgent care centre and virtual emergency department initiative; and
- Anson General Hospital regarding its use of the Emergency Department Locum Program to cover ongoing physician shortages.

We also met with staff from the following paramedic groups to discuss patient triage and ambulance off-loading challenges at emergency departments:

- Peel Regional Paramedic Services;
- Toronto Paramedic Services;
- Essex-Windsor Emergency Medical Services; and
- Ottawa Paramedic Service.

Throughout our audit, we met with and reviewed information from various stakeholders to better understand the challenges of delivering high-quality and timely emergency care:

- Institute of Clinical Evaluative Sciences, a community of research, data and clinical experts who lead research in various areas of Ontario’s health-care system, including emergency department care;

- Canadian Association of Emergency Physicians, a national advocate for emergency medicine physicians; and
- Ontario Nurses' Association, a union representing approximately 68,000 nurses and health-care professionals who work in a variety of settings, including hospital emergency departments.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standards on Quality Management and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

## 4.0 Detailed Audit Observations

### 4.1 No Comprehensive Provincial Strategy Was in Place to Prevent Emergency Department Closures

#### 4.1.1 There Were 203 Temporary Emergency Department Closures in the Past Year Due in Part to the Lack of a Comprehensive Strategy to Maintain Staffing Levels

Before 2019/20, unplanned closures of emergency departments were rare. However, between July 2022 and June 2023, 203 emergency departments in

Ontario, involving 23 hospitals, closed temporarily, most in rural or remote areas. **Appendix 2** lists the hospitals that experienced a temporary emergency department closure and the total hours they were closed.

We found that most closures were for a period of 14 hours or less, typically from the evening until the following morning. Most hospitals indicated they closed their emergency department because of staffing challenges, particularly a shortage of nurses (see **Section 4.5**), and that some of these closures could have been prevented if more staff resources were available.

While many closures were short, we noted that some hospitals had to close their emergency department repeatedly. Some closures lasted for a longer period. For example, in 2022, South Bruce Grey Health Centre's Chesley site closed its emergency department for 57 days, and Glengarry Memorial Hospital closed its emergency department daily from 6 p.m. to 8 a.m. for 15 days.

According to provincial protocols and policies, when a hospital identifies an anticipated or unanticipated emergency department closure, it is required to notify Ontario Health, which in turn informs the Ministry. In addition, hospitals have to develop a patient management plan to mitigate risks to patient care while the emergency department is closed, for example by working with paramedic groups to send patients to a nearby hospital and having diversion policies to direct patients to other health-care options. However, prior to June 2023, even when the Ministry and Ontario Health learned of a pending emergency department closure, we found that there was no comprehensive province-wide and centralized mechanism or strategy in place to provide support to try to avoid the closure or to reduce its duration. (The one exception is when the closure can be addressed through the Emergency Department Locum Program, discussed further in **Section 4.1.2**.) Instead, the Ministry and Ontario Health relied on hospitals to manage these situations independently, typically by closing down their emergency department or using agency staff if possible (discussed further in **Section 4.5.3**). In June 2023, Ontario Health implemented an updated emergency department closure



policy to begin proactively identifying and addressing ongoing risks of further closures and working with hospitals to determine if there are ways to prevent or reduce closures.

Most of the emergency department closures occurred in smaller or remote communities, where the emergency department is the only viable option for local patients to access urgent care. Closures in rural or remote areas create risks to patients' health that increase in proportion to travel times to the next nearest emergency department. We noted that for the hospitals that had to close temporarily from July 2022 to June 2023 (see **Appendix 2**), the next closest hospital was typically 30 to 45 minutes away, and in one case, North of Superior Healthcare Group's McCausland Hospital, the next closest emergency department was over an hour away.

## RECOMMENDATION 1

To help ensure the stability and continuity of emergency department services across Ontario, especially in smaller or remote communities, we recommend that the Ministry of Health, in collaboration with Ontario Health and hospitals, evolve and regularly update a strategy or action plan to prevent emergency department closures through mechanisms and initiatives including supporting local communities in training and retaining their health-care workforce as well as building capacity in primary and community services.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to evolve and regularly update a strategy or action plan to prevent emergency department closures through mechanisms and initiatives. On February 2, 2023, the Government of Ontario announced *Your Health: A Plan for Connected and Convenient Care*, its plan to provide people with a better health-care experience. As part of the broader Health Human Resources Strategy, the Ministry has been working with Ontario Health

to develop a strategic focus on supporting service delivery in emergency departments.

Further, part of this announcement included an investment to create up to 18 interprofessional primary care teams. This will help bridge the gap in accessing interprofessional primary care for vulnerable, marginalized and unattached patients to ensure they are able to connect to care where and when they need it. This investment of \$60 million over two years, beginning in 2023/24, also will sustain direct service delivery in existing interprofessional primary care teams that are experiencing increased operating costs.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

### 4.1.2 Rural and Remote Hospitals Have Been Relying Heavily on the Emergency Department Locum Program to Avoid Closures Even Though the Program Was Intended to Be Used as a Temporary Solution

To remain open, each emergency department must have at least one physician available. In 2006, in an effort to avert emergency department closures due to physician unavailability, the Ministry created the Emergency Department Locum Program (Locum Program). The goal of the program was to provide urgent locum coverage on an interim basis to hospitals facing significant challenges covering emergency department shifts. Since the introduction of the Locum Program in 2006, only four unplanned emergency department

closures were a result of physician unavailability, while the majority of the 203 closures noted in **Section 4.1.1** were caused by a shortage of nursing staff.

As of August 2023, the Locum Program had approximately 274 physicians travelling to work at emergency departments struggling to maintain physician staffing levels. To be eligible to work in the program, emergency department physicians must be actively working in an emergency department in Ontario and cannot take shifts through the Locum Program that overlap with their regular work commitments. These physicians are paid a premium hourly rate directly from the Locum Program (in addition to what the requesting hospital pays for physician coverage), and also may receive compensation for time spent travelling to and from rural and remote sites.

**Figure 6** shows the Locum Program's hours of coverage and costs over the past five years. In 2018/19, the program provided approximately 27,400 hours of coverage, which more than doubled to over 60,200 hours in 2022/23. During the same period, the cost of running the Locum Program increased by about 125% to over \$9.1 million.

Generally, the hospitals that have been requesting support through the Locum Program are smaller rural and remote hospitals. In discussions with

administrators at these hospitals, we found that a primary reason for their increased use of the Locum Program has been higher rates of local physicians retiring or leaving the community in the last couple of years. That has forced hospitals to rely on the Locum Program to fill longer-term physician vacancies even though the program was intended to be used as a temporary measure.

We noted that some hospitals have become particularly reliant on the Locum Program to run their emergency departments. For example, 12 hospitals requested and received at least 500 hours of coverage through the program in each of the last five years, and two of these hospitals had over 1,000 hours of coverage in each of those years. Furthermore, in 2022/23 the top 10 hospitals using the Locum Program all requested and received at least 2,500 hours of physician coverage, as seen in **Figure 7**.

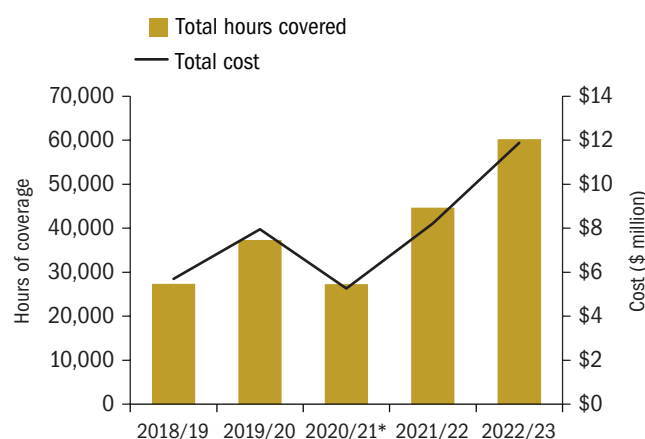
We reached out to hospitals that were regular and significant users of the Locum Program, such as Anson General Hospital, a small northern hospital in Iroquois Falls that received almost 5,000 hours of coverage through the Locum Program in 2022/23. The hospital administrators informed us that without that coverage, they would have had to shut down their emergency department frequently because they otherwise would have had no physician available.

As seen in **Figure 8**, Ontario Health estimates that the Locum Program has helped to avert over 800 emergency department closures over the last five years, with over 400 of those closures averted in 2022/23.

While the Locum Program has been a strong resource in helping hospitals avoid emergency department closures, relying on this temporary program is not necessarily a sustainable option for running an emergency department. For example, as noted in **Figure 7**, Haliburton Highlands Health Services (HHHS) has been significantly reliant on the Locum Program to operate its emergency departments at its two sites (Haliburton and Minden). In the last five years, the Locum Program provided HHHS with approximately 11,500 hours of physician coverage, including almost 4,000 hours in each of 2019/20 and 2022/23. Despite its reliance on the Locum Program, HHHS still had to

**Figure 6: Emergency Department Locum Program—Hours of Coverage and Cost, 2018/19–2022/23**

Source of data: Ontario Health



\* In 2020/21, both hours of coverage and cost decreased because the number of emergency department visits temporarily dropped due to the COVID-19 pandemic.



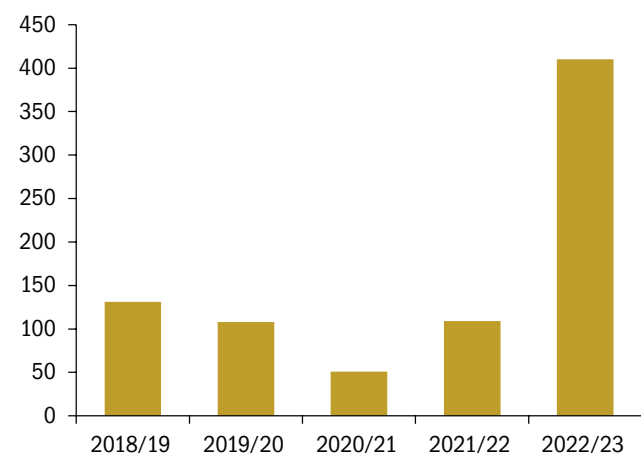
**Figure 7: Top 10 Hospital Users of the Emergency Department Locum Program, 2022/23**

Source of data: Ontario Health

Region	Hospital	Hours Requested	Hours Covered	% of Requested Hours Covered
North East	1. Anson General Hospital	4,981	4,873	98%
East	2. Deep River and District Hospital	6,124	4,504	74%
East	3. Haliburton Highlands Health Services (Haliburton and Minden sites)	5,476	3,936	72%
East	4. St. Francis Memorial Hospital	6,286	3,841	61%
North East	5. Notre-Dame Hospital	4,120	3,652	89%
West	6. Tillsonburg District Memorial Hospital	4,426	3,058	69%
North West	7. Sioux Lookout Meno Ya Win Health Centre	4,929	2,892	59%
East	8. North Hastings Hospital	4,211	2,855	68%
North East	9. Sensenbrenner Hospital	3,349	2,681	80%
West	10. Grey Bruce Health Services (Lion's Head site)	3,185	2,633	83%

**Figure 8: Number of Emergency Department Closures Averted Through Locum Program, 2018/19–2022/23\***

Source of data: Ontario Health



\* Based on the number of times the Emergency Department Locum Program was able to fill a physician shift to keep an emergency department open.

permanently shut its Minden emergency department on June 1, 2023 due to ongoing challenges with hiring and retaining physicians and nurses, and then consolidate staffing resources at its primary Haliburton site. We met with HHHS administrators and noted that even with the consolidation of its two emergency departments, HHHS expects to continue using the Locum Program to cover unfilled shifts.

#### 4.1.3 The Locum Program Cannot Keep Pace with Hospital Demand

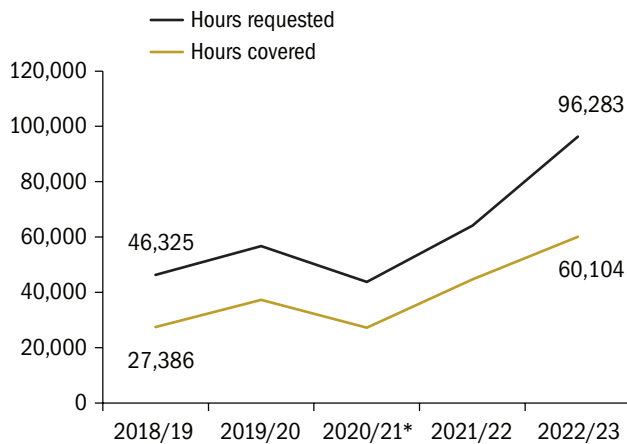
In addition to reviewing the hours covered by the Locum Program, we reviewed how well the Locum Program was able to keep up with hospital requests over the last five years. As seen in **Figure 9**, while hospitals requested over 96,000 hours of support from the Locum Program in 2022/23, the program was only able to cover approximately 60,000 hours.

Ontario Health informed us that due to an overall shortage of emergency department physicians, the Locum Program prioritizes hospitals with the most urgent needs, and considers requests from hospitals in northern communities before those in the south. In all cases, the Locum Program can only be used to fill vacant positions at emergency departments, not increase the number of overall physician positions.

When the Locum Program could not keep pace with requests, hospitals often had to reach out to Health Force (formerly the HealthForceOntario Marketing and Recruitment Agency), which is part of Ontario Health, or nearby hospitals and clinics to fill emergency department shifts and avoid closures. However, like the Locum Program, this coverage only provides temporary help and is therefore not sustainable. Hospitals told us

**Figure 9: Hours Requested and Hours Covered by Emergency Department Locum Program, 2018/19-2022/23**

Source of data: Ontario Health



\* Both hours requested and covered decreased in 2020/21 because the number of emergency department visits temporarily dropped during the COVID-19 pandemic as fewer patients with less-urgent needs sought emergency care.

there will continue to be significant risks of closure if physicians do not start filling permanent positions in rural and remote communities.

## RECOMMENDATION 2

To enable consistent and reliable access to emergency department physician care across Ontario and prevent future emergency department closures due to physician staffing, we recommend that the Ministry of Health, in collaboration with Ontario Health and hospitals:

- conduct a comprehensive review of the usage of the Emergency Department Locum Program to identify systemic issues with physician staffing across the province and develop a go-forward strategy; and
- implement mechanisms to incentivize physicians to take permanent roles in rural and remote emergency departments.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to review the Emergency Department Locum Program.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

## 4.2 Wait Times for Emergency Care Have Gotten Longer

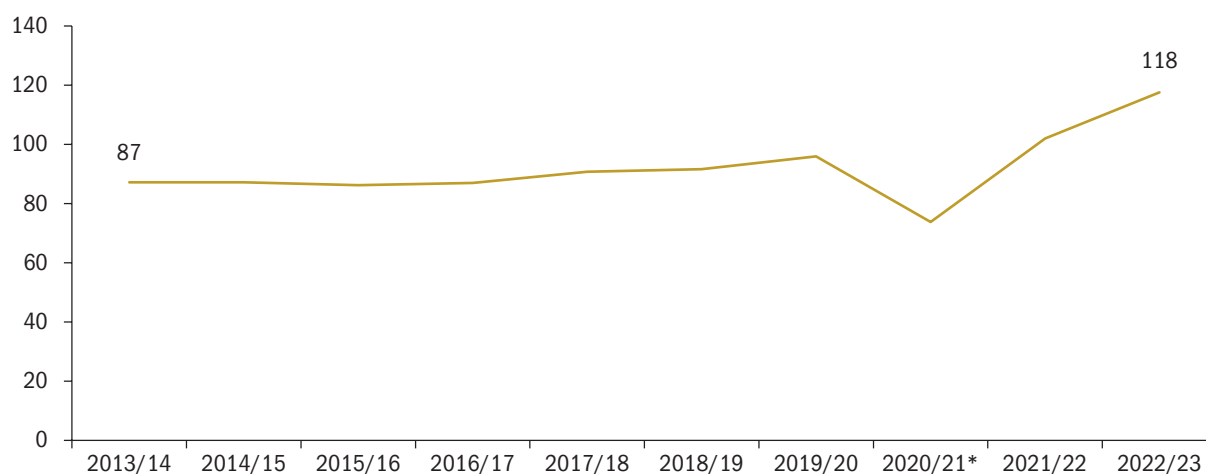
### 4.2.1 Wait Times to See a Physician Generally Increased, but Varied Significantly Across Ontario

Timely access to a physician assessment is critical in the delivery of high-quality patient care. A patient's first comprehensive assessment by a doctor helps determine what next steps are required, such as further testing, prescribing medication, or administering care. According to an Ontario study by the Institute for Clinical Evaluative Sciences, patients facing longer wait times for a physician initial assessment have a higher likelihood of needing inpatient admission to a hospital. The study also found that there was a slightly higher risk of death for each additional hour a patient waited in the emergency department.

Our review of wait-time data noted that the average wait times to see a physician were relatively stable prior to the COVID-19 pandemic, but have increased

**Figure 10: Average Wait Time for a Physician Initial Assessment, 2013/14–2022/23 (minutes)**

Source of data: Ontario Health



Note: This chart shows the average wait time for a physician initial assessment for all patients at different acuity levels (CTAS 1 to CTAS 5).

\* The average wait time for an initial physician assessment declined in 2020/21 as the COVID-19 pandemic discouraged patients with less urgent symptoms from visiting the emergency department.

significantly since then. We noted that high-acuity patients (CTAS 1, as discussed in **Section 2.2**) were typically able to see a physician in less than 30 minutes. However, in 2022/23 patients waited an average of 118 minutes (or almost two hours) after being triaged to receive their physician initial assessment, as seen in **Figure 10**. This compares with approximately 87 minutes in 2013/14, which is about 30 minutes longer than 10 years earlier. We also reviewed the 90th percentile wait time (the longest wait time after the top 10% of wait times are removed) and found that patients waited up to 257 minutes (or almost four and a half hours) to be seen by a physician in 2022/23, up from 183 minutes (or about three hours) in 2013/14.

Furthermore, the average wait time for an initial assessment by a physician varied widely by region and by hospital (see **Figure 11**). For example, patients living in the Champlain region waited more than twice as long to receive their physician initial assessment compared to patients living in the Central and Central West regions.

**Figure 12** shows the average wait time for a physician initial assessment across the hospitals we visited during our audit, while **Appendix 3** shows the wait

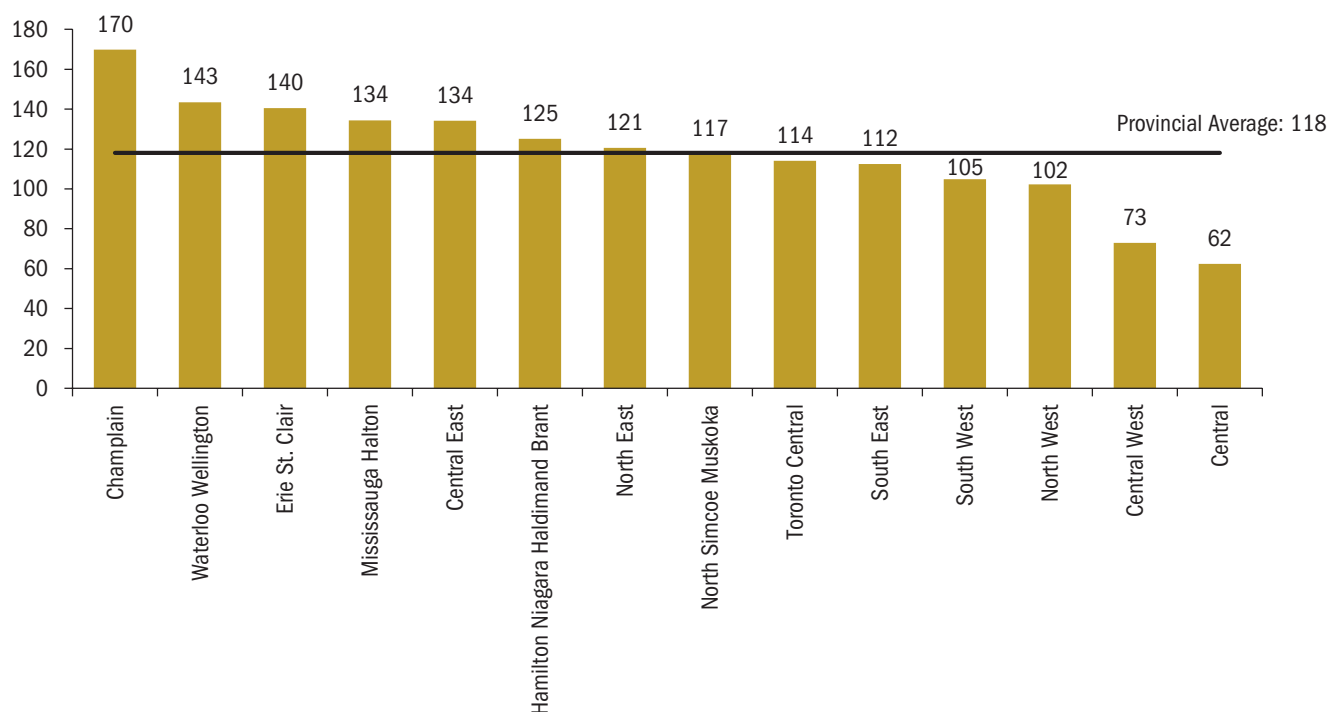
time across all of Ontario's emergency departments. Again, we noted significant variations of access to emergency care by hospital, with patients visiting Windsor Regional Hospital's Metropolitan campus waiting an average of 247 minutes (or over four hours) for a physician assessment—which was more than five times longer than the average 45-minute wait at William Osler Health System's Etobicoke General Hospital emergency department.

In speaking with administrators from Windsor Regional Hospital, we noted that one of the key reasons for their long wait times to see a physician was the lack of available primary care in the region, specifically in the evenings and on weekends. This resulted in patients using the emergency department for symptoms that would typically be treated in a primary care setting or to access diagnostic imaging. Furthermore, we found that physician payment structures may also impact the ability of patients to receive a physician assessment on a timely basis, as discussed further in **Section 4.5.4**.

As a result of the lengthening wait times, we found that the so-called left-without-being-seen rate increased as patients chose to leave an emergency

**Figure 11: Average Wait Time for Physician Initial Assessment by Sub-region, 2022/23 (minutes)**

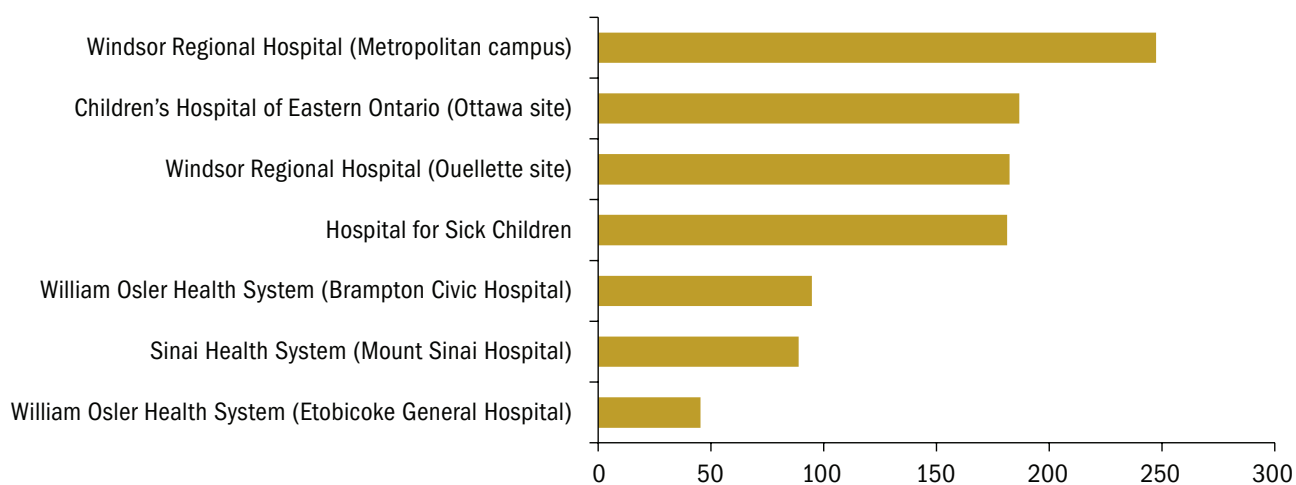
Source of data: Ontario Health



Note: Regions correspond to the boundaries of the Province's 14 Local Health Integration Networks (LHINs). While the Ontario government merged the LHINs into five Ontario Health regions in December 2019, Ontario Health has continued to report regional wait-time data by LHIN.

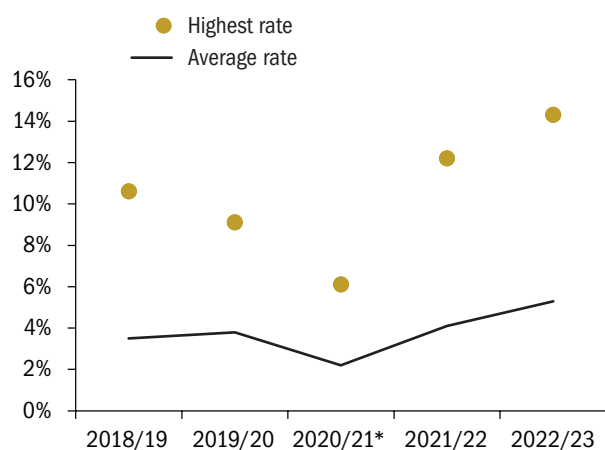
**Figure 12: Average Wait Time for a Physician Initial Assessment by Selected Hospitals, 2022/23 (minutes)**

Source of data: Ontario Health



**Figure 13: Percentage of People Who Left the Emergency Department without Being Seen, 2018/19–2022/23**

Source of data: Ontario Health



Note: “Highest rate” means the emergency department in Ontario with the highest percentage of people who left without being seen.

\* In 2020/21, both the average and highest rates of people who left the emergency department without being seen decreased as patient visits dropped due to the COVID-19 pandemic.

department without seeing a physician. As shown in **Figure 13**:

- The average left-without-being-seen rate increased from 3.5% in 2018/19 to 5.3% in 2022/23.
- Significantly long wait times to be assessed by a physician was the key contributing factor to higher left-without-being-seen rates. For example, in 2022/23 one hospital had 14.3% of patients leaving the emergency department without being seen, almost three times higher than the average province-wide rate. The wait time for a physician initial assessment at this hospital was approximately 175 minutes (or almost three hours), one of the longest wait times among hospitals.

While some of these patients chose to leave because they no longer required emergency care or decided to seek care elsewhere (for example, at their primary care provider), some patients who did require emergency care decided to leave because of long wait times and returned to the emergency department in a worse condition (see **Section 4.3.1**).

#### 4.2.2 Unnecessary Emergency Department Visits Contributed to Long Wait Times and High Care Costs

The emergency department is typically the only option for high-acuity patients who need urgent and comprehensive care. Low-acuity patients may also choose to visit an emergency department if they have no other timely option and still want to be seen as soon as possible. Emergency departments will often safely delay care for these patients until higher-acuity patients are seen.

We noted that lower-acuity patients, specifically those assigned a CTAS 4 (less urgent) or CTAS 5 (non-urgent) level by a triage nurse, accounted for about 23% (or 1.29 million) of all emergency department visits in 2022/23, as seen in **Figure 1**. Some of these patients, such as those experiencing a sore throat or cold, chose to visit the emergency department because it was the only option available at the time. Furthermore, emergency departments do not typically refer patients to more appropriate care settings until after they have assessed and treated the patients in the emergency department, although we did note some hospitals had patient diversion practices in place for specific patient populations (see **Section 4.7.1**).

We also noted that the independent, not-for-profit Canadian Institute for Health Information (CIHI) conducted a study in 2014 that found that in cases where emergency department patients were treated and discharged, one in five could have been treated in a doctor’s office or a clinic. Some of the common issues among these patients related to colds, sore throats and ear infections. These unnecessary visits to emergency departments have continued to impact the ability of hospitals to provide timely care to other patients.

Hospital staff and emergency department physicians that we spoke with indicated that some lower-acuity patients choose to visit the emergency department to access physician care because their own primary care provider may not be available in the evenings or weekends, or they cannot get any appointment on a timely basis. For example, Windsor Regional Hospital informed us that they had many patients who chose to visit an emergency department instead of

waiting to get an appointment with their family doctor or to avoid taking time off from work. According to the most recent health-care survey completed by the Ministry in 2019, only 41% of Ontarians were able to get an appointment with their primary care provider on the same or next day.

While patients need to have unrestricted access to emergency departments when they feel they need emergency care, it would be prudent for the Ministry and Ontario Health to determine the underlying reasons why lower-acuity patients are visiting the emergency department rather than other health-care settings (for example, primary care or walk-in clinics) and then identify ways to divert those patients to those alternative care options. This will help emergency departments focus on assessing and treating sicker patients, and help reduce overall costs in the health-care system since emergency department care comes at a significant cost. According to recent data from the CIHI, the direct cost of an emergency department visit in Ontario was approximately \$165 (as noted in **Section 2.3**), almost three times higher than alternative options like primary care, which cost about \$56 per visit.

### RECOMMENDATION 3

To offer equitable and timely access to emergency department care for patients who require it, we recommend that the Ministry of Health, in collaboration with Ontario Health, work with hospitals to identify and address challenges, such as the lack of timely access to primary care and lack of awareness of other health-care options, to help ensure lower-acuity patients receive care in the most appropriate care setting.

### MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals to identify and address challenges to help ensure that lower-acuity patients receive care in the most appropriate care setting. On February 2, 2023, the government of

Ontario announced Your Health: A Plan for Connected and Convenient Care, its plan to provide people with a better health-care experience. Part of this announcement included an investment to create up to 18 interprofessional primary care teams. The Ministry will use this investment to help address the Office of the Auditor General of Ontario's recommendation by bridging the gap in accessing interprofessional primary care for vulnerable, marginalized and unattached patients to ensure they are able to connect to care where and when they need it. This investment of \$60 million over two years, beginning in 2023/24, will also sustain direct service delivery in existing interprofessional primary care teams that are experiencing increased operating costs.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians.

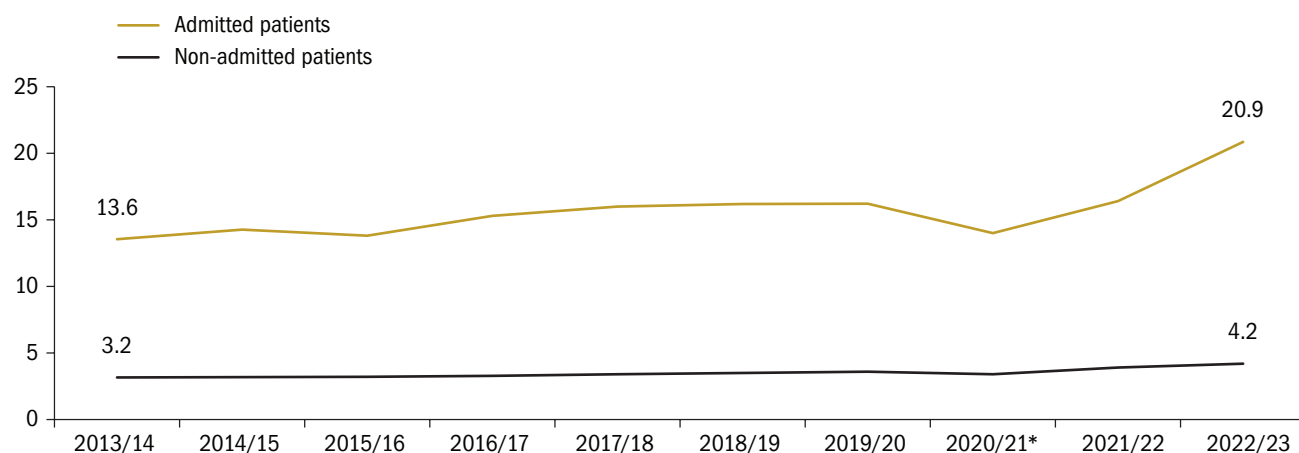
### 4.2.3 Medical Directives That Help Reduce the Time Patients Spend in Emergency Departments Were Not Used Consistently across Hospitals

Patients, regardless of whether they have to be admitted to the hospital or can be discharged after their emergency department visit, have had to spend significantly more time in the emergency department than they did prior to the COVID-19 pandemic. **Figure 14** shows the average time a patient spent in an emergency department for each visit over the last 10 years (2013/14–2022/23), from the time they were triaged by a nurse to when they left the emergency department. We found that:

- Patients who did not need to be admitted to an inpatient unit spent an average of 4.2 hours in an emergency department in 2022/23, over 30% more than the average 3.2 hours in 2013/14.

**Figure 14: Average Time Spent in the Emergency Department, 2013/14-2022/23 (hours)**

Source of data: Ontario Health



\* The average time patients had to spend in emergency departments dipped temporarily in 2020/21 as the number of visits decreased during the COVID-19 pandemic.

- Patients requiring inpatient admission spent an average of almost 21 hours in the emergency department in 2022/23, or 50% more time than the average 14 hours in 2013/14. (Wait times for inpatient admission are discussed further in **Section 4.2.4.**)

While some of the time spent waiting in an emergency department is unavoidable (for example, waiting for blood tests or diagnostic imaging results), we found that hospitals do not have or use medical directives consistently to help speed up patient care.

Medical directives, which are developed by a hospital's emergency department physicians, authorize nurses and other hospital clinicians (such as physician assistants) to begin the process of assessing patients and performing certain procedures before their physician initial assessment. Common examples include ordering blood tests or imaging and administering pain control medication. For example, a hospital may have a medical directive that indicates that patients presenting with cardiac chest pain should be given specific medication and sent for blood tests while patients who experienced an acute injury, such as a fall, in the previous 48 hours should be sent for an x-ray at the time of triage.

Empowering nurses and other hospital clinicians to act before the physician initial assessment allows certain basic emergency department testing

and procedures to be completed more quickly and efficiently, leading to better patient flow as well as improved patient care because physicians can administer treatment quicker.

Based on our review of medical directives at the emergency departments we visited, we noted significant variations in their use. For example:

- While all of the sites had medical directives, the number of directives in use ranged from nine to 37 depending on hospital, with some sites using the directives to address more specific conditions such as low blood sugar level.
- While data on the use of medical directives is not tracked centrally at hospitals, we noted that some may be using the directives more frequently to initiate care. For example, one hospital indicated that medical directives were used to begin providing patient care for about 50% of emergency department visits.

While medical directives are not always applicable (such as in cases where a physician assessment is needed for a patient with multiple symptoms), there is no formal province-wide system to share best practices on the use of medical directives among hospitals to reduce the amount of time that patients spend in an emergency department.



## RECOMMENDATION 4

To reduce the amount of time that patients spend in an emergency department, we recommend that Ontario Health, in collaboration with hospitals and emergency department physicians:

- review existing practices and usage of medical directives across hospitals; and
- develop and regularly update a set of standard medical directives that have shown success for hospital use when possible.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals and emergency departments to review existing practices and usage of medical directives and develop standard medical directives that have shown success. Ontario Health will continue to support sites interested in implementing medical directives where this resource is identified as an effective strategy for emergency department operations and flow performance.

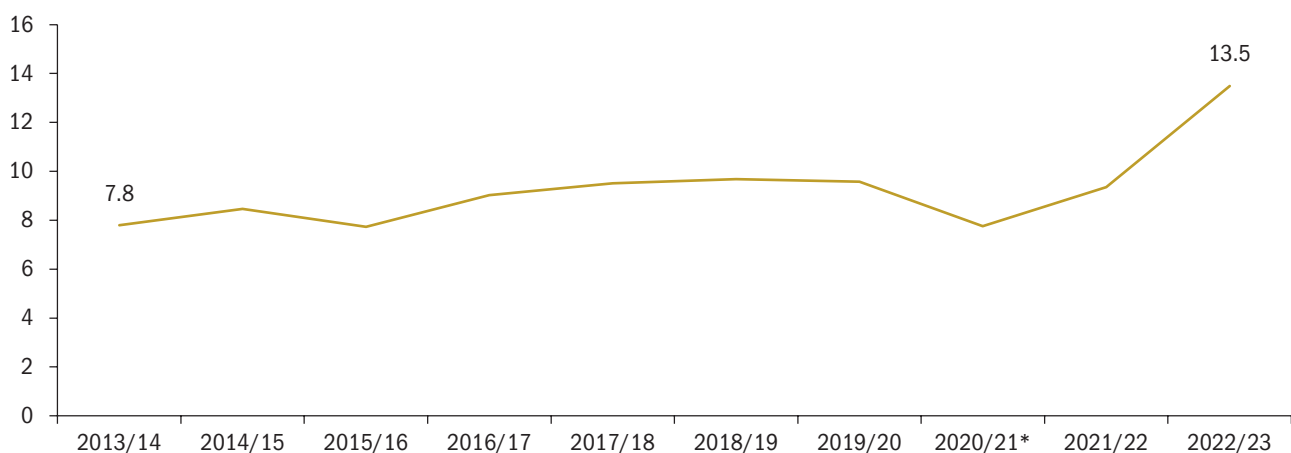
## 4.2.4 Emergency Patients Sometimes Had to Wait More than 24 Hours for an Inpatient Bed

Most patients who visit an emergency department are discharged the same day. However, some patients are admitted and transferred from the emergency department to an inpatient unit at the hospital for continuous monitoring or longer-term treatment. About 650,000 patients, representing 12% of all emergency department visits, required an inpatient admission in 2022/23 (compared with about 568,000 patients admitted in 2013/14).

As seen in **Figure 15**, in 2022/23 patients waited an average of 13 hours for an inpatient bed, a significant increase from the approximately eight to 10 hours they waited prior to the COVID-19 pandemic. When considering the 90th percentile wait time (the longest wait time after the top 10% are removed), patients waited 35 hours for an inpatient bed, compared with about 21 hours in 2013/14. Aside from the added strain this puts on patients and anyone accompanying them, the presence of people waiting for beds negatively affects the ability of the emergency department staff to focus on incoming patients.

**Figure 15: Average Wait Time for Inpatient Bed in Ontario, 2013/14–2022/23 (hours)**

Source of data: Ontario Health



\* Wait times for an inpatient bed fell in 2020/21 as fewer patients visited the emergency department during the COVID-19 pandemic.



**Figure 16: Average Wait Time for Inpatient Bed in Ontario by Sub-region, 2021/22–2022/23 (hours)**

Source of data: Ontario Health

Region	Average Wait Time			Longest Wait Time
	2021/22	2022/23	Change	2022/23
Central West	13.0	18.8	5.8	20.8
Central East	12.4	18.9	6.5	24.4
Hamilton Niagara Haldimand Brant	12.0	15.8	3.8	44.4
Central	10.9	15.1	4.2	20.4
Mississauga Halton	10.8	21.3	10.6	28.1
Toronto Central	9.3	12.7	3.4	23.3
Champlain	9.1	10.9	1.9	32.5
North West	8.9	10.3	1.3	11.4
North Simcoe Muskoka	8.6	11.7	3.1	14.5
North East	7.8	9.9	2.1	13.8
Waterloo Wellington	7.1	12.3	5.3	15.4
South East	6.7	9.3	2.6	13.9
South West	5.8	8.8	2.9	25.1
Erie St. Clair	4.9	9.1	4.2	12.0

Note: Regions in this table correspond to the boundaries of the 14 Local Health Integration Networks (LHINs). While the Ontario government merged the 14 LHINs into five Ontario Health regions in December 2019, regional wait-time data has continued to be reported by LHIN.

We also noted significant differences in wait times for an inpatient bed across regions and hospitals. As shown in **Figure 16**:

- Patients' wait times in emergency departments for an inpatient bed ranged from about nine to 21 hours, on average, in 2022/23, depending on where in the province they lived. This was a significant increase from five to 13 hours in 2021/22. During this time, patients could be taking up an emergency assessment room or waiting in a wheeled stretcher in a hallway.
- The wait times varied widely by hospital. For example, while the average wait time for an inpatient bed in the Hamilton Niagara Haldimand Brant region was 15.8 hours in 2022/23, some emergency department patients in the region had to wait almost 44 hours.

As seen in **Figure 17**, the wait times for an inpatient bed across the hospitals we visited ranged from 10 to 21 hours for general hospitals and 3.7 to 9.2 hours for pediatric hospitals.

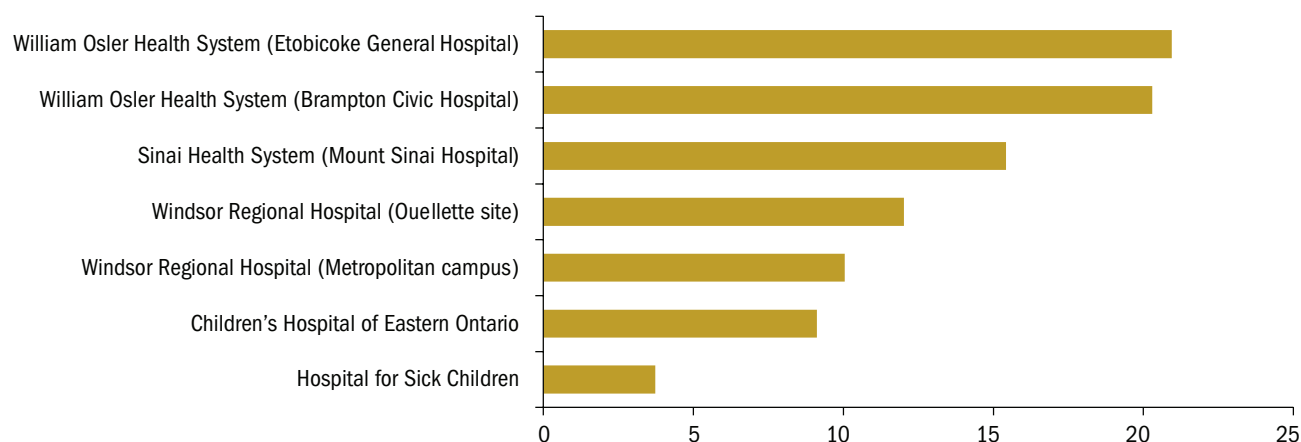
### Lack of Inpatient Beds and Hallway Patients

One factor contributing to long wait times for inpatient beds is the lack of available hospital beds in Canada relative to the population. In 2021, Canada had 2.55 hospital beds per 1,000 people, placing it eighth among the 38 countries in the Organisation for Economic Co-operation and Development (OECD). In comparison, France, Germany and Poland had more than double Canada's rate with 5.5 beds per 1,000 people. The OECD does not report information on a provincial level, but Ontario is estimated to be at or lower than the Canadian average.

The long wait time for inpatient beds has been a long-standing issue in Ontario. The Premier's Council on Improving Healthcare and Ending Hallway Medicine, created by the Province in 2018, said in its January 2019 report that hallway health care was a significant problem in Ontario. The report found that on any given day, there were at least 1,000 patients receiving health care in hospital hallways, including in emergency departments.

**Figure 17: Average Wait Time for an Inpatient Bed at Selected Hospitals in Ontario, 2022/23 (hours)**

Prepared by Office of the Auditor General of Ontario



Based on our analysis of current data and observations at some of the emergency departments we visited, the issue of “hallway patients” continues to be a challenge, creating a significant risk to the general public because it decreases the space in which emergency department staff can treat new patients. The overcrowding also creates added stress for staff, patients and their families. A review of crowding in emergency departments published in 2018 in *PLOS ONE*, an international research journal, noted that crowding is generally associated with poorer patient outcomes.

During our site visits to emergency departments, we found that staff had to keep patients on wheeled stretchers as they waited for an inpatient bed. For example, during our visit to William Osler Health System’s Brampton Civic Hospital, we noted a significant number of elderly patients being treated in tight hallways while ambulance paramedics struggled to bring in additional patients. On the day of our tour, we noted that 46 patients were stuck in the emergency department, receiving care in hallways or assessment rooms, because of a lack of available inpatient hospital beds. Since emergency department staff continued to be responsible for these patients, their ability to treat new patients in a timely manner was impacted.

### Alternate Level of Care Patients

Another contributing factor to the long wait times for inpatient beds is the relatively high number of

patients classified as alternate level of care (ALC). These patients are in a hospital bed but do not require hospital-level care and could be seen and treated elsewhere if space was available in a more appropriate facility, for example, a long-term care home. In our 2010 audit *Discharge of Hospital Patients*, we noted that ALC patients accounted for approximately 16% of the total number of days patients were hospitalized in Ontario. In comparison, the ALC rate in Ontario hospitals was approximately 15% in 2022/23, indicating a very slight improvement in reducing the impacts of ALC patients on inpatient admissions in the last 13 years.

## RECOMMENDATION 5

To improve patient flow within emergency departments and reduce wait times for inpatient beds, we recommend that the Ministry of Health work with Ontario Health and hospitals to expand the capacity of inpatient beds and increase the availability of community resources to reduce the need to treat patients in hallways, and speed up the transfer of inpatients to more appropriate facilities.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario’s recommendation to expand the capacity of inpatient beds and increase the availability of community

resources to reduce the need to treat patients in hallways, and speed up the transfer of inpatients to more appropriate facilities.

The Ministry remains committed to working with Ontario Health to support the hospital sector and to improve access to the right level of care for patients. In 2023/24, Ontario invested up to \$1.5 billion in funding to support the continued operation of over 3,500 acute, post-acute and critical-care beds. The Ministry worked closely with Ontario Health to support bedded capacity planning linked to this investment to ensure that the right mix of acute and post-acute beds were provided where they are most needed and would be responsive to patient-care needs. This enables patient flow, provides access to the right level of care in the appropriate care setting, and bolsters the hospital sectors' ability to respond to arising pressures or increasing demand for services, which will help reduce the need to treat patients in hallways.

In 2022/23, the Ministry began funding Ontario Health to implement various alternate level of care (ALC) and patient flow initiatives targeting a reduction in the ALC rate. The initiatives span five categories: capacity maximization, admission avoidance, discharge supports, the development of local strategies, and home and community care. The Ministry has provided Ontario Health, as system administrators, the flexibility within these initiatives to direct funding where it is most impactful and is responsive to the evolving needs of the health system as a whole. The ALC initiatives are focused on providing the right level of care in the right setting and supporting different sectors of the health system to work in cohesion for the benefit of the patient.

The government has also been committed to ending hallway health care and has made a targeted investment into regions particularly struggling with this issue. This dedicated investment began in 2020/21 with a one-time investment to support the creation of an additional 129 hospital beds to increase hospital capacity in the Durham-Scarborough and London regions to target hallway health care. In 2023/24, this investment was made permanent.

Finally, expansion of inpatient capacity is a key component of the Ministry's 10-year capital plan. As part of this plan, the Ministry is investing in 50 major hospital development projects that will add another 3,000 new hospital beds in Ontario. Ontario's health capital investments over the next 10 years will lead to \$40 billion in health infrastructure across the province.

## 4.3 Long Wait Times Impacted the Quality of Emergency Department Care, Resulting in Poor Patient Outcomes

### 4.3.1 Some Patients Returned to Emergency Departments within a Week in Worse Health

In 2016, Ontario Health introduced the Emergency Department Return Visit Quality Program (Quality Program), which was designed to build a culture of continuous quality improvement in emergency departments across the province.

To identify areas for improvement, the Quality Program requires participating hospitals to report to Ontario Health the reasons why patients return to emergency departments soon after their initial visit. The two types of return visits as defined in the program are:

- An emergency department return visit within 72 hours of discharge, and the return visit results in an inpatient admission.
- An emergency department return visit within seven days of discharge, and the return visit results in an inpatient admission and a sentinel diagnosis relevant to the diagnosis documented in the initial visit. A sentinel diagnosis is one that is severe and significant, such as a heart attack or pediatric sepsis (a bodily response to a serious infection that is considered life-threatening).

Each year, participating hospitals are required to audit all return visits with a sentinel diagnosis within seven days as well as a random selection of return visits within 72 hours. At least 50 return visits must be audited at each hospital and a summary sent to Ontario

**Figure 18: Examples of Poor Patient Outcomes**

Prepared by the Office of the Auditor General of Ontario

Patient Story	Patient Outcome
A patient reporting recurring episodes of abdominal pain was discharged from the emergency department after it was determined that the blood work, vital signs and a physical exam showed no concerns. A physician only examined the patient in the waiting room and didn't provide a follow-up plan or request outpatient imaging.	The patient returned two days later with a ruptured appendix that required emergency surgery.
A patient arrived at the emergency department complaining of difficulty swallowing. The patient waited for over five hours and, due to the long wait time, decided to take a taxi to another hospital.	Staff at the second hospital determined the patient needed a breathing tube and admitted the patient to the critical care unit.
A clinic referred a patient with a possible hip fracture to the emergency department. The patient received an X-ray about an hour after being triaged but was not seen by a physician until a further nine hours later. The physician then sent the patient for a CT scan, but because of the time already spent in the emergency department the patient decided to leave the hospital.	The patient received a CT scan as an outpatient and was eventually admitted for surgery the following day.
A patient at the emergency department presented with acute and chronic abdominal pain. A CT scan was ordered, but due to a long wait time for the scan the patient decided to leave and return the next day.	After returning to the emergency department for a CT scan the next day, the patient was diagnosed with a strangulated hernia and required inpatient admission.
A patient went to the emergency department with a skin reaction to chemotherapy. While the patient was discharged after receiving treatment, there were no discharge instructions on the record. The patient returned to the same emergency department the following day with the same symptoms. However, likely due to an expected long wait time, the patient left before receiving treatment.	The patient went to another hospital emergency department on the same day and was admitted as an inpatient.
Emergency department staff determined a patient had an obstructing kidney stone, but discharged the patient with a planned follow-up because there was no inpatient bed available.	The patient returned to the emergency department the next day with increased pain and was admitted to the hospital.

Note: These examples are based on a review of the documentation related to the Emergency Department Return Visit Quality Program, as well as discussions with staff at select hospitals we visited.

Health. These return visits may be the result of patients who left the emergency department without being seen by a physician due to long wait times during their initial visit (see **Section 4.2.1**).

We noted that in 2022, 1,135, or about 20%, of the 5,198 audits of return visits identified a quality-of-care issue or adverse event such as patient mismanagement (for example, lack of reassessment of patients), a delayed or missed diagnosis or an unsafe discharge decision. These audits included 274 return visits with a sentinel diagnosis, 104 of which identified a quality-of-care issue or an adverse event had occurred.

We reviewed the details of the audits performed by hospitals over the last five years and noted numerous examples where long wait times to see a physician, a lack of access to timely patient testing and a lack of inpatient bed availability resulted in poor patient outcomes. We also noted additional examples of poor patient outcomes during our work with hospitals (see **Figure 18**). In some instances, patients left emergency departments due to lengthy wait times, but returned shortly after their initial visits and required emergency surgery and hospital admission.

### 4.3.2 Hospitals Did Not Consistently Track and Report Emergency Department Return Visits and Related Quality-of-Care Issues

Participation in the Quality Program is not mandatory for all hospitals with an emergency department. Only emergency departments that participate in the Pay for Results (P4R) program (see **Section 4.6**) are required to participate in the Quality Program. At the time of our audit, 75 emergency departments participated in the Quality Program, so about half of Ontario's emergency departments were not required to report their data on return visits to Ontario Health. As such, Ontario Health did not know whether those hospitals internally audited their emergency department return visits to identify any issues related to quality-of-care or adverse events.

Furthermore, while the goal of the Quality Program is to foster a culture of continuous quality improvement, we found that hospitals did not report the results of their return-visit audits on a consistent basis, making it difficult to draw conclusions on how the province as a whole is performing. While hospitals are required to indicate whether a return visit was due to a quality-of-care issue (that is, a misdiagnosis or unsafe discharge), there was a wide variation in the way hospitals defined and classified these issues. For example, we found that in two very similar cases at different emergency departments, one hospital called the event a quality-of-care issue, while the other hospital did not. This may have contributed to the wide variation of return-visit rates we found across hospitals. For instance, one hospital indicated almost 35% of its return visits were due to a quality of care issue compared to 4% at another hospital.

Based on our review of data on return visits between 2018 and 2022, we found that the rate of return visits requiring admission remained constant even though the number of emergency department visits declined over that period.

Because of a Ministry decision to expand eligibility for participation in the P4R program, as discussed in **Section 4.6**, there is a likelihood more hospitals will be required to participate in the Quality Program.

## RECOMMENDATION 6

To help ensure that emergency departments provide high-quality care, we recommend that Ontario Health expand and monitor the Emergency Department Return Visit Quality Program by requiring all hospitals with emergency departments to participate and report their data on return visits and patient outcomes or issues related to adverse events consistently and on a timely basis.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation, and as a key component to the Pay for Results (P4R) expansion announced by the Ministry of Health in 2023/24, will work with hospital sites to begin planning implementation of the Emergency Department Return Visit Quality Program (Quality Program) in future fiscal years.

Ontario Health aims to maintain the goals of the Quality Program for all participating emergency departments, while designing appropriate program requirements in its expansion to include small-volume sites.

### 4.3.3 Ambulance Offload Times Contributed to Even Longer Wait Times for Patients and Risks to Communities

Ambulances are a critical part of the health-care system. While 80% of the patients who visited an Ontario emergency department in 2022/23 entered by their own means, 20% were brought in by ambulance. Despite the importance of the ambulance network, we noted that some paramedic groups have struggled to maintain timely service in recent years because ambulances were often stuck at emergency departments waiting to offload a patient. Since all patients arriving at emergency departments are assessed the same way, patients arriving by ambulance did not get priority to walk-ins.

We met with senior staff from various paramedic groups across the province to better understand the



ambulance offload process and challenges faced by paramedic groups when offloading patients at hospitals. While there is no formal provincial target for ambulance offload times, paramedic groups informed us that on average 30 minutes or less is considered best practice in the industry. We found, however, that this target has not been met consistently and there have been cases where offload delays were significantly longer than the 30-minute target. For example:

- Ottawa Paramedic Service experienced offload delays of as long as three hours and faced a total of about 98,000 hours in offload delays in 2022/23.
- Toronto Paramedic Services experienced delays of up to 52 minutes and indicated that they faced a total of almost 62,000 hours in offload delays in 2022/23.

Tying up ambulances poses a significant risk for communities, and it is an ongoing challenge. For example, on multiple occasions in 2023, Essex-Windsor Emergency Medical Services had to declare “code black,” a designation that signifies no ambulances are available in the community.

There are two main causes of offload delays: unavailability of nursing staff to immediately triage the patient and bring them into an assessment room; and limited assessment room space. As such, the paramedic must stay with the patient to provide support until emergency department staff take over.

To address the issue of lengthy offload times for ambulance staff, the Ministry implemented the Dedicated Offload Nurse Program in 2008. The program provides funding to some municipalities, which in turn transfer funding to local hospitals to hire nurses or other health-care professionals (i.e., paramedics) to help improve the timeliness and efficiency of the ambulance offload process so the paramedics can get back into the community in a timely manner. Paramedic groups have informed us that this program has been successful in improving offload times, but it does not address all of the main challenges. Given continuous hospital staffing issues and the unavailability of assessment rooms or

beds, offload times have remained long even at hospitals with a dedicated ambulance offload nurse.

Some paramedic groups have worked with local hospitals to address the long-standing ambulance offload delays, or shorten offload times, especially for lower-acuity patients. For example:

- Peel Regional Paramedic Services worked with William Osler Health System to implement the Fit2Sit program in October 2020. This program allows paramedics to discharge lower-acuity patients quicker if they are able to sit in the waiting area. Patients are accompanied by paramedic staff to triage, while the hospital takes responsibility for monitoring those patients. We noted that this program has resulted in offload times for patients that meet the Fit2Sit criteria of about nine minutes, significantly shorter than the 30-minute industry standard.
- Windsor Regional Hospital has directly hired two paramedics in one of its emergency department sites to help manage and monitor patients arriving by ambulance until they can be triaged and assessed so paramedics can return to the community quicker.

Despite their success, these practices and processes have not been consistently adopted across hospitals even in regions or hospitals that have experienced lengthy ambulance offload delays.

## RECOMMENDATION 7

To efficiently offload patients arriving at an emergency department by ambulance and more quickly free up ambulances to address other emergency calls, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- continue to review and enhance the Dedicated Offload Nurse Program to ensure it supports improvement in offload times; and
- work with hospitals and regional paramedic groups to continue identifying other initiatives, such as the Fit2Sit program in Peel region, that

have improved the offload process, and share these practices across the province to help address lengthy ambulance offload times.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges and supports this recommendation. The Ministry remains committed to continuing to review and enhance the Dedicated Offload Nursing Program (DONP) and to identify and share best practices across paramedic services and hospitals in order to help reduce ambulance offload times.

The Ministry has made the following progress on this recommendation:

- In the 2023 Ontario Budget, the government is investing an additional \$51 million over three years to strengthen the DONP.
- In 2023/24, the DONP funding invested will help 30 municipalities provide 650,000 hours of offloading support, transferring ambulance patients to hospital care, and allowing paramedics to return to the community faster to respond to 911 calls.
- Expanded DONP eligibility to allow hospitals to also hire other types of health providers (paramedics, respiratory therapists, and physician assistants) in offloading positions, providing more flexibility to better manage ambulance offload times.
- Continue to share best practices from hospitals high performing in ambulance offload times (for example, North York General Hospital) with paramedic services and other hospitals across the province to help them improve their ambulance offload. Resources that have been shared include a Tool Kit for Promoting Ambulance Offload, created by Toronto Paramedic Services, with all paramedic services in the province.

## 4.4 Triage Process Has Improved but More Oversight and Further Changes Are Needed

### 4.4.1 New Triage System Was in Place but Some Hospitals Were Not Using It

As discussed in **Section 2.2.1**, triaging is the process of prioritizing patients based on the urgency of their symptoms or injury to help ensure that resources are allocated effectively to treat the sickest patients first.

When a patient visits an emergency department, their first clinical interaction is typically with a triage nurse. Triage nurses assess the urgency of a patient's condition based on both subjective and objective information, including the patient's presenting symptoms, general appearance and health history. The triage nurse also conducts general tests that typically include a check of the patient's blood pressure and vitals. This information is then used to assign a priority level using the Canadian Triage and Acuity Scale (CTAS).

During our 2010 audit Hospital Emergency Departments, hospitals were manually conducting triaging. At the time, we found that file documentation was sometimes lacking and triage was not performed on a consistent basis. In response to our findings and recommendations, the Ministry and Ontario Health began implementing the electronic Canadian Triage and Acuity Scale system, known as eCTAS, across hospitals in 2016 to help ensure consistency and oversight of triaging across the province. The eCTAS system allows triage nurses to input pertinent patient information to determine a CTAS level for each incoming patient.

Based on our review of eCTAS and discussion with hospital staff, we found that nurses' use of the system has generally made the triage process more consistent and efficient. Furthermore, we noted multiple studies that looked at usage of the eCTAS system and noted its benefits. For example, one study published in the *Journal of American College of Emergency Physicians* in 2020 looked at the triage process before and after the

implementation of eCTAS in Ontario and found that it improved the consistency of triaging patients, especially among patients with multiple complaints such as chest pain, fever and shortness of breath. Another study published the same year in the medical journal *Annals of Emergency Medicine* reviewed the use of eCTAS at seven Ontario emergency departments before and after implementation and found that the system had improved the accuracy of the assigned triage levels compared to an auditor's assessment of CTAS level.

Despite these improvements, and even though both Ontario Health and the Ministry have encouraged hospitals to implement the eCTAS system, 44 emergency departments do not currently use eCTAS. Ontario Health informed us that it was in the process of onboarding 11 more emergency departments as part of an eCTAS expansion project scheduled to take place in 2023/24—though, once completed, that would still leave 33 emergency departments outside the system.

#### **4.4.2 Some Hospitals Were Consistently Overriding the Triage Level Assigned by the System, Indicating More Training May Be Needed**

In some situations, nurses can decide that the triage level assigned by the eCTAS system is not urgent enough—that is, the triage nurse's observation and assessment of the patient may lead the nurse to believe the patient is sicker than what the system indicates. In these cases, it is possible for the triage nurse to manually override the eCTAS system and assign a higher triage level. For example, if the eCTAS system assigns a patient CTAS 4 but the nurse believes the patient needs to be seen more urgently, the nurse could manually assign the patient a CTAS 2. When this happens, the system tracks the override and the reason for the override based on a drop-down menu. The triage override function only allows a nurse to increase a patient's priority, not lower it.

Ontario Health, which centrally oversees the eCTAS system, monitors when triage nurses at any particular hospital override the system more than 10% of the time. When a hospital does so, Ontario Health will send information related to the overrides to the hospitals and ask administrators to explain the high number of overrides.

We noted that in the last five years, the provincial average override rate has consistently exceeded 10%, ranging from 14% to 16%. In that time, over 70 hospitals were overriding eCTAS more than 10% of the time. In 2022/23, about 13 hospitals were overriding the eCTAS levels in more than 25% of their cases, or 2.5 times the expected threshold set by Ontario Health.

Furthermore, we noted that in some cases, override rates were attributable to certain triage nurses, with some overriding the triage levels more often than others, indicating that they may not have been adequately trained on the use of the eCTAS system and its override function. For example, one of the pediatric hospitals we visited was overriding eCTAS in almost 29% of cases, with even higher override rates in earlier years. We also noted that hospitals had initiated additional training to help ensure triage nurses understood how to correctly utilize the system. However, the hospital also mentioned that eCTAS was not as well integrated with pediatric triaging. As such, the hospital indicated that it would be beneficial to update the eCTAS system by adding more symptoms aligned with pediatric care that impact triage levels.

There are situations in which increasing the triage level is valid. For example, patients presenting with non-urgent symptoms may also be undergoing significant mental distress that needs to be treated but cannot easily be captured in the eCTAS system. However, since the purpose of implementing the eCTAS was to help ensure consistency and oversight of triaging, overrides may raise the risk that patients are not being triaged equitably or in accordance with their needs. Ontario Health informed us that the eCTAS system may



not be able to capture all of the patient's concerns when they present at the emergency department, and therefore having some overrides is unavoidable, but should be limited overall.

## RECOMMENDATION 8

To safely, effectively and equitably triage patients, we recommend that Ontario Health:

- work with all hospitals in the province to implement the electronic Canadian Triage and Acuity Scale (eCTAS) system;
- conduct a thorough analysis of why some hospitals, such as pediatric hospitals, have consistently high triage override rates and determine whether changes to the system are necessary; and
- ensure triage nurses are adequately trained on the use of the eCTAS system and receive regular ongoing training as needed.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation and, as a key component to the Pay for Results (P4R) expansion announced by the Ministry of Health in 2023/24, will use the opportunity to further work with hospital sites to begin planning implementation of eCTAS in future fiscal years and to analyze why some hospitals have consistently high triage override rates.

Ontario Health uses a Train the Trainer system to train a clinical lead in each of the sites using the Ontario Health eCTAS Application (Complex and Basic). Clinical Leads are responsible for training the staff at their facility in how to use eCTAS. Certification and Webservice sites have chosen the option to use their own process and documentation in their eCTAS tools.

## 4.5 Human Resource Shortages and Payment Structures Posed Risks to Emergency Department Accessibility

### 4.5.1 Significant Staffing Shortages Reduced Access to High-Quality Emergency Care

Staffing shortages and vacancies, particularly in nursing, have put many emergency departments under pressure and resulted in temporary closures in recent years (see **Section 4.1.1**).

In discussions with Ontario Health and hospitals, we noted the high staff turnover and difficulty with hiring and retaining nurses were mainly due to:

- the introduction of Bill 124, which limited wage increases for many employed professionals (including nurses) to 1% each year for three years, angering nurses, especially those working at hospitals in urban centres with higher costs of living, and leading to court challenges;
- higher pay and flexibility being offered by agencies (discussed further in **Section 4.5.3**);
- low staff satisfaction at hospitals;
- an increase in workplace violence in emergency departments; and
- nurses retiring or taking early retirement.

Since the Ministry and Ontario Health have never collected and tracked information on staffing shortages and vacancies across emergency departments, we requested staffing counts and vacancies from the emergency departments we visited and compared the information in 2019/20 (pre-COVID-19) and 2022/23 (see **Figure 19**). We noted that:

- Most emergency departments experienced a significant increase in vacancy rates between 2019/20 and 2022/23. For example, one emergency department's vacancy rate of full-time registered nurse increased significantly from 6% to 26%, and the rate for part-time registered nurses increased from 23% to 51%.
- Most emergency departments had high vacancy rates for full- and part-time registered nurses in 2022/23 ranging from 11% to 51%.

**Figure 19: Emergency Department Vacancies for Registered Nurses (RNs) at Selected Hospitals in Ontario, Pre- and Post-COVID-19 (%)**

Prepared by the Office of the Auditor General of Ontario

Hospital	Position	Vacancy Rate <sup>1</sup>	
		2019/20	2022/23
<b>William Osler Health System</b> (Brampton Civic Hospital and Etobicoke General Hospital)	Full-time RN	6	26
	Part-time RN	23	51
<b>Sinai Health System</b> (Mount Sinai Hospital)	Full-time RN	3	19
	Part-time RN	12	19
<b>Windsor Regional Hospital</b> (Metropolitan campus and Ouellette campus)	Full-time RN	6	17
	Part-time RN	15	25
<b>Children's Hospital of Eastern Ontario</b>	Full-time RN	10	11
	Part-time RN	12	20
<b>Hospital for Sick Children<sup>2</sup></b>	Full-time RN	8	22

1. As at March 31 fiscal year-end.

2. The Hospital for Sick Children did not have any part-time vacancies to report.

In summer 2022, Ontario Health began surveying hospitals on behalf of the Ministry to identify overall staffing pressures in emergency departments. We reviewed the results of this survey as of May 1, 2023 and found that out of the 71 hospitals that responded, 83% (or 59 hospitals) reported having a staffing shortage in their emergency departments to varying degrees. In the survey, 69% (or 49 hospitals) described the staffing shortage as moderate, while 14% (or 10 hospitals) said their staffing situation was severe or critical. Despite this, at the time of our audit neither the Ministry nor Ontario Health had developed a long-term strategy or acted upon this information to take specific actions related to hospitals with significant staffing shortages.

#### 4.5.2 Hospitals Had Limited Flexibility to Address Staffing Shortages at Emergency Departments Using Internal Resources

An organization can often resolve staffing shortages in a specific department by reorganizing its internal staffing resources on a temporary basis. We asked administrators at the hospitals we visited whether they were able to have nurses in other units provide temporary support in the event of a nursing shortage

in the emergency department. They informed us that hospitals' collective agreements with nursing staff provided them with limited flexibility to move nurses between units.

We noted that nurses are required to meet specific training requirements to work effectively in an emergency department. These requirements include:

- at least one to two years of hands-on training in addition to other certifications; and
- new nurses need to be overseen by an experienced and trained nurse.

While it is understandable that nurses with particular training and experience should work in areas where they have expertise, redeploying nurses from other units to fill temporary staffing gaps at emergency departments is a practical and feasible solution. We noted that the practice of redeploying nurses has been used by some hospitals we visited and was in place during the COVID-19 pandemic after a special order was issued by the Ontario government. Specifically:

- The government issued a special order during the pandemic under the March 17, 2020 declaration of emergency that allowed hospitals to temporarily reassign staff based on needs. This included redeploying staff (including nursing staff under collective agreements) within a

hospital or between hospital sites. For example, a hospital we visited indicated that because of this order, it was able to shift nurses from inpatient units into the emergency department on a temporary basis to fill significant vacancy gaps and sick leaves. The hospital indicated that it would be beneficial to continue to have this flexibility. However, this special order is no longer applicable.

- One of the hospitals we visited, where nurses were not part of collective agreements, had initiatives in place that enabled it to fill staffing gaps in the emergency department effectively without putting patient care at risk. Examples of such practices include:
  - using nurses from other units of the hospital to help fill staffing needs in the emergency department; and
  - having a trained and experienced emergency department nurse overseeing and supporting nurses redeployed to the emergency department from other units.

### 4.5.3 Hospitals Filled Staffing Gaps by Hiring Agency Nurses at Significantly Higher Hourly Rates

When a hospital is facing a nursing shortage that cannot be addressed by redeploying its own staff, it often has to rely on staffing agencies to fill gaps and vacant positions. This has put financial pressure on hospitals that employ agency nurses, partly because they are usually paid more than permanent staff.

While there are many staffing agencies in Ontario that provide nurses to fill positions, it is unclear how often hospitals use these agencies to fill vacancies at their emergency departments because the Ministry and Ontario Health do not collect such information. There also is no legislation that caps the amount these private, for-profit companies can charge hospitals. The Ministry and Ontario Health do not specifically track agency staff costs and rely on hospitals to manage their own budgets and make decisions related to agency staffing.

We reviewed data on agency-nurse spending across the hospitals we visited and found that in 2022/23, one

hospital spent about \$8 million on agency nurses in the emergency department, more than three times the amount it spent in 2021/22, and more than eight times its spending in 2019/20. Another hospital we visited spent \$2.7 million on agency nurses across its emergency departments in 2022/23, 4.5 times more than the approximately \$600,000 it spent in 2021/22.

Through our review of hospital finances, we found that the cost to use agency staff was significant because hospitals pay agency nurses significantly more than their own full-time permanent nurses. For example, agency nurses that hold the position of registered nurse working in an emergency department could get paid more than \$75 an hour, compared with about \$35 to \$50 an hour for the full-time permanent nurses employed by a hospital. One hospital paid agencies from \$99 to \$106 an hour to hire a registered nurse for its emergency department.

Through our Office's 2023 audit *Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care*, we found that the significant use of agency nurses extends beyond emergency departments. For example, that audit found that of the 34 Northern Ontario hospitals that responded to a questionnaire, 30 of them used agency nurses in 2022/23 at a cost of more than \$73 million. Furthermore, that audit found that agencies charged hospitals as much as \$160 an hour for a registered nurse.

Barring Ministry intervention, agency nursing costs may continue to rise. The higher pay and flexible hours for agency nurses have resulted in some permanent nurses leaving hospitals as well as high vacancy rates (as discussed in **Section 4.5.1**), which in turn has forced hospitals to rely on agency nurses even more to fill their nursing shortages.

## RECOMMENDATION 9

To efficiently and economically deliver emergency care, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- expand existing data collection to include vacancy data of emergency departments to identify staffing challenges and determine if any province-wide actions need to be taken;

- comprehensively collect and monitor hospital expenditures on agency staffing to determine the reasonableness of payments to staffing agencies and the need to negotiate or legislate such payments to ensure fairness and transparency; and
- work with collective-bargaining organizations to implement permanent mechanisms that allow for more flexibility of staff movement within each hospital in urgent and temporary situations.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to expand existing data collection to include vacancy data of emergency departments. The Ministry acknowledges the importance of effective data collection and analysis in support of effective health workforce planning. The Ministry will review the data-related aspects of the recommendation to determine how best to refine its data-collection practices in support of current and future work to support service delivery in emergency departments. Today, the Ministry already collects data regarding hospital staffing pressures, staffing positions, vacancies and staff absenteeism. Data related to compensation expenses for agency staff who provide direct care/services is collected on a quarterly basis in the Ontario Healthcare Financial and Statistical System. This information can be used to monitor the utilization of agency staff for particular service departments.

With respect to the element of the recommendation related to agency staffing, the Ontario government recognizes the role staffing agencies play in supporting a flexible workforce. The government also recognizes that agency rates in Ontario have increased significantly, creating instability for hospitals, long-term care homes and emergency departments. We are working to evaluate the issue of rising agency reliance and costs. This includes, as noted in the government's Plan to Stay Open:

Health System Stability & Recovery, engaging with frontline partners to better understand how we can bring stability to hospitals, long-term care homes and emergency departments, while protecting quality of care. The Ministry will also review mechanisms that allow for more flexibility of staff movement within each hospital in urgent and temporary situations.

### 4.5.4 Inconsistencies and Flaws in the Physician Payment Structure Could Impact Timeliness and Oversight of Emergency Department Care

As discussed in **Section 2.3**, the majority of emergency department physicians are compensated through an alternative funding arrangement (AFA), while some physicians use a fee-for-service (FFS) model and bill directly to the Ontario Health Insurance Plan. In cases where an emergency department is under the AFA model, all emergency department physicians working for that hospital are part of the same AFA. For physicians compensated through the AFA, there is typically a base funding component, which is essentially a salary divided among the physicians working under the AFA.

We noted that outdated AFAs can contribute to hiring and retention challenges in some communities, particularly in Northern Ontario. For example, one northern hospital indicated that its significant reliance on physicians through the Locum Program (described in **Section 4.1.2**) could be attributed to the outdated terms and conditions of the AFA, which did not adequately capture the number and complexity of patients that emergency physicians had to treat. Because many patients do not have access to primary care, the emergency department can be the only care provider in a northern community. The situation, in turn, may lead to further physician vacancies and further reliance on the Locum Program.

We also noted that there can be a lack of oversight of the pay and performance of individual physicians who are part of an AFA. Specifically, we noted that the Ministry does collect the total hours worked by physicians collectively at each hospital for adherence to AFA agreements, but does not review information on

the funding provided to each physician or the volume of patients seen by each physician. For example, there is no oversight mechanism to identify and review physicians who see a relatively low number of patients per shift or who spend longer on assessments compared to peers.

We also found that patient access to a physician could be directly impacted by whether physicians are compensated through an AFA or FFS model. Although only 15% of all emergency departments are under an FFS model, of the five hospitals with the shortest physician initial assessment wait times in **Appendix 3**, three were using an FFS model while all five of the lowest performing hospitals were on an AFA.

For example, William Osler Health System's emergency department physicians are under an FFS model. Despite the high volume of patients in its emergency department, it still had relatively short wait times for a physician initial assessment compared to all other hospitals we visited, as noted in **Figure 12**. An emergency department physician at the hospital told us that the shorter wait times to see a doctor were a result of process improvements that were easier to implement under an FFS model.

The Ministry and the Ontario Medical Association have agreed to undertake a study to evaluate the AFA, the workload of emergency department physicians and the time they spent treating patients. The study, which may ultimately impact base payments made to those physicians, was expected to begin in January 2024 and be completed in early 2025. However, we noted that there was no plan to evaluate the effectiveness of both the AFA and FFS models and to determine which model better meets patient needs.

## RECOMMENDATION 10

To effectively and efficiently compensate emergency department physicians, we recommend that the Ministry of Health work with Ontario Health and hospitals to comprehensively review all current compensation structures and make changes to help ensure they are patient-focused and incentivize timely patient care.

## MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to work with Ontario Health and hospitals to review current compensation structures and make changes as needed to ensure patient-focused and timely patient care.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

## 4.6 Oversight of Emergency Department Performance Was Lacking and Initiatives to Improve Performance Were Not Evaluated

To incentivize improvement in patient flow through emergency departments, the Ministry created the Pay for Results (P4R) program in 2008. Managed and overseen by Ontario Health, the program provides financial incentives to help hospitals improve the performance of their emergency departments. The objective of P4R is to support hospital innovation and practices that reduce patient wait times and length of stays.

The P4R program has focused on large hospitals with a high volume of emergency department visits. To be eligible to participate, an emergency department must have had at least 30,000 annual visits in the last two consecutive years. At the time of our audit, there were 75 hospital sites participating in the P4R program. On July 20, 2023, the government announced it would invest an additional \$44 million in the P4R program and expand the eligibility criteria to



allow smaller hospitals to participate in the program, although the funding allocation was still in progress at the time of our audit.

The program assesses the performance of each participating hospital's emergency department using six key performance indicators:

- Length of stay for admitted patients
- Length of stay for non-admitted high-acuity patients
- Length of stay for non-admitted low-acuity patients
- Time to physician initial assessment
- Time to inpatient bed
- Ambulance offload times

Each year, hospitals participating in the program are ranked based on their performance compared with other hospitals. For the first five performance indicators noted above, the ranking considers each participating hospital's most recent annual performance and historical performance since joining the P4R program. For the indicator related to ambulance offload times, the ranking only considers the most recent annual performance. Once all hospitals have been ranked, they are allocated a portion of the P4R program funding, which was approximately \$93 million in 2022/23.

#### 4.6.1 P4R Program Showed Initial Successes but It Has Become Less Effective at Improving Emergency Department Patient Flow

Despite showing some success over the years, the P4R program has not had a significant impact on improving patient flow and reducing patient time spent in emergency departments in recent years. We reviewed historical P4R program data and found that in the early years of the program, some key performance indicators showed wait time reductions at participating hospitals. However, we found that the hospitals' average annual performance had deteriorated leading up to the December 2018–November 2019 period, the most recent full-year results before the COVID-19 pandemic, and their average annual performance decreased further during the pandemic. As **Figure 20** shows, based on the five indicators that use historical performance as a benchmark, a significant number of hospitals saw their performance deteriorate in 2019 compared to when they first joined the P4R program. For example, as of 2019 almost half of the 74 hospitals participating in the P4R program at that time had a longer overall patient length of stay in the emergency department for admitted patients and a longer wait time for an inpatient bed compared to when they joined.

**Figure 20: Number of Hospitals Where Performance Deteriorated After Joining the Pay-for-Results (P4R) Program by Indicator, Pre-COVID-19**

Source of data: Ontario Health

Performance Indicator	Hospitals Where Performance Deteriorated After Joining the P4R Program	
	#	%*
1. Length of Stay for Admitted Patients	36	49
2. Length of Stay for Non-Admitted High-Acuity Patients	18	24
3. Length of Stay for Non-Admitted Low-Acuity Patients	32	43
4. Time Before Physician Initial Assessment	28	38
5. Time to Inpatient Bed	35	47

Note: The Ministry created the P4R program in 2008, and hospitals joined the program in different years. This chart is based on each participating hospital's performance data from the period between December 2018 and November 2019, the most recent full-year results prior to the COVID-19 pandemic. It excludes the sixth performance indicator that measures ambulance offload times because that indicator does not factor in historical performance.

\* The percentage is calculated based on data from the 74 hospitals that were participating in the P4R program in 2019.

**Figure 21: Length of Stay for Non-Admitted High-Acuity Patients at Selected Hospitals in Ontario (hours)**

Prepared by the Office of the Auditor General of Ontario

Hospital	Year Joined P4R	Hours Spent in Emergency Department*		
		Prior to Joining P4R Program	2019	2022
Sinai Health System (Mount Sinai Hospital)	2008/09	10.5	7.9	8.2
Hospital for Sick Children	2010/11	9.2	6.6	10.4
William Osler Health System (Brampton Civic Hospital)	2008/09	9.4	6.7	7.8
William Osler Health System (Etobicoke Hospital)	2009/10	8.0	6.4	7.0
Children's Hospital of Eastern Ontario (Ottawa site)	2010/11	6.8	6.9	9.5
Windsor Regional Hospital (Metropolitan campus)	2008/09	7.9	9.6	13.8
Windsor Regional Hospital (Ouellette campus)	2010/11	6.6	9.8	11.6

\* This is calculated using the 90th percentile, meaning times are calculated after removing the 10% of patients with the longest wait times.

We reviewed these indicators across the hospitals we visited and found similar trends (see **Figure 21**). For example, some hospitals had shown improvement in the length of stay for non-admitted patients in 2019 while others had gotten worse, but all had regressed between 2019 and 2022.

Furthermore, while P4R funding is allocated to hospitals based on the performance of their emergency departments, we noted that participating hospitals continued to receive P4R funding even when their performance slipped from 2019 to 2022.

Ontario Health and some hospitals informed us that demographic profiles for communities and regions have changed significantly since hospitals began joining the P4R program almost 15 years ago. For instance, population growth or increased emergency department utilization make it more difficult for hospitals to maintain or improve their performance.

Another reason that P4R has become less effective is related to the way some hospitals are using the P4R funding. Based on our review of P4R documentation and practices across the hospitals we visited, we found that instead of testing and trying new methods to help shorten wait times and the overall length of stay in an emergency department, some hospitals were using P4R funding to create and/or fill nursing or clinician positions in order to keep up with patient volumes and care needs. This approach helps address patient flow

in the short term, but may do little to improve patient wait times and length of stay in the longer term.

#### 4.6.2 Some Performance Initiatives Appeared Beneficial but Evaluations Were Not Being Done to Confirm Viability for Expansion

Through our review of initiatives funded by the P4R program at the hospitals we visited, we noted that some appeared to be beneficial in improving patient flow and reducing the time patients spend in the emergency department. For example:

- SickKids has used some of its P4R funding to create an emergency department hub to treat ambulatory patients who are at lower acuity (CTAS 3 to CTAS 5) and likely to be discharged home. These patients comprise 76% of the patient visits to SickKids' emergency department.
- Windsor Regional Hospital used some P4R funding to create a dedicated emergency department psychiatrist shift seven days a week to reduce wait times for a psychiatric consultation and to help certain patients transition between the emergency department and the mental health assessment unit.
- Four of the five hospitals we visited used some P4R funding to hire physician assistants, who

help free up time for emergency department physicians to see more patients.

While funding for the P4R program is meant to be flexible and used by hospitals to develop initiatives that improve the performance of their emergency departments, we found that the Ministry and Ontario Health had not done a thorough evaluation of potential best practices to determine if they could be implemented on a permanent basis and expanded to more hospitals. If this evaluation had been done, hospitals would have been able to more effectively identify practices that improve patient flow.

## RECOMMENDATION 11

To more effectively improve patient flow across emergency departments in Ontario, we recommend that Ontario Health, in collaboration with the Ministry of Health and hospitals:

- evaluate the effectiveness of the Pay for Results (P4R) program to determine what changes are necessary to meet the intended objectives, such as setting performance targets; and
- review hospitals' use of performance funding to ensure that these practices align with the objectives of the P4R program and that effective practices are adopted by more hospitals.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to evaluate the effectiveness of the Pay for Results (P4R) program and review hospitals' use of performance funding. In 2023/24, the Ministry announced significant changes to the P4R program. Ontario Health will work closely with the Ministry and hospital sites on implementation of the P4R expansion and will use this opportunity to continue work to address the recommendation. Ontario Health closely monitors performance of all sites participating in P4R.

## 4.7 Province Does Not Have Framework to Evaluate and Encourage Use of Effective or Emerging Practices

### 4.7.1 Effective Diversion Practices at Emergency Departments Were Not Being Shared with Other Hospitals for Province-Wide Implementation

During our site visits, we noted that some hospitals have unique practices to divert certain patients away from the emergency department to a specific unit or space within the hospital for treatment. Such practices not only can expedite care for patients in a more appropriate setting but also free up space and resources in emergency departments. Examples of these practices included:

- In September 2022, SickKids introduced the Rapid Assessment of Pediatric Patients Zone (RAPP Zone) to provide care for patients who showed up at the emergency department but did not need emergency level care and could be seen and treated by a primary care physician. Specifically, parents of lower-acuity patients arriving at the emergency department would be directed to record their child's symptoms and general health information through an online application using a QR code on their smartphone. If they met certain criteria based on symptoms and age, patients would be directed to a different area of the hospital where they would be seen by a primary care physician (without the need for triaging by the emergency department). While this service was only available during specific times, SickKids estimated that approximately 20% of its low-acuity patients were being diverted from the emergency department as a result of this initiative. SickKids indicated that the costs of delivering care in the RAPP Zone is less than the cost of delivering care in the emergency department as these patients only require limited medication administration and nursing



monitoring or interventions. While we noted there were similar rapid assessment practices at other hospitals we visited, patients at those institutions were still being treated within the emergency department, which can divert resources away from more urgent cases.

- For over 10 years, Windsor Regional Hospital's Metropolitan site has been using an initiative to fully divert pregnant patients who arrive at the emergency department with specific symptoms related to pregnancy (such as cramping and vaginal bleeding). Instead of being triaged and waiting at the emergency department to be assessed by a doctor, these patients are sent directly to the obstetrics and gynaecology unit for triage and treatment. This initiative has helped Windsor Regional Hospital divert about 6,000 emergency department patients each year.

We also noted that other hospitals had practices in place to treat specific patient conditions in a more timely and appropriate manner within the emergency department. During our site visit to Brampton Civic Hospital, we noted that patients arriving with minor complaints such as a potential fracture or orthopaedic concerns could be triaged to a separate area within the emergency department if the patients met specific medical criteria. This area was staffed with an orthopaedic technician during certain hours of the day, and if the patient required an x-ray, the imaging could be quickly reviewed and interpreted for next steps.

While these practices have shown success, we noted that hospitals did not consistently and effectively share best practices province-wide. The Ministry and Ontario Health also did not have any framework to evaluate and encourage or recommend the use of effective practices that have shown success to hospitals across the province.

## RECOMMENDATION 12

To provide patients with timely access to appropriate care, we recommend that Ontario Health work with hospitals to identify initiatives that

have successfully and safely diverted lower-acuity patients, or those with specific symptoms, away from emergency departments, and share those practices for province-wide implementation.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation. Ontario Health will work with hospitals and community partners to identify initiatives and best practices to provide system level successes to ensure patients access the right care at the right time and place.

### 4.7.2 Urgent Care Centres Can Be Expanded to Care for Low-Acuity Patients

Urgent Care Centres (UCCs) are health-care settings specifically designed, equipped and staffed to provide care to patients seeking prompt or immediate treatment for non-life-threatening conditions and injuries without prior appointments. At the time of our audit, there were 11 UCCs in Ontario, although only seven of them were required to report data such as wait times to Ontario Health. One of the hospitals we visited (Windsor Regional Hospital) was at an early stage of planning to set up a UCC to specifically deal with lower-acuity patients due to a lack of timely access to primary care in the community.

Seen as a way to take some pressure off of emergency departments, UCCs typically handle patients with acuity levels between CTAS 3 to CTAS 5, though they still need to be staffed and equipped to deal with life-threatening situations. The goal of a UCC, which does not typically have short-stay beds, is to treat and release patients back to their home or community. If a patient does require admission to an inpatient unit or longer-term care, they would be transferred to an emergency department. Each UCC requires an agreement with an affiliated hospital to transfer patients requiring full-service emergency department care or patients who are not well enough to be sent home after receiving care at a UCC.

**Figure 22: Time to See a Physician and Length of Stay at Urgent Care Centres (UCCs) in Ontario, 2022/23 (hours)**

Source of data: Ontario Health

Urgent Care Centre	Time to Physician Initial Assessment	Length of Stay
1. St. Joseph's Hospital	1.4	2.4
2. Niagara Health System (Douglas Memorial Hospital site)	1.1	2.0
3. Niagara Health System (Port Colborne General site)	1.3	2.0
4. William Osler Health System (Peel Memorial Centre)	0.8	2.2
5. Trillium Health Partners (Queensway Health site)	0.9*	2.5*
6. Mackenzie Health (Vaughan site)	1.2	1.6
7. Kingston Health Sciences Centre (Hotel Dieu Hospital)	1.4	2.9
<b>Provincial Average for Urgent Care Centres (UCCs)</b>	<b>1.2</b>	<b>2.3</b>
<b>Provincial Average for Emergency Departments</b>	<b>2.0</b>	<b>6.2</b>

\* Trillium Health Partners temporarily closed its UCC beginning April 2020 and has not reopened it since then. These results are from 2019/20, the most recent available data.

In 2022/23, there were approximately 230,000 patient visits to the seven UCCs that report data to Ontario Health. Patients visiting these UCCs were, on average, seen by a physician much quicker than they would have been in an emergency department and, in turn, their overall time getting the care they needed was significantly shorter. In 2022/23, patients waited an average of 1.2 hours in a UCC for their physician initial assessment compared to an average of two hours in emergency departments. Patients also spent an average of 2.3 hours in the UCC, which was over three times shorter than those visiting an emergency department. **Figure 22** provides a list of the seven UCCs and the average time to see a physician and length of stay.

Based on our visits to a UCC and an emergency department located in the same region that are both part of the William Osler Health System, we noted that the UCC at Peel Memorial Centre was able to see patients much quicker than the emergency department at Brampton Civic Hospital. Since the UCC and the emergency department are located relatively close to each other (about a 15-minute drive), we inquired whether William Osler Health System had a strategy to direct some lower-acuity emergency department patients to the UCC to help alleviate pressures on its emergency department and enable staff to focus on higher-acuity patients. While William Osler Health System did try to raise awareness and educate patients on the

appropriate use of the UCC, we noted that there was no such strategy or procedure to direct lower-acuity patients to its UCC.

### RECOMMENDATION 13

To improve access to emergency care for low-acuity patients, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- assess the feasibility of a review of the Urgent Care Centres (UCCs) model and determine where expansion of this model can be best utilized; and
- work with hospitals to raise public awareness of alternative care settings such as UCCs that may be more appropriate for low-acuity patients.

### MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to improve access to emergency care for low-acuity patients. The Ministry will engage with Ontario Health to determine if a review of the Urgent Care Centre model is required. The Ministry will also work with hospitals to determine the appropriate next steps in continuing to raise public awareness of alternative care settings for lower-acuity patients.

With respect to any new or existing Urgent Care Centre physician contracts, the Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

### 4.7.3 Virtual Urgent Care Pilot Program Has Shown Some Early Success but Subsequent Changes to the Program May Result in Worse Outcomes if Not Managed Effectively

In 2020, during the COVID-19 pandemic, the Ministry approved approximately \$4 million in one-time funding to support a virtual urgent care program, sometimes referred to as a virtual emergency department. The pilot program was created to support patients who had concerns about visiting an emergency department in-person, as well as to divert lower-acuity patients away from the emergency department. The virtual urgent care program offers patients a convenient way to get medical advice or care using a computer or smart-phone instead of going to an emergency department. Depending on patient needs, physicians working in virtual urgent care can provide a prescription, and advise patients whether to visit their primary care doctor or go to the nearest emergency department for an in-person assessment. In 2022/23, patients made over 50,000 virtual urgent care visits, compared with fewer than 20,000 visits in 2021/22.

In one example, two medical institutions in Toronto (University Health Network and Sunnybrook Health Sciences Centre) set up a virtual urgent care program in 2020. We met with staff involved in the delivery of the program and found that it was designed to offer same-day appointments to patients seven days a week, from 9 a.m. to 9 p.m. on Monday to Friday and from

9 a.m. to 1 p.m. on Saturday and Sunday. The virtual urgent care visit is meant for patients who cannot make an urgent appointment with their primary care provider but require urgent attention for non-life-threatening medical concerns. Symptoms suitable for virtual urgent care include a fever, body aches, sore throat or cough and fever.

Ontario Health engaged the Schwartz/Reisman Emergency Medicine Institute—a not-for-profit research, education and health policy institute under a partnership of the Sinai Health and North York General Hospital—to conduct an overall study of the virtual urgent care pilot program. The study, released in June 2022, highlighted a number of key outcomes:

- Over 75% of presenting complaints were low-acuity, with rash, fever, abdominal pain and COVID-19 vaccine queries representing about 30% of the issues discussed.
- Of the almost 83% of patients who had a primary care provider, about 31% indicated they contacted virtual urgent care because they could not make a timely appointment with their family physician.
- About 16% of patients were advised to visit their nearest emergency department while about 66% were discharged after receiving treatment and/or medical advice on next steps. The remainder were referred to primary care or other community care settings.
- 94% of patients rated their overall virtual experience as eight out of 10 or greater.

While the study identified positive outcomes, it also raised the concern that the program needed to be evaluated to determine if it was sustainable. In particular, the study indicated that patients, most of whom already had a primary care provider, were using the system in place of seeing a primary care provider to receive expedited medical advice. This was not the program's intended purpose and could put added strain on emergency department staff, who are responsible for running virtual urgent care initiatives.

The study also noted that a number of factors needed to be considered before a decision could be made to move forward with the virtual urgent care program. These included analyzing whether nurse

practitioners, physician assistants and primary care physicians can be utilized in the virtual program to support emergency department physicians, and whether virtual services can be amalgamated into a single provincial system, or network of regional systems, to better share resources among hospitals.

We also noted that another study, published in the *Canadian Medical Association Journal* in November 2023, questioned the overall impact of the virtual urgent care pilot program on both subsequent emergency department visits and hospital admissions. These indicate the need to better understand the inherent limitations of virtual care and ensure future virtual providers have timely access to in-person outpatient resources, to prevent subsequent emergency department visits.

Ontario Health informed us that it was integrating the virtual urgent care pilot program with the province-wide Health811 call service, which allows people to connect with a registered nurse day or night by phone to get certain kinds of medical advice. Patients who call 811 will be triaged by the registered nurse and if the patient is eligible for a virtual urgent care visit, the patient will be connected with the virtual urgent care clinic in their region and seen by a nurse practitioner. The nurse practitioner can assess the patient's needs, prescribe treatments and determine next steps, such as whether an emergency department visit is needed. This decision was based on findings from the virtual urgent care pilot program study that indicated most patients who accessed the program already had a primary care physician and also noted that nurse practitioners or other similarly trained individuals could provide the same level of care in a virtual setting.

However, there is a possibility that having a centralized model may not be as effective as virtual urgent care programs managed directly by hospitals, and further changes may be needed to move forward with the centralized model. For example:

- Through discussion with one of the hospitals we visited, we noted that the virtual urgent care clinic that the hospital previously ran was able to connect or refer virtual care patients for further assessment and treatment at the hospital if needed. For instance, the virtual urgent care clinic would be able to directly refer a patient

for diagnostic imaging, and could also provide a prescription if needed. In contrast, if the patient used the Health811 system, the patient's journey may not be as seamless. For instance, if the nurse practitioner indicates an in-person visit is needed, the patient would have to repeat the triage process upon entering the emergency department.

- The two medical institutions in Toronto that initiated the joint virtual urgent care program, as noted above, raised similar concerns about the centralized model proposed by Ontario Health. They indicated that Ontario Health and the Ministry should better incorporate local hospitals into any future virtual care program so that patients can more easily be referred to obtain further assessments and treatments (for example, booking blood tests and getting a prescription) by calling Health811 rather than having to physically visit an emergency department and restart the entire patient journey.

## RECOMMENDATION 14

To reduce the number of unnecessary emergency department visits and improve access to urgent care, we recommend that Ontario Health work with hospitals and physicians that deliver virtual urgent care to determine what changes should be made to the provincial Health811 program to better address health-care system gaps and meet patient needs.

## ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals and physicians that deliver virtual urgent care to determine what changes should be made to the provincial Health811. Ontario Health will work with the Women's College Hospital Institute for Health Systems Solutions and Virtual Care to evaluate current virtual urgent care models and ensure Health811 is leveraged to its potential to support gaps in patient care needs.

## Appendix 1: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1. Effective triage, discharge and transfer processes and practices are in place at emergency departments to ensure patients have timely access to high-quality services and care that meet their needs.
2. Responsibilities and accountabilities of parties involved in the delivery of services and care at emergency departments are well defined to ensure that proper oversight is in place and patients are kept safe and provided with high-quality services and care that meet their needs.
3. Adequate and effective programs or initiatives are in place to ensure that emergency departments have stable and adequate levels of staffing and resources to provide patients with timely and high-quality services and care.
4. Funding for emergency departments is appropriately allocated, used and monitored to address the differences in needs among hospitals, and is responsive to changes in needs on a timely basis.
5. Effective communications processes are in place to raise public awareness and understanding of options available for care based on needs.
6. Sufficient, accurate and timely information related to emergency departments, such as service volumes, wait times and triage levels is regularly collected, assessed and used to guide decision-making.
7. Appropriate performance measures and targets are established to ensure that services and care at emergency departments are continuously monitored against intended objectives. Results are publicly reported and corrective actions are taken on a timely basis when issues are identified.

## Appendix 2: Emergency Department Closures in Ontario, July 2022–June 2023

Prepared by the Office of the Auditor General of Ontario

Hospital	Approximate Hours of Closure
1. South Bruce Grey Health Centre (Chesley)	1,884
2. Glengarry Memorial Hospital	573
3. Perth and Smiths Falls District Hospital (Great War Memorial site)	529
4. Listowel Wingham Hospitals Alliance (Wingham and District Hospital)	502
5. Huron Perth Healthcare Alliance (Seaforth Community Hospital)	352
6. Huron Perth Healthcare Alliance (St. Marys Memorial Hospital)	175
7. South Bruce Grey Health Centre (Durham)	150
8. South Bruce Grey Health Centre (Walkerton)	123
9. Carleton Place and District Memorial Hospital	116
10. Campbellford Memorial Hospital	109
11. Huron Perth Healthcare Alliance (Clinton Public Hospital)	93
12. Hôpital général de Hawkesbury et district	86
13. Kemptville District Hospital	75
14. North Shore Health Network (Thessalon)	72
15. Listowel Wingham Hospitals Alliance (Listowel Memorial Hospital)	64
16. Almonte General Hospital	54
17. North Wellington Health Care (Louise Marshall Hospital)	28
18. Norfolk General Hospital	24
19. Arnprior and District Memorial Hospital	23
20. Hôpital Montfort	23
21. South Bruce Grey Health Centre (Kincardine)	14
22. Headwaters Health Care Centre (Orangeville site)	12
23. North of Superior Healthcare Group (McCausland Hospital)	10
<b>Total Hours</b>	<b>5,092</b>

## Appendix 3: Time to Physician Initial Assessment by Hospital, 2022/23 (hours)

Prepared by the Office of the Auditor General of Ontario

Hospital	Time to Physician Initial Assessment
South Bruce Grey Health Centre (Durham)	0.6
Southlake Regional Health Centre	0.7
William Osler Health System (Etobicoke General Hospital)	0.8
William Osler Health System (Peel Memorial Centre)	0.8
South Bruce Grey Health Centre (Chesley)	0.8
Grey Bruce Health Services (Markdale Hospital)	0.8
Mackenzie Health	0.8
Huron Perth Healthcare Alliance (Clinton Public Hospital)	0.9
Bluewater Health (Charlotte Eleanor Englehart Hospital)	0.9
Grey Bruce Health Services (Lions Head Hospital)	0.9
Quinte Healthcare (Prince Edward County Memorial Hospital)	0.9
Huron Perth Healthcare Alliance (Seaforth Community Hospital)	1.0
Sensenbrenner Hospital	1.0
Mackenzie Health (Cortellucci Vaughan Hospital)	1.0
Grey Bruce Health Services (Meaford Hospital)	1.1
Dryden Regional Health Centre	1.1
South Bruce Grey Health Centre (Walkerton)	1.1
Niagara Health System (Douglas Memorial Hospital site)	1.1
Markham Stouffville Hospital (Markham site)	1.2
Unity Health Toronto (St. Joseph's Health Centre)	1.2
St. Joseph's Hamilton (Charlton campus)	1.2
Mackenzie Health (Vaughan site)	1.2
Timmins and District General Hospital	1.2
North York General Hospital	1.2
Niagara Health System (Port Colborne General site)	1.3
Grey Bruce Health Services (Wiarton Hospital)	1.3
Renfrew Victoria Hospital	1.3
Perth and Smiths Falls District Hospital (Great War Memorial site)	1.3
Scarborough and Rouge Hospital (Birchmount site)	1.3
Hanover and District Hospital	1.3
Haldimand War Memorial Hospital	1.3
Hôpital Notre-Dame Hospital	1.3
Kingston Health Sciences Centre (Hotel Dieu Hospital)	1.4
Scarborough and Rouge Hospital (Centenary site)	1.4
Joseph Brant Hospital	1.4
Huron Perth Healthcare Alliance (St. Marys Memorial Hospital)	1.4
St. Joseph's Hospital (London)	1.4
Scarborough and Rouge Hospital (Scarborough General site)	1.4
South Bruce Grey Health Centre (Kincardine)	1.4
Bluewater-Sarnia General site	1.4



Hospital	Time to Physician Initial Assessment
St. Thomas-Elgin General Hospital	1.5
Halton Healthcare Services (Milton District Hospital)	1.5
Sinai Health System (Mount Sinai Hospital)	1.5
Lake of the Woods District Hospital	1.5
Huron Perth Healthcare Alliance (Stratford General Hospital)	1.5
Strathroy Middlesex General Hospital (Middlesex Hospital Alliance)	1.5
Chatham-Kent Health Alliance (Wallaceburg)	1.6
Muskoka Algonquin Healthcare (Huntsville District Memorial Hospital)	1.6
Woodstock Hospital	1.6
William Osler Health System (Brampton Civic Hospital)	1.6
Quinte Healthcare (North Hastings Hospital)	1.6
Perth and Smiths Falls District Hospital (Smiths Falls site)	1.6
Campbellford Memorial Hospital	1.7
West Nipissing General Hospital	1.7
Collingwood General and Marine Hospital	1.7
Alexandra Hospital	1.8
University Health Network (Toronto Western Hospital)	1.8
Niagara Health System (Greater Niagara General site)	1.8
Temiskaming Hospital	1.8
West Parry Sound Health Centre	1.8
Trillium Health Partners (Mississauga site)	1.8
Thunder Bay Regional Health Sciences Centre	1.8
Grey Bruce Health Services (Southampton Hospital)	1.8
Markham Stouffville Hospital (Uxbridge site)	1.8
Georgian Bay General Hospital (Midland site)	1.9
Muskoka Algonquin Healthcare (South Muskoka Memorial Hospital)	1.9
Brockville General Hospital (Charles Street site)	1.9
Unity Health Toronto (St. Michael's Hospital)	1.9
Lakeridge Health (Port Perry Hospital)	1.9
Toronto East Health Network (Michael Garron Hospital)	1.9
Soldiers' Memorial Hospital	1.9
St. Mary's General Hospital	1.9
Lakeridge Health (Bowmanville Hospital)	2.0
Hamilton Health Sciences (West Lincoln Memorial Hospital)	2.0
Quinte Healthcare (Trenton Memorial Hospital)	2.0
Kingston Health Sciences Centre (Kingston General)	2.0
Lakeridge Health (Oshawa Hospital)	2.0
Hôpital Montfort	2.0
Health Sciences North (Ramsey Lake Health Centre)	2.1
Norfolk General Hospital	2.1
Ross Memorial Hospital	2.1
Glengarry Memorial Hospital	2.1
Niagara Health System (Welland Hospital site)	2.1



<b>Hospital</b>	<b>Time to Physician Initial Assessment</b>
Headwaters Health Care Centre (Orangeville site)	2.1
Chatham-Kent Health Alliance (Chatham)	2.2
Northumberland Hills Hospital	2.2
Stevenson Memorial Hospital	2.2
Royal Victoria Regional Health Centre	2.3
London Health Sciences Centre (Victoria Hospital)	2.3
Erie Shores Healthcare	2.3
Grey Bruce Health Services (Owen Sound Hospital)	2.3
Trillium Health Partners (Credit Valley site)	2.3
University Health Network (Toronto General Hospital)	2.3
Tillsonburg District Memorial Hospital	2.3
Grand River Hospital (Kitchener-Waterloo site)	2.3
Guelph General Hospital	2.3
Pembroke Regional Hospital	2.4
Lennox and Addington County General Hospital	2.4
Halton Healthcare Services (Georgetown Hospital)	2.5
Lakeridge Health (Ajax Pickering Hospital)	2.5
Humber River Health (Wilson site)	2.5
Ottawa Hospital (Civic campus)	2.6
Hamilton Health Sciences (Hamilton General Hospital)	2.6
Hamilton Health Sciences (McMaster Children's Hospital)	2.6
Sault Area Hospital	2.6
Brantford General Hospital	2.7
Cornwall Community Hospital	2.7
North Bay Regional Health Centre	2.8
Peterborough Regional Health Centre	2.8
Groves Memorial Community Hospital	2.8
Niagara Health System (St. Catharines General site)	2.8
Queensway Carleton Hospital	2.8
Quinte Healthcare (Belleville General Hospital)	2.9
London Health Sciences Centre (University Hospital)	2.9
Cambridge Memorial Hospital	3.0
Hamilton Health Sciences (Juravinski Hospital)	3.0
Hospital for Sick Children	3.0
Windsor Regional Hospital (Ouellette site)	3.0
Children's Hospital of Eastern Ontario (Ottawa site)	3.1
Halton Healthcare Services (Oakville-Trafalgar Memorial Hospital)	3.3
Winchester District Memorial Hospital	3.5
Ottawa Hospital (General campus)	3.5
Sunnybrook Health Sciences Centre	3.7
Hôpital général de Hawkesbury et district	3.8
Windsor Regional Hospital (Metropolitan campus)	4.1

Note: This table is based on emergency departments and urgent care centres that report wait-time information to Ontario Health; some small hospitals are not currently required to report such information.



## Office of the Auditor General of Ontario


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Toronto, Ontario  
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[www.auditor.on.ca](http://www.auditor.on.ca)

**TAB 206**

# Emergency Departments AFA - Overview

Voytek Roszuk, April 24, 2024

# Agenda

- 
1. ED Funding Models
  2. EDAFA Overview
    - a) 24 Hr Model
    - b) Workload Model
  3. 2006 Emergency Department Coverage Incentive Plan
  4. Emergency Department Locum Program
  5. Temporary COVID-19 Incentives

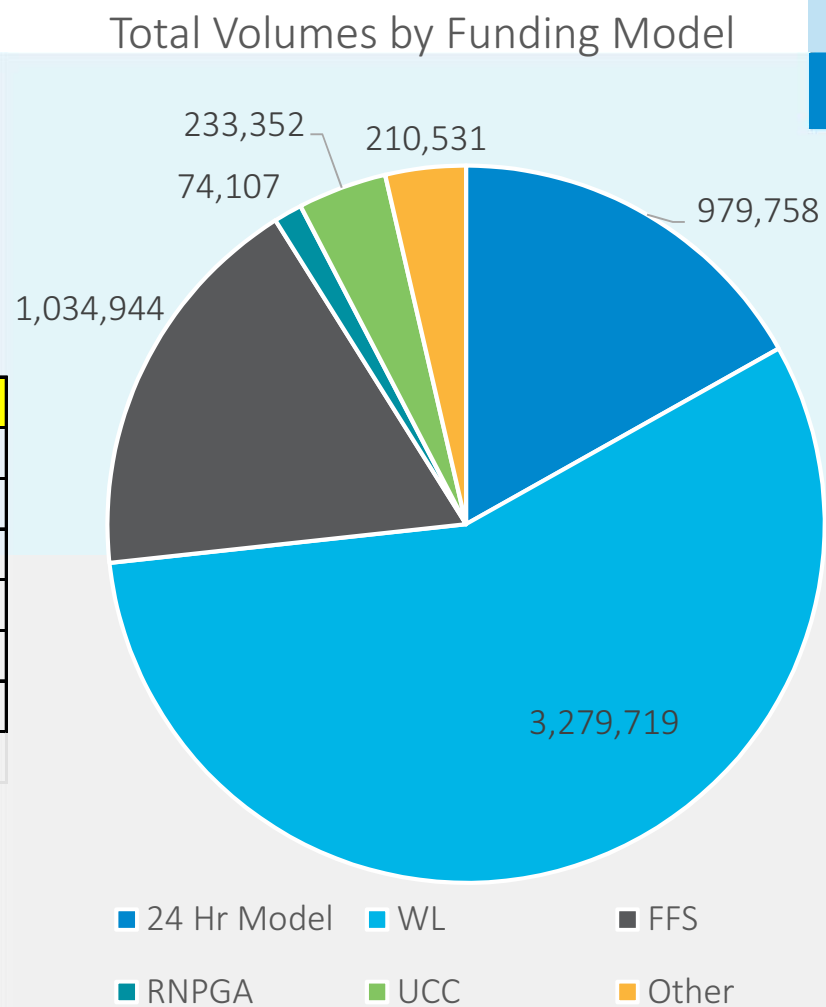


# ED Funding Models

Insert Presentation Title

## Visits per Funding Model

Funding Model	Number of Sites	Visits	% of all Visits
24 Hr Model	71	979,758	17%
WL	63	3,279,719	56%
FFS	13	1,034,944	18%
RNPGA	16	74,107	1%
UCC	6	233,352	4%
Other	8	210,531	4%
<b>Total</b>	<b>177</b>	<b>5,812,411</b>	<b>100%</b>



## EDAFA Summary

Model	#EDs	Base	SB premium	Admin	Total
24hr	71	\$99.3	\$14.8	\$1.9	<b>\$116.0</b>
Workload	65	\$291.0	\$99.3	\$2.4	<b>\$392.7</b>
<b>Total</b>	<b>136</b>	<b>\$390.3</b>	<b>\$114.1</b>	<b>\$4.3</b>	<b>\$508.8</b>

Total number of physicians billing under EDAFA groups - 2,887





## History of EDAFAs

- 90s chronic physician shortages, resulting in frequent ED closures
- Ministry, OMA and OHA came together to develop an Alternate Funding Arrangement for ED groups
  - 24Hr model
  - Workload model
- Available to every ED in the province.
- Most groups signed onto the EDAFA by 2004
- Last EDAFA agreement was effective April 1, 2006 and expired March 31, 2008
- In October 2006, as part of the Emergency Department Coverage Incentive Program, OMA and the ministry negotiated series of initiatives including several enhancements to EDAFA models

## EDAFA Common Characteristics

- Physician Group provides or ensures provision of emergency services for 24 hours a day, every day of the year
- The ED AFA covers emergency services provided by physicians to Insured Persons who presents or is presented to a hospital; and is triaged and registered in the emergency department
- Service encounter reporting (shadow billing) is used to record services provided by physicians participating in the AFA
- Unless specifically permitted under the EDAFA, no Emergency Service at a participating ED can be claimed through Fee-for-Service (FFS Controls).
- Each physician must complete Declaration and Consent and register under the EDAFA group before providing Emergency Services.
- **No definition of FTE or funding per physician. All funding based on services provided by a group.**
- Each group must have a governance agreement and select a designated physician representative

## 24Hr Model

- Available to smaller EDs – under 30,000 visits per year
- “Mostly” single physician coverage
- Lowest volume sites - those with 17,500 visits per year or less, do not require physician to be on site
- Funding levels based strictly on volumes as submitted through shadow billing
- Shadow billing premium at 10% or 37.42%
- Volumes reassessed each year and funding levels adjusted as required
- Second-On-Call and GP Expert groups available to help with surges

# 2022/23 24Hr Funding Levels

Hospital Volume	Hospital Volume Level	Option 1 Base Funding	Option 2 Base Funding	Administrative Funds	Second On-Call Physicians' Billing Limit
Less than 3,500 Visits	A	\$ 719,092	\$ 829,459	\$ 26,437	\$ 6,080
3,501 - 5,000 Visits	B	\$ 821,895	\$ 951,854	\$ 26,437	\$ 9,121
5,001 - 7,500 Visits	1	\$ 1,026,780	\$ 1,185,987	\$ 26,437	\$ 12,161
7,501 - 12,500 Visits	2	\$ 1,129,282	\$ 1,309,620	\$ 26,437	\$ 18,241
12,501 - 17,500 Visits	3	\$ 1,232,085	\$ 1,430,983	\$ 26,437	\$ 24,322
12,501 - 17,500 Visits	3A	\$ 1,355,704	\$ 1,563,086	\$ 26,437	\$ 31,724
17,501 - 20,000 Visits	4A	\$ 1,389,103	\$ 1,619,721	\$ 26,437	\$ 31,724
20,001 - 22,500 Visits	4B	\$ 1,438,714	\$ 1,680,127	\$ 31,724	\$ 47,586
22,501 - 25,000 Visits	5A	\$ 1,488,325	\$ 1,734,426	\$ 31,724	\$ 63,448
25,001 - 30,000 Visits	5B	\$ 1,513,130	\$ 1,770,644	\$ 31,724	\$ 84,597



## EDAFA WL Model

- Larger EDs, typically over 30,000 visits per year.
- Require more than 24 hours of coverage per day.
- Funding based on mathematical formula using CTAS volumes to calculate Hours of Coverage at each Emergency Department
- Formula includes midnight modifier and northern factor escalator
- There is no Second-On-Call funding available to WL sites
- Formula last updated in 2006 to reflect recommendations from the POWER II study.
- Receive Shadow Billing premium of 37.42%

# Hours of Coverage

$$\text{HOC} = (\text{CTAS1} \times 1.23 \text{ hours}) + (\text{CTAS2} \times 0.65 \text{ hours}) + (\text{CTAS3} \times 0.44 \text{ hours}) + (\text{CTAS4} \times 0.25 \text{ hours}) + (\text{CTAS5} \times 0.18 \text{ hours})$$

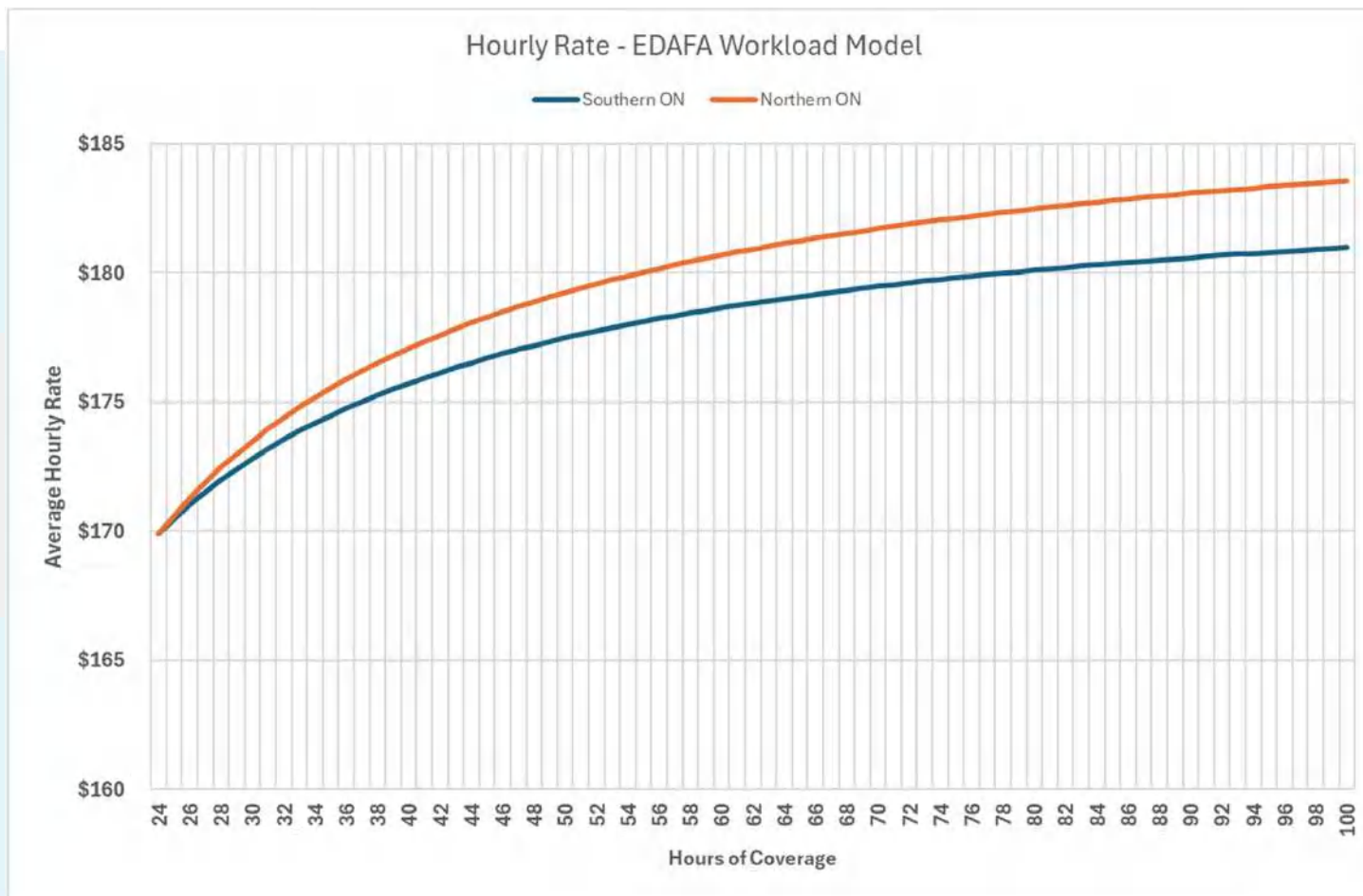
The Workload Model ED AFA formula:

- $C = (1/\text{PPH}) \times (V/365) + [8 - ((.15) \times (1/\text{PPH}) \times (V/365))]$
- C = Physician coverage in a 24-hour period
- PPH = Patients per hour from CTAS Acuity data
- V = ED volume based on CTAS volume data
- .15 = represents the proxy for the midnight factor and is expressed by the right hand side of the equation  $[8 - ((.15) \times (1/\text{PPH}) \times (V/365))]$

## Hourly Rates for Workload Model (includes temp. 2.8%)

South Ontario	2000 Base	2004 PSA (2.5%) April 1, 2005	2008 PSA (2.02%) April 1, 2011	2008 PSA (2.43%) April 1, 2012	2017 PSA (3.6198%) April 1, 2020	2021 PSA (2.0524%) April 1, 2023	2021 PSA (2.8%) April 1, 2024
First 24hrs	\$ 150.00	\$ 153.75	\$ 156.86	\$ 160.67	\$ 166.48	\$ 169.90	\$ 174.66
40% over 24hrs	\$ 150.00	\$ 153.75	\$ 156.86	\$ 160.67	\$ 166.48	\$ 169.90	\$ 174.66
40%-55% over 24hrs	\$ 165.00	\$ 169.00	\$ 172.41	\$ 176.60	\$ 183.00	\$ 186.75	\$ 191.98
55%-75% over 24hrs	\$ 170.00	\$ 174.00	\$ 177.51	\$ 181.83	\$ 188.41	\$ 192.28	\$ 197.66
75%-90% over 24hrs	\$ 175.00	\$ 179.00	\$ 182.62	\$ 187.05	\$ 193.82	\$ 197.80	\$ 203.34
90%-100% over 24hrs	\$ 180.00	\$ 184.50	\$ 188.23	\$ 192.80	\$ 199.78	\$ 203.88	\$ 209.59

North Ontario	2000 Base	2004 PSA (2.5%) April 1, 2005	2008 PSA (2.02%) April 1, 2011	2008 PSA (2.43%) April 1, 2012	2017 PSA (3.6198%) April 1, 2020	2021 PSA (2.0524%) April 1, 2023	2021 PSA (2.8%) April 1, 2024
First 24hrs	\$ 150.00	\$ 153.75	\$ 156.86	\$ 160.67	\$ 166.48	\$ 169.90	\$ 174.66
40% over 24hrs	\$ 150.00	\$ 153.75	\$ 156.86	\$ 160.67	\$ 166.48	\$ 169.90	\$ 174.66
40%-55% over 24hrs	\$ 170.00	\$ 174.00	\$ 177.51	\$ 181.83	\$ 188.41	\$ 192.28	\$ 197.66
55%-75% over 24hrs	\$ 174.50	\$ 179.00	\$ 182.62	\$ 187.05	\$ 193.82	\$ 197.80	\$ 203.34
75%-90% over 24hrs	\$ 180.00	\$ 184.50	\$ 188.23	\$ 192.80	\$ 199.78	\$ 203.88	\$ 209.59
90%-100% over 24hrs	\$ 182.00	\$ 189.50	\$ 193.33	\$ 198.03	\$ 205.19	\$ 209.41	\$ 215.27







# Reconciliation

- Hours of Coverage are recalculated each year based on previous year's CTAS volumes for insured patients
- In addition, each site submits to the ministry a report outlining actual hours of coverage provided during each 24-hour period
- Ministry will only fund actual hours of coverage provided up to calculated/contracted hours of coverage. If actual hours of coverage exceed calculated hours of coverage, ministry will only fund up to calculated hours.
- Reconciliation is performed annually and adjustments are made retroactively as appropriate.
- Sites are notified of new Hours of Coverage



# Emergency Department Coverage Incentive Fund - EDCIP

## Enhancements to EDAFAs and FFS

- Increased shadow billing premiums to EDAFA
- Equivalent flow through to FFS sites
- Holiday Coverage Premium
- Seasonal Variation Premium
- Contract Administration and Support

## Recruitment and Coverage Support

- ED Recruitment Program
- ED Coverage Support Demonstration Project (EDLP)

## Community ED Integration

- ED Mentorship

## HOCC Enhancement

# Results

- EDAFAs stabilized physician funding
- EDAFA introduced group accountabilities for provision of ED services at each Emergency Department
- EDAFAs along with investments to enhance ED coverage made through EDCIP resulted in no unplanned ED closures due to physician shortages between 2006 and 2019





# Emergency Department Locum Program

- Purpose was to provide urgent coverage as an interim measure of last resort to hospitals facing significant challenges filling emergency department shifts.
- Over the past decade the demand has shifted from a program of last resort for a small number of at-risk hospitals to a systemic support for the entire rural/Northern hospital sector.
- Many hospitals have had to increase their reliance on the program to keep emergency departments open.
- In 2018/19, the Locum Program provided approximately 27,400 hours of coverage, which more than doubled to over 60,200 hours in 2022/23.
- EDLP Funding increased from \$5.7M (2018/19) to \$11.7M (2022/23)

## Temporary COVID-19 Funding Initiatives for EDs

### Temporary COVID-19 EDAFA Funding (Surge Funding)

- For 24Hr EDAFAs – Ministry funded 4.8 additional hours per day
  - Suspended Second-On-Call funding
- For WL EDAFAs – 120% applied to the difference between Current Calculated Hours and the 80% of the Agreed Upon Hours of Coverage
- Program being phased out since July 1, 2023 from 20% additional HOC to current 5%. In March 2024 ministry halted phase out and extended program at 5% of additional HOC until March 31, 2025.

### Temporary Locum Program (Previously CTSLPE)

- Eligibility: 24HR EDAFA, RNPGA, Other EDs that receive EDLP support
- Program offers access to hourly premium consistent with EDLP (Tier 1 - \$36.33/hr, Tier 2 - \$72.66/hr)
- Program Currently set to expire September 30, 2024

**TAB 207**



# Something has to change in Ontario health care

[JOURNAL EDITORIAL BOARD](#)

| [SEPTEMBER 1, 2023](#)

| [EDITORIALS](#), [OUR PERSPECTIVE](#)



IMAGE BY: [ARDEN MASON-OURIQUE](#)

Ontario needs more doctors.

## The Print Edition



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student journalism

Effective Aug. 26, Kingston Health Sciences Centre's Urgent Care Centre (UCC) at Hotel Dieu Hospital began reducing its weekend hours of operation due to a shortage of doctors. The number of emergency medicine physicians wasn't sufficient to staff both the UCC and the Emergency Department (ED) at Kingston General Hospital.

Concerningly, this decision was based on the hospitals' usage during the summertime. The incoming student population will only place additional stress on Kingston's emergency services.

Worse, not only Kingston residents, but those in surrounding rural areas—who rely on Kingston's emergency services and their weekend availability for medical care—will be affected.

UCC's reduced hours reflect a broader trend in [increased unplanned emergency room closures](#) caused by insufficient staffing and unbearable strain on existing medical personnel.

In 2022, Ontario documented the unplanned closure of 145 emergency medical facilities. Prior to last year, only one ER in the province was documented as being closed due to insufficient staff in 16 years.

The severe shortage of primary health care physicians in Ontario is causing patients to flock in large numbers to emergency rooms for problems that would otherwise be cared for by their family doctors.

As Ontarians go longer without primary health care, the demand for emergency departments will only grow. The symptoms of those suffering with chronic illnesses left untreated will worsen, and in some cases will lead to additional health complications. For others, illnesses will arise and progress undiagnosed until severe enough to require drastic intervention.

Rather than closing medical facilities when it's no longer possible for staff to keep up, let's address root causes.

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The provincial government needs to provide incentives for medical students to practice primary and emergency medicine. Working conditions for current healthcare staff must be improved to make medicine sustainable for those practicing now and appealing to those considering it in the future.

Queen's School of Medicine and Lakeridge Health have created the [Queen's-Lakeridge Health MD Family Medicine Program](#), specifically designed to address the shortage of family doctors. Its graduates will be practice-ready, community-focused physicians.

Canada only has 17 medical schools, making admissions especially competitive and barring capable candidates from attending.

Ontario's provincial government and its universities should follow the example set by the Queen's-Lakeridge Program, which will promote primary health care and provide medical services across multiple municipalities .

Other Commonwealth nations allow students to graduate from high school and apply immediately to medical school. Doing so in Ontario would make medical school more accessible by saving aspiring medical students the cost of an additional degree.

Creating more opportunities for education in medicine is essential to remedying the shortage of healthcare providers.

—*Journal Editorial Board*

## Tags

[Healthcare](#), [Kingston](#), [medical school](#), [primary care](#)



**TAB 208**

**Source:** <https://northernontario.ctvnews.ca/critical-shortage-of-er-doctors-in-north-bay-1.6583479>

## **Critical shortage of ER doctors in North Bay**

CTV News: Northern Ontario  
Darren MacDonald  
CTVNorthernOntario.ca Journalist

Updated Sept. 30, 2023 10:15 a.m. EDT  
Published Sept. 29, 2023 4:08 p.m. EDT

The North Bay Regional Health Centre (opens in a new tab)said Friday that a critical shortage of emergency room doctors means longer wait times for less urgent cases.

As a result, the hospital has issued an emergency department critical physician staffing notice.

“The health centre is experiencing a critical shortage of ... physicians and currently our physician compliment is approximately half what would be required for normal operations of the department,” officials said in a news release Friday.

“Hospitals across the province are facing similar ... physician shortages. Patients seeking non-urgent care can expect to experience excessively long wait times.”

Patients who arrive at the emergency department with the most urgent needs will seen first.

“Patients who come in with an issue that is not urgent will be triaged accordingly,” officials said.

“We know that waiting when feeling unwell can be stressful and frustrating. We ask our community to respect that our team is under incredible stress, and have been experiencing high levels of verbal abuse, which cannot be tolerated. Help us create a safe environment for our team as they provide care.”

Options to access care other than going to the hospital include walk-in clinics, family doctors, virtual walk-in clinics, Health Connect Ontario(opens in a new tab) (available 24/7 at 811) and the mental health crisis line at 1-800-352-1141.

Pharmacists in Ontario can now assess for 13 minor illnesses or conditions(opens in a new tab) (urinary tract infection, cold sore, pink eye, tick bites, skin rashes), the hospital said.

This comes following an announcement in July([opens in a new tab](#)) that emergency department delays in North Bay could extend beyond the summer months.

**TAB 209**

[◀ All episodes](#)

# Inside the Village - A weekly podcast featuring newsmakers in Ontario

The doctor is out: Why one small town was forced to shut down its emergency room

MAY 25, 2023   TIM VINE, SCOTT SEXSMITH, MICHAEL FRISCOLANTI,   SEASON 2   EPISODE 18

Inside the Village - A weekly podcast featuring newsmakers in Ontario

## The doctor is out: Why one small town was

00:00 | 30:00

LISTEN ON



Show Notes

A doctor shortage forced the emergency department in small-town Thessalon, Ont., to lock its doors for 48 hours. After “exhausting all options,” the North Shore Health Network said it had no choice but shut the place down for two full days — leaving locals with nowhere to go in case of emergency. Sadly, the situation in Thessalon is not unique. Rural communities across Ontario are struggling to staff their hospitals. This week on Inside the Village, Frisco and Scott speak with Tim Vine, the CEO of the North Shore Health Network, to find out how things got so dire — and if there’s a cure in sight. Also on the podcast: a touching reunion between a firefighter and a man he saved 10 years earlier.

Podcasts we love



All content © 2024 Inside the Village - A weekly podcast featuring newsmakers in Ontario.

**TAB 210**

# Doctor shortage: Now the emergency ward in Blind River is closing

SooToday Staff

Jun 1, 2023 7:41 AM



*ElliotLakeToday file photo shows the Blind River welcome sign | Kris Svela for ElliotLakeToday*

[Listen to this article](#)

00:02:38

Over the past week, the North Shore Health Network (NSHN) has become Exhibit A of the doctor shortage plaguing northern Ontario.

Three times over the past seven days, the NSHN has been forced to shut down the emergency department in Thessalon — one of its three regional emergency wards — because there was no



doctor or nurse practitioner to report for duty.

This morning brought a [sliver of good news](#): today's closure, originally scheduled to last 24 hours, was cut in half because officials managed to find a doctor for the 12-hour shift that begins at 8 o'clock tonight.

But the good news was short-lived: in a separate press release, the NSHN now says its Blind River emergency department will be forced to temporarily shut down "due to physician shortages."

That facility will be closed for 24 hours, from 8 a.m. on Friday June 2 to 8 a.m. on Saturday June 3.

"NSHN would like to thank the community for your continued patience and understanding during this time as we work with our partners towards sustainable resources to serve your healthcare needs," the news release states.

April 30, 2024



Timothy Vine, CEO of the North Shore Health Network, was a guest on the latest episode of Village Media's [Inside the Village](#) podcast. He explained how the situation got so dire, if there's a reasonable cure in sight — and how he sleeps at night knowing that a community he serves has no emergency room for people to depend on. (You can watch the full interview [here](#).)

While the Blind River location is closed, anyone requiring immediate medical attention should call 9-1-1. Ambulances will be re-routed to one of the following:

NSHN Thessalon Site or St. Joseph's General Hospital Elliot Lake.

The closest Emergency Departments to the Blind River Site are:

- Thessalon Site – North Shore Health Network – 135 Dawson St., Thessalon ON, P0R 1L0
- St. Joseph’s General Hospital Elliot Lake – 70 Spine Rd., Elliot Lake, ON, P5A 1X2

Access to services for non-emergent health advice or information is available by calling Health811 by calling 8-1-1. Toll free TTY line: 1-866-797-007. Or start a live chat with an advisor online at:

<https://healthconnectontario.health.gov.on.ca>.

## Reader Feedback <sup>(5)</sup>

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idea?**

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editor**

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mistake**

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question**

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**TAB 211**



News



Derek Baldwin



Published Jun 29, 2023 • 2 minute read

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Quinte residents may encounter emergency room delays this summer compounded by a doctor shortage in Quinte Health emergency departments in Belleville General Hospital and others in the region, say senior staff. DEREK BALDWIN

Quinte residents may encounter emergency room delays this summer compounded by a doctor shortage in Quinte Health emergency departments in Belleville General Hospital and others in the region, say senior staff.

Stacey Daub, president and CEO, and Dr. Colin MacPherson, chief of staff, said Thursday residents may experience longer wait times as Quinte Health hospitals in Belleville, Quinte West, Prince Edward County and Bancroft struggle with more to do and less resources to it with.

[Start the conversation](#)



### Have your say

Leave a comment and share your thoughts with our community.



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Noting that Quinte Health operates 100 more beds than the corporation did four years ago, QHC managers warned challenges could see temporary closures this summer for some services.

“Leading into the summer, we want the community to understand what to expect considering the critical physician staffing shortages in our emergency departments. The increased demands and staffing limitations continue to create a challenging environment for all members of the team,” said Daubs and MacPherson in a joint statement.



#### Eastern Ontario Midday Roundup

Your weekday digest of the top stories from our newsrooms in Cornwall, Brockville, Kingston and Belleville.

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“Everyone is working as hard as they can to keep up, including attempting to fill significant voids in our physician coverage in our EDs this summer. The shortage will mean longer wait times, as we must decrease the number of patients we bring into the ED when we have fewer staff available to provide care.

“While our physician teams heroically managed to keep all four EDs operating all summer last year, we want our communities to know that, particularly at North Hastings Hospital, we are at significant risk of having temporary, short-term closures over the summer. While we continue to take an ‘all-hands-on deck’ approach to avoid this, we will notify our partners and the public as soon as possible in the event of a closure,” they stated.

“This is a system-wide issue, and we are certainly not alone in facing potential closures and longer wait times in our hospitals. This is not a sign of failure on the part of our remarkable frontline teams. It is a sign of the system strain despite the herculean efforts of our teams. It underscores the need to pursue innovative solutions, partnerships and come together across the system. Please recognize that the individual members of our hospital teams are carrying a significant workload and are dedicated to providing care to the communities we are proud to serve. Your support, patience, and kindness mean the world to our team. We are Stronger together.”

Other issues such as a greying population and chronic illness are pushing regional ERs to higher visits than others in the province.

“Our communities are aging at a faster rate than the rest of Ontario and have much higher rates of chronic illness like chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) in addition to other factors such as housing availability. Our



emergency departments (EDs) are used at a rate of 1.5 times more than the per capita average in Ontario. These same factors influence the number of patients that are admitted to hospital and how long they stay.”



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## LATEST NATIONAL STORIES

**Phil Rosenthal of Netflix's "Somebody Feed Phil" on his love of travel, food, discovering the unknown**

Plus, he can't live without travel



**TAB 212**

## 1. What is the Temporary Locum Program (TLP)?

The **Temporary Locum Program (TLP)** is a temporary expansion of the existing eligibility criteria and payment structure for emergency department (ED) physicians.

The program allows eligible hospitals to provide eligible ED physicians access to premiums in the highest-need rural and northern hospitals to maintain 24/7 ED services and to facilitate the safe operation of EDs.

## 2. How long will TLP remain operational?

The TLP is a time-limited program and will commence on April 1, 2024, and will run through to September 30, 2024.

## 3. How do I know if my hospital is eligible to use TLP?

Hospital eligibility:

- all 24-hour model Emergency Department Alternate Funding Agreement (EDAFA) sites
- all Rural and Northern Physician Group Agreement (RNPGA) sites
- any site that does not fit into either of these categories but is receiving support from Emergency Department Locum Program (EDLP).

## 4. What happens if we arrange coverage, and it falls through? Does that mean that the premiums are withdrawn?

TLP payments will not be withheld from a hospital that is forced to close due to a disruption in confirmed ED coverage where the disruption:

- is due to unforeseen circumstances (i.e., illness, accident, travel disruption etc.) and;
- occurs within 96 hours of a shift in question and the hospital engages with HealthForce Ontario (HFO) and their Ontario Health (OH) Region to make every effort to find last-minute coverage.



## 5. Which physicians can participate in the TLP?

Physicians eligible to participate in the TLP include local physicians and locums independent of EDLP who can be credentialed by the local site.

The premium rate is applied to each, and every hour of coverage provided by any physician at each eligible hospital except for hours paid under the EDLP from April 1, 2024 to September 30, 2024.

## 6. Does this mean that you have to be a locum physician to participate?

No. Physicians can participate in the program and receive TLP premiums as long as:

1. They are members in good standing with the College of Physicians and Surgeons of Ontario, **and**;
2. They can be credentialed to work independently in the ED at one or more of the eligible sites.

## 7. Can a physician belonging to an EDFAFA access these premiums? The EDFAFA agreement indicates that they cannot claim funds either directly or indirectly or accept payment for any Emergency Services, except for the permissible claims and payments authorized under certain sections.

Yes, EDFAFA physicians are eligible to participate in the TLP program and can access the premium rate regardless of section 6.1 of the agreement.

## 8. My hospital already receives support from the EDLP. Do I have to stop using EDLP if I want to use this program?

No. Eligible hospitals can continue to receive concurrent support from EDLP during this time period, however a physician cannot receive premiums from both EDLP and TLP from the same day or shift.

**9. If both programs can be used at the same time, can an EDLP physician access this program?**

As per question 6 and 7, a physician who normally provides services through the EDLP could provide services, but they would have to have an independent arrangement to provide services (i.e., not through the EDLP).

**10. What is the payment structure for TLP?**

Each eligible hospital is assigned to one of two payment eligibility tiers, reflecting service volumes and local scheduling practices. Payments will be made in alignment with that tier.

Lower volume sites where a single “day” of physician work can cover 24hrs are assigned to Tier 1. Those sites with higher volumes requiring two “days” of physician work to cover 24hrs are assigned to Tier 2.

The premium rate is applied to each, and every hour of coverage provided by any physician at each eligible hospital except for hours paid under the EDLP from April 1, 2024 to September 30, 2024.

Tier	Criteria	Premium
Tier 1	2019-20 annual visits between 1,000 and 8,999 annually	\$871.92/per day @ 24 hours a day = \$36.33/hour
Tier 2	2019-20 annual visits 9,000+	\$871.92/per day @ 12 hours a day = \$72.66/hour

NOTE: Premiums are based on pre-existing RNPGA daily stipends of \$871.92

Local physician groups have discretion over how the total amount of TLP premium earned will be paid out in accordance with local needs and governance structures.

**11. Eligible Expenses**

Physicians can claim payment for time taken to travel to a site to fulfil locum obligations under the TLP as follows:

Travel Hours	Minimum Amount Claimed (1 Trip Either Way)	Maximum Amount Claimed (Return Trip)
2-4 hours of travel	\$300/trip	\$600/trip
Greater than 4 hours of travel	\$500/trip	\$1000/trip

Payment for travel related expenses such as meals, accommodation, airfare etc. would be covered by the hospital in accordance with any hospital reimbursement policy and guidelines.

## 12. Reimbursement process

Under the TLP, hospitals are responsible for reimbursement of physicians directly according to the program parameters set out in this agreement. Eligible hospitals can submit eligible expenses for reimbursement through the Ministry's [Health Data Collection Service \(HDCS\) website](#).

## 13. The guide states Tier 2 funding is \$72/hour per 12-hour shift, does these mean Tier 2 hospitals only get the stipend for 12 hours of the 24 hours of coverage?

Tier 2 hospitals may claim \$871.92 per 12hrs of coverage (i.e., \$1,743.84 daily max). Hospitals may choose to apply the premium to each hour of coverage on the schedule (i.e., increase of \$72.66 per hour) or they may apply the funding to their scheduling gaps specifically or some combination of the two. Local physician groups have discretion over how the total amount of TLP premium earned will be paid out in accordance with local needs and governance structures.

## 14. How are hospital tiers determined? Is it based by a hospital corporation's overall ED volume or the volume of each hospital's ED volume?

Hospital tiers are determined based on hospital ED volumes. A hospital corporation may have hospitals with different tiers if the ED volumes differ from each individual site.

**15. Do hospitals have to "apply" for TLP or are hospitals automatically enrolled if they meet the eligibility requirements?**

No, hospitals do not have to apply for this program. A hospital is automatically enrolled if they meet the eligibility criteria. In addition to meeting the eligibility criteria, eligible hospitals have received notification from the ministry on their eligibility and the tier that they are in.

For program eligibility criteria, see question 3.

**16. Is this premium applicable to every qualified physician, including all local physicians working in their "own" ED? including physicians who work predominately at another site, and are essential to keeping the other site open?**

Physicians who are eligible to participate in the TLP include local physicians and locums independent of EDLP who can be credentialed to work independently in the ED.

**17. Is there any ability to access funding for Nurse Practitioners to keep an ED open?**

The ministry does not have a specific program that provides funding to hospitals for Nurse Practitioners to keep EDs open.

The ministry has various programs aimed at recruiting and retaining nurses in various departments such as the ED, which hospitals can apply for. Additional information regarding these programs is included below:

- The Community Commitment Program for Nurses (CCPN)
- Nursing Graduate Guarantee (NGG)
- Emergency Department (ED) Nursing Education, Retention and Workforce Program
- Clinical Scholar Program (CSP)

**CCPN**

To attract Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs) to work in hospitals, long-term care (LTC) homes, home and community care (HCC) agencies, primary care, and mental health and addiction agencies in greatest need across Ontario, the *Community Commitment Program for Nurses* (CCPN) provides \$25,000 in grant funding to eligible nurses in exchange for a two-year commitment to an

eligible employer. For more information about the CCPN, visit [Health Force Ontario's website](#).

## NGG

While NPs are not eligible for the Nursing Graduate Guarantee (NGG) program, as a response to current nursing workforce demands in areas of need, the ministry supports the operationalization of Nursing Graduate Guarantee program positions in acute care settings.

For more information about the NGG, please visit the [Ministry of Health's Health Human Resources page on the Government of Ontario's website](#).

## ED Nursing Education, Retention and Workforce Program

The ministry invested \$4.7 million in 2023/24 to create education programs for emergency department (ED) nurses. More information can be found at the [ED Nursing Education, Retention and Workforce Program](#) web page. Ontario Health offers access to ED nurse education and training opportunities to support small, rural, and remote EDs. This program is being offered to nurses who may be full-time, part-time, or casual hospital RNs and RPNs, as well as agency nurses.

## CSP

The CSP was launched in June 2023 and supports both recruitment and retention by creating mentorship opportunities. Through this program, experienced frontline nurses provide at-the-bedside mentorship and support to new graduate, internationally educated, or upskilling nurses to confidently transition into new health care working environments and nursing practice. This includes providing bedside mentorship to support ED upskilling for nurses.

For more information about the CSP, please visit the [Ministry of Health's Careers in health care page on the Government of Ontario's website](#).

## 18. Is there an updated version of the ED Closure Protocol?

The ED Closure Protocol has been updated and shared with hospitals. If you do not have a copy, please reach out to your OH Regional Representative.

**19. Is the travel premium in addition to the travel reimbursement for the locum program?**

No, the travel premium is not in addition to the travel reimbursement for the locum program. Physicians can be reimbursed for travel either through the TLP program **or** the locum program. They cannot be reimbursed for travel through both programs.

**20. To confirm for RNPGEA sites; the premium is applicable to our signatory RNPGEA doctors, who regularly cover their EDs, and not just locums?**

Yes, the TLP premium is applicable to RNPGEA doctors who regularly cover their EDs. Local physician groups have discretion over how the total amount of the TLP premium earned will be paid out in accordance with local needs and governance structures.

**21. In terms of ED Closure, at times, the 48-hour minimum notice period may not be reasonable given shorter notices of unstaffed shifts.**

The intention of the TLP program is to keep EDs open. Therefore, eligibility to receive support from TLP is restricted to sites that remain open. However, the ministry recognizes that there could be a circumstance where a hospital is forced to close due to a disruption in confirmed ED coverage. As stated in the TLP program guide on page 4, TLP payments will not be withheld from a hospital which is forced to close:

- Due to unforeseen circumstances (i.e., illness, accident, travel disruption etc.) and;
- Occurs within 96 hours of a shift in question and
- the hospital engages with HealthForce Ontario (HFO) and their Ontario Health (OH) Region to make every effort to find last minute coverage.

If a hospital ED is at risk of closure due to unstaffed shifts, hospitals must work with their Ontario Health Region and Health Force Ontario to find last minute coverage to avoid closure.

**22. When will money be paid to hospitals to forward to the MDs?**

Hospitals will be reimbursed for their expense claims on a quarterly basis.

**23. How does this premium apply to an ED with multiple physicians in a shift?**

Tier 1 hospitals may claim \$871.92 per 24hrs of coverage and Tier 2 hospitals may claim \$871.92 per 12hr of coverage (i.e., \$1743.84 daily max). Hospitals may choose to apply the premium to each hour of coverage on the schedule (i.e., increase of \$36.33/hr for Tier 1 sites or \$72.66/hr for Tier 2 sites) or they may apply the funding to their scheduling gaps specifically or some combination of the two. The local physician groups have discretion over how the total amount of the TLP premium earned will be paid out in accordance with local needs and governance structures.

**TAB 213**



# Temporary Locum Program (TLP)

Program Guide

Ministry of Health

Spring 2024

## Purpose

To provide an overview of the Temporary Locum Program (TLP). Through the TLP, the Ministry of Health will temporarily expand the eligibility criteria for emergency physician locums for rural and northern hospitals to facilitate the continued operation of Emergency Departments (EDs).

This guide outlines the eligibility criteria and expenses for TLP.

## Version

Current version: 6.0 (Spring 2024)

Previous version: 5.0 (Fall 2023)

Previous version: 4.0 (Spring 2023)

Previous version: 3.0 (August 2022)

Previous version: 2.0 (June 2022)

Previous version: 1.0 (July 2021)

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## Overview

Commencing April 1, 2024, and through to September 30, 2024, the TLP provides eligible hospitals in rural and northern Ontario the opportunity to offer eligible physicians a temporary premium to maintain 24/7 ED services.

Through TLP, hospitals will be provided a predetermined hourly premium for every hour of coverage provided in their eligible rural and northern ED, which is consistent with the current Emergency Department Locum Program (EDLP) eligibility parameters and Rural Northern Physician Group Agreement (RNPGA) daily stipend. Physicians are also eligible to receive payment for travel related expenses.

As per the eligibility requirements set out in this guide, these premiums will be paid to physicians via the hospital who requested their coverage. The ministry will reimburse hospitals for eligible expenses incurred through TLP.

## Hospital Eligibility

- all 24hr model Emergency Department Alternate Funding Agreement (EDAFA) sites
- all RNPGA sites
- any site that does not fit into either of these categories but that is receiving support from EDLP

Further, eligibility to receive support from TLP will be restricted to sites that remain open 24/7 from April 1, 2024 to September 30, 2024.

Notwithstanding the above, the TLP payments will not be withheld from hospital which is forced to close due to a disruption in confirmed ED coverage where the disruption of that confirmed ED coverage:

- is due to unforeseen circumstances (i.e., illness, accident, travel disruption etc.) and;
- occurs within 96 hours of a shift in question and the hospital engages with HealthForce Ontario (HFO) and their Ontario Health (OH) Region to make every effort to find last-minute coverage.

Nothing herein alleviates the obligations of the parties as set out in Article 7.0 Services of the RNPGA contract nor the obligations of the parties in section Article 3 of the EDAFA contract to provide ED coverage.

## **Payment Eligibility Tiers**

Each eligible hospital will be assigned to one of two payment eligibility tiers, reflecting service volumes and local scheduling practices. Payment will be made in alignment with the designated tier (see Eligible Expenses section for details).

## **Physician Eligibility**

Physicians eligible to receive ED coverage premiums include local physicians and locums independent of EDLP who can be credentialed by the local site.

Physicians must be able to be credentialed to work independently in the ED at one or more of the eligible sites to receive TLP premiums.

For clarity, the sites contemplated above can also continue to receive concurrent support from EDLP during this time-period, but a physician cannot receive premiums from both the EDLP and from TLP for the same day/shift of work.

## **Reimbursable Expenses**

Expenses must meet the criteria outlined below to be eligible for reimbursement.

### **TLP Premiums**

The premium rate will be applied to each, and every hour of ED coverage provided by any physician at each eligible hospital, except for hours paid under the EDLP, from April 1, 2024 to September 30, 2024.

Hospitals can claim up to 24 hours per day for the full 183 days between April 1, 2024 to September 30, 2024.

The TLP premiums are outlined in the table below and are based on pre-existing RNPGA daily stipends of \$871.92.

Local physician groups will have discretion over how the total amount of TLP incentive earned will be paid out in accordance with local needs and governance structures.

Table 1: TLP Premiums

<b>Tier</b>	<b>Criteria</b>	<b>Premium</b>
Tier 1	2019-20 annual visits up to 8,999 annually	\$36.33/hour
Tier 2	2019-20 annual visits 9,000+	\$72.66/hour

## Travel Related Expenses

Physician payment for travel time will be reimbursed at the rates outlined in the table below.

Table 2: Physician Payment for Travel Time

<b>Travel Hours</b>	<b>Minimum Amount Claimed (1 Trip, One-Way)</b>	<b>Maximum Amount Claimed (Return Trip)</b>
2-4 hours of travel	\$300/trip	\$600/trip
Greater than 4 hours of travel	\$500/trip	\$1000/trip

Other travel related expenses, e.g., meals, accommodations, airfare, etc., will be covered by the hospital in accordance with applicable hospital policy and guidelines.

## Reporting Requirements

All hospitals participating in TLP are required to provide monthly program reporting to the ministry, via the monthly Microsoft Forms report for program monitoring and evaluation purposes.

## Expense Submission

All hospitals eligible to participate in the TLP can submit eligible expenses for reimbursement through the Ministry's [Health Data Collection Service \(HDCS\) website](#).

Questions related to the HDCS can be emailed to [askhealthdata@ontario.ca](mailto:askhealthdata@ontario.ca).

## Further Information & Questions

The Ministry of Health will continue to work with Ontario Health and hospitals to monitor the staffing of EDs over the next six months.

For further information about the program and eligibility, please consult the accompanying FAQ document.

Questions related to program reporting and program parameters can be emailed to [HHRSupports@Ontario.ca](mailto:HHRSupports@Ontario.ca).

**TAB 214**





# CAEP position statement on violence in the emergency department

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**Keywords** Violence in the Emergency Department · Emergency Medicine · Workplace violence

## Definition

Workplace violence occurs when a person is physically or verbally abused, threatened, intimidated, harassed or assaulted in her or his employment. In Canada, employees have the right to a safe work environment, and it is the duty of the employer to provide it [1].

## Nature and magnitude of the problem

The problem of workplace violence in the emergency department (ED) is grave. Healthcare providers have an estimated fourfold higher rate of workplace violence and fully half of such attacks occur in the ED [2–9]. Studies suggest that 43% of hospital nurses will be sexually harassed or assaulted

this year [4] including over 50% of those working in the ED [10–15]. Over half of ED nurses are physically or verbally abused in any given week [10, 11]. The Canadian Federation of Nurses Unions (CFNU) reported in 2017 that “the number of violence-related lost-time claims for frontline health care workers has increased by almost 66% over the past decade, three times the rate of increase for police and correctional service officers combined” [8]. It is shocking that the risk of violence for a doctor or nurse working in a Canadian emergency department is increasing so dramatically and intolerable that it be left to rise unabated. The level of ED violence can reasonably be expected to continue to increase in the future due to the changing ED population, the prevalence of guns and paucity of services available to those prone to violence due to underlying medical, substance abuse or mental health disorders.

The increasing trend noted by the nursing profession is echoed by emergency physicians. Nearly 70% of emergency physicians say that ED violence has increased in the past five years, with 25% reporting it has increased greatly [16]. This high level of ED violence is undoubtedly a contributing factor in the already high ED physician burnout rate [17–19]. ED violence negatively affects both the quality of care which can be offered and the financial cost to the health care system [20]. In Ontario alone, ED violence costs \$23.8 million annually [21].

The increasing pattern of violence against health care workers is disturbing not only because of its prevalence but also because of the culture of silence surrounding it and lack of effective mitigating action, despite its incredibly high human and financial cost. The CFNU's recent poll highlighted that, although violence in the ED is common, few people report the incidents and fewer still seek help from their unions. Many assume it is an occupational hazard they must accept and yet, not surprisingly, two thirds (66%) of nurses have thought of leaving their job in the past year [8]. The unhealthy work environment contributes

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to nurse absenteeism, which is higher than all other occupations. In 2016, the annual cost of absenteeism due to illness or disability was at least \$989 million” [8]. ED violence costs Canadians billions of dollars annually, money which could otherwise be spent constructively on necessary health and social services.

## Changing the prevailing culture

The prevailing culture in the hospital system has implied that ED violence is part of the job, an inherent risk that it is futile to try to address [22]. The Canadian Association of Emergency Physicians (CAEP) seeks to change this perception and increase ED safety for physicians, hospital staff and patients. CAEP finds the level of ED violence unacceptable, the dearth of available mitigation techniques dangerous, the lack of effective recourse neglectful and callous, and the wasted human and financial resources unconscionable.

The most important component of any violence prevention program is a clear commitment by management. CAEP expects unequivocal support from hospitals and regional health authorities for workplace safety. Explicit, written policies and procedures to prevent ED violence must be implemented and adhered to, along with safe physical spaces and the provision of counselling and support of ED violence victims. Although physicians are not normally entitled to the benefits of regular hospital employees, in the event of workplace violence they should be fully supported.

Policies related to violence in the ED should: [1].

- (1) Be developed by management and front-line representatives.
- (2) Apply to management, employees and patients.
- (3) Define workplace violence in precise, concrete language.
- (4) Provide clear examples of unacceptable behaviour and working conditions.
- (5) State in clear terms the organization’s view toward workplace violence and its commitment to the prevention of workplace violence.
- (6) Precisely state the consequences of making threats or committing a violent act, and outline concrete protocols and options that are available at the moment. This should include roles and notifications (i.e. security, police, management, etc.)
- (7) Outline the process by which preventive measures will be developed.

- (8) Mandate the reporting of all incidents of violence.
- (9) Outline the confidential process by which employees can report incidents and to whom.
- (10) Assure no reprisals will be made against reporting employees.
- (11) Outline the procedures for investigating and resolving complaints including the right to recompense for time taken off work to deal with the physical, emotional or legal effects of the violence for all health-care professionals.
- (12) Describe how information about potential risks of violence will be communicated to employees.
- (13) Make a commitment to provide support services to victims of violence including all health-care professionals.
- (14) Offer a confidential Employee Assistance Program (EAP) to allow all health care professionals to seek help.
- (15) Make a commitment to fulfill the violence prevention training needs of different levels of personnel within the organization.
- (16) Specifically address the measures which can be taken when an individual who has acted violently in the past presents to the ED for treatment.
- (17) Commit to monitor and regularly review the policy.
- (18) State applicable regulatory requirements.

In addition to the above policies, CAEP advocates for the following [23–32]:

- (1) The development of a national safety standard to be developed in conjunction with security experts and other partners which outlines best practices, benchmarks and comprehensive plans for improved safety and security in EDs. Hospital administrators should be obligated to meet these standards within an urgent timeframe. The standards should include
  - (a) Providing for improved environmental design for Canadian EDs to prevent the dangers of isolation without limiting privacy. Restricting access to the ED has been shown to prevent violence.
  - (b) Providing for improved security measures for all Canadian emergency departments. Where feasible a visible security-presence is desirable. Alarm systems should also be explored.
  - (c) Developing guidelines and protocols for Code Silver: Active Shooter situations [33–40].

(d) Training for all staff to recognize aggressive and escalating behaviours and de-escalation training for all emergency staff.

(e) Equipping staff with appropriate medical protocols for the control, restraint and sedation of (potentially) violent patients as clinically appropriate.

- (2) Better community access for mental health and substance use disorder patients.
- (3) Support of initiatives to better understand and mitigate the barriers to reporting violence in the ED.

## Multiple causes, zero tolerance

Violence in the ED has many antecedents, including poverty, racism, substance use, gang and personal violence. The violent patient may be exhibiting manifestations of delirium from a myriad of acute medical causes, or dementia. Inadequate community resources for those with mental health disorders and addictions have been a major contributor, as well. We believe the violent patient deserves the same optimal care expected by any patient and their individual medical and social circumstances must be considered in their ultimate care plan. Violence in the ED is more often than not a symptom rather than a personality trait; thus, we urge caution with respect to a ‘zero tolerance’ policy in which patients with a history of violence are denied access to care. We do believe, however, that maximal administrative efforts must be made to provide health care workers and our patients a safe and secure work environment.

It is incumbent upon hospital administrations to make full and complete efforts to help address the rising incidence and increasing toll of ED violence. They must provide a respectful and collaborative environment in which all cases of violence are reported without fear or intimidation. They must commit to staff engagement with violence prevention, including mandatory de-escalation training. Improving staffing ratios and patient flow will help provide a more secure facility for both patients and staff.

Physicians and nurses in our EDs struggle to contend with increased violence and burnout, with fewer and fewer supports and resources, in an era of increasing funding cuts. It is the position of CAEP that the escalating human and financial burden of these cuts is not only detrimental to society, but also violates the rights of healthcare workers to a safe work environment that will allow them to provide appropriate care to the public. In addition to the preservation of human dignity, skill and security, there is the potential for great financial savings in addressing ED violence nationally. It is thus imperative to meaningfully address the epidemic of

violence in Canadian emergency departments and, for any delay in that regard, there should indeed be zero tolerance.

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**TAB 215**



# ENOUGH IS ENOUGH

## PUTTING A STOP TO VIOLENCE IN THE HEALTH CARE SECTOR

- A DISCUSSION PAPER -



CANADIAN FEDERATION  
OF NURSES UNIONS  
LA FÉDÉRATION CANADIENNE  
DES SYNDICATS D'INFIRMIÈRES  
ET INFIRMIERS



JUNE 2017

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## About this discussion paper

The Canadian Federation of Nurses Unions has produced this discussion paper in order to catalyze a national discussion on violence in health care – one that brings together the disparate stories from coast to coast, highlighting its broad and pervasive impacts. Further, this paper is intended to serve as a national Call to Action. As the national federation of nurses' unions, representing close to 200,000 frontline care providers, and nursing students, the CFNU is calling on governments, employers, unions and frontline nurses themselves to work together to put a stop to violence in health care.

Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.



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# A MESSAGE FROM THE CFNU

## Linda Silas, President

Over the past two decades, as nurses we have experienced an increase in violence in our workplaces. Every day we go to work knowing that we may be verbally or physically abused. Nurses in every health care sector are being punched, kicked, spat on and sworn at. It is time to speak up, and say clearly and emphatically: "Violence is not part of our job!" This is the take-home message of CFNU's discussion paper, *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*.

The number of violence-related lost-time claims for frontline health care workers has increased by almost 66% over the past decade, three times the rate of increase for police and correctional service officers combined. CFNU's recent poll on patient safety and working conditions for nurses found that 61% of nurses have had a "serious" problem with some form of violence in the past 12 months, whether bullying, emotional or verbal abuse, racial or sexual harassment, or physical assault, but unfortunately, only about a quarter of these nurses sought help from their nurses unions (and only 60% reported it). Significantly, two thirds (66%) of nurses have thought of leaving their job in the past year, either to work for a different employer or go into another occupation.

It's a pressure cooker out there for nurses on the front line. Higher patient populations, greater patient acuity and increased workloads are all on the rise, and the quality of care is declining. Violence is a symptom of an unhealthy work environment. It contributes to nurse absenteeism (own illness or disability): 9.0% for full-time public sector health care nurses in 2016, compared to 5.7% (average of all other occupations). In 2016, the annual cost of absenteeism due to own illness or disability is conservatively estimated at \$989 million.

It is the CFNU's position that all health care workers should have a right to work in safe workplaces which are free from all forms of violence, bullying, harassment and abuse – whatever the form and whatever the source. This paper is a Call to Action – one that encourages all nurses to tackle the issue of violence. Collectively, speaking with one loud voice, we can put a stop to violence.

The CFNU is calling on governments, employers, unions and other health care stakeholders to come together because we all have an interest in tackling this problem. This paper offers a way forward to take action on violence with the following recommendations.



## CFNU Recommendations

### Identify and advocate for provincial policy and legislative levers

*That the CFNU and its member organizations work with provincial/territorial governments:*

- To strengthen and improve OH&S legislations so as to create safe workplace standards for health care workplaces.
- To ensure meaningful and consistent enforcement and reporting, as well as strong language around the prevention of violence and bullying in health care workplaces, through risk assessments, education, training and emergency preparedness.

### Identify and advocate for federal policy and legislative levers

*That the CFNU and its member organizations work with the federal government:*

- To ensure charges are laid, when appropriate, under Bill C-45, otherwise known as the "Westray Bill" (Section 217.1 of the Criminal Code), against organizations and individuals if they fail to ensure the safety of workers and the public.
- To amend the federal Criminal Code (Section 269.01) to require a court to consider the fact that the victim of an assault is a health care worker to be an aggravating circumstance for the purposes of sentencing.
- To include health care workers and physicians in the federal PTSD framework across Canada.

**"It's a pressure cooker out there  
for nurses on the front line."**

### Identify and develop potential enablers/alliances

#### That CFNU and its member organizations:

- *Develop memorandums of agreement with the Crown and police to improve the investigation of workplace safety incidents and make it easier to lay criminal charges against patients who assault nurses.*
- *Host a meeting with federal/provincial/territorial health ministers on a Violence Is Not Part of the Job campaign.*

### Act as the lead on violence prevention, developing national resources and data

#### That CFNU and its member organizations:

- *Host a national roundtable on violence in health care.*
- *Develop and disseminate a communications strategy to bring national attention to the issue of violence against nurses.*
- *Highlight best practices in the health care sectors with a national violence prevention toolkit.*
- *Undertake a national survey to obtain data on workplace violence from all provinces.*

As nurses, we are committed to caring for our patients, to helping them get well. When we experience violence, and the related physical and psychological impacts, it affects our ability to deliver quality care. Violence contributes to burnout, compassion fatigue, depression, and PTSD symptoms, all of which erode our ability as nurses to provide quality care and safeguard the health and wellbeing of our patients. As Justice Archie Campbell, who led the SARS Commission in Ontario, reminded us, if workers aren't safe, neither are patients. If the mining industry can enforce strict OH&S standards, to safeguard workers safety, then we as nurses also deserve workplaces with zero tolerance of violence.

Change won't be easy. We are working in workplaces where violence has been normalized. Where even other nurses may tell us to 'suck it up'.

**"As nurses, we reject violence as 'just part of the job' and we will be part of the solution!"**

**- CFNU President Linda Silas**

We need a drastic change in the culture of our health care workplace – from one that responds to violence after it occurs to one that prevents violence before it occurs. For change to happen, it will involve all of us working together – governments, employers, unions and yes, nurses themselves. As nurses on the front line, coping with violence, the change starts with us every day when we go to work.

What does positive cultural change look like?

One provincial example in Ontario described in the paper is the Michael Garron Hospital (formerly Toronto East General Hospital) which established a violence prevention program, developed in partnership with the Ontario Nurses' Association. Among its key features were comprehensive frontline training, reporting, preventive risk assessments, improved communication technologies, better identification and care plans for patients with a history of violent behaviours, and an appropriately trained and supportive security staff. The result has been a proactive responsive workplace culture. It may not be perfect – no doubt that more needs to happen – but this example provides a roadmap for change. It shows what can be accomplished when employers and unions work in partnership towards systemic change with the goal of preventing violence in health care settings.

I would like to thank Carol Reichert, the author of *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*, CFNU's project team, and the members of CFNU's OH&S network: Dewey Funk (UNA), Denise Dick (SUN), Tom Henderson (MNU), Erna Bujna (ONA), Jennifer Dickison (NBNU) and Paul Curry (NSNU), for their work on this report which serves as a Call to Action for the CFNU, its member organizations and nurses across Canada.

As nurses, we reject violence as 'just part of the job' and we will be part of the solution!

In solidarity always,



Linda Silas  
CFNU President

# 1. EXECUTIVE SUMMARY


Violence in the health care sector is on the rise; violence – whether verbal, or physical, or both – happens every day in our health care facilities from coast to coast. The cost of violence in Ontario hospitals alone is about \$23.8 million annually, making up 10% of hospital lost-time injuries,<sup>1</sup> the majority of these injuries occurred among nurses.<sup>2</sup> Understaffing and inappropriate staffing, a lack of security, the increasing patient population, as well as the rise in patients' acuity and complexity, are all contributing to an erosion of safety for both patients and staff. The situation in hospitals is particularly acute in emergency departments and in psychiatric facilities. Emergency departments are at the front lines of health care. Since anyone can wander in off the street, the risks are unknown and difficult to assess. Patients in emergency departments are under stress and frequently in pain, facing long wait times in overcrowded rooms. Armed police may bring in individuals who have been involved in altercations, are high on drugs, or have mental health issues, and then leave them with staff in emergency. Psychiatric facilities or departments, where patients are suffering from mental health disorders, are another setting where there is a high potential for violence. Finally, in long-term care, where staffing has not kept pace with the numbers – often one or two nurses provide care for upwards of 100 individuals – nor with the rising acuity levels of residents, violence is a common, everyday occurrence.

Violence, bullying and domestic violence impacts in the workplace affect all nurses and their work environments. They contribute to high numbers of lost-time injuries. The Association of Workers Compensation Boards of Canada (AWCBC) 2015 accepted lost-time injury statistics show that the health care/social services industry tops the list for the number of lost-time injuries at 41,111, representing about 18% of all lost-time injuries. This dubious distinction is one the health care/social services industry has held for a number of years.<sup>3</sup> In 2015, frontline health care workers had more than double the number of violence-related lost-time injuries when compared to police and correctional services officers combined. More significantly, while the number of lost-time injuries

for police and correctional service officers, taken together, has risen gradually over the past decade, the number of lost-time injuries for frontline health care workers has grown at three times the rate for police and correctional service officers, rising year over year (see Figure 1).<sup>4</sup> Lost-time injuries contribute to the high rates of nurse absenteeism in Canada. The rate of absenteeism for full-time public sector health care nurses in 2016 was 9.0%, substantially higher than the average for all other professions (5.7%), leading to annual costs estimated at \$989 million.<sup>5</sup>

Awareness of the problem of violence in health care settings is growing in Canada, but legislation, policies, practices and enforcement have lagged behind. Violence is an occupational health and safety hazard – all provinces recognize this in their Occupational Health & Safety (OH&S) legislation, except for the province of New Brunswick. It is the CFNU's position that employers should strive to mitigate and, ultimately, aim to eliminate all forms of violence. Nurses have the right to work in an environment that is free from all forms and sources of violence, bullying, harassment and verbal abuse whatever the source (i.e., patients, families, doctors, colleagues, management) or origin (internal or external to the facility). Violence in workplaces impacts both staff and patients. It erodes the quality of care and impacts health outcomes. As the Honourable Justice Archie Campbell, who led Ontario's Commission of Inquiry<sup>6</sup> into the SARS tragedy, noted, *"if workers are not protected from health and safety hazards, patients and the public are not protected either."*<sup>7</sup> Unsafe violent workplaces are unsafe for everyone.

Evidence suggests the situation with respect to violence and bullying has worsened over the past two decades. Unfortunately, because the government agencies that would undertake a comprehensive survey on nurses' health have failed to act for more than a decade, the CFNU must fill the void, piecing together a fragmented picture. From the data that is available a picture is emerging – one where nurses are being assaulted and abused on a regular



basis, creating hazardous workplaces for nurses and potential safety and security risks for patients. While all health care workers are impacted by the increasing violence in health care settings, rates of violence correlate to patient contact time. Therefore, regulated nurses and nursing aides are, by definition, among the most at risk for violence.

We know violence is occurring – we know the workers that are most at risk – and we have positive examples of what works to help reduce violence against health care workers. As such, the failure of governments to take concerted action on the issue is deplorable. In the absence of government's meaningful and consistent enforcement of provincial OH&S legislation, and related federal legislation, many employers are refusing to acknowledge the extent of the problem, and some are even silencing nurses who speak up.

**As nurses, we will not be silenced;  
we will speak up.**

The CFNU and the Canadian Nurses Association *Joint Position Statement on Workplace Violence and Bullying* calls for zero tolerance of violence in health care workplaces. It states, "It is unacceptable to work in, receive care in, govern, manage and fund health-care workplaces where violence and bullying exist."<sup>8</sup> For the purpose of this paper, violence is defined as the exercise of physical force by a person against a worker, that is work-related, that causes or could cause physical injury to the worker; violence can also take the form of verbal abuse. Both physical and verbal abuse result in psychological and emotional repercussions for workers. CFNU and CNA's *Joint Position Statement on Workplace Violence and Bullying* describes bullying as "generalized psychological harassment"; bullying is a form of "psychological aggression and intimidation."<sup>9</sup> High rates of bullying in health care represent a human resource challenge for employers seeking to retain finite resources.

In the absence of sufficient and comprehensive data on violence against health care workers in Canada, and in light of fragmented approaches to dealing with the issue, this paper aims to fill the gap by telling the stories of those most impacted – frontline nurses. This paper aims to catalyze a national discussion on violence in health care – one that brings together the disparate stories from coast to coast, highlighting its broad and pervasive impacts. Further, this paper is intended to serve as a national Call to Action. As the national federation of nurses' unions, representing close to 200,000 frontline care providers and nursing students, the CFNU is calling on governments, employers, unions and frontline nurses themselves to work together to put a stop to violence in health care.

**Violence should never be 'just part  
of the job'!**

## 2. INTRODUCTION

### A Call to Action – Putting a STOP to Violence in Health Care

This paper documents the decline of the health and workplace environments of nurses over the past decades by focusing on the escalating tide of violence as it impacts frontline workers. Given the dearth of data since the last major survey of nurses' health was undertaken in 2005, and nurses' understandable reluctance to speak about their experiences with violence, either because they accept it as part of the job, or because they fear career repercussions, this paper does not propose to provide a comprehensive discussion of the issue. Any picture of violence in the health care workplace is necessarily incomplete. Nurses may feel – and be told by their managers – that if it was not a physical attack, violence does not need to be reported to their employer or workers' compensation boards. Other nurses may even reinforce this narrative, telling nurses to 'suck it up'. In this way, violence in the workplace is normalized. Nurses become inured to violence and reluctant to report it. When they do speak up, nurses may face retaliation: a nurse was fired for reporting violence, according to a recent media report.<sup>10</sup> A consultant with the International Council of Nurses (ICN) estimates that "70% to 80% of assaults are never reported."<sup>11</sup> The CFNU and its member organizations are sounding the alarm – it is time to put a STOP to all forms of violence, bullying and harassment in health care.

Over the past decade, violence in the health care sector has increased dramatically (Figure 1) – both the number and intensity of attacks are growing at an alarming rate. The rise in violence-related incidents has paralleled, and may be linked to, other negative trends that impact nurses' work environments and patient care, such as increases in nurses' workloads, inadequate or inappropriate staffing, and excessive use of overtime. Violence is pervasive throughout all health care sectors, impacting all those who work in hospitals, the community and long-term care facilities. In hospital settings, those who work in emergency rooms and psychiatric care have been shown to be particularly at risk. Home

care, where nurses work in isolation, and long-term care facilities, where there are few staff for many residents, many of whom suffer from dementia, and increasing levels of acuity, also have high rates of violence. For example, in Nova Scotia, where the seniors' population is outpacing investments in nursing homes, violence-related injuries to staff are disproportionately high in long-term care when compared to the acute care sector.

In health care, violence is impacted by, among other factors, inappropriate admissions of patients into facilities that are ill-equipped to deal with the patients' acuity/complexity; short staffing and inappropriate staffing, particularly in high-risk areas; inadequate or inappropriate security or security measures; inadequate communications protocols/practices with respect to violence risks; lack of violence-prevention training; isolated work assignments (night shifts, home and community care, long-term care); poorly managed transportation/ placement of patients (e.g., lack of secure rooms in emergency) and unrestricted access to health care facilities.

Violence and bullying can take many different forms: overt – physical, verbal, psychological (e.g., intimidation, threats of harm), and sexual behaviours; or covert – neglect, rudeness, humiliation and withholding information. Violence and bullying can occur between employees – colleagues at different levels in the organization (i.e., horizontal, vertical), or the source can be from those external to it – non-employees (e.g., patients, families, visitors).

Domestic violence is also emerging as a workplace issue in health care settings and is garnering the attention of governments, employers and unions. Canadian and international research has found that domestic violence often spills over into the workplace, compromising workers and their colleagues' personal safety and security.<sup>12</sup>





### 3. BACKGROUND

The last national comprehensive government survey to consider the health and wellbeing of nurses was conducted by Health Canada, Statistics Canada and the Canadian Institute for Health Information (CIHI). Entitled *Findings from the 2005 National Survey of the Work and Health of Nurses*, it found that of the nearly 19,000 regulated nurses surveyed, about a third of hospital nurses had suffered physical abuse at the hands of patients over the previous 12 months. In long-term care homes, the situation was even worse with about 50% of nurses reporting physical abuse by patients in a 12-month period.<sup>13</sup>

The 2005 survey also took into account emotional or psychological abuse. Emotional abuse from patients, visitors, physicians and other nurses was experienced by nurses. Close to 50% of nurses working in both hospitals and long-term care were emotionally abused by patients. The findings on violence and emotional abuse from the 2005 survey of nurses may be linked to the higher rates of reported depression in nurses (almost one in 10) and to the higher rates of medication use, when compared to the general employed population. For example, 8.5% of nurses had used sleeping pills in the previous month, perhaps as a result of sleep disturbances from irregular shift work, exceeding the usage for even other shift workers. The vast majority of nurses also took aspirin- or acetaminophen-based pain relievers or anti-inflammatories during the month – a higher usage than the general employed population.<sup>14</sup>

*Please refer to survey results on the following page*

It is notable that the term ‘bullying’ is not used in the 2005 survey questions. However, the survey does refer to ‘emotional abuse’ and ‘being exposed to hostility and conflict from the people you work with’. Awareness of “bullying” as a significant factor impacting workers’ health, wellbeing, productivity and retention has grown over the past decade. While bullying data is self-reported and not readily collected, all evidence points to high rates of bullying in the health care profession, both from external sources (non-employees) and internal sources (employees). This is particularly true for young nurses, who may leave the profession due to the reality shock of encountering both high workloads and bullying from colleagues, other members of the health care team, managers, and patients and their families.<sup>15</sup>

Similarly, the mental health of frontline health care workers including nurses – as expressed through high rates of burnout, compassion fatigue, depression and PTSD – has been steadily eroded over the past decade, following a similar trajectory to that of firefighters, police and correctional service officers (Figure 2).<sup>16</sup>

In addition to violence and bullying, this report will explore domestic violence as a workplace issue. Australia’s joint efforts by governments, employers and unions to recognize domestic violence as a workplace issue have galvanized Canadian unions, in conjunction with academic researchers, to take action on this issue.

## 2005 National Survey of the Work and Health of Nurses<sup>17</sup>

	Physically assaulted by a patient over 12-month period	Emotionally abused by a patient over 12-month period	Experienced depression in 12-month period	Physical/mental health made it difficult to handle workload over past 4 weeks	
				Physical	Mental
National	28.8	43.6	9.4	31.2	18.4
NL	36.2	43.5	5.3	34.1	12.6
PE	27.4	43.8	5.7	27.4	14.5
NS	32.2	43.3	9.0	30.0	16.0
NB	30.4	41.7	8.6	32.0	17.5
QC	26.5	35.3	10.7	28.5	15.4
ON	28.4	44.9	9.0	32.1	18.9
MB	32.9	49.1	9.1	34.5	23.1
SK	32.2	51.6	8.4	36.7	22.3
AB	25.3	47.2	10.3	28.5	19.2
BC	32.5	50.0	8.7	33.5	22.1
YT, NT, NU	27.1	58.6	7.1	18.8	16.8



## 4. FINDINGS

### A) Violence in Health Care: A Worldwide Epidemic

Violence against health care personnel is a widespread problem throughout the industrialised world, as well as in developing and transitional countries, and it affects health care workers in nearly all work environments – assault can take the form of intimidation, harassment, stalking, beatings, stabbing, and rape. Perpetrators tend to be primarily patients, their families and visitors.<sup>18</sup> A 2013 global review that estimated nurses' violence exposure rates, drawing on data from more than 150,000 nurses from 160 international samples, found that more than a third of nurses had been physically assaulted, and around two thirds had experienced non-physical assaults. Physical violence was most prevalent in emergency departments, geriatric and psychiatric units. Both physical violence and sexual harassment were most prevalent in the Anglo region, which included the U.S., Canada and England. Forty per cent of nurses experienced bullying.<sup>19</sup> The World Health Organization recognizes that health workers are at high risk of violence all over the world. It notes that not only is violence unacceptable, but that violence has a cascading effect, impacting the psychological and physical wellbeing of health care staff, their job motivation, compromising the quality of care, and leading to health care sector financial losses.<sup>20</sup>

#### U.S.

Health workers experience assaults at significantly higher rates than that of other occupations: eight assaults per 10,000 workers compared to two per 10,000 for the general workplace.<sup>21</sup> Thirty-five percent of attacks occur in hospitals; 53% in nursing or residential care facilities.<sup>22</sup> In the U.S., attacks on health care workers account for about 70% of all non-fatal workplace assaults that lead to days off from work.<sup>23</sup>

#### England

In total 70,555 National Health Service staff in England were assaulted in 2015-2016, according to NHS Protect figures. This was an increase of 4% over the previous year.<sup>24</sup> A petition calling for it to be a specific offence to attack any member of the NHS staff states that there are 193 attacks on NHS staff every day in England, which means there are eight attacks on workers in health care settings every hour of every day.<sup>25</sup>

#### Europe

Results from the European project NEXT involving 10 EU countries, focused on premature departures from the nursing profession, found that exposure to frequent violent events was highest amongst nurses from France (39%), the United Kingdom (29%) and Germany (28%). In France, 19.5% of nurses experienced violence at least once a week from patients or their relatives; in the UK the figure was 12.3%, and in Germany it was 11.5%.<sup>26</sup>

## B) Violence in Health Care in Canada: A Complex Narrative

As indicated, Canada has not undertaken a major national survey of nurses' health and their workplaces since 2005. Building a profile of what is happening in Canada with respect to violence and the health of nurses means cobbling together data from various sources. The data from various provincial nurses unions shows that nurses are getting hurt on a daily basis. Physical and verbal abuse are experienced by most nurses; during the course of their careers almost all nurses will experience violence. Together, the data paints a picture of a dangerous workplace – one that is unsafe for both nurses and patients. Being punched, kicked, spat on, slapped, pinched and verbally abused are common occurrences in all health care sectors, in all provinces and territories. Below you will find a small snapshot of what is happening in Canadian hospitals, which reflects the broader picture of the enormous toll that everyday violence takes on our health care workers, our patients, and our health care system as a whole. This is unacceptable and must be addressed by a concerted effort on the part of governments, employers and unions working collectively to end violence.

### Violence in Hospitals

In Nova Scotia's emergency rooms, from January to November 2016, there were 61 incidents of violence and threats. In October 2016, an armed man threatened emergency department staff at Middleton's Soldiers Memorial Hospital, prompting a joint union and government response to violence and a comprehensive action plan.<sup>27</sup> In New Brunswick, emergency rooms are described as places where nurses are routinely spat upon and sworn at during the course of their work.<sup>28</sup> In 2015, in the violence-plagued Abbotsford Regional Hospital emergency room in B.C., three quarters of ER staff said they had been physically assaulted while working in the previous year, with more than half saying they had experienced such abuse more than 20 times over a 12-month period.<sup>29</sup>

In Saskatchewan, almost three quarters of registered psychiatric nurses reported experiencing violence (physical and/or verbal)<sup>30</sup> during a 12-month period. One study has shown the rate of workplace violence in psychiatric settings as being three times the already high rate for nurses.<sup>31</sup> In Ontario, there have been a rash of charges brought against psychiatric facilities due to extremely violent incidents that have occurred. In March 2017, the Ministry of Labour, in the latest series of charges, laid three charges against Waypoint Centre for Mental Health Care under the *Occupational Health and Safety Act (OH&S Act)*. The charges related to an incident at the hospital in April 2016, involving a patient stabbing a nurse with a screwdriver.<sup>32</sup> However, these charges came after a disappointing decision, when a Brockville judge acquitted the Royal Ottawa Mental Health Centre of four of five provincial charges laid, after a mentally ill patient stabbed a nurse multiple times in the head and neck in 2014, leaving her seriously injured.<sup>33</sup>



## A Snapshot of Violence in the Canadian Health Care Sector

- **Alberta and British Columbia:** Of 8,780 RNs in Alberta and BC in 210 hospitals, 46% had experienced violence in the previous five shifts.<sup>34</sup>
- **Saskatchewan:** Almost 75% of Saskatchewan Registered Psychiatric Nurses (RPNs) had experienced violence in the previous year; 33% physical violence; 64% reporting verbal abuse.<sup>35</sup> In one health region, Regina Qu'Appelle Health Region, violent incidents almost doubled from 224 to 416 over the past year.<sup>36</sup>
- **Manitoba:** 52% of Manitoba's nurses have been physically assaulted, 17% have dealt with an individual with a weapon, and another 76% have been verbally abused; 37% of nurses working in psychiatric units, and 30% of ER nurses experience physical violence *at least once per week*.<sup>37</sup>
- **Ontario:** 54% of Ontario nurses have experienced physical abuse; 85% experienced verbal abuse, and 19% have experienced sexual violence or abuse.<sup>38</sup>
- **Quebec:** 86.5% of nurses have been the victims of violence on more than one occasion.<sup>39</sup>
- **New Brunswick:** 66% of nurses had experienced physical or verbal abuse during a one-year period.<sup>40</sup>
- **Newfoundland and Labrador:** 87% of nurses had experienced some form of violence or abuse in the workplace. Physical abuse was reported by 52% of nurses working in acute care.<sup>41</sup>

**Please note:** The above data was collected during different time periods, with different survey parameters, making cross-provincial comparisons difficult; this furthers the case for an update of the national survey with fully comparable data.

## Violence in the Long-Term Care Sector

In 2015, the CFNU raised the alarm with respect to seniors' care in its report, *Before It's Too Late: A National Plan for Safe Seniors' Care*, which called for a national strategy with minimum standards of care.<sup>42</sup> Since that report, the long-term care sector, which was already struggling to meet seniors' health needs, has become increasingly dangerous for both residents and staff.

Ontario, where the majority of long-term care facilities are for-profit, also suffers from some of the lowest staffing levels.<sup>43</sup> In Nova Scotia and New Brunswick, where long-term care facilities are at capacity due to the high seniors' populations in these provinces, staffing remains inadequate.<sup>44,45</sup> Staffing has not kept pace with the number of residents, nor the rising levels of acuity, meaning there is often only one or two nurses caring for 60-100 residents, resulting in threats to everyone's safety. Recently, an access to information request revealed that eight Nova Scotia long-term care residents had died due to violence from other residents over an eight-year period.<sup>46</sup> In Ontario, there were 12 homicides in nursing homes within a period of two years.<sup>47</sup> These deaths are not anomalies. CTV's *W5* program found at least 60 nursing home homicides over a 12-year period. While homicides are sensational and reported in the media, *W5* found more than 10,000 "incidents," during the course of one year, of resident-on-resident abuse in long-term care homes.<sup>48</sup> In Ontario, research by the Ontario Association of Non-Profit Homes and Services for Seniors found that 11% of Ontario's long-term care residents are deemed aggressive.<sup>49</sup> It is estimated that 60% of those in care have various forms of dementia, and up to 80% of those individuals will at some point exhibit anxiety, depression, paranoia or aggression.<sup>50</sup>

With few provinces having legislated minimum number of direct care hours for long-term care residents, minimum standards of care, or adequate investments in specialized training in gerontology,<sup>51</sup> the situation with respect to violence in these homes is reaching crisis levels in some settings. With a growing seniors' population, increasing levels of acuity and complexity, including a large number of seniors with dementia, the situation in long-term care is poised to become even more precarious over the next decade. A violent workplace is not only unsafe for patients and staff, it also erodes patient care by reducing already low staffing levels through high turnover rates, lost-time injuries, fatigue and burnout.<sup>52</sup> Physical violence in long-term care is a common experience for almost all frontline health care providers, leading to high rates of injuries requiring time off work. For example, in Manitoba, staff working in long-term care were injured more than 700 times over a five-year period, costing the workers compensation program about \$500,000 per year.<sup>53</sup> Similarly, a recent NSNU report in Nova Scotia also found a disproportionate number of violence-related lost-time injuries among staff in long-term care: the hospital, with at least three times the number of employees, had 81 violence-related claims in 2013, compared to 115 in Nova Scotia's nursing homes.<sup>54</sup>

Home care also presents risks for health care workers. In Newfoundland and Labrador, for example, where many community health workers visit people in their rural homes to provide health care, health care workers reported feeling unsafe when conducting home visits. Many experienced verbal abuse but did not report it.<sup>55</sup> The potential devastating risks were graphically illustrated by the murder of a Camrose mental health worker in a client's home in 2011 in Alberta,<sup>56</sup> and again in 2012 when a youth worker was murdered at a Camrose group home for teens;<sup>57</sup> both workers were not sufficiently made aware of the risks of caring for these patients.

### A Snapshot of Violence in Long-Term Care (LTC)

- **Newfoundland and Labrador:** 66% of LTC nurses had experienced physical abuse.<sup>58</sup>
- **New Brunswick:** 65% of LTC nurses had experienced physical abuse, and 78% had experienced verbal abuse during a one-year period.<sup>59</sup>
- **Nova Scotia:** 14% of LTC nurses reported incidents of violence frequently (twice a month), 24% often (twice a year); 23% experienced bullying and aggression frequently.<sup>60</sup>
- **Manitoba:** 31% of LTC nurses experience physical violence at least once per week.<sup>61</sup>
- **Manitoba, Ontario, Nova Scotia:** In 71 unionized LTC facilities, 43% of personal support workers experienced physical violence on a daily basis, nearly seven times the rate in Denmark, Finland, Norway and Sweden; another 25% experienced violence every week.<sup>62</sup>

*The above data was collected during different time periods, with different survey parameters, making cross-provincial comparisons difficult; this furthers the case for an update of the national survey with fully comparable data.*



## C) Bullying in Health Care Settings

Even as there has been an increasing focus on mental health in Canada, and on addressing the related stigma, the mental health of health care workers has continued to decline. One of the reasons is the high rates of bullying in health care from colleagues and managers.<sup>63</sup> Bullying in health care workplaces is on the rise, but it remains under the radar, with few workplaces acknowledging the extent of the problem.

Bullying may be described as “generalized psychological harassment.” It is a form of psychological aggression and intimidation. Bullying can be amongst colleagues (horizontal) or between staff at different levels of an organization (vertical: e.g., physician-nurse, manager-nurse).<sup>64</sup> Although awareness of bullying in the workplace has increased significantly over the past decade, there is still no uniform definition of bullying. Further, victims may be reluctant to report bullying (or identify themselves as victims), and hospital administrators may often not recognize the true extent and impact of bullying within the workplace. Without a standard definition and understanding of what constitutes bullying, data collection is difficult. However, common definitions include repeated, frequent, and long-term negative or aggressive behaviours that undermine confidence and lower self-esteem, which the victim feels powerless to defend themselves against or stop. The effects of bullying may be social, psychological or psychosomatic problems. Bullying may take the form of verbal (or physical) abuse, social exclusion, or undermining one’s professional status.<sup>65</sup>

In 2010, Dr. Claire Mallette led a study on horizontal violence (bullying) for the University Health Network. Ninety-five percent of the 160 nurse participants had observed horizontal violence; 71% had been targets. Kathleen Bartholomew, a Seattle-based RN and the author of *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other*, says the situation with respect to

bullying is actually worse in Canada than in the U.S., where it is estimated that 60% of newly registered nurses leave their first job within just six months after experiencing some form of lateral violence.<sup>66</sup> According to Bartholomew, “studies of workplace instability show that it’s worse in Canada than it is in the United States due to the fact that (Canada has) a culture of being much more polite than Americans.”<sup>67</sup> In Britain, while official tallies put the rate of bullying among National Health Service staff at about 25%, *The Guardian* newspaper’s own survey found much higher rates. Among 1,500 doctors, nurses and other health workers in hospitals, primary care and community settings, 81% had experienced bullying, and for almost half of them it was still ongoing. A third of those bullied signed off sick, and another 40% needed counselling to cope with the bullying.<sup>68</sup>

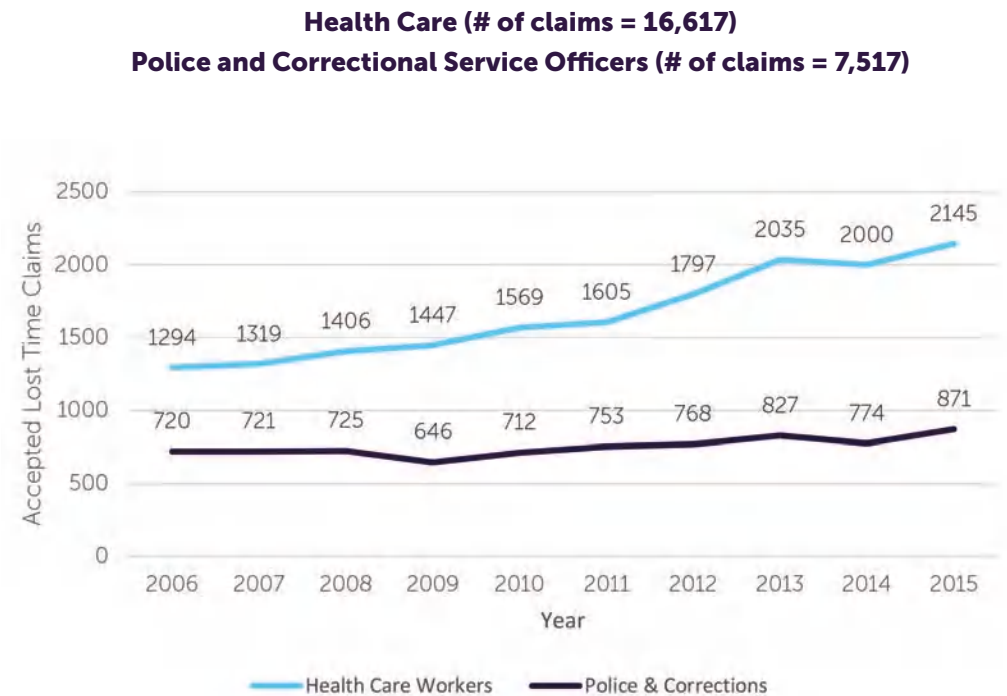
Nurses unions have identified bullying as a key HHR issue, particularly with respect to the retention of younger nurses entering the workforce. In terms of health outcomes, bullying has also been linked to medication errors and an erosion in the quality of patient care. Bullying is also costly: the estimated international costs of bullying-related outcomes is between \$17 and \$36 billion annually.<sup>69</sup>

## D) The Failure to Act on Violence in Health Care: Rising Costs

The following data vividly documents the extent of the violence against nurses. The problem is growing rapidly, and costs are continuing to rise. Meanwhile, the media continues to focus on the dangers of what is traditionally 'men's work' – 95% of media reports concern men's injuries – even though 37% of injuries involve women. Assaults and violent acts are almost never reported. Media reports continue to focus primarily on fatalities in construction, mining and manufacturing, even though the national data shows that health care and social services are more dangerous in terms of the overall number of lost-time injuries, in some cases – far more dangerous than these traditionally male domains. As the data illustrates, even when compared to police and correctional service officers combined, health care workers experienced more than double the number of incidents that result in violence-related lost-time.<sup>70</sup> Accepted lost-time violence-related claims for health care workers have increased by almost 66% over the past decade, rising at three times the rate of police and correctional service officers combined. This pattern showing an increase in violence-related lost-time incidents between 2006 and 2015 is evident in every province; in some provinces, violence-related claims have doubled or even tripled. Even taking into account that there are likely more frontline health care workers employed in Canada than police and correctional service officers combined, in 2006, violence-related claims for health care workers were already 80% higher than those for police and correctional officers. In 2015, the gap widened to almost 150%.

**Figure 1**

### Violence-Related Accepted Lost-Time Claims 2006-2015



*Accepted lost-time claims for event or exposure to assaults, violent acts, attacks, harassment, for patient service associates, orderlies, nurses aides, LPNs, RNs, and nurse supervisors in health care and social services in comparison to police officers and correctional service officers - 2006-2015.<sup>71</sup>*





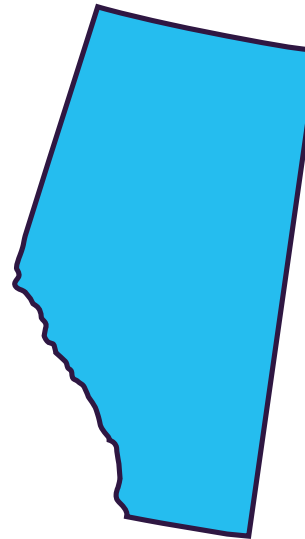
## E) Nurses' Stories: The Experience of Violence on the Front Lines of Health Care

### British Columbia



*At Abbotsford Regional Hospital Emergency Department, BC, a facility with a history of violence, a registered psychiatric nurse (RPN) suffered a severe concussion after getting kicked in the head by a patient in the ER; two RPNs and a security guard were also assaulted by another patient. In both cases, the assailants had been patients with mental health issues, brought in by police.<sup>72</sup>*

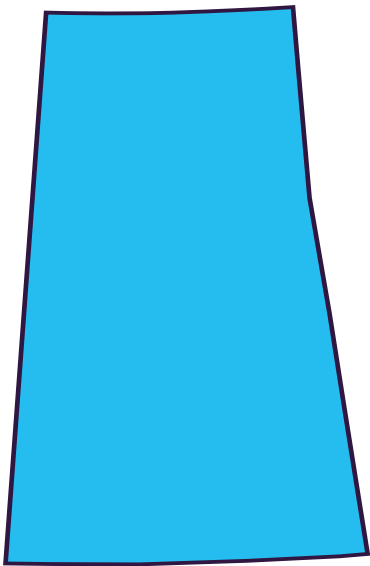
### Alberta



*A nurse, providing care for an intoxicated patient, was told, "you are going to be my wife." The nurse said this was inappropriate, and asked him not to speak to her like that. When she tried to start an IV, the patient grabbed the nurse's vagina and said, "I'm going to ram my penis down your throat." The nurse restrained his hands, calling security; then the RCMP was called.*

*The patient was charged, receiving 30 days for assault — not sexual assault. During the same shift, the same nurse was assaulted again, receiving a kick in the back of the head from a child receiving psychiatric care.*

### Saskatchewan



*In 2014, a nurse leaving her late night shift at a hospital in Regina was walking to her parked car when she was attacked by a man who punched her in the throat, the arm and chest.<sup>73</sup>*

### Manitoba



*At 6:45 a.m. an operating room (OR) nurse was starting her shift. She knocked on the locked OR door. An irate man emerged carrying a large bag and yelling obscenities at her, and fled. The nurse found that the hand sanitizer dispensers were broken; the alcohol gel pouches were missing. Addicts take them because of their high alcohol content. Hospital staff describe feeling like "security guards or bouncers," scared to be at work, especially at night, when they are alone.*

### Ontario

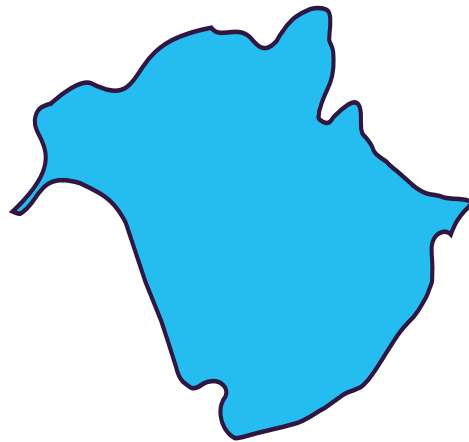
*The police had brought in a man to Emergency; he was put in a private room, and they left. Then the man left the room and ran at the nurse. She was punched and kicked in the head and neck many times. Security came and helped her break free. She received a concussion, multiple bruises and contusions all over her body.*

*A patient grabbed a nurse and locked her and himself in a visitors' room. The patient said he would beat and rape her, then kill her. The patient beat her beyond recognition, while others watched helplessly because no one was able to get in the room. The patient started to rip off the nurse's clothes. The nurse thought she was going to die. A co-worker broke into the room, saving her life. This nurse will never return to work.*



### Ontario (Con't)

*In one year, in just one hospital in Ontario, where a patient attacked a nurse, choking her, 20 staff were physically harmed — from scratches and bruises to more serious injuries. There were another 200 incidents where staff were threatened.*



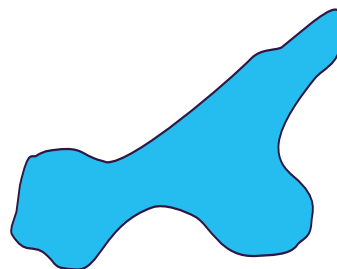
### New Brunswick

*The police brought in a man to Emergency after he had been in a fight. He was transferred to a unit by staff, who warned that he'd already been violent in the ER. There were several patients in critical condition, one female RN, and a pregnant doctor. The man was assessed by the doctor and lashed out at her; she screamed for help. He then headed towards a patient in traction. The RN stepped in front of the patient and he threw her down, repeatedly beating her head against the floor. By the time the Code White was responded to, the RN had sustained serious head injuries.*



### Nova Scotia

*A nurse in a long-term care home was bending down to tie a resident's shoe when he grabbed her by the hair and slammed her face into the floor – again and again – she lost track of the number of times her face hit the floor. The attack was totally unexpected – the resident had been in a good mood all day. Luckily, somebody overheard her screams and came to help.*



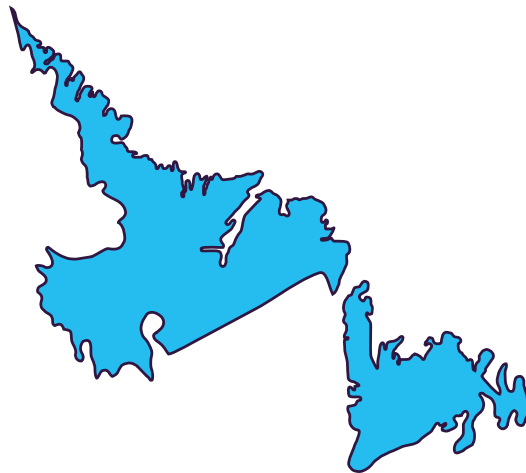
### Prince Edward Island

*A young nurse was working at a community home in PEI, with 50 residents. Late one evening, a 6'5" male resident suffering from bipolar disorder, violently threw everything electrical from his room out into the hall. The staff (the in-charge nurse and patient care worker) tried to calm him down but he verbally abused them.*

*The nurse called the doctor and was told to medicate the patient. He refused treatment and continued to berate staff. Called again, the doctor told staff to call police. When the police finally arrived, it took four officers to remove the man from the facility.*

### Prince Edward Island (Con't)

*A resident was wandering on nights. When staff approached, they noticed he was soiled and asked him if he wanted to change his clothes; he agreed. Upon entering his room, the resident turned suddenly and pinned the staff member against the door, putting both hands around their throat. The staff member managed to yell for a colleague, and the resident released his hold.*



### Newfoundland and Labrador

*A patient suffering from paranoid schizophrenia, was admitted to a St. John's Hospital. He punched a doctor and nurse in the face, then pushed another nurse to the floor and punched her several times in the back of the head.*

## 5. MAKING THE LINK

### Violence in Health Care Settings and the Mental Health Impacts on Nurses

A number of studies have documented the short- and long-term consequences of repeated exposure to violence. Although treatment for physical violence may eliminate the scars, there may be both short- or long-term psychological consequences in the case of both physical and verbal abuse. Psychological outcomes may include anger and fear, post-traumatic stress disorder (PTSD) symptoms, guilt, shame and avoidance, decreased job satisfaction and increased intent to leave the organization, and lowered health-related quality of life (HRQoL).<sup>74, 75, 76, 77</sup> Other factors that may be related to violence include sleep disorders, headaches, fear and anxiety.<sup>78</sup>

Violence may be linked to nurses' high rates of burnout and depression. CBC's 2013 *Fifth Estate* program in its national survey of more than 4,500 registered nurses in over 250 hospitals found nearly 40% of nurses suffered from high levels of burnout.<sup>79</sup> The prevalence of major depression in Canadian nurses is double the national average for working women.<sup>80</sup>

Nurses who are suffering from untreated mental health issues may be prone to addictions. However, because of regulatory practices focused on discipline, and the stigma attached to addictions, nurses may be reluctant and unable to seek help.<sup>81</sup>

#### Violence and Post-Traumatic Stress Disorder (PTSD)

According to groundbreaking research conducted by the Manitoba Nurses Union (MNU), violence, or the threat of violence, plays the largest role in PTSD development in nurses. One in four Manitoba nurses consistently experiences PTSD symptoms; more than half have experienced critical incident stress, a precursor to the development of PTSD.<sup>82</sup> The frequency of workplace bullying

as a form of violence – a common occurrence in health care workplaces – has also been shown to be significantly related to the development of PTSD symptoms.<sup>83</sup> Excessive workloads also play a role: a BC nursing workload study found PTSD symptoms among the nurses studied, with about 35% of nurses requiring further evaluation.<sup>84</sup> With these factors taken together as a whole, it is not surprising that health care workers have been shown to have high rates of PTSD symptoms.<sup>85</sup>

Post-traumatic stress disorder (PTSD) is a psychiatric disorder – an extreme reaction to either direct or indirect exposure to trauma. Nurses experience trauma on a regular basis in their work environments either directly (primary), as witnesses (secondary), or through vicarious trauma (compassion fatigue). The trauma may be cumulative, resulting in symptoms similar to PTSD (e.g., avoidance) and in disorders such as anxiety and depression. Symptoms of PTSD fall into four categories: re-experiencing, avoidance, negative cognitions and mood, and arousal.<sup>86</sup> The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) states that PTSD is a psychological reaction following exposure to, or learning of, death or threatened death, serious injury or sexual violence to self or a loved one, or repeated exposure to aversive details of trauma.<sup>87</sup>

Epidemiological surveys have found that PTSD is twice as common in women as in men. In addition, there are gender differences in the type of trauma exposure, presentation of the illness, and the co-morbidities. While some of these differences are non-biological, others relate to how women's biological system altered by PTSD may be modulated by sex hormones.<sup>88</sup> Since about 90% of the more than 400,000 regulated nurses in Canada are women, PTSD in nurses must be understood in the context of gender differences.

Often nurses may be misdiagnosed with burnout or compassion fatigue. A number of research studies have looked at burnout rates in nurses. At some point in their careers about 71% of nurses will experience burnout, according to research.<sup>89</sup> The BC workload study found similar rates of burnout, with about 70% of nurses in the study reporting medium to high levels of emotional exhaustion, a key indicator of burnout. Almost 80% of the nurses in this study failed to seek professional help.<sup>90</sup> A report on the interaction of PTSD and burnout syndrome (BOS) among nurses shows that nurses with PTSD will almost uniformly have symptoms of BOS. Of nurses in this study, 22% had symptoms of PTSD, 18% met the diagnostic criteria for PTSD, and 86% met the criteria for BOS.<sup>91</sup>

Given the high rates of PTSD and PTSD symptoms among nurses – and the gendered nature of how symptoms manifest themselves in nurses, such that it is likely nurses are often misdiagnosed with burnout (which is highly prevalent) or other co-morbid disorders – nurses exclusion from presumptive PTSD legislation in Alberta, Ontario, New Brunswick and federally, in Bill C-211, is difficult to comprehend. Nurses who face high rates of violence every day in their jobs should not be doubly victimized when they get sick as a result of this violence by having to relive the trauma of abuse in order to prove to a WCB tribunal that their PTSD claim is justified.





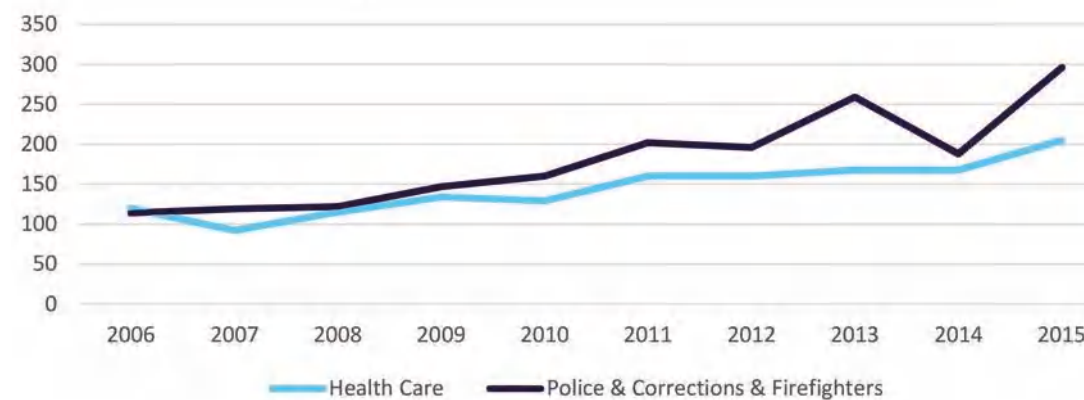


This graph shows the accepted lost-time claims for mental health-related injuries, comparing frontline health care workers with firefighters, police and correctional service officers combined. Although the latter group has a slightly higher number of claims, the two groups are on a similar trajectory in terms of the rates of increase. In terms of accepted lost-time claims for nurses, the percentage of PTSD-related mental health claims were similar, hovering around 50% of total mental health-related lost-time claims for both groups.<sup>92</sup>

**Figure 2**

**Mental Health-Related Accepted Lost-Time Claims 2006-2015**

**Health Care (# of claims = 1,451)**  
**Firefighters, Police, Correctional Service Officers (# of claims = 1,803)**



*Accepted lost-time claims for nature of injury mental health ("52 mental disorders or syndromes") for patient service associates, orderlies, nurses aides, LPNs, RNs, and nurse supervisors in health and social services in comparison to firefighters, police officers and correctional service officers - 2006- 2015.*

## 6. DOMESTIC VIOLENCE AND THE HEALTH CARE SETTING

### An Emerging Issue in Canada

In Canada, the Canadian Labour Congress collaborated with Western University in Ontario on groundbreaking research to determine the prevalence of domestic violence impacts in the workplace in Canada. Their survey of workers defined domestic violence as any form of physical, sexual, emotional or psychological abuse, including financial control, stalking and harassment that occurs between opposite- or same-sex intimate partners, who may or may not be married or living together. The survey report entitled *Can Work be Safe, When Home Isn't?* found one third of Canadian workers have experienced domestic violence; in over half of these cases it followed them to work in the form of harassing emails, texts, phone calls or stalking and other intrusive measures. Sadly, 8.5% of victims lost their jobs as a result of domestic violence impacts.<sup>93</sup>

Internationally, governments, employers and unions have become increasingly attuned to both the personal and financial consequences of domestic violence in the workplace. Thanks to an initiative entitled *Safe at Home, Safe at Work*, led by the Australian government in conjunction with academics, employers and unions, about two million workers in Australia now have domestic violence rights and entitlements as part of their negotiated workplace protections, including leave provisions and safety policies.<sup>94</sup>

The Conference Board of Canada surveyed employers about the impacts of domestic violence in Canadian workplaces. Over 90% of Canadian employers surveyed by the Conference Board of Canada said domestic violence has an impact on workers' performance and productivity; almost three quarters of employers surveyed reported having to protect a victim of domestic violence.<sup>95</sup> Canadian employers lose \$77.9 million annually due to the direct and indirect impacts of domestic violence (including loss of productivity and late/distracted employees).<sup>96</sup>

Nurses' workplaces are open to the public, with little security. In November 2005, an ONA member, RN Lori Dupont, was murdered by her ex-partner, an anesthesiologist who worked at the same hospital. Lori Dupont had repeatedly expressed her concerns regarding her safety to her hospital employer. The case resulted in the first legislation on domestic violence and the workplace in Canada, with an employer obligation to address domestic violence when it spills over into the workplace.

In New Zealand an analysis of recommended workplace protections that included paid leave provisions, workplace training, and flexible working arrangements found the employers' costs are offset by net improvements in productivity.<sup>97</sup>

Galvanized by international experience, Canadian research, and growing awareness of costs to both employers and employees of not addressing domestic violence, Manitoba passed legislation in 2016, which means workers who are victims of domestic violence are able to retain their attachment to the workplace because they have access to both paid and unpaid leave from work, and guaranteed job security if they have to take time off as they seek safety from abusers. Similar bills are currently being reviewed in Ontario and Saskatchewan.<sup>98</sup> Due to persistent stigma surrounding domestic violence, workers will only be able to effectively make use of such leave if there are designated people within the workplace, trained to respond compassionately and without judgement, to assist the worker to access the leave in a confidential manner. Therefore, nurses unions, working with the Canadian Labour Congress and Western University, are examining the potential of collective agreement language to address domestic violence in the workplace and to increase proactive policies, training and awareness to reduce the domestic violence workplace impacts.





## 7. MAKING THE CASE FOR CHANGE

### Nurses Unions Take Action

Increasingly, all provincial unions are enhancing their professional responsibility/ complaints process in negotiations, through data collection, and through employer-union processes to help prevent the conditions in which violence flourishes.

#### British Columbia

The British Columbia Nurses' Union (BCNU) has launched a 24/7 hotline for nurses to call if they have suffered an assault at work, with a trauma counsellor available to talk to nurses and a promise of a one-day follow-up from BCNU staff to guide nurses through the process of responding to violent incidents. They have also launched graphic commercials to raise awareness of the issue.

#### Alberta

United Nurses of Alberta (UNA) is encouraging members to take a stand against violence, following the 2013 successful appeal of disciplinary actions against a group of nurses who had exercised their right to refuse unsafe work. On the night of January 17, 2011, eight RNs and RPNs told their manager they would not treat a violent patient who had previously threatened staff with violence. The patient was being held in a seclusion room the nurses believed to be insecure. When able-bodied security staff had to take physical control of the patient, some were injured; one was placed on modified duties. For failing to treat the patient and place themselves in imminent danger, the nurses were suspended without pay. After considering the evidence on appeal, the employer was ordered to cease all disciplinary action against the nurses, pay them what they would have earned if they had not been disciplined, and remove any reprimand

or other reference to the matter from their employment record. This 'right to refuse' case is precedent-setting, representing a singular victory for nurses in Alberta and across Canada.<sup>99</sup>


Alberta is now also piloting a visual violence alert to identify patients who have exhibited violent behaviours – and is posterizing facilities throughout the province to raise awareness of violence in the workplace. Those who experience violence are to receive counselling, and UNA has prepared a brochure to help workers negotiate a path to recovery after violent incidents occur.

#### Saskatchewan

Saskatchewan has announced a Provincial Violence Prevention Framework/ Strategy with a toolkit that provides information, training and resources to be rolled out in provincial health care facilities. Saskatchewan Union of Nurses (SUN) sits on the multi-stakeholder Provincial Violence Prevention Steering Committee that meets monthly and is engaged in developing and implementing the strategy to reduce violence and acts of aggression in Saskatchewan's health care sector. Work has started by piloting Ontario's Public Services Health & Safety Association's Workplace Violence Risk Assessment Toolkit (WPRA) in a few selected sites, with the objective of building Saskatchewan's own toolkit.

#### Manitoba

Informed by the work of the Manitoba Nurses Union on the Minister's Advisory Group, the Manitoba government has established a province-wide violence prevention policy for all health care facilities, which includes mandatory



training for workers, an alert system to identify patients at risk of violence, security measures, and mandatory reporting and investigation of violent incidents. Recently a new symbol has been introduced into Winnipeg health care facilities in an attempt to reduce violence. Two interlocking purple rings posted on the doors of hospital rooms will flag the patient as having a history of violent behavior. The rings are being launched in conjunction with four mandatory learning modules that offer strategies for diffusing difficult behaviours and conflicts, and seeking assistance when needed.

Manitoba Nurses Union has also established the link between violence, as experienced by nurses, and the development of PTSD symptoms. As a result of MNU's efforts, only in Manitoba does presumptive legislation stipulate for the purposes of the Workers Compensation Board that if a worker suffers from post-traumatic stress disorder, the disorder must be presumed to be an occupational disease the dominant cause of which is the employment, unless the contrary is proven.

## Ontario

Ontario Nurses' Association (ONA) is part of a three-year provincial Workplace Violence Prevention in Health Care Executive Committee and Leadership Table which was tasked with developing a comprehensive action plan. Their recent report makes 23 specific recommendations, including a minimum security and training standard and joint Ministry of Health and Labour promotion of the Public Services Health and Safety Association's Violence, Aggression and Responsive Behaviour Tools, as well as a quality improvement plan indicators for workplace violence.<sup>102</sup>

In addition, ONA has expanded their *Nurses Know* ad and public awareness campaign regarding hospital funding and RN cuts, calling a code on health care in Ontario, which includes calling for a Code White to reveal the painful reality of workplace violence against nurses, whenever and wherever they are providing care. Ontario Nurses' Association also has set up a website [www.violence.ona.org](http://www.violence.ona.org) on which it shares resources and encourages nurses to share their stories of violence in the workplace. ONA has developed a Violence Prevention Toolkit with information and resources for its membership.

Recently, some charges are being laid by Ontario's Ministry of Labour against facilities which do not uphold their obligations under the *Occupational Health and Safety Act*, allowing violence against nurses to occur.

The Michael Garron Hospital's (formerly Toronto East General Hospital) collaboration with ONA to combat violence shows what can be done when employers commit to working with the union to combat violence. Among the comprehensive elements in place at the Michael Garron Hospital are strategic partnerships with a committed leadership and active union engagement as key stakeholders, workplace violence prevention (WVP) committees and numerous measures and procedures, widely posted zero tolerance signs, proactive external and internal risk assessments and two-way voice communication with security, a comprehensive patient flagging and alert system, incident reporting software, employee training, specially trained security and security measures, data collection, and support for employees when incidents occur. As a result of these measures, staff satisfaction and engagement has increased, and the severity of violent incidents has decreased. Further, patient outcomes have improved, and absenteeism has also declined, resulting in organizational benefits.<sup>103</sup>





## Nova Scotia

In 2015, the Nova Scotia Nurses' Union (NSNU) published *Broken Homes*, which documented the violence in the province's nursing homes and made recommendations to improve safety in the province's facilities for both patients and staff.<sup>104</sup> NSNU has also targeted violence in acute care emergency departments. In response to a troubling incident at a rural emergency department, and at the insistence of the NSNU, the Premier established a working group co-chaired by the NSNU and the Provincial Health Authority, to develop recommendations around improving safety in community emergency departments. The group developed a 12-point action plan which will be fully implemented by December 2017. NSNU is also launching ads to raise awareness among the public and its membership that violence is not an acceptable part of the job for nurses.<sup>105</sup>

## New Brunswick

As a result of a letter of intent in the collective agreement between the New Brunswick Nurses Union (NBNU) and the NB Association of Nursing Homes, the New Brunswick Nursing Home Workplace Violence Prevention Working Group – of which NBNU is a member – has been tasked with developing a violence prevention toolkit and identifying, developing and sharing training and resources to reduce incidents of violence in New Brunswick's nursing homes. It is encouraging all nurses to report violence when it occurs.

The NBNU also negotiated a letter in their collective agreement with New Brunswick's two health authorities, which covers nurses working in hospitals and community, to develop and implement comprehensive violence prevention

programs. In consultation with NBNU, Horizon, NB's English health authority, has developed and piloted a program which is being gradually rolled out Horizon-wide. Unfortunately, the pace of the roll-out is slow, and the program has been allotted limited resources. Vitalité, NB's French health authority, began meetings with representation from NBNU and the authority's upper management in late 2016 to improve and expand their violence prevention measures.

The NBNU is also lobbying the provincial government to specify that violence is a workplace hazard within the province's *OH&S Act* as New Brunswick is the only province that does not have OH&S-legislated protection against violence.

## Prince Edward Island

The Prince Edward Island Nurses' Union (PEINU) is in the initial process of collecting data on violence in the workplace from members. An action plan announcement is planned for fall 2017.

## Newfoundland and Labrador

Since 2015, Registered Nurses' Union of Newfoundland and Labrador (RNUNL) has partnered with employers and government to develop posters for an anti-violence campaign in health care sites across the province to raise awareness of the issue, as well as increase their efforts to educate RNUNL's branch leaders regarding bullying impacts and prevention.



## 8. CONCLUSION

### A Call to Action

The Canadian Federation of Nurses Unions and its member organizations recognize that this discussion paper is the first step on a longer journey to eliminate violence in the health care sector. This paper paints a grim picture of the current reality with respect to violence in the health care sector and the resultant personal and financial toll on our health care system.

Since the *2005 National Survey of the Work and Health of Nurses*, the number of violence-related lost-time injuries for health care workers has increased dramatically; health care workers have also experienced an erosion of their mental health with high rates of burnout, compassion fatigue, depression, and PTSD symptoms. With the rising levels of acuity and complexity for patients in both the hospital, community and long-term care sectors, and ongoing concerns about safe staffing, this situation with respect to violence in the health care sector is likely to continue to worsen unless concerted action is taken now.

This paper is a Call to Action. It is the CFNU's position that all health care workers should have a right to work in safe workplaces which are free from all forms of violence, bullying, harassment and abuse – both verbal and physical – and that it is the responsibility of employers to try to mitigate, and ultimately eliminate, workplace violence hazards. Violence in the workplace impacts everyone – both staff and patients – and negatively impacts the quality of care and patient outcomes. Violence is extremely costly, affecting organizations' and employers' bottom line, and damaging health care workers wellbeing and quality of care for patients.

We know violence is increasing in our health care settings, and the factors that contribute to this increase. We know the workers that are most at risk, and we have positive examples of what works to help reduce violence against health care workers. As such, governments, employers, unions and other health care stakeholders must come together to take concerted action on the issue. Governments must provide meaningful and consistent enforcement of provincial OH&S legislation, and related federal legislation. Governments must also champion new legislation to help health care workers impacted by violence, PTSD and domestic violence; employers must provide leadership for systemic organizational change, acknowledging the impact of violence and the extent of the problem, speaking up to safeguard the health of employees and patients. Finally, unions and other health care stakeholders must speak as one voice to say unequivocally – Enough is Enough – we reject violence as 'just part of the job'.

Working together we can stop violence in health care.

**“We must speak as one voice to say unequivocally – Enough is Enough – we reject violence as ‘just part of the job’. ”**

**- CFNU President Linda Silas**

## CFNU Plan to Stop Violence in the Health Care Sector – 2017-2018

- Identify barriers, enablers, and potential policy and legislative levers.
- Work with member organizations to strengthen and improve OH&S legislation so as to create safe workplace standards for health care workplaces.
- Work with member organizations to ensure meaningful and consistent enforcement of OH&S legislation and consistent reporting, as well as strong language around the prevention of violence & bullying in health care workplaces, through risk assessments, education, training and emergency preparedness.
- Lobby for memorandums of agreement (with the Crown and police) to improve the process of investigating workplace safety incidents and the subsequent laying of criminal charges against patients who assault nurses.
- Lobby for charges to be laid under the federal Bill C-45 (The “Westray Bill”) for organizations and individuals who fail to ensure the safety of workers and the public.
- Lobby for amendments to the federal *Criminal Code* (section 269.01) to require a court to consider the fact that the victim of an assault is a health care worker to be an aggravating circumstance for the purposes of sentencing.
- Lobby to include health care workers and physicians in the PTSD presumptive legislation framework federally.
- Develop and deliver a communications strategy to bring national attention to the issue of violence against nurses.
- Host a national roundtable on violence in health care.
- Develop a national violence toolkit highlighting best practices in health care sectors.
- Conduct a national survey to obtain data on workplace violence from all provinces.

# 9. MESSAGE DE LA FCSII

## Linda Silas, Présidente

Au cours des deux dernières décennies, nous, infirmières et infirmiers, avons observé une augmentation de la violence dans nos milieux de travail. Chaque jour, nous nous rendons au travail sachant que nous pourrions faire l'objet de violence verbale ou physique. Coups de poing, coups de pied, mots grossiers ou se faire cracher dessus, voilà à quoi sont confrontés les infirmières et les infirmiers de chaque secteur de la santé. Le temps est venu de dénoncer et de dire clairement et énergiquement : « la violence ne fait pas partie de notre travail! » C'est le message du document de travail de la FCSII *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*.

Le nombre de demandes d'arrêt de travail en raison de blessures liées à la violence chez les travailleurs de la santé de première ligne a augmenté de près de 66 % au cours de la dernière décennie, soit un taux d'augmentation trois (3) fois plus élevé que chez les agents de police et les agents correctionnels confondus. Selon le récent sondage mené par la FCSII sur la sécurité des patients et les conditions de travail du personnel infirmier, 61 % du personnel infirmier a fait l'objet d'un type de violence au cours des 12 derniers mois (intimidation, violence psychologique ou verbale, harcèlement sexuel ou en raison de la race, agression physique) mais, malheureusement, le quart seulement de ces personnes ont demandé l'aide de leur syndicat infirmier (et seulement 60 % l'ont signalé). Plus important encore, 66 % des infirmières et des infirmiers ont considéré quitter leur emploi au cours de la dernière année, soit pour travailler pour un autre employeur ou choisir une autre profession.

Les infirmières et les infirmiers aux premières lignes sont dans une marmite à pression. Tout augmente : populations plus élevées de patients, augmentation de l'acuité des besoins des patients, et augmentation des charges de travail, pendant que la qualité des soins diminue. La violence est un symptôme d'un milieu de travail malsain. Elle contribue à l'absentéisme chez le personnel infirmier en raison de maladie ou incapacité : 9,0 % chez les infirmières à temps plein du secteur public en 2016, comparativement à 5,7 % (moyenne pour toutes les autres professions). En 2016, le coût annuel de l'absentéisme en raison de maladie ou incapacité est estimé, de façon conservatrice, à 989 millions \$ par année.

La position de la FCSII est que chaque travailleur de la santé devrait avoir le droit à la sécurité dans son milieu de travail et être à l'abri de tout type de violence, d'intimidation et de harcèlement, qu'importe la forme ou la source. Ce document est un Appel à l'action qui encourage les infirmiers et les infirmières à mettre un frein à la violence. Collectivement, en nous exprimant d'une seule voix forte, nous pouvons y arriver.

La FCSII demande aux gouvernements, aux employeurs, aux syndicats et autres intervenants du secteur de la santé de s'unir parce que nous voulons tous régler ce problème. Ce rapport ouvre la voie et recommande les mesures suivantes pour régler le problème de la violence.

## Recommandations de la FCSII

**Déterminer les politiques provinciales et les options législative, et lutter pour leur mise en place. Que la FCSII, et ses organisation membres, collaborent avec les gouvernements provinciaux et territoriaux :**

- Pour renforcer et améliorer la législation en matière de santé et de sécurité au travail afin d'établir des normes assurant la sécurité des milieux de travail du secteur de la santé.
- Pour assurer une mise en application conséquente et le signalement régulier des incidents, ainsi qu'une formulation claire par rapport à la prévention de la violence et de l'intimidation dans les milieux de travail infirmiers, soit une formulation qui tient compte des évaluations des risques, de l'éducation, de la formation et de la préparation aux situations d'urgence.

**Déterminer des politiques fédérales et des options législatives, et lutter pour leur mise en place. Que la FCSII, et ses organisation membres, collaborent avec le gouvernement fédéral :**

- Pour assurer que des accusations soient portées, lorsque cela s'avère pertinent, en vertu du projet de loi C-45, connu aussi sous le nom de projet de loi Westray (section 217.1 du Code criminel), contre les organisations et les personnes qui n'assurent pas la sécurité des travailleurs et du public.
- Pour amender le Code criminel fédéral (section 269.01) afin d'exiger qu'un tribunal considère comme circonstance aggravante le fait que la victime de l'agression soit un travailleur de la santé.
- Pour inclure les travailleurs de la santé et les médecins de partout au Canada dans la structure fédérale du projet de loi relatif au TSPT.

**Déterminer les complices potentiels et forger des alliances. Que la FCSII et ses organisations membres :**

- Élaborent des mémorandums d'entente avec la Couronne et la police pour améliorer le processus d'enquête des accidents du travail, et facilitent le processus pour que des accusations criminelles soient portées contre les patients qui agressent un membre du personnel infirmier.
- Organisent une rencontre avec les ministres de la Santé FPT pour parler d'une campagne dont le thème serait : « la violence ne fait pas partie du travail ».

**Être chef de file par rapport à la prévention de la violence, à l'élaboration de ressources nationales, et à la collecte de données. Que la FCSII et ses organisations membres :**

- *Organisent une table ronde nationale sur la violence dans le secteur de la santé.*
- *Élaborent et diffusent une stratégie de communication afin d'attirer l'attention, à l'échelle du pays, sur le problème de la violence envers le personnel infirmier.*
- *Mettent en lumière les pratiques exemplaires dans les secteurs des soins de santé grâce à une trousse nationale de prévention de la violence.*
- *Mènent un sondage à l'échelle du pays pour recueillir des données de chaque province sur la violence au travail.*

En qualité d'infirmières et d'infirmiers, nous voulons prendre soin de nos patients et les aider à guérir. Lorsque nous faisons l'objet de violence, et de ses répercussions physiques et psychologiques, notre capacité à dispenser des soins de qualité est affectée. La violence joue un rôle dans le burnout, l'usure de compassion, la dépression et le TSPT, et cela nuit à notre capacité de dispenser des soins de qualité et protéger la santé et le bien-être de nos patients. Comme nous l'a rappelé le juge Archie Campbell qui a présidé la Commission sur le SRAS en Ontario : si les travailleurs de la santé ne sont pas en sécurité, les patients ne le sont pas non plus. Si l'industrie minière peut mettre en application des normes strictes en matière de santé et de sécurité au travail afin d'assurer la sécurité des travailleurs, alors nous, en qualité d'infirmières et d'infirmiers, méritons aussi des milieux de travail qui ont une tolérance zéro par rapport à la violence.

Le changement ne se fera pas facilement. Nous travaillons dans des milieux où la violence est normalisée. Et où d'autres infirmières peuvent nous dire de « l'avalier ».

**En qualité d'infirmières et d'infirmiers, nous rejetons l'idée que la violence « fait simplement partie du travail », et nous allons faire partie de la solution!**

**- Linda Silas, Présidente de la FCSII**

Nous avons besoin d'un changement radical à la culture des milieux de travail infirmiers. Il faut passer d'une culture qui réagit à la violence après coup à une culture qui fait la prévention de la violence avant qu'elle n'arrive. Pour que cela se concrétise, nous allons devoir collaborer – gouvernements, employeurs, syndicat et, oui, personnel infirmier. Pour les infirmières et les infirmiers aux premières lignes qui doivent gérer la violence, le changement commence avec eux, à chaque jour, lorsqu'ils se rendent au travail.

À quoi ressemble un changement de culture positif?

Le rapport présente l'exemple de l'Hôpital Michael Garron en Ontario (anciennement Hôpital général Toronto East) qui a mis en place un programme de prévention de la violence, élaboré en collaboration avec l'Association des infirmières et des infirmiers de l'Ontario. Parmi les principales caractéristiques, mentionnons une formation complète aux premières lignes, signalement, évaluations préventives des risques, meilleures technologies de communication, meilleure élaboration de plan de soins pour les patients ayant des antécédents de comportements violents, ainsi qu'un personnel de sécurité formé adéquatement et offrant du soutien. Le résultat est une culture de travail proactive et réceptive. Ce n'est peut-être pas parfait – certes, il faut faire davantage – mais cet exemple est une feuille de route pour amorcer le changement. Il illustre ce qui peut être accompli lorsque les employeurs et les syndicats collaborent pour amorcer un changement systémique dans le but de prévenir la violence dans les milieux de travail infirmiers.

J'aimerais remercier Carol Reichert, auteure de *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*, l'équipe de projet de la FCSII, et les membres du réseau de la FCSII en matière de santé et de sécurité au travail, notamment Dewey Funk (IIUA), Denise Dick (SIIS), Tom Henderson (SIIM), Erna Bujna (AIIO), Jennifer Dickison (SIINB), et Paul Curry (SIINÉ), pour leur contribution à ce rapport qui se veut un Appel à l'action pour la FCSII, ses organisations membres et les infirmières et les infirmiers de partout au Canada.

En qualité d'infirmières et d'infirmiers, nous rejetons l'idée que la violence « fait simplement partie du travail », et nous allons faire partie de la solution!

Toujours solidaire,



Linda Silas  
Présidente de la FCSII


## 10. EXECUTIVE SUMMARY (FRENCH)

La violence augmente dans le secteur de la santé; la violence – qu'elle soit verbale, physique ou les deux – est chose quotidienne dans nos établissements de santé d'un océan à l'autre. Dans les hôpitaux de l'Ontario seulement, le coût de la violence se chiffre à 23,8 millions de dollars par année, et représente 10 % des absences résultant de blessures. Le manque d'effectifs, la dotation inadéquate, le peu de sécurité, l'augmentation du nombre de patients, ainsi que l'augmentation de l'acuité et de la complexité des besoins des patients, sont tous des facteurs qui contribuent à diminuer la sécurité des patients et du personnel. La situation est particulièrement problématique dans les salles d'urgence et les établissements psychiatriques. Les salles d'urgence sont aux premières lignes des soins de santé. Puisque n'importe qui peut y entrer facilement, les risques sont inconnus et difficiles à évaluer. Les patients des salles d'urgence sont stressés, ressentent souvent de la douleur, et doivent gérer de longs délais d'attente dans des salles surpeuplées. Les policiers y amènent souvent des personnes impliquées dans des altercations, sous l'effet de la drogue, ou souffrant de maladies mentales, et les laissent aux mains du personnel des urgences. Les établissements ou services psychiatriques, qui s'occupent de patients ayant des problèmes de santé mentale, présentent aussi un potentiel élevé de violence. Finalement, dans les établissements de soins de longue durée, la violence se vit au quotidien, surtout si les effectifs infirmiers ne se sont pas harmonisés à l'augmentation du nombre de patients – souvent une ou deux infirmières pour dispenser des soins à 100 personnes – ni à l'augmentation de l'acuité des besoins des patients.

Les répercussions de la violence, de l'intimidation et de la violence conjugale au travail affectent tous les infirmières et les infirmiers et le milieu de travail. Elles contribuent au nombre élevé de blessures entraînant un arrêt de travail. Les statistiques 2015 de l'Association des commissions des accidents du travail du Canada (ACATC) sur les absences résultant de blessures indiquent que les secteurs des services de santé et des services sociaux sont au sommet de la liste avec 41 111 blessures ayant entraîné un arrêt de travail, ce qui représente 18 % des absences en raison de blessures. Ce record

peu flatteur a été maintenu par le secteur des services de santé et des services sociaux depuis plusieurs années. En 2015, le nombre d'absences en raison de blessures avait plus que doublé chez les travailleurs de la santé de première ligne, comparativement aux policiers et aux agents de correction confondus. Plus important encore, pendant que le nombre d'absences en raison de blessures chez les policiers et les agents de correction confondus est demeuré relativement stable au cours de la dernière décennie, le nombre d'absences en raison de blessures chez les travailleurs de la santé de première ligne continue d'augmenter d'une année à l'autre (voir Tableau 1). Les blessures entraînant un arrêt de travail contribuent aux taux élevés d'absentéisme chez le personnel infirmier du Canada. En 2016, le taux d'absentéisme chez le personnel infirmier à temps plein du secteur public était de 8,8 %, soit un taux substantiellement plus élevé que le taux moyen pour les autres professions (6,7 %). Le coût annuel est estimé à 989 millions de dollars.

Bien que l'on soit de plus en plus conscient du problème de la violence dans les établissements de santé au Canada, la législation, les politiques, les pratiques et la mise en application accusent un retard. La violence est un danger professionnel. Toutes les lois en matière de santé et de sécurité au travail des provinces, sauf du Nouveau-Brunswick, le reconnaissent. Selon la FCSII, les employeurs devraient déployer des efforts pour diminuer et, ultimement, éliminer tout type de violence. Les infirmières et les infirmiers ont le droit de travailler dans un milieu exempt de tout type et de toute source de violence, d'intimidation, de harcèlement, de violence verbale qu'importe la source (patients, familles, médecins, collègues, gestionnaires) ou l'origine (à l'intérieur ou à l'extérieur de l'établissement). La violence au travail a un impact sur le personnel et les patients. Elle affecte la qualité des soins et a un impact négatif sur les résultats de santé. Comme l'a si bien énoncé le juge Archie Campbell, qui a présidé la Commission d'enquête sur le SRAS en Ontario, "si les travailleurs ne sont pas protégés contre les risques à la santé et à la sécurité, les patients et le public ne sont pas protégés non plus." Des milieux de travail dangereux et violents sont dangereux pour tous.



Selon les études, la situation par rapport à la violence et à l'intimidation s'est envenimée au cours des deux dernières décennies. Malheureusement, parce que les agences gouvernementales pouvant mener une enquête approfondie sur la santé du personnel infirmier n'ont pas agi pendant plus d'une décennie, la FCSII doit combler le vide et dresser un portrait fragmenté des milieux de travail rongés par la violence. Une image émerge des données disponibles, une image montrant le personnel infirmier faisant l'objet de violence physique et verbale sur une base régulière, ce qui engendre un milieu dangereux pour le personnel infirmier et des risques potentiels à la santé et à la sécurité des patients. Tous les travailleurs de la santé sont affectés par l'augmentation de la violence dans les établissements de santé, et les taux de violence sont liés à la durée du contact avec les patients. Par conséquent, et par définition, le personnel infirmier réglementé et les aides-infirmières courent le plus grand risque de faire l'objet de violence.

Nous savons que la violence est présente – nous savons quels travailleurs sont le plus à risque – et nous avons des exemples positifs de mesures qui aident à diminuer la violence envers le personnel de la santé. Par conséquent, il est déplorable de voir que les gouvernements n'agissent pas de façon concertée à cet égard. En l'absence d'une mise en application musclée et régulière de la législation provinciale en matière de santé et de sécurité au travail, et de la législation fédérale connexe (projet de loi C-45), plusieurs employeurs refusent de reconnaître l'ampleur du problème, et certains imposent le silence au personnel infirmier. En qualité d'infirmières et d'infirmiers, nous ne serons pas réduits au silence; nous allons prendre la parole et dénoncer les actes de violence.

L'énoncé de position commun de la FCSII et de l'Association des infirmières et infirmiers du Canada sur la violence et l'intimidation demande la tolérance zéro par rapport à la violence au travail dans le secteur de la santé. On peut y lire qu'il est « inacceptable de financer, d'administrer et de gérer un système de santé offrant un milieu de travail malsain, ainsi que d'y travailler ou d'y recevoir des soins ». Pour les besoins de ce texte,

la violence est définie comme l'exercice d'une force physique par une personne, et contre un travailleur, dans un lieu de travail, et qui entraîne ou peut entraîner une blessure physique à la victime; la violence peut aussi prendre la forme de violence verbale. La violence physique et la violence verbale ont des répercussions psychologiques et émotionnelles. L'énoncé de position commun de la FCSII et de l'AIIC sur la violence et l'intimidation définit l'intimidation comme un « harcèlement psychologique général »; l'intimidation est une « forme d'agression physique et de maltraitance ». Les taux élevés d'intimidation dans le secteur des soins de santé sont un défi pour les services des ressources humaines et les employeurs qui tentent de maintenir en poste un nombre limité de ressources.

En l'absence de données suffisantes et complètes sur la violence envers les travailleurs de la santé du Canada, et à la lumière des approches fragmentées pour régler le problème, ce document vise à combler l'écart en racontant le vécu des personnes les plus touchées, notamment les infirmières et les infirmiers de première ligne. Ce document vise à déclencher une discussion nationale sur la violence dans le secteur de la santé, une discussion qui rassemble les expériences disparates d'un océan à l'autre, et qui met en relief l'étendue et l'intensité des répercussions de la violence au travail. De plus, ce document représente un appel à l'action à l'échelle nationale. En qualité de fédération nationale des syndicats infirmiers, représentant près de 200 000 professionnels de la santé de première ligne, et étudiants en sciences infirmières, la FCSII demande aux gouvernements, aux employeurs, aux syndicats et au personnel infirmier de première ligne de collaborer pour mettre fin à la violence dans le secteur de la santé. La violence ne devrait jamais « faire partie du travail »!



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CANADIAN FEDERATION  
OF NURSES UNIONS  
LA FÉDÉRATION CANADIENNE  
DES SYNDICATS D'INFIRMIÈRES  
ET INFIRMIERS

**TAB 216**

# Emergency departments are in crisis now and for the foreseeable future

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In recent weeks, hundreds of emergency physicians in Canada have signed open letters describing their inability to provide safe and timely care in overcrowded and understaffed emergency departments across the country.<sup>1,2</sup> Despite the World Health Organization's recent announcement of the pandemic emergency coming to an end, Canadian emergency departments face another summer of record-setting wait times and closures.<sup>3</sup> June to August will be precarious and exhausting months for emergency care providers, with dire consequences for health system functioning, patient outcomes and provider well-being.

After a dramatic decrease in April 2020, emergency department visits in Canada returned to baseline volumes by the summer of 2022.<sup>4</sup> Despite this return to baseline, the capacity of emergency departments to provide care has been outstripped. Hospital staffing shortages and resulting bed closures have meant admitted patients are subjected to much longer emergency department stays.<sup>4,5</sup> In addition to other contributors, the inability to move admitted patients from emergency beds has resulted in crowding and increased wait times and prevented the delivery of timely and effective care. These problems are plaguing Canada's health care system.<sup>5</sup> This perpetual cycle is not news to most people in Canada, as it is pervasive, has lethal consequences and will continue to exhaust Canadian emergency services and providers.<sup>5</sup>

As an emergency physician I've observed that the trends in use of emergency departments have also changed. Before the pandemic, increased use occurred predictably during influenza season and, to a lesser extent, in the summer months, when patients had reduced access to their usual health care providers and when injuries were more likely to occur.<sup>6</sup> The peaks were brief and sharp and were buffered by long troughs.<sup>6</sup>

Unlike these short accelerations followed by rapid declines, emergency departments now operate at peak occupancy for weeks at a time.<sup>7</sup> Patient volumes may briefly return to expected levels but quickly rise again, offering little buffer for hospitals to clear backlogs, or for emergency care providers to recover from the moral injury that occurs when they must treat sick patients in waiting rooms and feel unable to provide high-quality care in overwhelmed emergency departments.<sup>5</sup> The summer months

now also bring a higher risk for climate-related disasters, like the heat dome of 2021 or the wildfires that have already resulted in widespread evacuations this spring, that can quickly exceed the capacity of emergency services and hospital resources.<sup>8,9</sup>

This new pattern contributes to the human resource crisis faced by emergency departments, as evidenced by the substantial number of closures of rural and medium-sized emergency departments and of sections of large-volume emergency departments in the summer of 2022.<sup>3</sup> Measures recently put forward by the federal or provincial governments, such as recruitment of health care workers internationally or expansion of health care workforce training programs, are unlikely to prevent the same closures in the summer months ahead.<sup>10,11</sup>

Attempts to mitigate the effects of this crisis on patients and providers have been made in rural areas of BC and Ontario. In April 2020, BC launched Real-Time Virtual Supports, which includes 4 programs that provide on-demand clinical support for emergency providers working in rural, remote and Indigenous communities throughout BC.<sup>12</sup> This basket of virtual supports is aimed primarily at advancing equitable access to care in BC; an additional goal is to increase recruitment and retention of the rural health care workforce. Based on interviews of participants using the peer-to-peer pathways, the programs are building capacity, establishing relationships between providers and strengthening the community of practice in rural emergency care.<sup>13</sup>

Another pragmatic program that has promise to support rural emergency physicians in Ontario is the Emergency Department Peer-to-Peer program, launched in October 2022.<sup>14</sup> This program supports 56 rural and remote emergency departments and gives physicians access to immediate, on-demand peer coaching for all patient acuity levels. Perhaps the program's secret sauce is that peers are trained to answer the call with, "How can I help?". Thus, in addition to receiving clinical guidance from a provider with rural experience, callers also feel supported when caring for sick patients in rural hospitals.

These attempts, while laudable, fall short of the necessary, system-wide response to the current crisis, which has been decades in the making and was predicted by emergency personnel and accelerated by the pandemic.<sup>15</sup> For physicians and

nurses working in emergency departments in Canada, no end is in sight for growing patient volumes and crowding, and the demand for emergency care exceeds the capacity of emergency medicine health human resources in all regions of Canada now and for the foreseeable future.

Thus, practical and immediate steps must be taken at all levels of the health care system to mitigate harms caused by long wait times for emergency care, to build buffers within emergency services to accommodate external disasters in an already strained system, and to protect the emergency health care providers who are continuing to shoulder the prolonged demand for emergency services that have emerged in the wake of the pandemic.

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CANADA

## Other programs can help uninsured, Ontario health minister says as coverage to end

By Liam Casey • The Canadian Press

Posted March 27, 2023 12:13 pm ✓

3 min read



Ontario Health Minister Sylvia Jones makes an announcement on health-care in the province with Premier Doug Ford in Toronto, Monday, Jan. 16, 2023. Jones says the province will not reverse course on cutting a program that provides care for people without health insurance. . **THE CANADIAN PRESS/Frank Gunn**

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TORONTO — The decision to end funding for a program that provides care for patients without **health insurance** will not be reversed, Ontario's health minister said Monday as she defended the move that's come under fire from the province's doctors.

Sylvia Jones said uninsured patients can still receive health care through other programs after the Physician and Hospital Services for Uninsured Persons Program ends this Friday.

"There's no change in the way that uninsured persons will receive care in the province of Ontario, the only change is how hospitals, community health, and midwifery centres will be reimbursed for ensuring and providing that care," Jones said in the legislature's question period on Monday.

Hospitals cannot refuse care to a patient who has a life-threatening emergency and there are community-based programs to help those without a health card get primary care, Jones said.

STORY CONTINUES BELOW ADVERTISEMENT



The province informed Ontario's doctors about its decision to end the program last Friday, which caught them by surprise.

The Ontario Medical Association had asked for a six-month extension to work on a better solution for the uninsured. Its president said ending the program would be detrimental to those who do not have health coverage.

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The association has said those who are uninsured include people who are homeless, those facing language barriers or mobility issues, many newcomers, migrants and international students.

Under the program — introduced in March 2020 when the pandemic hit — 7,000 doctors billed the province for providing some 400,000 patient services, the OMA said.

**The latest health and medical news emailed to you every Sunday.**

Jones and Dr. Rose Zacharias, the president of the association, spoke by phone over the weekend about the issue.

“The OMA feels the decision to end the program will be detrimental to the livelihood of marginalized Ontarians who often face the greatest barriers in our society,” Zacharias said Monday.

“Instead, the government will rely on the goodwill of physicians who often exercise a moral obligation to care for uninsured persons without being compensated.”

STORY CONTINUES BELOW ADVERTISEMENT



The program cost \$6.8 million in 2020-21, \$6.3 million in 2021-22 and \$2.7 million so far this year, the OMA said.

The association is still asking the government to reverse its decision.

Jones said after question period that the program would not be extended.



3:09

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She said the program was put in place to help reduce the spread of COVID-19 at a time when movement outside Ontario was restricted due to border closures.

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She said there are other programs already in place that can help the uninsured get health care.

“That could be through an emergency department, that can be at over 75 community health care centres that operate in the province of Ontario today, right now, and are funded to ensure that people can get access without an OHIP card,” Jones said.

STORY CONTINUES BELOW ADVERTISEMENT

But those community health centres are not an adequate substitute, said Dr. Michaela Beder, a psychiatrist who works with marginalized patients in Toronto.

“There’s just not enough of them, many, many people will not be able to access care through these centres,” said Beder, who is also part of Healthcare 4 All Coalition, a collective of health-care workers who advocate for permanent access to health care.

“This is a devastating cut \_ cutting this program will cause suffering and might cost people their lives.”

Doctors said the soon-to-be-cancelled program has been wildly successful.

The issue of providing care for those without insurance or with lost or expired health cards has been a decades-long problem that the province had seemingly solved with the program, they said.

“The uninsured program was a very welcome and progressive policy to ensure that people could get better access during a global pandemic,” said Dr. Andrew Boozary, the executive director of social medicine at University Health Network.

“You can’t pull this back completely and believe there are not going to be serious consequences for people who are already very marginalized and structurally vulnerable.”

Boozary said the policy helped uninsured individuals feel comfortable enough to go to a clinic to get vaccinated against COVID-19 or to receive treatment for another illness.

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“This policy saves lives because it removes barriers,” he said.

Doctors and the OMA are hopeful something can be salvaged by Friday.

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 JOURNALISTIC STANDARDS

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**TAB 218**

# Recommendations for Radiation Peer Review



Guidance Update

May, 2021

# ACKNOWLEDGEMENTS

Radiation Treatment Program, Ontario Health (Cancer Care Ontario)

Peer Review Quality Assurance Team, Ontario Health (Cancer Care Ontario)

Members of the Radiation Oncology Provincial Advisory Committee (ROPAC), Ontario Health (Cancer Care Ontario)

# EXECUTIVE SUMMARY

Radiation oncology peer review consists of the evaluation of a radiation treatment plan by a peer radiation oncologist to ensure that the plan is appropriate from both patient safety and treatment effectiveness perspectives.

This guidance document outlines the required quality standards for radiation oncology peer review across Ontario. This document is intended for Ontario Health (Cancer Care Ontario) (OH (CCO)) staff, Regional Cancer Centre (RCC) leadership, data administrators, clinicians, as well as others who require context around radiation oncology peer review in Ontario. The document builds upon the [Radiation Oncology Peer Review Guidance Document](#) developed in 2013, recognizing that peer review is now a standard of care for radiation treatment in Ontario.

The document provides a brief background and evidence-base for peer review, and outlines the recommendations for peer review from a broad radiation programmatic perspective. The recommendations aim to provide high-level guidance on the key elements of peer review, while allowing for flexibility in their implementation based on local and regional contexts.

The recommendations are organized into the following sections:

- Case selection
- Peer review process
- Roles and responsibilities of team members
- Data and documentation recommendations

The document concludes with some comments regarding provincial oversight, and potential future directions.

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# BACKGROUND

Radiation oncology peer review ('peer review') consists of the evaluation of the radiation treatment (RT) plan to ensure it is appropriate from both patient safety and treatment effectiveness perspectives. Peer review is designed to:

- Improve patient outcomes (efficacy and safety) by improving the quality of radiotherapy plans;
- Facilitate education for other RT team members;
- Ensure robust processes and quality improvement initiatives; and,
- Support best practice sharing, collaboration and open communication.

The evidence base supporting the effectiveness of peer review in achieving these outcomes includes data from Ontario, other provinces, and other countries. A reference list that includes selected key publications is included in the appendix.

While peer review requires an organizational culture that allows and encourages review of physician decisions from an inter-professional perspective, the responsibility of patient care remains with the attending oncologist, and recommendations from peer review will be implemented at their discretion.

The rationale for updating the Peer Review Guidance document stemmed from input received within the Radiation Oncology Provincial Advisory Committee (ROPAC). The ROPAC is responsible for advising the Provincial Head of Radiation Treatment Program on all matters relating to the discipline specific planning, implementation, and delivery of radiation services in Ontario. This has led to interviews conducted with Radiation Oncology Leads and respective team members from 12 cancer centres, to achieve saturation with respect to themes emerging during the interviews responses. The interview summary and proposed recommendations were brought forward to the Provincial Radiation Treatment Program Committee (PRTPC), where they were approved.

## Purpose

This guidance document outlines the required quality standards for radiation oncology peer review across Ontario. This document is geared towards Ontario Health (Cancer Care Ontario) (OH (CCO)) staff, Regional Cancer Centre (RCC) leadership, data administrators, clinicians, as well as others who require context around radiation oncology peer review in Ontario. The document is meant to build upon the [Radiation Oncology Peer Review Guidance Document](#) developed in 2013, given that peer review is a standard of care for radiation treatment in Ontario.

## Scope of Work

The document outlines the recommendations for peer review from a broader radiation programmatic perspective. For disease-specific peer review guidance for breast, head and neck and lung, please refer to the reporting section of the [Radiation Treatment Program Website](#).

## Key Terms

The following are definitions of key terms used throughout the document:

- **Peer review:** The evaluation of the clinical decision, contours (e.g., target, Organs at Risk (OARs)), and dosimetry of a radiation treatment plan by a second radiation oncologist. For the

purpose of this document, review of the clinical decision alone (e.g., at a multidisciplinary case conference) is not sufficient for meeting the criteria for radiation oncology peer review.

- **Primary Cases:** Peer review of a treatment plan targeting the primary cancer and regional nodes if relevant. For simplicity, all primary treatment plans are considered complex, even in simple radiation techniques are used for palliation of the primary tumour.
- **Metastatic Cases:** Peer review of a new tumour and/or disease that has spread distant to the primary.
  - **Complex Cases:** Complex cases refer to the treatment of metastatic disease with high precision techniques (e.g., Stereotactic Body Radiation Therapy (SBRT), Intensity Modulated Radiation Therapy (IMRT)) for sites such as brain, lung, liver and spine metastases, high doses per fraction, or re-treatment of metastases.
  - **Simple Cases:** Simple cases refer to all other metastatic treatment plans not falling under the “complex” category.
- **Inter-professional:** Refers to the peer group in radiation oncology, which typically consists of Radiation Oncologists, Physician Residents, Medical Physicists, Dosimetrists, and Medical Radiation Therapists. Nurses, while key members of care teams, are generally not involved in the peer-review process for radiation planning. Some elements of peer review can be delegated to members of the team with specific competencies based on departmental considerations.

## RECOMMENDATIONS

The following recommendations aim to provide high-level guidance on the key elements of peer review, while allowing for flexibility in their implementation based on local and regional contexts. They are organized into the following sections:

- Case selection;
- Peer review process; and,
- Roles and responsibilities of team members.

### Case Selection

The following recommendations will clarify which types of peer review should be conducted for which types of cases.

1. All treatment plans administered with primary intent should be reviewed. The target metric of 80% is based on striving for 100%, recognizing that this is not always possible.
2. All metastatic plans that are complex in nature (see categories below) should be reviewed (also with a target metric of 80%).
3. Selected simple metastatic plans should be reviewed (target 20%). Each radiotherapy program is expected to have a process for either random or targeted selection of these cases according to local program operations. An example of targeted selection includes re-treatment plans.

4. Peer review should occur before the start of treatment or prior to 25% of the total prescribed dose has been delivered. Additional peer review may occur at any point during treatment as issues and/or concerns about the treatment are identified (e.g., Cone Beam Computed Tomography (CBCT) review).

### Categories of Peer Review Cases

In the *Peer Review Guidance* (2013), cases selection for peer review were classified as either Radical or Palliative. In the current document, the categories have been revised into Primary and Metastatic with “simple” and “complex” under metastatic peer review. In alignment with the development of the Radiation Treatment Quality Based Procedure (RT QBP), peer review methodology has undergone a few noteworthy changes. As of April, 2021, peer review will be reported at the protocol level. As such, for multi-phase protocols, as long as the first course is peer reviewed, the entire protocol will be flagged as peer reviewed. As well, the peer review intent has been revised from Radical and Palliative (simple, complex) to Primary and Metastatic (simple, complex). The below five protocols have been classified as simple metastatic at the protocol level:

#### Simple Metastatic:

RT_PROTOCOL_CD	RT_PROTOCOL_DESC
BONE_MET_CON_SINGLE	Bone Mets- conventional RT- single
UNSPEC_MET_MULT_FRAC	Unspecified Met- conventional RT- multiple (not liver, bone, or brain)
UNSPEC_MET_SINGLE	Unspecified Met- conventional RT- single (not liver, bone, or brain)
BONE_MET_CON_MULTI	Bone Mets- conventional RT- multiple fractions
CNS_BRAIN_MET_WBRT	CNS Brain Mets-Whole brain

All other Metastatic protocols that do not fall under the simple level will be classified as complex. The timing of peer review (e.g., prior to 25% of treatment delivery) will be based on the number of fractions in the reviewed protocol, or the fractions in the first course for multi-phased protocols. For simplicity, all primary plans will be considered as complex, even if simple palliative techniques are occasionally employed.

Please refer to the recent targets in Table 1. These revised categories aim to better reflect treatment complexity, disease progression, and technique involved.

**Table 1. Peer Review Targets (FY 21/22)**

Fiscal Year:	1. Primary Peer Review Provincial Performance Target	2. Simple Metastatic Peer Review Provincial Performance Target	3. Complex Metastatic Peer Review Provincial Performance Target
2021/2022	80%	20%	80%

## Peer Review Process

Peer review can occur in using a variety of approaches:

- **One-on-One Peer Review**

**Description:** A second Radiation Oncologist reviews the primary Radiation Oncologist's treatment plan. This consists of an individualized process as per the centre's workflow (e.g., one-on-one meetings, review through patient chart, etc.).

- **Inter-Professional Team Peer Reviews**

**Description:** A group that consists of various RT disciplines such as Radiation Oncologists, Physician Residents, Medical Physicists, Dosimetrists, and Medical Therapists, meet and discuss presented treatment plans in an in-person and/or virtual format to validate treatment plans, particularly those treated with more complex techniques.

- **Inter-Institutional Peer Reviews**

**Description:** RT professionals from different institutions meet to discuss treatment plans. These inter-institutional peer reviews can occur in three ways: formal meetings (e.g., sarcoma), a joint meeting between a host and a partner centre, as well as informal meetings. It must include a robust and safe mechanism for facilitating the sharing of RT files. This approach is especially valuable for partner centres that lack certain expertise to gain access to centres with more experience in a particular disease site group/treatment technique for guidance and advice.

**Case study examples:**

- Royal Victoria Regional Health Centre & Sunnybrook Health Sciences Centre: Lung SBRT implemented jointly
- Royal Victoria Regional Health Centre & Princess Margaret Hospital: Collaboration around cervix cases
- Multiple Centres: Sarcoma peer review

- **Brachytherapy Peer Review:**

**Description:** Brachytherapy cases typically involve the applications of interstitial or intracavitary radiation. Current evidence indicates that specialized technology such as interstitial brachytherapy or two fraction brachytherapy High-dose-rate (HDR), elicits improved patient outcomes in some disease sites. It is strongly advised that all brachytherapy treatments be peer reviewed, even post hoc. Brachytherapy peer review has important implications for programmatic quality. This form of peer review involves an inter-professional team, whereby ROs are primarily responsible for evaluating quality.

## Roles and Responsibilities during Peer Review

- All members of the team have a role in informing the peer review process.
- The peer review process is enhanced when it occurs in an inter-professional setting with participation from Medical Radiation Therapists and Medical Physicists.
- There are certain opportunities to delegate roles within the peer review process to additional team members, as required. For instance, Clinical Specialist Radiation Therapists (CSRTs) can take on advanced directives from physicians around the triage and preliminary review of peer review cases.
- Recommended team positions are outlined below:

Role	Description	Recommended Team Member
Most Responsible Provider	<ul style="list-style-type: none"> <li>• Leadership around patient safety and appropriate care decisions</li> <li>• Liaise with inter-professional team, particularly as complexity of care increases</li> </ul>	<ul style="list-style-type: none"> <li>• Radiation Oncologist or delegate (e.g., CSRT)</li> <li>• <i>Example:</i> Refer to the Walker Family Cancer Centre-Palliative CSRT roles and responsibilities in Appendix</li> </ul>
Coordination and Case Triage	<ul style="list-style-type: none"> <li>• Assisting in inter-professional coordination of cases for peer review</li> </ul>	<ul style="list-style-type: none"> <li>• Radiation Therapist, QA coordinator</li> </ul>
Technological Safety and Support	<ul style="list-style-type: none"> <li>• Alignment of technological applications to ensure appropriate treatment and safety measures</li> <li>• Applicable analysis and reporting</li> <li>• Treatment modifications, as required</li> </ul>	<ul style="list-style-type: none"> <li>• Medical physics</li> </ul>
Image and Plan Coordination	<ul style="list-style-type: none"> <li>• Provide image cataloguing as required</li> <li>• Support equipment/treatment QA of complex plans</li> </ul>	<ul style="list-style-type: none"> <li>• Dosimetrist</li> </ul>
Treatment Provision	<ul style="list-style-type: none"> <li>• Make care decisions based on peer reviewed plan</li> <li>• Adjust treatment parameters (e.g., positioning of patient), as required</li> </ul>	<ul style="list-style-type: none"> <li>• Radiation therapist, Radiation Oncologist</li> </ul>
Administration and Data Management	<ul style="list-style-type: none"> <li>• Support broader peer review program agenda, in relation to organizational plan/strategies</li> <li>• Support patient safety goals and expectations</li> </ul>	<ul style="list-style-type: none"> <li>• Health administrator, manager, and/or delegate</li> </ul>

	<ul style="list-style-type: none"> <li>• Monitor peer review data on an ongoing basis, and use as a platform for key decision making</li> </ul>	
Information Technology Support	<ul style="list-style-type: none"> <li>• Ensure appropriate functionality and connectivity of systems to support peer review</li> </ul>	<ul style="list-style-type: none"> <li>• IT professional, QA coordinator</li> </ul>

## Documentation

- The peer review process includes communication of recommendations to the attending oncologist (who may accept or decline to adopt the recommendations in accordance with their role as attending)
- Documentation of peer review may include: documentation indicating that peer review has occurred, recommended changes, as well as the outcome of the recommendations (e.g., plan changed or plan has not changed)
- Documentation may occur in the medical record, the treatment record, or offline, but should be consistent across cases.

## Peer Review Data

- The collection of peer review outcome data (e.g., change is recommended) by Regional Cancer Centres (RCCs) is strongly recommended
  - Peer review outcomes should be recorded and regularly reviewed by the centre, according to specific institutional practices
- RCCs are strongly encouraged to analyze centre-specific peer review outcomes, and factor in results into programmatic improvement initiatives and monitoring
- Data and quality expectations around peer review may be cross referenced with the [Canadian Partnership for Quality Radiotherapy \(CPQR\)](#) and [Accreditation Canada guidance](#).

## Provincial Oversight

- The mandate of OH (CCO) is to work alongside its provincial partners in order to effectively connect and coordinate parts of the health care system to ensure that Ontarians receive the best care possible. The collaboration between OH (CCO) and RCCs will help facilitate local peer review to ensure patient safety and treatment effectiveness.
- Peer Review aligns with the following strategic objective of the “Safe” goal in the [Ontario Cancer Plan 2019 to 2023](#), and it is also a key area of focus within the [Radiation Treatment Program’s Implementation Plan 2019-2023](#)
  - Over the next 4 years, the program will work with RCCs to strengthen all aspects of the safe delivery of radiation treatment. A key focus is the advancement of safety through further development of the Peer Review Quality Assurance Program (introduced in 2013)

- As part of this goal, the work plan will focus on four initiatives:
  - 1) Define and document elements for best practice peer review in the primary and metastatic domains and develop a process to measure adherence to these recommendations;
  - 2) Develop and implement novel peer review strategies in other aspects of radiation treatment (e.g., medical physics and radiation therapy plan checks);
  - 3) Investigate the possible role of artificial intelligence approaches in peer review; and,
  - 4) Establish and facilitate peer review between regional cancer centres to support reduced variation in radiation treatment delivery across the province and facilitate the delivery of advanced treatment approaches closer to home.
- The mandate of RCCs is to address all aspects of safe radiation treatment planning and delivery, including:
  - The organization of radiation treatment programs
  - The qualifications of the personnel involved in radiation treatment
  - The performance of the planning and treatment equipment
  - Policies and procedures, and
  - Monitoring and reporting of incidents.

## FUTURE DIRECTIONS

In summary, the intent of the document is to highlight the required quality standards for radiation oncology peer review across Ontario. Future considerations for peer review must be centred on:

- The development of a robust and reliable process for the sharing of peer review data across provincial cancer centres
- Enhanced inter-institutional peer review processes consisting of robust and safe mechanisms for the inter-provincial sharing of RT files
- The role that automated peer review and artificial intelligence (AI) can play in enhancing the reliability of treatment planning, as well as identifying outliers

For more information on peer review, please consult the references outlined in the appendix.

# Appendix

PEER REVIEW GUIDANCE: PALLIATIVE RADIATION TREATMENT CASES  
WALKER FAMILY CANCER CENTER  
DEPARTMENT OF RADIATION MEDICINE (May 2021)

## Background:

Radiation Oncology palliative peer review of metastatic treatment plans is an essential component of quality assurance within the Radiation Medicine clinical program. Adherence to peer review at Walker Family Cancer Center (WFCC) is required to conform to the Canadian Partnership for Quality Radiotherapy, and the Accreditation Canada Q-mentum Module for Radiation Oncology. At WFCC, the Metastatic Disease Peer Review Program is managed by the Palliative Clinical Specialist Radiation Therapist (pCSRT). The pCSRT reviews **all** Palliative Treatment Plans prior to Radiation Oncologist peer review and radiation therapy treatment delivery. Patient priority, treatment complexity, retreatments and dose fractionation are essential components for the WFCC palliative peer review (PPR) process.

The implementation of the WFCC pCSRT **Electronic** Peer Review Process has provided an exemplary Quality Assurance Program consistently achieving above the Cancer Care Ontario provincial target rate.

## WFCC PPR Guidelines:

<b>SINGLE FRACTION</b>	<b>Prior to Treatment Delivery, all single fraction radiation plans require a second Radiation Oncologist treatment plan review</b>
<b>MULTI-FRACTION</b>	Prior to 25% Treatment Delivery, radiation plans require a second Radiation Oncologist Treatment Plan review

## WFCC PPR Electronic QA Process:

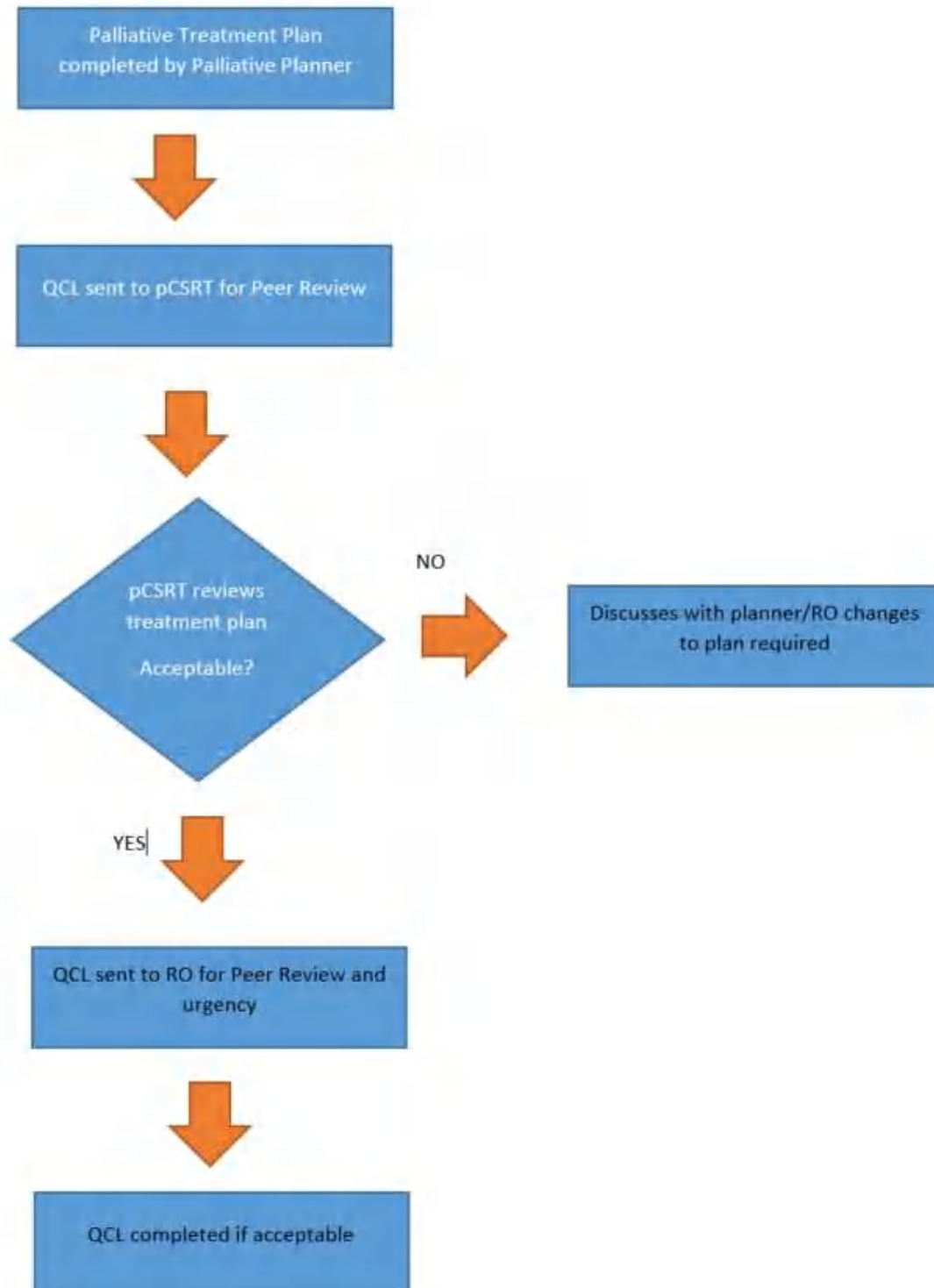
- Planner to call / qcl pCSRT for urgent palliative peer review (PPR)
- Non urgent cases require a QCL sent to pCSRT, attached to careplan
- pCSRT qcl's RO for Palliative Peer Review after initial QA with comments indicated in qcl
- pCSRT speaks with RO if discrepancy or concern of treatment plan
- Changes to treatment plan are communicated to pCSRT and treatment planner by RO

## pCSRT independent quality assurance of treatment plan reviews the following:

<b>RO Prescription Dose and Fractionation</b>
Beam arrangement
Beam energy
Clinical Target Volume
Organs at Risk (OARs)
Complexity: Retreatment/Overlap/BED/Composite Distribution
Pre Treatment Medication



## WFCC PALLIATIVE PEER REVIEW PROCESS



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**TAB 219**

## **Radiation Oncology**

**Call for New Data for Purpose of Relativity Calculation  
in the CANDI Model**

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# 1 Introduction and Rationale

Radiation oncologists are medical specialists with unique knowledge, understanding and expertise in the diagnosis and care of patients with malignant disease. They are integrally involved in the formulation and execution of the management plan of cancer patients and therefore require specific knowledge and skills in the application of ionizing radiation to cancer treatment. Using an evidence-based approach, they are responsible for the appropriate recommendation, prescription, clinical management and supervision of patients during and after delivery of therapeutic ionizing radiation.

The competent and ethical discharge of these responsibilities results in improved quality of life and/or survival for cancer patients, which in turn benefits families, society and future care. Typically, a radiation oncologist practices in a multidisciplinary fashion in close collaboration with general and subspecialty surgeons, medical and gynecological oncologists. Ambulatory patient care is the norm. Cancer centres, within the province of Ontario, are generally located in large cities.

Until 2002, radiation oncologists had been employees of the Ontario Cancer Treatment & Research Foundation (Ontario, Canada) and later Cancer Care Ontario (CCO). Beginning in 2002, radiation oncologists entered into a Physician Services Agreement with the Ministry of Health (Ministry) and on April 1, 2015 joined Medical Oncology and Gynecologic Oncology in the Provincial Oncology AFP (Appendix A). The Provincial Oncology AFP (POAFP) is to support the provision of high-quality and timely access to cancer care. In providing funding through both “**Base Funds**” and “**OHIP Approved Claims**” its purpose is to align funding with the provision of clinical services and to ensure provincial compensation levels for these specialties are managed within a contained human resources plan.

**With persistent confusion regarding the OHIP Approved Claims for Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322) used to remunerate radiation oncologists and the increasing CCO mandated targets to undertake radiotherapy treatment plan peer review, the support of the OMA was requested for the administration of a survey to better understand the impact on after-hours work.**

## 2 Funding

**“Base Funds”** are the funds provided for the provision of Clinical and Indirect Services in addition to other Activities. **“Clinical Services”** mean any Insured Service provided in a Hospital, or in any other hospital where the Group provides Insured Services, to an Insured Person at any time including during the On-Call Coverage period; and **“Indirect Services”** include those services ancillary to Clinical Services including: coordinating patient care with other health care providers; preparing for and attending multidisciplinary team conferences; communicating with other physicians, orally and in writing; communicating with the family of the patients but does not include counselling; medical dictation, charting and maintenance of patient records; and signing off patient charts on cancer staging. **“OHIP Approved Claim”** means a claim that a Physician submitted for a Clinical Service that OHIP has approved (Appendix A POAFP).

Unfortunately, confusion persists with regards to the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322) used to remunerate radiation oncologists for a series of tasks, including both direct preparation, and supervision of the preparation of a treatment plan, and all subsequent adjustments by any physician to that treatment plan during that complete course of treatment. The clinical activity remunerated by the planning fee codes is not a single event, and these tasks span the entire length of time of the treatment planning and delivery of a given course of radiotherapy (1 - Appendix B). However, the billing of the associated code will only occur at a single time point.

Given the nature of radiation treatment planning, and the normal operating hours of many departments of radiation oncology, some proportion of the time spent on the activities remunerated by the Radiation Treatment Planning fee codes occurs outside of daytime hours.

### Reference:

1. Report on Survey of Radiation Oncology Physicians prepared by OMA Economics November 11, 2013



### 3 Erroneous CANDI and RAANI Ranking

In 2013, the executive members of the Section on Radiation Oncology, including Drs. D'Souza, McGowan, Dinniwell, and Sun, met with senior OMA staff and elected members including the President, Dr. Doug Weir to advocate for a review of radiation oncology and relativity (1). The Comparison of Average Net Daily Income (CANDI), did not control for the way Treatment Planning Complexity Codes are used by Radiation Oncologists. Following this meeting, the OMA compiled additional data to better inform the modeling for and ranking of Radiation Oncology. The ranking was then revised based upon this data. Unfortunately, a review of the MOHLTC Physician Income Relativity Model Methodology and the Technical Notes raises the very same issue. The OMA has been requested to make the Panel aware of limitations with the MOHLTC Physician Income Relativity Model Methodology as it pertains to the After-Hours and Weekend Adjustment Factor for the work conducted by radiation oncologists, which results in an incorrect Relativity Adjusted Annual Net Income (RAANI) ranking for Radiation Oncology.

Both the earlier work of the OMA with their initial CANDI methodology and more recently with the MOHLTC and RAANI encounter challenges related to the inclusion of Daytime Radiation Treatment Planning Codes for the purpose of relativity calculations. The OHIP Schedule of Benefits does not differentiate between the Treatment Planning codes performed during daytime and after-hours. As a consequence of this limitation, the calculated daytime income becomes overstated if the full amount of these codes is included in the calculation. This concern also arises because of the nature of radiation treatment planning in the normal operating hours of many departments of radiation oncology, which suggest that some proportion of the time spent on the activities remunerated by these codes occurs outside of daytime hours.

Indeed, past studies (as described above) and more recent work demonstrate that the Radiation Treatment Planning codes (X310, X311, X312, X313) represent, on average, approximately 59% of total billings for Radiation Oncologists and about 51% of the Radiation Treatment Planning codes are provided during regular daytime hours (Appendix B).

The same error occurs in the RAANI ranking for Radiation Oncology, as in the CANDI methodology - improper metrics are being applied in relation to the Radiation Treatment Planning codes during regular daytime hours, thereby resulting in an incorrect RAANI ranking for Radiation Oncology.

#### Reference:

1. Report on Survey of Radiation Oncology Physicians prepared by OMA Economics November 11, 2013

## 4 Radiotherapy Peer Review

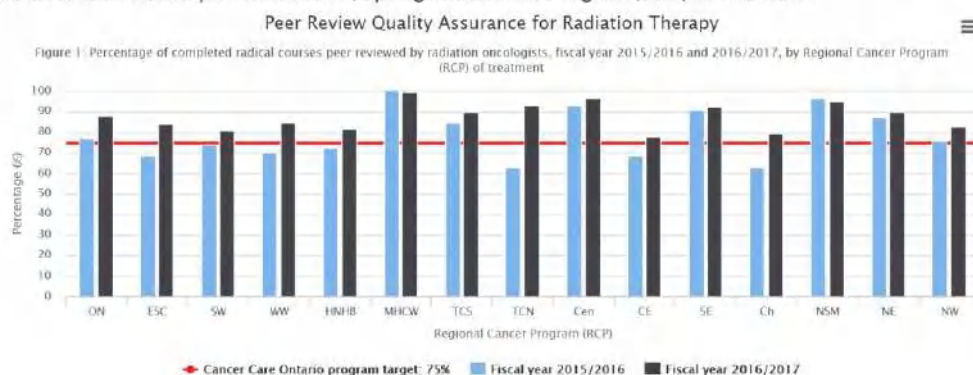
As a component of the Provincial Oncology AFP (POAFP), radiotherapy peer review is included as a developmental accountability. Radiotherapy peer review, if properly planned and implemented, can further the quality of care for all patients. The number of cases undergoing peer review continues to increase. Indeed, [in 2016/2017, more than 30,000 radical courses of radiotherapy were peer reviewed](#). The introduction of peer review for **complex and simple palliative courses** has increased this even further. Peer review is not currently funded. Data as to the impact of peer review on the clinical work undertaken by radiation oncologists, when it is done and how it impacts on the work outside of daytime hours (0700 to 1700) has previously been unavailable.

In the context of quality radiation treatment practice, the Cancer Care Ontario Radiation Treatment Program has defined peer review as the evaluation of components of the attending radiation oncologist's treatment plan by a second radiation oncologist, ideally with multidisciplinary input from physicists and radiation therapists. All radiation treatment plans administered with adjuvant or curative intent are to be considered for Radiation Oncologist peer review (Appendix C). Ideally, this is to occur before the start of treatment in all cases or before 25% of the total prescribed dose has been delivered. **CCO has mandated the performance of peer review for both radical and palliative cases.**

**For 2017, the targets for peer review were 75% of all curative cases with the introduction of a target of 30% for all palliative cases with the results publicly reported** (<https://www.csqi.on.ca/indicators/peer-review-quality-assurance-radiation-therapy>).

The overall Ontario average of curative cases undergoing peer review has increased year over year. In fiscal year 2015/2016, 77% of all curative cases were peer reviewed and in 2016/17 88% of all cases were peer reviewed (Appendix D). With the initiation of palliative peer review quality assurance, additional cases are now undergoing peer review. In March 2017, close to 30% of all palliative courses underwent peer review in Ontario.

Figure 1. Percentage of completed radical courses peer reviewed by radiation oncologists, fiscal year 2015/2016 and fiscal year 2016/2017, by Regional Cancer Program (RCP) of treatment



More information regarding the [methodology](#) is available.

**Report date:** December 2017

**Data source:** ALR

**Prepared by:** Analytics and Informatics, Cancer Care Ontario

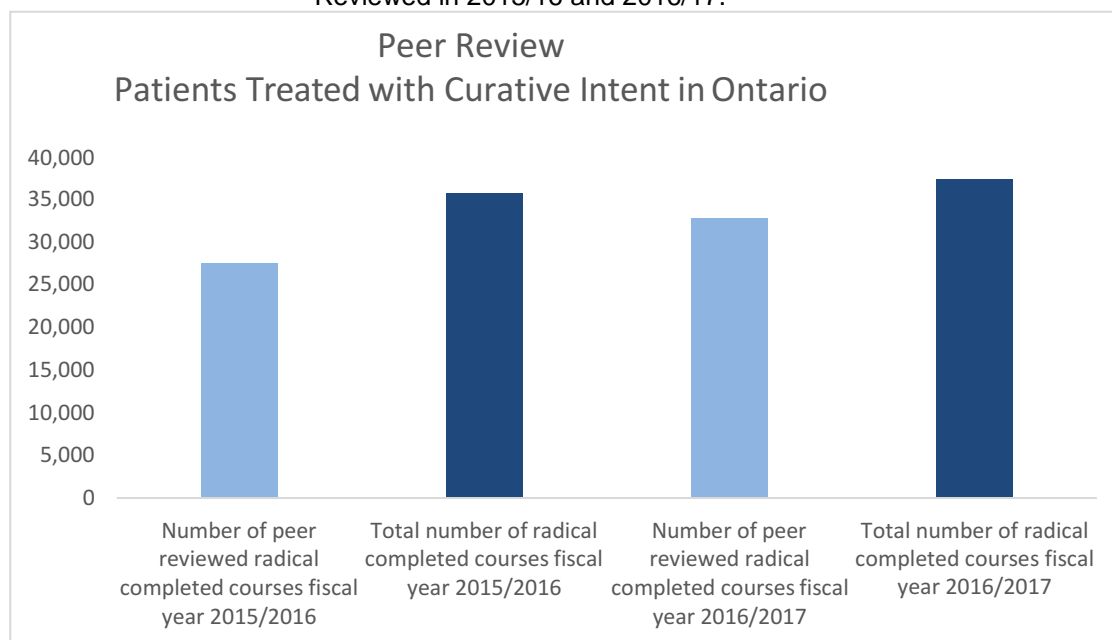
**Note:**

1. Fiscal years 2015/2016 and 2016/2017 data is based on the Activity Level Reporting (ALR) data cut in December 2017.

#### Data Sources:

- Peer Review Quality Assurance for Radiation Therapy ( <https://www.csqi.on.ca/indicators/peer-review-quality-assurance-radiation-therapy>, this website provides a detailed breakdown of radiotherapy peer review and relevant source material.)

Figure 2. Number of Courses of Radiotherapy Delivered with Curative Intent and Number of Courses Peer Reviewed in 2015/16 and 2016/17.



#### Data Sources:

- Peer Review Quality Assurance for Radiation Therapy ( <https://www.csqi.on.ca/indicators/peer-review-quality-assurance-radiation-therapy>, this website provides a detailed breakdown of radiotherapy peer review.)

## 5 Analysis and Conclusions

From November 12 to November 28, inclusive 207 radiation oncologists were invited to participate in a survey. At the close of the survey, 123 or 59.4% of radiation oncologists had participated with 115 or 55.6% completing it. The mean start and end times for a weekday were reported as 7:55AM and 6:17PM respectively with 80% of radiation oncologists reporting they work 6 or more hours outside of the work day (weekday (Monday to Friday), between 7:00 and 17:00).

For any given 7-day week, a mean of 59.5% and a median of 60% of total billings arise from the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322). A significant proportion of the work done (mean 47% and median 40%) relating to the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322) occurs outside of the work day (weekday (Monday to Friday), between 7:00 and 17:00).

All respondents (122) reported participating in peer review with 92% reporting that this participation has increased the volume of clinical activities that occur outside of the work day (weekday (Monday to Friday), between 7:00 and 17:00). Only 33% report having procedural protections for the peer review they undertake. During the week, a mean of 3.9 hours and a median of 3.0 hours are spent undertaking peer review for a mean and median of 3.8 and 3.0 different tumour sites respectively. The respondents note that this has resulted in a mean of 3.8 hours and a median of 3.0 hours of work being performed outside of the work day (weekday (Monday to Friday), between 7:00 and 17:00) due to peer review. 91% of all respondents reported participating in Multidisciplinary case review (two or more radiation oncologists +/- radiotherapy and physics staff meet on a recurring basis) (Appendices E to G).

### **Three main conclusions that arise from the survey are:**

- Radiation Treatment Planning code workload (X310, X311, X312, X313) continues to represent 59 to 60% of total billings for Radiation Oncologists;
- A significant proportion (mean 47%) of the Radiation Treatment Planning code workload is provided outside of regular daytime hours; and
- The conduct of unfunded peer review during daytime hours (mean 3.9 hours) is linked to a corresponding increase (mean 3.8 hours) of clinical activities undertaken outside of daytime hours. Not only does this impact upon income relativity as it pertains to after-hours and weekend adjustments for the work conducted by radiation oncologists but as importantly it is relevant to physician wellness and the need for organizational strategies to promote personal resilience-enhancing behaviors including limiting work hours or fund the work that is done.

## Results (Version #1.1)

November 30, 2018

### 1. Methodology:

#### 1.1 Statistical Analysis:

- ❖ Descriptive Statistics were generated for all survey questions for all participants (n=123) and stratified by academic institution (yes/no), FTE status (1.0 vs. < 1.0), and Position ((1) clinical vs. clinician scientist vs. administrative; (2) clinical vs. clinician scientist), compared using the chi-square test, Fisher's exact test, two-sample t-test or wilcoxon rank sum test, ANOVA or Kruskal-Wallis test as appropriate.
- ❖ All statistical analysis was performed using SAS version 9.4 software (SAS institute, Cary NC) using two-sided statistical testing at the 0.05 significance level.

Academic	Primary_Location	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0	Barrie	8	6.50	8	6.50
0	Grand River	2	1.63	10	8.13
0	Mississauga	7	5.69	17	13.82
0	Newmarket	5	4.07	22	17.89
0	Oshawa	8	6.50	30	24.39
0	St. Catherines	1	0.81	31	25.20
0	Sudbury	4	3.25	35	28.46
0	Thunder Bay	2	1.63	37	30.08
0	Windsor	3	2.44	40	32.52
1	Hamilton	6	4.88	46	37.40
1	Kingston	9	7.32	55	44.72
1	London	16	13.01	71	57.72
1	Ottawa	11	8.94	82	66.67
1	Toront- Odette	18	14.63	100	81.30
1	Toront- PMH	23	18.70	123	100.00

**Results:**

Table 1. Characteristics of all survey participants (n=123) stratified by academic institution (yes/no), FTE status (1.0 vs. < 1.0), and Position (clinical vs. clinician scientist vs. administrative).												
Characteristic	N	All Participants (n=123)	Academic (n=83)	Non-Academic (n=40)	p-value	FTE 1.0 (n=110)	FTE < 1.0 (n=12)	p-value	Clinical (n=97)	Clinician Scientist (n=19)	Administrative (n=6)	p-value All C vs. CS
<b>Academic – n(%)</b>												
Yes	123	83 (67.5)	83 (100)	--	--	76 (69.1)	7 (58.3)	0.519	59 (60.8)	19 (100)	5 (83.3)	< 0.001
No		40 (32.5)	--	40 (100)		34 (30.9)	5 (41.7)		38 (39.2)	0 (0)	1 (16.7)	< 0.001
<b>FTE Status – n(%)</b>												
1.0	122	110 (90.2)	76 (91.6)	34 (87.2)	0.519	110 (100)	--	--	86 (88.7)	19 (100)	5 (83.3)	0.238
< 1.0		12 (9.8)	7 (8.4)	5 (12.8)		--	12 (100)		11 (11.3)	0 (0)	1 (16.7)	0.207
<b>Position – n(%)</b>												
Clinical	122	97 (79.5)	59 (71.1)	38 (97.4)	< 0.001	86 (78.2)	11 (91.7)	0.234	97 (100)	--	--	--
Clinician Scientist		19 (15.6)	19 (22.9)	0 (0)		19 (17.3)	0 (0)		--	19 (100)	--	
Administrative		6 (4.9)	5 (6.0)	1 (2.6)		5 (4.6)	1 (8.3)		--	--	6 (100)	
<b>Supervision – n(%)</b>												
Yes	122	98 (80.3)	82 (98.8)	16 (41.0)	< 0.001	88 (80.0)	10 (83.3)	1.00	75 (77.3)	18 (94.7)	5 (83.3)	0.218
No		24 (19.7)	1 (1.2)	23 (59.0)		22 (20.0)	2 (16.7)		22 (22.7)	1 (5.3)	1 (16.7)	0.116
<b>% Billing X-Codes – mean ± SD, median, (IQR)</b>												
	122	59.5 ± 15.0 60.0 (50.0, 70.0)	57.2 ± 16.2 60.0 (50.0, 68.0)	64.4 ± 10.9 65.0 (60.0, 72.0)	0.005	59.8 ± 15.0 60.0 (50.0, 70.0)	57.1 ± 15.8 59.5 (40.0, 72.5)	0.553	59.6 ± 15.1 60.0 (50.0, 70.0)	59.3 ± 16.1 60.0 (50.0, 67.0)	59.7 ± 13.1 62.5 (50.0, 72.0)	0.997 0.946
<b>% Time Planning Codes – mean ± SD, median, (IQR)</b>												
	122	53.0 ± 24.0 60.0 (30.0, 75.0)	55.8 ± 23.2 60.0 (40.0, 75.0)	47.1 ± 25.1 50.0 (25.0, 75.0)	0.070	53.1 ± 23.9 60.0 (30.0, 75.0)	53.0 ± 26.7 55.0 (31.5, 80.0)	0.995	51.3 ± 24.9 60.0 (30.0, 75.0)	63.6 ± 18.7 68.0 (50.0, 80.0)	48.0 ± 17.3 45.0 (33.0, 60.0)	0.107 0.019
<b>Hours Peer Review – mean ± SD, median, (IQR)</b>												
	122	3.9 ± 3.1 3.0 (2.0, 5.0)	3.5 ± 3.0 3.0 (2.0, 4.0)	4.6 ± 3.4 4.0 (3.0, 5.0)	0.018	4.0 ± 3.3 3.0 (2.0, 5.0)	2.8 ± 1.3 3.0 (2.0, 4.0)	0.225	4.1 ± 3.3 3.0 (2.0, 5.0)	2.8 ± 1.9 2.0 (1.5, 3.0)	4.2 ± 3.1 3.0 (2.0, 5.0)	0.055 0.017
<b>Peer Review Sites – mean ± SD, median, (IQR)</b>												
	122	3.8 ± 2.2 3.0 (2.0, 4.0)	2.8 ± 1.4 3.0 (2.0, 3.0)	5.8 ± 2.1 5.0 (4.0, 8.0)	< 0.001	3.7 ± 2.1 3.0 (2.0, 4.0)	4.6 ± 3.0 3.5 (2.0, 8.0)	0.507	4.1 ± 2.1 4.0 (3.0, 4.0)	2.3 ± 2.5 2.0 (1.0, 3.0)	3.5 ± 0.8 4.0 (3.0, 4.0)	< 0.001 < 0.001
<b>≥ 4 Peer Review Sites – n(%)</b>												
Yes	122	54 (44.3)	18 (21.7)	36 (92.3)	< 0.001	48 (43.6)	6 (50.0)	0.673	49 (50.5)	1 (5.3)	4 (66.7)	< 0.001
No		68 (55.7)	65 (78.3)	3 (7.7)		62 (56.4)	6 (50.0)		48 (49.5)	18 (94.7)	2 (33.3)	< 0.001
<b>Structured Multi-disciplinary Case Review – n(%)</b>												
Yes	122	111 (91.0)	74 (89.2)	37 (94.9)	0.500	101 (91.8)	10 (83.3)	0.295	86 (88.7)	19 (100)	6 (100)	0.338
No		11 (9.0)	9 (10.8)	2 (5.1)		9 (8.2)	2 (16.7)		11 (11.3)	0 (0)	0 (0)	0.207

IQR – Interquartile range; FTE – Full-time equivalent; C – Clinical; CS – Clinician scientist

**Table 1 (Continued). Characteristics of all survey participants (n=123) stratified by academic institution (yes/no), FTE status (1.0 vs. < 1.0), and Position (clinical vs. clinician scientist vs. administrative).**

Characteristic	N	All Participants (n=123)	Academic (n=83)	Non-Academic (n=40)	p-value	FTE 1.0 (n=110)	FTE < 1.0 (n=12)	p-value	Clinical (n=97)	Clinician Scientist (n=19)	Administrative (n=6)	p-value All C vs. CS
<b>Structured Partner Review and Sign Off – n(%)</b>												
Yes	122	33 (27.1)	26 (31.3)	7 (18.0)	0.121	31 (28.2)	2 (16.7)	0.510	24 (24.7)	6 (31.6)	3 (50.0)	0.321
No		89 (73.0)	57 (68.7)	32 (82.1)		79 (71.8)	10 (83.3)		73 (75.3)	13 (68.4)	3 (50.0)	0.571
<b>Structured Asynchronous Review – n(%)</b>												
Yes	122	66 (54.1)	44 (53.0)	22 (56.4)	0.725	62 (56.4)	4 (33.3)	0.129	54 (55.7)	8 (42.1)	4 (66.7)	0.502
No		56 (45.9)	39 (47.0)	17 (43.6)		48 (43.6)	8 (66.7)		43 (44.3)	11 (57.9)	2 (33.3)	0.278
<b>Structured Other – n(%)</b>												
Yes	122	11 (9.0)	6 (7.2)	5 (12.8)	0.326	11 (10.0)	0 (0)	0.599	9 (9.3)	1 (5.3)	1 (16.7)	0.654
No		111 (91.0)	77 (92.8)	34 (87.2)		99 (90.0)	12 (100)		88 (90.7)	18 (94.7)	5 (83.3)	> 0.99
<b>Increased Clinical Time – n(%)</b>												
Yes	122	112 (91.8)	73 (88.0)	39 (100)	<b>0.030</b>	102 (92.7)	10 (83.3)	0.255	90 (92.8)	17 (89.5)	5 (83.3)	0.506
No		10 (8.2)	10 (12.1)	0 (0)		8 (7.3)	2 (16.7)		7 (7.2)	2 (10.5)	1 (16.7)	0.640
<b>Extra Hours Worked – mean ± SD, median, (IQR)</b>	112	3.8 ± 3.6 3.0 (1.8, 5.0)	3.6 ± 3.7 2.5 (1.0, 5.0)	4.2 ± 3.3 3.5 (2.0, 5.0)	0.125	3.8 ± 3.5 3.0 (2.0, 5.0)	3.9 ± 4.4 2.3 (1.0, 4.0)	0.511	4.0 ± 3.7 3.0 (2.0, 5.0)	3.1 ± 2.8 2.0 (1.0, 3.0)	3.9 ± 2.2 3.5 (3.0, 5.0)	0.314 0.172
<b>Not Funded Clinical Activities – n(%)</b>												
Yes	122	67 (54.9)	46 (55.4)	21 (53.9)	0.870	61 (55.5)	6 (50.0)	0.718	55 (56.7)	11 (57.9)	1 (16.7)	0.176
No		55 (45.1)	37 (44.6)	18 (46.2)		49 (44.6)	6 (50.0)		42 (43.3)	8 (42.1)	5 (83.3)	0.924
<b>Procedural Protections – n(%)</b>												
Yes	122	40 (32.8)	24 (28.9)	16 (41.0)	0.184	36 (32.7)	4 (33.3)	> 0.99	29 (29.9)	9 (47.4)	2 (33.3)	0.331
No		82 (67.2)	59 (71.1)	23 (59.0)		74 (67.3)	8 (66.7)		68 (70.1)	10 (52.6)	4 (66.7)	0.138
<b>Peer Review – n(%)</b>	122	122 (100)	83 (100)	39 (100)	--	110 (100)	12 (100)	--	97 (100)	19 (100)	6 (100)	--
<b>Start Time (AM) – mean ± SD, median, (IQR)</b>	119	7:55 ± 0:37 8:00 (7:30, 8:00)	7:54 ± 0:37 8:00 (7:30, 8:00)	7:56 ± 0:36 8:00 (7:30, 8:15)	0.934	7:53 ± 0:36 8:00 (7:30, 8:00)	8:10 ± 0:35 8:00 (7:45, 8:45)	0.224	7:57 ± 0:33 8:00 (7:30, 8:00)	7:57 ± 0:45 8:00 (7:30, 8:30)	7:25 ± 0:52 7:45 (7:15, 8:00)	0.335 0.687
<b>End Time (PM) – mean ± SD, median, (IQR)</b>	119	6:17 ± 1:00 6:15 (5:45, 7:00)	6:18 ± 0:59 6:22 (5:45, 7:00)	6:15 ± 1:04 6:00 (5:30, 6:30)	0.481	6:16 ± 1:00 6:00 (5:45, 7:00)	6:25 ± 1:05 6:45 (5:15, 7:07)	0.369	6:18 ± 1:01 6:22 (6:00, 7:00)	6:10 ± 0:49 6:15 (5:30, 7:00)	6:17 ± 1:29 6:00 (5:45, 6:30)	0.827 0.779

IQR – Interquartile range; FTE – Full-time equivalent; C – Clinical; CS – Clinician scientist

**Table 1 (Continued). Characteristics of all survey participants (n=123) stratified by academic institution (yes/no), FTE status (1.0 vs. < 1.0), and Position (clinical vs. clinician scientist vs. administrative).**

Characteristic	N	All Participants (n=123)	Academic (n=83)	Non-Academic (n=40)	p-value	FTE 1.0 (n=110)	FTE < 1.0 (n=12)	p-value	Clinical (n=97)	Clinician Scientist (n=19)	Administrative (n=6)	p-value All C vs. CS
<b>Total Time</b> – mean ± SD, median, (IQR)	119	10:21 ± 1:19 10:30 (9:45,11:00)	10:23 ± 1:18 10:30 (9:37,11:00)	10:18 ± 1:22 10:00 (9:45,11:00)	0.780	10:22 ± 1:19 10:15 (9:45,11:00)	10:15 ± 1:27 10:52 (8:52,11:15)	0.763	10:21 ± 1:17 10:30 (9:45,11:00)	10:12 ± 1:13 10:00 (9:30,11:00)	10:52 ± 2:19 10:07 (10:00,11:15)	0.884 0.668
<b>Break Time (Min)</b> – mean ± SD, median, (IQR)	119	19.0 ± 16.8 15.0 (0.0, 30.0)	19.7 ± 16.3 15.0 (0.0, 30.0)	17.7 ± 17.8 15.0 (0.0, 30.0)	0.360	19.5 ± 16.9 15.0 (0.0, 30.0)	15.0 ± 15.7 15.0 (0.0, 30.0)	0.396	18.2 ± 16.4 15.0 (0.0, 30.0)	21.3 ± 16.8 30.0 (0.0, 30.0)	25.0 ± 22.6 30.0 (0.0, 30.0)	0.531 0.402
<b>Hours Outside Regular Hours</b> – n(%)	119				0.159			0.426				
0		2 (1.7)	2 (2.5)	0 (0)		1 (0.9)	1 (8.3)		1 (1.1)	0 (0)	1 (16.7)	0.105
1-5		21 (17.7)	16 (20.0)	5 (12.8)		19 (17.8)	2 (16.7)		14 (14.9)	6 (31.6)	1 (16.7)	0.395
6-10		61 (51.3)	42 (52.5)	19 (48.7)		53 (49.5)	8 (66.7)		51 (54.3)	9 (47.4)	1 (16.7)	
11-15		21 (17.7)	11 (13.8)	10 (25.6)		20 (18.7)	1 (8.3)		17 (18.1)	2 (10.5)	2 (33.3)	
16-20		8 (6.7)	7 (8.8)	1 (2.6)		8 (7.5)	0 (0)		5 (5.3)	2 (10.5)	1 (16.7)	
21-25		6 (5.0)	2 (2.5)	4 (10.3)		6 (5.6)	0 (0)		6 (6.4)	0 (0)	0 (0)	
<b>% Administrative</b> – mean ± SD, median, (IQR)	118	40.2 ± 25.1 40.0 (20.0, 50.0)	43.0 ± 24.6 40.0 (22.5, 51.0)	34.3 ± 25.7 30.0 (10.0, 50.0)	0.080	39.9 ± 24.9 40.0 (20.0, 50.0)	42.7 ± 28.2 50.0 (17.5, 65.0)	0.750	39.2 ± 25.2 40.0 (20.0, 50.0)	41.7 ± 26.3 48.0 (20.0, 52.0)	50.0 ± 22.6 50.0 (30.0, 75.0)	0.575 0.696
<b>% Publicly Funded</b> – mean ± SD, median, (IQR)	118	68.3 ± 27.7 80.0 (50.0, 90.0)	66.5 ± 26.2 71.5 (50.0, 90.0)	72.2 ± 30.7 80.0 (75.0, 90.0)	0.117	68.8 ± 27.7 80.0 (50.0, 90.0)	64.0 ± 29.1 75.0 (32.5, 90.0)	0.658	70.9 ± 27.7 80.0 (60.0, 90.0)	52.6 ± 26.1 50.0 (40.0, 74.0)	77.5 ± 16.0 80.0 (70.0, 90.0)	<b>0.013</b> <b>0.004</b>
<b>Allocation 7am-5pm</b> – mean ± SD, median, (IQR)	116	69.1 ± 15.6 70.0 (60.0, 80.0)	71.0 ± 13.9 70.0 (60.0, 80.0)	65.1 ± 18.3 70.0 (52.0, 80.0)	0.162	68.4 ± 15.6 70.0 (60.0, 80.0)	76.1 ± 14.1 75.0 (70.0, 85.0)	0.166	68.4 ± 16.0 70.0 (60.0, 80.0)	71.7 ± 14.2 75.0 (60.0, 80.0)	71.7 ± 14.4 80.0 (65.0, 80.0)	0.591 0.410
<b>Allocation 5pm-7am</b> – mean ± SD, median, (IQR)	116	21.1 ± 11.6 20.0 (15.0, 30.0)	20.5 ± 11.1 20.0 (15.0, 25.0)	22.4 ± 12.8 20.0 (15.0, 30.0)	0.536	21.6 ± 11.8 20.0 (15.0, 30.0)	16.0 ± 9.2 18.5 (10.0, 20.0)	0.190	21.6 ± 11.7 20.0 (15.0, 30.0)	18.6 ± 10.3 20.0 (10.0, 25.0)	21.7 ± 15.7 15.0 (10.0, 30.0)	0.527 0.301
<b>Allocation Weekends and Holidays</b> – mean ± SD, median, (IQR)	116	9.8 ± 7.7 10.0 (5.0, 10.0)	8.5 ± 6.3 7.5 (5.0, 10.0)	12.5 ± 9.6 10.0 (5.0, 16.0)	<b>0.035</b>	10.0 ± 7.6 10.0 (5.0, 10.0)	7.9 ± 8.6 5.0 (2.0, 10.0)	0.193	10.0 ± 8.1 10.0 (5.0, 10.0)	9.7 ± 6.4 10.0 (5.0, 10.0)	6.7 ± 2.6 5.0 (5.0, 10.0)	0.658 0.839
<b>On Call</b> – n(%)	116	116 (100)	79 (100)	37 (100)	--	106 (100)	10 (100)	--	91 (100)	19 (100)	6 (100)	--
<b>On Call Days Per Month</b> – mean ± SD, median, (IQR)	116	3.0 ± 3.0 2.0 (2.0, 3.4)	2.1 ± 1.1 2.0 (1.0, 2.0)	4.9 ± 4.5 4.0 (3.0, 5.0)	<b>&lt; 0.001</b>	3.0 ± 3.1 2.0 (2.0, 3.0)	2.5 ± 1.1 2.0 (2.0, 3.5)	0.872	3.3 ± 3.3 3.0 (2.0, 4.0)	1.8 ± 0.8 2.0 (1.0, 2.0)	2.1 ± 1.1 2.0 (1.0, 2.5)	<b>0.002</b> <b>&lt; 0.001</b>
<b>% On Call Requiring Hospital Visit</b> – mean ± SD, median, (IQR)	116	47.9 ± 29.6 49.5 (22.0, 72.5)	49.8 ± 29.7 50.0 (22.0, 70.0)	43.7 ± 29.4 35.0 (22.0, 75.0)	0.301	49.2 ± 29.8 50.0 (25.0, 75.0)	34.1 ± 25.0 26.5 (15.0, 51.0)	0.100	46.6 ± 30.1 40.0 (20.0, 75.0)	56.2 ± 30.4 50.0 (31.0, 100)	40.8 ± 15.0 50.0 (30.0, 50.0)	0.368 0.208

IQR – Interquartile range; FTE – Full-time equivalent; C – Clinical; CS – Clinician scientist



Structured_Other_Details	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Asynchronous review, but also includes physics, therapists	1	9.09	1	9.09
Contouring checking and decision checking on-the-go as needed (mostly for complex cases)	1	9.09	2	18.18
For complex SBRT cases and some patients on studies that need peer - will get a fellow site expert to review case on ad hoc basis	1	9.09	3	27.27
Independent asynchronous contour reviews prior to treatment planning	1	9.09	4	36.36
Multidisciplinary clinics & teleconferences	1	9.09	5	45.45
Providing feedback to other radiation oncologists re: treatment approach/planning for patients reviewed in multidisciplinary tumour boards	1	9.09	6	54.55
Review of difficult planning decisions (volume delineation, beam trajectories) during initial contouring/planning process with colleague	1	9.09	7	63.64
asynchronous review for palliative cases during on call week and may be out of hours	1	9.09	8	72.73
contour reviews for cranial radiosurgery and spine SBRT cases	1	9.09	9	81.82
on call Rad Onc will peer review all straightforward palliative plans	1	9.09	10	90.91
partner reviews contour submitted before planning, partner reviews plan after I have accepted before treatment is delivered	1	9.09	11	100.00
Frequency Missing = 112				

# 2018 Relativity Survey - Radiation Oncology

## Primary Location

*Single Choice Question : Drop Down*

### 1. What is your primary practice location?

- Barrie
- Grand River
- Hamilton
- Kingston
- London
- Mississauga
- Newmarket
- Ottawa
- Oshawa
- St. Catherines
- Sudbury
- Thunder Bay
- o Toronto – PMH
- o Toronto – Odette
- o Windsor

## FTE Status?

*Single Choice Question : Drop Down*

### 2. What is your FTE status?

- 0.0
- 0.1
- 0.2
- 0.25
- 0.3
- 0.4
- 0.5
- 0.6
- 0.7
- 0.75
- 0.8
- 0.9
- 1.0

## Position

Single Choice Question : Drop Down

**3. What is your position? Please select one of the options below:**

- Clinical
- Clinician Scientist
- Administrative

## Supervise?

Single Choice Question : Buttons

**4. Do you regularly supervise residents or fellows? Please select one of the options below:**

- Yes
- No

## %billing codes

Numeric : Slider

**5. On any given 7-day week, what percentage of your total billings is for the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322)? (Please enter a number between 0 and 100)**

- 

## %Time Planning codes

Numeric : Slider

**6. On any given weekday (Monday to Friday), what percentage of your time spent for activities associated with the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322) is between 7:00 and 17:00? (Please enter a number between 0 and 100)**

- 

## Hours Peer Review

Numeric : Text Field

**7. How many hours a week do you spend undertaking Peer Review?**

- 

## # Peer Review Sites

*Numeric : Text Field***8. How many different disease sites do you perform Peer Review for?**

- 

**Structure***Multiple Choice Question***9. Please indicate the structure of your Peer Review. (Select all that may apply.)**

- Multidisciplinary case review (two or more radiation oncologists +/- radiotherapy and physics staff meet a recurring basis)
- Partner review and sign off (two radiation oncologists meet and undertake to review each other's radiotherapy plans)
- Asynchronous review and sign off (a radiation oncologist will undertake to review and sign off the work of another in a manner that is not limited by place or time)
- Other, please explain

**Clinical Time***Single Choice Question : Buttons***10. Has Peer Review increased the amount of time you undertake clinical activities outside of the period from 07:00 to 17:00?**

- Yes
- No

**Survey Logic**

Display the questions if all of the following conditions are true:

- [This Survey] - 10. Has Peer Review increased the amount of time you undertake clinical activities outside of the period from 07:00 to 17:00? : is Yes

**Extra Hours Worked?***Numeric : Text Field***10a. Please indicate the number of hours a week you are working before 07:00 or after 17:00 as a consequence of Peer Review.**

-

## Not Funded Clinical Activities?

Single Choice Question : Buttons

11. Are you currently undertaking any additional clinical activities that are not funded?

- Yes
- No

## Survey Logic

Display the questions if all of the following conditions are true:

- [This Survey] - 11. Are you currently undertaking any additional clinical activities that are not funded? : is Yes

### Short Answer

Open Ended : No Validation

11a. Please indicate the additional clinical activity and number of hours you engage in it over the course of a week.

- 

## Single Choice

Single Choice Question : Buttons

12. Do you have procedural protections to ensure all potential liability issues are adequately addressed, communicated and diminished (for example, not including peer review results in patient files)?

- Yes, please elaborate
- No

## Peer Review?

Single Choice Question : Buttons

Do you perform Peer Reviews?

- Yes
- No

## Survey Logic

Display the questions if all of the following conditions are true:

- [This Survey] - Do you perform Peer Reviews? : is Yes

### Site 1

*Open Ended : Buttons*

For each disease site/program you perform Peer Review please provide the name of the site, the start time, end time of the session and frequency. Sample Responses: Site: Gastrointestinal Peer Review Start Time: 1:30 PM Peer Review End Time: 2:30 PM Frequency: Weekly Site: Palliative Radiotherapy Program Peer Review Start Time: 1:30 PM Peer Review End Time: 2:30 PM Frequency: Weekly

- Site:

### Start 1

*Open Ended : Buttons*

- Peer Review Start Time

### End 1

*Open Ended : Buttons*

- Peer Review End Time:

### Frequency 1

*Open Ended : Buttons*

- Frequency:

## More sites?

*Single Choice Question : Buttons*

2. Add more Peer Review sites?

- Yes
- No

## Survey Logic 2

Display the questions if all of the following conditions are true:

- [This Survey] - 2. Add more Peer Review sites? : is Yes

**Site 2***Open Ended : Buttons*

For each disease site/program you perform Peer Review please provide the name of the site, the start time, end time of the session and frequency. Use as many Sample Responses:Site: GastrointestinalPeer Review Start Time: 1:30 PMPeer Review End Time: 2:30 PMFrequency: Weekly Site: Palliative Radiotherapy ProgramPeer Review Start Time: 1:30 PMPeer Review End Time:\_2:30 PMFrequency: Weekly

- Site:

**Start 2***Open Ended : Buttons*

- Peer Review Start Time

**End 2***Open Ended : Buttons*

- Peer Review End Time:

**Frequency 2***Open Ended : Buttons*

- Frequency:

**More sites 3***Single Choice Question : Buttons***3. Add more Peer Review sites?**

- Yes
- No

**Survey Logic 3**

Display the questions if all of the following conditions are true:

- [This Survey] - 3. Add more Peer Review sites? : is Yes

**Site 3***Open Ended : Buttons*

For each disease site/program you perform Peer Review please provide the name of the site, the start time, end time of the session and frequency. Use as many Sample Responses:Site: GastrointestinalPeer Review Start Time: 1:30 PMPeer Review End Time: 2:30 PMFrequency: Weekly Site: Palliative Radiotherapy ProgramPeer Review Start Time: 1:30 PMPeer Review End Time:\_2:30 PMFrequency: Weekly

- Site:

**Start 3***Open Ended : Buttons*

- Peer Review Start Time

**End 3***Open Ended : Buttons*

- Peer Review End Time:

**Frequency 3***Open Ended : Buttons*

- Frequency:

**Start Hour***Single Choice Question : Drop Down***13. What time do you typically start your clinical day? (24-hour format) (Hour)**

- 00
- 01
- 02
- 03
- 04
- 05
- 06
- 07
- 08
- 09
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24

**Start Minute***Single Choice Question : Drop Down***(Minute)**

- 00
- 15



- 30
- 45

## End Hour

*Single Choice Question : Drop Down*

**14. What time do you typically end your clinical day? (24-hour format) (Hour)**

- 00
- 01
- 02
- 03
- 04
- 05
- 06
- 07
- 08
- 09
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24

## End Minute

*Single Choice Question : Drop Down*

**(Minute)**

- 00
- 15
- 30
- 45

## Breaks

*Single Choice Grid : Grid*

**15. How much time do you typically take for breaks during your clinical day?**

- 0

- 15
- 30
- 45
- 60
- 75
- 90
- 105
- 120, or more

- Time is provided in minutes:

### Hours outside regular Hrs.

*Single Choice Question : Drop Down*

**16. Considering only Monday to Friday, excluding statutory holidays, how many hours a week do you spend on clinical services performed outside of regular hours (7AM to 5PM)?**

- Zero hours
- 1 to 5 hours
- 6 to 10 hours
- 11 to 15 hours
- 16 to 20 hours
- 21 hours to 25 hours
- More than 26 hours

### % Administrative

*Numeric : Slider*

**17. Considering only Monday to Friday, excluding statutory holidays, what percentage of your time after 5PM is dedicated to completing administrative responsibilities associated with clinical services performed during regular hours (7AM to 5PM)? (You can enter the number in the box provided)**

- 

### % publicly funded

*Numeric : Slider*

**18. What percentage of time during your typical clinical day is dedicated to providing publicly funded clinical services and completing those administrative responsibilities associated with these services, including those related to running the office to support these services? (You can enter the number in the box provided)**

-

## Allocation

*Allocation*

**19. Please consult any relevant financial reports related to your practice, as required, to answer this question. Consider your typical weekly (Monday to Sunday) gross income earned for providing publicly funded clinical services. Under the POAFP, your gross income will consist of your monthly "Base Funds" and claims that a Physician submitted for a Clinical Service that OHIP has approved. NB: The clinical activity remunerated by the Radiation Treatment Planning fee codes (X310, X311, X312, X313, X322) is not a single event, and these tasks span the entire length of time of the treatment planning and delivery of a given course of radiotherapy. However, the billing of the associated code will only occur at a single time point. What proportion of this income is earned during the following time periods: (You can enter the number in the box provided)**

Amount to Allocate: **100**

- Monday to Friday, between 7AM and 5PM (weekday regular days)
- Monday to Friday, between 5PM and 7AM (weekday evenings and nights)
- Saturday, Sunday (weekends) and Statutory Holidays

## Single Choice

*Single Choice Question : Buttons*

**20. Do you provide "On Call" to any hospitals?**

- Yes
- No

## Survey Logic

Display the questions if all of the following conditions are true:

- [This Survey] - 20. Do you provide "On Call" to any hospitals? : is Yes

### Number

*Numeric : Text Field*

**20a. On average, how many days a month do you provide On Call coverage to the hospital? (You can enter the amount in the box provided)**

- 

### Allocation

*Allocation*

**20b. On average, what percentage of calls each month involve going into the hospital? (You can enter the number in the box provided)**

Amount to Allocate: **100**

•

## Text & Image

*Instruction*

**Thank you so much for your responses! Once you click 'Next', your responses will be submitted so feel free to go back and review your answers before continuing!**

## End Survey

**Type of Termination Point:** Redirect

**Reason for Termination:** Complete

**Redirect to:** URL

**Redirect URL:** <http://www.thoughtlounge.ca>

**Message to display to respondent:** Thank you for taking the time to participate in this survey. If you have any questions, please email me at [Robert.Dinniwell@lhsc.on.ca](mailto:Robert.Dinniwell@lhsc.on.ca). With appreciation, Dr. Robert Dinniwell, Chair, Section of Radiation Oncology

**TAB 220**

# IMPACT & EVOLUTION OF CHEO'S PHYSICIAN

## CRISIS: From recruitment challenge to recruitment and retention emergency

The initial Make Kids Count submission of 2021 identified a doctor shortage as the key barrier to addressing pediatric backlogs of care. Now, CHEO's rapidly escalating physician recruitment and retention crisis has become the greatest barrier to meeting the needs of a growing population of children and youth. Our 2022 proposal to modernize the province's second-oldest alternate funding plan was submitted as that year's viral surge accelerated. From the summer of 2022 onwards, we held discussions with the deputy minister, associate deputy, ADM, Negotiations Branch officials and senior Ontario Health representatives to brief them on CHEO's increasing struggle to retain medical staff and the inability to recruit new physicians. Officials recognized the role CHEO plays in providing one-of-a-kind specialized services for a vast swath of eastern and northern Ontario, and they understood the urgency of the issue and have been supportive of finding solutions. However, CHEO's circumstance was overtaken by other provincial physician remuneration priorities, including the physician services agreement renegotiation. In early 2024, CHEO, CHAMO and the OMA jointly presented an urgent bridge proposal to help stabilize the situation while PSA negotiations continue at a provincial level.

# HIGHLIGHTS

- Right-sizing Ontario's pediatric healthcare organizations was a game-changer. Failing to address current and growing physician coverage gaps means **we can't take full advantage of this investment** in kids and correct harmful delays in accessing care.
- CHEO has already had **to scale back its operating room schedule with several closures each week**. Surgical and medical imaging backlogs are growing again and additional OR closures will be required, despite growing demand, due to our shrinking physician workforce.
- **We do not have physician coverage to continue or expand regional initiatives** such as the pediatric regional surgical program, which are crucial components of addressing the backlog of care.
- We also do not have sufficient physician coverage to maintain our current inpatient pediatric medicine capacity, which has been consistently at or above 100% occupancy for the past eight months. **This will necessitate bed closures starting in July 2024.**
- Despite multiple ED diversion strategies, including physician extenders and low acuity Kids Come First clinics that see up to 2,000 patients a month, **we can't address the unacceptable wait times and backlog of ED boarded patients.**
- Starting in September 2024, **we will need to divert more patients out of region, out of province and, for some highly specialized services, out of country** due to physician shortages.
- For children and families urgently sent out of the region, we have provided additional resources and social work support and are currently discussing with the CHEO Foundation about additional money to support these extra pressures.

# THE PROBLEM

Children & families in eastern and northeastern Ontario face increasing gaps in care: long, unsafe wait times in specialized medical, surgical, medical imaging and mental health care.

**More than 60% of children wait longer to see a doctor than is clinically recommended. This includes children with:**

- Serious medical conditions, developmental concerns (cerebral palsy, autism), surgical problems or mental health crises;
- Children needing medical imaging tests such as brain scans and ultrasounds. CHEO has the longest MRI wait times in the province. CHEO is a Level 1 Trauma Centre and cannot sustain 24/7 interventional radiology coverage. As a result, children who have sustained trauma may not have necessary treatment.

**Children have reduced access to surgery. Multiple Operating room closures on a weekly basis since 2023 due to shortage of anesthesiologists. Surgical backlog is starting to grow again as a result.**

- An additional 1,680 children could have surgery at CHEO each year if we had a full cohort of anesthesiologists. This could eliminate the out-of-window wait list within two years.

**Children whose waits for a surgeon are outside the clinically safe window may be left with lifelong physical, developmental, and educational impacts.**

- Children who require ear, nose and throat surgeries for issues like sleep apnea or hearing loss have up to a 14-month wait-list: serious lifelong impacts on hearing, speech and development. Those with easily correctable complications of ear infections (cholesteatomas) wait eight months and it can permanently impact hearing and balance or cause facial paralysis;
- Children who need orthopedic surgeries to fix muscle tone or bone deformities are being delayed outside of a safe developmental window, which has a lifelong impact on mobility;
- Delays in dental surgery at critical ages can have permanent impacts on speech acquisition;
- Strabismus surgery delays have impact on vision and education.



**In some cases, children waiting for surgical procedures sustain acute life-threatening conditions:**

- A child awaiting surgical correction for narrowing of the airway presented to the ED in extremis due to a mild cold;
- Children waiting for obstructive sleep apnea surgery become unstable with childhood colds and require critical care support;
- A child waiting six months for ear tubes developing a brain abscess and a large clot in a major brain blood vessel.

**Sick children wait in the ED up to 24-36 hours for an inpatient bed. This will worsen by this summer when inpatient beds need to close due to pediatrician shortages. Children will need to be sent out of the region/province for hospitalizations.**

- These are babies, young children and teens admitted with illnesses such as pneumonia, asthma, seizures, diabetes, meningitis, blood and kidney infections, failure to thrive, etc

**Young teens with severe eating disorders will need to be sent out of region/country without additional adolescent health physicians and psychiatrists over next six months.**

**Because care from pediatric sub-specialists is prioritized for the sickest children and teens, those with lower priority but significant illnesses wait well beyond clinically recommended waiting times.**

- Currently 350-400 children and teens being followed with inflammatory bowel diseases (IBD) like ulcerative colitis and Crohn's disease, with only one full-time IBD specialist. Most of these children require complex biologic therapies with specifically timed treatment, endoscopy and follow up. Diversion of the other gastroenterologists to help ensure safe care of children with IBD has led to decreases in the total number of new consults that can be seen.
- Large increase in children and teens with depression, anxiety, eating disorders and other mental health illnesses over the past few years. To meet the acute needs of children and youth admitted with emergency mental health conditions, care must be diverted from those waiting for outpatient treatment. Children and youth waiting much longer to access certain specialized and/or new mental health programs (Neurodevelopmental mental health care, addiction care, gender care etc) in this region.

# WHY

## Physician HHR crisis

**CHEO has been facing an unprecedented number of doctors who leave CHEO due to CHAMO's non-competitive remuneration.**

- Shortage of doctors flagged as key barrier to addressing pediatric backlogs of care;
- Make Kids Count (MKC) funding has helped right-size the system enabling recruitment of needed roles like pediatric nurses, respiratory/rehab therapists, mental health professionals and physician extender human resources. However, potential access to care enhancements thanks to this historic MKC investment **cannot be actualized without urgent investment in physician resources** as well.

**In next few months, we can't expand services to address the backlogs, and can no longer even sustain current levels of clinical activity in key areas.**

### **Current Challenges:**

- Department of Anesthesiology and Pain Medicine has 28% of positions vacant; anticipated 50% vacancy by mid-2025; unable to recruit locum or permanent replacements;
- Inpatient Medicine has 28% of positions (5/18) unfilled due to resignations and medical leaves; unable to recruit locum or permanent replacements;
- Radiology has 40% of positions vacant with three resignations in last 18 months to other pediatric centres in Ontario, plus retirements; unable to recruit permanent or locum positions.

**For pediatric specialties and subspecialties across all physician groups, there are such small numbers of qualified individuals, that we need to be competitive in the Canadian and international market.**

# WHY Critical Challenges: Recruitment & Retention

**CHEO's rapidly escalating physician recruitment and retention crisis is now the greatest barrier to our ability to address the needs of a growing population of children and youth.**

- **Non-competitive remuneration AND workloads are at root of failures to retain and recruit over past 5+ years.**
- **Resignations and failed recruits to CHEO include those:**
  - Going to other pediatric academic hospitals (Ontario or elsewhere in Canada) where the remuneration and workload are better than at CHEO; where they can have academic time not currently possible in many departments at CHEO due to physician shortages, increasing clinical demand and workload;
  - Going to community settings (both pediatric and adult depending on specialty) where less complex patients are seen with much higher remuneration;
  - Going to private settings (private surgical/dental centres) where remuneration is much greater.
- **Cannot attract community-based physicians for work at CHEO— more complex patients, poorer remuneration.**

## **WHY** CHAMO AFP severely outdated

- Fully converted AFP since 2002; last significant AFP renegotiation in 2008;
- CHAMO AFP covers 99% of all CHEO-based physicians and provides only mechanism to hire new locum or permanent physicians;
- Without designated MOH approval, cannot recruit physicians to address access priorities or respond quickly to clinical surge/crisis situations;
  - New approvals take months to years.
  - Cannot use FFS to bring on new physicians to respond to urgent or evolving situations.

### **No increase in the number of funded physician positions within CHAMO for the last four years;**

- Letter of intent to submit for renegotiation in September 2022 to Ministry and OMA;
- Full CHAMO AFP Submission to Ministry and OMA in April 2023.

**Discussions held with deputy minister, Associate deputy, ADM, Negotiations Branch officials and senior Ontario Health representatives to brief them on CHEO's increasing struggle to retain medical staff and inability to recruit new ones.**

- Jan. 2024: CHEO/CHAMO/OMA joint submission to Ministry for urgent bridge funding to help stabilize the situation while awaiting AFP renegotiation.

**TAB 221**

# **Diagnostic Services Committee**

## **Progress and Priorities Report**

**March 2008**

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## 1 Summary Recommendation

The Diagnostic Services Committee (DSC) has learned through its work that the major challenges in improving diagnostic services in the province are interdependent; their solutions must therefore be multi-faceted and interconnected for real progress to occur.

The Committee has undertaken to identify future priorities to be undertaken over a 3 to 4 year time frame that it believes will contribute to Ontarians continuing to have a high performing, accessible, quality, and safe diagnostic care system to rely upon.

The Committee recognizes that the future of the DSC is a matter of negotiations between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) in which the Ontario Hospital Association (OHA) has observer status. The recommendations in this report do not necessarily reflect the views or positions of any of these parties.

### 1.1 A Continuing Vehicle for Multi-Party Collaboration

The DSC has demonstrated itself to be an effective vehicle for multi-party collaboration. The work that it has completed lays solid foundations upon which to move forward on an agenda of practical improvement to the province's diagnostic services system. Committee effectiveness could be improved with the addition of LHINs representation and a more formalized relationship with OHTAC.

### 1.2 Strengthening Accountability

The DSC experience suggests that a clearer framework of accountability is needed within which to work. The Committee proposes that the MOHLTC, OMA and OHA consider entering into a long term Accountability Agreement with respect to the DSC or its successor setting out priorities and clarifying reporting and decision making relationships.

### 1.3 New Funding

Current funding for diagnostic services does not reflect today's cost and service delivery realities. Technical fees have received only a 1% increase since 2000. While some infusion of funding through the Federal Diagnostic Medical Equipment fund has occurred, there is a pattern of under-investment in diagnostic equipment and an inability to afford the transition to higher cost digital equipment.

New funding for diagnostic services should be made available to address: current inflationary pressures; replacement of aging diagnostic equipment and conversion from analog to digital; and, strategic investments for new technologies, quality and safety improvements, and targeted research and evaluation.



Advice should be sought from the DSC or its successor regarding the specific use and allocation of additional funds.

#### **1.4 Segregated Diagnostic Funding Envelope**

A separate envelope for the compensation of diagnostic technical services and equipment will enable a more sustained focus on the needs of diagnostic services and facilitate broader system improvements. A separate funding envelope for technical diagnostic services and diagnostic equipment through segregation of technical fees within the OHIP pool should be implemented no later than March 31, 2009 and include a multi-party advisory or governance structure.

#### **1.5 Renovation of the Technical Compensation System**

Through its two Task Forces the DSC has concluded the current technical compensation system needs renovation. The DSC is proposing a process of renovation of the technical compensation system over three-year time frame within a multi-year financial framework that, among other things, addresses transition issues.

The purpose of the renovation would be to:

- Create a method of accountability, such as a separate funding stream of capital funding for major diagnostic equipment replacement and acquisition that ensures capital funds are spent for capital purposes, and there us timely, appropriate equipment replacement including the transition from analog to digital equipment.
- Replace the “one procedure fee fits all” compensation methodology by one that recognizes significant cost differences resulting from geographic location or facility type and takes into account efficiency standards and opportunities for the consolidation of fees.

#### **1.6 Enhancing System Performance and Accountability**

The Committee is proposing three measures be undertaken to strengthen performance and accountability as a way of achieving greater quality, safety and value for money in the delivery of diagnostic services.

- Development of Diagnostic Replacement Equipment guidelines linked to the diagnostic services payment system:
  - Currently there are no commonly established guidelines for equipment replacement.
- Introduction of a province wide Accreditation System for Diagnostic Services in hospitals, IHF and physician offices/clinics building on the current Ontario Laboratory Accreditation (OLA) and IHF systems.
- Development of Service Delivery Productivity and Performance Standards.

## 1.7 Strategic Initiatives

Two primary initiatives are being proposed:

- Development of a business case and pilots for diagnostic on-line order entry through OMA / OHA collaboration;
- An assessment of voluntary group purchasing arrangements and opportunities for diagnostic equipment in collaboration with Ontario Buys.

## 2 Introduction

The Diagnostic Services Committee (DSC) was created through the 2004 *Physician Services Framework Agreement* (PSA) as a tripartite committee of the Ministry of Health and Long-Term Care (MOHLTC), the Ontario Medical Association (OMA), and the Ontario Hospital Association.

### **DSC Mandate**

The DSC is an advisory body to the Minister of Health and Long-Term Care for the purpose of planning and coordinating an efficient and effective diagnostic service system in the Province of Ontario with accountability among users and providers of diagnostic services.

The Committee's responsibilities include developing advice and recommendations to the Ministry on provincial planning and funding, quality and standards, compensation for technical services, utilization review and management, implementation and distribution of new and existing technologies, and the acquisition and replacement of equipment. The DSC has restricted its focus to non-laboratory diagnostic services. (See Appendix A for Terms of Reference.)

The purpose of this report is to provide a summary of the activities and results of the Committee's work over the past two and a half years and recommendations on future priorities that build on this work.

### 2.1 An Effective Culture of Collaboration

Since the inaugural meeting in November 2005, the DSC, through open constructive dialogue and consensus-building, has established a successful multi-party working relationship. The outcome is a series of accomplishments highlighted by:

- A long term vision and strategic roadmap for future directions in non-lab diagnostic services in Ontario;
- A proposed new funding structure for the operating and capital cost components of diagnostic services that includes an implementation framework;
- An assessment of the state of diagnostic equipment in the province and a proposed action plan to address key issues;
- Completed a comprehensive analysis of the current diagnostic compensation system leading to recommending renovation of the system; and
- A framework and strategy for moving ahead on a province-wide accreditation system for diagnostic services.

### **DSC Members**

#### **CHAIR**

Mr. Jay Kaufman

#### **MOHTLC**

Dr. Les Levin

Mr. Bruce Kirton /

Ms. Susan Fitzpatrick

Ms. Sandy Nuttall, Ph.D.

#### **OMA**

Dr. Mark Frieditis

Dr. Robert Wald

Dr. Virginia Walley

Dr. Gregory Flynn

#### **OHA**

Mr. Kevin Empey

Mr. Jim Flett

Dr. William Shragge

#### **IHF**

Dr. Michael Romeo

Going forward, the Committee believes that effective multi-party collaboration is essential to Ontario having a high performing, patient-centred system of safe, quality diagnostic services. Having said this, the DSC experienced ongoing challenges of accountability, reporting and communications that hampered its effectiveness. A much clearer framework of accountability than is now the case for the DSC is required as parties look to the future.

The Ministry's move towards a stewardship role and the advent of LHINs changed the operating context for the Committee during its tenure. This contributed to uncertainty over the role of the Committee, particularly around how it ought to relate to LHINs. Successful collaboration requires clarifying relationships especially in areas such as diagnostic services where significant parts of the delivery system fall outside the direct responsibility and control of LHINs. A provincial multi-party mechanism for diagnostic services such as the DSC would benefit from having direct LHINs participation.

### 3 Committee Activities and Accomplishments

#### 3.1 Physician Services Agreement (PSA) Initiatives

In the first year of its mandate, the Committee completed two assignments from the PSA; the allocation of \$40 million for the funding of diagnostic equipment, and the transfer of in-patient professional fee funding from hospitals to the OHIP pool.

- *Allocation of \$40 million Diagnostic & Medical Equipment (DME) funding.*  
Through matching funds, the DSC was able to secure more than \$100 million in total investment in replacement diagnostic equipment and added substantially to the digitization capacity of the province's diagnostic services system.
- *Implementation of in-patient professional fee (p-fee) funding transfer from hospital global budgets to the OHIP pool.*  
Relying on the advice from the Committee, the MOHLTC successfully implemented the full transfer of in-patient p-fee funding to the OHIP pool by October 31, 2006.

#### 3.2 Collaborating with Ontario Health Technology Assessment Committee

The Committee's mandate called for working with Ontario Health Technology Assessment Committee (OHTAC) in considering the implementation, distribution, and quality management of existing and new diagnostic technologies. Since 2005, the DSC has worked closely with OHTAC to provide advice on several diagnostic technologies issues, including:

- Ultrasound screening for abdominal aortic aneurysms;
- CT safety;
- Expansion of scintimammography; and
- MRI breast cancer screening.

#### 3.3 Reporting on Strategic Directions

In Spring/Summer 2007, the Committee produced a Summary Report on Strategic Direction for Diagnostics in Ontario entitled *Building on Strength: A High-performing Diagnostic Services System for Ontario's Future*.

The purpose of the report was to set out a vision and strategic directions for diagnostic services that support the Ministry's goal of providing timely, equitable access to patient focused, high quality and safe health care services within a sustainability health system.

### **DSC Vision for a Provincial Diagnostic System**

Ontarians receive accessible, high quality and safe diagnostic care from a proactive, planned, integrated system, easily able to respond to future challenges and change with thoughtful investment and funding designed to improve health services and practices.

The *Strategic Directions Report* identifies key trends and challenges facing Ontario's diagnostic services system and proposes strategies and 39 recommendations supporting a more integrated provincial approach to diagnostic services.

The Report was informed by 5 background research papers commissioned by the DSC that include an analysis of diagnostic services in Ontario and their utilization, a review of diagnostic services in other jurisdictions, and new diagnostic technologies on the horizon. (See Appendix B for a summary of the Research Reports.)

The proposed strategies include:

- Enhancing the capacity for provincial strategic leadership and direction so there is effective, integrated development of the province's diagnostic services:
  - Including planning frameworks and guidelines for distributing and utilizing diagnostic services, technologies and resources efficiently and appropriately;
- Giving LHINs adequate authority and tools to plan and steer the development of diagnostic services in their local areas;
- Implementing an integrated provincial framework for performance and accountability:
  - Including provincial quality and utilization management programs, productivity and service delivery standards, and public reporting;
- Strengthening our diagnostic evidence platform by giving OHTAC a broadened mandate, and investing in and better coordinating our research infrastructure;
- Promoting and investing in the integrated use of information and communications technology; and
- Realigning the funding system for diagnostic services to bring more focused attention in the needs of diagnostics and leverage change and improvement through strategic investment.

(See Appendix C for a snap shot of these strategies.)

## **3.4 The State of Diagnostic Equipment**

The DSC undertook through its Task Force on Diagnostic Equipment to assess the state of diagnostic equipment in the province through an inventory of major diagnostic equipment in hospitals and IHFs. The Task Force found that:

- There is a general pattern of under-investment in diagnostic equipment.
- Approximately 20% of major diagnostic equipment in hospitals and IHFs is more than 10 years old – older equipment is concentrated in radiology, pulmonary function studies and nuclear medicine.

- The comparatively higher percentage of ultrasound equipment less than 5 years old indicates a response to changing technology.
- Hospitals are focusing their investments on high cost MRI and CT equipment leading to less capital investment in other diagnostic modalities.
- Digitization of diagnostic equipment is a driving force in equipment replacement, however there are significant differences in the level of digitization between hospitals and IHFs.
- The current fee structure does not recognize the additional cost impact of newer technologies which in turn is impacting on equipment replacement decisions.

In recognizing the issues raised by the Task Force, particularly as they relate to potential quality and safety issues as well as timely equipment replacement, the DSC had endorsed the following directions:

- Equipment Replacement Guidelines should be developed and linked to funding for major diagnostic equipment that takes into account the age and utilization of equipment.
- In developing Guidelines the following factors should be considered:
  - The impact that new technology has on specific equipment (e.g. full digital mammography); and
  - Areas of high utilization (e.g. radiology).
- The Diagnostic Equipment Funding Strategy should address:
  - capital costs related to equipment replacement and related operating costs (one time and ongoing, e.g. service costs and costs of migrating to a digital platform);
  - establishing a separate payment structure for capital costs through changes to the current fee payment system;
  - prioritizing capital investment to address key areas for capital replacement along with shifting from analog to digital equipment and platforms; and
  - establishing appropriate incentives for hospitals, IHFs and physician offices to invest resources in meeting equipment replacement standards.

### 3.5 Compensation of Technical Diagnostic Services

As an early priority, the DSC established a Task Force on Technical Compensation to access the costing methodology for technical fees. The results of the Task Force's analysis, in conjunction with the findings on the state of diagnostic equipment in the province, clearly point to a need for significant change in the current technical fee payment system.

The following are the key conclusions of the Task Force:

#### *Costing methodology*

- While the present CTC costing methodology (subject to refinement) can be used as a basis to establish reasonable per procedure costs, the current fees do not reflect today's cost realities.

- The capital and operating cost components of a technical fee can be readily identified and separated to allow for an examination of equipment capability, replacement and cost options.

*Analog to digital*

- The introduction of digital based technologies has significantly increased capital costs (the cost of equipment – and the related financing, support and maintenance costs) and generally increased the ratio of capital and capital related costs to total cost per procedure.
- The current costing methodology can be adjusted to reflect the new digital cost environment.

*Factors contributing to significant cost differences*

- A “one procedure fee fits all” for diagnostic services is not supportable as a result of significant cost differences resulting from geographic location or facility type.
- Major groupings of facilities by cost differences can be identified and workable options developed.
- Total procedure cost is further and significantly impacted by the efficiency (time to complete) of a procedure as well as equipment cost and lifespan.
- Standards and guidelines can be implemented to manage the impacts of procedure efficiency, equipment cost and lifespan.

### 3.6 Provincial System for Accreditation of Diagnostic Services

The DSC sees strengthening diagnostic services performance and accountability as a key priority, the strategies for which are outlined in its *Strategic Directions Report*.

As a first measure, through its Sub-Committee on Quality and Utilization Review and Management (QURM), the DSC undertook an assessment of accreditation and quality management practices in Ontario and in other provincial and international jurisdictions. This review found that:

- Accreditation is a major feature in the delivery of diagnostic services in all jurisdictions considered (B.C., Alberta, Manitoba, Quebec, U.K., Australia, New Zealand, U.S.).
- Accreditation is either mandatory or linked to public funding of services.
- There is a clear trend outside Ontario towards expanded use of accreditation as a means of ensuring diagnostic service and quality standards are met and service and clinical improvement are promoted.
- Accreditation of diagnostic services in Ontario is more limited, applying only to labs and IHFS, and lags the western provinces reviewed:
  - Accreditation of diagnostic services includes both lab, radiology and other diagnostic services in all provider settings;
  - All approaches combine both mandatory and voluntary components and are:
    - Moving beyond compliance to include continuous quality and safety improvement, and
    - Placing stronger emphasis on meeting performance standards.



- Best practices include a more activist approach through education, knowledge transfer around best practices, mentoring, the use of improvement teams, and public reporting of accreditation results, none of which are features in Ontario's current diagnostic accreditation systems.

Based on these findings, the DSC is proposing that accreditation be adopted as a strategy for improving the quality, safety, performance and accountability of diagnostic services in Ontario.

### **3.7 Diagnostic Health Human Resources**

The DSC's research identified that Ontario does not have an adequate picture of the supply, mix and distribution of diagnostic professionals within the province or a sense of what future supply and demand needs and challenges might be. There are indications of a shortage of diagnostic imaging technologists which the Committee feels may well be exacerbated in the near future.

The Committee has recommended to the MOHLTC that an assessment of diagnostic human resource needs be undertaken with priority given to obtaining a picture of the current and near term labour supply and demand situation for diagnostic imaging technologists and its impact on service productivity, efficiency and access.

## 4 Future Priorities and Directions

The Committee has undertaken to identify future priorities and directions for the DSC or its successor committee. The priorities identified below reflect a consensus of the current members of the Committee.

These priorities are intended to be undertaken over a 3 to 4 year time frame.

The Committee recognizes that the future of the DSC is a matter of negotiations between the MOHLTC and the OMA in which the OHA has observer status. The recommendations in this report do not necessarily reflect the views or positions of any of these parties.

**Please note subsequent references to the DSC means “the DSC or its successor committee.”**

The proposed priorities build on and reflect earlier consensus discussions and reports of the Committee,

- DSC Strategic Directions Report and recommendations
- Establishment of a Segregated Diagnostic Funding Envelope
- DSC Self Assessment

as well as the work undertaken by the Task Forces on Technical Compensation and Diagnostic Equipment and the Sub-Committee on Quality and Utilization Review and Management.

The proposed future priorities and activities align with the goals of the DSC’s *Strategic Directions Report* for diagnostic services.

Both the OMA and OHA have recently indicated an interest in having the mandate of the DSC expanded to include lab services. The OMA Board has passed a resolution to this effect. The Committee has not formally considered this expansion in mandate but, should it occur, DSC priorities would have to be revisited. (The issue of labs is briefly taken up below)

In proposing priorities Committee members have been mindful of the changing context for provincial health delivery and health care goals:

- Transformation of Ontario’s health care system that continues to evolve, most notably within the context of the Ministry’s new stewardship role and LHINs.
- A strengthened commitment to improving quality, performance, and accountability, including greater accountability to both the public and users of the health care system.
- Greater reliance on the role of experts in providing policy and strategic advice.
- A strong commitment multi-party collaboration processes that provide practical value and benefit to the health care system.

The Committee believes that a clearer accountability framework is required to strengthen the DSC's effectiveness and increase the likelihood that its work will be supported and implemented.

In this regard, the Committee recommends that the MOHLTC, the Ontario Medical Association and the Ontario Hospital Association enter into a long term Accountability Agreement with respect to the DSC that sets out the commitments of the parties, DSC priorities, and reporting and accountability relationships.

## **4.1 New Funding**

Funding for the operating and capital costs of providing diagnostic services have not kept pace with inflation nor has it been adjusted to reflect newer and higher cost of modalities associated with digitization of diagnostic equipment. The tight labour supply for diagnostic technologist is pushing up labour rates. There is also clear evidence of ongoing under-investment in the replacement of diagnostic equipment, which presents both quality and accountability concerns.

The Committee believes that an immediate infusion of new funding for diagnostic services is required to address:

- Current inflationary pressures (technical diagnostic services have had only a 1% increase in fees since 2000);
- Replacement of aging diagnostic equipment and the conversion from analog to digital equipment;
- Strategic investments for new technologies, quality and safety improvements and targeted research and evaluation, and
- Resources to carry out the priority agenda recommended in this Report.

The Committee recommends that the DSC provide advice on the specific use and allocation of additional funding to optimize the benefits of this new investment.

The Committee also recommends that:

- A multi-year financial framework be established with input from the DSC that sets out the financial parameters within which the priorities agenda being proposed by the DSC is to be carried out.
- These financial parameters should include funding to support transition requirements and continuing access to services.

## **4.2 Segregation of the Diagnostic Funding Envelope**

The DSC recommends:

- The creation of a separate funding envelope for the technical components of diagnostic services as an essential step in:
  - Bringing a more sustained focus to the needs of diagnostic services, and for

- Supporting and leveraging improvements to Ontario's diagnostic services system.
- The initial steps in creating the proposed diagnostic funding envelope be done through the segregation of technical fees from within the OHIP pool and the integration of non-OHIP funding for IHFs.
- New funding for diagnostic service be explicitly linked to the segregation of t-fees, which should occur no later than March 31, 2009.

### 4.3 Renovation of the Current Technical Fee System

Based on its review of technical compensation and the state of major diagnostic equipment in the province, the DSC has concluded that the current technical fee system requires renovation to better reflect current realities, achieve greater accountability for replacement and acquisition of diagnostic equipment and address the new cost structure associated with the shift from analog to digital equipment.

The Committee recommends that a process of renovation of the technical compensation system be undertaken consistent with the following principles:

- Capital Funding:
  - Create a method of accountability, such as a separate funding stream for major diagnostic equipment replacement and acquisition, that ensures:
    - capital funds are spent for capital purposes; and
    - there is timely, appropriate replacement of diagnostic equipment including the transition from analog to digital equipment.
  - A new compensation methodology be developed based on:
    - a definition of capital that includes the cost of equipment, and related financing, support and maintenance costs; and
    - life cycle and efficiency-based utilization standards.
  - New investment in capital be implemented in such a way as not to reward providers who have not taken action to appropriately replace their equipment.
- Operating Funding:
  - The current "one procedure fee fits all" compensation methodology be replaced by one that recognizes significant cost differences resulting from geographic location or facility type and the shift from analog to digital equipment.
  - New fees be established taking into account appropriate efficiency standards with respect to the utilization of equipment and procedure time and the consolidation of fees for a related cluster of procedures.
  - Special consideration in the compensation structure be given to service providers in under-serviced areas.
- Accessibility to services should not be compromised as a result of changes to the compensation system.
- Time Frame:
  - A 3 year time frame be set for undertaking the renovation of the technical compensation system.

## 4.4 Enhancing System Performance and Accountability

### 4.4.1 *Diagnostic Replacement Equipment Guidelines*

The DSC inventory of major diagnostic equipment raises substantial concerns about the timely replacement of diagnostic equipment and the lack of any established standards for when such equipment should be replaced. The results of the inventory also reveal a major problem of accountability with respect to the use of funds being made available for capital replacement.

The Committee recommends:

- Guidelines be developed for the life cycle and replacement of diagnostic equipment based on quality and safety standards using the advice of experts. Expert Groups should draw upon individuals from the three diagnostic delivery sectors, physician specialists and industry.
- The application of life cycle guidelines be linked to the diagnostic payment system.
- A permanent inventory of major diagnostic equipment be established to ensure appropriate reporting and accountability with respect to funded equipment.
- Formal arrangements be established between the DSC and Medical Advisory Secretariat (MAS)/OHTAC for research and advice on diagnostic equipment.

### 4.4.2 *Accreditation of Diagnostic Services*

Based on its review of accreditation and quality management practices, the DSC has concluded that considerable improvement to the quality and performance of Ontario's diagnostic services system can be made through an accreditation process.

As such, the Committee recommends:

- A province-wide system of accreditation for diagnostic services be introduced as means of improving the quality, safety, performance and accountability of these services in hospitals, IHF and physician offices and clinics.
- While the Committee's focus has been on insured services, it recommends that accreditation of facilities providing non-insured services also be considered.

The following approach to accreditation is proposed:

- A standardized approach to accreditation for diagnostic services should be adopted that includes both mandatory and voluntary components.
  - The current OLA and IHF systems should be utilized and built upon as they incorporate many of best practice features;
  - In the absence of legislation, accreditation requirements should be tied to the funding of services.
- Accreditation should be used to introduce and support a system of quality management for the delivery of diagnostic services in the province that includes the assessment of performance and the user experience as well as public reporting of results.

- Accreditation should apply in principle to all service delivery settings, however, the extent of its application within the physician offices/clinics sector requires further review.
- A review of options for funding a provincial accreditation system should be undertaken that includes incentives for service provider participation.

(See Appendix D for guiding principles and core design features of the proposed diagnostic accreditation system.)

The Committee also recommends:

- A multi-party/experts Committee steer the development and implementation process, and
- Early on consultation with the field be undertaken through a Discussion Paper on Diagnostic Accreditation building on the work of the QURM Sub-Committee.

#### 4.4.3 *Service Delivery Productivity and Performance Standards*

There are currently no established performance standards for productivity and efficiency for diagnostic service. The DSC's Task Force on Technical Compensation has concluded that efficiency levels have a significant bearing on procedure costs and that new fees be benchmarked to efficiency standards. Service delivery standards are also required in the event of moving to a system of accreditation.

The Committee recommends:

- A task force drawn from experts among provider groups (hospitals, IHFs and physician offices) develop operating standards for diagnostic services. These standards would include both efficiency and customer service standards. Efficiency standards would be used in the proposed renovation of technical compensations.
- Options for sector-wide collection, sharing and reporting of data on diagnostic service delivery performance be evaluated.

### 4.5 Strategic Initiatives

#### 4.5.1 *Planning and Research*

Through its *Strategic Directions* exercise the DSC has completed foundation work on long term directions for diagnostics in Ontario. The proposed directions have not been widely shared or discussed within the diagnostic services community. A broad consensus on future goals and directions for diagnostic services in Ontario would facilitate understanding and movement on the issues and proposed changes that have been identified by the DSC.

The Committee has also identified the need for expanded investment in diagnostic services research, particularly with respect to issues of utilization, such as repeat testing and the rapid increase of multiple tests for the same person, the distribution of and access to diagnostic services and resources, future diagnostic human resource needs, and technology assessment.

The Committee recommends:

- Building on its *Strategic Directions Report*, there be a consultation with stakeholders on future directions for diagnostic services in Ontario. The result of the consultation would be used to inform Ministry planning and serve as input to a planning framework for future DSC activities.
- A multi-year plan for diagnostic service research and evaluation be developed with input from provider and research stakeholders.

#### 4.5.2 *On-line Diagnostic Order Entry*

The DSC views the development of on-line order entry for diagnostics as key strategy for achieving more appropriate utilization of diagnostic services and improving patient care. DSC's *Strategic Directions Report* recommends the development of a business case for diagnostic on-line order entry and pilot projects. This type of initiative is supportive of MOHLTC's e-health strategy.

The Committee recommends:

- The OMA and OHA collaborate on developing a business case for diagnostic on-line order entry, including identifying recommendations for pilot projects.

#### 4.5.3 *Group Purchasing*

The Task Force on Diagnostic Equipment concluded there are opportunities for savings through group purchasing arrangements. However, the Task Force recommended that such arrangement only be considered if they are not mandatory and that they include:

- Negotiated best rates (by or with the assistance of the provincial government);
- Flexibility to allow individual facilities to negotiate a more favourable deal, based on their own circumstances.

Building on this advice, the Committee recommends:

- An assessment of voluntary group purchasing arrangements and opportunities for diagnostic equipment be undertaken in collaboration with Ontario Buys.
- Based on the results of this assessment, a strategy be developed to support and promote voluntary group purchasing of diagnostic equipment.

### 4.6 Other Issues

#### 4.6.1 *Relationship with OHTAC*

DSC terms of reference call for interaction with OHTAC with respect to the consideration and implementation, distribution, quality management to support existing and new diagnostic technologies. While the relationship between OHTAC/MAS has been a constructive one, the lack of a formal understanding or arrangement with OHTAC has lead to some confusion about the roles and relationship of these two vehicles.

There is clear benefit to having a more formal arrangement between OHTAC and the DSC whereby the DSC would be able to draw upon the assistance and resources of

OHTAC to undertake needed evaluative and evidence-based assessments of diagnostic technologies and equipment.

#### *4.6.2 Expanding the DSC Mandate*

There have been suggestions to expand the responsibilities of the DSC to include laboratory services. The Committee has not taken a position on this issue. Such a step would expand the Committee's workload and require some changes in the DSC's membership. The inclusion of labs would be consistent with the DSC's recommendations for an integrated approach to diagnostic services and respond to the sun-setting of the Provincial Advisory Group for Lab Services. Many of the issues, such as accreditation of services, are common across diagnostic services.

#### *4.6.3 DSC Membership*

The Committee has discussed the need to include LHINs representation within the Committee. LHINs have a critical role in the development of diagnostic services and their participation on a body such as the DSC would ensure the needs and perspectives of LHINs are adequately taken into account.

The Committee recommends:

- The addition of one or more representatives from the LHINs as members of the DSC.



## Appendix A

### Diagnostic Services Committee Terms of Reference, April 15, 2004

#### **MANDATE:**

The Diagnostic Services Committee will function as an advisory body to the Minister of Health and Long Term Care for the purpose of planning and coordinating an efficient and effective diagnostic services system in the Province of Ontario with accountability among users and providers of diagnostic services.

#### **RESPONSIBILITIES:**

##### **Planning and Strategies to Address Health Care Needs**

1. Using a planning-based approach to the diagnostic services system, recommend strategies to address access and health care needs with a patient focus – including access in under-serviced areas, new approaches to meet patient needs, addressing capacity and waiting lists, improving patient education, educating physicians on referral patterns and guidelines etc.

##### **Funding and Structure**

2. To provide advice and recommendations on the funding and structure for the province-wide diagnostic system based on growth, supply, and changing patient needs.
3. To provide advice and recommendations for the use of any new funding, and for the funding of new diagnostic services.

##### **Quality and Service Standards**

4. To provide advice to strengthen quality assurance practices and guidelines. Using a collaborative approach, develop strategies to move toward a systemic and integrated approach to quality management to support appropriate quality and service standards for diagnostic services.

##### **Compensation of Technical Component**

5. To develop and establish how the technical component of diagnostic services (currently described as technical fees) will be evaluated, compensated, and administered, including establishing a costing methodology, and an ongoing review process to reflect that reimbursement is based on actual costs and current service volumes.

##### **Utilization Management**

6. To develop and recommend a province-wide utilization management process for the system, including technical fees. To conduct periodic reviews of utilization and utilization trends and provide advice on appropriate evidence-based utilization management.

**Diagnostic Technologies**

7. To consider and recommend implementation, distribution, quality management and other strategies to support existing and new diagnostic technologies – including interaction with the Ontario Health Technology Advisory Committee (OHTAC)

**Capital and Equipment**

8. To assess and make recommendations concerning equipment acquisition and replacement issues and related equipment standards and quality assurance.

**MEMBERSHIP:**

The DSC will consist of the following members:

- 3 physician members recommended by the OMA with 1 physician from an IHF
- 3 hospital members recommended by the OHA with 1 physician member
- 1 IHF member recommended by the Ministry of Health and Long-Term Care
- 3 government members recommended by the MOHLTC (appointments to be made with a view to balance)

Recommendations are forwarded to and approved by the Minister of Health and Long-Term Care.

**INDEPENDENT CHAIR:**

An independent chair will be appointed by MOHLTC after consultation with all parties. The chair will facilitate DSC meetings, provide strategic leadership and support, and report regularly to the Minister and other parties on the Committee's progress.

**SUB-COMMITTEES:**

The DSC may establish sub-committees to support its mandate and provide technical and other expertise and support as required.

**REPORTING:**

The DSC will report formally, at least on an annual basis, to the Minister of Health and Long-Term Care, and on a regular basis to the parties. The deliberations and reports of the DSC will be available to the parties. A system of reporting should be developed that includes commitments to performance goals through specific steps within specified time frames.

**FUNDING:**

The MOHLTC will fund the costs of the Committee including the Chair and Secretariat, and such expenses of the Committee as proposed by the Committee through an annual business plan and approved by MOHLTC. This may include: establishment of sub-committees, contracting technical expertise and research, consultations etc.

All payments to and expenses incurred by the appointees of each party will be the responsibility of that party.

**DSC SECRETARIAT:**

The DSC will be supported by a Secretariat.

Date: April 15, 2004

## Appendix B

### Summary List of DSC Reports and Advice (November 2005 - March 2008)

#### General

- 1 Regular update Report on the Diagnostic Services Committee (DSC) to the Physician Services Committee, including the results of the DSC Self-Assessment, October, 2007.

#### Planning and Strategies to Address Health Care Needs

- 2 DSC Strategic Directions Summary Report, *Building on Strength: A High-performing Diagnostic Services System for Ontario's Future*, June 2007.
- 3 *Horizon Scan of Diagnostic Technologies: Technology Push or Treatment Pull*, Michael Tremblay, Tremblay Consulting, 2006. An environmental scan of technological development to the year 2020 and trends that have the potential to influence diagnostic practices within Ontario.
- 4 *Profile of Ontario's Diagnostic Services: An Analysis Based on Ontario Health Insurance Plan Data (2001/2002 to 2005/2006)*, prepared by Nora Peterson, Ministry of Health and Long-Term Care, and Suk Yiu, KTA Inc., 2007. A comprehensive synopsis of how diagnostic services are funded, delivered and utilized in Ontario.
- 5 *Delivery of Diagnostic Imaging Services in Ontario: A Jurisdictional Review and Descriptive Analysis*, ICES Investigative Report, 2007. A two-part examination of the delivery of diagnostic imaging services in other jurisdictions to inform policy on diagnostic services in Ontario and how over 30 diagnostic tests are currently utilized in Ontario.
- 6 *Change and Innovation in Diagnostic Services Delivery*, The Change Foundation, 2007. Innovations in diagnostic care being considered or implemented elsewhere as the basis for considering some models or scenarios for application to Ontario to strengthen the diagnostic services system.
- 7 Letter of advice on the possible shortage of diagnostic imaging technologists in Ontario, January 2008.

#### Funding and Structure

- 8 Consensus Report on DSC Discussion on a Technical Diagnostic Funding Envelope, October 2007.

#### Quality and Service Standards / Utilization Management

- 9 Utilization Review and Management of Non-Laboratory Diagnostic Testing – Ideas for Consideration, Tom Closson, November 2006.

- 10 Report on Accreditation of Diagnostic Services, DSC Sub-Committee on Quality and Utilization Review and Management, March 2008.

### **Compensation of Technical Component**

- 11 Draft Report from the DSC Task Force on Technical Compensation, Phase 1 (review of costing methodologies), May 2007.
- 12 Final Report from the DSC Task Force on Technical Compensation, Phase 2, March 2008.

### **Diagnostic Equipment and Technologies**

- 13 Advice on the following diagnostic technologies issues:
  - a. MR CT safety issues, June 2006.
  - b. Ultrasound screening for abdominal aortic aneurysms, August 2006.
  - c. Expansion of scintimammography, February 2007.
  - d. MRI breast cancer screening, August 2007.

### **Capital and Equipment**

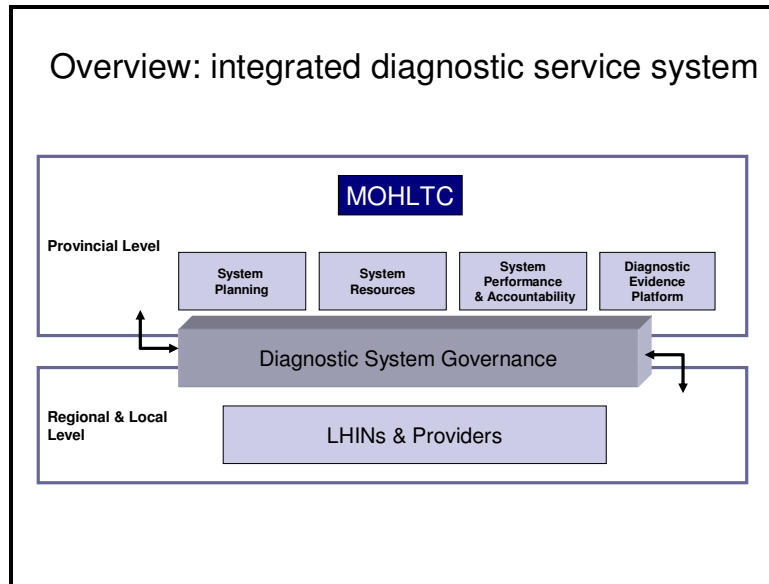
- 14 DSC Advice to Ministry of Health and Long Term Care on the Allocation of \$40 million DME fund, December 2005.
- 15 Summary Evaluation of the \$40 million Diagnostic Medical Equipment (DME) fund prepared by the DSC Diagnostic Equipment Task Force, February 2007.
- 16 Report on the Inventory of Major Diagnostic Equipment in Hospitals and IHFs, DSC Diagnostic Equipment Task Force, March 2008.

## Appendix C

### Strategic Directions Highlights

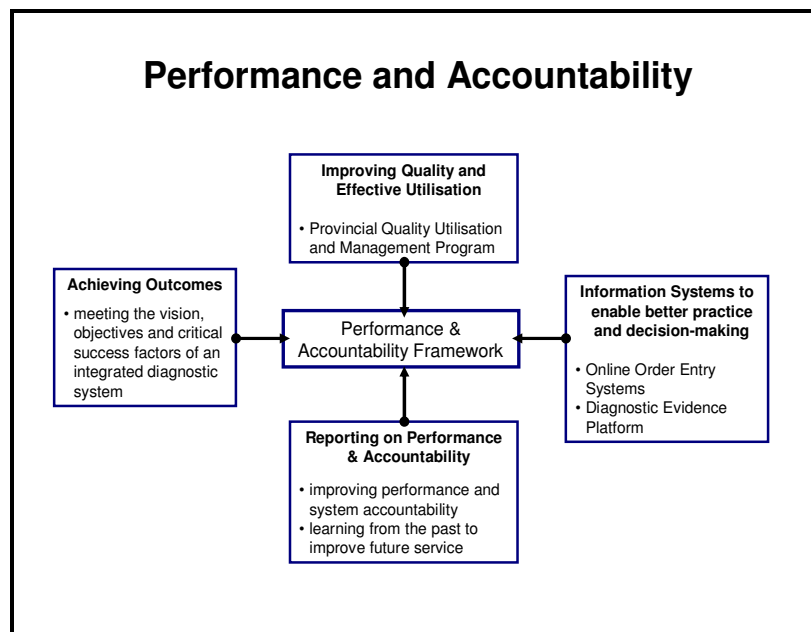
#### Building Diagnostic System Capacity

Core to the DSC's vision is a diagnostic services system with an integrated provincial diagnostic capacity able to assess, coordinate and distribute diagnostic services and capabilities, and provide a common province-wide reference point for standards, quality and outcomes.



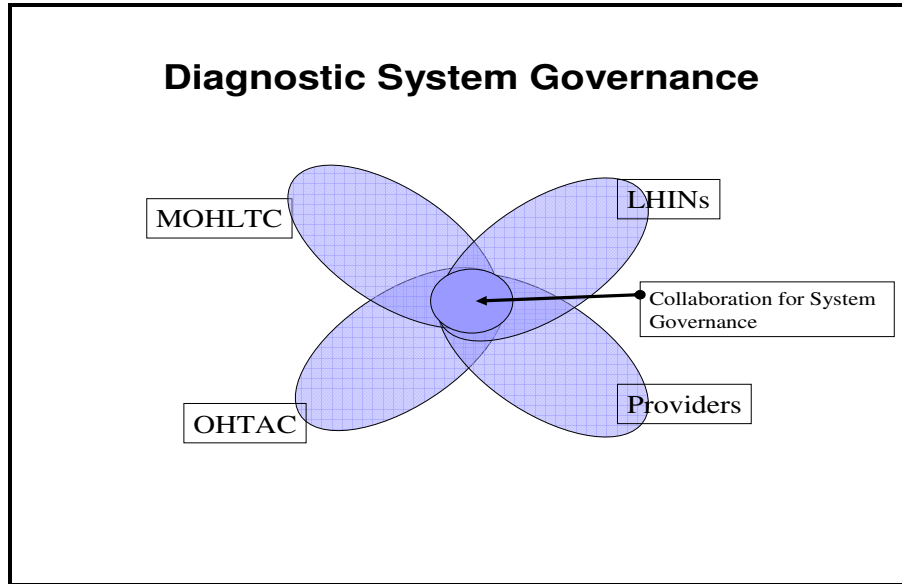
#### System Performance and Accountability

Achieving better performance requires providers, clinicians and patients taking more responsibility for the appropriate and efficient use of diagnostic resources. The public and patients also need to be better informed so that they can take greater responsibility for setting expectations and using services appropriately.



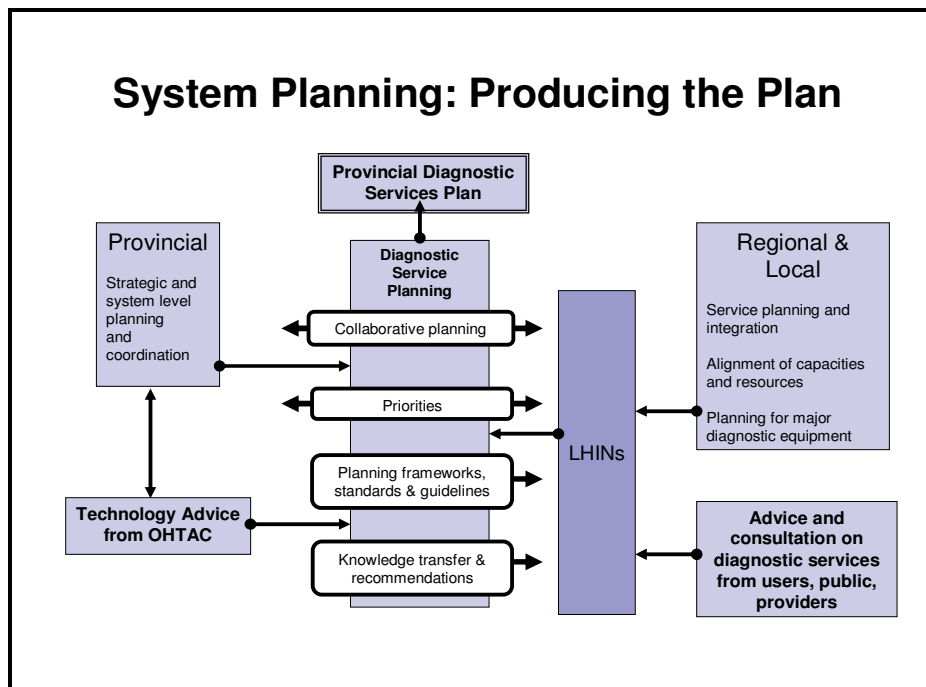
## Developing Diagnostic System Governance

A governance system that unites the interests of key health system participants, in particular the LHINs and providers in system governance would provide specific accountability for diagnostic services, and a framework for overseeing system planning and resourcing as well as performance and accountability.



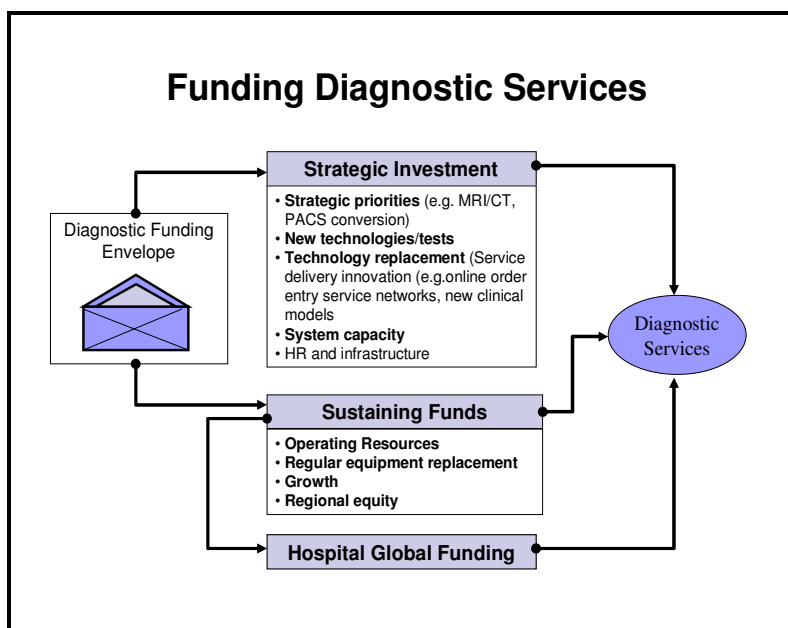
## System Planning: Planning and Integrating Diagnostic Services

Better diagnostic planning is central to moving to a proactive, integrated and system-oriented diagnostic service model.



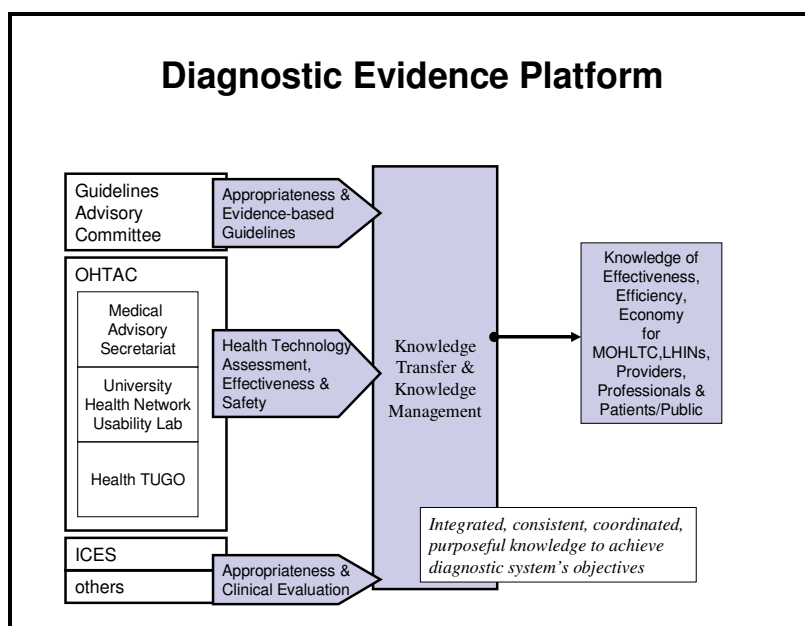
## System Resources: Aligning the Diagnostic Resources System

A fit-for-purpose funding system is an essential enabler of diagnostic service improvement.



## Developing a Diagnostic Evidence Platform

Achieving a high performing, outcome-oriented diagnostic services system has to be knowledge and evidence driven if it is to be effective in providing optimal benefits to patients and the provinces health care system.





## Appendix D

### Diagnostic Services Accreditation

#### 1. Goal

- A quality management oriented system of accreditation for non-lab diagnostic services in Ontario that supports and promotes the highest level of quality, safety and performance possible within a system of integrated patient-centred care.

#### 2. Guiding Principles

- A system of accreditation that satisfies international standards
- Evidence-based peer review through an independent authoritative body
- A consistent process of accreditation across provider settings recognizing the need for flexibility with respect to differences among diagnostic specialties and service delivery settings
- A comprehensive accreditation approach that includes quality management, proficiency testing, assessment of performance and user experience (patients & referring physicians), and continuous improvement through education, mentoring and the use of 'improvement teams'
- Public reporting of accreditation results

#### 3. Primary Design Features

- An assessment cycle of 4 years with a mid-cycle self-assessment, along with complaint and "for cause" reviews
- Variable lengths and conditions of accreditation depending on accreditation results
- Assessors sourced from the peer community with appropriate training
- On-site review and self-auditing
- Knowledge transfer of best practices
- An appeals process

**TAB 222**



# Task Force on Technical Compensation

Report to the DSC – March 19, 2008

Rainer Beltzner - Chair



# Index

- Executive Summary
- Mandate
- Approach
- Highlights and observations
- Conclusions
- Appendices
  - Appendix A - Assumption used
  - Appendix B - Comparative costs across sample fee codes
  - Appendix C – Task force membership



# Executive Summary

## Background

The Diagnostic Services Committee (DSC) established a Task Force on Technical Compensation to respond to its mandate: “To develop and establish how the technical component of diagnostic services (currently described as technical fees) will be evaluated, compensated, and administered, including establishing a costing methodology, and an ongoing review process to reflect that reimbursement is based on actual costs and current service volumes.”

## Mandate for this Phase

As a result of the recommendations arising from Phase I of the Task Force, the DSC established a mandate for Phase II that focused on:

- Decomposing a technical fee into its operating and capital components
- Identifying the impact on a technical fee as a result of the transition from an analog to a digital environment
- Identifying the factors that contribute to significant differences in costs as a result of a facility type or geographic location across the province



# Executive Summary

## **Finding # 1 – Technical fee operating and capital costs**

- The capital and operating cost components of a technical fee can be readily identified – there are no technical impediments to determining capital costs
- The capability to separately identify operating and technical costs allow for an examination of equipment capability, replacement and cost options

## **Finding # 2 – Analog to digital**

- The introduction of digital based technologies has significantly increased capital costs (the cost of equipment – and the related financing, support and maintenance costs)
- The ratio of capital and capital related costs to total cost per procedure has generally increased
- Existing fees do not reflect the cost realities (level of cost as well as types of cost) of the digital environment
- The current costing methodology can be adjusted to reflect the new digital cost environment



# Executive Summary

## **Finding - #3 – Factors contributing to significant cost differences**

- A “one procedure fee fits all” for diagnostic services is not supportable as a result of significant cost differences resulting from geographic location or facility type
- Total procedure cost is further and significantly impacted by the efficiency (time to complete) of a procedure as well as equipment cost and lifespan
- Major groupings of facilities by cost differences can be identified for examination of options
- Standards and guidelines can be implemented to manage the impacts of procedure efficiency, equipment cost and lifespan



# Mandate

## Technical Fees

- Identify components contributing to capital and operating costs
- Identify major differences in costs across geographical and facility settings
- Develop results model to demonstrate equipment and volume options

## Analog to Digital

- Identify major costs of change of transitioning to digital
- Identify other factors





# Approach

- Sample fee codes identified
- Data gathered from Task force members and external parties
- Cost models developed and reviewed with Task Force (see note below)
- Commentary on cost components and assumptions developed to assist understanding of cost changes over time
- Final report developed and reviewed with Task Force

Note : Cost models were developed for the specific purpose of the current mandate. Models are based on a single procedure being provided at one site with discrete staff providing required functions in support of the procedure. The assumptions used and incorporated into the cost models do not reflect all business practice efficiencies or multiple tests/modalities at the same site. As a result, they may not represent current diagnostic service practices at hospital or community based settings.



# Approach

## - Cost Models

- General assumptions identified
- Operating costs identified
- Capital costs identified
- Two digital (CR and DR) cost models developed for comparison (where applicable)
- Cost models for three practice types (IHF, Teaching Hospital, General Hospital) developed for comparison.
  - We also considered the use of the cost model for a fourth practice type (private physician office - e.g. cardiology) but did not complete this due to time constraints.



# Highlights and Observations

## - Significant cost components

- There are six cost components with significant impact on total costs  
(Refer to Appendix A for explanation of assumptions (amounts in brackets indicate range of % on total procedure cost))
  - Expected return on investment (IHF – 17%-19%/ Hospital – 3%-6%)
  - Technician labor (13%-33%)
  - Administrative and support labor(7% -20%)
  - Office supplies & overheads(7%-20%)
  - Equipment cost (12%-31%)
  - Equipment maintenance (6%-24%)



# Highlights and Observations

## - Key variables to per procedure costs

- There are five key variables that can significantly impact the calculated per procedure cost
  - Period costs for non capital cost components (labor, space, supplies)
    - All costs that are not directly variable with patient or procedure volumes are allocated over the estimated maximum number of procedures (see average procedure time).
  - Capital cost of equipment
    - Capital costs will differ by as much as 100% depending on the equipment used to satisfy the desired range of functionality.
  - Life expectancy of equipment
    - Life expectancy impacts financing and maintenance costs.
  - Efficiency of equipment use
    - We have assumed an 80% efficiency based on standard working hours to account for required maintenance and other “down time”.
  - Average procedure time
    - A reduction/increase in average procedure time will reduce/increase procedure cost.



# Highlights and Observations

## - Differences in provider settings

- There are significant cost differences across provider settings (Refer to Appendix B - Comparative costs across sample fee codes)
  - IHF locations outside of GTA/Ottawa central have lower per procedure costs. (Appendix B - Table 1 and Table 2)
    - Wages outside of the central Toronto and Ottawa areas appear to be lower. However, the competitive demand for technicians is likely to normalize wage costs and benefits across the Province to be consistent with union rates and benefits.
    - Space cost is currently \$15 (gross) per sq. ft. (30%) lower outside of central Toronto/Ottawa areas. Space costs are likely to normalize to the higher rate in future according to real estate brokers.
  - See next page for Academic and General Hospital discussion....



# Highlights and Observations

## - Differences in facility settings, cont'd

- Academic and General Hospitals do not have the same per procedure cost – and it is also different from IHFs. Hospitals have some higher costs - but they also enjoy some cost reductions that help to reduce the difference
  - Higher - Hospital wages tend to reflect current union rates and include an additional cost of 10% of wage rates for the employer contribution to employee pension.
  - Higher - Equipment capital costs (and as a result, financing and maintenance) tend to be higher reflecting the hospital choice of more expensive equipment.
  - Higher - Academic hospitals incur an additional cost (reported to be 30%) on most non capital cost components resulting from their teaching activities.
- See next page for costs that can be lower.....



# Highlights and Observations

## - Differences in facility settings, cont'd

- Hospital cost differences continued....
- Lower - Hospitals enjoy a lower tax burden as a result of their ability to recover most GST as compared to IHFs that are generally unable to recover any GST. For 2008, the comparative GST rate is 0.8% for hospitals and 5% for IHFs. Additional differences exist for Retail Sales Tax as well.
  - Lower - IHFs are totally compensated on a fee for service basis with resulting impact on available working capital access to retained earnings for capital investments. Hospitals have broader access to working capital resulting from their nature of government and donation funding.
  - Lower - IHFs operate as “for profit” entities as compared to hospitals that are “not for profit”. IHF’s require some return on investment impacting both operating and capital costs. Hospitals do not pay income tax. IHFs are required to pay income and other taxes such as property taxes (subject to their specific business structure and timing of capital investments).



# Task Force Conclusions

## - Cost methodology

- The present CTC cost methodology (subject to refinement ) can be used as a basis to establish reasonable per procedure costs. Some possible refinements identified through the cost models include:
  - Additional cost elements need to be added to reflect the use of current technology
  - Cost assumptions need to be agreed and/or reaffirmed
  - Formal standards are needed to reduce the number of costs determined through estimates





# Task Force Conclusions

## - Sample cost models

- Specifically in response to our mandate, sample code cost models have been developed that:
  - Separately identify capital and operating cost components
    - In our sample code cost models, we were able to identify thirteen distinct cost components
    - We identified ten separate operating cost components
    - We identified three separate capital cost components
  - Identify provider differences
    - We identified determined that there were at least five distinct provider groupings for cost purposes (IHF GTA/Ott Central; IHF All other Ontario; Physician office; Academic Hospitals; General Hospitals)
    - A separate cost model for each sample code was developed (except for physician office - due to time constraints)
  - Allow for demonstrating options
    - We developed the cost model to allow for changes to key assumptions as well as individual costs to be dynamically reflected in a total procedure cost
    - Where applicable, the cost models differentiate the two levels of digital environments allowing for an examination of cost differences as well as cost components.



# Task Force Conclusions

## - Fee code cost differences

- There are significant cost differences across provider settings as well as the level of technology used, reducing the likelihood that a single fee can reasonably and fairly compensate in all provider settings
  - Appendix B – Tables 1 and 2 demonstrate the variability in per procedure costs (up to 31%) as a result of a change to provider setting.
    - The cost models indicate that IHF locations outside of the GTA core as well as General hospitals have lower per procedure costs as compared to IHFs in the GTA/Ottawa central and Academic hospitals.
    - The cost models indicate that generally, Academic hospitals have the highest cost per procedure.
  - Appendix B – Table 3 demonstrates the variability in per procedure costs (up to 32%) as a result of a change to the level of digital technology used (CR vs. DR)
    - The cost models indicate that DR environments have higher per procedure costs.



# Task Force Conclusions

## - Technology standards

- Formal minimum technology standards are needed to reduce variability in costs and improve accountability. The preparation of the cost models reflecting the newer technology environment has identified the need for additional focus on:

- Technology life cycle for equipment replacement.

New technologies have constant improvements in quality as well as the range of functionality. However, the rapid pace of change in technology including associated software has also reduced the useful life span of many technology components. This, combined with the need to provide for and access maintenance often results in more frequent equipment and software replacement. There is an increasing gap between functioning and functional technology.

- Continued next page.....



# Task Force Conclusions

## - Technology standards, cont'd

- Data and image format standards

Data and image format standards are necessary for the ability to transmit data and images from one device to another or to a communications network. It is essential that equipment and software comply with an agreed set of standards if data sharing is deemed appropriate or necessary. Not all equipment and software used in the provision of services funded by technical fees uses a consistent set of data and image format standards such as DICOM and HL7.

- Software costs

There is a wide variety of software used in a digital environment including PACS (Picture archive and communication system) in addition to (RIS) all of the necessary medical and business as well as technical administrative functions. In addition to initial licensing, there are costs for periodic upgrades and replacement.

A further complication to establishing cost arises from varying billing approaches used by software suppliers which can include one time licensing, a per use charge, or a combination of both.

- Continued on next page....



# Task Force Conclusions

## - Technology standards, cont'd

- Technology support costs

Technology support costs have increased dramatically as a result of (i) the pervasiveness of technology in all aspects of service delivery (ii) the complexity and diversity of technology (iii) the need for data and image communications and storage/retention (iv) the need to mitigate exposures such as data loss, data security breach and service interruption.

It is common to employ an individual with responsibility for the management of technology supported by additional (often third party) technical staff or organizations.

- Licensing, regulatory and standards of care costs

There is a desire and responsibility by the profession to establish appropriate procedures consistent with the use of new technologies to support the standard of patient care.



# Task Force Conclusions

## - Compensation and space guidelines

- Formal guidelines regarding technician and administrative staff compensation and benefits, as well as required space, can reduce variability in actual delivery costs and improve accountability
  - Minimum staff compensation and benefits could be aligned with present union agreements
  - A standard minimum space allocation per procedure could be determined



# Task Force Conclusions

## - Academic and General hospital costs

- The cost models for Academic and General Hospital environments indicate several significant cost differences to IHFs that should be examined further
  - The reported use by hospitals of technology with higher functionality than used by IHFs leads to higher per procedure costs. The need for and extent of differences in functionality should be examined further.
  - Academic hospitals (as well as other teaching environments) incur a time and cost impact from “students”. The extent of the impact is reported as 30% on technician and other staff, as well as space and supplies. The extent of real impact should be examined further.



# Appendix A

## - Assumption used for cost models

### ○ **Per Procedure Cost**

- The cost of a procedure is directly dependent on a period cost for non capital cost components such as labor, supplies and space; the capital cost of equipment and assumed life expectancy measured in years; the effective efficiency (availability) of equipment; and the average time per procedure.
- Any significant change to any of these cost components can result in a significant change to the total procedure cost.

### ○ **Operating Margin Assumption**

- Operating Margin includes the cost of working capital in addition to a profit component. The calculation is based on all costs excluding capital equipment for which a separate cost of capital can be used.
- Considerations for the use of an operating margin should include:
  - The desirability of providing for a profit component.
  - The rate to be used.
    - Investors in private as well as public listed companies typically strive for a profit margin in the range of 10%-15% before taxes.
    - Public funded organizations that are not for profit (eg hospitals) generally do not have a requirement to achieve a profit from their operations.
- Operating margin rates used in our analysis are:
  - - 15 % for IHF environments.
  - - 0% for Academic or General Hospital environments





# Appendix A

## - Assumption used for cost models, cont'd

### ○ Technician Labor

- Technician hourly labor rates used are consistent with current hourly Union Rate at the midpoint of experience for the specific category of technician.
- In addition to the labor rate, an additional labor rate burden of 20% for IHF and 30% for hospital environments was used. Technicians that are covered under OPSEU generally attract up to an additional 10% of the labor rate as the employer contribution to the pension plan. If all employers agreed to or were governed under an identical collective agreement, an identical burden rate would apply.
- Academic hospitals will have longer per procedure time due to accommodate their instruction environment. A 30% increase in average per procedure time has been assumed.
- Facilities other than Academic Hospitals may also be required to perform similar instruction roles. These facilities will also incur some increase in average per procedure time as a result.
- The calculation of actual per procedure cost is dependent on the standard working hours per year as well as the assumed average time per procedure. The total per procedure cost is highly sensitive to any change in average hourly technician cost as well as average per procedure time.
- IHF and hospital environments typically use 1,750 annual working hours. The number of working hours does not impact the calculation of per procedure cost as the calculation is based on the same Hourly Rate (except for burden %) and the identical average minutes per procedure.
- Some difference in the hourly rate can result based on location but this is not expected to continue due to competitive nature of demand for technicians.



# Appendix A

## - Assumption used for cost models, cont'd

### ○ Admin & Support Staff

- This staff category includes reception/patient registration, PACS and IT support as well as office management.
- Administrative and support staff perform a wide variety of support functions for the facility as well as technicians to improve the efficiency of technician and thus per procedure time. For example, some of these duties will include:
  - preparation, update and maintenance of PACS and RIS data
  - patient data validation
  - patient scheduling
  - general office administrative responsibilities including inbound and outbound correspondence, purchasing and receiving.

A small amount of time is actually spent with the patient to handle scheduling, registration and related matters.

- The calculation of actual per procedure cost is determined on an FTE basis from the annual gross compensation divided by the number of patient visits that can be handled. A reasonability test is then applied to the calculated average minutes per procedure by staff category.
  - Reception and admin staff – 18 minutes per case.
  - PACS and IT support staff – 1.5 minutes per case.
  - Office management staff – 3 minutes per case
- The cost applicable to Academic Hospitals was increased by 30% to account for the impact of their teaching activity.



# Appendix A

## - Assumption used for cost models, cont'd

- **Accounting & Billing**

- This includes the cost of accounting assistance and OHIP billing. The calculation is based on an FTE annual gross compensation divided by the number of cases handled. A reasonability test is then applied to the calculated average minutes per procedure (case).
- The cost applicable to Academic Hospitals was increased by 30% to account for the impact of their teaching activity.

- **Office Supplies and General Overhead**

- This includes all office and general supply costs with the exception of staff, space, quality assurance/licensing and equipment.
- The cost applicable to Academic Hospitals was increased by 30% to account for the impact of their teaching activity.



# Appendix A

## - Assumption used for cost models, cont'd

- **Quality Assurance, Licensing, Regulation and Standard of Care**
  - This includes required and desirable measures to meet current standard of care, quality assurance measures, licensing, accreditation, and regulatory requirements. It includes educational costs for technicians to maintain their licenses.
  - The cost applicable to Academic Hospitals was increased by 30% to account for the impact of their teaching activity.
- **Transcription Labor**
  - Transcription rates used are consistent with current actual and include a similar labor burden as previously discussed. A time of 5 minutes per procedure is used.
  - The transcription cost per procedure is not large compared to other procedure cost categories.
  - The cost applicable to Academic Hospitals was increased by 30% to account for the impact of their teaching activity.



# Appendix A

## - Assumption used for cost models, cont'd

### o **Space - Specific**

- This includes the cost for space dedicated to the equipment. A survey of practices has identified the typical space as follows:

- Total Clinic – 2 machines – 1,300 sq. ft.
- CR general x-ray or Mammo room 200 sq. ft.
- DR general x ray or Mammo room 150 sq. ft.
- CR Processor room 100 sq. ft.

Note that dedicated space for a modality is supported by additional general clinic space to accommodate patient reception, change rooms, washrooms, storage, administration staff, data/communications and other common areas of the facility.

- Per procedure space cost is determined by annual cost for the required number of square feet divided by the annual number of procedures. The annual number of procedures is determined by the standard annual equipment hours less downtime provision divided by the required time per procedure. Factors that can influence the actual per procedure cost for space include:
  - Annual space cost per square foot
  - Required square feet
  - Annual available equipment hours
  - Time per procedure



# Appendix A

## - Assumption used for cost models, cont'd

- **Space - Specific, cont'd**

- Average gross rent based on independent survey is found to be:
  - GTA Tor/Ott Central - \$50.00 sq.ft.
  - Other Ontario - \$35.00 sq.ft.
- Space calculation for CR based general x-ray or mammography room is 300 sq. or 23% of 1,300 sq. ft. @ rate.
- Space calculation for DR general x-ray or mammography room is 150 sq. ft. or 11.5% of 1,300 sq. ft. @ rate.



# Appendix A

## - Assumption used for cost models, cont'd

### o Space – General

- Dedicated space for a modality is supported by additional general clinic space to accommodate patient reception, change rooms, washrooms, storage, administration staff, data/communications and other common areas of the facility.
- Per procedure space cost is determined by annual cost for the required number of square feet divided by the annual number of procedures. The annual number of procedures is determined by the standard annual equipment hours less downtime provision divided by the required time per procedure. Factors that can influence the actual per procedure cost for space include:
  - Annual space cost per square foot
  - Required square feet
  - Annual available equipment hours
  - Time per procedure
- Assuming a two machine clinic, average space is assumed to be 1,300 sq. feet as follows:
  - Two machine rooms @ 200 sq. ft each = 400 sq. ft.
  - One CR room @ 100 sq. ft. = 100 sq. ft.
  - Common space = 800 sq. ft. or 62%.
- Average gross rent based on independent survey is:
  - Tor/Ott Central - \$50.00 sq.ft.
  - Other Ontario - \$35.00 sq.ft.



# Appendix A

## - Assumption used for cost models, cont'd

- **Software**

- Software includes both machine related PACS and RIS including any administrative IS.
- We have used an estimate of \$2.00 per procedure.





# Appendix B

## - Table 1 Cost comparison of CR to GTA CR

Fee Code	CR		CR		CR		CR	
	IHF		IHF		Academic		General	
	GTA		Other Ontario		Hospital		Hospital	
X091	\$	1.00	\$	0.93	\$	1.03	\$	0.86
X113	\$	1.00	\$	0.93	\$	1.03	\$	0.86
X185	\$	1.00	\$	0.98	\$	0.99	\$	0.86
X224	\$	1.00	\$	0.93	\$	1.02	\$	0.86



# Appendix B

## - Table 1 J135 cost comparison to GTA

Fee Code	IHF	IHF	Academic	General
	GTA	Other Ontario	Hospital	Hospital
J135	\$ 1.00	\$ 0.85	\$ 1.16	\$ 0.97



# Appendix B

## - Table 2 Cost comparison of DR to GTA DR

Fee Code	DR		DR		DR		DR	
	IHF		IHF		Academic		General	
	GTA		Other Ontario		Hospital		Hospital	
X091	\$	1.00	\$	0.95	\$	1.21	\$	1.04
X113	\$	1.00	\$	0.95	\$	1.23	\$	1.09
X185	\$	1.00	\$	0.99	\$	0.95	\$	0.85
X224	\$	1.00	\$	0.94	\$	1.22	\$	1.06



# Appendix B

## - Table 2 Cost comparison of DR to CR

Fee Code	DR		DR		DR		DR	
	IHF		IHF		Academic		General	
	GTA		Other Ontario		Hospital		Hospital	
X091	\$	1.00	\$	1.01	\$	1.17	\$	1.21
X113	\$	1.15	\$	1.18	\$	1.38	\$	1.46
X185	\$	1.32	\$	1.34	\$	1.27	\$	1.31
X224	\$	0.99	\$	1.01	\$	1.18	\$	1.23



# Appendix C

## - Task Force Membership

- Chair
  - Rainer Beltzner
- MOHLTC
  - Katherine Tessier, MOHLTC
- OHA
  - Nan Brooks, UHN
  - Bill Hart, Kingston General Hospital
- OMA
  - Dr. Isadore Czosniak
  - Dr. James Swan
- IHF
  - Dr. Nabil Bechai
  - Ray Foley

**TAB 223**



# **Cost of Selected Technical Fee Codes**

## **Pilot Study**

### **Phase II Report to the TFWG**

**February 2022**

Prepared by: Rainer Beltzner FCPA FCA FCMC



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## 1 Summary

The Ontario Medical Association established the Technical Fees Working Group (TFWG) to study issues related to technical services and the costs associated with the provision of technical services in Ontario. A pilot technical fee costing project to identify current costs for a limited selection of technical fee codes was approved.

### 1.1 Purpose of the pilot costing project

There are over 350 technical fee codes in use today. The purpose of the pilot costing study was to identify the current costs of a small number of fee codes for comparison to actual amounts paid. The results of the pilot study could then be used to identify:

- Areas where the costing methodology could be improved
- Opportunities and challenges for expanding the number of fee codes for study

### 1.2 The TFWG selected six technical fee codes for study

The TFWG decided on a small number of fee codes for the pilot. The full TFWG methodology for selecting these six codes is set out in the attached Appendix 1.

Table 1: Selected fee codes

Fee Code	Descriptor	Primary Specialty	Secondary Section	Total Payments FY2019	Total Billings FY2019	Number of MDs FY2019	Patients FY2019
G570A	Echocardiography - Complete study - 1 and 2 dimensions - technical component	Cardiology	Internal and Occupational Medicine	94,740,143	9.5%	808	773,401
J135B	Diagnostic Ultrasound - Thorax, abdomen and retroperitoneum - Abdominal scan - Complete	Diagnostic Radiology	Family Practice & Practice in General	45,678,299	4.6%	1,087	866,987
X091B	Diagnostic Radiology - Chest & Abdomen - Chest - Two views	Diagnostic Radiology	Family Practice & Practice in General	39,767,475	4.0%	1,077	1,424,242
G315A	ECG - Stress Testing - Maximal stress ECG - technical component	Cardiology	Internal and Occupational Medicine	17,288,087	1.7%	1,169	369,537
J310B	Pulmonary Function Studies - Functional residual capacity - Carbon monoxide diffusing capacity by single breath method	Respiratory Diseases	Internal and Occupational Medicine	3,649,390	0.4%	440	163,150
G455A	Physical Medicine - Needle electromyography and nerve conduction studies - Schedule A - technical component	Neurology	Physical Medicine	4,081,483	0.4%	341	140,945

### 1.3 Findings - Cost per procedure

The OHIP Schedule of Fees for Independent Health Facilities sets out the definition of what the technical fee is intended to cover. The definition does not provide clarity whether the procedure is to be viewed as stand-alone (all costs to provide the procedure) or, whether the medical procedure is to be added to an existing operating facility (only include incremental costs to the facility). Both full cost and incremental cost models are included below.

The costs reflected in the pilot are based on today's costs for equipment meeting current standards (as determined by the TFWG), technologist labor costs consistent with current OPSEU Central Wage Rates, space costs consistent with class A medical buildings in the GTA, as well as general overhead and procedure specific costs.

The calculated cost per procedure is directly affected by the average time per procedure as this directly impacts the average per day, and thus the share of major cost components such as equipment, technologists, physical space, and overhead. In general, longer procedure times result in higher per procedure costs.

#### 1.3.1 Summary of current costs per procedure

Current costs per procedure are higher than the approved technical fees. The most significant cost increases come from the current cost of technologists (and to some extent the support admin staff) where wage rates have seen significant upward pressures due to the current competitive environment. This is unlikely to change in the future until more technologists enter the market. Diagnostic equipment has seen increases particularly with respect to cost of repair, maintenance, and software version upgrades. While many peripheral devices (servers, PC's, etc) have seen cost reduction because of a competitive environment, this is offset by the increased need for system integration, security, and the supporting skill set to support an increasingly complex environment. COVID -19 has and continues to have an impact on procedure costs both because of the direct cost of protective measures as well as lower patient volumes – both of which have been largely reflected in the cost models.

### 1.3.2 Current cost per procedure (full cost)

Table 2: Procedure costs - full

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	\$26.50	\$34.38	\$10.31	\$11.83	\$4.47	\$12.40
Personnel	\$76.08	\$49.06	\$21.66	\$56.88	\$19.74	\$61.91
Space	\$37.10	\$24.53	\$8.22	\$40.60	\$8.45	\$9.32
Other	\$14.56	\$8.01	\$9.16	\$9.72	\$4.72	\$9.75
<b>Total Current Cost Per Procedure</b>	<b>\$154.23</b>	<b>\$115.98</b>	<b>\$49.35</b>	<b>\$119.04</b>	<b>\$37.38</b>	<b>\$93.98</b>
<b>T-Fee Per Procedure</b>	<b>\$116.60</b>	<b>\$50.50</b>	<b>\$24.40</b>	<b>\$45.05</b>	<b>\$22.15</b>	<b>\$28.35</b>
<b>Difference Per Procedure</b>	<b>\$37.63</b>	<b>\$65.48</b>	<b>\$24.95</b>	<b>\$73.99</b>	<b>\$15.23</b>	<b>\$65.03</b>
	31%	130%	102%	164%	69%	229%

### 1.3.2 Current cost per procedure (incremental cost)

Table 3: Procedure costs - incremental

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	\$20.31	\$31.30	\$9.43	\$8.12	\$3.65	\$9.65
Personnel	\$70.43	\$43.41	\$16.01	\$50.32	\$17.51	\$53.39
Space	\$12.71	\$5.30	\$2.77	\$9.35	\$2.99	\$6.57
Other	\$14.56	\$8.01	\$9.16	\$9.72	\$4.34	\$9.75
<b>Total Current Cost Per Procedure</b>	<b>\$118.00</b>	<b>\$88.01</b>	<b>\$37.37</b>	<b>\$77.51</b>	<b>\$28.48</b>	<b>\$79.35</b>
<b>T-Fee Per Procedure</b>	<b>\$116.60</b>	<b>\$50.50</b>	<b>\$24.40</b>	<b>\$45.05</b>	<b>\$22.15</b>	<b>\$28.35</b>
<b>Difference Per Procedure</b>	<b>\$1.40</b>	<b>\$37.51</b>	<b>\$12.97</b>	<b>\$32.46</b>	<b>\$6.33</b>	<b>\$51.00</b>
	1%	74%	53%	72%	29%	180%

## 1.4 Findings - Approach to the costing study

### 1.4.1 Initial pilot design

The pilot was designed to provide reasonable information about current costs and their relationship to the approved technical fee within the constraints of time and access to actual practice data. The best cost information is obtained from direct observation, financial records, and operating data. In order to gain access to actual practice, we agreed to respect the confidentiality of the participating facilities and their data.

The study approach included:

- Background on-line research on the diagnostic procedure
- A physical visit to a diagnostic facility
- Direct observation of the procedure, equipment, space, supplies
- Interviews with physician, technologist, and admin staff
- Review of facility financial and/or operating data provided in confidence
- On-line research on diagnostic equipment, technologist rates, space costs
- Interviews with equipment suppliers and real estate agents

### 1.4.2 Potential improvements to the costing methodology for individual technical fees

Increasing the number of facilities participating in the study that have significant patient volumes for the fee code. The experience and data of at least three different (independent) facilities could remove perceived bias.

Identifying all procedures and their volumes, using the same equipment over a period of at least one year would allow for a more appropriate allocation of equipment, space, and overhead costs to any individual technical fee code (similar in concept to what was done with J310). This assumes the availability of detailed procedure volume data for the facility.

Improved access to facility financial and operating data to better identify costs unrelated to the technical fee.

Equipment and other cost data could be supplemented with a formal competitive RFP/RFQ process conducted by the OMA.

#### 1.4.3 *The comprehensive study options*

A comprehensive study of current technical fee costs that represent actual experience would include:

- Stratification of facility type, size, and location across the province
- Random selection of a representative and statistically valid sample of facilities
- Access to facility financial and operating data for a full year
- Review and normalizing of financial and operating data
- Costing of all individual diagnostic procedures related to a singular diagnostic equipment for the year

This would provide data on the actual current costs experienced by facilities and allow for specific technical fee cost comparison. This approach could also be used to determine the overall revenue and costs from technical fees (facility profitability before other income and costs).

Comprehensive studies of this nature have several significant challenges:

- Prior agreement on the use of results
- Participation of facilities
- Time to design and complete
- Cost to complete

#### 1.4.4 *The current methodology as a scalable approach*

The project scope included the development of a scalable approach to allow for cost estimation of additional fee codes. To use the current model, the best opportunity lies with many fee codes that would use the same equipment, technologist, space, overhead. The other requirement is consistent time per procedure. For these instances, the only significant change in total procedure cost would arise from the average number of procedures possible within a defined time (adjusted for the cancellation rate). Of the six fee codes selected for the pilot, procedures related to X091 and J135 provide the best opportunity as there are many other related fee codes. Procedures that can have significant time differences such as G455 should be reviewed in detail to establish the weighted average time. Situations where multiple procedures are typically completed together (such as with J310) requires an allocation of time for each to appropriately allocate costs to any individual procedure.

## 2 Project Methodology

### 2.1 Selection of fee codes

The TFWG initially identified six technical fee codes. The full TFWG methodology for selecting these six codes is set out in the attached Appendix 1.

“The selection of individual technical fee codes was based on the following three criteria:

- i) The fee codes selected should be commonly billed and representative of the work typically performed (measured by total payments, service volume, number of physicians, and patient counts)
- ii) Fee codes should be selected that are billed in a variety of care settings (i.e., Independent Health Facility (IHF), Hospitals, and private office settings).
- iii) Codes should be selected from different Specialties (noting that not all specialties that bill technical fees can be included in this limited pilot study).”

### 2.2 Cost components

The OHIP Schedule of Fees for Independent Health Facilities sets out the definition of what the technical fee is intended to cover:

- Preparing the patient for the procedure.
- Performing the diagnostic procedure(s).
- Making arrangements for any appropriate follow-up care.
- Providing records of the results of the procedure to the interpreting physician.
- Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.
- Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.
- Providing premises, equipment, supplies and personnel for all *specific elements* of the facility fee components.

The OHIP Schedule of Fees for Independent Health Facilities sets out the definition of what the technical fee is intended to cover. The definition does not provide clarity whether the procedure is to be viewed as stand-alone (all costs to provide the procedure) or, whether the medical procedure is to be added to an existing operating facility (only consider incremental costs to the facility). Existing infrastructure that is shared in the incremental cost model are reflected in equipment, personnel (management), and space costs. Both full cost and incremental cost models are included below.

This study determined the full costs to provide the procedure as if it were the only procedure of the facility (full cost model).

This study also considered the costs where the procedure is added to an existing facility (incremental cost model). Adding a procedure creates the need for a dedicated procedure space but typically will share other common space, some equipment, and management cost. For purposes of this study, we have assumed no allocation of these costs to the incremental cost model.

To fully understand the cost components, the project:

- Visited a representative IHF/hospital facility
- Observed the procedure related to the technical fee code
- Interviewed the physician, technologist, receptionist, and other support staff
- Identified equipment, furniture, supplies, and space used

## 2.3 Equipment and costs

The TFWG agreed that the study should include equipment that meets current standards. For example, CoreHealth Ontario has published “Standards for Provision of Echocardiography in Ontario, April 2021.” The diagnostic equipment identified and used for the cost study was reviewed and agreed to by TFWG members as meeting current standards. Equipment costing was based on the following:

Table 4 – Diagnostic equipment

	G570A	J135B	X091B	G315A	J310B	G455A
<b>Model</b>	GE Vivid S70	GE Voluson E10	GE Optima 646 HD	GE CASE with Treadmill & Sun Tech BP Monitor	MGC Diagnostics - Platinum Elite DL - RTD	Magpro R30 Sierra Summit Base Unit
<b>Cost inc. GST/HST</b>	\$113,000	\$242,000	\$281,935	\$50,850	\$50,850	\$136,052
<b>Lifespan years</b>	7	7	10	7	5	10
<b>Maintenance/year</b>	\$9,040	\$9,982	\$22,555	\$4,068	\$5,690	\$3,554
<b>Annual Cost</b>	\$26,946	\$40,199	\$55,223	\$11,332	\$16,654	\$19,319

Diagnostic equipment has evolved considerably since T-fees were first introduced. The more significant changes have included:

- A full transition to digital technology and supporting intelligent software including the methods to capture, transfer, display, interpret, report and store data and images, including subsequent sharing of data and images to other health care providers.
  - o Prior manual intensive processes and storage space has been replaced with integrated technical solutions/equipment/software.

- The scope of integrated technology now includes patient communication, procedure scheduling, patient registration & acceptance at site, procedure conduct, interpretation of results, report preparation, reporting of results, and image/data storage and retrieval.
- The need for specialized technical support to maintain:
  - Diagnostic equipment and software
  - Integration with and updates to RIS, EMR, EHR, dictation software, processors, servers and supporting operating systems
- The need for specialized technical solutions and third-party support to counter internal as well as external threats, including:
  - Dedicated and duplicate back-up capability
  - Enhanced cyber security monitoring and staff training

### 2.3.1 *Equipment includes the following components:*

- The diagnostic equipment plus space refit as required for x-ray
- Workstation PC
- EMR, PACS, RIS, Dictation software & servers (as required)
- Radiology workstation screens and servers (as required)
- Scanners
- Patient and user furniture
- Maintenance and support

### 2.3.2 *Cost determination*

Telephone/video interviews and/or email data requests were held with sales representatives from GE, Canon, and Siemens to obtain lifespan as well as purchase and maintenance pricing for x-ray and Ultrasound equipment. Some equipment pricing was obtained from actual recent supplier invoices provided on a confidential basis by some facilities. Suppliers interviewed included:

Tony Steele - ([Tony.Steele@medical.canon](mailto:Tony.Steele@medical.canon)) for Ultrasound & X-Ray  
Regional Sales Director- Central Canada  
Canon Medical Systems

Jason Doyle - ([Jason.doyle@siemens-healthineers.com](mailto:Jason.doyle@siemens-healthineers.com)) for Ultrasound & X-Ray  
Director of Sales, Central Region - Siemens Healthcare

Bryan Henderson – ([bryan.henderson@ge.com](mailto:bryan.henderson@ge.com))  
General Manager, Central Canada · GE Healthcare

Sandeep Kaher - ([sandeep.kaher@ge.com](mailto:sandeep.kaher@ge.com)) for Ultrasound  
Product Sales- ULTRASOUND · GE Healthcare

Stephen Truong – ([Stephen.Truong2@ge.com](mailto:Stephen.Truong2@ge.com)) for Ultrasound  
GE Healthcare

Brad Hudson – ([Brad.Hudson@ge.com](mailto:Brad.Hudson@ge.com)) for X- Ray & ECG  
Medical Imaging Sales at GE Healthcare

Laura Weber – ([Laura.Weber@ge.com](mailto:Laura.Weber@ge.com)) for X-ray & ECG  
Specialty Sales Representative · GE Healthcare



Table 5 – X-Ray Equipment

	X091B	X091B	X091B	X091B	X091B	X091B
<b>Model</b>	GE Optima 646 HD	Canon Omera Dual	Carestream DRX Ascend	Siemens Multi Impact - single	Siemens Multi Impact - dual	Siemens xpre
<b>Cost inc. GST/HST</b>	\$281,935	\$273,460	\$186,450	\$163,850	\$282,500	\$339,000
<b>Lifespan years</b>	10	10	10	10	10	10
<b>Maintenance/year</b>	\$22,555	\$38,420	\$17,148	\$14,690	\$31,075	\$40,680
<b>Annual Cost</b>	\$55,223	\$70,107	\$38,752	\$33,676	\$63,809	\$79,961

Table 6 – Ultrasound Equipment

	J135B	J135	J135	J135
<b>Model</b>	GE Voluson E10	GE LOGIQ e10	Siemens Sequoia	Canon Aplio 600
<b>Cost inc. GST/HST</b>	\$242,000	\$169,500	\$146,900	\$135,600
<b>Lifespan years</b>	7	7	7	7
<b>Maintenance/year</b>	\$9,982	\$21,000	\$14,747	\$15,255
<b>Annual Cost</b>	\$40,199	\$47,859	\$38,025	\$36,742

Table 7 – Ultrasound/General Examination Room Other Equipment/Furniture

<b>Equipment</b>	<b>Cost Estimate inc. GST</b>
Examination Bed	\$3,800
Ergonomic Technologist Chair	\$1,150
PC	\$1,100
Scanner	\$150
Telephone	\$150
Defibrillator	\$1,500
Desk	\$600
Guest Chairs	\$240
Towel Trolley	\$200
Waste Bin	\$20
<b>Total</b>	<b>\$8,910</b>

Interviews with IHF facility staff and IT professionals for PACS/RIS/EMR/Voice recognition/dictation software, workstations, servers, scanners, and furniture. Review of web based posted supplier costs for components.

### 2.3.3 Key assumptions for equipment

- Finance interest rate = 3%
- Useful life (as advised by manufacturers)
  - o X-ray = 10 years
  - o Ultrasound = 7 years
  - o ECG & Treadmill for Stress Test = 7 Years
  - o Body plethysmograph = 5 years
  - o EMG = 10 years
  - o Furniture = 10 years
  - o Workstations, screens, servers = 5 – 7 years
- Annual equipment maintenance rate = 8% - 11% (as advised by manufacturers)
- Annual furniture maintenance rate = 5%
- Working days = 240 (250 less downtime for maintenance)
- Procedure hours per day = 7

## 2.4 Staff and costs

The delivery of the diagnostic procedure for a patient in the IHF environment requires not only the technologist, but also the time of an administrator/receptionist as well as an office manager.

The interviews with IHF facilities identified a shortage in available technologists resulting in a higher than usual competitive market for experienced technologists. A review of publicly available job posting across the Ontario market demonstrate that hospital and certain private health clinics offer the highest compensation. IHF facilities competing for scarce resources are experiencing higher technologist costs and these are likely permanent.

The time required by all staff for patient interaction has also increased because of the additional procedures necessitated by COVID-19.

### 2.4.1 Staff Rates

To determine the current market rates for technologists and administrative staff, the study examined job postings listed on websites and interviewed some technologists and facility management. For purposes of this study, we have used technologist staff rates from the recent OPSEU Central Wage Rates (April 1, 2019 – March 31, 2022) “**Senior:** Ultrasound Technologist, Echocardiographer, MRI Technologist, Respiratory Therapist, Medical Laboratory Technologist, Radiation Technologist”

**Senior 4-year technologist's base rate** = \$43.89/hr. (Annual salary \$91,291)

Base rate for the cost model is increased by 8% vacation pay, 0.98% EHT, 5.45% CPP and 2.21% EI. Additional annual benefits estimated at \$2,500.

**Administrative/Receptionist base rate** = \$22/hr. (Annual salary \$45,760)

Base rate for the cost model is increased by 6% vacation pay, 0.98% EHT, 5.45% CPP and 2.21% EI. Additional annual benefits estimated at \$1,250.

**Manager base rate** = \$75/hr. (Annual salary \$156,000)

Base rate for the cost model is increased by 0.98% EHT, 5.45% CPP and 2.21% EI. (Fully loaded equivalent to \$81.48/hr or \$169,478 annual salary)

#### 2.4.2 Technologist time per procedure

The study determined the technologist activities and time per procedure through:

- Interview with technologist
- Observation of the procedure
- Interview with receptionist/admin staff responsible for booking
- Booked time allocated for the procedure
- On-line procedure information from medical information sites

The average time per procedure includes:

- Room and equipment preparation
- Patient and procedure data input
- Patient interview and procedure preparation
- Procedure conduct and data input
- Patient exit
- Equipment and room infection control procedures
- Supply replenishment as required

Table 8: Average procedure time

	G570A	J135B	X091B	G315A	J310B	G455A
Minutes	60	30	10	45	30	37.45

#### 2.4.3 Procedures per day

Procedures per day determined by the allocated technologist time per procedure based on an available 7-hour day adjusted for patient cancellation rate of 8%.

Patient cancellation rate determined through interviews with IHF management and staff responsible for procedure booking, facility management as well as actual 2020 data from a facility with over 20,000 annual patient procedures.

Table 9: Effective procedures per day

	G570A	J135B	X091B	G315A	J310B	G455A
Number	6.4	11.4	38.6	9.2	11.4	9.5

#### 2.4.4 Administrative/Receptionist time per patient/procedure

The average time per patient is estimated at 15 minutes and includes at least:

- Patient and procedure scheduling
- Patient reception and registration
- Patient and health provider communication

Average time estimate established through interviews with receptionist/admin as well as through direct observation.

#### 2.4.5 Management time per procedure

An IHF facility requires some time to provide oversight and management of the operations of the facility and staff. Responsibilities would typically include:

- Staff and contracted services hiring/management/payroll/payment/set-up
- Daily facility oversight & management
- Periodic purchasing and supplies management
- Technical support as required

The cost of contracted professional services such as for bookkeeping, financial reporting, and payroll are included in Other Costs.

The average management time per procedure will vary according to the total number of all procedures of the facility. The cost study considered the operations of a facility operating with an average of approximately 30,000 annual procedures over the past two years. Based on a fully loaded annual managerial cost of \$169,478, the average managerial cost per procedure is \$5.65.

## 2.5 Space and costs

Each of the selected procedures requires a dedicated space. In addition to the dedicated procedure space, the facility typically includes:

- a patient reception area that includes a separate space for the receptionist
- a patient change room and facilities
- a room for the physician to interpret the procedure results
- a storage area for servers and communication equipment
- a storage area for supplies and business records

Larger facilities may also include a kitchen, staff/meeting room, as well as other offices to accommodate additional staff dedicated to management and support.

### 2.5.1 Space cost

The cost of space varies across Ontario. For purposes of this study, we examined published listings for class A medical buildings in the GTA. We also followed up with real estate agents who specialize in space appropriate in size and facilities. The current cost per sq. ft./year was determined to be \$42 (\$44.86 GST included) inclusive of base rent plus TMI (taxes, maintenance, and insurance).

In addition to the space cost, it is common to incur an initial build cost (leasehold improvements) of \$150/sq. ft. allocated over a term of 20 years.

The initial build cost for an x-ray room is \$190/sq. ft. over 20 years with a further assessment and retrofit cost of approximately \$173/sq. ft. after 10 years to accommodate a change to new equipment.

### 2.5.2 Space sq/ft

Table 10: Procedure room space

	G570A	J135B	X091B	G315A	J310B	G455A
Procedure room	250 <sup>1</sup>	150	340	250 <sup>1</sup>	150	150
Admin/receptionist	100	100	100	100	100	100
Physician view room	100	100	100	100	100	100
Common area (reception, washroom, change room, etc)	800	800	800	800	400	400

<sup>1</sup> As per Standards for Provision of Echocardiography in Ontario, April 2021

## 2.6 Other costs

Other costs were determined from financial records provided by several facilities and include the following:

- Maintenance (\$4.49 per procedure)
  - o Facility maintenance and repairs
  - o Cleaning
  - o Paper products/sanitation products
- Utilities (\$1.12 per procedure)
- Office (\$2.40 per procedure)
  - o Insurance
  - o Licenses
  - o Paper and related copier, print services

- Business forms
- Office improvements
- Postage, courier
- Parking
- Towels, gowns, technical supplies, laundry
- Procedure specific
  - Procedure specific costs such as needles, gas, electrodes, etc. unique to a procedure were identified through observation/discussion/internet supplier search.

## 2.7 Specific fee code cost determination

### 2.7.1 G455A – Needle electromyography and nerve conduction studies

The G455 code is used for three procedures intensities that include both time and per procedure cost differences.

- A basic EMG of 25 minutes
- A needle EMG of 45 minutes
- A complex needle EMG of 60 minutes

The basic as well as complex EMG are billed as professional fees under G456 and G473 respectively. However, there is no separate professional fee code for the basic needle EMG of 45 minutes.

To determine the cost of G455, the costs for each of the variations was determined and a weighted average cost calculated based on frequency (40%, 57%, 3%).

### 2.7.2 J310B – Pulmonary function studies

J310B is a procedure that is typically completed as one of several done at the same time rather than as a stand-alone procedure. The procedures that are completed during the same patient visit include J304B, J306B, J307B, and J310B. This is consistent with OHIP billing data. The same equipment/software is used with a total elapsed time of approximately 30 minutes to prepare patient, complete the procedures and post procedure steps.

To determine the cost of J310, the cost for all procedures completed during the patient visit was established and J310 allocated 40% of the cost (based on observed time estimates), in addition to an additional per patient cost of two gas mixtures unique to J310.

### 2.7.3 Impact of business scope and intensity

The cost of any single procedure over time depends on the number of procedures completed during that time. It also depends on the extent to which non-procedure specific costs can be spread across other procedures over the same time – the scope of the facility. This difference is best demonstrated by the incremental vs full costing models.

Practice intensity (# patients/day, # hours/day, # days/week, etc.) can be limited by choice in high demand environments. However, there can be procedures that are limited by the lack of patients for a variety of reasons such as population density or limited referrals. The cost model considers a standard work week and procedure time to establish a norm for costing purposes and does not necessarily reflect actual practice intensity. Some will expand working hours and/or reduce average time per procedure to spread fixed costs over a larger practice volume, thereby reducing the average cost per procedure.

Current technical fees do not reflect the extent of variability in the scope and intensity of the facility.

### **3 Considerations for the TFWG**

#### **3.1 Study limitations**

This study is a pilot to test a costing methodology. As a result, the number of facilities visited as well as the data validation methods were limited to obtain reasonable but not exact data. This cost study does not consider the variations in urban, rural, or remote clinic locations that may impact costs related to space, supplies and personnel as well as patient volumes. Possible improvements to the study methodology are set out in section 1.4 of this report.

#### **3.2 Additional matters for potential study**

##### ***Inflation***

Ontario's annual inflation rate is 5% (CPI: Nov.2020 – Nov. 2021). While the CPI may not be a precise measure of the impact of inflation on the equipment, personnel, space, and other procedure support costs, it does indicate an upcoming period of increasing costs. Base rates for technologists and administrative staff are likely to see the most pressure over the course of the next year.

Inflation has not been a significant factor for a period prior to 2020. Monitoring and measuring the impact of future inflation on technical fees could be considered by the TFWG.

## **Covid-19**

The cost of providing diagnostic services has been impacted by COVID-19. Some costs have been reflected in this study. Specifically:

- Increased sanitation and related supplies
- Technologist and admin staff base rates
- Increased cancellation rates by patients
- Effective procedures per day

The study did not specifically examine the impact of changes to practice intensity and efficiency over the past two years because of the current pandemic environment. The past year has experienced closures of diagnostic facilities as well as reduction in the scope services provided. The TFWG could consider monitoring and measuring the impact of facility closures and/or service reductions.

## ***Increased regulation and standards***

COVID – 19 has already increased the cost of business through required measures to limit the spread of the virus. Some of these measures are likely to recede but be replaced by others such as changes to building ventilation/air recirculation standards.

The medical profession itself continues to review the need for updating or establishing new standards. These can impact diagnostic equipment, physical space, supplies used, and many other factors affecting the delivery of a diagnostic procedure and thus cost.

Identifying, monitoring, and measuring the impact of future regulatory and standards changes to technical fees could be considered by the TFWG.

## ***Cyber threats and business interruption***

The introduction of digital technology focused on data duplication (back-up) and off-site storage as protection against data loss and business interruption. The transition to the current environment of multiple operating and business information systems operating on interconnected internal as well as external networks has significantly changed how data back-up and recovery is managed.

In addition to the challenges of maintaining hardware, software, and multiple generations of operating systems, there has always been the additional challenge of protecting against inadvertent as well as intentional unauthorized access and their consequences. The recent increase in cyber-attacks including those to health care providers (phishing, denial of service, ransom) pose a significant on-going threat.



The impact of a security breach and unauthorized access to patient data requires that the facility advise the patient of that breach on a timely basis. This could involve many patients and result in significant time and costs to the facility.

The future cost of providing reasonable protection against data/image loss and interruption to workflow will by necessity increase and include such measures for medium sized facility with 5 – 10 servers as:

- Firewall protection (\$10,000 – \$15,000)
- End-point detection and response (\$8-\$10/user/month plus \$10-\$15/server/month)
- Email protection (\$5/user/month)
- Staff training on cybersecurity (\$15,000 - \$20,000)
- Cybersecurity assessment services
  - o Vulnerability assessment (\$10,000 - \$20,000)
  - o Web application assessment (\$15,000 - \$25,000)
  - o Security architecture review (\$40,000 - \$50,000)
  - o Security program development (\$45,000 - \$60,000)

These increased cybersecurity costs have not been included in this study. Identifying, monitoring, and measuring the cost impact of increased cyber security measures and their impact on technical fees could be considered by the TFWG.

### ***Changes to the delivery of technology needs***

Diagnostic equipment technology change and resulting diagnostic equipment/software cost changes are to be expected and more easily identified and accounted for.

Internal and third-party information systems including software applications, operating system software, and related hardware to support the operations of the facility will become increasingly challenging to manage and proactively plan for necessary changes and their costs.

It is likely that there will be a shift to the use of subscription-based services for the delivery of EMR, RIS and other applications, to significantly reduce the need for in-house expertise, software, equipment maintenance, as well as physical space. Cloud based services for data storage provide the added potential of eliminating on-site server and storage racks including their environmental protection.

Identifying, monitoring, and measuring the impact of technology shifts and their changes to technical fees could be considered by the TFWG.

### ***Increase to data and image sharing***

There has been an increase in the desire and need to share the results of diagnostic procedures (data and image) with other health care facilities/providers. The cost of connecting to other health networks to receive or send data and their changes to technical fees could be considered by the TFWG.

## **4 Appendix 1: OMA Technical Fee Working Group Cost Accounting Project: Technical Fee Code Selection**

Economics Policy & Research, September 30, 2021

### **DRAFT - Updated**

Prepared for: OMA Negotiations Task Force

#### **PURPOSE:**

The OMA's Technical Fee Working Group (TFWG) has resolved to commission an independent medical accounting expert to compute the typical cost associated with providing medical services with a technical component. The purpose of this document is to outline the selection of technical fee codes for use in the cost accounting project.

#### **TECHNICAL FEE CODE SELECTION METHODOLOGY:**

On August 13, 2021, TFWG met virtually with Rainer Beltzner, CPA, to discuss a proposed technical fee cost accounting project. The project has the aim of collected detailed cost accounting data on a limited set of technical fees to better understand the cost of providing technical services in Ontario. The TFWG requested that as many codes as possible be evaluated in this study. Mr. Beltzner recommended that at most, six (6) different services with an associated technical component could be studied in detail, given the TFWG's limited timeframe. The codes for study were finalized by TFWG on September 29, 2021.

Of the \$992M in diagnostic technical fees billed in FY2019, Diagnostic Radiology and Cardiology account for approximately 72% of this total, by dollar value. On this basis, TFWG decided to select two (2) codes primarily billed by Diagnostic Radiology and two (2) billed primarily by Cardiology for study. The remaining two (2) codes were selected from the common technical codes billed by other Specialties.

The selection of individual technical fee codes was based on the following three criteria:

- iv) The fee codes selected should be commonly billed and representative of the work typically performed (measured by total payments, service volume, number of physicians, and patient counts)
- v) Fee codes should be selected that are billed in a variety of care settings (i.e., Independent Health Facility (IHF), Hospitals, and private office settings).

- vi) Codes should be selected from different Specialties (noting that not all specialities that bill technical fees can be included in this limited pilot study).
- vii) Codes should have well defined equipment and quality standards.

Table 1: Selected Technical Fee Codes for Study

Fee Code	Descriptor	Primary Specialty	Secondary Section	Total Payments FY2019	Total Billings FY2019	Number of MDs FY2019	Patients FY2019
G570A	Echocardiography - Complete study - 1 and 2 dimensions - technical component	Cardiology	Internal and Occupational Medicine	94,740,143	9.5%	808	773,401
J135B	Diagnostic Ultrasound - Thorax, abdomen and retroperitoneum - Abdominal scan - Complete	Diagnostic Radiology	Family Practice & Practice in General	45,678,299	4.6%	1,087	866,987
X091B	Diagnostic Radiology - Chest & Abdomen - Chest - Two views	Diagnostic Radiology	Family Practice & Practice in General	39,767,475	4.0%	1,077	1,424,242
G315A	ECG - Stress Testing - Maximal stress ECG - technical component	Cardiology	Internal and Occupational Medicine	17,288,087	1.7%	1,169	369,537
J310B	Pulmonary Function Studies - Functional residual capacity - Carbon monoxide diffusing capacity by single breath method	Respiratory Diseases	Internal and Occupational Medicine	3,649,390	0.4%	440	163,150
G455A	Physical Medicine - Needle electromyography and nerve conduction studies - Schedule A - technical component	Neurology	Physical Medicine	4,081,483	0.4%	341	140,945

Combined, the six (6) codes selected for study represent approximately 21% of the technical fees billed in Ontario in FY2019, by dollar value. The TFWG believes these codes represent a reasonable sample of codes to study given the limited time and resources available for the cost accounting pilot. The list of codes may be expanded at a future date to capture a greater degree of the variety of physician work in Ontario. The rationale behind the selection the specific codes is described below:

- G570A (Echocardiography) was the top Cardiology technical fee billed by dollar value; it has a large number of both providers and patients. The top two ECG codes by dollar value commonly billed by cardiology were G315A and G310A. Both were considered and G315A was selected as the second cardiology code for study. These tests have well established quality and equipment standards.
- The top three diagnostic ultrasound services in FY2019, by dollar value, are: J162B, J135B, J138B. All three codes have reasonably similar service volumes and billings. After discussion, one the three (J135B) was selected. Parallels in the cost accounting work are expected to exist between this code and other common diagnostic ultrasound

services. After the diagnostic ultrasound services, X091B was the code commonly billed by Diagnostic Radiology.

- Though technical fees for sleep medicine are commonly billed (by dollar value); the most common sleep medicine codes are billed by fewer than 200 MDs and had much lower patient counts and service volumes in FY2019 compared to the other top codes considered. As such, the committee felt that the sleep medicine codes did not sufficiently meet the fee code selection criteria.
- Some Nuclear Medicine codes (e.g., J807B, J813B) were discussed for inclusion. However, since these codes are commonly billed by both Cardiology and Diagnostic Radiology, different codes were selected to allow for greater diversity.
- Among the codes commonly billed by other Specialties (removing services commonly billed by Diagnostic Radiology and Cardiology, and the other exclusions noted), common Pulmonary Function Studies codes were identified to have high levels of services and overall payments associated. J304B was discussed along with J307B and J310B. Given the wide range of equipment standards associated with J304B, this was deemed to be a challenging code to study. J310B was the subsequently highest value code by dollar value and service volumes (of the Pulmonary Function Studies codes) and was selected for study. This code is primarily billed by Respiratory Diseases and has well established quality and equipment standards.
- The next fee code selected by the committee is G455A. The committee felt that G455A would be a reasonable code to include in the evaluation, as it would lend to having a more diverse set of codes for evaluation (e.g., a code billed commonly by two smaller specialties). This code is billed by Neurology and Physical Medicine; concerns have been raised over patient access to these services both to the NTF and PSC.

# **Cost of Selected Technical Fee Codes**

## **Scalable Approach**

### **Phase III Report to the TFWG**

**February 2022**

Prepared by: Rainer Beltzner FCPA FCA FCMC

## 1. Summary

The Ontario Medical Association established the Technical Fees Working Group (TFWG) to study issues related to technical services and the costs associated with the provision of technical services in Ontario. A pilot technical fee costing project to identify current costs for a limited selection of technical fee codes was approved and completed.

The project scope included Phase III, the development of a scalable approach to allow for cost estimation of additional fee codes. To use the current model, the best opportunity lies with many fee codes that would use the same equipment, technologist, space, overhead and a consistent time per procedure. For these instances, the only significant change in total procedure cost would arise from the average number of procedures possible within a defined time (adjusted for the cancellation rate). Of the six fee codes selected for the pilot, procedures related to X091 and J135 provide the best opportunity. Procedures that can have significant time differences such as G455 should be reviewed in detail to establish the weighted average time. Situations where multiple procedures are typically completed together (such as with J310) requires an allocation of time for each to appropriately allocate costs to any individual procedure.

## 2. Cost for x-ray and ultrasound procedures

The process for either the full cost or incremental cost models:

- Identify the fee codes like X091 and J135 that use the same equipment, technologist, space, and overhead.
- For each identified fee code, identify the time to complete the procedure. Typically, this can be determined from direct observation and/or from the time allocated from patient booking. Determine the optimal number of procedure bookings per day – typically less than the maximum to allow for staff breaks, interruptions, etc.
- For each identified fee code determine whether there are any *unique* supplies required for the procedure as the cost of this must be added to the per procedure cost.
- Using the model spreadsheet, replace the time per procedure (B12 on Assumptions spreadsheet), optimal bookings per day (B14 on Assumptions

spreadsheet) and any additional procedure specific cost (B39 on Assumptions spreadsheet) to calculate the total per procedure cost.

- Compare to the technical fee

### **3. Cost for other procedures**

Procedures that utilize equipment not covered in this pilot study can be costed using the approach and methodology followed by the pilot study. Any of the full/incremental cost worksheets can be used as a base model to capture data and calculate the total procedure cost. Some adjustments/refinements will likely be necessary to reflect unique situations.

The key elements of this approach include:

- Background on-line research on the diagnostic procedure
- A physical visit to a diagnostic facility
- Direct observation of the procedure, equipment, space, supplies
- Interviews with physician, technologist, and admin staff
- Review of facility financial and/or operating data
- On-line research on diagnostic equipment, technologist rates, space costs
- Interviews with equipment suppliers and real estate agents

### **4. Attachments**

Total cost models for G570A, J135B, X091X, G315A, J310B, G455A.

Incremental cost models for G570A, J135B, X091X, G315A, J310B, G455A.

**TAB 224**



# ADDRESSING PHYSICIAN BURDENS



## What are burdens and why do they matter?

Doctors are increasingly faced with tasks or demands that do not contribute to or limit their ability to provide quality patient care. These include tasks that are duplicative, unnecessary, not clearly evidence-based, or when the volume of demands is so great they cannot be reasonably accomplished. While these tasks may seem like a minor annoyance, they accumulate over time from many sources to become overwhelming and burdensome. Literature shows that when doctors feel overwhelmed by these types of tasks, it can negatively impact quality and access of care, physician well-being, and health system sustainability.

## How can we address burdens?

Doctors of BC has developed the Burdens Solutions Tool, which outlines a series of steps to find the best solution to eliminate, or reduce the impact of, these types of tasks. Rather than trying to pose a solution to every potential burdensome task, this tool provides a framework to think through different solutions in a logical manner. It can be used to examine existing demands, or before a new task is introduced, to prevent new burdens from emerging. Doctors of BC is committed to embedding this tool in all of our work. We are also calling on the Ministry of Health and other groups that create burdens on doctors to implement the tool in their decision-making processes.

# BURDENS SOLUTIONS TOOL



*Engage Physicians*

## How is the tool used?

Consider if and how each of the five steps could be applied to a task. While there may be a single simple solution in some cases, other tasks may require multiple solutions. Some burdens may be resolved with one small change (i.e., reducing the number of questions on a form so it only asks for clinically relevant information). More complex burdens may require multiple solutions (i.e., automating a process and ensuring it is funded appropriately). To the extent that is possible, doctors should always be engaged when identifying solutions to ensure they reflect their clinical needs.

**Step 1: Eliminate** — Ask if the demand supports access and quality of care. If it does not, try to eliminate the demand. If the demand cannot be eliminated, consider other demands that could be eliminated.

**Step 2: Simplify** — Ask if and how the demand can be simplified to be as efficient as possible, so that it only focuses on clinically relevant information. Consider various ways to simplify demands, including technological solutions, reducing the number of questions or steps, etc.

**Step 3: Collaborate** — Ask if and how the demand could be better managed through improved collaboration and harnessing the expertise of existing team members (both clinical and administrative).

**Step 4: Resource** — Ask if there are sufficient resources, including compensation, staff, or time to complete the demand. If the demand is necessary to support access and quality of care, and cannot be effectively managed through simplifying or collaborating, ensure resourcing is increased to support the demand.

**Step 5: Communicate** — Regardless of which solution(s) are applied, always consider when and how new or changing demands are communicated, to prevent physicians from becoming overwhelmed with too many changes happening at the same time.

For more information on how to reduce burdens and support quality and access to care, see Doctors of BC's policy paper [Creating Space for Doctors to be Doctors: A Cumulative Impact Lens on Physician Demands](#).






**TAB 225**

# ACTIONS to reduce unnecessary administrative burden for Nova Scotia's doctors

Unnecessary administrative burden affects doctors in many ways: their ability to take on additional patients, their productivity, work-life balance, and job satisfaction. Government understands the need to remove some of this burden and is taking action.

**By the end of 2023, we will reduce the unnecessary administrative burden doctors face by 50,000 hours a year, the equivalent of 150,000 patient visits.**

More than a dozen actions are underway to meet the target and, most importantly, give doctors more time to do what they do best – take care of patients. These actions include reducing duplicative or overly complex forms, improving out-of-date processes, and working to ensure that doctors are doing work only they can do; work that cannot be done by other healthcare providers or support staff.

Action	Description	Status
<b>Improve the Employment Support and Income Assistance (ESIA) Medical Assessment Form</b>	This form, used by Income Assistance clients to access additional health-related supports through Community Services, has been improved to reduce back and forth with doctors and to allow for tailored forms requesting only relevant sections for each client. Additionally, ESIA will be increasing the compensation provided to doctors for completion of the medical forms. The fee increase is anticipated before the end of the calendar year.	
<b>Simplify Credentialing for the IWK</b>	The IWK moved its credential application process from being paper-based to an easy-to-access and complete online system in June 2022.	
<b>Simplify the Maternal Serum Screening Process</b>	The form and lab work will transition over time from being completed twice during pregnancy to once, in the patient's first trimester. This improvement, in place in other provinces, upholds patient care and safety while reducing time for the patient, doctor and lab technicians.	
<b>Improve the Short-Term Illness Benefit Application Form for Government Employees</b>	Doctors and other stakeholders will be consulted on how to streamline or improve this frequently completed form for ease and faster completion.	
<b>Improve Pharmacare Exception Status Drug Request Forms</b>	High-volume Exception Status Drug forms, including for Non-Insulin Antidiabetic Agents and Chronic Obstructive Pulmonary Disease Therapy, will be improved.	

Action	Description	Status
<b>Introduce the Medavie Portal</b>	All Exception Status Drug forms will be added to a new online portal for easier access and submission for doctors.	
<b>Update the Nova Scotia Health (NSH) By-laws</b>	Updates to the NSH by-laws, which govern privileging and credential processes, are underway and will move credentialing applications from paper-based to online.	
<b>Eliminate Duplication of Test Results</b>	The process for communicating test results (i.e., lab reports and blood bank reports) will move to an online portal, eliminating the need for paper-based reports.	
<b>Empower Healthcare Professions to Operate Within their Full Scopes of Practice in Primary Care</b>	A pilot project is examining scopes of practice within some clinics. The aim is to educate and empower all healthcare providers to undertake work they are trained and approved to do. This will redirect some work from doctors to other healthcare professionals to give doctors more time to do work only they can do.	
<b>Review Use of Sick Notes in Nova Scotia Health</b>	A review of NSH's policies is underway to amend or eliminate their sick note requirement for incidental illness up to three days. When a note is necessary, the sick note form will be streamlined to reduce the time it takes to complete.	
<b>Introduce Auto-fill Capabilities for Common Forms in the EMR</b>	Auto-fill capabilities will be introduced for some specific and high-volume forms in the EMR system.	
<b>Simplify Hiring and Intake in Nova Scotia Health</b>	NSH is removing the need for vulnerable sector checks for incoming doctors and eliminating the need for doctors to sign off on vaccination records for new staff.	
<b>Improve the Report of Child Abuse Form</b>	Doctors and other stakeholders will be consulted on how to streamline, standardize across government and healthcare providers, and digitize the form.	
<b>Improve the Medical Report on Adopting Applicant and the Medical Report on Foster Applicant Forms</b>	Doctors and other stakeholders will be consulted on how to combine and shorten these forms.	
<b>Evaluate the Use of the Medical Status Report Form</b>	This form accompanies Long-Term Care applications and must be regularly updated. With input and guidance from stakeholders, the form's need and effectiveness will be evaluated.	



**TAB 226**

# Challenges with the Infant Registration Program for Newborns in Ontario

Submitted by:

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September 2023

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## Background

A "Good faith" claims payment policy was in place until March 1, 1998. This policy existed for situations where "the provider could not determine an eligibility problem by looking at the health card, claims were paid until such time as the provider had been notified by the Ministry via the provider's monthly RA" (Ref: June 2015 version of Registration for Ontario Health Insurance Coverage). Bulletin 4303 (see Appendix A) describes the end of these "Good Faith" payments. The discontinuation of this policy was justified by the existence of 3 automated validation mechanisms made available to hospitals in 1994. As there were now ways to confirm the validity of a patient's health card number, the rationale was that the "Good Faith" payment policy was no longer necessary.

The newborn registration process was not taken into account during the discontinuation of the "Good Faith" payment policy. To this date, there is no way for physicians to validate the Pre-Assigned Health Number (PAHN) issued to a newborn at birth by hospital staff. Any claims billed under the PAHN can be rejected 3 months later for reasons completely outside of a physician's control. For the past 25 years, physicians caring for newborns have had to deal with rejected newborn claims leading to a high administrative burden in efforts to obtain updated health card numbers and lost income when this information cannot be obtained from the family.

## The Infant Registration Program is Complex

The Infant Registration Program in Ontario is outlined in a complex, 42 page "Manual for Birthing Hospitals". The introduction of this manual states that the program uses "the Ontario Health Coverage Infant Registration form 4440-82 to expedite Ontario Health Insurance registration for infants born in an Ontario hospital". Many steps are required, by various hospital staff and the newborn's parents, for form 4440-82 to be completed correctly and to be received by the ministry.

There are many nuances described in this manual. A newborn is not to be issued a PAHN if there is a surrogacy arrangement. There are different processes for situations such as a neonatal death or CAS apprehension. The Ministry distributed a memo to hospitals in June 2019 (Appendix B) which outlines how form 4440-82 should be handled in some special situations. However, given the complexity and the high staff turnover that is the reality in today's healthcare workforce, it is unreasonable to expect every hospital employee in every Ontario hospital to be aware of these nuances and follow the complex instructions accurately. Failure at multiple potential steps in this process is resulting in physicians not being paid for some of the most complex neonatal resuscitations and neonatal deaths. The only recourse available when the claim is rejected is to insist the family visit Service Ontario to register their deceased newborn. This is obviously not pursued by most physicians for ethical and compassionate reasons.

For uncomplicated newborns, many hospitals have processes in place which are dependent on the parents' ability to navigate the system and their cooperation. As an example, this was the experience of one family who recently delivered a baby in a Hamilton hospital:

- PAHN form was provided to parents upon admission. They were instructed to complete the form and take it to patient registration before being discharged.
- They completed the form and the father took it to patient registration. The form was reviewed with father to ensure completeness and accuracy and they were given a copy.
- During the discharge process, the nurse on the post-partum floor inquired about registration to ensure it had been completed.

There are many barriers to this process being completed correctly. It is challenging for a family new to Canada where there is a language barrier. This process would also be difficult if the post-partum parent did not have a support person that could make trips to other areas of the hospital. The process relies on nurses to collect the forms and ensure correct completion. This is especially challenging during the current human health resource crisis facing all hospitals. It is difficult when nurses are short-staffed to be dealing with administrative tasks as they need to prioritize patient care. There can be many other issues, outside of a physician's control, which can lead to form 4440-82 not reaching the ministry and or being correctly registered by Service Ontario, leading to a VH9 rejection.

### **Obtaining Correct Health Card Information is Often Not Possible**

The PAHN rejects as a VH9 error code (health number not registered with MOH) when the infant turns 90 days if the form has not been completed correctly or if not received by the ministry. The onus is then on the physician to obtain the new, correct information. Although the hospital is responsible for issuing PAHNs, hospital administration does not get involved in obtaining correct health cards for infants when the PAHN is rejected. This is a task left up to individual physicians. Obtaining a new, valid health card number for the newborn is very challenging and often impossible for the following reasons:

- Contact information for parents in the hospital chart is incorrect. Given that 3 months has passed after the baby's birth, the family may have moved and changed phone numbers. There are parents who do not have a phone number at times, and list a friend or relative's contact information on file instead. As mentioned, there are frequent instances of language limitations that adds an extra barrier to communication.
- Patients and families increasingly do not answer their phone, fearing scam or solicitation calls. When a message is left, they do not call back.
- If parents are reached by phone, they are often angry that they need to visit Service Ontario. If they have obtained a new health card number they often refuse to give "my baby's personal health information" over the phone.

- There is a discrepancy of names for the infant provided through different avenues. It is therefore not possible to try to find the valid health card number using existing systems since the legal name of the infant is not available. For example:
  - o name originally provided at birth hospital: *Smith, Newborn Female*
  - o updated name provided verbally by family member or social worker's notes: *Smith-Campbell, Jennifer*
  - o actual name on birth certificate & health card: *Campbell, Jennifer Smith*
- If an infant has had a longer stay in hospital, parents are often upset they are being contacted by multiple physicians separately for the same information, stating "we already gave this information to someone else".
- Written requests to provide a valid OHIP number are often ignored by the family. Same with sending invoices for payment of services.
- The physician (or billing agent working on their behalf) risks serious privacy breaches. For example, a family was contacted at the only phone number available in the hospital chart. There was; however, a confidential adoption that had taken place and not all members in the family were aware for cultural reasons. By trying to contact the family, the physician inadvertently exposed a family secret and upset the family member on the phone. A potential for CPSO or a privacy complaint being launched against a physician simply trying to follow-up on a rejected claim is a serious risk.
- In cases of a CAS apprehension, it is very challenging to track down where the child has been placed as the agencies do not want to give out confidential information. This is the case especially once the child has been discharged from CAS care.
- External organizations such as the Midwives groups often are not held to a specific standard in terms of how much contact information they collect from patients. It is also quite difficult to obtain information through them as they do not want to release information once the child has been discharged from their care.
- Not all families will have a family physician/NP or they may not be listed as the primary care provider (PCP) in the newborn's hospital chart. It is therefore often not possible to obtain updated information through the infant's PCP.
- As mentioned above, in the case of a neonatal death, this often results in a VH9 rejection given the complexity of the handling of the PAHN form that is required. In cases where the infant survives for only a few days as is common with extremely premature babies, the parents may be in possession of the form but never complete it. Once rejected, for ethical reasons, physicians

will generally not contact the family to insist that they visit a Service Ontario location to complete the registration for their deceased baby.

## **Ministry's Attempts to Improve the Process Have Not Been Successful**

In meetings with OMA's Adjudication Committee, the Ministry informed OMA that a policy was implemented whereby forms are registered using approved placeholders for fields which may be missing or illegible. This was expected to decrease the number of VH9 rejections. However, according to individual physicians and billing agents, the issue has not improved since this policy change and VH9 rejections continue and seem to actually be increasing. Presumably the increase in rejections may be related to the high staff turnover in hospitals and challenges navigating the complex registration process, as discussed above.

Also note that the "Infant Registration Reminder" memo (Appendix B), sent to hospitals in June 2019 has also not improved the situation for the complex cases such as neonatal deaths or CAS apprehensions. Also note that not all claims rejected are given a 'Claim Number' which is required in order to send in a Remittance Advice Inquiry.

## **The New 3-Month Claim Submission Period**

As of April 1, 2023, the ministry adjusted the claims submission period from 6 months to 3 months. This change has created additional administrative burden in dealing with rejected newborn claims. Given that the PAHN rejects at 90 days, even when a new valid number is successfully obtained from the family, the resubmitted claim will be rejected as staledated if the standard process is used. Given that it is a brand new health card number, it will be treated as a new claim by the ministry's system that is beyond the new 3 month claim submission period. A claim for manual review will be necessary, further increasing administrative burden and introducing delay in payment. Many physicians report issues with the electronic system and submitting claims for manual review as it is often down, needing to resort to faxing instead.

### **Examples of challenges physicians and billing agencies working on behalf of physicians experience:**

#### **1. A pediatrician's billings for November – December 2022**

- Number of newborns billed = 80
- Number of newborns rejected for invalid version code (error code EH2) = 2
- Number of newborns rejected for HN not registered with MOH (error code VH9) = 19 (23%)

The billing agency he works with noted that most of his rejections were from one particular hospital site for this billing period. All of the babies at that hospital site which were rejected in November were born between November 2-5 and all of the babies rejected in December were born between December 22-25, suggesting this could have been a hospital registration issue during those periods.

When inquiring, the advice from the Ministry was as follows: *"You could discuss with the labour/delivery unit to ensure forms are completed fully, or sent to Service Ontario more frequently, to ensure that they are processed sooner. On the flip side of that, if they are completed too soon, the version codes are issued and become required for all claims (and if you haven't billed yet you will need to obtain it)."*

## **2. A hospital ran out of PAHN forms**

- There were no 4440-82 forms available to assign to newborns for a few days. All of these needed to be followed up on and increased the administrative burden.

## **3. Ministry has incorrect information**

- There are instances where a newborn claim with reject for an "incorrect date of birth". The error is not in the claim as the date of birth is correct and can easily be verified with the hospital chart. The ministry has received incorrect information (e.g. form completed by sleep-deprived parents) or there has been a data entry error. These claims are very difficult to correct as the ministry will insist that the DOB is incorrect but will not disclose what DOB is in their records.
- Other instances include differing admission dates for in-patient claims between the hospital system and MOH. This leads to rejections of 'admit date mismatches' and is hard to correct as we do not know the admission date that is showing on the MOH side.

## **4. Service Ontario Help Desk**

- When Service Ontario agents are reached through the Health Number Release line, they verify the following information prior to releasing the patients' health card number for a VH9 rejection:
- PAHN – to which usually their response is "it's not showing up," "nothing is showing up" in which case they move on to do a hard search and ask for
- Last name on health card, First name on health card, DOB, M/F, sometimes postal code (if you do not have the updated name they will not release this information)
- Experience with the degree of "helpfulness" varies greatly when calling. One billing agent reported having great success with someone helping at the InfantRegistrationSO@ontario.ca email address. However, they were later informed that *"moving forward this area will no longer be actioning this type of request. Please submit the pre-assigned form with your regular batches to the Service Ontario office."*

## 5. Billing agency experiences

### Billing agency #1 (bills for 148 pediatricians)

- July 2022 to April 2023: VH9 rejections affected 1100 physician claims in that time period
- At the beginning of COVID, we did notice an uptick in the number of VH 9 rejections. Inquiry into this with the Ministry revealed that Service Ontario was behind in entering the registrations into their system.
- We have also received VH9 rejections which were caused by inaccurate data entry of HN registrations by Service Ontario.
- Physicians are at the mercy of the efficiency and accuracy of the host hospital, the patient/family as well as Service Ontario in order to be paid for their newborn services.

### Billing agency #2 (bills for 62 pediatricians, only some of these provide episodic newborn care)

- Currently we have 80 active VH9 rejections. These are the most time-consuming rejection types to deal with as they often require multiple follow-ups with the family after they have obtained a new number from Service Ontario.
- Many parents do not return phone calls and the contact information from the hospital is often not correct.
- Babies cannot be tracked down by other means since the name from hospital does not match their given name. **An added level of complexity is if we call Service Ontario Help Desk (ie. speak to an actual person), they will not provide us with any information unless we have a complete first name, last name and date of birth match.** Often we only have Baby Boy or Baby Girl, and often the surname has changed since birth. This means that there could be valid coverage but they can't tell us what it is.

## 6. Mail strike

- During the last Canada Post strike, a pediatrician had 53 VH9 rejections resulting from 5 days of work. It took many hours of calling trying to contact the families and payment for less than half was recovered.

## 7. Revenue Lost

- One hospital-based paediatrician started to keep track of all VH9 rejected claims for OHIP-eligible newborns where the family could not be reached and the new, valid number could not be obtained.
  - Time Period: 2017 -2023
  - Total Claims: 67
  - Revenue lost: \$10,418.91 at minimum

- A physician group from a tertiary care centre provided the following data on rejections pertaining to the challenges of this nature. This physician group has a dedicated staff who actively follows up on rejected claims which is a service not available to most individual physicians unless they employ a very knowledgeable and experienced billing agent.

Time Period	Total Claims Rejected	Revenue Lost
2018	75	\$10,159.50
2019	122	\$20,059.87
2020	48	\$7,788.30
2021	20	\$3,655.20
2022	42	\$8,799.60

#### **8. Rejections from COVID-19 Physician and Hospital Services for Uninsured Patients Program**

- Although this temporary program seemed to be an alternate path to payment in cases of rejected newborn claims, physicians have also had their claims rejected though the Uninsured Patients Program. The hospital will claim that there is valid OHIP coverage and that the claim has been rejected by the ministry. Submissions to Claims Management has resulted in the inquiry being forwarded to the OHIP Eligibility Review Committee (OERC). One physician has several pending claims with OERC. One of the claims is from a service date of April 30, 2020 and it remains pending at this time since *“the OERC is experiencing a large volume of requests at present.” “Your file has yet to be assigned for review.”* It is unclear whether this committee will approve payment for these now stale-dated claims for newborn services provided to OHIP-eligible newborns where the PAHN rejected and the family could not be reached.

#### **9. Early neonatal death claims are still rejected**

- Even when great care is taken by hospital staff to follow the exact instructions outlined in the “Infant Registration Reminder” memo sent to hospital in June 2019. As an example, one pediatrician has been closely working with the nursing manager at their hospital to ensure that the PAHN is submitted correctly in cases of an early neonatal death. Despite this, physicians involved in these resuscitations have had their claims rejected. The nursing manager reports that when contacting the Ministry, she is sometimes successful in receiving a response (although this is reportedly only 50% of the time) and something is done on the Ministry’s end to “correct” and register the submitted PAHN. This; however, is also not consistent and creates high administrative burden, especially now with the more complex process of resubmitting stale-dated claims after 3 months from the service date.

## Birth Tourism

Many Ontario hospitals see a high number of families who travel to Canada to deliver for the sole purpose of obtaining Canadian citizenship for the newborn. There are many companies which facilitate this process. See a few examples of websites (in English) are [CanadaMama](#) and [Immigration Canada Services](#). Many other similar services exist.

As an example, prior to the pandemic one hospital in Mississauga noted that approximately 8% of the 6,000 annual deliveries were in visitors to Canada. The numbers are now again increasing. Many families arrive misinformed about the costs of healthcare services and most commonly expect that since the infant will be receiving Canadian citizenship, this will also come with full healthcare coverage. This leads to significant conflict in hospitals as some families become aggressive to the point that a code white needs to be called when hospital staff will not issue a PAHN for the newborn. These families may also try to obtain obstetrical and newborn care through midwifery groups.

Section 2.4.3 of the *Infant Registration Program - Manual for Birthing Hospitals* states that a birth is not eligible for Form 4440-28 if:

- The infant's primary place of residence is not in Ontario
  - This is often difficult for hospital staff to determine as some families have been carefully coached on what to say. The companies they work with provide accommodations and therefore they are able to provide a local Ontario address.
- The infant will not be physically present in Ontario for at least 153 days in any 12-month period
  - As hospital staff are not able to ask for proof of residency, families are learning to simply state that yes, the infant will be in Ontario for at least 153 days.

Some hospitals have chosen to direct families who are visitors to Canada to Service Ontario and not issue a Form 4440-28 in hopes of avoiding conflict over the assignment of a PAHN. It is not possible for the hospital staff to confirm eligibility criteria for the newborn. The ministry should be aware that these birth tourism families will present to Service Ontario and may be well prepared to state what they need to state in order to attempt to fraudulently obtain an OHIP number for the infant.

Physicians caring for newborns of visitors to Canada are at risk of not being paid for their services since the PAHN, if assigned, cannot be validated prior to submitting a claim. The decision of whether or not a PAHN is assigned to a newborn is not up to the physician. If a PAHN number is available on the hospital chart, the physician will be under the impression there is OHIP coverage for the newborn. If, however, the PAHN rejects as a VH9 after 90 days because the infant is deemed ineligible for coverage, the physician has lost the opportunity to charge the family directly for their services. The family will likely have already returned to their home country and cannot be billed. This again highlights the underlying problem with the fact that a PAHN cannot be validated prior to submitting a claim.

## Conclusion



The current Infant Registration Program is too complex. The failure points are completely out of the physician's control and rest in the hands of parents, nurses and hospital staff. Although the hospital is responsible for issuing PAHNs, hospital administration does not get involved in obtaining correct health cards for infants when the PAHN is rejected. This is a task left up to individual physicians. Staffing challenges that have been experienced in all areas of healthcare since the pandemic makes this complex process especially unreasonable given that patient care will always (and should) take precedence over the correct completion and collection of ministry forms. Rejections are more common in recent immigrants and low SES families who have more barriers to the accurate completion of the various steps involved in the PAHN being correctly registered. Any Ministry interventions thus far to improve the program have been ineffective.

No other situation exists within OHIP where a physician cannot validate the health card number at the time of providing the service and be potentially faced with rejected claims 90 days later. For the past 25 years, since the "Good Faith" payment policy was discontinued, physicians have had an unacceptably high administrative burden dealing with rejected newborn claims and losing significant revenue when families cannot be reached or refuse to provide information. Given that this mostly affects paediatricians and family physicians, both female-dominated specialties, this issue further exacerbates the gender pay gap.

If a PAHN is issued at birth, this number needs to be considered valid until the family can present a verifiable health card with a version code. Physicians who provide newborn services must have the ability to validate that there is active OHIP coverage and be compensated for their work, without a high administrative workload.

## Appendix A – Good Faith Claims Payment Policy – Bulletin 4303, December 23, 1997

# bulletin



Bulletin Number <b>4303</b>	Date <b>December 23, 1997</b>	Direct inquiries to <b>Ministry of Health Processing Office</b>
Distribution <b>Physicians, Hospitals, Clinics, and Laboratories and Independent Health Facilities</b>		<i>(address below)</i>

### Subject **GOOD FAITH CLAIMS PAYMENT POLICY**

In an ongoing effort to implement the government's "zero tolerance" strategy for health care fraud and streamline the claims payment process, the Ministry will be shortly ending the "good faith" claims payment policy. This measure, announced by the Minister in September, will place responsibility on the card holder to have a valid card and to carry it at all times. The Ministry will no longer pay for services rendered when the eligibility of the card holder has ended, or for services rendered in a hospital setting when the health number has a missing or incorrect version code. To that end, public advertising will highlight the need for Ontarians to share responsibility for maintaining the integrity of their health cards and, ultimately, the province's health system.

While this measure was originally to be introduced on January 1, 1998, changes to the legislation which will effectively eliminate "good faith" payments will come into effect March 1, 1998. The Ministry has delayed the implementation of this policy for a short period of time to allow for appropriate communication to the public and providers. Effective March 1, 1998, the Ministry will no longer pay for services rendered when eligibility has ended, or when the health number has a missing or incorrect version code.

This change to the "good faith" payment policy has been made possible with the establishment of three automated validation mechanisms available to providers starting in 1994. At that time, all health care providers were invited to take advantage of the first, Interactive Voice Response (IVR), which makes use of common touch tone telephone technology. Magnetic stripe swipe Health Card Readers (HCRs) were also made available to hospitals in 1994 and large groups in 1995. Overnight Batch Eligibility Checking (OBEC) is currently being piloted to pre-validate those with scheduled appointments. At present, over 17,000 health care providers and facilities have access to the Ministry's validation systems with at least one type of validation service available to each provider.

Providers who are not now registered to use one of the validation systems may contact the Ministry of Health Validation Help Desk at 1-800-262-6524 or in Kingston at 548-7981 for details or assistance.

All providers have the ability to take the necessary steps to verify the validity of health cards presented or used in billing the Ministry before claims are submitted; therefore, the Ministry is actioning the following two initiatives:

1. Revoke Regulation 552, section 4 under the HIA

Regulation 552 will be amended to revoke section 4 of the Regulation. The original intent of this section, to honour claims where premium based/coverage problems existed for the eight digit OHIP number which the health care provider could not know at the time the service was rendered, is no longer relevant.

2. Discontinue payment of claims for hospital-based services when the health number version code is missing or incorrect for the date of service

As a result of the 1993 MOH/OMA Agreement, the Ministry was required to pay claims in good faith for hospital-based services when the version code was missing or incorrect for the date of service. In 1996 the Agreement was revoked, but the Ministry continued to pay this type of claim in good faith. Since all hospitals can access validation systems or could have the patient complete a Health Number Release form, this practice is unnecessary.

As is the case now, the Ministry wants to ensure that emergency health services continue to be provided to persons in need. We do recognize that physicians providing services in an emergency department environment may have difficulty in acquiring the correct health number and version code for the patient for billing purposes. The Ministry will provide additional assistance to staff or physicians in an emergency department, so that the release of this information using a Health Number Release form will be accelerated when an invalid validation response has been received.

Enquiries or requests for clarification regarding the elimination of "good faith" payments can be made to your local Ministry of Health - OHIP office.

#### REIMBURSEMENT FOR MALPRACTICE FEES - 1997 PROGRAM (Physicians only)

Applications for the 1997 Malpractice Reimbursement Program will be mailed to all eligible Ontario physicians on or about January 15, 1998. The application packages will be forwarded by the CMPA; it will include a covering letter, an application form, eligibility requirements, 1997 CMPA fee schedule, your CMPA acknowledgment and a return envelope. Application packages will be mailed directly from the Ministry of Health for those physicians not ensured with the CMPA.

Physicians are reminded that the CMPA acknowledgment is required in their submission to the Ministry for reimbursement. Physicians' insured with other insuring agents must submit a receipt reflecting full payment of premiums.

Applications must be completed and forwarded to the Ministry by June 30th, 1998 at:

Ministry of Health  
Reimbursement of Malpractice Fees  
P.O. Box 48  
Kingston ON K7L 5J3

**Enquiries regarding reimbursement of malpractice fees should be directed to your local Ministry of Health - OHIP office.**

#### Office locations

<b>Barrie</b> 30 Poyntz St. L4M 3P2	<b>Hamilton</b> 119 King St. W P.O. Box 2280, Stn. A L8N 4C8	<b>Kenora</b> 220-808 Robertson St. P9N 1X9	<b>Kingston</b> 1055 Princess St. P.O. Box 9000 K7L 5A9	<b>Kitchener</b> Canada Life Square Main Floor 235 King St. E., N2G 4N5
<b>London</b> 217 York St., 5th Floor P.O. Box 5700 Terminal A N6A 1B7	<b>Mississauga</b> 201 City Centre Dr. P.O. Box 7020, Stn. A L5A 3M1	<b>North Bay</b> 101-447 McKeown St. P1B 9S9	<b>Oshawa</b> Exec. Tower, Oshawa Centre. 419 King St. W. P.O. Box 635 L1H 8L4	<b>Ottawa</b> Fuller Building 75 Albert Street K1P 5Y9
<b>Owen Sound</b> 981 2nd Avenue E. N4K 2H5	<b>Peterborough</b> 550 Lansdowne St. W. K9J 8J8	<b>St. Catharines</b> 59 Church St 3rd Floor L2R 3C3	<b>Sarnia</b> 452 Christina St. N. N7T 5W4	<b>Sault Ste. Marie</b> Roberta Bondar Place 70 Foster Dr., Ste. 100 P6A 6V4
<b>Sudbury</b> 199 Larch St., Suite 801 P3E 5R1	<b>Thunder Bay</b> 435 James St. S., Suite 113 P7E 6T1	<b>Timmins</b> 38 Pine St. N., Ste. 110 P4N 6K6	<b>Toronto</b> 2195 Yonge St. P.O. Box 1700 Stn. A M5W 1G9	<b>Windsor</b> 1427 Ouellette Ave. N8X 1K1
<b>Head Office</b> P.O. Box 38 Kingston, ON K7L 5J2				

## Appendix B – Infant Registration Reminder

**ServiceOntario**

Ministry of Government and  
Consumer Services  
ServiceOntario

Ministère des Services gouvernementaux et  
Des Services aux consommateurs  
ServiceOntario

Card Management Office  
Kingston Production & Verification Services  
Branch  
49 Place d'Armes  
Kingston ON

Bureau de la gestion des cartes  
Direction de la production et de la vérification - Kingston  
49, Place d'Armes  
Kingston, ON K7L 5J3

June 17, 2019

Hospital Name  
Address  
ATTN:

### Infant Registration Reminder

In order to ensure timely and accurate registration of infants for the Ontario Health Insurance Plan (OHIP) and therefore timely payment of claims for health care providers, this letter is to address several issues related to the Pre-Assigned Health Number (PAHN) Form 4440-82. Please note it is the responsibility of hospital staff to ensure forms are completed and returned to ServiceOntario. The hospital's role is particularly critical in instances of stillbirth and newborn death. **Please ensure that all staff who provide PAHN forms to parents or who submit forms to ServiceOntario are reminded of the following mandatory requirements:**

**All forms must be filled out completely. Mandatory entries include:**

- surname (first and middle names can be left blank)
- date of birth
- residential addresses (this cannot be a Box number or only a Rural Route number)
- mailing address if it is different than the residential address
- a parent's signature.

Forms that are not accurately and completely filled out cannot be registered and a health card will not be issued. **Please check all forms before the parent leaves the hospital in case corrections are required.**

To be eligible for PAHN Form 4440-82 the following criteria must be met:

- the birth takes place in or enroute to an Ontario hospital that has a birthing facility, or with the assistance of a midwife who is associated with a birthing facility
- the infant's primary place of residence is and will continue to be in Ontario
- the infant will be physically present in Ontario for at least 153 days in any 12-month period
- the infant has not yet been discharged
- the infant was not born to a surrogate

There are **special processes for completing forms for births that are followed by an infant's demise, a Children's Aid Society (CAS) apprehension, or a confidential adoption**. Failure to follow these directions correctly may impact the child and parents' privacy and physician payments, often following difficult situations.

**Ontario** 

<b>Demise</b>	<ol style="list-style-type: none"> <li>1. <b>Hospital staff</b> complete the form (birth mother's last name, newborn's sex, DOD/DOB, and first name if known);</li> <li>2. <b>Leave the address field blank.</b> This is important because entering an address will result in the parents receiving a health card for the deceased infant.</li> <li>3. Write 'Stillbirth' or 'Early Death' <b>at the top of the form, not on the back.</b> If the date of demise is different than the date of birth, this date should be written on the form also.</li> <li>4. Leave the tear-off strip attached to the top of the form.</li> <li>5. <b>Submit the entire form</b> to ServiceOntario with the weekly batches.</li> </ol>
<b>CAS Apprehension</b>	<ol style="list-style-type: none"> <li>1. <b>Hospital staff</b> complete the form (birth mother's last name, newborn's sex, DOB, and first name if known, and the CAS address)</li> <li>2. Write 'Apprehension' <b>at the top of the form, not on the back.</b></li> <li>3. Leave the tear-off strip attached to the form.</li> <li>4. Give the health number from the form to the CAS representative.</li> <li>5. Submit the entire form to ServiceOntario with your weekly batches.</li> </ol>
<b>Confidential Adoption</b>	<ol style="list-style-type: none"> <li>1. <b>Hospital staff</b> complete the form (birth mother's last name, newborn's sex, DOB, and first name if known).</li> <li>2. Leave the address field blank.</li> <li>3. Write 'Adoption' <b>at the top of the form, not on the back.</b></li> <li>4. Leave the tear-off strip attached to the form.</li> <li>5. Do not give the health number or the form to CAS/adoption agency/lawyer.</li> <li>6. Submit the entire form with your weekly batches at a full suite ServiceOntario centre.</li> </ol> <p>CAS/Private Adoption Agency/Lawyer will register the newborn for a new HN at ServiceOntario centre.</p>

ServiceOntario requests that PAHN forms be sent in **no later than two weeks after the date of birth**. Forms should not be held at the hospital while waiting for additional births to occur/additional PAHN forms to be completed.

There have been multiple occurrences where hospitals have not submitted their PAHN forms to ServiceOntario in a timely manner or have submitted incomplete forms. This results in the OHIP registration not being completed within 90 days from the date of birth of the child, and the form is 'lapsed'. **Once a form is lapsed, the PAHN is no longer valid.** As a result

- the physician is not able to bill the health number for care provided to the infant.
- the parent/guardian is required to attend a ServiceOntario office to register their infant for a new health number.
- the parent/guardian then needs to return to the hospital with the new health number in order for the hospital and health care providers to submit claims. **This causes unreasonable delay and inconvenience for parents and providers and is extremely difficult and challenging in the cases of stillborn and newborn death.**

For more information regarding how to complete and submit PAHN forms, please reference the Infant Registration Manual that ServiceOntario has provided to your facility.

Questions may also be addressed to [InfantRegistrationSO@Ontario.ca](mailto:InfantRegistrationSO@Ontario.ca)