

**SEAMO
Task Group on Allocation System Review**

- Report and Recommendations -

**As amended and approved by the SEAMO Governing Committee
2010 February 17**

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SEAMO Task Group on Allocation System Review

- Report and Recommendations -

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INTRODUCTION

Task Group History

On June 2 2009, SEAMO signatories held a retreat to consider the method by which SEAMO allocates its resources. Following the retreat, the Signatories created Task Group on Allocation System Review (TGASR). TGASR was formed and charged with the review of allocation practices and with developing recommendations for an amended system consistent with SEAMO principles (Terms of Reference are found in Appendix A).

Task Group Membership

The Task Group, appointed by the Signatories, is composed of five members:

- Hugh MacDonald (Chair)
- Sherif El-Defrawy
- Karen Smith
- Iain Young
- David Zelt

In conducting its work, the Task Group was assisted by:

- Bernita Drenth
- John Jeffrey
- John Lott
- Paul Rosenbaum
- Sally Stanton

Process and Consultations

The Task Group met on a weekly basis between late August and December 2009. It sought advice within and outside of SEAMO to assist in its deliberations:

- **SEAMO Reports** - TGASR reviewed previous SEAMO reports applicable to its work. In particular, the reports of the Advisory Committee on Departmental Deliverables (ACDD) whose recommendations have been accepted by the Governing Committee, formed a framework from which the Task Group began its work. TGASR considered also the Task Group on Operationalizing Principles of SEAMO, the SEAMO Resources Committee reports, the Report on the Postgraduate Medical Education Workforce Survey and others.

- **SEAMO Clinical Heads** – Approximately mid-point in its work, the TGASR distributed a set of draft principles and concepts to all Clinical Heads and sought advice and feedback. Written feedback was received back from most and was generally supportive of the Task Group's direction.
- **Presentations to TGASR** – TGASR received informative presentations regarding undergraduate medical education (Dr. Sanfilippo), postgraduate education (Dr. Flynn) and research (Dr. Deeley).
- **Provincial AHSC AFP Initiative** - The Task Group examined the provincial AHSC AFP methodology and background work associated with that initiative including the Accountability Expert Panel report.
- **Other Jurisdictions** - A literature review was conducted of trends in faculty practice plan allocation models and other information relevant to TGASR's deliberations.
- **Ontario AHSCs** - Practice plan leadership at a number of other Ontario AHSCs including the Hospital for Sick Children, University Health Network and St. Michael's Hospital were consulted to obtain information about allocation systems in other academic physician groups.
- **Departmental consultation** – Following receipt of the Task Group Report, copies of the Report were provided to all SEAMO-funded physicians. Department Heads were asked to review the Report with their members and to provide comments and questions to the Task Group. On receipt of these comments, the Task Group continued to meet and prepared an *Addendum* to the Report. This *Addendum* provided additional commentary and suggested two alterations to the recommendations.

This Report, in its amended form, and the attached *Addendum* were approved by the SEAMO Governing Committee on 2010 February 17. Both documents form a single approved approach to allocation of resources and accountability.

FRAMEWORK

The work of the Task Group represents a significant step in SEAMO's ongoing and iterative process of pursuing more effective and transparent governance and accountability. The Task Group's goal was an allocation system designed to foster strong performance and to better align funding with outcomes. Excellence in patient care, teaching and research are objectives of this system.

The following framework for SEAMO's allocation system is recommended:

- **Changes to the allocation system should build off direction and recommendations previously accepted by the Governing Committee including those contained in the March 2008 ACDD and other SEAMO reports.**

Key ACDD principles applicable to the work of this committee included:

- Approaches to departmental accountability must be iterative.
- The focus for SEAMO is on departmental activity, not individuals.
- Departments should be assisted in developing robust systems for measuring and influencing the work of individual members of the department.
- Measurement and accountability should rely on data that are readily available, centrally collectable, standardized, reliable and applicable to most departments.
- Measures should represent core deliverables in the three domains: patient care, education and research.

The TGASR also considered methodologies currently in place to distribute AHSC AFP funds. In the area of academic activity, the TGASR focused on measurement systems in place or under development.

- **The recommended approach should align with the provincial AHSC AFP template and the direction of the AHSC AFP initiative where applicable / appropriate.**

The Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) have signaled their intent to consolidate and standardize the number and variability of academic physician alternate funding arrangements (AFA). At SEAMO's inception, its funding plan was unique in the province where the vast majority of academic physicians were remunerated on a fee-for-service basis. Today, in contrast, virtually all academic physicians in Ontario belong to one AFA or another.

The Ministry has communicated its goal to improve consistency between these arrangements and to focus more strongly on accountability and measurable "value for money". The Ministry is interested in pursuing blended models of payment that provide a stable base of funding which supports clinical and academic effort not recognized or remunerated appropriately through the Schedule of Benefits while also maintaining an incentive basis of payment to stimulate and reward productivity. SEAMO has seen this transition begin to take place in the form of increases to its funding being attached to claims submission.

- **The allocation approach should measure and allocate on the basis of each of SEAMO's core mandates: clinical care, teaching and research.**

Each core mandate should be assigned objectives, measures and incentives/risk.

Objectives to support SEAMO's clinical mandate include:

- To better track and account for services being provided;
- To improve alignment with SEAMO core deliverables; and,
- To encourage productivity and appropriate service mix.

To support SEAMO's academic mandate the goal should be to meet required teaching deliverables while focusing on advancing SEAMO's research profile.

- **Core deliverables should be defined at the departmental level. These core deliverables, both clinical and academic, must be aligned with the priorities of SEAMO and of the hospital and university Signatories.**

The allocation methodology should be at the level of the department and/or division, not individual physicians.

The university and hospitals should define for all clinical units their program requirements and expectations.

A SEAMO Deliverables Committee should be established, separate from the Resources Committee and reporting to the Governing Committee. The Deliverables Committee would receive program requirements and expectations and use them to define core deliverables in consultation with department heads. Once accepted by the Governing Committee, these would be the expectations against which performance is measured. The Deliverables Committee would assign fee penetration expectations to each department as well as a set of core deliverables to ensure role expectations are being met. The committee would re-evaluate deliverable expectations, adjudicate exceptions and disputes and assist departments in successfully meeting their core deliverables.

- **While core deliverables should encompass all domains, measures should be selective and representative.**

Measurement should avoid complexity and should use, wherever possible, existing data and reporting systems. Clinical deliverables must include measures of activity based on claims submission, as this is the metric that will be relied on externally. However, it is recognized that fee schedule penetration on its own is an inadequate measure of productivity and service profile. Deliverables and their measurement must include the role of each clinical unit and recognition of the need for efficient and effective patient care.

- **Minimum practice plan standards are necessary to support a robust and transparent allocation system.**

The Task Group reaffirmed SEAMO's responsibility for allocation of funds to departments and the departments' responsibility to then allocate to individuals. Departments are, and should remain, ultimately responsible for management and

oversight of their members' roles, responsibilities and activities. Nevertheless, the Task Group believes that minimum standards for departmental practice plans should be in place to ensure that they are sufficiently robust – and there is basic consistency between them – to enable SEAMO's collective mandate to be met.

Centralized reporting systems appear to be a necessary component of a robust system of accountability.

- **Moving to an allocation approach based in SEAMO-level goals and measures will not be accomplished in one step.**

The initial allocation methodology will provide centralized data and shared learnings to support a sustainable allocation system. As a first and fundamental step, meeting core clinical deliverables will impact a department's level of funding. In the longer term, core academic deliverables will impact a departments' level of funding. The new system of allocation should be fully implemented by the end of 2011-2012.

- **Funding will be clearly linked to output and outcome.**

Funding sources used to support this methodology should be linked to aspects of the methodology that relate to them: i.e. clinical funding for clinical deliverables. Therefore the notional departmental base funding should be notionally split into clinical and academic to support each core mandate.

Stable base funding sources, not variable funds that change or may be temporary, should be used to support SEAMO-driven goals and measures. Provincial AHSC AFP Phase III funds should be used to recognize and support specific SEAMO priorities such as research. Other variable sources of funding should continue to be flowed separately but used to measure and inform core deliverables.

Although university funding is not SEAMO controlled, it is recommended that the Medical School move from an allocation approach that appears to be largely historical, to one which measurably supports academic activity.

- **Where there is a gap between expected versus actual activity, corrective action will be taken by SEAMO.**

Corrective action could include ensuring adequate resources are available or temporary 'holdback' of funds while the gap in activity is addressed. Incentives should also be built into the methodology – for example, exceeding productivity goals.

- **The hospitals and university must define clearly and in a timely fashion their program needs.**

In order to establish core deliverables with which to measure performance, SEAMO must understand the institutions' program requirements.

- **The new allocation system should support a concentrated and shared focus on academic excellence.**

This Academic Health Sciences Centre (AHSC) must support and enhance its academic programs which lie at the heart of its activities. AHSCs in Ontario are distinguished by the presence of programs in medical education and research. Recruitment of clinical faculty, funding, indeed the identity of the centre, is dependent on these activities.

TGASR believes strongly that research should be a priority and, as such, central allocation in support of research is desirable. SEAMO has not had a central research strategy supported by targeted funding. Funding has been to individual departments and it has been the responsibility of the departments to allocate internally to support their research strategy. This should continue. The addition of a central funding strategy that allows for recruitment of clinician-scientists will help augment existing efforts. It is proposed that, in addition to department-driven research, SEAMO also create a central, competitive research fund to be used to recruit clinician-scientists.

TGASR also believes that a strong central investment in focused educational leadership is required. Recent accreditation experience demonstrates the need for a dedicated investment to oversee curriculum redevelopment, promote academic excellence across specialties and support ongoing departmental responsibilities.

LINKING FUNDING TO OUTCOME

The recommendations of the TGASR regarding an improved and more accountable and performance-oriented allocation system are summarized in the following chart which itemizes the funding streams flowing into SEAMO and how they should be linked to appropriate accountabilities and shared SEAMO priorities.

SEAMO ACCOUNTABLE FUNDS				
Base Funding		Variable AHSC AFP Funding		
<p>Applicable Funding:</p> <ul style="list-style-type: none"> • SEAMO Notional Base Departmental Funding • Flow through (i.e. price change funding) • 3% Retroactive (i.e. retroactive price change) 		<p>Applicable Funding:</p> <ul style="list-style-type: none"> • AHSC AFP Academic Fund (\$5.6M) • AHSC AFP Clinical Fund (\$5M) 		
Notional Clinical Funding 70% of Base	Notional Academic Funding 30% of Base	Medical Education Development Fund	Strategic Research Development Fund	Clinical Fund
<ul style="list-style-type: none"> • Department fee schedule penetration minimum (70% or more with exceptions TBD) <p><i>AND</i></p> <ul style="list-style-type: none"> • Department-level core deliverables met: <ul style="list-style-type: none"> • Mix • Market-share • Efficiency 	<ul style="list-style-type: none"> • UGE hours as assigned • PGE hours as measured <p><i>AND</i></p> <ul style="list-style-type: none"> • Research productivity as measured 	<ul style="list-style-type: none"> • SEAMO fund to recruit faculty consultancy positions • \$1M in year 1*; \$2M in years following 	<ul style="list-style-type: none"> • SEAMO competitive fund to recruit and support clinician-scientists • \$1.8M in year 1*; \$3.6M after 	<ul style="list-style-type: none"> • Still to be determined
<p><i>*In year 1, balance of \$5.6 to be distributed using current Phase III funding methodology</i></p>				

OTHER FUNDS	
Separate Flow to Departments Maintained	Non-SEAMO Funds Flow Same
<p>Applicable Funding:</p> <ul style="list-style-type: none"> • Shadow billing premium (10%) • Wait time funding • Specialty Review Funds 	<p>Applicable Funding:</p> <ul style="list-style-type: none"> • Out-of-scope payments • Hospital On Call Coverage funding • GFT hard funding (with recommendation that Medical School realign this funding moving forward)

All SEAMO accountable funds should be 'at risk' to support core SEAMO deliverables, both clinical and academic. Variable AHSC AFP funding, on the other hand, should be used for recognition and incentive. The Task Group recommends that other variable sources of funding should continue to be flowed separately to departments, but should be used to measure and inform core deliverables.

It is recognized that a significant change in the method of allocation to departments requires time for adjustment. It is proposed that this model be phased in with full implementation by fiscal year 2011/12.

I. SEAMO ACCOUNTABLE FUNDS

A. BASE FUNDING

Base Funding To Be Assigned As "SEAMO Accountable"

TGASR recommends that base sources of funding that should be put 'at risk' and also used to calculate fee-for-service (FFS) penetration include:

- **Notional base departmental funding**

Notional base departmental funding represents the AFP's base level of funding that was established based on 2005 price and levels of activity. Notional base funding amounts to approximately 63% of SEAMO's total funding.

- **Flow through ("L" code) funding and 3% retroactive funding**

Flow through funding reflects the impact of changes in price since 2005. If total activity is measured based on price x volume, then flow through funding is part of establishing price. Flow through funding impacts each specialty differently but is based on a consistent provincial-level approach.

The 3% funding recognizing retroactive price changes should also be included as it too was a flow through price change.

Funding that should *not* be included to express a department's clinical activity level:

- **Specialty Review Funding (SRF)**

SRF funding going to neurosurgery, surgical oncology and family medicine should not be included as it is (i) based on provincial specialty methodologies; (ii) not stable or base funding; and (iii) top-up funding (i.e. not based on providing additional or defined volume).

- **Pathology** (funded under a separate agreement)

- **Gynaecology Oncology** (funded under a separate agreement)

- **Rideau Regional**
- **Phase III clinical repair funds**

The repair portion, as allocated by SEAMO, of the Phase III repair funds constitute a source of income replacement or top-up to current levels of activity using a provincial methodology that is not directly applicable to SEAMO internally and not reflective of additional clinical activity.

- **GFT hard funding**

After much consideration, the TGASR concluded that GFT hard funding, which comprises roughly 4% of total funding to departments, should not be included in the calculation of base funding. SEAMO does not have control over how University funding is distributed. It is recommended to the Medical School that, on a go-forward basis, it allocate these funds for specific, updated and measurable academic purposes.

B. CORE DELIVERABLES AND BASE FUNDING

Base funding should flow to departments based on their meeting core deliverables. These core deliverables will include hospital service specific measures. Accountability and reporting will be at the level of the department. Where core deliverables are not met, funding will be adjusted as set out below.

1. Clinical Core Deliverables

Departmental core deliverables for clinical activity should be assessed against two measures: FFS penetration targets and a representative set of defined core deliverables that address role expectations:

Fee for service penetration

As previously stated, SEAMO accountable funding is notionally split into 70% clinical and 30% academic funding. This is a widely-accepted proportion to describe aggregate or total effort across a multi-specialty academic medicine group. It is used in the provincial AHSC AFP methodology and supported across jurisdictions and in a review of academic medicine literature.

FFS penetration is calculated by comparing a department's base funding to its shadow billing.

Expected FFS penetration per department will be a minimum of 70% of the SEAMO Accountable Base.

FFS penetration exceptions

Exceptions would be determined through a SEAMO process where: (i) FFS is deemed to be not adequate/appropriate to meet SEAMO defined core deliverables (external validation); (ii) there are quantifiable critical mass issues; and, (iii) there are groups already working under provincial specialty targets that set workload expectations. A different monitoring approach may be assigned to departments given an exception to the FFS penetration expectation.

Clinical groups may also be assigned targets higher as appropriate.

- **Role expectation**

Role expectation should be defined based on the following key indicators:

1. Mix of services
2. Market share by service
3. Efficiency measures

A small but representative set of core measures will be established for each department. It is recommended that a Deliverables Committee be established to support this new allocation system.

It is understood that the allocation system must be flexible and able to recognize and adapt to changing circumstances. For example, if service resources / plans as set by hospital or university change for a division or department, that group's FFS penetration target and/or core deliverables regarding role expectation may be altered.

SEAMO will continue to fund departments and will improve its accountability mechanisms at the departmental level to support this. Nevertheless, there will also be minimum expectations set at the divisional level. Understanding the variability between divisions in terms of their ability to penetrate the FFS schedule, SEAMO, through a Deliverables Committee, requires a mechanism to trigger an examination of performance at the division or service level.

Accountability for Clinical Core Deliverables

Departments will be given regular reports detailing clinical activity versus target and as well as the implications in terms of missed revenue to their department.

The Task Group recommends that accountability provisions for meeting core clinical deliverables be as follows:

- **FFS penetration**

If a department meets its minimum requirement for FFS penetration, it will receive its full share of the portion of its base funding notionally attached to clinical activity (70% of its total base funding unless exception).

In the first year (2010-2011) of this new allocation system, if a department does not meet its minimum requirement, it will be put on notice but there will be no

funding adjustment. Further, in the first year, if a department exceeds its minimum requirement it will have access to the Clinical Recognition Fund described below.

Beginning in 2011-2012, if there is a gap between the total minimum requirement amount and the total amount shadow billed during the set time period, base funding to that department should be withheld by that amount pending correction.

- **Role expectation**

Beginning in the second year (2011-2012) of this new allocation system, the TGASR recommends that 5% of each department's clinical base funding be held back and flowed based on an assessment that the department has met its core role expectation deliverables during that year. The Deliverables Committee should assess shortfalls and consequences which should, first and foremost, include steps to restore lost funding. However, the full amount held back is at risk pending a department meeting and reporting its minimal clinical deliverables.

Departments will be given regular division-level reports that include lost opportunity for income.

After 2011-2012, departmental base funding may be adjusted based on the previous two years' experience (recalibrating departmental full-time equivalent numbers for provincial reassessment / SEAMO contractual negotiations)

Family Medicine

Shadow billing payments for Family Medicine include the 10% shadow billing premium, flow through increases, and Family Health Network (FHN) clinical incentives. To ensure consistency in measurement, FHN premiums should be excluded from calculations of shadow billing.

2. Academic Core Deliverables

Academic accountability will be based in quantifiable measurement of teaching and research activity using an approach consistent across all departments and aligned with university requirements and expectations. Academic core deliverables will be expressed in total ½ days:

- **Undergraduate education**

At the request of the SEAMO Governing Committee and the Medical School, the Undergraduate Medical Education Office sets expectations for medical education for each department. These expectations include calculation of expected preparation, student contact, follow-up and leadership. These expectations are expressed in ½ days.

- **Postgraduate education**

The expectation set for each department in terms of postgraduate education should be the total ½ days using a methodology currently under development by

the Postgraduate Office. The calculation will include administrative/leadership demands of postgraduate programs based on the number of postgraduate trainees, rotations, non-clinical teaching time, evaluation and resident selection.

- **Research**

There is an explicit understanding that groups and/or individuals within a department will have varying contributions to each of the academic domains. Individual role descriptions should clearly specify the percentage of an individual's time for protected research. The aggregate FTE allocated to research by a department would then be submitted to the Deliverables Committee for approval. Approval by the Deliverables Committee would be considered in the context of the department's productivity in all other areas.

Departments will report on the allocation of time for research by individual. The expected productivity (using the Research Template now being further refined by the Research Office) will be compared to actual productivity. Funding at risk will be the shortfall.

Accountability for Academic Core Deliverables

Accountability for academic core deliverables should be as follows:

- **Undergraduate education**

TGASR recommends that, in any year, a shortfall in meeting UGE requirements result in a one-time loss of funding (corresponding to the ½ day value of education requirements not met, or the replacement cost if higher) to that department.

- **Postgraduate education**

PGE activity will be tracked by SEAMO. It is recognized that accreditation results are the fundamental measure of accountability for postgraduate medical education. In addition, it is recommended that the postgraduate office complete its calculation of departmental investment in half-days complete its work so it can be implemented in 2011-2012. In the interim, departments will report through the postgraduate office, the names of the program directors and statements confirming that these individuals were provided with the protected half-days required as these days were defined by the postgraduate office.

- **Research**

TGASR members recognize the complexity in establishing and measuring research expectations at the level of divisions and departments. However, in principle, a department's total funding should reflect total measured output, including research. As a first phase in establishing accountability for research deliverables, SEAMO will focus on greater transparency and consistent reporting. Departments will be asked to report research output using the ACDD-recommended template. At the end of an initial implementation phase for this

new allocation system, these data should be used to assess funding at risk and changes in departmental FTEs.

In order to report research activity, each department should be asked to identify the half-days of protected research time by individual. Productivity will be compared to the expected productivity as defined in the research template.

C. VARIABLE AHSC AFP FUNDING

SEAMO receives AHSC AFP funding in addition to its notional base department funding and other payments. AHSC AFP funding is considered variable, not base. In the past, SEAMO paid these funds to departments retrospectively based on activity. The TGASR recommends that AHSC AFP funding now be applied strategically.

Variable AHSC AFP funding should be allocated to:

- **AHSC AFP Academic Fund** (approximately \$5.6M)
- **AHSC AFP Clinical Fund** (Approximately \$5M).

Last year, 60% of the AHSC AFP Clinical Fund was flowed to departments as clinical repair based on the provincial AHSC AFP methodology for assessing which OHIP specialties require clinical repair to make them more competitive with their community colleagues in the same specialty. SEAMO Governing Committee has determined that future disposition of these funds be considered carefully. These funds should be allocated to support the strategic interests of this Centre. The AHSC AFP Clinical Fund will be held centrally pending a recommendation of the Executive Committee

TGASR recommends that variable AHSC AFP Academic Funding be used to support the following two initiatives, which should be phased in to allow for successful implementation:

- **Medical Education Development Fund**

The TGASR recommends that a new Medical Education Development Fund be set up as dedicated support for faculty consultancy positions.

A model to consider in establishment of this fund is the Academy at Harvard Medical School established in 2001 to provide direct support to renewing Harvard's educational mission. Other faculties (e.g. University of California at San Francisco) have followed suit since then. "By bringing together a select group of some of the school's most talented and dedicated faculty and providing direct support for their work related to education, the academy has created a unique mechanism for increasing the recognition of teaching contributions of both academic members and the teaching faculty at large, fostering educational innovation, and providing a forum for the exchange of ideas related to medical education that cross departmental and institutional lines." (*Academic Medicine* 2003: 78: 673-681)

In the first year, this fund should be \$1 million and, thereafter, should be \$2 million. In each year, unused funds should be distributed using the current SEAMO Phase III Academic Fund methodology.

- **Strategic Research Development Fund**

The TGASR recommends that a Strategic Research Development Fund be established to provide focused funding to enhance SEAMO's research profile. This would be a competitive fund for new clinician-scientists.

As non-academic hospitals become more involved in academic activity and more complex clinical work, research is becoming the defining characteristic of an academic medical centre. There are significant challenges to advancing SEAMO's collective research profile using existing strategies: small department sizes, heterogeneity across departments and lack of a central mechanism to stimulate research activity. (*Deeley presentation to TGASR*) A central fund that supports individuals (as opposed to portion of time spent on research) will foster research focus, productivity and competitiveness with other AHSCs. All other AHSCs in Ontario have a research institute and a central research fund supported by faculty members is common here and in other jurisdictions.

On the basis of a competition, the fund should provide all funding for new clinician-scientist positions. It will fund both the research time of the clinician-scientists and the clinical time that may be assigned to the individual. There must be clear research performance expectations expressed for each clinician-scientist and a termination of funding if these expectations are not met.

In the first year, this fund should be \$1.8 million and, thereafter, should be \$3.6 million. In each year, unused funds should be distributed using the current SEAMO Phase III Academic Fund methodology.

II. OTHER FUNDS

Funds that will flow separately to departments and will not be considered SEAMO-accountable funds include:

- **Shadow billing premium** (currently 10%)
- **Wait time funding**
- **Specialty Review Funding (SRF)**

SRF funding going to neurosurgery, surgical oncology and family medicine should not be included as it is (i) based on provincial specialty methodologies; (ii) not stable or base funding; and (iii) top-up funding (i.e. not based on providing additional volume).

- **GFT hard funding**

- **Non-SEAMO funds**

Non-SEAMO funds should not be considered SEAMO accountable funds. These sources of funding include:

- Out-of-scope activity
- Hospital On-Call Coverage (HOCC) payments

PRACTICE PLANS

To support the above recommended allocation system, the Task Group recommends the following minimum requirements be put in place for all SEAMO practice plans:

1. Every Department shall have a Practice Plan that is developed and approved through collegial and democratic processes. Such Practice Plans must be approved by SEAMO to ensure they meet SEAMO's requirements and the requirements of the SEAMO funding agreements.
2. Department Practice Plans shall, at a minimum, address the following:
 - Provision of clinical and academic core deliverables as required by SEAMO in accordance with the requirements of SEAMO funding agreements. The provision of clinical deliverables shall be subject to the Hospitals using best efforts to provide the necessary funding, resources and support for the provision of clinical services;
 - The requirement that all Practice Plan members submit *Annual Reports*.
 - Allocation to the Practice Plan members of SEAMO funds and other sources of members' incomes as may be deemed relevant by the Practice Plan;
 - The reporting to the Practice Plan members, on a frequency approved by the members, of how all SEAMO funds are allocated;
 - The reporting to SEAMO, on a frequency determined by SEAMO, regarding the allocation of all funds.
3. Practice Plans must ensure that each member has a written role description with clear expectations. Such role descriptions must be supportive of the core deliverables of the department and must avoid conflicts of interest or commitment.
4. Compensation of members must be tied to performance with rules linking responsibility and workload to compensation.
5. Practice Plans must provide for a dispute resolution mechanism to resolve disputes that may arise between or among members of the Practice Plan. The dispute resolution mechanism must be consistent with the requirements of SEAMO policy and with the requirements of funding agreements between SEAMO and the Ministry of Health and Ontario Medical Association.
6. Practice Plans must ensure the alignment of clinical and academic services with the Hospitals' strategic directions and accountability agreements with the Ministry, and with the University's academic mandate.

TERMS OF REFERENCE

The Task Group on Allocation System Review is a five person Task Group created by the SEAMO Signatories to review the system of allocation by which resources are allocated to departments and to propose to the Governing Committee amendments to this system. Following completion of its review, the Governing Committee will make recommendations to the Signatories.

The Task Group will take into account the work of the Advisory Committee on Departmental Deliverables (“ACDD”) and the recommendations of the Advisory Committee that were approved by Governing Committee in principle. Nevertheless, in developing its recommendations, the Task Group may deviate from the ACDD’s recommendations.

The Task Group will:

1. Consult broadly with Signatories, departments, Clinical Teachers, and others as the Task Group feels necessary.
2. In its deliberations, take into account SEAMO’s contractual obligations, the *Agreement to Establish SEAMO*, the *Principles of SEAMO*, the *GFT Agreement*, and other documents that may have a bearing on the matters under consideration.
3. Propose to Governing Committee a system of allocation that furthers the programmatic interests of this Health Sciences Centre by:
 - a. Providing patient care within programs as defined by the hospitals
 - b. Providing for exemplary medical and postgraduate medical education to meet the needs of the medical school
 - c. Nurturing an environment in which basic and applied health research flourishes, and
 - d. Allowing for the leadership and management required by a modern academic health sciences centre.
4. Develop proposals for system of allocation for departments consistent with the realities of clinical teachers as independent health professionals.
5. Determine the minimum standards for departmental practice plans to ensure that they are supportive of the objectives of the system of resource allocation.
6. Develop a communications strategy to ensure Signatories, Governors and clinical faculty are fully apprised of developing recommendations.
7. Report the final recommendations to the SEAMO Governing Committee no later than 2009 October 27.

Membership

Members will be appointed by the Signatories.

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SEAMO
Task Group on Allocation System Review

– **Addendum to the December 14 Final Report** –

Approved by SEAMO Governing Committee
2010 February 17

On December 22, the SEAMO Governing Committee provided the *Report of the Task Group on Allocation System Review* to all SEAMO physicians. The Governing Committee wrote to all heads of SEAMO-funded departments and asked that they provide their comments to the Task Group no later than January 21. Responses were received from several departments and from individual clinical faculty.

The Task Group on Allocation System Review (“TGASR”) met face-to-face on two occasions and by email in order to consider the comments it received. This Addendum to the *Final Report* provides additional commentary aimed at clarifying issues raised in the Report and by those who provided thoughtful comments and suggestions.

➤ **Incentives for patient care, for education, and for research**

- The Task Group was asked if there were any incentives for academic activity or if the model would move all departments into claims submission at the expense of teaching and research. The Task Group believe that there is incentive for clinical work and for academic activity.

- Patient care
 - Minimum fee schedule penetration required with funding holdbacks related to clinical role
 - Department-level core deliverables defined with holdbacks dependent on performance against the defined role

- Medical education
 - Existing SEAMO policy requires the Associate Dean UGME and the Workload Committee to assign medical education responsibilities to departments
 - Failure to meet medical education requirements would result in defined financial penalties.

- Postgraduate education
 - All administrative time to support postgraduate programs in ½ days to be calculated by PGE Office. This work is now underway. It includes all aspects, e.g., program director time, resident appraisal, CaRMS.

- Departments are required to report on their assignment of the postgraduate office calculated program director ½ days as a minimum requirement pending completion of the PGE Office calculation.
- Medical Education Development Fund
 - A Medical Education Development Fund will support the growth and development of members' involvement in innovation, curriculum renewal, mentoring and information exchange.
- Research
 - In our report, the Task Group recommended that the time available for research be seen as the total notional academic days (n.=135) and that research time available to a department be the time available once calculated medical education commitment and postgraduate education commitment is removed from the total notional amount. Having reviewed the advice received, the Task Group wishes to change this recommendation to the Governing Committee.
 - There is an explicit understanding that groups and/or individuals within a department will have varying contributions to each of the academic domains. Individual role descriptions should clearly specify the percentage of an individual's time for protected research. The aggregate FTE allocated to research by a department would then be submitted to the Deliverables Committee for approval. Approval by the Deliverables Committee would be considered in the context of the department's productivity in all other areas.
 - Departments will report on the allocation of time for research by individual. The expected productivity (using the Research Template now being further refined by the Research Office) will be compared to actual productivity. Funding at risk will be the shortfall.
 - Departments must protect the time of productive researchers in order to protect that portion of their funding.
 - A Strategic Research Development Fund will provide for new positions for clinician-scientists.
 - Application may be made for new clinician-scientist funding for an existing member in order to release the corresponding amount of base funding for reallocation to another clinical service-based position. Such applications will be considered in the event that the new clinician-scientist funding is justified by the research productivity of the member's unit and provided the funding will enable the growth of clinician-scientist research.
- **Deliverables Committee**
 - The Deliverables Committee will receive program requirements from the three hospitals and the University. The Deliverables Committee will define "core deliverables" that will meet the clinical and academic program requirements of the institutions.

- There will be asymmetric distribution of departmental contributions to patient care, education and research
 - Although the Deliverable Committee will consult with Department Heads, the Deliverables Committee will be empowered to define core deliverables.
 - The issue of resource limitations to performance was raised. TGASR expects that this would be part of the work of the Deliverables Committee in setting expectations for departments in the context of available resources and during the process of managing any measured shortfall in departmental productivity.
- **Clinical role expectations**
- Clinical performance is to be measured through fee schedule penetration and performance against a representative set of defined core deliverables that address role.
 - The list of role expectations on page 10 of the TGASR report was **not** intended to be comprehensive. For example, measures of quality may be suggested. Having received the institutions' program requirements, the Deliverables Committee will develop role expectations.
- **Administration**
- Administration, as measured in expected ½ days, is built into the calculation of medical education. This is now SEAMO policy and is assigned and reported by the undergraduate office.
 - Administration, as measured in expected ½ days, is to be built into the calculation of postgraduate medical education. It is expected that this will occur early in the first year.
 - Administration is built into the research requirements. Clinician-scientists, under the leadership of the Associate Dean Research calculated expected research productivity. This calculation takes into account all aspects of research and reports on expected productivity. It is subject to further revision.
- **Phase-in**
- 2010-11
 - \$1M Medical Education Development Fund
 - \$1.8M Strategic Research Development Fund
 - FFS penetration measured and reported
 - Postgraduate education administration requirements calculated
 - Research performance metric further refined
 - Practice plans revised to meet minimum standards

- 2011-12
 - \$2 M Medical Education Development Fund
 - \$3.6 M Strategic Research Development Fund
 - FFS penetration measured. If there is a gap, funding is withheld pending correction
 - 5% withheld and distributed based on department meeting core deliverables
 - Postgrad ½ day investment identified and reporting on postgrad assignments required of departments
 - Research performance tied to funding with withholds pending improvement

- 2012 –
 - Base funding may be adjusted based on a) two year performance and/or b) provincial calculation of FTE equivalents.

➤ **Target incomes**

- Target incomes for groups should be based on both marketplace compensation and marketplace productivity. At present, the best measure of clinical marketplace tied to productivity is claims submission comparisons. The approach developed by the Task Group ties clinical income to performance, but does not tie that income automatically to academic performance. For example, a department with insufficient fee schedule penetration could have a clinical funding adjustment, but would not have an automatic reduction in the notional academic funding. Academic funding would be adjusted based on academic performance.

- Funding will adjust over time as performance metrics are implemented.

- There is an approach to income target setting on the provincial level. The provincial approach is based solely on an examination of OHIP claims submission. The provincial approach uses claims submission and compares to claims submission elsewhere. This is then used to calculate a “notional FTE complement”. Funding flows on the basis of this notional FTE calculation.

- The TGASR proposed allocation method was designed to deal with pressing internal and external issues. It is intended to demonstrate performance and to help steer group performance. This need should not be underestimated.

- The proposed method is not designed to set a permanent, unchanging allocation to any group.

➤ **Reporting of all professional earnings**

- Several respondents expressed concern about the reporting of all income to SEAMO. The TGASR report does not recommend that individuals report all professional earnings to SEAMO centrally. It would require the reporting of

professional earnings to the practice plan. It is a practice plan responsibility to determine what funds are to be considered in the allocation to individuals. Indeed, the TGASR report states that practice plans are responsible for the *allocation to the Practice Plan members of SEAMO funds and other sources of members' incomes as may be deemed relevant by the Practice Plan* [our emphasis added here].

- Following receipt of advice, the Task Group reconsidered its recommendation that Practice Plans include this requirement. At the heart of the issue is growing concern about “conflict of commitment”. This may occur when individuals expend significant effort in non-SEAMO related activities. It is not clear to the Task Group if its recommendation would adequately address this complex issue.
- The Task Group suggests that, in addition to the TGASR recommendation on this matter, the Governing Committee consider as an alternative the deletion of this requirement and that governors consider, on an urgent basis, the need to consider the components of the underlying issue.