SECTION ON LABORATORY MEDICINE

SECTION SEPTEMBER 28, 2018 UPDATE: OAP ANNUAL GENERAL MEETING

Dr. Demo Divaris, Chair
Dr. Neil Davis, Secretary-Treasurer

OMA
ONTARIO MEDICAL ASSOCIATION

OUTLINE

- Section Executive, Council and Tariff Committee Members 2018-19
- Brief OMA Update
- Main Focus of Section Update: Current Challenge and Call to Action
  - Framing the problem re: our income relativity position within this current fee negotiations
  - Deeper (but brief) explanation
  - Section multi-pronged plan to address problem
  - What we need from you, our members

EXECUTIVE, COUNCIL AND TARIFF 2018–19

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OMA UPDATE

- With the new PC government in place, the OMA and Ministry have moved out of arbitration and back into negotiations. This rare development presented to the OMA membership as an ‘olive branch’.
- At present, we do not know the status of those negotiations discussions as these remain ‘closed door’.
- We anticipate an update at a special Council meeting held October 21, 2018 in Toronto.
- Within these current fee negotiations, our specialty faces a major problem.

TO PUT IT SUCCINCTLY …

Lab MDs have been significantly disadvantaged in the current negotiations process that sets the stage for how any new monies (or potentially discounts) may end up being allocated to us once negotiations or arbitration have been concluded.

FRAMING THE PROBLEM

- The crux of this problem is a component of the fee allocations process called income relativity that puts all 35 clinical specialties on an income scale.
- Where lab med sits on the scale relative to the specialist average of 1.0, determines how much we get if there are new monies to distribute after negotiations (or arbitration) is concluded.
- Lower than 1.0 is better.
- For decades, lab med has sat at .94 or <1.0. This reflects the fact that most lab MDs are salaried, hospital-based physicians who have no opportunity to earn more if their workload increases. We simply absorb the extra workload and work the extra hours with no additional $.

FRAMING THE PROBLEM Cont'd

- In this current negotiations process, the OMA and the Ministry struck an Interim Relativity Agreement whereby the parties agreed to use a hybrid of their respective income relativity methodologies to allocate fees in the first 2 years of any fee services agreement. (i.e., Lab Med's score is the average of our OMA score and our Ministry score).
- The OMA's methodology is called CANDI (Comparison of Adjusted Net Daily Income).
- The Ministry's methodology is called RAANI (Relativity-Adjusted Annual Net Income).
- Lab Medicine has been significantly short-changed by both methodologies.

PROBLEM WITH MINISTRY'S RAANI

- The Ministry's RAANI methodology is fraught with problems and many other Sections oppose its use.
- Lab Med has its own distinct problem, however, in that it has been assigned a RAANI score of 1.35.
- How we got this score is unknown.
- In the Ministry's technical document that supports its RAANI methodology, lab med is specifically excluded as Lab MDs are salaried.
- But suddenly in June, we see we have been assigned a score of 1.35 that no one within the OMA can explain.
- We are delving deeper to see how this has occurred but are finding little cooperation within the OMA.

BUT OUR FOCUS TODAY IN THIS PRESENTATION IS WITH OMA'S CANDI METHDOLOGY

AND WE ARE GOING TO NEED YOUR HELP TO ADDRESS THIS ISSUE

FROM THE 'GET GO', CANDI HAS BEEN PROBLEMATIC FOR OUR SECTION

- The OMA decided to revise its CANDI methodology as part of the current negotiations process. To that end, it struck a Relativity Review Committee (RRC).

- **When we presented in October 2017 to the RRC, we noted that lab med's CANDI score of .94 was already artificially elevated due to a number of factors:**

  - CANDI uses a weighted average of daily income where FFS pathologists are given a weight of approximately 20% of the entire lab medicine group and LMFFA MDs' weight is 80%. Daytime FFS pathologists, however, represent ~1-2% of our entire membership, so these weight allocations are wrong.

  - CANDI should exclude part time FFS pathologists (after hours/weekends) as income earned during after hours and weekends is not counted in CANDI.

  - CANDI does not recognize the significant unpaid work that is done after hours by the vast majority of our members (e.g., increasing work volumes; work related to QMP; precision medicine) which has become an enormous component of our work. This stressor is exacerbated by our flat fee structure and inability to add new LMFFA-funded positions.

PROBLEMS WITH CANDI Cont'd

- Exacerbating this situation, the OMA decided to issue a survey to all OMA members to try and capture new data including data related to income earned after hours. This data would revise each Section's after-hours modifier in its CANDI methodology equation.
- Before the survey was even issued, we argued that those particular questions were biased and really irrelevant to LMFFA-funded lab MDs who don't earn extra monies to handle workload that spills over a 7.5-hour day and that those respondents should be allowed to skip any questions related to that.
- Our arguments were ignored.
- The OMA released its survey unaltered.
- As predicted by us, those Lab MDs who answered the OMA survey misinterpreted those questions and the data resulting from their answers inadvertently reduced our after-hours modifier from 20% to 5.6%.
- A lower after-hours modifier dramatically increases lab med's CANDI score.
- Suddenly, we went from a CANDI score of .94 to 1.11.

PROBLEMS WITH CANDI Cont'd

- When the OMA announced the revised CANDI scores for all Sections:
  - It didn't inform affected Sections, like ours, who might have been able to successfully argue against the rationale that was used by the OMA's Relativity Review Committee before everything was set in stone.
  - It bypassed Council who traditionally approves changes to CANDI's methodology. The OMA Board simply unilaterally approved the changes. Many Sections are incensed about this.
- Throughout the summer, your Section Executive has tried repeatedly to argue lab medicine's case for a reversal back to its old CANDI score. Numerous letters have been written to OMA President Dr. Nadia Alam. We have been seeking a face-to-face meeting to help foster a better understanding within the OMA of the lab medicine situation.
- The response from OMA has been lackluster at best.

SECTION'S MULTI-PRONGED STRATEGY

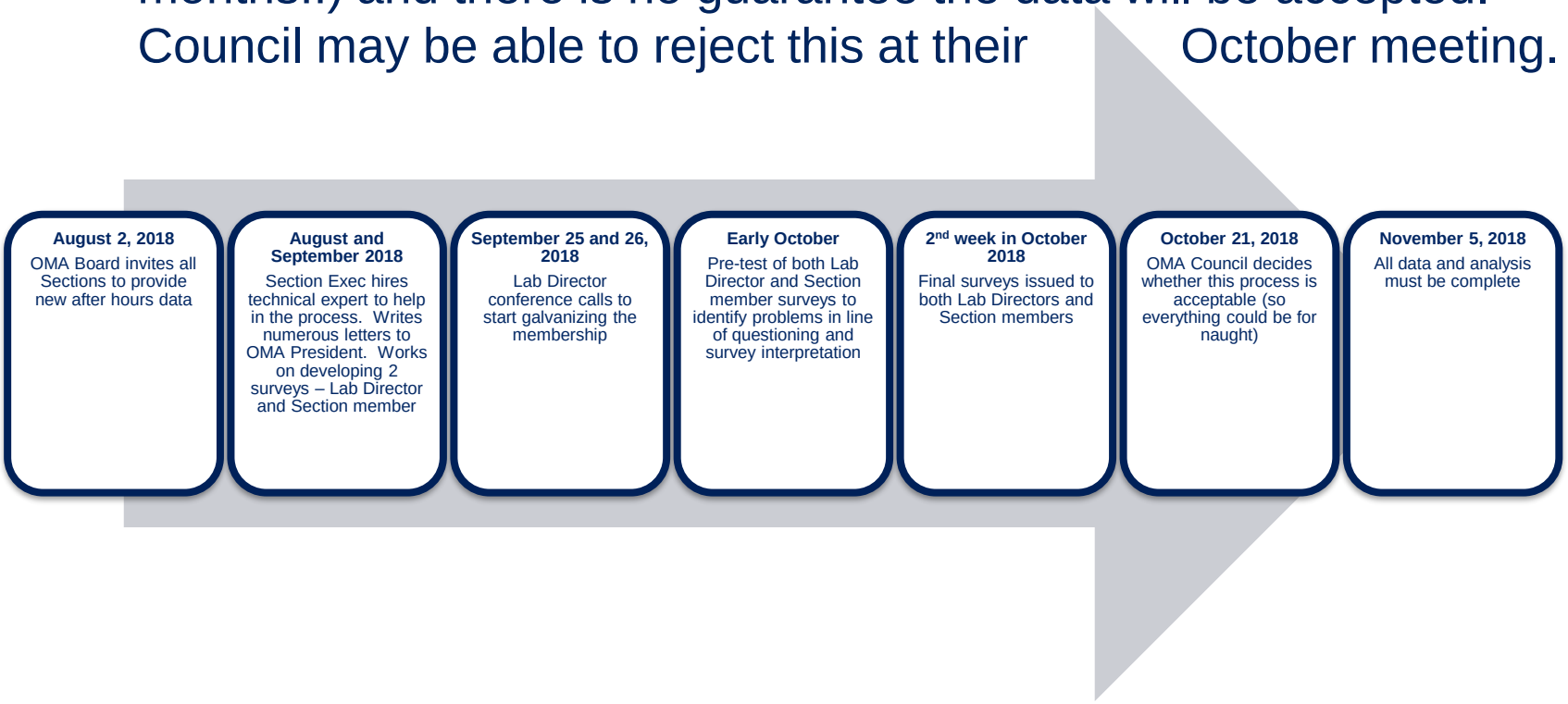
- Get OMA to go back to the old CANDI score for all Sections and instruct OMA Negotiations Committee to use that score instead.

  - There is a special October Council coming up dealing with relativity. Many Sections want to go back to old CANDI so we intend to push for that motion and secure other Sections' support.

- Keep on pursuing how we got a RAANI score of 1.35. Ideally, we should have no score at all since we were intended to be excluded.
- Respond to a recent OMA Board 'offer' made to all Sections to submit new after-hours data that may or may not be used to alter one's after-hours modifier and therefore, CANDI score. This data can be attained through a new survey of Section members and it will be reviewed by an independent 3rd party who will make the final determination as to its acceptability.
- The Section will issue 2 surveys:
  - 1 to all Section members.
  - Another survey to Lab Directors to capture after hours and workload data that cannot be provided by members alone.

SUBMITTING NEW AFTER HOURS DATA IS A GAMBLE THAT WE NEED TO TAKE

- For one thing, the timeline to submit data is extremely short (only 2 months!!) and there is no guarantee the data will be accepted. Council may be able to reject this at their October meeting.



SUBMITTING NEW AFTER HOURS DATA IS A GAMBLE THAT WE NEED TO TAKE Cont'd

- We don't really meet the criteria for the kind of data that is acceptable. Once again, we have informed OMA of this but to-date, they seem unconcerned.

- The following lists the (OMA-suggested) data sources in order of priority:

  1. Direct work activity measurement

  2. Time stamped activity / OHIP claims for out-of-hours activity (for the most part, we don't have after-hours OHIP billing codes)

  3. Prior PWC surveys (we are requesting this info from OMA, not hopeful it provides much for us)

  4. New survey data – this is what we are responding to.

SECTION SURVEY OBJECTIVES

- What we are specifically trying to achieve with conducting these 2 surveys of lab directors and Section members:
  - Prove the 19% weight given to FFS pathologists in the CANDI equation is excessive. A lower weighting for this subset of the lab MD population should lower our CANDI score.
  - Demonstrate how much of our daily LMFFA income is actually 'earned' after hours and on weekends. Going back to our old 20% after-hours modifier (or even higher) will help lower our CANDI score.
    - The lab directors' survey will help us capture after hours and workload data that cannot be provided by members alone.

WHAT WE SEEK FROM LAB MDs

- We need some of you to volunteer to participate in the pilot tests of our surveys (Section member and if you are a lab director, that as well). We want to issue these by next week.

- When the final versions of both surveys are ready to be issued (ideally 2nd – 3rd weeks in October):

  - We need you to complete the Section member survey and encourage everyone at your site to participate

  - If you are also a lab director:

    - We need you to encourage your staff to complete the survey.

    - We need you to also respond to the Section member survey yourself.

BOTTOM LINE – WHAT WE NEED FROM EVERYONE

- We cannot emphasize this enough ..
- The results of these 2 surveys (lab director and Section member) have the potential to significantly impact our CANDI scores, (and our ability to secure our share on any new fees).
- These survey results are critical to our ability to correct these injustices.
- We are aiming for 100% compliance across the profession – please make sure you and EVERYONE in your department complete them.

OPEN DISCUSSION