OAC Information Webinar

Ontario Association of Cardiologists

ontarioheartdoctors.ca

Agenda

1. State of the Nation Summary

2. Debrief on the Special OMA Council Meeting (January 29, 2017)
   - OMA Leadership Review
   - Strategic Next Steps for the Profession

3. February 6, 2017 events and implications

4. Cardiologist Action plan

5. Discussion

Coalition Principles

- **Mission**
- Our mission is to facilitate renewal of the Ontario Medical Association (OMA) to achieve more effective advocacy for patient care, responsiveness to membership and process ,transparency and accountability.
- **Objective**
- We aim to re-establish physicians as respected leaders and patient care champions by re-establishing a collaborative relationship as equals with the Ontario government.
- The keys here are:

  (1) Reform the OMA to make it more transparent, accountable and responsive to grassroots members.

  (2) To unify and restore respect of the profession thereby improving how the OMA is perceived by government and the general public.

Physician Burnout Survey: Summer 2016 (COD)

- 78% burned out
- 86% say the reason for burn out is the attacks by Wynne and Hoskins
- Ontario physician suicide rates twice the general population average and rising in last year
- Burnout is a symptom of the underlying pathology – system wide failure, lack of funding, more clerical work, increased patient demands, increased scrutiny - Bill 41 and Bill 87, rising acuity of patient care
- The enthusiasm for service is gone, love for human kind is being destroyed and the want to do what is right for your patient sucked out of you by a government bureaucracy that does not care about you or your patient
- Wynne plans on balancing her budget on the backs of doctors with no patient accountability
- Falk report (2011, *Fiscal Sustainability and the Transformation of Canada's Healthcare System*) still evident – when in trouble create more chaos and see if some good comes from it
- **Trust between profession ,government and OMA Central remains broken – Walley and April 1 , 2016 negotiations process and Hoskins attacks on the profession**

MoH PSA Proposal (December 2016): *Background*

- Ontario Health and Long-Term Care Minister Eric Hoskins delivered a new PSA "proposal" to the OMA on Wednesday, December 14th at 8am then publicized the proposal through the media at 9am.
- **Three-year plan** to manage the Physician Services Budget (PSB); its guiding principles are:
  - Responsible Management of the PSB (*by underfunding annual increases and maintaining a hard cap*)
  - Strengthening Primary Care (*by investing more $$ in FHN & FHO models adding more new grads*)
  - Relativity (CANDI) (*by reducing specialists' fee codes and implementing high biller claw-backs*)
- This proposal actually amounts to **a PSB reduction of $971 million** over a four-year period compared to the tPSA, which was rejected in August 2016.

MoH PSA Proposal (December 2016): *Highlights*

- 2.5% annual increase to PSB; comprehensive primary care model payments would be increased by 1.4% annually

- Cardiology fee code cuts (over three-years):
  - Cardiac Diagnostics (includes Echo) = $16,682,091 (*10% reduction*)
  - No further reduction to ECG proposed

- Restoration of the E078 CHF code:
  - "The ministry proposes to introduce a new premium for Cardiology, Internal Medicine and Gastroenterology specifically for complex congestive heart failure and liver cirrhosis."
  - MOH use OAC definition of CHF patient (2015)?

Hoskins December 2016 Proposal

3a. MODERNIZE SCHEDULE OF BENEFITS

i. **Fee Code Reduction Proposals**

- Opportunities for fee code reductions exist where technology has enabled greater efficiencies and volume of services which has resulted in over-valued fee codes.

	Reduction	Savings *
Diagnostic X-Rays	10.0%	$19,956,328
Diagnostic CT/MRI	10.0%	$28,737,361
Cardiac Diagnostics (includes Echo)	10.0%	$16,682,091
Cataract	10.0%	$5,805,174
Laser Eye Procedures	10.0%	$4,512,773
Total		**$75,693,727**

48.6 million

10.3 million

3b. PROGRESSIVE DISCOUNTS

- Progressive Discounts on FFS billings for the the professional component of any insured service in excess of $1M is proposed.
  - 10% on billings between $1M and $2M
  - 20% on billings $2M and over

<$1M	$1M-$2M	>$2M	Total Discount*
0%	10%	20%	$19.4M

Another 26%

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Cardiac Diagnostic Fee Code Cuts (includes Echo) – slide 1 of 2

G112A	Dipyramidole Thallium stress test	G283A	Single chamber reprogramming including electrocardiography	G518A	Phlebography and/or carotid pulse tracing (with systolic time intervals)
G120A	Impedance plethysmography	G307A	Pacemaker pulse wave analysis including electrocardiography	G571A	Complete Study - 1 and 2 dimensions
G126A	Digital photoplethysmography, per extremity	G319A	Maximal stress ECG	***G572A***	***Complete study (P2) - Discontinued in Oct. 2015***
G175A	Insertion of oesophageal electrode in monitoring position	G320A	Interpretation of telephone transmitted ECG rhythm strip	G575A	Focused echo study
G180A	Dual chamber reprogramming including electrocardiography	G517A	Ankle pressure determination, includes calculation of the ankle-arm index systolic pressure ratio	***G578A***	***Cardiac Doppler – Discontinued in Oct. 2015***

Cardiac Diagnostic Fee Code Cuts (includes Echo) – 2 of 2

G579A	Saline study (including venipuncture, to G571, G574, G581 or G584.	G649A	Holter Level 1 - professional component - 14 or more days recording	G658A	Holter Level 1 - professional component - 36 to 59 hours recording
G580A	Insertion of oesophageal transducer	G650A	Holter Level 1 - professional component - 12 to 35 hours recording	G659A	Holter Level 1 - professional component - 60 hours to 13 days recording
G581A	Transoesophageal echocardiography	G653A	Holter Level 2 - - professional component - 12 to 35 hours recording	G660A	Event recorder
G583A	Stress study	G656A	Holter Level 2 - professional component - 36 to 59 hours recording	G690A	Cardiac loop monitoring (per 14 day test)
G584A	***Stress study (P2) - Discontinued in Oct. 2015***	G657A	Holter Level 2 - professional component - 60 hours to 13 days recording		

Diagnostic CT/MRI Fee Code Cuts (Cardiology)

X234C – CT colonography
X235C – CT cardio-thoracic
X400C – MRI - Head without IV contrast
X401C – MRI - Head with IV contrast
X402C – MRI - Complex head
X403C – MRI - Neck without IV contrast
X404C – MRI - Neck with IV contrast
X405C – MRI- Complex head with IV contrast
X406C – MRI - Thorax without IV contrast
X407C – MRI - Thorax with IV contrast
X408C – MRI - Complex head with and without IV contrast
X409C – MRI - Abdomen without IV contrast
X410C – MRI - Abdomen with IV contrast
X412C – MRI - Extremities without IV contrast
X413C – MRI - Extremities with IV contrast
X415C – MRI - Spine(s) without IV contrast
X416C – MRI - Spine(s) with IV contrast
X417C – MRI - Spine(s) Three dimensional CT acquisition sequencing...
X421C – MRI - Head multislice sequence
X425C – MRI - Head, repeat
X431C – MRI - Neck multislice sequence
X435C – MRI - Neck, repeat

All MRI

X441C – Thorax, multislice sequence
X445C – Thorax, repeat
X446C – Breast – unilateral or bilateral multislice sequence
X447C – Breast, repeat
X451C – Abdomen, multislice sequence
X455C – Abdomen, repeat
X461C – Pelvis, multislice sequence
X465C – Pelvis, repeat
X471C – Extremity or joint(s), multislice sequence (one)
X475C – Extremity or joint(s), repeat
X480C – MRI guidance of biopsy or lesion ablation, breast, unilateral
X481C – MRI guidance of biopsy or lesion ablation, internal organ
X486C – Complex spine (2 or more non-adjoining seqments), when cardiac gating is performed (must include application of chest electrodes and ECG interpretation)
X487C - Complex spine (2 or more non-adjoining seqments), when gadolinium is used
X488C – Extremity or joint(s), multislice sequence (two or more)
X489C - Extremity or joint(s), multislice sequence (two or more), repeat
X490C – Limited spine (one segment), multislice sequence
X492C - Limited spine (one segment), repeat
X493C – Intermediate spine (2 adjoining segments), multislice sequence
X495C – Intermediate spine (2 adjoining segments), repeat
X496C – Complex spine (2 or more non-adjoining segments), multislice sequence
X498C - Complex spine (2 or more non-adjoining segments), repeat
X499C - Complex spine (2 or more non-adjoining segments), Three Dimensional MRI acquisition sequence, including post-processing

Fee cuts

- Echocardiography
- Stress testing
- Pacemaking non invasive codes (programming)
- CT/MRI

No cuts

- ECG
- Nuclear cardiology
- PET
- Procedures – EP , cath , hospital work ,consultation and visit fees

MoH PSA Proposal (December 2016): *Highlights Cont'd*

- Modernization of the Schedule of Benefits would include the following:
  - A comprehensive review and modernization of fee codes
  - An evaluation of codes that have not been used in many years
  - A review of services where technology has enabled increases in volume
  - A review of the relative value of codes within a speciality
  - An analysis of relativity across specialities consistent with OMA's Comparison of Average Net Daily Income (CANDI) - used to assess relativity in physician compensation

- Progressive discounts on FFS billings for the **professional component** of any insured service in excess of $1M.
  - 10% on billings between $1M and $2M
  - 20% on billings $2M and over

MoH PSA Proposal (December 2016): *What Is Not In There*

- Any commitment to, or discussion of, binding arbitration.
- An indication of financial responsibility for annual PSB overages (*should they occur*).
- No relief for the increased population growth in Ontario and the services associated with it (government wants the doctors to pay for it).
- A recognition that the proposed annual increases will not be enough to cover the expected annual cost increases to the healthcare system based on aging and demographic growth forecasts.
  - Yet, Premier Wynne & Finance Minister Sousa have asked for annual increases of 5.2% in the Canada Health Transfer from the federal government.
  - OAC hired economist Jack Carr predicted in August 2016 growth rate between 4% and 5% an government offered 2.5% (August 2016 TPSA additional deficit would be $0.9 - $2.2 billion over the contract)

Cardiology Cuts (2012-17)

Service	Description	Effective	% Cut
Various (incl. ECG; pre-op echo; cardiac catheterization & others)	Reduction in fees & harmonization of codes	FY 2012/13	10%
Congestive Heart Failure Patient Care	Chronic Disease Assessment Code (E078) eliminated for cardiologists treating patients with congestive heart failure	April 2015	100%
Echocardiography and Nuclear Cardiology Procedures	Two professional fees combined and reduced for various types of echocardiography and nuclear cardiology procedures	October 2015	20% of previous P1 fee
All cardiology procedures and services	"Across the Board" discount applied to all OHIP physician billings (incl. professional and technical fees)	April 2013 (0.5%) February 2015 (2.65%) October 2015 (1.3%)	4.45%
Global Billing Cap	The government to claw back any OHIP physician services budget spending that exceeds a 1.25% increase over previous year	April 2016	Unknown amount

State of the Nation: February 2017 (Part 1)

- Hoskins says he is concerned about the sustainability of the province's health-care system.
- The concerns come as Ontario draws up its 2017-18 budget — one it has promised to balance for the first time in many years, while still increasing spending in the more than $50-billion health file.
- Premier Kathleen Wynne and Health Minister Eric Hoskins announced Tuesday that the province would invest an unspecified amount — somewhere between $50 million and $100 million — in a facility at Sunnybrook Health Sciences Centre that will offer treatment such as stem cell transplants for blood cancers.
- Ontario government believes that is spending enough and making the "right investments"
- Ontario Chamber of Commerce member survey found that just 14 per cent are confident in the sustainability of the system.

State of the Nation: February 2017 (Part 2)

- Hoskins and Wynne both point their finger at the federal government. Feds have offered a 3.5 per cent annual increase with additional money for home care and mental health, but Ontario has asked for a 5.2-per-cent increase.
- Yet, the latest Ministry proposal (December 2016), Hoskins offered doctors less than half what they asked the feds for and was rejected by profession
- The government has limited growth in the health sector over the past few years to about 2 per cent, largely through cutting payments to doctors and freezing hospitals' base operating funding — though in the fall economic update it added $140 million in new health spending for hospitals.
- But the financial accountability office said Ontario is set to be over this fiscal year's target by $400 million, rising to $900 million next year and $1.5 billion in 2018-19.
- 140,000 people come to Ontario each year – no funding for health to accommodate
- Private deal AFP for all academics may be in the works – take them out of Fee for service

Special Council Meeting (SCM) Jan. 29, 2017:
Excerpt from OMA Council members' letter to Tom Magyarody (Jan. 11, 2017)

Over the past 18 months, Council Delegates have identified substantial concerns and issues with OMA strategy, structure and function. Using the proper channels, delegates raised these concerns with respective Board Directors. However, these concerns were dismissed or deferred. These concerns have been compiled for your review in the attached document, "Grievances against OMA Board Executive Committee".

Despite multiple requests and opportunities for course-correction by the OMA Board, there has been no substantive change. The unfortunate consequence of such risk-averse and conflict-avoidant behaviour has been poor leadership. Poor leadership has contributed to an environment where physicians are routinely marginalized, disrespected, insulted and ignored by the current government. The profession desperately needs unity, and unity will only be achieved with strong, effective, and determined leadership. Since the OMA Board has proven itself unable to lead change, OMA Council must exercise its duty to govern.

SCM 2017:
Grievances Against OMA Board Executive Committee

GRIEVANCES AGAINST OMA BOARD EXECUTIVE COMMITTEE

Special Council Meeting, 2017

Submitted by a group of engaged OMA members

Concerns Regarding:

1. The new negotiations advisors (Howard Goldblatt and Steven Barrett)
2. Negotiations Advisor Selection Committee
3. PR campaign on Bill 41, (formerly Bill 210)
4. The response to Bill 87, *Protecting Patients A*ct
5. Lack of expediency in contracting with a new public relations firm
6. The Pricewaterhouse Coopers (PwC) Audit
7. The OMA Censoring email
8. OMA waste of member funds
9. Grassroots movements not receiving timely response or minimal support
10. OMA Social Media efforts still focusing on extraneous issues
11. OMA Board's refusal to institute proper governance
12. How the OMA Board has handled Navigator
13. The OMA Board's role in initiating the "Yes" Campaign for the tPSA

To access a copy of "Grievances against OMA Board Executive Committee" visit: http://bit.ly/2jUJiQy

25 OMA Council Members Behind the SCM & Motions

- Dr. Audrey Karlinsky
- Dr. Geoffrey Forbes
- Dr. Paul Hacker
- Dr. Ernest Hajcsar
- Dr. Clay Hammett
- Dr. Samantha Hill
- Dr. Michael Hiscox
- Dr. Nikolina Mizdrak
- Dr. Michelle Jacobson
- Dr. Hariclia Johnston
- Dr. V.S. Kapoor
- Dr. Natalie Leahy
- Dr. Mark Linder
- Dr. Cathy Mastrogiacomo
- Dr. M.S. Ghandi
- Dr. E. Samson
- Dr. Nadia Alam
- Dr. Aly Abdulla
- Dr. Greg Baran
- Dr. Raymond Chan
- Dr. Paul Wong
- Dr. Silvy Mathew
- Dr. Roozbeh Matin
- Dr. Rajinder Rathee
- Dr. Lisa Salamon

SCM 2017: *Motion #1*

- That OMA Council express to the OMA Executive Committee that Council has lost confidence in the leadership provided by the Executive.
  - Result: 55% In Favour; 45% Against
  - This Motion passed; it did not need to achieve a 2/3rds majority threshold

OMA media release (January 29, 2017): “Today, at a Special Meeting of Council, doctors in Ontario affirmed their confidence (?) in the elected leaders of the Ontario Medical Association (OMA).”

SCM 2017: *Motion #2*

- That, pursuant to 10:5:4 of the OMA Bylaws, the OMA Council does hereby immediately remove from the Board of Directors:
  - Dr. Virginia Walley; Dr. Stephen Chris; Dr. Gail Beck; Dr. James Stewart; Dr. Atul Kapur; Dr. Michael Toth (voted on individually)

- All Motions failed as they did not achieve the 2/3rds majority threshold required.

SCM 2017:
End of Day Summary - Jan. 29, 2017

- OMA Board of Directors and Executive remained intact
- Binding Arbitration: Not to be completed before next TPSA (violates August 14, 2016 resolution)
- Consultation with Physician Leaders (i.e. Section Chairs) on OHIP negotiations with government: Non-existent until then
- Job Action: Discussed but no concrete proposals or timeframe provided. PAWG created and will be in touch
- Board member divulged inadvertently in a breakout session, that they knew that more cuts are coming on April 1, 2017

SCM 2017:
Coalition of Ontario Doctors Response (includes COD)

- Issued media release calling on the OMA Executive to do the right and honourable thing: **Resign**.
- Considering options including calling another General Meeting of Members (GMOM) to deal with leadership issues.
- Visit www.coalitionofontariodoctors.ca to learn more.

UNPRECEDENTED LOSS OF CONFIDENCE MOTION IN OMA EXECUTIVE PASSED

OMA Knowingly Misleads Doctors and Public about Leadership Crisis

For the first time in OMA history, Council has passed a resolution declaring it has lost confidence in the OMA Executive Committee by a 55% vote. Despite that, an OMA communication released immediately after the meeting knowingly lied about Council members who had expressed a clear non-confidence motion against the Executive. In the opening sentence of the OMA news release it shockingly stated, "doctors in Ontario affirmed their confidence in the elected leaders of the OMA".

The OMA's untruthful statement following the non-confidence motion is inexcusable. It further erodes an already abysmal level of confidence that doctors have in the credibility of the OMA's current leaders, who have repeatedly refused to step down.

The OMA Executive have over-stayed their welcome despite the:

- **63% rejection of a grossly flawed tPSA endorsed by this Executive**
- **3 Court decisions against their deliberate efforts to thwart a fair PSA vote**
- **84.5% of doctors do not trust the OMA leadership's handling of issues post-PSA**
- **84% of doctors have no confidence in OMA leadership's ability to negotiate a satisfactory agreement with the MOH**
- **73% of the membership who felt the OMA President & Executive should resign**

Ontario Association of Cardiologists

February 6, 2017: Events & Implications

- In a surprise move, OMA executive committee resigns (Drs. Walley, Chris, Beck, Stewart, Kapur, & Toth) but stay on OMA Board of Directors
- Dr. Laurie Colman appointed as OMA board spokesman until May 2017 Council meeting
- **Same old ideas remain; deck chairs on Titanic shuffled again**
- COD and Coalition calling for the executive committee to leave the Board. Only then will trust be restored

February 6, 2017: Events & Implications Cont'd

- Conflict of Interest Issues re: New OHIP Negotiations Advisors (Goldblatt and Barrett) remain unresolved
  - Legal action is taking place this week against the OMA Executive Committee in Superior Court of Justice (Ontario)

- Evidence exists that OMA senior leadership had direct knowledge of Wynne government plans to implement unilateral cuts on April 1st, yet did not disclose this to grassroots members or section Chairs

Political Landscape:
Winter/Spring 2017

- Wynne government focused on eliminating deficit by 2017-18
  - Next provincial election: June 2018
- Pressure is on to keep health care spending (esp. physician services budget) “under control”
- August 2016 tPSA and December 2016 proposal lacked appropriate funding to maintain health care standards in Ontario (Jack Carr report)
- Unilateral cuts a distinct possibility in near future (April 2017)
  - MOHLTC proposal (December 2016): Cut cardiac diagnostic services fees by 10% ($16.6 million) & implement income relativity and high biller premium

Strategic Next Steps

- Profession needs to present a strong, united front to government against prospective physician services budget cuts.
  - Cardiologists are required now to take a leadership role on job action and other related options to protect current patient access to cardiac care
- Work with Opposition parties to secure support/commitments in lead-up to next provincial election.
- OAC to fight for restoration & fair remuneration for ECG, heart failure treatment (E078) and other cardiac services.
- OAC to assume leadership role in tripartite working group focused on improving quality, cost and utilization based on Auditor General's *2016 Annual Report.*

Job Action ideas to date

- Close physician offices and/or community/hospital outpatient clinics one day/week. (*Supported by 57.6% of survey respondents*)
- Send urgent patients to the emergency department
- Close physician offices and/or community/hospital outpatient clinics indefinitely. (*Supported by 30.3% of survey respondents*)
- Instruct patients if they wish to be seen to go to the emergency department
- Stop seeing elective new referrals in your office. (*Supported by 59.1% of survey respondents*)
- Send all urgent referrals sent to the emergency department

- All cardiologists and cardiology-focused internists should resign from hospital committees.
- cardiologists and internists should only interpret ECGs performed on patients who are under their care. Otherwise ECG interpretation should require formal consultation. " I will be happy to see your patient in consultation and to interpret the ECG "...
- Establish free temporary clinics staffed by volunteer cardiologists, much as lawyers have recently done at Pearson Airport to advise people caught in the chaos caused by the Trump travel ban. I was impressed by this initiative as it puts lawyers in a different light. A similar initiative would be good public relations for doctors too. It would shame the government for branding us as selfish and greedy overpaid specialists.
- Dr John Parker is heading this up for cardiology

Summary

- SCM 2017 failed to deliver initially meaningful change in OMA leadership and overall strategic approach.
  - Impact of message sent by grassroots members led to change Feb. 6, 2017
  - Extent of change to OMA Board and Executive is fluid as of today
- Cardiology services remain vulnerable to further budget cuts in 2017-18 due to the bias for PRIMARY CARE (all models) of both government and OMA.
- OAC membership in *Coalition of Ontario Doctors* is valuable as we stand with like-minded family doctors and specialists seeking genuine reform at OMA and fair treatment by government. (Membership>50% of OMA membership)
- OAC leveraging Auditor General's *2016 Annual Report* to assertively insert itself into government policy decision-making affecting cardiology services.

Questions/Answers

Discussion