



Academic Funding Plan
Agreements
Review of Governance,
Compliance and
Financial Processes

July 2010



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Executive summary

In recent years there has been a significant increase in the cost experienced by the Department of Health (DoH) related to Academic Funding Plans (AFPs). In the three-year period 2006/07 to 2008/09 AFP costs have increased by 16% from \$149 million to \$173 million and consistently exceeded budgeted amounts of \$139 million to \$161 million over this timeframe. Not only was the amount of spending an issue, but the health outcomes of our population have not shown a correlating increase and there has been no tangible link between population health outcomes and spending on physician skills and services. As a result there is an appearance that the Province's talented physicians working under the AFPs are not being deployed to realize their full potential in a manner that is rewarding and meaningful for them and in the best interests of the health objectives of the Province of Nova Scotia.

Due to this concern for accountability for spending, Deloitte was requested to review the effectiveness and efficiency of the governance, compliance and financial processes related to current AFPs on behalf of the Province of Nova Scotia's Internal Audit centre. Overall, the findings of this report indicate that the current AFP process and structure contain a number of issues that preclude effective governance, compliance and financial oversight. The report includes a high level set of recommendations encouraging the Province to lead the health system to develop a meaningful way to exert governance, compliance and financial oversight in the health care system, as it pertains to physician spending.

The historic shortcomings in the performance of financial accountability over the AFPs are not only due to deficiencies with current processes that are in place, but also due to the lack of compliance with often misunderstood processes and contract frameworks. At present, the process is focused on negotiation of the agreements and reactive attention to understanding cost increases. The process is not set up to be proactive with proper governance, control structures and financial oversight. Conflicting understandings and interpretations consistently expressed by the interviewees around leadership, process, measurement and accountability suggest that the process currently in place is either not effective and/or not commonly understood. Historically there has been a great deal of energy used to negotiate the pool of funds available for spending through the AFP; it is our overall observation that this negotiating energy must shift to negotiating expected outcomes to be achieved as a result of distributing a set financial pool.

Our findings and recommendations are based on the current AFP model used in Nova Scotia. As noted further in the executive summary we have reviewed models used in other jurisdictions. We have noted that the model used in Ontario (the Ontario Academic Health Sciences Centres Alternative Funding Program) contains many of the elements desirable in Nova Scotia. While adoption of an entirely new model is an alternative for Nova Scotia, consideration should be given to refinement of the current model, as well as implementation of the recommendations noted in this report which identify areas of weakness in the current model.

Some of the key high level findings are as follows:

- While AFPs were designed with good intentions for effective physician remuneration and to correct issues with Fee For Service (FFS) billings, it would seem that the negotiation processes has distracted from the possible strengths available through meaningful outcome measures and effective performance evaluation. Revised oversight, governance and engagement of stakeholders are needed to get the AFP philosophy back on track with its originally stated objectives.
- During the course of our interviews we sought to understand the current AFP negotiation process; however, we were not successful in finding any one consistent or complete explanation of the process. From the various interviewees we have developed the flowcharts covering the key steps in the AFP negotiation process (See Appendix E and F).

- It was noted there is a lack of formal documentation pertaining to AFP negotiations. Without complete and accurate documentation of negotiation sessions, which is shared on a regular and timely basis amongst the stakeholders, there is the risk that parties may interpret discussions differently or have different recollections of discussions.
- From the data provided, significant dollar increases year over year in the departments under AFP agreements, appear to be explainable within the terms of the AFP agreements in place. This would indicate there is a potential lack of understanding of the terms of the agreement.
- One of the fundamental reasons for putting AFPs in place was to assist in the retention of physicians who were practicing in an academic environment. Although we do not have specific data, many instances of anecdotal evidence in our interviews indicated that retention of physicians in Nova Scotia, and in the AFP environment specifically, is not an issue. This would provide some evidence that remuneration within the province is adequate.

Our recommendations can be categorized into four sections (use of AFPs, governance, compliance and financial) and are summarized at a high level in the following table:

Section	Recommendation areas
Use of AFP's	<ul style="list-style-type: none"> • Reduction in the number of AFP agreements • Linkage between remuneration method and outcomes • Revisiting outcome measurements
Governance	<ul style="list-style-type: none"> • Development and communication of strategic direction • Development of physician resource plan • Responsibility for achievement of outcomes • Determination of performance expectations • Revitalization of issues resolution process
Compliance	<ul style="list-style-type: none"> • Increased awareness, education and documentation • Clearly defined roles and responsibilities • Adequacy of DoH resources and skills • Effectiveness of Performance Management Committee • Academic deliverables and performance reporting
Financial	<ul style="list-style-type: none"> • Timeliness of negotiations • Process for changes to AFP during life of AFP • Physician resource planning • Rewards and recognition

As part of this review, Deloitte completed a comparison between the Nova Scotia AFP model and that of other jurisdictions to identify practices that could be leveraged by Nova Scotia in improving the current AFP process. Included in the jurisdictional scan were the Ontario Academic Health Sciences Centre's (AHSC) Alternative Funding Program, Queen's University Plan, Alberta Academic Alternate Relationship Plans and the Bundled Payment System – Episode Based Payments (a proposed academic funding system in the United States). Information regarding each of these locations was obtained through studies which had already been completed or documents which included information regarding the model. There was no primary research done as part of this review. Each model was evaluated to assess the scope, structure, process, mandate, and accountability along with the Pros and Cons in terms of applicability to Nova Scotia.

Through the jurisdictional review it was determined that the Ontario AHSC model contained the most desirable number of elements to assist Nova Scotia in revitalizing the AFP process. Although the entire model may not be suitable for Nova Scotia, and additional dimensions should be added, we believe that a number of the components of this model align with the recommendations of this review. While adoption of an entirely new model is an alternative for Nova Scotia, consideration should be given to refinement of the current model, as well as implementation of the recommendations noted in this report which identify areas of weakness in the current model. Key components of the tailored to Nova Scotia model should include:

- Creating an accountability framework for Cabinet of the Province's elected government to set the tone for oversight and decision-making around AFPs;
- Developing an oversight and accountability team led by senior DoH resources responsible for governance, communications, and accountability measures;
- Allowing the oversight and accountability team noted above to provide input, direction and dispute resolution for:
 - i) The allocation of funds to participating physicians;
 - ii) The movement of funds within the payment plan;
 - iii) Changes in physician complement, including issues involving retention and recruitment; and
 - iv) The locations where medical services are to be provided;
- Collapsing the current multiple AFPs into one provincial AFP;
- Creating a separate stand alone management organization with responsibility for contract negotiation and fund disbursements;
- Having the physician group focus on quality performance that support key strategic objectives of the Province, Capital District Health Authority (CDHA), IWK Health Centre (IWK) and Dalhousie University; and
- Using measurements and reporting within specified timeframes that improve team based delivery and seek areas for innovation and cost savings.

If AFPs are to continue as the preferred funding model for academic physicians in the Province, which is a reasonable expectation, certain fundamental process and structural issues must first be addressed. The current governance and processes do not allow for effective outcomes and value for money invested in the system. Furthermore, the physician community is not appropriately recognized for the talents they bring to the system and the strength of the potential impact they can bring to the system. With fundamental changes to capture the potential available in the system, better governance, compliance and financial oversight can be implemented. The current issues cross a broad spectrum of areas including communication, education, governance, accountability, financial management, leadership and process deficiencies. These need to be addressed and refocused to ensure appropriate delivery of strong health outcomes and fiscal responsibility for the people of Nova Scotia.

Definitions

AFP Performance Management Committee – Governance committee as described in the current AFP agreements comprised of members representing the Minister, CDHA and/or IWK, the Department Head, the Faculty of Medicine from Dalhousie University and one non-voting member representing the Medical Society. The role of the committee is to:

- Monitor implementation of the agreement;
- Review effectiveness of method of alternative funding;
- Receive and review Deliverables provided by the Department;
- Determine any penalties for non compliance;
- Review and consider requested changes and make recommendations to DoH;
- Report annually to the parties of the agreement on all aspects of performance of the agreement; and
- Issuing the summary of Annual Funding and the contributions to the Annual Funding.

Annual Funding – Clinical Medical Services Insurance (MSI) Funding plus Enhanced Funding

Clinical MSI Activity Target – the annual target of Shadow Billings set for the Department

Clinical MSI Funding – funding for Clinical Services set out in AFP agreement

Clinical MSI Services – services traditionally remunerated under the MSI fee schedule and which are reported through Shadow Billings

Deliverables – reporting deliverables as set out in Schedule C of the AFP agreement or other required reporting defined per the AFP agreement

Department Practice Plan – the internal arrangement agreed to by the AFP physicians with respect to the roles and responsibilities of the AFP physicians, and which includes the mechanism for determining the responsibilities and revenue sharing mechanism of the AFP physicians

Enhanced Funding – funding set out in AFP agreement for the services other than the Clinical MSI Services

Fee-For-Service (FFS) – health care model where services performed by physicians (relating to office visits, tests, procedures, consultations, etc.) are unbundled and billed by and paid to the physician separately

Full-Time Equivalent (FTE) – a measure of the total physicians within a particular AFP agreement

Medical Service Insurance (MSI) – program administered on behalf of the Province, for the payment to physicians for providing Insured Medical Services pursuant to the *Health Authorities Act*

Shadow Billings – the reported billings of the AFP Physicians of each insured service encounter information submitted to MSI, in the form prescribed by the Department of Health

Stakeholders – for the purposes of this report the stakeholders are considered to be Government of Nova Scotia, Department of Health (DoH), Treasury Board Office (TB), Capital District Health Authority (CDHA), IWK Health Centre (IWK), Dalhousie University (DAL), Doctors Nova Scotia (DNS) and the academic physician group

Unit Value System – the representation of the actual fees for Insured Medical Services by separate unit categories: the Medical Service Unit (MSU) and the Anesthesia Unit (AU)

Introduction

Background

Deloitte was engaged by the Province of Nova Scotia's Internal Audit Centre (IAC) to conduct the following review on their behalf – Academic Funding Plan Agreements, Review of Governance, Compliance and Financial Processes (AFP review).

Objectives

The five objectives of the AFP review were as follows:

1. To evaluate the effectiveness and efficiency of existing governance structures and relationships between the parties accountable for the negotiation, approval, funding and monitoring of Academic Funding Plan (AFP) agreements;
2. To evaluate monitoring and compliance with terms of the existing AFP agreements, including any correlation between cost increases and improved outcomes;
3. To evaluate the financial performance related to trends in costs associated with the agreements over the past three (3) years to compare the actual with the budgeted or estimated costs and explain the underlying causes of the variances;
4. To evaluate the New Framework for AFPs approved by the Labour Relations Committee of Executive Council in 2006 and up-dated in 2009 to evaluate if it includes appropriately designed compliance activities to satisfy the requirements of the funding provider; and
5. To make such recommendations as necessary to improve the governance, compliance, financial processes and timeliness of negotiations associated with the AFP agreements.

Scope

The scope of the AFP review included the following:

1. All AFP agreements and all stakeholder groups identified as the parties that are signatories to the agreements;
2. Evaluation of the effectiveness, timeliness and follow-up activities related to the reporting requirements within the agreements;
3. Examination of AFP agreements to determine significant cost drivers;
4. Review of available documentation; and
5. Review of new framework for AFPs approved by the Labour Relations Committee of Executive Council in 2006.

Approach

To complete the AFP review we examined various documents, presentations and articles provided to us by the different AFP stakeholders and engaged AFP stakeholders in interviews and discussions. Refer to **Appendix A** for a complete list of AFPs reviewed. Refer also to **Appendix B** and **Appendix C** for a list of AFP Stakeholders and Physicians with whom interviews were held.

AFP background

Prior to the first AFP in Nova Scotia, physicians practicing in teaching/academic facilities (IWK and CDHA) were remunerated based on a fee-for-service (FFS) model. Under this model, physicians billed the government through Medical Service Insurance (MSI) for each service provided to a patient. There are numerous fee codes and billing rules per the MSI Physician's Manual used to cover the various services provided by physicians. Payment for the service is based on the Unit Value System whereby each service is assigned a number of medical service units (MSUs) or anesthesia units (AUs). The amount paid is the number of MSUs or AUs for the service multiplied by the established value of the MSU or AU.

The FFS model has been criticized in the past for a number of reasons, including:

- Physicians were being rewarded for volumes and level of service as opposed to quality of care outcomes;
- There was no incentive for efficiency of service delivery, quality or value built into the FFS model for the services provided;
- The FFS model did not promote process innovation or the use of other health care professionals;
- There was no focus on disease prevention through FFS; and
- There was no limit on the number of claims that could be submitted by physicians through FFS which consequently made budgeting for costs difficult.

In the mid-1990s the first AFP was negotiated within the Province of Nova Scotia. At the time, AFPs were meant to provide reasonable remuneration for physician service delivery where FFS would not necessarily provide a stable and consistent level of funding due to the non-clinical component of the work carried out by these physicians.

In 2000, the Auditor General issued the "Physician Alternative Funding Initiatives Report" which had a number of observations and recommendations, including weaknesses in the following areas:

- Controls in the payment process (both in shadow billings and in reducing payments when service levels were not achieved);
- The shadow billing process; and
- The AFP evaluation of clinical outcomes.

In 2005 the North South Group Inc. was engaged to conduct an audit of the Department of Medicine Alternative Funding Arrangement. Their report (commonly referred to as the 'North/South' report) cited 43 recommendations in the following areas:

- Policy improvements;
- Process / contract related issues;
- Management issues;
- Governance issues;
- Administration;
- Management information systems; and
- Funding / financial issues.

New AFP Framework

In 2006 a New AFP Framework (revised 2009) was endorsed by Labour Relations Committee of Executive Council which was intended to address 41 of the 43 recommendations in the North/South report. Our review of this framework noted a number of deficiencies:

- Although noted as a requirement in the preamble to the document there is no accountability framework outlined;
- The deliverables section of the document does not outline to whom the deliverables must be submitted;
- Definition of roles and responsibilities of the parties to the agreement are not adequate; and
- There is no method of communication and action steps to deduct funds.

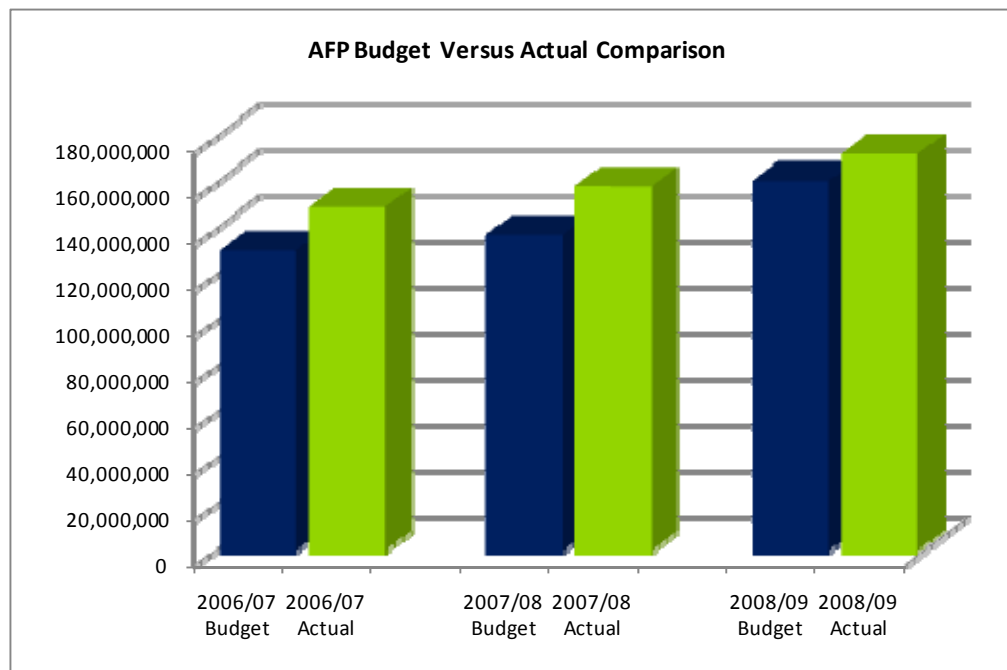
The new AFP framework provides for two components of funding – base funding and incentive funding. The base funding is further broken down into clinical and enhanced funding. Definitions are as follows:

- **Clinical** - Clinical funding is tied to the Physician Services Master Agreement and is based on FFS. Physicians submit shadow billings which determine the amount of clinical funding received. In the first iteration of AFP negotiations under the new framework, the amount of the base clinical funding that could be received was capped. In the most recently negotiated agreements, this cap has been removed and there is no limit to the clinical funding that can be received.
- **Enhanced** - Enhanced funding is meant to provide monies for the non-clinical portion of the work performed by physicians referred to as 'CARE' work (Clinical, Administration, Research and Education). The amount of the funding provided to physicians for this work is a set amount negotiated in the AFP agreement.
- **Incentive** - Incentive funding was meant to encourage increased volumes. For those physicians who exceeded the capped amount of clinical funding they would be eligible to receive a percentage of the FFS amount of services provided above the cap. This percentage was set at 40% of the FFS amount of the service. For those agreements negotiated without a clinical funding cap, as noted above, incentive funding was no longer used.

Under the new AFP framework, the intent was that during the term of the AFP agreement, the total funding could only change as a result of increases in the FFS payments through the physician services master agreement, or if the Nova Scotia Department of Health (DoH) identified a need for additional services (volume increase).

From one of the documents we examined it was noted that remuneration under the revised AFP framework was "...not to exceed average full time provincial FFS experience, unless there is a demonstrated need to address national marketplace realities to ensure recruitment and retention". It was also noted in this same presentation that there would be a financial risk to the DoH if the clinical activity deliverable targets were exceeded and that mitigating factors included hospital facility infrastructure limitations, the Faculty of Medicine pressure for academic deliverables and the 'deep' discounting of the incentive funding portion.

AFPs have become the primary method of remuneration for the majority of the physicians practicing at the IWK and CDHA. The cost of these agreements represents a significant portion of the provincial budget each year (approximately \$150 million in 2006/07; \$159 million in 2007/08 and \$173 million in 2008/09, compared to budgeted amounts of \$131 million, \$138 million and \$161 million over the same three-year period). A summary graph of total AFP spending and the associated budget is presented here along with a table comparing actual versus budgeted amounts for each physician group over the 3-year period of this review:



Physician Group	2006/07 Actual	2006/07 Budget	2007/08 Actual	2007/08 Budget	2008/09 Actual	2008/09 Budget
Pediatric Nephrology	548,800	528,600	548,800	548,800	548,800	548,800
Gynecologic Oncology	1,330,800	1,380,200	1,246,700	1,400,800	1,330,800	1,400,800
Diagnostic Imaging	1,956,300	2,111,700	2,082,400	1,893,500	2,781,600	1,902,500
Pediatric Anaesthesia and Pediatric Critical Care	2,498,000	2,486,400	3,694,000	2,498,000	3,762,600	3,374,000
Women's and Obstetrics Anesthesia	3,172,000	2,498,000	3,515,800	3,175,300	3,826,200	3,376,900
Family Medicine	3,480,000	2,974,800	3,540,100	3,669,200	3,967,100	3,740,800
Radiation Oncology	3,336,400	3,336,400	3,336,400	3,304,200	4,704,000	3,336,200
Critical Care	3,768,000	3,837,900	4,125,000	4,291,500	4,125,000	4,125,000
Neurosurgery	4,940,000	5,200,000	4,680,000	5,150,000	4,704,600	4,766,300
Emergency Medicine	5,511,000	n/a	6,709,500	5,511,000	7,126,400	6,894,500
Pathology/Laboratory Medicine	7,923,400	7,768,100	7,923,400	7,691,400	9,992,900	7,923,400
Pediatric	13,189,500	12,594,100	13,767,800	12,944,800	14,609,100	13,519,200
Psychiatry	14,360,100	13,288,000	15,784,800	14,787,700	19,570,400	16,308,900
Anaesthesia	15,062,100	13,000,000	16,679,300	12,799,600	17,349,400	16,557,000
Dalhousie Surgery	30,888,000	21,193,500	32,379,800	20,761,000	34,968,500	32,551,100
Medicine	37,951,400	38,772,500	39,155,700	37,523,100	39,760,000	41,143,600
Totals	\$ 149,915,800	\$ 130,970,200	\$ 159,169,500	\$ 137,949,900	\$ 173,127,400	\$ 161,469,000

Key stakeholders involved in the current AFP process include:

- Government of Nova Scotia
- Department of Health (DoH);
- Capital District Health Authority (CDHA);
- IWK Health Centre (IWK);
- Doctors Nova Scotia (DNS);
- Dalhousie University (DAL);
- Treasury Board Office (TB); and
- Physician groups.

While AFPs were designed with good intentions for effective physician remuneration and to correct issues with FFS billings, the negotiation processes have distracted from the possible strengths available through meaningful outcome measures and effective performance evaluation. Revised oversight, governance and engagement of stakeholders appears necessary to get the AFP philosophy back on track with its originally stated objectives and to ensure budgeting mandates are maintained.

Alternative AFP models

As part of our review, Deloitte was asked to prepare a comparison between the Nova Scotia model and that of other jurisdictions to determine best practices. The following summary of key elements provides a high level comparison of the various jurisdictions that were examined in exploring alternatives to the Nova Scotia model. Further details of each of the jurisdictions are provided in **Appendix D**.

	Nova Scotia	Ontario Academic Health Sciences Centres (AHSC)	Queens University	Bundled Payment System – Episode Based Payments (US based)	Academic Alternate Relationship Plans (Alberta)
All funding sources considered (merger of revenue sources)	✗	✓	✗	✗	✓
Agreement covers all service types (education, research, clinical)	✓	✓	✓	✗	✓
Defined /measurable deliverables (education, research, clinical services, administration)	✓	✓	✗	✗	✓
Human resource plan	✗	✓	✓	✗	✓
All stakeholders involved	✗	✓	✗	?	✓
Dispute resolution process	✓	✓	✓	?	✓

Legend

- ✓ meets criteria
- ✗ does not meet criteria
- ? could meet criteria; more information needed

Upon examination of these models it was determined that the Ontario AHSC and Alberta models ranked the highest in comparison to the Nova Scotia model. The AHSC model, however, appeared to be the more robust and advanced. It contained the most desirable number of elements to assist Nova Scotia in revitalizing the AFP process. Although the entire model may not be suitable for Nova Scotia, and additional dimensions should be added, we believe that a number of the components of this model align with the recommendations of this review. While adoption of an entirely new model is an alternative for Nova Scotia, consideration should be given to refinement of the current model, as well as implementation of the recommendations noted in this report which identify areas of weakness in the current model.

The following is further information on the Ontario model and how it could be applied in Nova Scotia.

Ontario AHSC model background

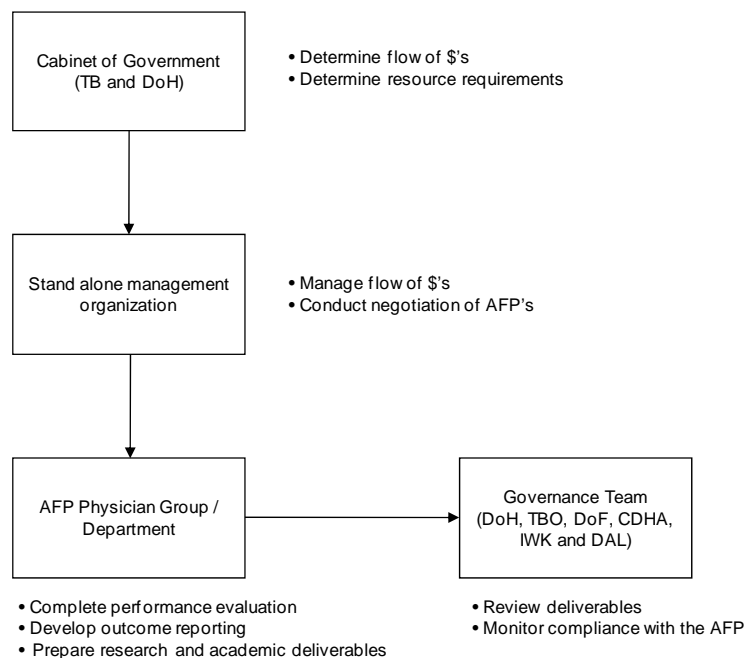
At the time of development of the current Ontario model, a review was undertaken in Ontario to determine the existing issues with physician payments and the best practices which they should use in the development of a new payment model.

This review was lead by Ontario but included an interprovincial scan. The resulting process to develop the model took over a decade to get the AFP agreements to where they are at present. As a result there is a lot of learning compiled within this model. The issues raised by the Toronto Academic physician group as part of this process provided findings similar to the current Nova Scotia environment.

Due to the rigor involved in this review, the resulting findings and the success that Ontario is currently experiencing with the revised model, we believe it is a reflection of accumulating best practices across the country.

Applying the Ontario AHSC model to Nova Scotia

The following diagram is based on the structure of the Ontario AHSC model and updated to reflect appropriate governing stakeholders in Nova Scotia. This modified model highlights the roles of the relevant parties and how they would be involved in governing an AFP in Nova Scotia.



Cabinet and Government (TB and DoH)

Responsibilities of the TB and DoH include:

- Communication of roles and responsibilities;
- Determination / communication of physician human resource requirements;
- Development of recruitment and retention strategies;
- Determination of total funding available for AFPs;
- Determination of outcome based metrics; and
- Determination of research and academic reporting metrics;

Governance Team (led by DoH)

This oversight team would not include any of the physician groups as they deliver the service.

Responsibilities would include:

- Coordination of stakeholder expectations and feedback reporting;
- Evaluation of performance; and
- Determination and exercising of penalties.

Stand alone management organization

There is a separate stand alone management organization that supports the physician group and manages their best interests.

Responsibilities for this group include:

- Communication of the negotiation process;
- Lead the negotiation process with physicians within the parameters and requirements;
- Management of AFP dollars available;
- Payment for and deployment of staff and facility resources for individual physicians;
- Management of policies and benefits related to physician remuneration;
- Assistance in relationship management with stakeholders (Dalhousie, IWK, CDHA, DoH);
- Support for outcome reporting of physician activity;
- Integration of the deliverables and outcomes requested by the stakeholders (Dalhousie, IWK, CDHA, DoH); and
- Distribution of dollars to physicians in accordance with AFP agreement.

Required staff for this organization includes, at a minimum, a skilled negotiator and a highly experienced financial professional. This is separate and apart from government, allowing the government to effectively fulfill their governance role, stay focused on the oversight role related to cost and funding controls and monitor the value of outcomes received for the program funding.

AFP Physician Group / Department

Responsibilities for the physician department which is remunerated under the AFP include:

- Negotiation as to allocation of pool of monies between the physicians;
- Setting performance expectations for each physician in alignment with overall stakeholder expectations;
- Performance reporting within the timeframe, and in the manner requested;
- Improvements on team based delivery; and
- Seeking areas for innovation and cost savings, together with the appropriate rewards and recognition.

With an appropriate delegation of duties around the specifics of funding allocation to the physician departments, the government should be less inclined to become preoccupied with negotiations. The role of government should be focused on governance of the program and the setting of priorities and parameters around service expectations and physician resource planning.

This model promotes a proactive approach with strong governance and controls built in, as well as proper segregation of governance from the management of the agreement. It allows stakeholders to have input and hold participants accountable. It also allows physicians to be recognized for agreed upon performance in areas where they perform best.

Findings and recommendations

Use of AFPs

1.1 – Number of AFPs are too onerous

While AFPs have proven to be a successful tool in managing the physician service relationships in other jurisdictions, the current number of AFPs (16) for the CDHA and IWK is too numerous (in contrast, the Province of Ontario has 16 AFP agreements for the entire Province). In addition to appropriateness of size and scale of Nova Scotia, the number of AFPs is too numerous for the following reasons:

- The extensive time required by the various stakeholders to negotiate each of these agreements;
- With each AFP there are administrative responsibilities for a number of the stakeholder groups. The DoH requires resources to administer and negotiate the agreements. Doctors Nova Scotia, who are the representative of the physicians in the province must spend increased amounts of time negotiating and administering each of the AFPs, potentially to the detriment of other physicians in the province whom they represent as well. The DoH Division of Finance requires resources to administer the financial payments and corresponding shadow billings. Each physician departments (which has an AFP) require resources to develop the department plan, analyze and provide deliverables and determine individual physician compensation within the deliverable;
- Expired AFP agreements do not properly serve any of the stakeholders. The credibility of the process diminishes with expired agreements, budgeting becomes difficult as there is the unknown 'retroactive' portion that may be required to be paid upon renegotiation, and the needs and direction of the provincial health plan and, more directly, the needs of the IWK and CDHA are less likely to be met with an expired agreement; and
- The new template was intended to provide consistency between the various AFP agreements; although the intention of the template provides for a consistent agreement, the physician departments will be inclined to use what was most recently agreed upon for another department as their starting point in negotiation, increasing the potential for raising the costs. This inadvertently creates competitive pressures within the province amongst the physician groups. Such competitive pressure would be better served in a stronger performance evaluation and accountability framework.

Recommendations

It is recommended that the number of AFP agreements be significantly reduced to one agreement for the Province. The AFP should be funded based on the needs and business plan of CDHA and IWK, the physician resource plan of the Province, the specialized resource requirements of the system and the strategic direction of the Province around health outcomes and fiscal restraint. Within the one AFP it should then become the responsibility of the physician group to determine the allocation of the funds among the physicians.

It is our understanding that some of the components mentioned above as underlying inputs to the AFPs are either not yet developed or in development stage.

It is recommended that current and robust business plans, resource plans and strategic direction be developed and understood to allow for negotiation of AFPs that best serve the provincial direction.

1.2– Method of remuneration not linked to outcomes

The North South report recommended that AFP funding be based on a more rational approach and that clinical and non-clinical funding should be differentiated. In response to this the new framework incorporated the FFS model to fund the clinical portion of the AFP agreements. As such a number of the issues with FFS have found their way into the AFP model.

However fundamental issues with the fee for service model in general, and in an AFP environment in particular, were not addressed. Specifically:

- It was noted by the majority of our interviewees that the current fee rates per the Physician Services Master Agreement is out of date. Fee codes in a number of instances have not kept up with changing technologies and procedures. As such procedures which were in the past very labour intensive and therefore paid a higher rate, have not been adjusted for current technology which significantly reduces the procedure time;
- FFS compensates physicians for volumes of procedures performed and not necessarily for quality of service, nor for achievement of facility or provincial health goals;
- As FFS is a procedural based payment; it does not adequately reward diagnostic thought;
- FFS can create an environment where there is a financial incentive for the physicians to over perform specific procedures which pay at a higher rate. This, combined with the lack of financial incentive for diagnostic thought, may result in patients receiving unnecessary treatment;
- FFS does not encourage collaboration/referral amongst departments or from outside the AFP environment into the AFP environment as fee for service pays for the procedures performed within a given department;
- FFS is seen as undesirable by some of the physicians as it does not smooth out income earnings. In a fee for service environment the physician is subject to highs and lows in income, based on the number of procedures performed;
- The current framework for the AFPs does not provide a cap for the amount of fee for service which can be billed. Rather it provides for an upper limit within which FFS is paid at 100%, and then paid at a reduced amount for procedures over this limit. This does not serve as an expenditure management tool as the number of procedures which will ultimately be billed for cannot be known; and
- FFS has the potential to increase assisted procedures as each physician can then bill for services performed increasing the risk of 'double dipping'.

The fundamental issue with any given method of payment is that there needs to be outcome based reporting associated with the services performed. Outcome based reporting needs to mean more than the number of patients served. There needs to be components for measuring the achievement of facility goals and reduced repeat visits. Until these types of deliverables are determined and linked directly to the compensation model chosen, any model of payment will have flaws. Shadow billing is an outdated measurement tool that measures volumes of service provided. If the Province determines that this is not the outcome measure that is most relevant, than shadow billing should not be used in the AFP environment for performance measurement. It is our understanding that shadow billing is required for other administrative reasons which may necessitate its continued use in the short term by the physician groups.

The North South report's recommendations intended for an incentive system which rewarded superior performance and penalized inferior performance. FFS can be argued to be a system that rewards superior performance, in that the higher the number of procedures performed the higher the compensation. The stakeholders need to determine if this is the measurement of success that they are trying to achieve and consequently the proper measurement of superior performance. Based on the interviews that we conducted it would be apparent that volumes are not the proper measure of success.

Ultimately the measures used to assess AFP performance should satisfy the collective goals of the stakeholder group. Although these measures may not yet be in place there are interim measures, which we understand are tracked and include measuring: turnaround times, infection rates, readmission rates, incident rates, length of stay, number of tests, etc. The use of benchmarks is also effective at measuring desired outcomes. In time the Province should evolve the desired outcomes to appropriateness of care, decreased obesity, improved chronic conditions, decreased mortality rates, decreased accident rates, etc. The following recommendation deals with more appropriate measurements.

Recommendations

It is recommended that the method of clinical payment used for the physicians be one that is clearly tied to the delivery of the required / negotiated outcomes. These outcomes should not be input volume based and should satisfy the collective goals of the stakeholders. A stronger and timelier performance evaluation process will need to be developed to monitor the achievement of negotiated outcomes by the physician groups.

In defining clinical outcome measures consideration for the varying time and intensity required by the different types and experiences of physicians should be considered. As each physician group's practice plan is outlined and tied to performance outcomes, consideration for types of patient, age of patient, nature of intervention, etc should be factored into the physician expectation. Movement towards a true outcome focused measurement framework should be considered.

The payment method should also provide for incentives for meeting the required outcomes and penalties for not meeting these outcomes. Operational objectives (including administrative needs) of CDHA and IWK and system objectives of the Province should be factored into the outcome measure development, tailored to motivate the physician group. Feedback from CDHA and IWK on their satisfaction with the physician population should be factored into the outcome measures framework.

It is also recommended that the clinical portion of the funding for the AFP be clearly differentiated from the academic and research portions of the funding and clarity around the expectations of the physicians in exchange for this payment be emphasized. This will be further discussed in the compliance section of the report. Additional outcome measures that would be included in physician practice plans to reflect academic and research goals include feedback on the student experience, number of students, research publications, research funding generated, speaking engagements, etc.

Communication and education are two additional key areas where issues have been noted. Our findings on the following pages specify areas where governance, controls and financial oversight can be more effectively supported by improved communication and education.

Governance

Overview

Governance reflects the systems and processes that an organization has in place to protect the interests of and create value for its diverse stakeholder groups. It is a collection of cohesive policies and processes that are put in place to define expectations and drive intended performance and provide consistent oversight and feedback.

There are a number of key stakeholders to the AFP process which include the DoH, CDHA, IWK, DNS, DAL, TB and the physician group. Currently one of the core governance functions for the AFP is through the AFP Performance Management Committees which include members from all stakeholder groups with the exception of the TB.

Our findings focus on this current state of governance and provide recommendations on how to strengthen the effectiveness of the oversight function.

2.1 - AFP development structure

Throughout the course of our work, there were variations as to what happens first in the negotiation process. Some parties noted that the process starts with the physician departments providing their proposal to DoH which initiates the AFP development and negotiation process, while others noted that they felt there were back room dealings that decided on the dollars prior to consultation with the physician groups or CDHA and IWK (refer to **Appendix E** for a flowchart of the AFP negotiation and approval process). Neither of these are the proper drivers of the process.

The Government of Nova Scotia through the DoH should have a clear definition of the physician resource needs as well as the service delivery direction for the Province before entering into AFP physician negotiations. If the DoH does not have clear direction on: 1) the strategic direction that the Province wishes to pursue with respect to health care, 2) the current status of physician recruitment and retention issues and challenges and 3) the cost constraints inherent in the overall government funding over the next 3 to 5 years. There is increased risk that the negotiated AFPs will not provide the desired service delivery results or the desired costs. Cost constraints should be clearly established and well communicated amongst the stakeholder group up-front, prior to negotiations, in order to define the funding limits and to ensure that negotiations can take place within these parameters.

The Government of Nova Scotia, through the DoH should communicate clear expectations regarding performance measures and financial restrictions to the CDHA and IWK of what they should be achieving. These expectations need to form part of the plans and strategic directions of the facilities (CDHA and IWK). The physician department plans should then be developed to satisfy these plans. In addition, Dalhousie can plan for and incorporate the value of academic services exchanged in the AFPs as part of the medical school oversight.

Recommendations

It is recommended that the Province, through the DoH, ensure that there is a strategic direction and physician resource plan for health care services detailing the needs of IWK and CDHA. The DoH will need to work with CDHA, IWK and Dalhousie to define the clinical, research, academic and administrative workload expected by the physician group in order to meet operating, transformation and budgeted expectation. This should be part of the larger strategic direction and physician resource plan for the Province and clearly communicated to IWK, CDHA and Dalhousie in a timely manner for consideration and inclusion in their business and HR planning.

The IWK, CDHA and Dalhousie need to clearly assume the responsibility for the delivery and achievement of the desired outcomes within their facilities. Their business and HR plans should be developed in order to achieve the desired outcomes that complement the provincial direction. Although the DoH is the payor of the funds in the AFP agreements, it is the IWK and CDHA that need to take clear responsibility and accountability that the AFPs are negotiated such that they are in alignment with the facility direction. It is important that they actively take part in a feedback

process to the Province to report back on the achievement of the objectives which can be used in the performance evaluation process.

It is recommended that the IWK and CDHA increase their level of involvement in the negotiation of the AFP agreements. Although not employees of the facilities, the physician group is one of the essential talent and leadership groups that the facilities require in achieving their goals. The IWK and CDHA need to ensure that they have a strong and consistent voice in the negotiation process and that their goals are one of the primary considerations in the negotiation process of performance outcomes.

In addition, it is recommended that the facility business and HR resource plans should be the basis of the proposals submitted by the departments for consideration in the AFP negotiation process. Physician complement and outcomes should be based on the achievement of these plans.

It is recommended that the issue resolution process which is currently part of the AFP should be revisited to ensure proper parties are at the table; the process allows for timely resolution of issues; and the means of escalation are clearly defined. Deviations from the outlined process should be minimal and reasons for such should be clearly documented.

2.2 - AFP negotiation awareness and documentation

The negotiation process is one of the most critical components of the AFP process and having the correct individuals and stakeholders at the negotiation table ensures that all parties are aware of the decisions being made and have the ability and opportunity to raise questions and concerns throughout the process. However, from the various interviews we conducted, it is clear that there are many different views on how the negotiations are conducted and on the respective level of involvement by each party in the process.

For example, it was indicated that there is limited representation from the DoH Division of Finance during the initial negotiations and no involvement from TB. DoH Division of Finance is accountable to the government for explaining cost increases and ensuring adequate funding within the approved DoH budget while the TB is responsible for paying the amounts as well as making recommendations to Cabinet on decisions such as approving AFP agreements. Various stakeholders felt that they were only on the periphery of the negotiation process and informed late in the process or after an agreement had been reached. They therefore had little understanding of the cost and impact to their respective organizations, with little input around outcome specification or resource requirements.

In addition, it was noted there is a lack of formal documentation pertaining to AFP negotiations. Without complete and accurate documentation of negotiation sessions, which is shared on a regular and timely basis amongst the stakeholders, there is the risk that parties may interpret discussions differently or have different recollections of discussions.

Recommendations

It is recommended that a clear and concise negotiation process be established and documented. This process should be developed with consideration of all the relevant stakeholder groups including:

- **DoH - Physician Services, Resource Planning, Finance;**
- **CDHA and IWK executive;**
- **Doctors Nova Scotia;**
- **Dalhousie;**
- **Physician groups;**
- **Treasury Board (TB) Cabinet Committee; and**
- **Provincial Cabinet.**

As noted in section 2.3, the process needs to clearly define the roles and responsibilities of each of the stakeholders in the negotiation process as well as the timing of the process.

Once the negotiation process and timing process has been established each of the stakeholder groups need to determine what their appropriate representation is in the negotiations. This representation should be consistent throughout the process and these individuals must clearly understand their roles in achieving a negotiated agreement which meets the collective and aligned goals of the group.

Should the TB not be included as a key party in the AFP negotiation process then DoH should develop an appropriate communication process to ensure that TB is apprised of all relevant information and activities pertaining to AFP negotiations at pre-approved points in the process. The TB should ensure that the goals of government are clearly articulated up front and included as part of the negotiations for outcome targets as well as provide clear messaging around the limitations for the pool of funds available to service the agreement.

We recommend that formal minutes of negotiation meetings be prepared and distributed to the stakeholder group. This recommendation would also apply to any other AFP related committee meetings. This is necessary to ensure that complete and accurate records of all relevant AFP discussions are maintained.

2.3 - AFP roles and responsibilities

A consistent theme amongst the stakeholders was a view that there are many areas of miscommunication and lack of communication between AFP stakeholders as well as a general lack of education and understanding of the AFP process. We noted a lack of understanding of how the roles and responsibilities of the various stakeholders interrelated and affected other stakeholders within the process. In addition there was a lack of understanding around the expected outcomes of the AFP and its related processes.

This issue of communication and understanding has caused mistrust in the process. In addition, a lack of understanding of roles and responsibilities significantly increases the risk that parties will not perform their required duties causing a breakdown in the process. The lack of education and understanding amongst all the stakeholders also increases the risk that there will be parties who have unrealistic or unfounded expectations of the process. This exists particularly for government which is making significant decisions on large amounts of funding through approved AFP budgets, potentially without a clear understanding of the expectations and demands of all parties.

Recommendations

It is recommended that a clearly established roles and responsibility framework be defined and communicated to all parties and stakeholders to the AFP agreements. The framework should re-establish authority within the process and re-introduce trust back into the process. Each party and stakeholder should be made aware of their role and expectations within the AFP process.

In addition, it is recommended that education surrounding the purpose of AFPs be re-introduced. This education should be future oriented to enable forward movement and capturing of significant potential benefits around the (revised) AFP processes, the related accountabilities, and the importance of the role of AFPs in health care delivery. This education should be developed and presented to relevant stakeholders including the parties to the agreement, as well as members of government.

2.4 – Increasing DoH resources and skills

The Physician Services group within the DoH is responsible for the negotiation of the AFPs on behalf of the Provincial Government and the subsequent monitoring and review of the AFP deliverables to ensure compliance with requirements. There are currently 16 AFPs in place, 13 of which have expired, for this group to negotiate.

To adequately execute their role, the Physician Services group requires an appropriate number of resources with appropriate skill-sets. This relates not only to the negotiation team, where negotiation skills and experience should be a requirement, but the individuals responsible for the physician resource plan,

the strategic direction of health care in the Province, as well as the review and monitoring of the deliverables to the individual agreements and regular follow up with the stakeholder groups. As the AFPs are one of the most significant areas of cost for the Province, DoH should assess the desired workload of the physician services group and then ensure that appropriate levels of resourcing are in place to administer the process.

Recommendations

It is recommended that DoH assess the roles and responsibilities of its current officers with respect to the AFP process and compare this to the desired future workload. More dedicated resource allocation at senior levels of DoH are required to maintain appropriate oversight of the accountability expectations.

It is also recommended that DoH ensure there are adequate resources and skills in place to fulfill the roles and responsibilities defined above to achieve the desired workload, both for ongoing oversight and for periodic negotiation. The DoH roles for oversight of performance measures and resource planning are important specialized roles that require objectivity and system oversight which only the Province can provide.

2.5- AFP Performance Management Committee

For each AFP agreement there is a requirement for an AFP Performance Management Committee or similarly named function. The role of the committee is to:

- Monitor the implementation of the agreement;
- Review effectiveness of the method of funding;
- Receive and review the deliverables as required in the AFP agreement;
- Determine the reduction in enhanced funding if departments failed to meet deliverables;
- Consider requests for changes in targets and funding; and
- Report annually to parties of the agreement on all aspects of the agreement including performance of deliverables, standards and achievements, physician status and changes, all financial aspects and assessments on the effectiveness with respect to leadership, clinical, research and academic activities.

The Committee is intended to serve in a governance capacity through the duration of the AFP agreement. However, through our discussions the following was noted, indicating limited effectiveness of this committee in a governance capacity:

- Frequency of meetings is not consistent;
- Minutes are not readily available of the meetings;
- Annual reports to parties of the agreement were not readily available;
- There have been no instances noted of reduction in enhanced funding, although there is no formal academic delivery model; and
- No documentation on the effectiveness of the method of funding was available.

Recommendations

It is recommended that to effectively govern the current AFP agreements, the AFP Performance Management Committee must follow the terms of reference set out in the agreements. Minutes should be taken at each of these meetings. The agenda of the meeting should focus strictly on governance matters and should be broadened to include stronger oversight activity. The AFP Performance Management Committee should also ensure that appropriate and meaningful reports are developed and delivered to the parties of the agreement as required per the AFP.

Compliance

Compliance with respect to the AFPs is the process whereby the physician departments that receive funding through the AFP provide accountability to the other parties of the agreement for the services provided to support the funding received. The compliance processes within the AFPs are primarily driven through the deliverables outlined in each individual AFP agreement. In order to demonstrate strong accountability and responsibility, all deliverables should be prepared within the terms of the agreement and should be delivered to appropriate stakeholders within the timelines described in the agreement.

The AFP Performance Management Committee has the responsibility to review the deliverables and assess the performance of the physician department based on the deliverables and to enforce any penalties as noted in the agreement for non compliance or non-performance. Refer to **Appendix F** for the current AFP compliance process flow.

Shadow billing currently is one of the tools used by the stakeholders to measure performance in relation to the agreements; however, the overwhelming consensus from our interviews indicates that shadow billing is not an effective means of reporting or measuring desired performance. Value should not be placed on the tasks performed but rather on the outcomes achieved.

3.1 – AFP reporting requirements and awareness

Currently, each AFP agreement has specific reporting requirements which are meant to hold the physician departments accountable for AFP funding received and ensure that stakeholder expectations are met. The deliverables form a key foundation in the governance of the AFPs and form the core monitoring process of AFP performance.

One of the clearest messages from the various parties that were interviewed is the importance of reported deliverables. However, many stakeholders had not received or seen the deliverables, and those that had received or seen them had not always reviewed them. The Province's Internal Audit Centre conducted interviews with the physician department heads and found that the deliverables were prepared by and resident in each of the departments and were noted as having been submitted to Physician Services. It was unclear as to whether these had been distributed and received by the relevant stakeholders. Our interviews with the non-physician stakeholders and attempts to gather these completed deliverables would indicate that whether or not the deliverables were initially received, they are, for the most part, currently not resident within the non physician stakeholder group. Clearly there is no formalized process for the tracking of the deliverables outside of the physician group.

The current deliverables produced as a result of the AFP agreements are not consistently viewed as providing the appropriate content. In any situation where government dollars are expended for services performed, the value for the dollars spent is the most desirable set of reporting outcomes. However, the determination of what constitutes value-for-money in an AFP agreement has not been agreed upon within the stakeholder group, nor has the measurement of this value been clearly articulated. It was noted that the current performance measures included may not be the most relevant measures for the AFP stakeholders and a clearly defined, relevant and consistent set of indicators would be more appropriate.

The AFP Performance Management Committee has the responsibility to receive and review the deliverables; they are also mandated to determine any reductions in funding. However, there is no clear responsibility or guidelines for assessing the adequacy of the deliverables, interpreting the results of the deliverables, assessing value-for-money and determining if any changes to the agreements are required as a result of the findings in the analysis of the deliverables.

In addition, we noted that the completion of these deliverables is a time consuming and potentially expensive process for many of the physician departments to undertake. Department Heads indicated that they keep these measures for their own management purposes and supplying them to DoH did not create additional time requirements.

Recommendations

It is recommended that a tracking mechanism be put in place by Physician Services to account for all deliverables received. This mechanism should track the timeliness of the receipt of the deliverable and the actual receipt of the deliverable by the stakeholders.

It is recommended that for all deliverables received that feedback is obtained from the parties to whom these deliverables have been distributed. The focus in oversight must shift from negotiating the size of the funding pool to negotiating, tracking and rewarding the achievement of outcomes received in exchange for the value of the funding pool.

It is recommended that all AFP stakeholders identify and develop a reasonable set of reporting requirements that accurately reflect the desired outcomes of the AFP agreements. The content of the deliverables should be concise, meaningful and provide adequate information to ensure that the physician department is meeting the required measures and provide useful information to the users and recipients. The deliverables should also be transparent in that, within a public environment, the value received can be assessed by those outside of the agreements.

As part of the development of outcome measures, the DoH needs to ensure that there is a clear link between results and financial compensation provided under the AFP. Penalties and consequences for instances of non-compliance are required and should be clearly defined and enforced. The AFP Performance Management Committee should deliver on its responsibility to provide feedback on success of physician departments in meeting the requirements and provide recommendations for not only punitive action where requirements have not been met but more importantly for rewards and incentives where important stakeholder objectives have been achieved or exceeded.

It is recommended that clear accountability with respect to the deliverables be outlined. The following should be included:

- Responsibility for receipt and distribution of deliverables;**
- Responsibility for tracking of deliverables;**
- Guidelines for analysis of deliverables;**
- Guidelines for reporting on analysis of deliverables**

3.2 – Lack of academic deliverables and performance reporting

A significant portion of the AFP funding (approximately 25 - 30%), relates to the non-clinical part of the physicians role (research and academic). While there are prescribed academic reporting requirements within the AFPs, statements vary as to whether this reporting is provided to the stakeholders. In addition, although the AFP agreements note consequences for non-compliance, no action is typically taken. Good governance would require that value-for-money be determined for each of the AFP agreements. Without reporting requirements that are received and monitored for the non-clinical portion of the work performed under the AFP, the stakeholders and parties to the AFP agreement have no way of measuring if they are receiving value for the funding provided.

It is argued that measuring the clinical side of the AFP agreements is difficult and that a proper measurement tool is not in place. However, many of these physician departments perform research and provide academic support outside of the AFP environment (i.e. 3rd party research grants). Value for money reporting is not new to health care services and current models can be modified to suit the Nova Scotia challenges.

Recommendations

It is recommended that the AFP agreement develop a clear and concise set of non clinical deliverables. These deliverables should be developed with the input of all stakeholders, particularly Dalhousie. The deliverables should reflect the goals of the medical school as well as the goals of the facilities and the physicians and should include items such as articles published,

research milestones achieved, recognition received and inclusions in significant endeavors which promote the goals of the stakeholders.

It is recommended that key academic deliverables are required to be tracked and reported by the physician departments as required by the AFP. A clear process needs to be in place so that it is understood who the deliverables should be provided to. If Physician Services acts as an intermediary, proper tracking and timely distribution to the remaining stakeholders needs to take place.

It is recommended that the AFP Performance Management Committee, as currently mandated in the AFP agreements, reviews the non-clinical AFP deliverables and recommends clear penalties for non-compliance with these requirements. Such penalties should be communicated to the stakeholders and feedback from the stakeholders on administration of required penalties should be sought. Penalties should then be enforced by the DoH and districts and Dalhousie (where relevant) for situations not in compliance with the AFP agreement. Alternatively, and perhaps more importantly, where appropriate stakeholder objectives are met, certain additional incentives and rewards should be provided as documented in the AFPs. Rewards can be monetary or non-monetary in nature.

3.3 – Defining control of the academic portion of the AFPs

Currently the physicians are paid funds from the DoH for the non clinical portion of their work through the enhanced funding portion of the AFP. In addition, it is our understanding that these physicians receive monies directly from Dalhousie University through tuition fees as well as funding from the Department of Education. During our review, it was identified that approximately \$40 million is provided through the AFPs to support the Dalhousie medical school. It has been questioned whether or not the DoH is the appropriate source for the non clinical portion of this funding. Many of the interviewees feel that a proper AFP would have clinical funding from the DoH which is paying for the clinical services being provided and that the non clinical portion of the AFPs should be funded through the University and the Department of Education. This would allow for better accountability and performance tracking.

From our interviews it appears that Dalhousie does not have control over the AFP portion of the funding, nor how the funding is allocated in relation to carrying out their education mandate. The lack of control over the use of funding is primarily due to the limited role that Dalhousie currently plays in the AFP negotiation process when measures and deliverables are set as well as the number of AFPs that are in place.

Dalhousie should play an active role in the AFP negotiation process and be privy to increased communication of information as would be expected amongst all AFP stakeholders.

Recommendations

It is recommended that consideration be given to the various sources of the funding of the non-clinical portion of the AFP (academic and research funding). Currently the DoH does not have a complete picture of the other sources of income the physician groups receive for non-clinical work. This includes but is not limited to funding directly from Dalhousie University, from the Department of Health, and other 3rd party external funding sources. A determination may be made that this portion of funding should come from somewhere other than the DoH. Even if the DoH continues to finance this portion of the funding, at a minimum all funding sources need to be considered in the contemplation of the non clinical portion of the funding.

It is also recommended that Dalhousie work jointly with the broader AFP stakeholder group to determine and agree on the critical academic goals and needs. From this, the group can develop realistic and practical outcome measures in order to properly monitor activities and AFP funding. As well these goals and needs should drive the practice plans of the physician departments in their submissions for AFP funding.

Financial

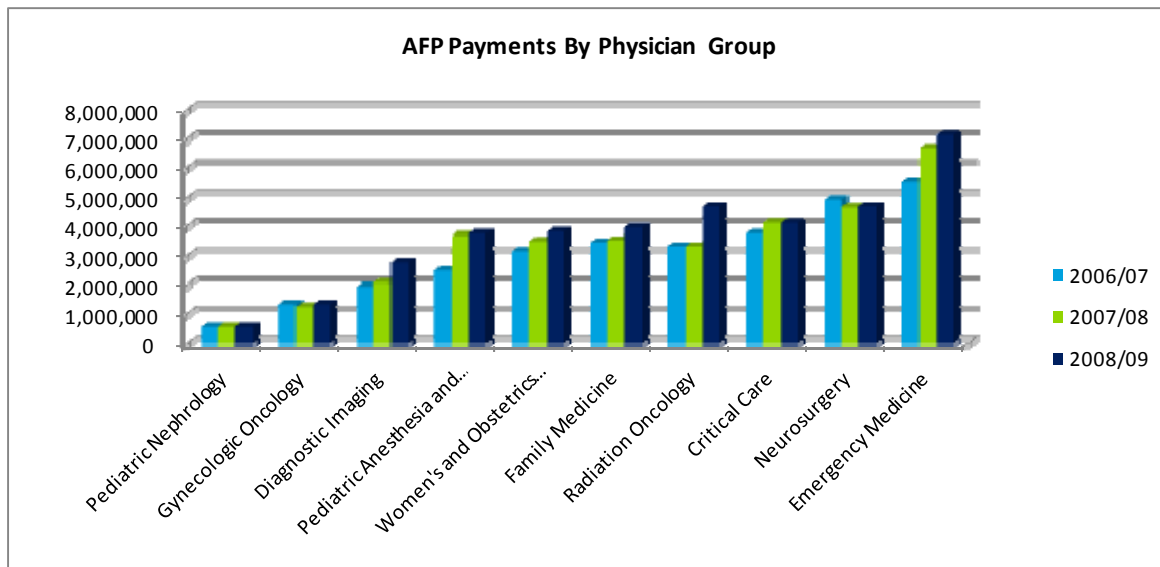
Overview

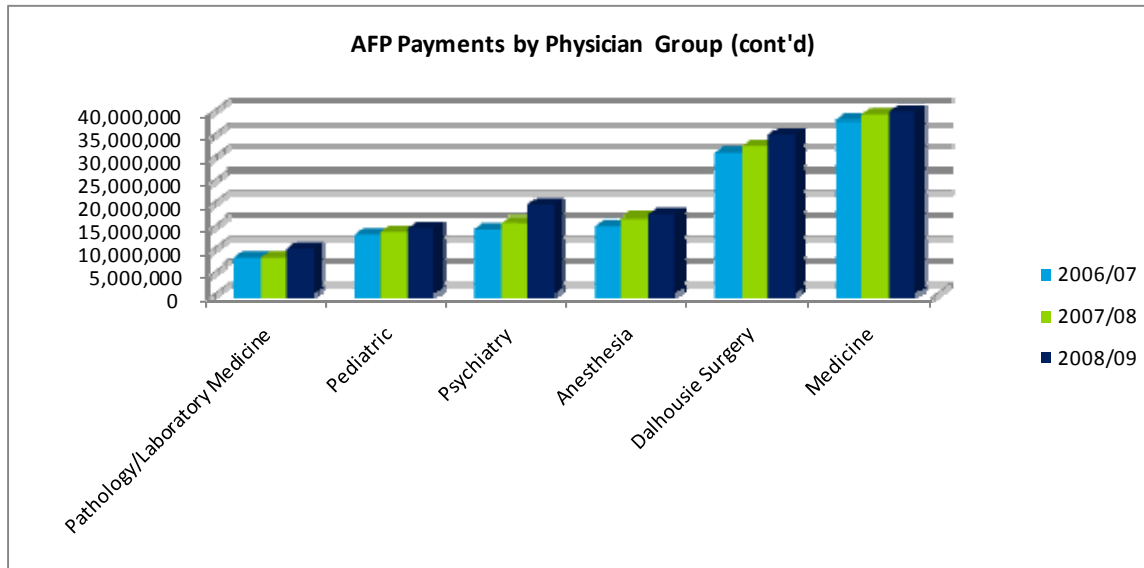
Increased AFP costs incurred by the government were one of the primary drivers behind the request for this review. Proper controls around AFP costs require clear budgets within which funding is forwarded and adequate approval with respect to known variances. Refer to **Appendix G** for a charting of expenditures for a prior three years period (2006/07 to 2008/09) by AFP agreement.

The current payment structure of the recent AFP agreements provided for the majority of the agreement to be based on FFS; however, there is no maximum amount which can be billed and claimed by a physician. Without a limit in place on physician claims or access to hospital facilities there are limited means of controlling the cost of the AFP agreements. As a result, government must reactively determine the factors and drivers contributing to the increase in costs, which may include increased procedures and services being provided.

The following two tables summarize the AFP information for both FFS and FTE remuneration. The data has been divided into two tables. The first table shows agreements with costing up to eight million dollars and the second table shows agreements with costs over this amount. As can be seen, almost all of the AFPs have shown steady increases over the past three years. **Appendix G** notes specific areas in each department AFP where costs have increased.

From the data provided in **Appendix G**, significant increases year over year, are explainable within the terms of the AFP agreements in place.





Cost drivers

Through our review of the various AFP agreements, as well as the Physician Master Service agreement the following specific items were noted as being potential drivers of increased costs. These are direct excerpts from the various AFP agreements currently in place.

Department of Medicine

9.0 Clinical Associates / Assistants and Hospitalists Resources.

9.1 Funding for those positions characterized by the District as Clinical Associates / Assistants and Hospitalists in an amount to be determined, which currently forms part of the District's operational funding will, effective April 1, 2007 for part of the Minister's funding under this Agreement and be provided to the Department as non-portable funding for purposes of retaining Hospitalists / Clinical Associates / Assistants personnel.

Department of Anesthesia

8.10 The parties acknowledge that the District's contribution to Enhanced Funding is not the only mechanism through which the District provides funding to the Department. Other funding for the fiscal year beginning April 1, 2006 includes:

- *Physician Administrative Stipends in the amount of \$385,000, which will be adjusted annually to reflect changes in appointments of Department members to senior administrative roles within the District, in accordance with University and Faculty policies and procedures.*

Department of Neurosurgery

8.1 The Clinical Activity Target for the Department for the fiscal year beginning April 1, 2007 is comprised of the following:

- *8.1.1 \$1,971,380 which will be measured by shadow billings; and*
- *8.1.2 \$492,820 which will be measured by an agreed upon process.*

Department of Radiation Oncology

2.0 Funding

2.1 If the Department physician complement remains at 12 FTEs or less, the Minister shall provide funding to the Department as follows:

- *2.1.1 Commencing April 1, 2008, the Minister shall pay to the Department annual base funding of \$4,248,000 for a minimum Department total annual new patient workload of 2,544 new patients.*

2.2 If additional Radiation Oncologists are recruited in order to increase the Department physician complement, the Minister shall provide funding to the Department as follows:

- 2.2.1 Commencing April 1, 2008, the Minister shall pay to the Department additional annual based funding of \$354,000 to a maximum annual base funding of \$4,602,000.

Department of Pathology

2.1 Commencing April 1, 2008, continuing until March 31, 2012, the Minister will provide annual funding to the Department to meet the deliverables of 80% clinical and 20% academic / research as follows:

- Effective April 1, 2008 \$312,635 per FTE;
- Effective April 1, 2009 \$317,325 per FTE;
- Effective April 1, 2010 \$320,498 per FTE; and
- Effective April 1, 2011 \$326,908 per FTE.

2.2 The following FTEs have been approved and will be funded at the prescribed rate retroactive to 30 days before the individual physician commences work:

- April 1, 2008 - 30.5; and
- January 1, 2009 - 4.0.

2.5 There will be a one-time payment of \$15,000 to all physicians who are members of the Department on April 1, 2008.

Department of Critical Care

3.0 Subject to Article 3.2 and Article 14.4 of this Agreement, the Minister will provide annual funding to the Department in the amounts and for the applicable periods as follows:

- 3.1.1 From April 1, 2004 to August 17, 2004 to fund up to 7 FTEs in the amount of \$258,988 per FTE per year;
- 3.1.2 From August 17, 2004 to September 1, 2005 to fund up to 10 FTEs in the amount of \$300,000 per FTE per year;
- 3.1.3 From September 1, 2005 to April 1, 2006 to fund up to 10.75 FTEs in the amount of \$300,000 per FTE per year;
- 3.1.4 From April 1, 2006 to September 1, 2006 to fund up to 11.75 FTEs in the amount of \$300,000 per FTE per year;
- 3.1.5 From September 1, 2006 to January 1, 2007 to fund up to 12.75 FTEs in the amount of \$300,000 per FTE per year; and
- 3.1.6 From January 1, 2007 to March 31, 2007 to fund up to 13.75 FTEs in the amount of \$300,000 per FTE per year.

Adequacy of physician remuneration

In January 2009 a report to the Nova Scotia Department of Health titled 'Selected Comparisons of the Compensation of Academic Physicians' (referred to as the Peachy Report) was issued. This report was intended to provide a comparison of the compensation of academic physicians across Canada. It should be noted that we did not perform an in depth analysis of this report, however the following should be noted in the area of adequacy of physician remuneration:

- From the Peachy Report it is noted that there are real challenges in harmonizing data amongst different jurisdictions and that academic medicine is particularly difficult given the limited availability of data and the detail of such data that is provided. The report outlines a number of limitations to the data and factors to be considered in the reading of the report.
- There is no clear reasoning for the inclusion and conversely the exclusion of some provinces, other than, potentially, that information was not available. As such Nova Scotia is being compared to only Ontario, Manitoba, Alberta, British Columbia and Newfoundland and Labrador.
- In a number of areas throughout the report information is not provided for the 5 provinces that Nova Scotia is being compared to.

- As in Nova Scotia, government funding is not the only source of remuneration for these physicians. Without the full scope of funding sources and amounts it is difficult to provide relevant comparators.
- One of the fundamental reasons for putting AFPs in place in an academic environment was to assist in the retention of physicians who were practicing in an academic environment. Although we do not have specific data, many instances of anecdotal evidence in our interviews indicated that retention of physicians in Nova Scotia, and in the AFP environment is not an issue. This would provide some evidence that remuneration within the province is adequate.

Findings and recommendations

4.1– Current AFP contracts

There are currently 16 physician departments financially remunerated through separate AFP agreements; however, of these 16 departments, only three have agreements which extend beyond March 31, 2010.

During a period when there is no agreement in place, departments continue to work in good faith that as part of the negotiation process for the next agreement, there will be consideration and funding for the time period when no agreement existed. The lack of valid agreements places an additional financial risk on the TB, CDHA and the IWK with respect to the delinquency of agreement negotiations. Historically, it has been noted there have been verbal promises made to physician departments that adjustments will be made to compensate for perceived financial shortcomings during a period when no agreement existed. It is unclear as to the authority under which these verbal promises have been made, and the level of communication to the stakeholder group of such promises. These are often considered as retroactive adjustments for the periods in which the agreements were expired, and, in most instances, are increases over the previous agreement that subsequently must be covered by the TB. These are typically lump sum payments that appear to significantly spike the amount of payments made in the year of renegotiation.

Recommendations

We recommend that timely negotiations of agreements take place for the following reasons:

- **Retroactive payments for periods in which a valid agreement does not exist increase the costs to the TB, CDHA and IWK and the amounts the payments are unknown until a new agreement is negotiated. If offline agreements are made for these stub periods they should be clearly documented and communicated to the stakeholder group.**
- **To align with the goals and targets of IWK and CDHA. With this information included in the agreements, the ability to accurately budget and forecast changes will improve, particularly when negotiations occur in a timely manner.**
- **To allow for the agreements to properly reflect the amount that is available for funding (i.e. the budget) rather than the budget trying to catch up to the agreement.**
- **To ensure that outcome measures are clearly defined and expectations around outcomes are clearly communicated in advance of the performance of the physician group.**

4.2 – Within agreement time period renegotiation

In the framework for the AFP agreements clauses 11.8.5 and 11.8.6 allow for the AFP Performance Management Committee to receive and consider changes to the agreements throughout the term of the agreement. These changes could be due to new technology, changes in the physician resource requirements (either upwards or downwards) or changes in the strategic direction of the facilities. However, we did not encounter any instances where these clauses were utilized throughout the term of the agreements other than when the physician departments applied to increase the FTE compliment and the corresponding funding.

Recommendations

We recommend that all stakeholders be aware of and utilize these clauses to the agreements when valid reasons exist for adjusting the agreement during its term.

4.3 – Physician resource planning

Based on our review and through discussions with the various AFP stakeholders, it was noted that there is not a fully coordinated and integrated provincial physician resource plan that drives physician resources as it relates to the AFPs and physician groups. Currently, it is up to the individual physician departments to assess their staffing requirements, including recruitment and retention plans, and approach the DoH for adjustments to their full-time-equivalent (FTE) complement as required. The lack of coordination amongst AFP stakeholders, including CDHA and IWK, has also created a lack of trust amongst the various AFP stakeholders as concerns have been raised as to the appropriateness (both over and under) of the current level of physician resources.

Recommendations

It is recommended that a provincial physician resource plan, which is critical to the success of the health care within the Province, be developed taking into consideration the non-clinical commitments of the physicians (administration, research and academic) which will help drive the FTE requirement discussions during AFP negotiations. The resource plan should also consider recruitment and retention planning to ensure that adequate resources are retained with the AFP facilities (and more broadly within the Province).

4.4 – Innovation is not supported by AFPs

When the clinical components of AFP agreements are based on an FFS model there is an increased risk that innovation in service delivery will not be considered a priority and can lead to inefficiencies in the health system. This is not intended to suggest that the AFP be the vehicle for determining which procedures are allowed by non-physicians.

The current FFS model service is structured on the premise that the physician must see the patient and in turn receives a fee for that service. It was noted during a number of our interviews that there are a number of non-physician trained individuals within the Province's health care system who are equally capable of performing some of the tasks required in patient treatment within the AFP for which FFS applies (i.e. nurses, nurse practitioners, etc.) and that current procedures allow for this integration of resources. However, for a physician to be compensated in a FFS environment there is little motivation to use the alternative resources where allowed.

As well there may be other non human resource related innovations that are not being considered or utilized if the potential for reduced FFS remuneration exists. The current model of AFP payment does not encourage this, as physicians potentially would not have to see the patient, and would therefore be unable to bill based on fee for service, generating no income for themselves or the AFP physician group.

Recommendations

It is recommended that in the long-term the FFS basis for clinical payment of the AFP agreements be discontinued as it is not the most desirable method of payment to encourage the physician group to think 'outside the box' and implement innovative and cost saving measures for the health care system. The AFP stakeholders should develop a rewards and recognition system that encourages and rewards innovations and savings in the delivery of health care in the Province.

Appendix A – AFP agreements reviewed

The following AFPs were subject to examination during this review:

Department	Expiry Date
Department of Diagnostic Imaging	March 31, 2006
Department of Pediatrics	March 31, 2007
Department of Pediatric Nephrology	March 31, 2007
Department of Critical Care	March 31, 2007
Department of Family Medicine	March 31, 2007
Department of Gynecologic Oncology	March 31, 2007
Department of Psychiatry	March 31, 2008
Department of Medicine	March 31, 2009
Department of Anesthesia	March 31, 2009
Department of Women's and Obstetrics Anesthesia	March 31, 2009
Department of Pediatric Anesthesia and Pediatric Critical Care	March 31, 2010
Department of Surgery, Division of Neurosurgery	March 31, 2010
Department of Emergency Medicine	March 31, 2010
Department of Radiation Oncology	March 31, 2011
Department of Pathology and Laboratory Medicine	March 31, 2012
Department of Surgery	March 31, 2013

Appendix B – AFP stakeholder interviews

During the review, Deloitte conducted a number of interviews with various AFP stakeholders to understand the current challenges facing the AFP process with respect to governance, compliance and financial implications. The following individuals were interviewed during the course of our work:

Stakeholder Interviewed	Title and Organization
Abram Almeda	Executive Director, Acute & Tertiary Care, DoH
Rick Anderson	Senior Director, Labour Relations, DoH
Dr. Brendan Carr	VP Medicine, CDHA
Doug Clarke	CEO, DNS
Elizabeth Cody	Assistant Deputy Minister – Expenditure Management Initiative, TB
Harold Dunston	Contract Negotiation Advisor, DoH
Diana Eisenhauer	Executive Director, TB
Paula English	Acting Chief of Program Delivery, DoH
Victoria Goldring	Acting Director Physician Services, DoH
Vicki Harnish	Deputy Minister, Finance
Allan Horsburgh	CFO, IWK
Eleanor Hubbard	Acting Executive Director Physician & Pharmaceutical Services, DoH
Frank Lussing	Past Executive Director, DoH
John Malcom	CEO, Cape Breton District Health Authority
Kevin McNamara	Deputy Minister, DoH
Dr. Thomas Marrie	Dean of Faculty of Medicine, DAL
Anne McGuire	President & CEO, IWK
Elaine Morash	Senior Project Executive – Expenditure Management Initiative, TB
Linda Penny	CFO, DoH
Brent Powers	Director Medical Services Administration, CDHA
Chris Power	CEO, CDHA
Dr. Robin Walker	VP Medicine, IWK
Amanda Whitewood	VP Sustainability, CFO, CDHA

Appendix C – AFP physician interviews

The following interviews were conducted on behalf of Deloitte by the Province of Nova Scotia's Internal Audit Centre to further enhance our understanding of AFP stakeholder challenges with respect to governance, compliance and financial implications:

Stakeholder Interviewed	Title and Organization
Dr. Tetteh Ago	Chief of Radiation Oncology, CDHA
Dr. David Barnes	Chief of Diagnostic Imaging, CDHA
Dr. David Bell	Chief of Urology, CDHA
Dr. Nicolas Delva	Chief of Psychiatry, CDHA
Dr. Godfrey Heathcote	Chief of Pathology and Laboratory Medicine, CDHA
Dr. David Kirkpatrick	Acting Chief of Surgery, CDHA
Dr. Jonathan Kronick	Department of Pediatric Critical Care, IWK
Dr. Michael Murphy	Chief of Anesthesia, CDHA
Dr. Alan Purdy	Chief of Medicine, CDHA
Dr. Chris Soder	Department of Pediatric Critical Care, IWK
Dr. John Sullivan	Department of Cardio Vascular Surgery, CDHA
Dr. Philip Yoon	Chief of Emergency, CDHA

Appendix D – Detailed assessment of alternative AFP models

Ontario Academic Health Sciences Centres (AHSC's) Alternative Funding Program	
Scope	4 AHSCs (Hamilton, London, Ottawa and Toronto) were examined and reported on in a Report of the Provincial Working Group: Alternative Funding Plans for Academic Health Sciences Centres, Ontario, February 2002
Structure	<p>Funding sources include:</p> <ul style="list-style-type: none"> • Fee for Service income from the Ontario Health Insurance Plan (OHIP); • Technical fee income; • Hospital operating funding; • Clinical Education Budget funding; • University operating funding; • Health sciences research funding; and • Government of Ontario. <p>Components to the AFP:</p> <p>Definitions: AHSC – Academic Health Sciences Centres AFP – Alternative Funding Plans PWG – Provincial Working Group GFT – Geographic full-time MOHLTC – Ministry of Health and Long-Term Care</p> <p>Component One: Governance Structure</p> <p>All AHSCs that hope to develop an AFP must establish a body responsible for overseeing the activities of the AHSC under the AFP and ensuring accountability between the parties of the AFP. In developing structures for governing their AFP, the facilities must adhere to the following five principles:</p> <ol style="list-style-type: none"> 1) <i>Requirement for legitimate representation</i> <ul style="list-style-type: none"> • Membership in the governing structure must include legitimate representation from the involved medical staff; the teaching hospital; and the university (legitimate representation is defined as the authority of a representative to act on behalf of their respective constituency). 2) <i>Responsibility for Meeting Defined Deliverables</i> <ul style="list-style-type: none"> • AFP governing structures shall be responsible for meeting defined deliverables in the areas of clinical service, education, research, and associated administration. 3) <i>Accountability</i> <ul style="list-style-type: none"> • The governing structures shall be accountable to the Government for the management of the AFP. • Management of the AFP shall be understood to mean meeting the deliverables. These deliverables include annual planning as well as financial management and allocation of resources. • AFP resources are defined as funding (i.e. dollars flowing), human resources and capital infrastructure.

4) Merger of Revenue Sources

- Recognizing that direct and indirect AFP funding will be derived from a number of different sources within government, there should be a merger (notional or actual) of these funds before they are flowed to the individual AFP governance structures in the AHSCs.
- All location governance structures should have the capacity to receive merged (notionally or actually) resources and reallocate them to the members of the AFP.

5) Dispute Resolution

- All AHSC AFPs must have established dispute resolution procedures for dealing with conflicts and disagreements arising in the course of operating its governance, such as:
 - The allocation of funds to participating physicians;
 - The movement of funds within the AHSC;
 - Changes in physician complement, including issues involving retention and recruitment; and
 - The locations where services are to be provided.

Component Two: Funding

AFP funding must include all new and existing dollars to support education, research, clinical service and administration in an AHSC.

Direct Educational Funding

All AFPs must account for the funding that directly or indirectly supports the educational mission of the AHSCs and consider the extent to which that funding might be part of the AFP. The AFP funding includes the following:

- Notional grant funding to the Faculties of Medicine through the universities funding formula.
- Clinical Education Budget funding including a) residents salaries and benefits b) GFT funding to Faculties of Medicine c) Medical Education Supplies funding to the teaching hospitals, and d) GFT secretarial support.
- Tuition fee revenue from undergraduate medical students flowing to the Faculty of Medicine.
- Administrative fees from postgraduate medical residents and fellows.
- Off-shore stipends.
- Hospital operating dollars support of educational activity.
- Hospital Foundation support of educational activity where such support exists.
- Physician practice plan revenue support of educational activities e.g. clinical fellowships.
- Non-MOHLTC residents funding.
- Private Foundations.

Direct Funding for Clinical Service

All AFPs will need to account for the funding that directly or indirectly supports the respective clinical service mission for AHSCs and consider the extent to which that funding might be part of the AFP. Funding includes the following:

- OHIP and non-OHIP fee revenue for specialists and sub-specialists with privileges at a fully affiliated teaching hospital and an academic appointment from the relevant university's faculty of medicine/health sciences; and, family physicians with hospital privileges at a fully affiliated teaching hospital and designated as a GFT by the Faculty of Medicine.
- Hospital operating dollars and other funding sources e.g. national or regional programs, associated with the provision of clinical service by physicians with an AHSC.
- Hospital in kind support for the provision of clinical service by physicians within an AHSC.
- University resources associated with the provision of clinical services by physicians.

Direct Research Funding

All AFPs will need to account for the funding that directly or indirectly supports the respective research mission for AHSCs and consider the extent to which that funding might be part of the AFP. Funding includes the following:

- National Agencies;
- Provincial Agencies;
- Government contract research;
- Industry contract research;
- Fee-for-service sponsored research;
- University sponsored research with the AHSC context;
- Hospital and Foundation sponsored research;
- Independent research units; and
- Research collaborative.

Component Three: Measurable Deliverables

All AFPs must include a schedule of measurable deliverables for each of education, research, clinical service and administration. Accurate and timely performance measures are required to ensure accountability to the parties. Other AHSCs (e.g. the Department of Paediatrics in the Faculty of Medicine at the University of Calgary) have pioneered technological solutions that have resolved this tension. Palm-based technology, for example, has been developed that will allow for the measurement of clinical, educational and research services; reduce significantly, if not totally eliminate, the need for paper-based records; and, improve the timeliness and quality of the data collected. AHSCs are strongly encouraged to investigate such technological solutions.

Education

- Education deliverables must be expressed through the provincially and nationally defined units of measurement for quantifying teaching workload in each of: pre-clerkship education; clerkship education; postgraduate education (residency & fellowship); continuing medical education; public education and other graduate level education.

Research

- Research deliverables must be expressed through the provincially and nationally defined units for measurement for quantifying research performance.

Clinical Service

- Clinical deliverables must be expressed through provincially accepted measures of activity. Notwithstanding the need to create new performance measures these new measures should be expressed in terms that are consistent with current activity measures.

Administration

- Each of deliverables, education, research and clinical services, should include a measurable unit of service associated with administration. AHSCs are strongly encouraged to review the administrative workload associated with managing an AFP governance structure and incorporate that workload into the AFP.

Component Four: Methodology for Payment

The governance structure for each AFP in an AHSC must design, implement and manage a payment methodology for participating physicians. The payment of participating physicians will be a function of the total value of the AFP, and the individual physician's specific deliverables in the context of the AFP. In all cases the remuneration of an individual physician must be based on agreed upon volume measures for each of education, research, clinical services and administration.

Component Five: Human Resources Plan

All AHSC AFPs must develop a physician human resource plan, for the term of the AFP, to ensure that the parties succeed in meeting their deliverables. The plan must clearly articulate the medical personnel required to meet each deliverable.

Component Six: Provisions for Change

Given the fluid nature of education, research and clinical service the AFP must include a mechanism for forecasting and reporting changes in the deliverables. The AFP must also include a mechanism for responding to unforeseen changes affecting the AHSCs ability to meet the deliverables.

Component Seven: Broad Participation

In order to maximize the opportunities for potential AFP members to meet their deliverables the AFP should only move forward if there is broad physician participation for each of the core programs within the AHSC.

- Governance Structure;
- Funding;
- Measurable deliverables;
- Methodology for payment;
- Human Resources Plan;
- Provisions for change; and
- Broad participation.

Process

The development of the AFP involves six steps as follows:

Step One: Pre-AFP Self Assessment

Each of the potential members of an AFP (i.e. medical staff, teaching hospital and university) has different methods and rationale for measuring and monitoring their respective activities. The Pre-AFP self assessment is intended as a preliminary attempt to collect and coordinate the various information sources that will be necessary to measure and monitor the educational, research, clinical service and administrative activities of an AHSC under an AFP. The pre-AFP self assessment should include the following information:

- A description of the existing organizational structures in an AHSC.
- A description of current activities in the AHSC for each of education, research and clinical service – the description should include indicators that allow measurement of the volume, scope and location of activities.
- An accounting of the total resource base currently dedicated to the AHSC – the accounting should include all direct and indirect resources.

Step Two: Defining a Common Data Set to Articulate the Deliverables of an AHSC

In accordance with the four principles of governance structure set out under Component One the respective AHSC AFP working group should define a common data set that will serve as a basis for articulating AHSC deliverables.

Step Three: Articulation of AHSC Activities under an AFP

Flowing from the definition of a common data set, the AHSCs AFP working group should engage with the MOHLTC Negotiation Team to articulate:

- Activities that the AHSC intends to manage.
- Activities that the AHSC intends to change.
- New activities that the AHSC hopes to meet following implementation of the AFP.

The parties should ensure that the deliverables are measurable and that they are expressed in a style consistent with the common data set. Deliverable performance measures should also be consistent with the measures in hospital operating plans or the evolving institutional service agreements.

Step Four: Creation of a Governing Body

Flowing from Component One, all AHSCs will be required to develop a body responsible for overseeing the activities of the AHSC and ensuring accountability between the AHSC and Government. Although the creation of a governing body is set out here as step four, it should be understood that its creation is evolutionary. In that regard, AHSCs are encouraged to engage in discussions concerning the development of a governance structure in tandem with each of the steps previously outlined.

While the creation of a governance structure must adhere to the principles outlined in Component One, it should be noted that governance structures are likely to vary across AHSCs. Irrespective of the form that an AHSC adopts for its governance structure, it is critical that the governing body ensures that the parties of the AFP meet their respective deliverables

Step Five: Finalizing the Agreement – Ensuring Consistency with the Seven Components

Notwithstanding the evolutionary nature of the development of an AFP, the final agreement must confirm to the seven components.

A draft AFP proposal will be submitted to the Provincial AFP Steering Committee for comment. The Steering Committee will advise the Assistant Deputy Minister of Health and Long Term Care, Health Services Division, on the viability of the AFP proposal.

Step Six: Approval

The parties must approve the final agreement as follows:

- Universities should approve the final agreement through the standard processes and governance required by its senior administration e.g. board of governors or governing council.
- Teaching hospitals should approve the final agreement through the standard processes and governance required by its senior administration e.g. the hospital board.
- Involved medical staff should approve the agreement through a ratification process.
- The OMA should approve the agreement on the basis of medical staff ratification after the OMA and MOHLTC have agreed to the conversion mechanism for OHIP funds.
- The Government of Ontario should approve the agreement through its standard approval processes.

Mandate	<p>Parties to an AFP include:</p> <ul style="list-style-type: none">• Universities (McMaster University, University of Western Ontario, University of Ottawa, University of Toronto).• Teaching hospitals (Hamilton Health Sciences Corporation, St. Joseph's Healthcare, London Health Sciences Centre, St. Joseph's Health Care, The Ottawa Hospital, Sisters of Charity of Ottawa Health Services Inc., Royal Ottawa Health Care Group, Children's Hospital of Eastern Ontario; Baycrest Centre of Geriatric Care, Bloorview MacMillan Centre, Centre for Addiction and Mental Health, Mount Sinai Hospital, St. Michael's Hospital, Sunnybrook & Women's College Health Sciences Centre, Toronto Rehabilitation Hospital, University Health Network).• Medical staff.• The Ontario Medical Association (official representative of the medical profession).
Accountability	<p>See principles of governance structure noted above in the structure area.</p>
Pros and Cons	<p>Pros</p> <ul style="list-style-type: none">• All funding sources are considered in agreement negotiations.• Limited number of AFPs - one per facility.• Established deliverables in both clinical and academic area.• Requires a human resource plan.

- Governance structure with guidelines which are consistent for each site.
- Stabilization of workforce.

Cons

- Governance structures may still operate at different levels of effectiveness.
- Risk that governing bodies may be reluctant to govern (including determining the appropriate use of funds) and act mainly as management groups.

Queens University

Scope

The Queen’s model, also in Ontario, was also examined for comparison and to seek additional insights.

- From review of AFP template which includes the following:
 - Kingston General Hospital;
 - The Religious Hospitallers of St. Joseph of the Hotel Dieu of Kingston;
 - St. Mary’s of the Lake Hospital;
 - Southeastern Ontario Academic Medical Organization (SEAMO); and
 - Queen’s University.

Structure

- Agreement covers in-scope services:
 - Clinical – all insured services provided to insured persons;
 - Academic – teaching and evaluation of undergraduate medical students, residents and fellows; and organization and delivery of continuing medical education activities; and
 - Research – basic, health service research, program evaluation and quality assurance, innovation projects, clinical trials, publishing.
- SEAMO physicians cannot bill fee for service when part of the agreement;
- Ability of Minister to withhold funding for failure to provide reports until such reports are provided;
- Ability of Minister to recover funds if number of FTEs falls by xx% below the number of FTEs provided for in agreement;
- If performance levels (as measured by service encounter reports and hospital based data) fall below amount of previous year parties shall discuss issue in an attempt to find mutually acceptable ways to address situation; and
- Hospital’s responsibilities:
 - Support physicians to provide in-scope services by providing hospital space, staff and other resources; and
 - Not pay out of operating budget and funds for provision of clinical services or offset any loss of teaching funds from the University.
- University responsibilities:
 - Set standards with respect to the quality and quantity of education and scholarly activity by the members;
 - Appoint academic staff at the University;
 - Set academic standards for the University;
 - Establish academic programs at the University; and
 - Provide support for research and teaching for SEAMO physicians.
- Annual meeting of parties of the agreement to discuss issues arising from the Agreement (Attendees: Assistant Deputy Minister of Health, CEO of SEAMO and

	<p>CEO of Ontario Medical Association).</p>
Process	<ul style="list-style-type: none"> • Funding: <ul style="list-style-type: none"> – Base funding – lump sum funding amount comprised of: <ul style="list-style-type: none"> • Historical fee for service amount; • Amount from clinical education budget; • Annualized amounts for specific departments; • Amount for new initiatives and recruitment; • Retroactive amount; • Amount for existing and new positions; • Administrative amount; • Amount for retention of clinical teachers; • Amount for increase as per the Master Agreement; • Amount to enhance academic mission; and • Amount for overhead expenses. – Amount to provide SEAMO with the same advantages as physicians working in other Academic Health Sciences Centres; – Amount from funding transfer from the Health Planning Branch of the Ministry for Clinical Education; – Amount equalling XX (changes each year) of the fee for service value of all service encounter reports; and – Levelling amount. • Reporting (with associated timing detailed in agreement): <ul style="list-style-type: none"> – Hospital – Business Planning Brief; – SEAMO – Human Resource Report; – SEAMO – Annual Report; – SEAMO – Developmental Disabilities Program Annual Report; – SEAMO – Audited Financial Statements; – SEAMO - Change of status notice; – SEAMO – Signed declaration and consent form; – SEAMO – encounter reports; and – SEAMO – Governance agreement.
Mandate	<ul style="list-style-type: none"> • Includes physicians within the noted facilities.
Accountability	<ul style="list-style-type: none"> • SEAMO to have a governance agreement amount the SEAMO parties to (in part): <ul style="list-style-type: none"> – Provide for the prudent and effective management of the Funds; – Provide for the preparation and delivery of all reports and other documents

	<p>required; and</p> <ul style="list-style-type: none"> – Provide dispute resolution processes. <ul style="list-style-type: none"> • Ministry, SEAMO and OMA meeting within 6 months of signing agreement to review and update accountability reporting mechanisms.
Pros and Cons	<ul style="list-style-type: none"> • Pro's <ul style="list-style-type: none"> – One AFP covers multiple departments and facilities • Cons <ul style="list-style-type: none"> – Uses a shadow billing model – No separation between clinical and non clinical payments – Service measurement based on prior year volumes (inputs rather than outputs) – Accountability framework not clearly established – Governance structure not outlined in agreement

Bundled Payment System – Episode Based Payments	
Scope	Proposed system in United States – a payment approach that focuses on outcomes rather than volumes.
Structure	<p>An episode-based payment (EBP) bundles all costs of care across a clinical condition for a defined period of time and for all settings involved in direct and indirect care to the patient. An episode may include several levels and types of care providers, and may cross a number of venues including office, outpatient, hospital, rehabilitation, pharmacy and home health services. A key feature of EBP is its alignment with evidence-based best practices, including clinical guidelines and quality measures. Determining the best treatment is premised in evidence, and agnostic to predispositions of organizations that might otherwise prefer to protect a specific domain of expertise. In EBP, the provider organization is responsible for managing a process of adherence to evidence-based practices on what is done rather than who does it.</p> <p>Additional payments to providers for other services, such as teaching and research (academic medical centres), or for indigent care, could be added to the global-episode-bundled payment to encourage these activities by provider.</p> <p>By bundling all clinical services into a single rate, and establishing rates based on the resources required to deliver optimal value (outcomes and efficiency), EBP offers policy makers a mechanism to align payments towards results instead of volume.</p>
Process	Commercial proprietary episode groupers group inpatient, outpatient and pharmacy claims data into clinically meaningful episodes through the use of proprietary software algorithms.
Mandate	<p>Used in various facilities across the United States for specific episodes of care including:</p> <ul style="list-style-type: none"> • Coronary Artery bypass grafts in central and northeast Pennsylvania; and • Medicare heart bypass center – Atlanta, Ohio, Columbus and Boston.
Accountability	<p>Financial and quality measures are evaluated including:</p> <ul style="list-style-type: none"> • Feasibility of bundling payments; • Volume increase; • Patient outcomes; • Appropriateness of care; • Physician payments; • Reimbursement difficulties; and • Achievement of goals.

Pros and Cons	<p>Pros</p> <ul style="list-style-type: none"> • Pilots indicated a decrease in readmissions, shorter than average length of stay. • Provides incentive for collaboration. <p>Cons</p> <ul style="list-style-type: none"> • How to address outliers in the patient population. • How to align individual performance recognition with the episode payment. • How much to pay per episode. • How to pay the various providers in a non private system.
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Academic Alternate Relationship Plans

Scope	Alberta – approximately 650 physicians with a number of programs in various stages of development.
Structure	<p>Constructed on four pillars:</p> <ul style="list-style-type: none"> • Clinical service and innovation; • Education; • Research; and • Administration. <p>Funding of ARPs are based on a pooled arrangement where all program funding sources and expenditures are identified in the program budget. Accountability and governance structure focus on ensuring accuracy in program funding and transparency in the reporting procedures.</p> <p>Participating physicians continue to have full access to all physician benefit programs under the Master Agreement on the same basis as physicians who only bill fee for service.</p>
Process	<p>AFP program delivers a program proposal which includes a service delivery plan, governance and accountability measures, a budget and workforce plan.</p> <p>Payments from Crown - Maximum number of clinical FTEs are approved under the agreement. Payment based on number of participating physicians. Funding can be adjusted downward or upward if number of participating physician's decreases / increases based on approved plan.</p> <p>Payments from University – University continues to provide monetary and non-monetary support and contributions to the (Department) and those participating physicians who are members of the academic staff of the University.</p> <p>Payments from the Region – payments made in accordance with agreement for specialty services.</p> <p>Shadow billing is used to collect data with respect to the provision of clinical services, and other service activity information.</p> <p>Accountability framework developed for each AFP specifying expected outcomes, performance measures and targets to which the parties agree.</p> <p>Issues Management Group comprised of representatives from parties to agreement. Any disputes arising under the agreement referred to this group.</p>
Mandate	Interested programs within the Alberta healthcare system.
Accountability	Management Committee established by the participating physicians who are accountable to the participating physicians and have the authority to receive, disburse and account for funds.

**Pros and
Cons**

Pros

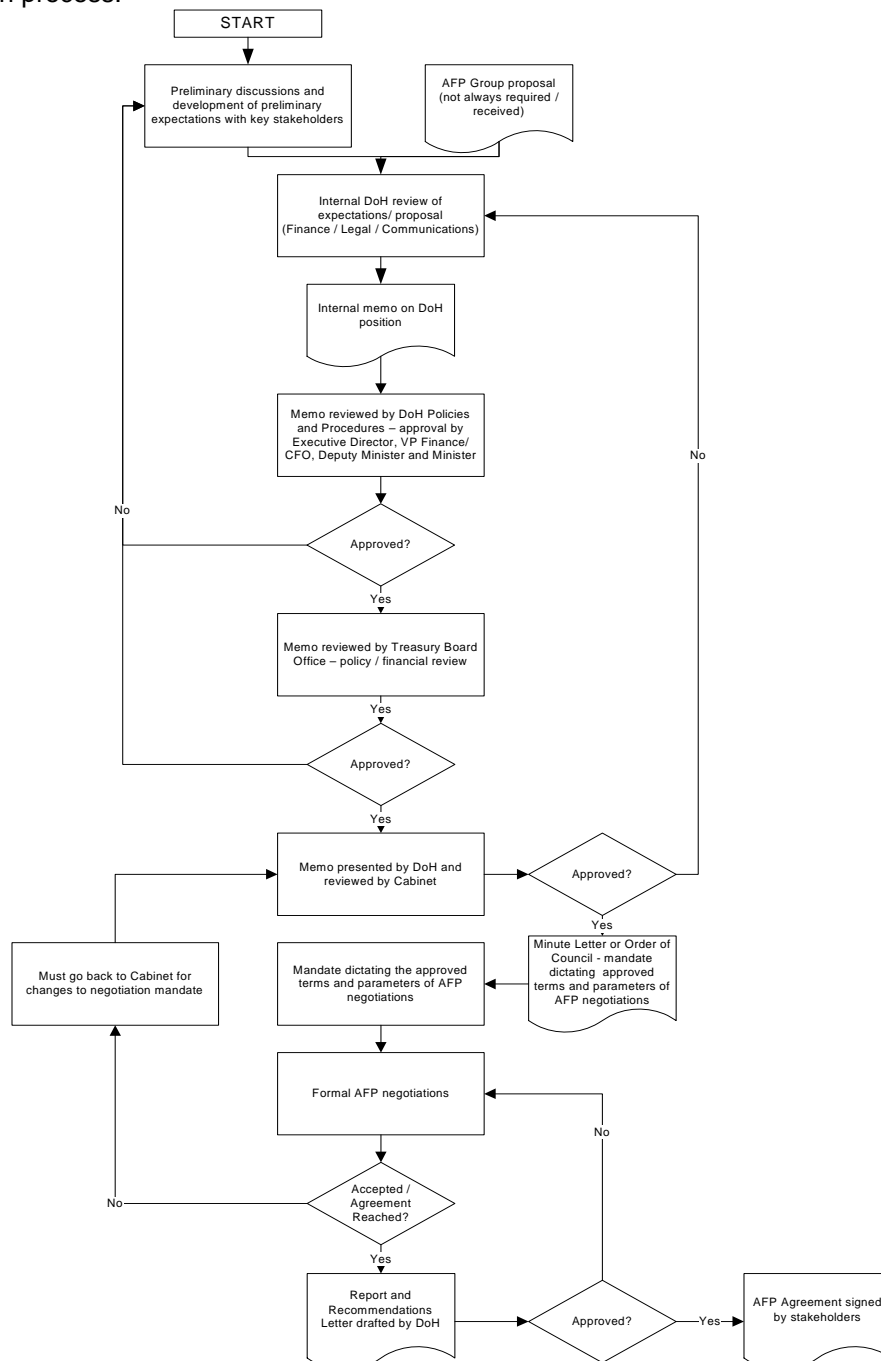
- Value of an hour of clinical work is equal to an hour of teaching, is equal to an hour of research is equal to an hour of administration.
- Remuneration to physicians is a contractual amount based on an income grid.
- Incentives for outstanding performance; money is withheld for non performance.
- Outcomes and success is achieved through an accountability framework.

Cons

- Payments from different sources (Crown, University, Region).
- Deliverables may not be consistent across AFPs.

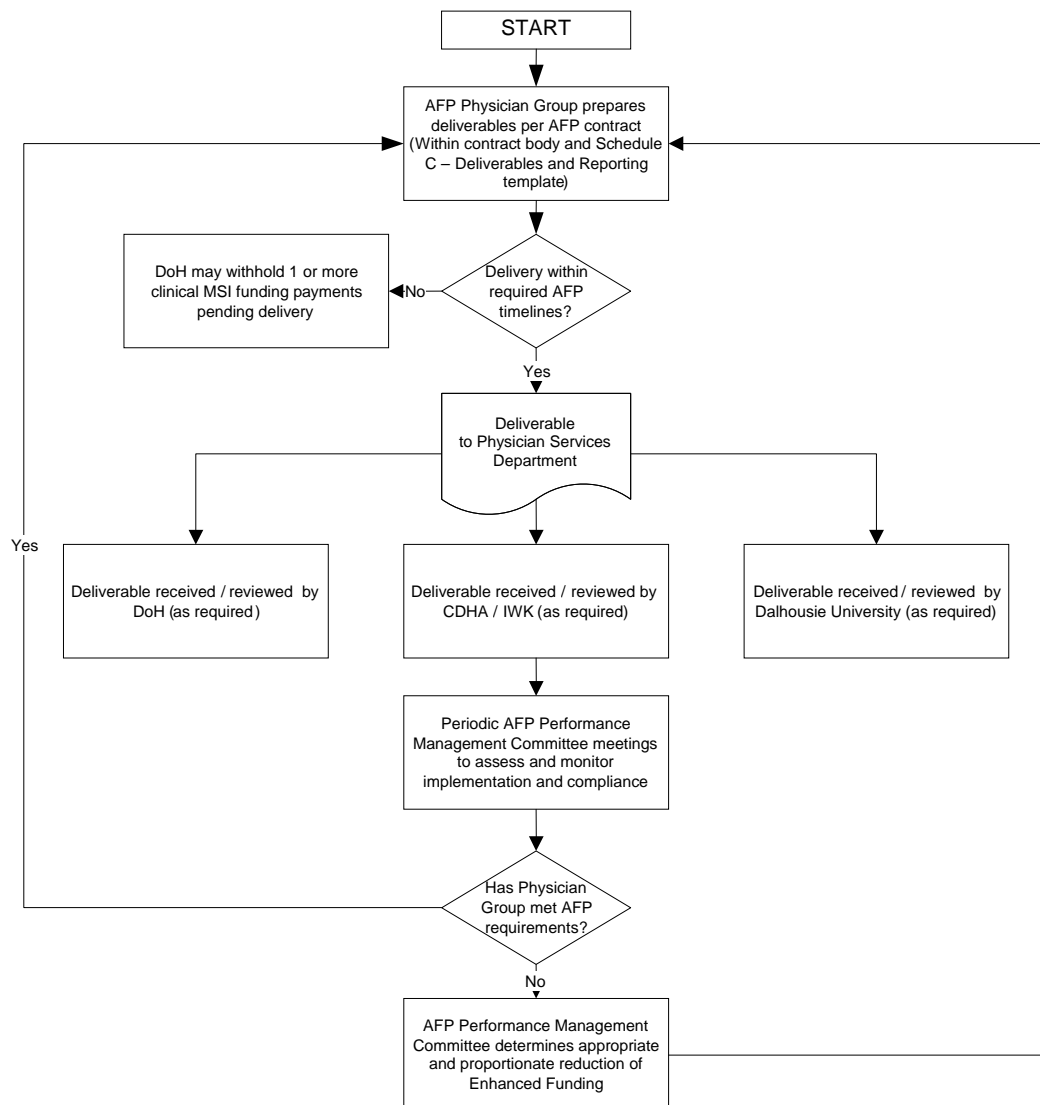
Appendix E – AFP negotiation and approval process flowchart

During the course of our interviews we sought to understand the current AFP negotiation process; however, we were not successful in finding any one consistent or complete explanation of the process. From the various interviewees we have developed the following flowchart covering the key steps in the AFP negotiation process.



Appendix F – AFP compliance flowchart

During the course of our interviews we sought to understand the current AFP compliance process; however, we were not successful in finding any one consistent or complete explanation of the process. From the various interviewees we have developed the following process flowchart covering the key steps in the AFP compliance process.



Appendix G – AFP payments

The following graphs and financial data were compiled based on information provided by the Nova Scotia Department of Health and on deliverables provided by the physician departments. These graphs represent only the DoH's financial contribution to the AFP agreements.

We have in no way audited or verified any of the numbers in these graphs or deliverables. The purpose of this information is to demonstrate the change in costs for the AFPs year over year and to provide some insight into possible variance explanations. If there is a zero balance in the data we received, this is shown as a \$0.

Fee for Service AFPs (New Framework)

The following AFPs are administered under the new framework which normally provides for clinical remuneration based on the FFS model which includes the following components:

- Clinical MSI target – the annual amount of shadow billings targeted for the department (budget);
- Actual Clinical MSI Activity – actual accumulation of shadow billings for the year;
- Shadow billings – reported service information where the value is based on the Unit Value System; and
- Unit Value System – cost of service based on the Medical Service Unit (MSU) or the Anesthesia Unit (AU). Different types of services are assigned a number of predetermined MSUs. The Master Service Agreement, negotiated by the Department of Health and the Medical Society of Nova Scotia determines the value of an MSU or AU.

Remuneration is then based on the number of MSUs for the service multiplied by the value of the MSU and MSU / AU values were set as follows:

Rate	Medical Service Unit (MSU)	Percentage increase	Anesthesia Unit (AU)	Percentage increase
2006/07	2.17	n/a	15.14	n/a
2007/08	2.21	1.84%	15.75	4.03%
2008/09	2.23	0.90%	15.91	1.02%

Individual AFPs

The following AFPs have been negotiated using the new framework developed as a result of the North South Report

Department of Medicine

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	9,956,977	87.20%	27,994,467	-	-	37,951,445	38,772,500	(821,055)	-2.2%
2007/08	10,095,800	88.85%	29,059,903	3.81%	-	39,155,704	37,523,100	1,632,604	4.2%
2008/09	10,095,800	92.69%	29,664,200	2.08%	-	39,760,001	41,143,600	(1,383,599)	-3.5%



From 2006/07 to 2007/08 enhanced funding increased by \$138,823. The AFP agreement notes that on an annual basis the mix and status of AFP physicians is assessed to determine if there is any change in the Enhanced Funding. From 2006/07 the physician complement increased from 139.18 FTEs to 141.18 FTE. The 2006/07 enhanced funding represented approximately \$71,540 per FTE. Using this same per FTE amount and the number of FTE's in 2007/08 the enhanced funding amount is in line.

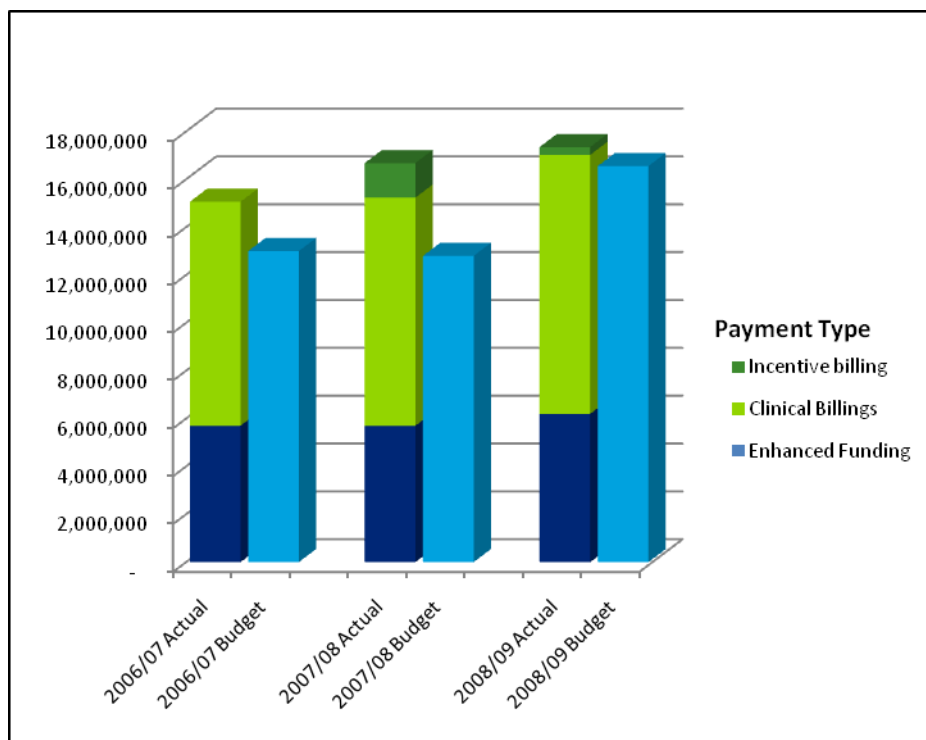
Clinical funding increased 3.81% from 2006/07 to 2007/08 and 2.08% from 2007/08 to 2008/09. This is higher than the percentage increase in the MSU value. Schedule C of the AFP for the Department of Medicine indicates that the volume of service (total billing units) increased over this time period as follows:

- 2006/07 – 11,613,142 units;
- 2007/08 – 11,937,801 units; and
- 2008/09 – 12,311,247 units.

In all years, except 2008/09 the actual clinical funding was less than the clinical funding targets.

Department of Anesthesia

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	5,699,883	95.00%	9,362,259	-	-	15,062,142	13,000,000	2,062,142	13.7%
2007/08	5,699,883	118.05%	9,534,834	1.84%	1,444,549	16,679,266	12,799,600	3,879,666	23.3%
2008/09	6,200,100	103.01%	10,823,146	13.51%	326,134	17,349,380	16,557,000	792,380	4.6%

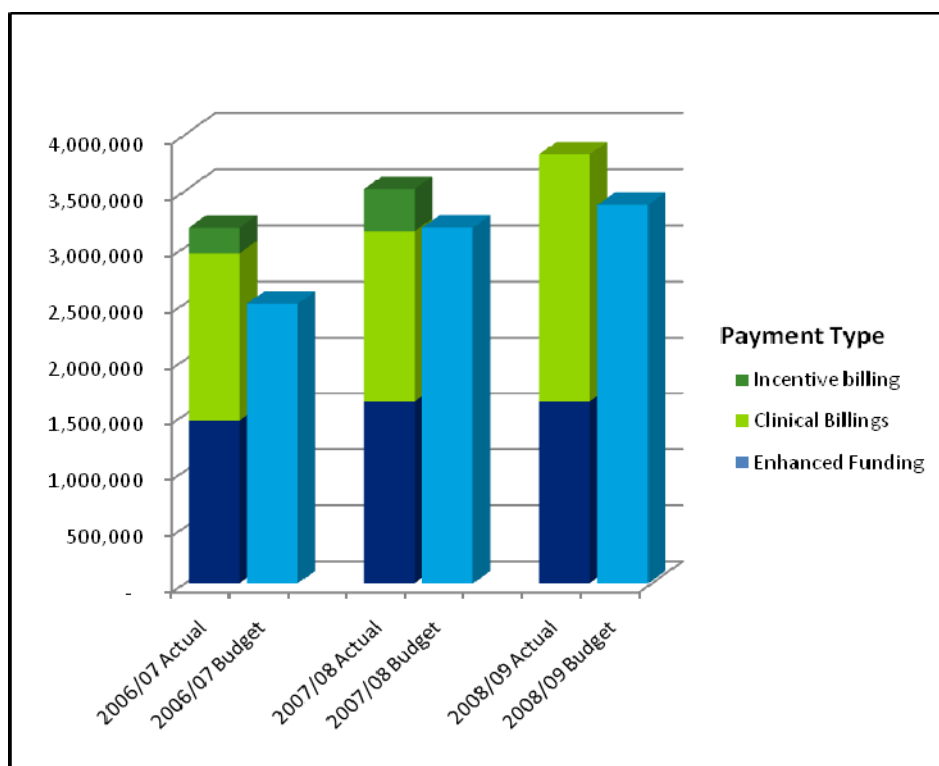


Clinical funding increased by 1.84% from 2006/07 to 2007/08 and by 13.51% from 2007/08 to 2008/09. The AFP agreement under the new framework was effective April 1, 2006. In that year the department achieved 95% of the clinical billings target. In 2007/08 this percentage was over 100%. As such, the incentive billing portion of the remuneration was applied and the shadow billing in excess of the target would have been paid at 40%. In 2008/09, when the increase was 13.51%, the clinical billings target cap was removed and all clinical billings were paid at 100%.

In addition in 2007/08 same day admission and Anesthesia assistants were added to the clinical billing part of the AFP. These would not previously have been included here. The amount related to this in 2007/08 was \$925,156. In 2008/09 \$62,000 for the ASPENS program was transferred from Acute Care to the clinical billing amount.

Department of Women's and Obstetrics Anesthesia

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	1,447,124	115.17%	1,497,751	-	227,140	3,172,015	2,498,000	674,015	21.2%
2007/08	1,616,873	138.16%	1,525,359	1.84%	373,609	3,515,841	3,175,300	340,541	9.7%
2008/09	1,616,873	95.70%	2,209,333	44.84%	-	3,826,206	3,376,900	449,306	11.7%

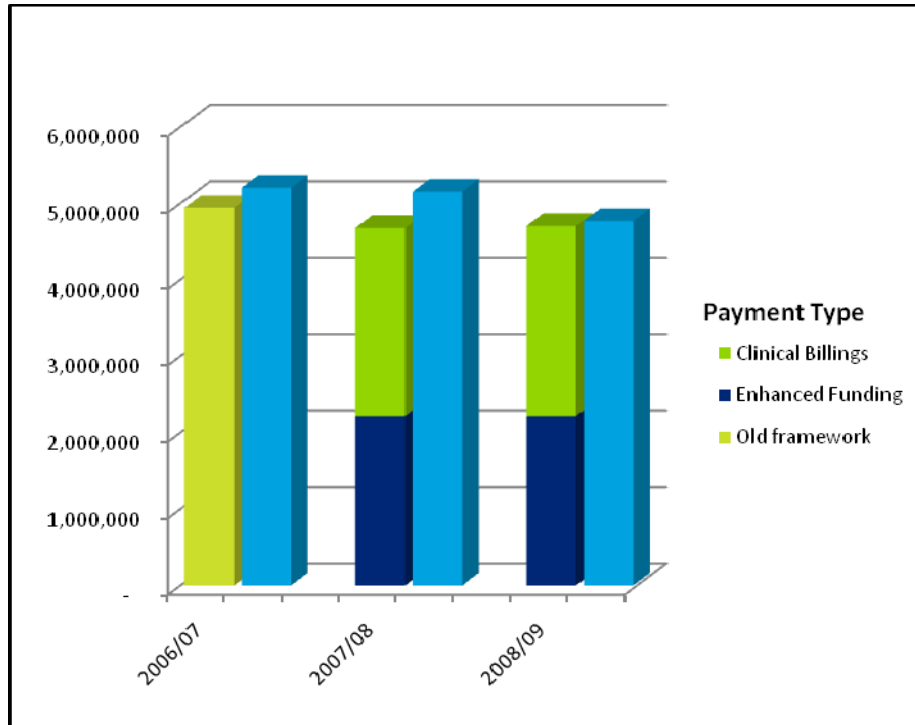


The AFP agreement states in section 8 that the enhanced funding paid by the DoH would be \$1,397,124 in 2006/07 (actual total enhanced funding of \$1,447,124) and in 2007/08 would be \$1,604,749 (actual total enhanced funding of \$1,654,749).

Clinical billings significantly exceeded targets in 2006/07 and 2007/08 causing incentive billings to be paid. Because of increased billings during 2007/08, the clinical activity target was increased to \$2,308,603 in 2008/09, thus allowing for increased clinical billings at 100% payment.

Department of Neurosurgery

	Enhanced Funding	Clinical billings % of target	Clinical Activity Target	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	-	-	-	4,940,000	5,200,000	(260,000)	-5.3%
2007/08	2,215,800	73.58%	2,464,200	-	-	4,680,000	5,150,000	(470,000)	-10.0%
2008/09	2,215,800	84.42%	2,488,842	1.00%	-	4,704,642	4,766,300	(61,658)	-1.3%

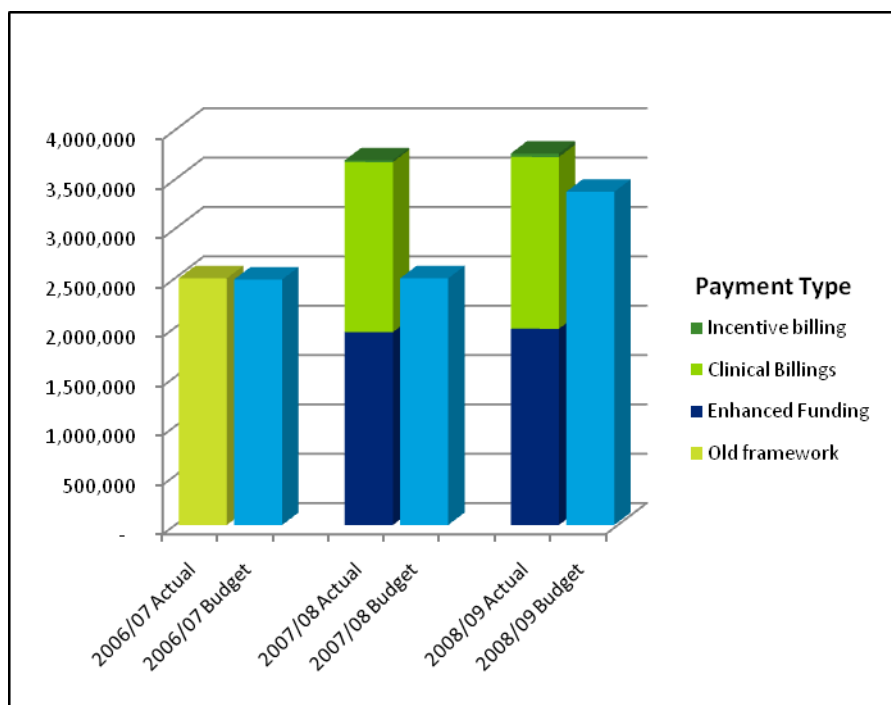


Department of Neurosurgery began to use the new AFP framework effective April 1, 2007; therefore, the 2006/07 remuneration is on an FTE basis.

DoH portion of enhanced funding was set at \$2,215,800 in the AFP agreement. Shadow billings did not meet the target established in the AFP, nor did they meet the 90% threshold for 100% payment of target amount, however, as a result of a separate memorandum, dated October 1, 2007, the Department was paid 100% of the target amount.

Department of Pediatric Anesthesia and Pediatric Critical Care

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	-	-	-	2,498,000	2,486,400	11,600	0.5%
2007/08	1,952,592	102.72%	1,722,627	-	18,735	3,693,954	2,498,000	1,195,954	32%
2008/09	1,987,302	105.09%	1,739,853	1.00%	35,457	3,762,612	3,374,000	388,612	10%

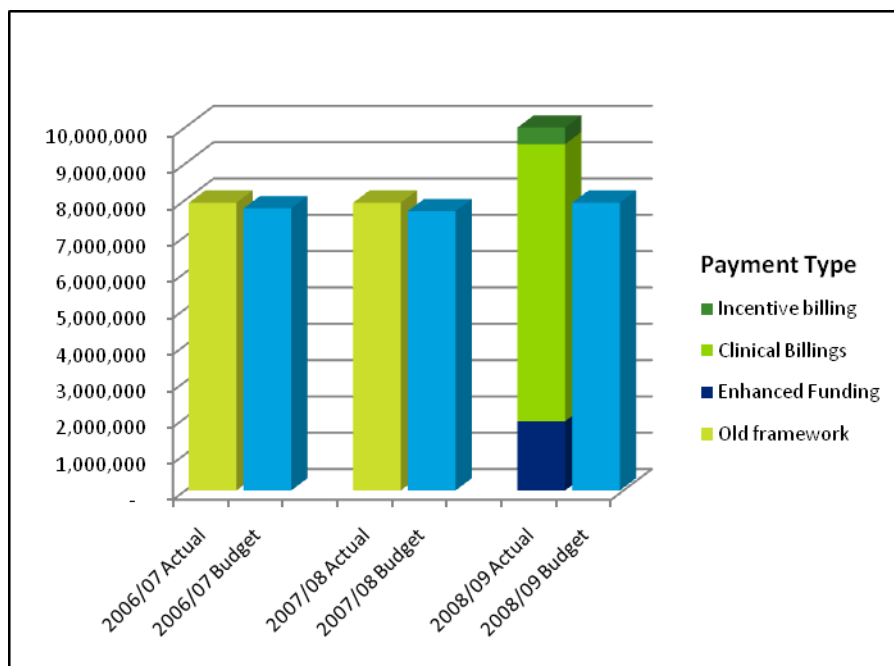


Department of Pediatric Anesthesia and Critical Care began to use the new AFP framework effective April 1, 2007; therefore, the 2006/07 remuneration is on an FTE basis.

The amount of enhanced funding payments in 2007/08 and 2008/09 represented at least 75% of the total funding that was made in 2006/07. Clinical funding for these two years was fairly consistent, and incentive billing was negligible. The significant increase in costs for this department is represented by the amount of enhanced funding paid.

Department of Pathology & Laboratory Medicine

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Rate per FTE	Budget	Variance	% Variance
2006/07	-	-	-	-	-	7,923,400	259,784	7,768,100	155,300	2.0%
2007/08	-	-	-	-	-	7,923,400	259,784	7,691,400	232,000	2.9%
2008/09	1,907,100	-	7,628,300	-	457,500	9,992,900	317,235	7,923,400	2,069,500	20.7%



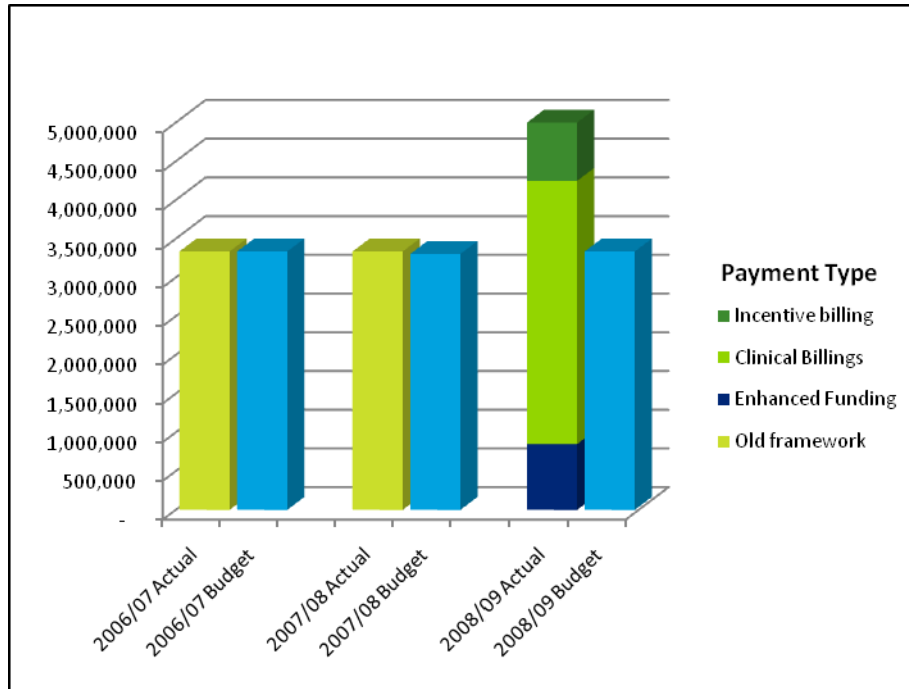
Department of Pathology & Laboratory Medicine began to use the new AFP framework effective April 1, 2008; therefore, the 2006/07 and 2007/08 remuneration is based on the old framework. However, both the old and the new agreements for this department are based on FTE remuneration.

In 2008/09 the following payments were noted:

- A \$15,000 one-time payment to all physicians who were members of the department as of April 1, 2008 for a total of \$457,500;
- An FTE rate of \$312,635, a significant jump from the previous rate of \$259,784; and
- The AFP also provided for an additional 4 FTEs effective January 1, 2009.

Department of Radiation Oncology

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	-	-	-	3,336,400	3,336,400	-	0.0%
2007/08	-	-	-	-	-	3,336,400	3,304,200	32,200	1.0%
2008/09	849,600	-	3,398,400	-	810,000	5,058,000	3,336,200	1,721,800	34.0%



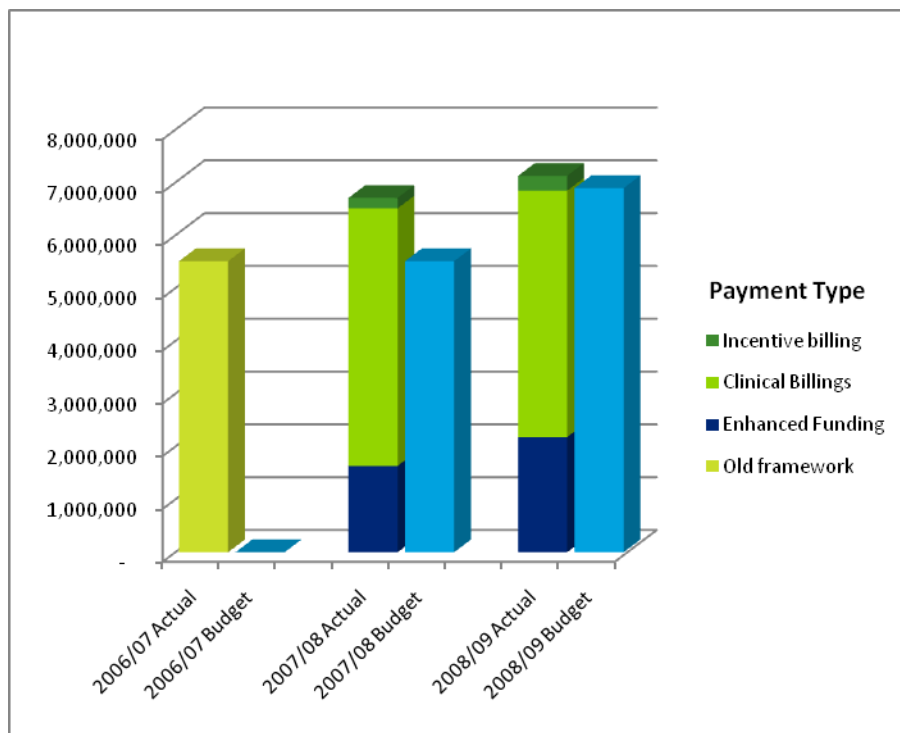
Department of Radiation Oncology began to use the new AFP framework effective April 1, 200; therefore, the 2006/07 and 2007/08 remuneration is based on the old framework. However, both the old and the new agreements for this department are based on FTE remuneration.

In 2008/09 the following payments were noted:

- Annual based funding of \$4,248,000 beginning April 1, 2008 which was a significant increase from the prior years;
- Additional base funding of \$354,000 for additional FTE (note the agreement allows for this additional base funding amount to a maximum of \$4,602,000); and
- A one-time payment of \$456,000 which is noted as such in the agreement.

Department of Emergency Medicine

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	5,511,033	-	-	5,511,033	-	5,511,033	100.0%
2007/08	1,635,658	-	4,876,067	-11.52%	197,780	6,709,505	5,511,000	1,198,505	17.9%
2008/09	2,180,877	-	4,664,411	-4.34%	281,100	7,126,388	6,894,500	231,888	3.3%



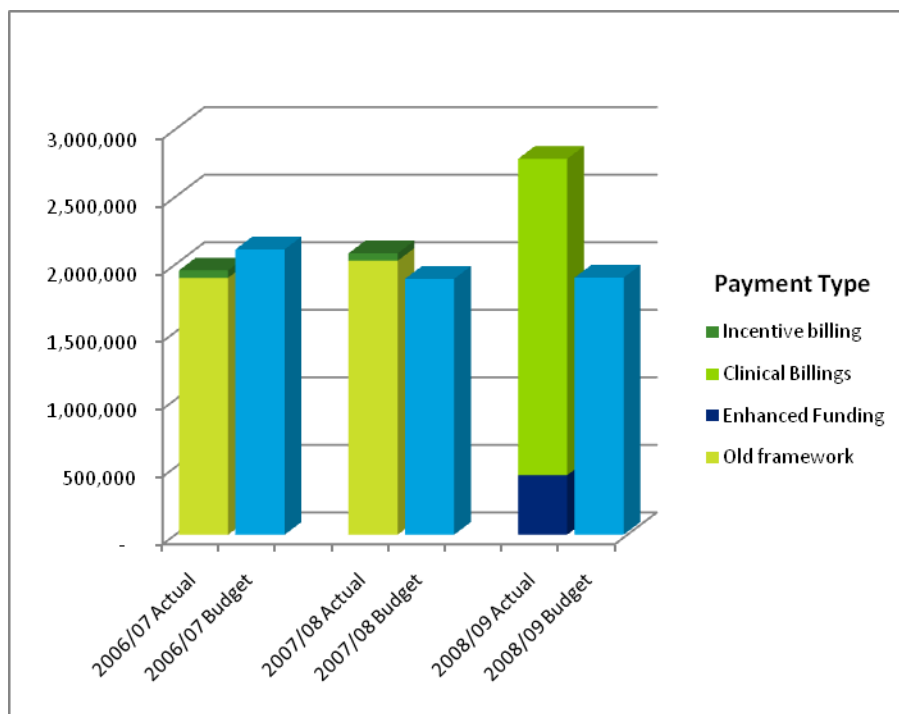
Department of Emergency Medicine began to use the new AFP framework effective July 1, 2007. Clinical funding for this department is based on the Murray Formula (as noted in the AFP document).

The following items were noted as increased costs in 2007/08 and 2008/09:

- Enhanced funding payments began in 2007/08. For the 2007/08 fiscal year this funding was 9/12 of \$2,180,877 and was \$2,180,877 for fiscal 2008/09;
- Funding for call backs became eligible for claims based reimbursement. For 2007/08 this amount was \$36,905 and for 2008/09 was \$49,206;
- A competitive adjustment of \$160,875 was paid in 2007/08; and
- Left without being seen payments (a type of payment for emergency physicians) of \$231,894 were made in 2008/09.

Department of Diagnostic Imaging

	Enhanced Funding	Clinical billings % of target	Clinical Billings	Percentage change clinical	Incentive billing	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	1,901,300	-	55,000	1,956,300	2,111,700	(155,400)	-7.9%
2007/08	-	-	2,027,400	6.63%	55,000	2,082,400	1,893,500	188,900	9.1%
2008/09	440,800	-	2,340,800	15.46%	-	2,781,600	1,902,500	879,100	31.6%



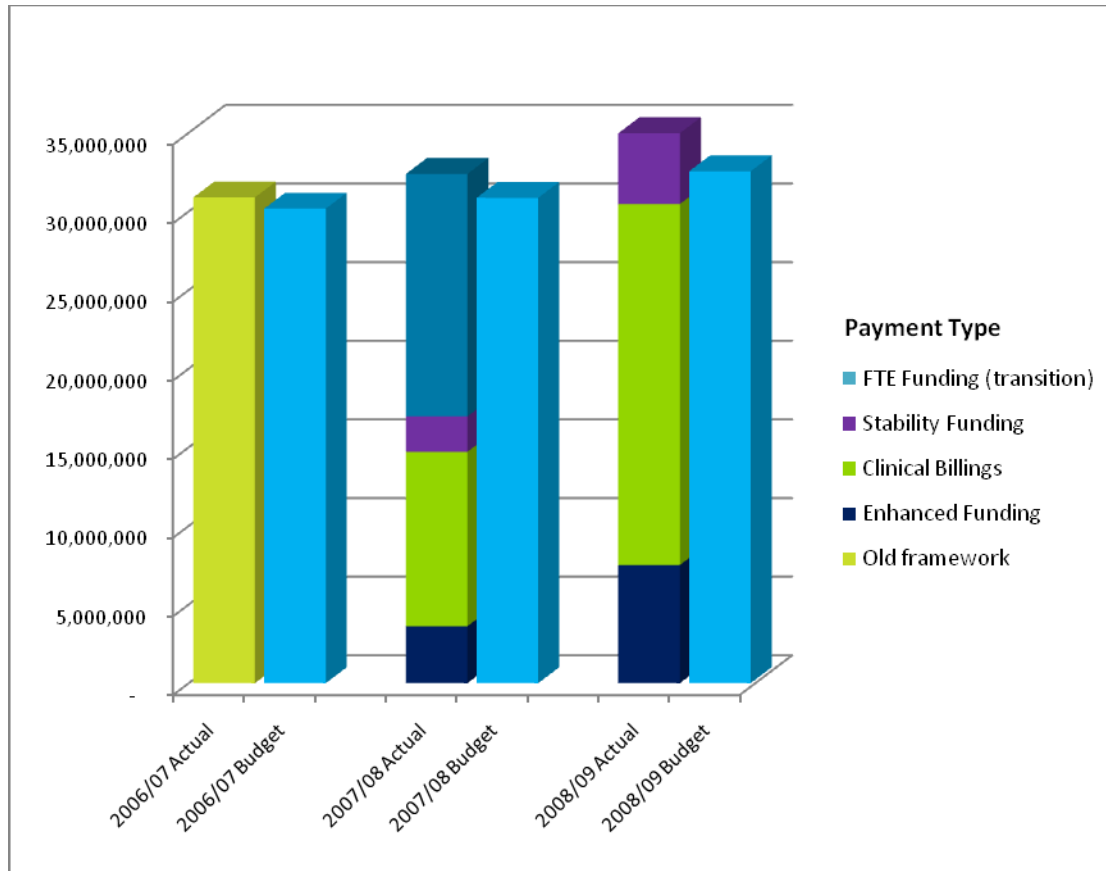
Department of Diagnostic Imaging began to use the new AFP framework effective April 1, 2008; therefore, the 2006/07 and 2007/08 remuneration is based on the old framework and an FTE basis of remuneration.

For the 2008/09 the following items were noted:

- Enhanced funding payments began in 2008/09. These payments are 20% of the clinical billings. For the 2008/09 year these amounted to \$440,800;
- Clinical funding increased by approximately \$300,000 when remuneration method changed from FTE based to FFS based; and
- On call funding which was provided for under the old AFP agreement is no longer provided for under the new agreement accounting for a reduction in clinical billings of \$55,000.

Department of Surgery

	Enhanced Funding	FTE Funding (transition)	Clinical Billings	Percentage change clinical	Stability Funding	Total DoH cost	Budget	Variance	% Variance
2006/07	-	-	-	0.0%	0	30,888,000	30,175,500	712,500	2.3%
2007/08	3,621,800	15,416,300	11,091,700	0.0%	2,250,000	32,379,800	30,864,900	1,514,900	4.7%
2008/09	7,511,900	-	22,956,600	107.0%	4,500,000	34,968,500	32,551,100	2,417,400	6.9%

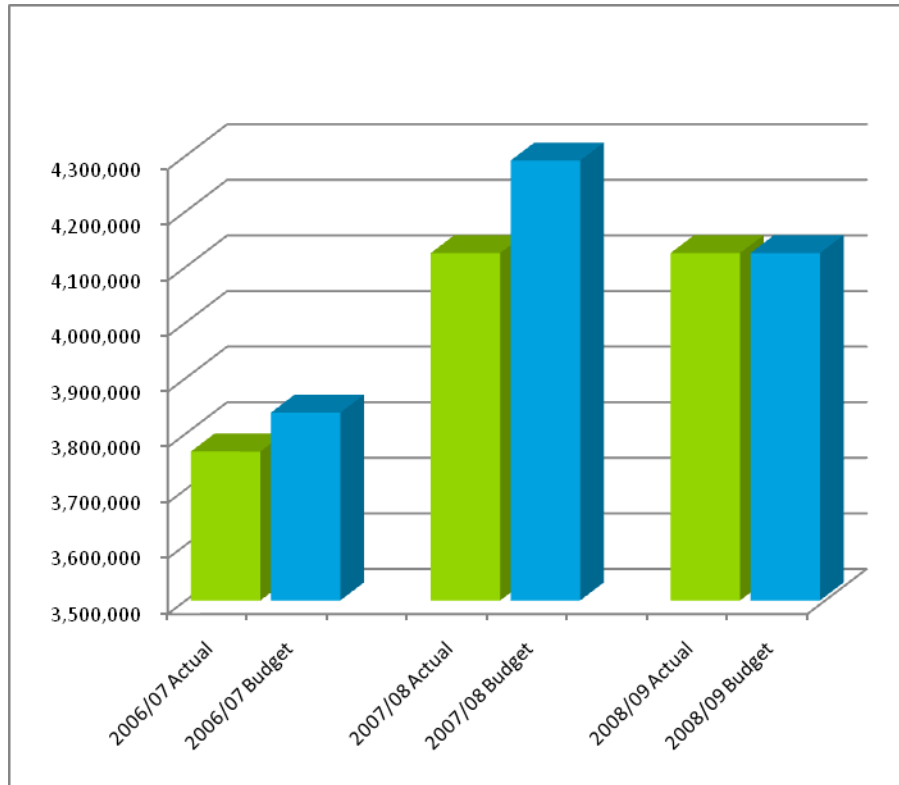


Department of Surgery began to use the new AFP framework during the 2007/08 fiscal year; therefore, the 2006/07 and a portion of the 2007/08 remuneration is based on the old framework and an FTE basis of remuneration (with 2007/08 funding denoted as transition FTE funding).

The following AFPs are under the prior framework with remuneration based on FTEs:

Department of Critical Care

	FTE funding	Rate	Actual Costs	Budget	Variance	% Variance
2006/07	10.75 to 13.75	300,000	3,768,000	3,837,900	(69,900)	-1.9%
2007/08	13.75	300,000	4,125,000	4,291,500	(166,500)	-4.0%
2008/09	13.75	300,000	4,125,000	4,125,000	-	0.0%

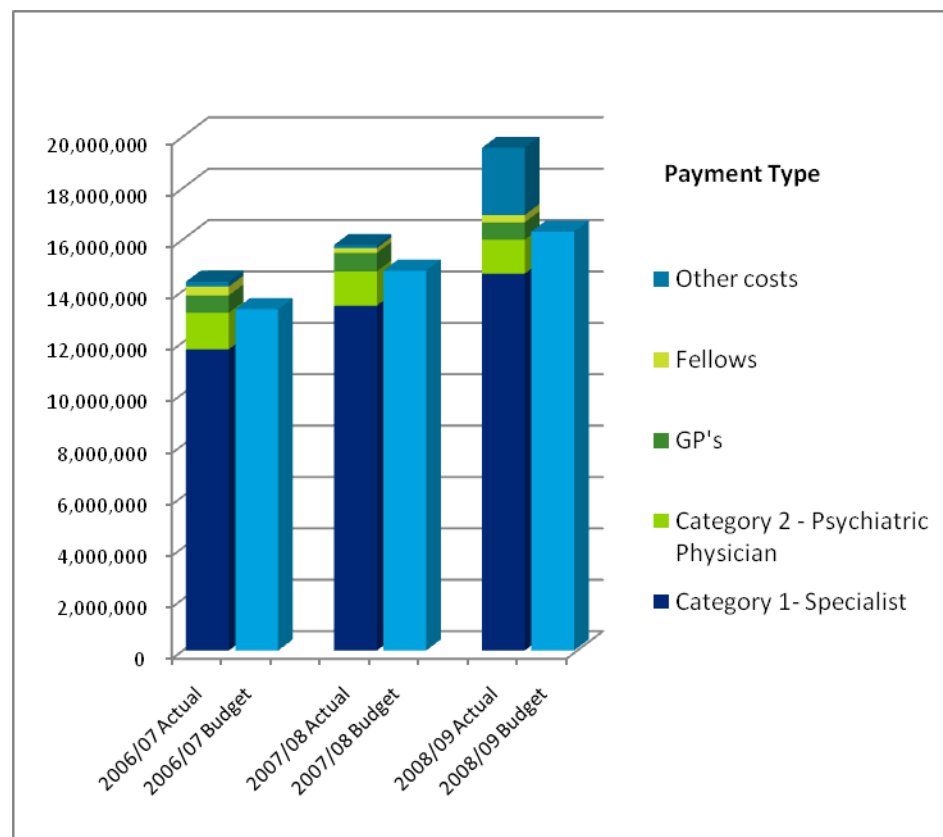


The main difference for the cost increases from 2006/07 to 2007/08 is due to the fact that the Department was funded at the maximum number of FTEs allocated under the AFP rather than the actual number of FTEs, which was significantly less. The cost per FTE remained constant at \$300,000.

Department of Psychiatry

	FTEs (average)			Rates			Cost		
	2006/07	2007/08	2008/09	2006/07	2007/08	2008/09	2006/07	2007/08	2008/09
Category 1- Specialist	45.15	50.74	55.45	259,784	264,564	264,564	11,729,200	13,423,500	14,669,200
Category 2 - Psychiatric Physician	6.85	6.32	6.25	207,827	211,651	211,651	1,423,600	1,338,500	1,322,800
GP's	4.79	5.00	4.73	140,716	143,305	143,305	674,000	716,500	677,700
Fellows	2.63	1.39	2.17	129,892	132,282	132,282	341,600	184,100	286,600
	59.42	63.45	68.59						
						Other cost	191,700	122,200	2,614,100
							14,360,100	15,784,800	19,570,400

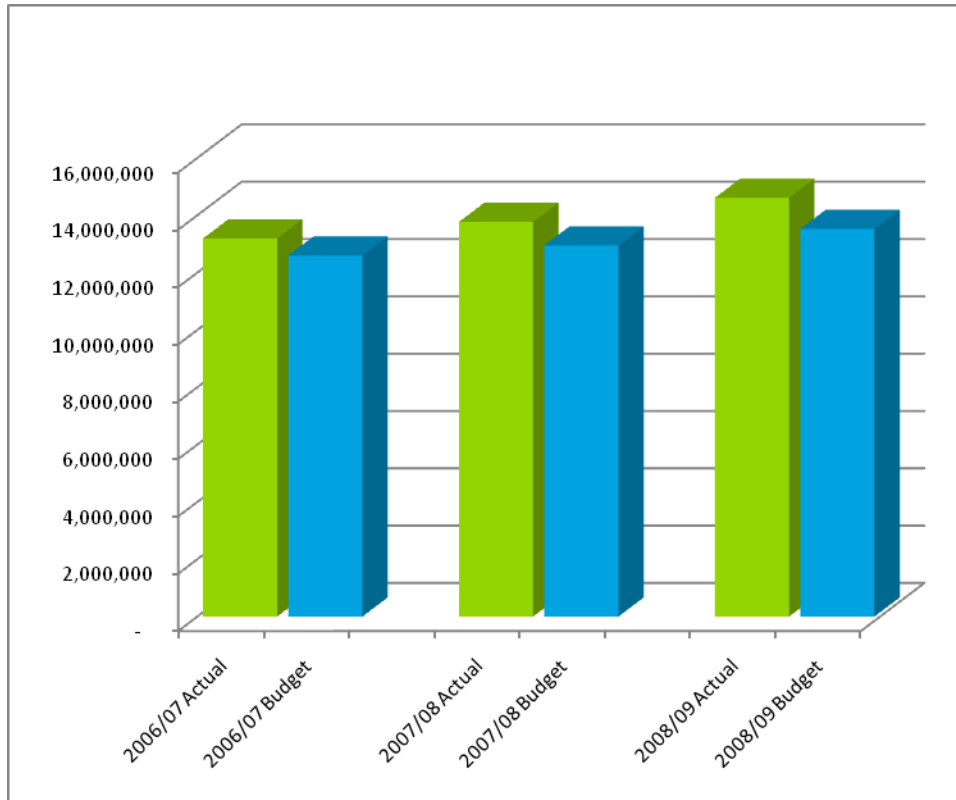
	Cost		
	2006/07	2007/08	2008/09
Category 1- Specialist	11,729,200	13,423,500	14,669,200
Category 2 - Psychiatric Physician	1,423,600	1,338,500	1,322,800
GP's	674,000	716,500	677,700
Fellows	341,600	184,100	286,600
Other cost	191,700	122,200	2,614,100
Total Cost	14,360,100	15,784,800	19,570,400
Budget	13,288,000	14,787,700	16,308,900
Variance	1,072,100	997,100	3,261,500
% Variance	7%	6%	17%



Year over year the primary reason for the increase in funding has been the increasing number of FTEs, combined with the increase in the rates for each of the categories. However in 2008/09 the CSP physicians were transferred to this AFP. This resulted in an increase of \$2,486,900 for the fiscal year.

Department of Pediatrics

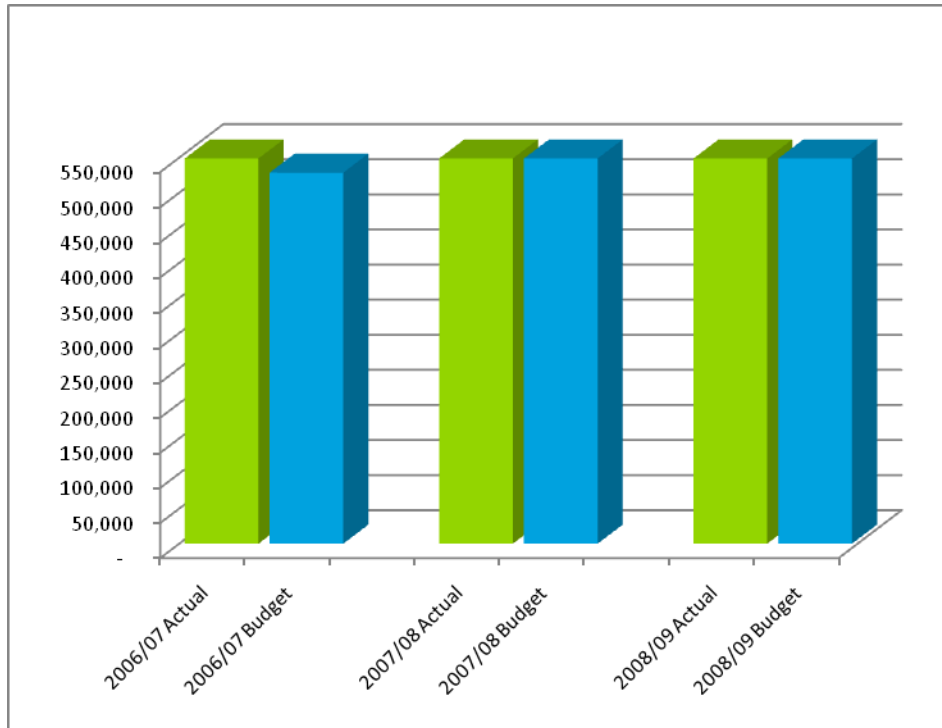
	FTE funding	Rate	Percentage increase	Actual Costs	Budget	Variance	% Variance
2006/07	52.83	249,659	2.00%	13,189,485	12,594,100	595,385	4.5%
2007/08	54.15	254,253	1.84%	13,767,800	12,944,800	823,000	6.0%
2008/09	56.89	256,795	1.00%	14,609,068	13,519,200	1,089,868	7.5%



Year over year the primary reason for the increase in funding has been the increasing number of FTEs, combined with the increase in the rates per FTE.

Department of Pediatric Nephrology

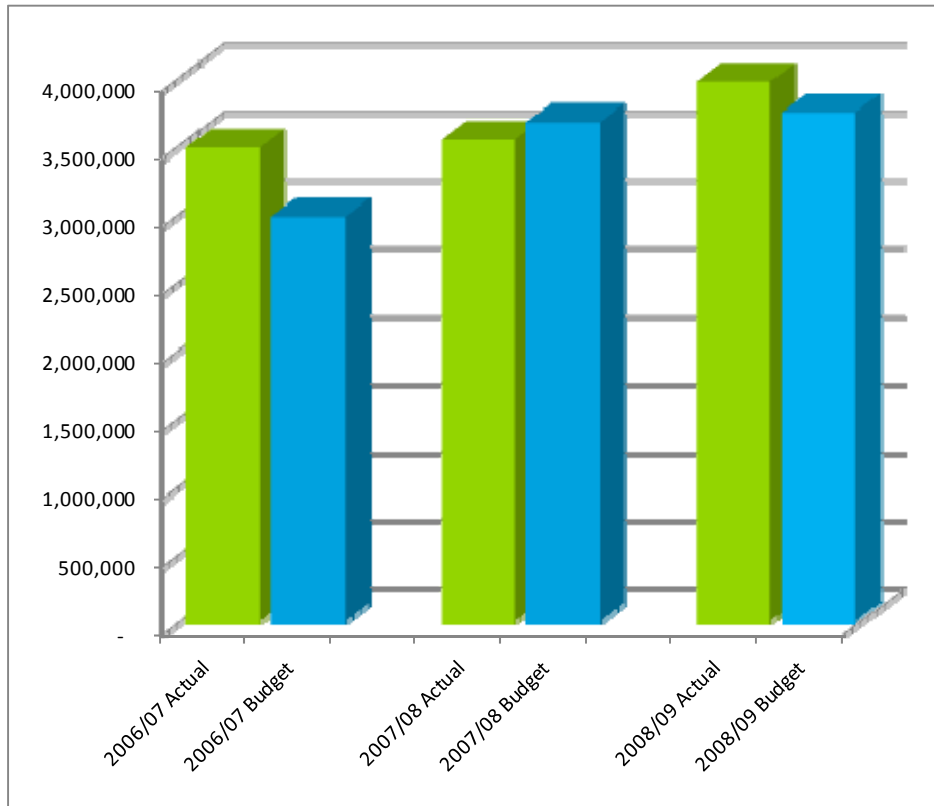
	FTE funding	Rate	Actual Costs	Budget	Variance	% Variance
2006/07	2	274,404	548,808	528,600	20,208	3.7%
2007/08	2	274,404	548,808	548,800	8	0.0%
2008/09	2	274,404	548,808	548,800	8	0.0%



Costs for this department have remained consistent year over year.

Department of Family Medicine

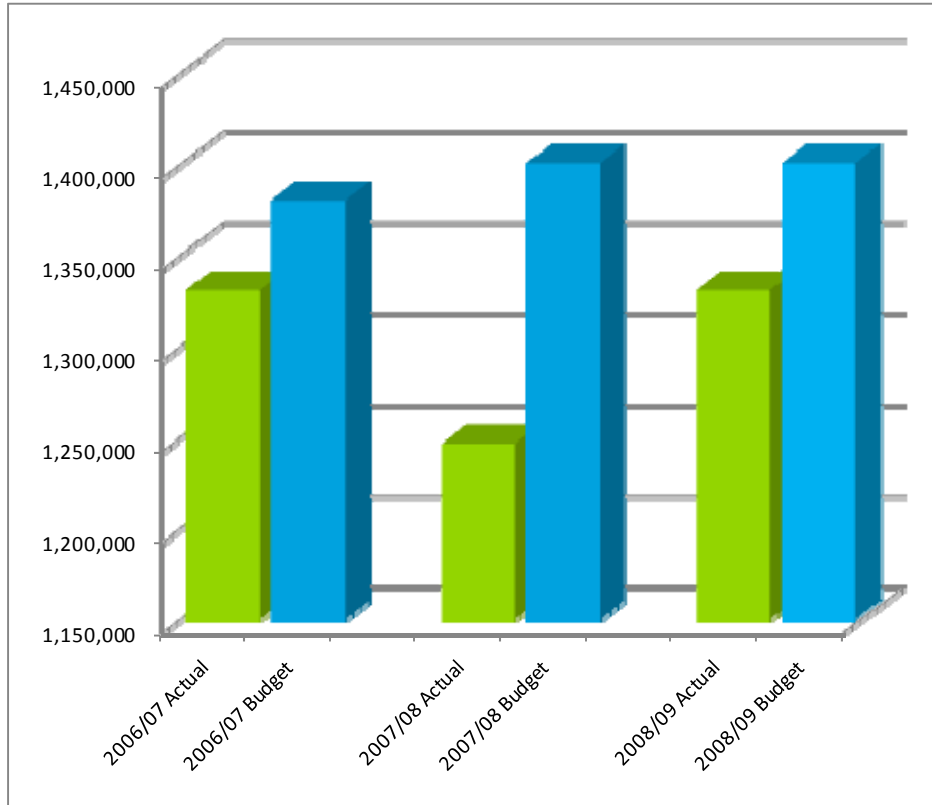
	FTE funding	Rate	Actual Costs	Budget	Variance	% Variance
2006/07	18.21	191,104	3,480,004	2,974,800	505,204	14.5%
2007/08	18.19	194,620	3,540,138	3,669,200	(129,062)	-3.6%
2008/09	18.46	214,903	3,967,109	3,740,800	226,309	5.7%



Year over year the primary reason for the increase in funding has been the slight increase in the number of FTEs, combined with the increase in the rates per FTE.

Department of Gynecologic Oncology

	Actual Costs	Budget	Variance	% Variance
2006/07	1,330,800	1,380,200	(49,400)	-3.7%
2007/08	1,246,700	1,400,800	(154,100)	-12.4%
2008/09	1,330,800	1,400,800	(70,000)	-5.3%



Costs for this department have remained consistent year over year.

Appendix H – Detailed review findings and management responses

1.1 – Number of AFPs are too onerous	
Finding	<p>While AFPs have proven to be a successful tool in managing the physician service relationships in other jurisdictions, the current number of AFPs (16) for the CDHA and IWK is too numerous (in contrast, the Province of Ontario has 16 AFP agreements for the entire Province). In addition to appropriateness of size and scale of Nova Scotia, the number of AFPs is too numerous for the following reasons:</p> <ul style="list-style-type: none"> • The extensive time required by the various stakeholders to negotiate each of these agreements; • With each AFP there are administrative responsibilities for a number of the stakeholder groups. The DoH requires resources to administer and negotiate the agreements. Doctors Nova Scotia, who are the representative of the physicians in the province must spend increased amounts of time negotiating and administering each of the AFPs, potentially to the detriment of other physicians in the province whom they represent as well. The DoH Division of Finance requires resources to administer the financial payments and corresponding shadow billings. Each physician departments (which has an AFP) require resources to develop the department plan, analyze and provide deliverables and determine individual physician compensation within the deliverable; • Expired AFP agreements do not properly serve any of the stakeholders. The credibility of the process diminishes with expired agreements, budgeting becomes difficult as there is the unknown ‘retroactive’ portion that may be required to be paid upon renegotiation, and the needs and direction of the provincial health plan and, more directly, the needs of the IWK and CDHA are less likely to be met with an expired agreement; and • The new template was intended to provide consistency between the various AFP agreements; although the intention of the template provides for a consistent agreement, the physician departments will be inclined to use what was most recently agreed upon for another department as their starting point in negotiation, increasing the potential for raising the costs. This inadvertently creates competitive pressures within the province amongst the physician groups. Such competitive pressure would be better served in a stronger performance evaluation and accountability framework.
Recommendation	<p>It is recommended that the number of AFP agreements be significantly reduced to one agreement for the Province. The AFP should be funded based on the needs and business plan of CDHA and IWK, the physician resource plan of the Province, the specialized resource requirements of the system and the strategic direction of the Province around health outcomes and fiscal restraint. Within the one AFP it should then become the responsibility of the physician group to determine the allocation of the funds among the physicians.</p>
Management Response	TBD
Finding	It is our understanding that some of the components mentioned above as underlying

	inputs to the AFPs are either not yet developed or in development stage.
Recommendation	It is recommended that current and robust business plans, resource plans and strategic direction be developed and understood to allow for negotiation of AFPs that best serve the provincial direction.
Management Response	TBD
1.2 – Method of remuneration not linked to outcomes	
Finding	<p>The North South report recommended that AFP funding be based on a more rational approach and that clinical and non-clinical funding should be differentiated. In response to this the new framework incorporated the FFS model to fund the clinical portion of the AFP agreements. As such a number of the issues with FFS have found their way into the AFP model.</p> <p>However fundamental issues with the fee for service model in general, and in an AFP environment in particular, were not addressed. Specifically:</p> <ul style="list-style-type: none"> • It was noted by the majority of our interviewees that the current fee rates per the Physician Services Master Agreement is out of date. Fee codes in a number of instances have not kept up with changing technologies and procedures. As such procedures which were in the past very labour intensive and therefore paid a higher rate, have not been adjusted for current technology which significantly reduces the procedure time; • FFS compensates physicians for volumes of procedures performed and not necessarily for quality of service, nor for achievement of facility or provincial health goals; • As FFS is a procedural based payment; it does not adequately reward diagnostic thought; • FFS can create an environment where there is a financial incentive for the physicians to over perform specific procedures which pay at a higher rate. This, combined with the lack of financial incentive for diagnostic thought, may result in patients receiving unnecessary treatment; • FFS does not encourage collaboration/referral amongst departments or from outside the AFP environment into the AFP environment as fee for service pays for the procedures performed within a given department; • FFS is seen as undesirable by some of the physicians as it does not smooth out income earnings. In a fee for service environment the physician is subject to highs and lows in income, based on the number of procedures performed; • The current framework for the AFPs does not provide a cap for the amount of fee for service which can be billed. Rather it provides for an upper limit within which FFS is paid at 100%, and then paid at a reduced amount for procedures over this limit. This does not serve as an expenditure management tool as the number of procedures which will ultimately be billed for cannot be known; and • FFS has the potential to increase assisted procedures as each physician can then bill for services performed increasing the risk of ‘double dipping’. <p>The fundamental issue with any given method of payment is that there needs to be outcome based reporting associated with the services performed. Outcome based reporting needs to mean more than the number of patients served. There needs to be components for measuring the achievement of facility goals and reduced repeat visits. Until these types of deliverables are determined and linked directly to the compensation model chosen, any model of payment will have flaws. Shadow billing is an outdated measurement tool that measures volumes of service provided. If the Province determines that this is not the outcome measure that is most relevant, than shadow billing should not be used in the AFP environment for performance measurement. It is our understanding that shadow billing is required for other administrative reasons which may necessitate its continued use in the short term by</p>

	<p>the physician groups.</p> <p>The North South report's recommendations intended for an incentive system which rewarded superior performance and penalized inferior performance. FFS can be argued to be a system that rewards superior performance, in that the higher the number of procedures performed the higher the compensation. The stakeholders need to determine if this is the measurement of success that they are trying to achieve and consequently the proper measurement of superior performance. Based on the interviews that we conducted it would be apparent that volumes are not the proper measure of success.</p> <p>Ultimately the measures used to assess AFP performance should satisfy the collective goals of the stakeholder group. Although these measures may not yet be in place there are interim measures, which we understand are tracked and include measuring: turnaround times, infection rates, readmission rates, incident rates, length of stay, number of tests, etc. The use of benchmarks is also effective at measuring desired outcomes. In time the Province should evolve the desired outcomes to appropriateness of care, decreased obesity, improved chronic conditions, decreased mortality rates, decreased accident rates, etc. The following recommendation deals with more appropriate measurements.</p>
Recommendation	<p>It is recommended that the method of clinical payment used for the physicians be one that is clearly tied to the delivery of the required / negotiated outcomes. These outcomes should not be input volume based and should satisfy the collective goals of the stakeholders. A stronger and timelier performance evaluation process will need to be developed to monitor the achievement of negotiated outcomes by the physician groups.</p> <p>In defining clinical outcome measures consideration for the varying time and intensity required by the different types and experiences of physicians should be considered. As each physician group's practice plan is outlined and tied to performance outcomes, consideration for types of patient, age of patient, nature of intervention, etc should be factored into the physician expectation. Movement towards a true outcome focused measurement framework should be considered.</p> <p>The payment method should also provide for incentives for meeting the required outcomes and penalties for not meeting these outcomes. Operational objectives (including administrative needs) of CDHA and IWK and system objectives of the Province should be factored into the outcome measure development, tailored to motivate the physician group. Feedback from CDHA and IWK on their satisfaction with the physician population should be factored into the outcome measures framework.</p> <p>It is also recommended that the clinical portion of the funding for the AFP be clearly differentiated from the academic and research portions of the funding and clarity around the expectations of the physicians in exchange for this payment be emphasized. This will be further discussed in the compliance section of the report. Additional outcome measures that would be included in physician practice plans to reflect academic and research goals include feedback on the student experience, number of students, research publications, research funding generated, speaking engagements, etc.</p>
Management Response	TBD
2.1 – AFP development structure	
Finding	Throughout the course of our work, there were variations as to what happens first in the negotiation process. Some parties noted that the process starts with the physician departments providing their proposal to DoH which initiates the AFP development and negotiation process, while others noted that they felt there were back room dealings

	<p>that decided on the dollars prior to consultation with the physician groups or CDHA and IWK (refer to Appendix E for a flowchart of the AFP negotiation and approval process). Neither of these are the proper drivers of the process.</p> <p>The Government of Nova Scotia through the DoH should have a clear definition of the physician resource needs as well as the service delivery direction for the Province before entering into AFP physician negotiations. If the DoH does not have clear direction on: 1) the strategic direction that the Province wishes to pursue with respect to health care, 2) the current status of physician recruitment and retention issues and challenges and 3) the cost constraints inherent in the overall government funding over the next 3 to 5 years, there is increased risk that the negotiated AFPs will not provide the desired service delivery results or the desired costs. Cost constraints should be clearly established and well communicated amongst the stakeholder group up-front, prior to negotiations, in order to define the funding limits and to ensure that negotiations can take place within these parameters.</p> <p>The Government of Nova Scotia, through the DoH should communicate clear expectations regarding performance measures and financial restrictions to the CDHA and IWK of what they should be achieving. These expectations need to form part of the plans and strategic directions of the facilities (CDHA and IWK). The physician department plans should then be developed to satisfy these plans. In addition, Dalhousie can plan for and incorporate the value of academic services exchanged in the AFPs as part of the medical school oversight.</p>
<p>Recommendation</p>	<p>It is recommended that the Province, through the DoH, ensure that there is a strategic direction and physician resource plan for health care services detailing the needs of IWK and CDHA. The DoH will need to work with CDHA, IWK and Dalhousie to define the clinical, research, academic and administrative workload expected by the physician group in order to meet operating, transformation and budgeted expectation. This should be part of the larger strategic direction and physician resource plan for the Province and clearly communicated to IWK, CDHA and Dalhousie in a timely manner for consideration and inclusion in their business and HR planning.</p> <p>The IWK, CDHA and Dalhousie need to clearly assume the responsibility for the delivery and achievement of the desired outcomes within their facilities. Their business and HR plans should be developed in order to achieve the desired outcomes that complement the provincial direction. Although the DoH is the payor of the funds in the AFP agreements, it is the IWK and CDHA that need to take clear responsibility and accountability that the AFPs are negotiated such that they are in alignment with the facility direction. It is important that they actively take part in a feedback process to the Province to report back on the achievement of the objectives which can be used in the performance evaluation process.</p> <p>It is recommended that the IWK and CDHA increase their level of involvement in the negotiation of the AFP agreements. Although not employees of the facilities, the physician group is one of the essential talent and leadership groups that the facilities require in achieving their goals. The IWK and CDHA need to ensure that they have a strong and consistent voice in the negotiation process and that their goals are one of the primary considerations in the negotiation process of performance outcomes.</p> <p>In addition, it is recommended that the facility business and HR resource plans should be the basis of the proposals submitted by the departments for consideration in the AFP negotiation process. Physician complement and outcomes should be based on the achievement of these plans.</p> <p>It is recommended that the issue resolution process which is currently part of the AFP should be revisited to ensure proper parties are at the table; the process allows for timely resolution of issues; and the means of escalation are clearly defined. Deviations from the outlined process should be minimal and reasons for such should</p>

	be clearly documented.
Management Response	TBD
2.2 – AFP negotiaton awareness and documentation	
Finding	<p>The negotiation process is one of the most critical components of the AFP process and having the correct individuals and stakeholders at the negotiation table ensures that all parties are aware of the decisions being made and have the ability and opportunity to raise questions and concerns throughout the process. However, from the various interviews we conducted, it is clear that there are many different views on how the negotiations are conducted and on the respective level of involvement by each party in the process.</p> <p>For example, it was indicated that there is limited representation from the DoH Division of Finance during the initial negotiations and no involvement from TB. DoH Division of Finance is accountable to the government for explaining cost increases and ensuring adequate funding within the approved DoH budget while the TB is responsible for paying the amounts as well as making recommendations to Cabinet on decisions such as approving AFP agreements. Various stakeholders felt that they were only on the periphery of the negotiation process and informed late in the process or after an agreement had been reached. They therefore had little understanding of the cost and impact to their respective organizations, with little input around outcome specification or resource requirements.</p> <p>In addition, it was noted there is a lack of formal documentation pertaining to AFP negotiations. Without complete and accurate documentation of negotiation sessions, which is shared on a regular and timely basis amongst the stakeholders, there is the risk that parties may interpret discussions differently or have different recollections of discussions.</p>
Recommendation	<p>It is recommended that a clear and concise negotiation process be established and documented. This process should be developed with consideration of all the relevant stakeholder groups including:</p> <ul style="list-style-type: none"> • DoH - Physician Services, Resource Planning, Finance; • CDHA and IWK executive; • Doctors Nova Scotia; • Dalhousie; • Physician groups; • Treasury Board (TB) Cabinet Committee; and • Provincial Cabinet. <p>As noted in section 2.3, the process needs to clearly define the roles and responsibilities of each of the stakeholders in the negotiation process as well as the timing of the process.</p> <p>Once the negotiation process and timing process has been established each of the stakeholder groups need to determine what their appropriate representation is in the negotiations. This representation should be consistent throughout the process and these individuals must clearly understand their roles in achieving a negotiated agreement which meets the collective and aligned goals of the group.</p> <p>Should the TB not be included as a key party in the AFP negotiation process then DoH should develop an appropriate communication process to ensure that TB is apprised of all relevant information and activities pertaining to AFP negotiations at pre-approved points in the process. The TB should ensure that the goals of government are clearly articulated up front and included as part of the negotiations for outcome targets as well as provide clear messaging around the limitations for the pool of funds</p>

	<p>available to service the agreement.</p> <p>We recommend that formal minutes of negotiation meetings be prepared and distributed to the stakeholder group. This recommendation would also apply to any other AFP related committee meetings. This is necessary to ensure that complete and accurate records of all relevant AFP discussions are maintained.</p>
Management Response	TBD
2.3 – AFP roles and responsibilities	
Finding	<p>A consistent theme amongst the stakeholders was a view that there are many areas of miscommunication and lack of communication between AFP stakeholders as well as a general lack of education and understanding of the AFP process. We noted a lack of understanding of how the roles and responsibilities of the various stakeholders interrelated and affected other stakeholders within the process. In addition there was a lack of understanding around the expected outcomes of the AFP and its related processes.</p> <p>This issue of communication and understanding has caused mistrust in the process. In addition, a lack of understanding of roles and responsibilities significantly increases the risk that parties will not perform their required duties causing a breakdown in the process. The lack of education and understanding amongst all the stakeholders also increases the risk that there will be parties who have unrealistic or unfounded expectations of the process. This exists particularly for government which is making significant decisions on large amounts of funding through approved AFP budgets, potentially without a clear understanding of the expectations and demands of all parties.</p>
Recommendation	<p>It is recommended that a clearly established roles and responsibility framework be defined and communicated to all parties and stakeholders to the AFP agreements. The framework should re-establish authority within the process and re-introduce trust back into the process. Each party and stakeholder should be made aware of their role and expectations within the AFP process.</p> <p>In addition, it is recommended that education surrounding the purpose of AFPs be re-introduced. This education should be future oriented to enable forward movement and capturing of significant potential benefits around the (revised) AFP processes, the related accountabilities, and the importance of the role of AFPs in health care delivery. This education should be developed and presented to relevant stakeholders including the parties to the agreement, as well as members of government.</p>
Management Response	TBD
2.4 – Increasing DoH resources and skills	
Finding	<p>The Physician Services group within the DoH is responsible for the negotiation of the AFPs on behalf of the Provincial Government and the subsequent monitoring and review of the AFP deliverables to ensure compliance with requirements. There are currently 16 AFPs in place, 13 of which have expired, for this group to negotiate.</p> <p>To adequately execute their role, the Physician Services group requires an appropriate number of resources with appropriate skill-sets. This relates not only to the negotiation team, where negotiation skills and experience should be a requirement, but the individuals responsible for the physician resource plan, the strategic direction of health care in the Province, as well as the review and monitoring of the deliverables to the individual agreements and regular follow up with the stakeholder groups. As the AFPs are one of the most significant areas of cost for the Province, DoH should assess the desired workload of the physician services group</p>

	and then ensure that appropriate levels of resourcing are in place to administer the process.
Recommendation	<p>It is recommended that DoH assess the roles and responsibilities of its current officers with respect to the AFP process and compare this to the desired future workload. More dedicated resource allocation at senior levels of DoH are required to maintain appropriate oversight of the accountability expectations.</p> <p>It is also recommended that DoH ensure there are adequate resources and skills in place to fulfill the roles and responsibilities defined above to achieve the desired workload, both for ongoing oversight and for periodic negotiation. The DoH roles for oversight of performance measures and resource planning are important specialized roles that require objectivity and system oversight which only the Province can provide.</p>
Management Response	TBD

2.5 – AFP Performance Management Committee

Finding	<p>For each AFP agreement there is a requirement for an AFP Performance Management Committee or similarly named function. The role of the committee is to:</p> <ul style="list-style-type: none"> • Monitor the implementation of the agreement; • Review effectiveness of the method of funding; • Receive and review the deliverables as required in the AFP agreement; • Determine the reduction in enhanced funding if departments failed to meet deliverables; • Consider requests for changes in targets and funding; and • Report annually to parties of the agreement on all aspects of the agreement including performance of deliverables, standards and achievements, physician status and changes, all financial aspects and assessments on the effectiveness with respect to leadership, clinical, research and academic activities. <p>The Committee is intended to serve in a governance capacity through the duration of the AFP agreement. However, through our discussions the following was noted, indicating limited effectiveness of this committee in a governance capacity:</p> <ul style="list-style-type: none"> • Frequency of meetings is not consistent; • Minutes are not readily available of the meetings; • Annual reports to parties of the agreement were not readily available; • There have been no instances noted of reduction in enhanced funding, although there is no formal academic delivery model; and • No documentation on the effectiveness of the method of funding was available.
Recommendation	<p>It is recommended that to effectively govern the current AFP agreements, the AFP Performance Management Committee must follow the terms of reference set out in the agreements. Minutes should be taken at each of these meetings. The agenda of the meeting should focus strictly on governance matters and should be broadened to include stronger oversight activity. The AFP Performance Management Committee should also ensure that appropriate and meaningful reports are developed and delivered to the parties of the agreement as required per the AFP.</p>
Management Response	TBD

3.1 – AFP reporting requirements and awareness

Finding	<p>Currently, each AFP agreement has specific reporting requirements which are meant to hold the physician departments accountable for AFP funding received and ensure that stakeholder expectations are met. The deliverables form a key foundation in the governance of the AFPs and form the core monitoring process of AFP performance.</p>
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	<p>One of the clearest messages from the various parties that were interviewed is the importance of reported deliverables. However, many stakeholders had not received or seen the deliverables, and those that had received or seen them had not always reviewed them. The Province’s Internal Audit Centre conducted interviews with the physician department heads and found that the deliverables were prepared by and resident in each of the departments and were noted as having been submitted to Physician Services. It was unclear as to whether these had been distributed and received by the relevant stakeholders. Our interviews with the non-physician stakeholders and attempts to gather these completed deliverables would indicate that whether or not the deliverables were initially received, they are, for the most part, currently not resident within the non physician stakeholder group. Clearly there is no formalized process for the tracking of the deliverables outside of the physician group.</p> <p>The current deliverables produced as a result of the AFP agreements are not consistently viewed as providing the appropriate content. In any situation where government dollars are expended for services performed, the value for the dollars spent is the most desirable set of reporting outcomes. However, the determination of what constitutes value-for-money in an AFP agreement has not been agreed upon within the stakeholder group, nor has the measurement of this value been clearly articulated. It was noted that the current performance measures included may not be the most relevant measures for the AFP stakeholders and a clearly defined, relevant and consistent set of indicators would be more appropriate.</p> <p>The AFP Performance Management Committee has the responsibility to receive and review the deliverables; they are also mandated to determine any reductions in funding. However, there is no clear responsibility or guidelines for assessing the adequacy of the deliverables, interpreting the results of the deliverables, assessing value-for-money and determining if any changes to the agreements are required as a result of the findings in the analysis of the deliverables.</p> <p>In addition, we noted that the completion of these deliverables is a time consuming and potentially expensive process for many of the physician departments to undertake. Department Heads indicated that they keep these measures for their own management purposes and supplying them to DoH did not create additional time requirements.</p>
Recommendation	<p>It is recommended that a tracking mechanism be put in place by Physician Services to account for all deliverables received. This mechanism should track the timeliness of the receipt of the deliverable and the actual receipt of the deliverable by the stakeholders.</p> <p>It is recommended that for all deliverables received that feedback is obtained from the parties to whom these deliverables have been distributed. The focus in oversight must shift from negotiating the size of the funding pool to negotiating, tracking and rewarding the achievement of outcomes received in exchange for the value of the funding pool.</p> <p>It is recommended that all AFP stakeholders identify and develop a reasonable set of reporting requirements that accurately reflect the desired outcomes of the AFP agreements. The content of the deliverables should be concise, meaningful and provide adequate information to ensure that the physician department is meeting the required measures and provide useful information to the users and recipients. The deliverables should also be transparent in that, within a public environment, the value received can be assessed by those outside of the agreements.</p> <p>As part of the development of outcome measures, the DoH needs to ensure that there is a clear link between results and financial compensation provided under the AFP. Penalties and consequences for instances of non-compliance are required and should be clearly defined and enforced. The AFP Performance Management</p>

	<p>Committee should deliver on its responsibility to provide feedback on success of physician departments in meeting the requirements and provide recommendations for not only punitive action where requirements have not been met but more importantly for rewards and incentives where important stakeholder objectives have been achieved or exceeded.</p> <p>It is recommended that clear accountability with respect to the deliverables be outlined. The following should be included:</p> <ul style="list-style-type: none"> •Responsibility for receipt and distribution of deliverables; •Responsibility for tracking of deliverables; •Guidelines for analysis of deliverables; •Guidelines for reporting on analysis of deliverables
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Management Response	TBD
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3.2 – Lack of academic deliverables and performance reporting

Finding	<p>A significant portion of the AFP funding (approximately 25 - 30%), relates to the non-clinical part of the physicians role (research and academic). While there are prescribed academic reporting requirements within the AFPs, statements vary as to whether this reporting is provided to the stakeholders. In addition, although the AFP agreements note consequences for non-compliance, no action is typically taken. Good governance would require that value-for-money be determined for each of the AFP agreements. Without reporting requirements that are received and monitored for the non-clinical portion of the work performed under the AFP, the stakeholders and parties to the AFP agreement have no way of measuring if they are receiving value for the funding provided.</p> <p>It is argued that measuring the clinical side of the AFP agreements is difficult and that a proper measurement tool is not in place. However, many of these physician departments perform research and provide academic support outside of the AFP environment (i.e. 3rd party research grants). Value for money reporting is not new to health care services and current models can be modified to suit the Nova Scotia challenges.</p>
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Recommendation	<p>It is recommended that the AFP agreement develop a clear and concise set of non clinical deliverables. These deliverables should be developed with the input of all stakeholders, particularly Dalhousie. The deliverables should reflect the goals of the medical school as well as the goals of the facilities and the physicians and should include items such as articles published, research milestones achieved, recognition received and inclusions in significant endeavors which promote the goals of the stakeholders.</p> <p>It is recommended that key academic deliverables are required to be tracked and reported by the physician departments as required by the AFP. A clear process needs to be in place so that it is understood who the deliverables should be provided to. If Physician Services acts as an intermediary, proper tracking and timely distribution to the remaining stakeholders needs to take place.</p> <p>It is recommended that the AFP Performance Management Committee, as currently mandated in the AFP agreements, reviews the non-clinical AFP deliverables and recommends clear penalties for non-compliance with these requirements. Such penalties should be communicated to the stakeholders and feedback from the stakeholders on administration of required penalties should be sought. Penalties should then be enforced by the DoH and districts and Dalhousie (where relevant) for situations not in compliance with the AFP agreement. Alternatively, and perhaps more importantly, where appropriate stakeholder objectives are met, certain additional incentives and rewards should be provided as documented in the AFPs. Rewards can be monetary or non-monetary in nature.</p>
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Management Response	TBD
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3.3 – Control of the academic portion of the AFPs

Finding	<p>Currently the physicians are paid funds from the DoH for the non clinical portion of their work through the enhanced funding portion of the AFP. In addition, it is our understanding that these physicians receive monies directly from Dalhousie University through tuition fees as well as funding from the Department of Education. During our review, it was identified that approximately \$40 million is provided through the AFPs to support the Dalhousie medical school. It has been questioned whether or not the DoH is the appropriate source for the non clinical portion of this funding. Many of the interviewees feel that a proper AFP would have clinical funding from the DoH which is paying for the clinical services being provided and that the non clinical portion of the AFPs should be funded through the University and the Department of Education. This would allow for better accountability and performance tracking.</p> <p>From our interviews it appears that Dalhousie does not have control over the AFP portion of the funding, nor how the funding is allocated in relation to carrying out their education mandate. The lack of control over the use of funding is primarily due to the limited role that Dalhousie currently plays in the AFP negotiation process when measures and deliverables are set as well as the number of AFPs that are in place.</p> <p>Dalhousie should play an active role in the AFP negotiation process and be privy to increased communication of information as would be expected amongst all AFP stakeholders.</p>
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Recommendation	<p>It is recommended that consideration be given to the various sources of the funding of the non-clinical portion of the AFP (academic and research funding). Currently the DoH does not have a complete picture of the other sources of income the physician groups receive for non-clinical work. This includes but is not limited to funding directly from Dalhousie University, from the Department of Health, and other 3rd party external funding sources. A determination may be made that this portion of funding should come from somewhere other than the DoH. Even if the DoH continues to finance this portion of the funding, at a minimum all funding sources need to be considered in the contemplation of the non clinical portion of the funding.</p> <p>It is also recommended that Dalhousie work jointly with the broader AFP stakeholder group to determine and agree on the critical academic goals and needs. From this, the group can develop realistic and practical outcome measures in order to properly monitor activities and AFP funding. As well these goals and needs should drive the practice plans of the physician departments in their submissions for AFP funding.</p>
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Management Response	TBD
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4.1 – Current AFP contracts

Finding	<p>There are currently 16 physician departments financially remunerated through separate AFP agreements; however, of these 16 departments, only three have agreements which extend beyond March 31, 2010.</p> <p>During a period when there is no agreement in place, departments continue to work in good faith that as part of the negotiation process for the next agreement, there will be consideration and funding for the time period when no agreement existed. The lack of valid agreements places an additional financial risk on the TB, CDHA and the IWK with respect to the delinquency of agreement negotiations. Historically, it has been noted there have been verbal promises made to physician departments that adjustments will be made to compensate for perceived financial shortcomings during a period when no agreement existed. It is unclear as to the authority under which these verbal promises have been made, and the level of communication to the</p>
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	stakeholder group of such promises. These are often considered as retroactive adjustments for the periods in which the agreements were expired, and, in most instances, are increases over the previous agreement that subsequently must be covered by the TB. These are typically lump sum payments that appear to significantly spike the amount of payments made in the year of renegotiation.
Recommendation	<p>We recommend that timely negotiations of agreements take place for the following reasons:</p> <ul style="list-style-type: none"> • Retroactive payments for periods in which a valid agreement does not exist increase the costs to the TB, CDHA and IWK and the amounts the payments are unknown until a new agreement is negotiated. If offline agreements are made for these stub periods they should be clearly documented and communicated to the stakeholder group. • To align with the goals and targets of IWK and CDHA. With this information included in the agreements, the ability to accurately budget and forecast changes will improve, particularly when negotiations occur in a timely manner. • To allow for the agreements to properly reflect the amount that is available for funding (i.e. the budget) rather than the budget trying to catch up to the agreement. • To ensure that outcome measures are clearly defined and expectations around outcomes are clearly communicated in advance of the performance of the physician group.
Management Response	TBD

4.2 – Within agreement time period renegotiation

Finding	In the framework for the AFP agreements clauses 11.8.5 and 11.8.6 allow for the AFP Performance Management Committee to receive and consider changes to the agreements throughout the term of the agreement. These changes could be due to new technology, changes in the physician resource requirements (either upwards or downwards) or changes in the strategic direction of the facilities. However, we did not encounter any instances where these clauses were utilized throughout the term of the agreements other than when the physician departments applied to increase the FTE compliment and the corresponding funding.
Recommendation	We recommend that all stakeholders be aware of and utilize these clauses to the agreements when valid reasons exist for adjusting the agreement during its term.
Management Response	TBD

4.3 – Physician resource planning

Finding	Based on our review and through discussions with the various AFP stakeholders, it was noted that there is not a fully coordinated and integrated provincial physician resource plan that drives physician resources as it relates to the AFPs and physician groups. Currently, it is up to the individual physician departments to assess their staffing requirements, including recruitment and retention plans, and approach the DoH for adjustments to their full-time-equivalent (FTE) compliment as required. The lack of coordination amongst AFP stakeholders, including CDHA and IWK, has also created a lack of trust amongst the various AFP stakeholders as concerns have been raised as to the appropriateness (both over and under) of the current level of physician resources.
Recommendation	It is recommended that a provincial physician resource plan, which is critical to the success of the health care within the Province, be developed taking into consideration the non-clinical commitments of the physicians (administration, research and academic) which will help drive the FTE requirement discussions during AFP negotiations. The resource plan should also consider recruitment and retention planning to ensure that adequate resources are retained with the AFP facilities (and more broadly within the Province).

Management Response	TBD
4.4 – Innovation is not supported by AFPs	
Finding	<p>When the clinical components of AFP agreements are based on an FFS model there is an increased risk that innovation in service delivery will not be considered a priority and can lead to inefficiencies in the health system. This is not intended to suggest that the AFP be the vehicle for determining which procedures are allowed by non-physicians.</p> <p>The current FFS model service is structured on the premise that the physician must see the patient and in turn receives a fee for that service. It was noted during a number of our interviews that there are a number of non-physician trained individuals within the Province’s health care system who are equally capable of performing some of the tasks required in patient treatment within the AFP for which FFS applies (i.e. nurses, nurse practitioners, etc.) and that current procedures allow for this integration of resources. However, for a physician to be compensated in a FFS environment there is little motivation to use the alternative resources where allowed.</p> <p>As well there may be other non human resource related innovations that are not being considered or utilized if the potential for reduced FFS remuneration exists. The current model of AFP payment does not encourage this, as physicians potentially would not have to see the patient, and would therefore be unable to bill based on fee for service, generating no income for themselves or the AFP physician group.</p>
Recommendation	<p>It is recommended that in the long-term the FFS basis for clinical payment of the AFP agreements be discontinued as it is not the most desirable method of payment to encourage the physician group to think ‘outside the box’ and implement innovative and cost saving measures for the health care system. The AFP stakeholders should develop a rewards and recognition system that encourages and rewards innovations and savings in the delivery of health care in the Province.</p>
Management Response	TBD

Appendix I – Sources

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