OAC Information Webinar

Séminaire Winter Arrhythmia School

Annual Cardiac Arrhythmia Meeting
Division of Cardiology, University of Toronto
1. State of the Nation Summary

   - 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.
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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Reduction</th>
<th>Savings</th>
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<tbody>
<tr>
<td>Diagnostic X-Rays</td>
<td>10.0%</td>
<td>$19,856,328</td>
</tr>
<tr>
<td>Diagnostic CT/MRI</td>
<td>10.0%</td>
<td>$28,737,361</td>
</tr>
<tr>
<td>Cardiac Diagnostics (includes Echo)</td>
<td>10.0%</td>
<td>$16,682,091</td>
</tr>
<tr>
<td>Cataract</td>
<td>10.0%</td>
<td>$5,808,174</td>
</tr>
<tr>
<td>Laser Eye Procedures</td>
<td>10.0%</td>
<td>$4,512,773</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$75,693,727</strong></td>
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</tbody>
</table>

48.6 million

3b. PROGRESSIVE DISCOUNTS

- Progressive Discounts on FFS billings for 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

<table>
<thead>
<tr>
<th>Billings Range</th>
<th>Discount</th>
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<tbody>
<tr>
<td>&lt;$1M</td>
<td>0%</td>
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<tr>
<td>$1M-$2M</td>
<td>10%</td>
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<tr>
<td>&gt;$2M</td>
<td>20%</td>
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<tr>
<td><strong>Total Discount</strong></td>
<td><strong>$19.4M</strong></td>
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</table>

Another 26%

10.3 million
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G112A</td>
<td>Dipyramidole Thallium stress test</td>
<td>G283A</td>
<td>Single chamber reprogramming including electrocardiography</td>
<td>G518A</td>
<td>Phlebography and/or carotid pulse tracing (with systolic time intervals)</td>
</tr>
<tr>
<td>G120A</td>
<td>Impedance plethysmography</td>
<td>G307A</td>
<td>Pacemaker pulse wave analysis including electrocardiography</td>
<td>G571A</td>
<td>Complete Study - 1 and 2 dimensions</td>
</tr>
<tr>
<td>G126A</td>
<td>Digital photoplethysmography, per extremity</td>
<td>G319A</td>
<td>Maximal stress ECG</td>
<td>G572A</td>
<td>Complete study (P2) - Discontinued in Oct. 2015</td>
</tr>
<tr>
<td>G175A</td>
<td>Insertion of oesophageal electrode in monitoring position</td>
<td>G320A</td>
<td>Interpretation of telephone transmitted ECG rhythm strip</td>
<td>G575A</td>
<td>Focused echo study</td>
</tr>
<tr>
<td>G180A</td>
<td>Dual chamber reprogramming including electrocardiography</td>
<td>G517A</td>
<td>Ankle pressure determination, includes calculation of the ankle-arm index systolic pressure ratio</td>
<td>G578A</td>
<td>Cardiac Doppler - Discontinued in Oct. 2015</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>G579A</td>
<td><strong>Saline study</strong> (including venipuncture, to G571, G574, G581 or G584).</td>
<td>G649A</td>
<td>Holter Level 1 - professional component - 14 or more days recording</td>
<td>G658A</td>
<td>Holter Level 1 - professional component - 36 to 59 hours recording</td>
</tr>
<tr>
<td>G580A</td>
<td><strong>Insertion of oesophageal transducer</strong></td>
<td>G650A</td>
<td>Holter Level 1 - professional component - 12 to 35 hours recording</td>
<td>G659A</td>
<td>Holter Level 1 - professional component - 60 hours to 13 days recording</td>
</tr>
<tr>
<td>G581A</td>
<td><strong>Transoesophageal echocardiography</strong></td>
<td>G653A</td>
<td>Holter Level 2 - professional component - 12 to 35 hours recording</td>
<td>G660A</td>
<td>Event recorder</td>
</tr>
<tr>
<td>G583A</td>
<td><strong>Stress study</strong></td>
<td>G656A</td>
<td>Holter Level 2 - professional component - 36 to 59 hours recording</td>
<td>G690A</td>
<td>Cardiac loop monitoring (per 14 day test)</td>
</tr>
<tr>
<td>G584A</td>
<td><strong>Stress study (P2) - Discontinued in Oct. 2015</strong></td>
<td>G657A</td>
<td>Holter Level 2 - professional component - 60 hours to 13 days recording</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 segments), when cardiac gating is performed (must include application of chest electrodes and ECG interpretation)
X487C – Complex spine (2 or more non-adjoining segments), 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
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 specialty
- An analysis of relativity across specialties 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)

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