Clinical ARPs 101

Welcome! Thank you for joining early

Start Time: 12:00 PM promptly

- Your **camera, mic,** and the Zoom **chat** function are disabled for the entirety of this session
- **To ask questions:**
  - At any time during the webinar, click on the **'Q&A button'** and type in your question
  - If you have the same or similar question to one already showing, you can "vote" for it instead of typing a new one
  - Speakers will address questions during the final 30 minutes, starting with most common themes / highest voted questions first
  - Answers to questions not addressed will be provided in a follow-up FAQ document on the AMA website

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Clinical ARPs 101

Webinar Series:
Maintaining and Optimizing Your Practice During Times of Rapid Change

May 29, 2020

Speakers:

Dr. Rick Ward
Family Physician, Crowfoot Village Family Practice ARP

Dr. Richard Hanelt
Family Physician, Good Samaritan Seniors' Clinic ARP

Dr. Catherine Ross
Pediatric Critical Care Medicine, Calgary PICU ARP

Dr. Julia Carter
Family Physician, Sexual and Reproductive Health ARP

Moderators:

Lacey Hoang
Didi Wimmer-Frank
AMA Employees

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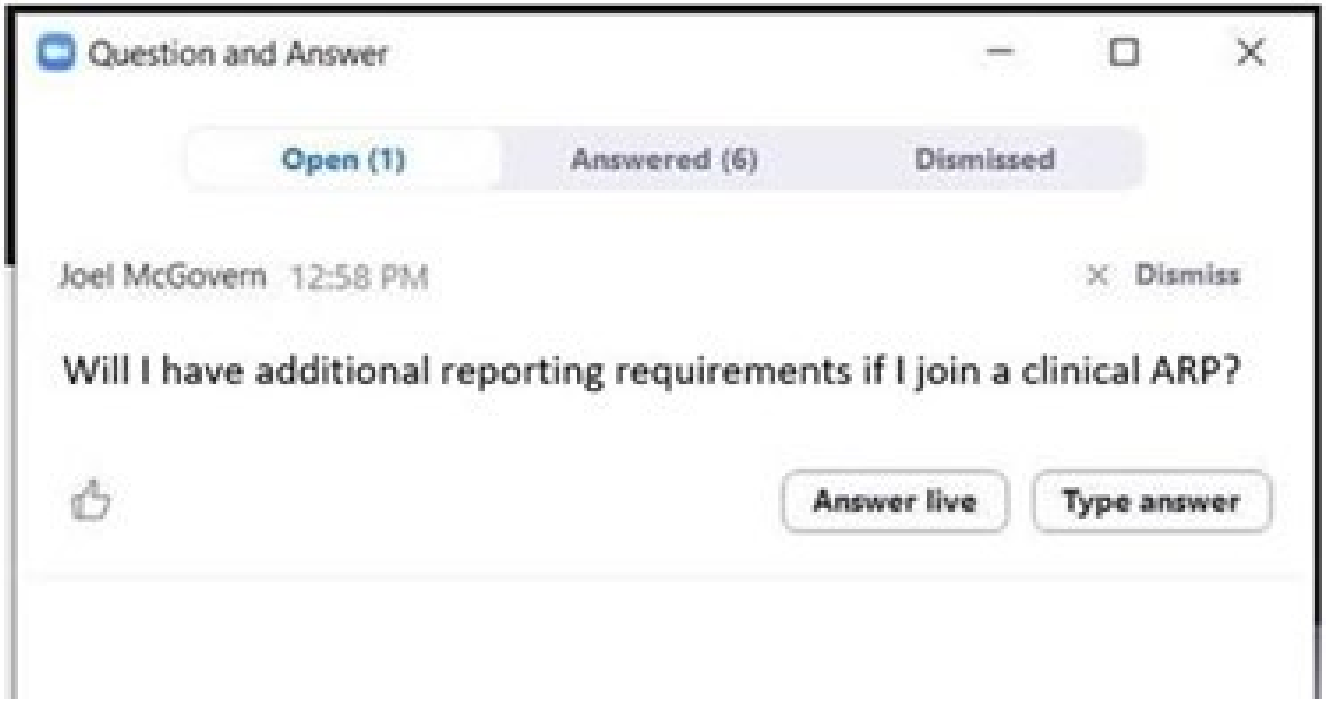
Q&A Process



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Live Recording

- *Privacy Statement: Please note that the webinar you are participating in is being recorded. By participating, you understand and consent to the webinar being made publicly available via a link on the AMA website for an undetermined length of time.*

- *By participating in the Question & Answer function, your name entered into the Zoom sign-in may be visible to other participants during the webinar and/or in the recording.*

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Land Acknowledgment

We would like to recognize that we are webcasting from, and to, many different parts of Alberta today. The province of Alberta is located on Treaty 6, Treaty 7 and Treaty 8 territory and is a traditional meeting ground and home for many Indigenous Peoples.

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Disclosure of Financial Support

This program has not received any financial or in-kind support.

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Speaker / Moderator Disclosures

Speakers:

- Dr. Rick Ward: board member-AMA; honoraria-AMA
- Dr. Richard Hanelt: honoraria-AMA
- Dr. Catherine Ross: honoraria-AMA
- Dr. Julia Carter: honoraria-AMA; grant-Health Innovation, Implementation & Spread

Moderators:

- Lacey Hoang: AMA employee
- Didi Wimmer-Frank: AMA employee
- Jim Huston: AMA employee

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Welcome from AMA Board

Opening Remarks:

Dr. Alison Clarke, AMA Past President

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Session Overview

The key things you need to know about clinical ARPs – Dr. Rick Ward

Perspectives from experienced clinical ARP physicians

- Annualized Model (FP) – Dr. Richard Hanelt
- Annualized Model (Specialist) – Dr. Catherine Ross
- Sessional Model – Dr. Julia Carter
- Capitation Model – Dr. Rick Ward

Q & A Session

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Learning Objectives

At the end of this session participants will be able to:

- Describe the key aspects that apply to all clinical ARPs
- Describe the differences between clinical ARP models
- Identify how to access AMA resources for further information and support on clinical ARPs
- Utilize the perspectives of experienced clinical physicians to assist in their own decision-making around preferred payment model

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The Key Things You Need to Know About Clinical ARPs

Dr. Rick Ward

Family Physician, Crowfoot Village Family Practice ARP

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Hmmm ….. Where to start?

Guiding Principles

Program Parameters

On-call

Internal Payment Distribution

Purpose

Change Management

Conditions of Payment

Capitation

Letter of Participation

Ministerial Orders

Authorized Representative

Benefits

Overhead

Physician Practice Agreement

Application Form

Banking

Sectional Increases

Funding Models

Sessional Model

Physician Autonomy

Expression of Interest

Participating Physician

Service Event Reporting

Government objectives

"lower-of" rule

Stakeholders

Service Delivery Model

ARP Codes

FTE Report

AHS Service Agreement

Internal Governance

Rates and FTE Definitions

Performance Measures

Quarterly Report

Negation

Blended Capitation

Quality Improvement

Work Hours

Payment Reconciliation

Locums

Bedside teaching

Annualized Model

Basket of services

Support Resources

Patient Affiliation

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Let's simplify things

The top ten things you need to know about clinical ARPs are . . .

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10. Government wants more of them

- **ARPs currently represent <10% of total physician clinical payments in AB:**
  - Clinical ARPs (cARP): 4.3%
  - Academic ARPs (AMHSP): 5.0%

- **Government plans to increase ARP % of total physician clinical payments:**
  - UCP platform, MacKinnon Blue Ribbon report, AH business plan
  - Alternative payments in Canada = 27.4%; Ontario = 36%
  - Current focus is on expanding cARPs; not AMHSP
  - Announced streamlined internal processing to accommodate more cARPs; this remains to be seen
  - May introduce new cARP models in the future

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9. AMA can help you make an informed decision

- AMA supports voluntary payment model choice
- Physicians should be fully informed before making this choice
- Your first step should be to contact the AMA - excellent supports available to educate and inform physicians, support payment model transition, and assist with implementation and change management

Alternative Relationship Plan
Physician Support Services

For the Annualized, Sessional and Capitation Models:
contact: arpinquiries@albertadoctors.org or (866) 953-3130

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For the primary care Blended Capitation Model (BCM):
contact: christine.deMontigny@albertadoctors.org or (780) 970-6204

- AMA negotiations and advocacy support is also available

contact: Didi.Wimmer-Frank@albertadoctors.org or (780) 482-0698

8. Funding is for clinical services only

Set remuneration amounts in exchange for delivering . . .

Scope					
Narrow	e.g.,	Pediatric anesthesia out-of-OR services	One small clinic	Patients with chronic wounds needing specialized treatment
Broad	e.g.,	Office-based FP primary care services	All NICUs in Edmonton	Inpatients in all Calgary hospitals

- **Eligible services for potential inclusion in cARP:**
  - All services as covered under FFS (SOMB) codes
  - 12 “ARP codes” (non-SOMB; indirect-patient care services)

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cARPs do not fund . . .

- On-call availability
- Teaching (except bedside)
- Research
- Travel time
- Vacation / sick time
- Administration / meetings
- Employee pension, health/dental benefits, etc.
  - cARP physicians are independent contractors
- Any time for which you are earning other clinical income
  - FFS, WCB, AHS clinical stipends, etc.

cARP physicians are eligible to receive physician benefit program payments (e.g., RRNP, BCP, SOC, ROC, etc.)

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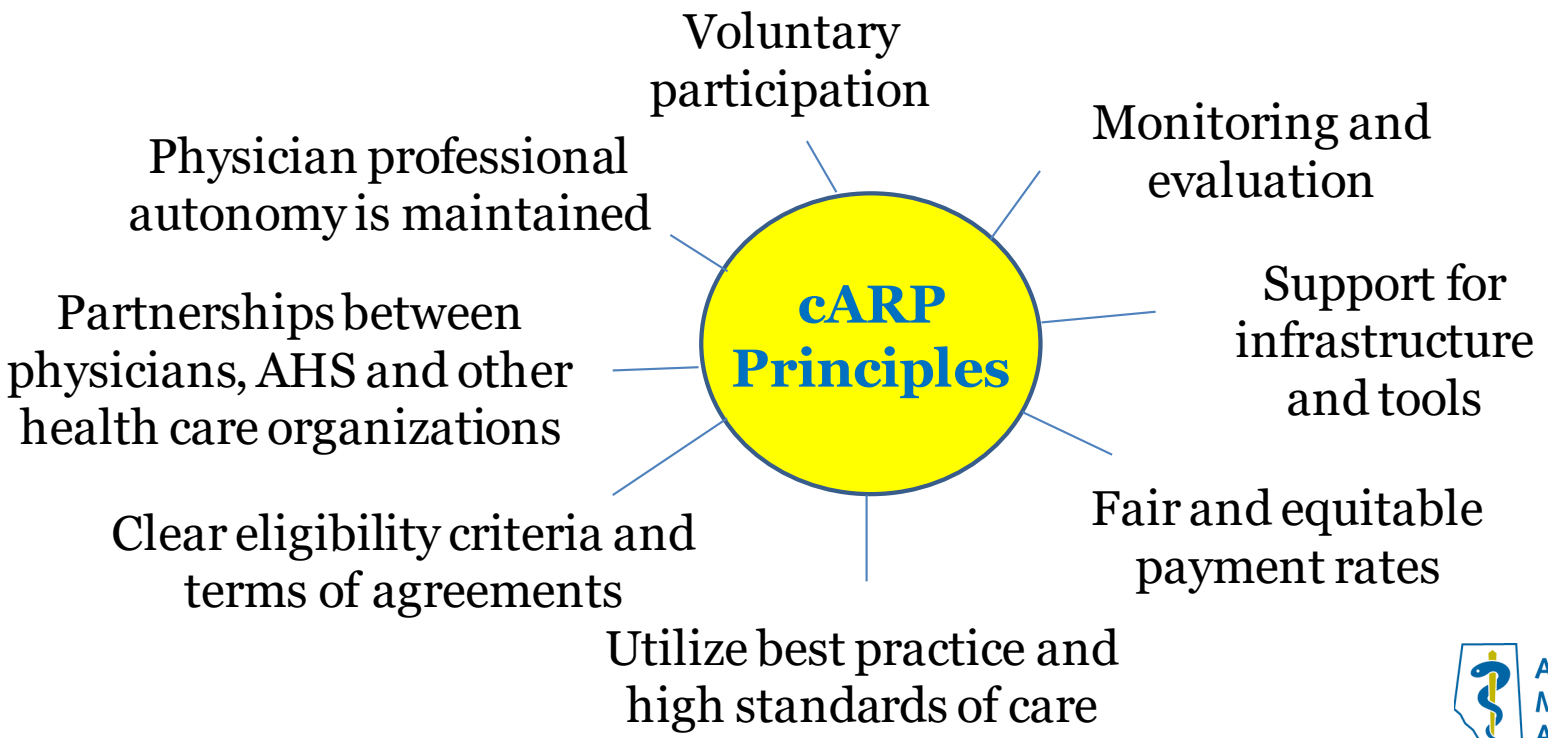
7. Purpose and guiding principles

Purpose:

- cARPs are designed to provide an alternative to the FFS payment method and support one or more of the following dimensions: recruitment and retention, team-based approach, access, patient satisfaction and value for money.



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6. Legally governed through Ministerial Orders

- **cARP Ministerial Orders (MOs):** Two parts:
  - The **Program Parameters MO** sets out the general terms and conditions for all cARPs
  - The **Conditions of Payment MO** sets out the terms and conditions for a specific cARP (including funding)
- **Letter of Participation**
  - Signed by each participating physician to bind them to the MOs
  - Can be reversed through a **Letter of Termination**
- **Authorized Representative(s)**
  - Physician(s) selected/authorized by the other participating physicians to act as their agent in dealings with AH, AHS, and other partners
- **AHS Services Agreement**
  - For programs in AHS facilities, AHS may also require physicians to sign a separate service agreement to ensure service coverage

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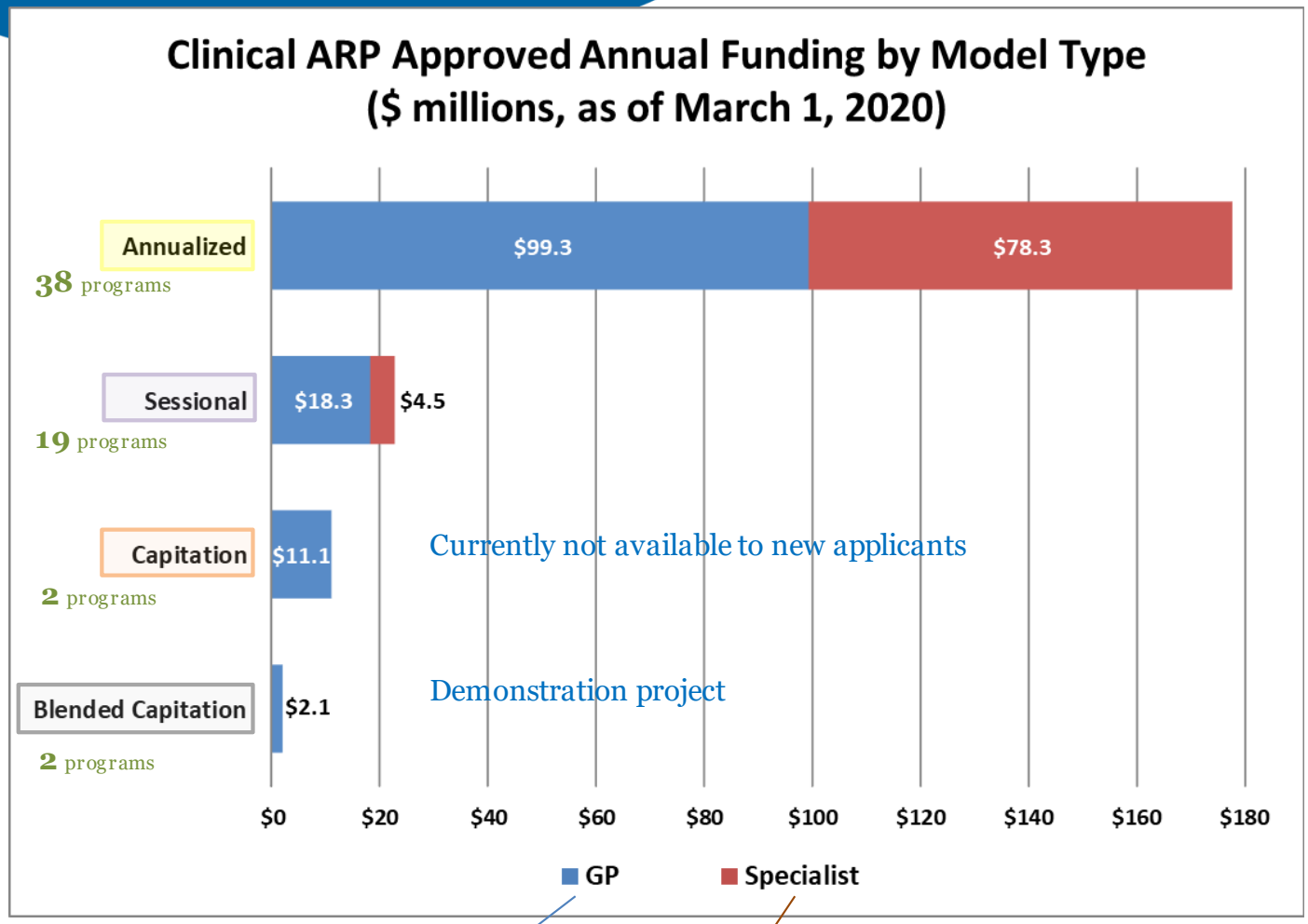
5. Four types of models

Annualized (FP or specialist)	Sessional (FP or specialist)	Capitation (FP primary care)	Blended Capitation (FP primary care)
➢ cARP funding is based on # of physician full-time equivalents (FTEs) required to deliver ARP services (determined through application) multiplied by rate per FTE ➢ Funding rate per 1.0 FTE varies by specialty (e.g., FP = $364,582 per year) ➢ FTE is a time-based unit of measure (e.g. FP = 241 days or 1928 hours/year) ➢ Can participate part-time or full-time in ARP ➢ Can bill FFS for non-ARP services (outside of ARP time)	➢ cARP funding is based on # of annual hours required to deliver ARP services (determined through application) multiplied by hourly funding rate ➢ Funding rate is $221.73 per hour (all specialties) ➢ Intended for small specialized programs ➢ Only allows for part-time participation up to 16 hours per week (832 hours annually) ➢ Can bill FFS for non-ARP services (outside of ARP time)	➢ cARP funding is based on an annual amount per patient to deliver ARP services (capitation rate) multiplied by the # of affiliated patients ➢ Different cap rates for 40 age/gender categories (avg ≈ $325/patient/year) ➢ "Negation" if physician outside the ARP provides ARP services (at FFS value up to cap rate) ➢ Can bill FFS for non-ARP services and un-affiliated patients (limits) ➢ Crowfoot: formal signed affiliation; office services only (91 codes) ➢ Taber: geographic roster; office, ED, inpatient and LTC services (98 codes)	Similar to capitation model. Key differences are: ➢ Annual amount per patient is a blend of 85% of cap rate plus 15% of FFS rate for ARP services (up to max of 100% cap rate) ➢ Different cap rates for 9,560 categories based on age, gender, and health risk (average 100% cap rate ≈ $280-$320/pt/year depending on panel) ➢ Negation at FFS value up to max of 85% of patient cap rate ➢ No negation for first year of implementation ➢ Office services only (59 codes)

Total current funding by model



Total of 61 programs						
	Total Funding	$130.8M	+	$82.8M	=	$213.6M
	Total FTE	347	+	177	=	524

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Source: Conditions of Payment Ministerial Orders for each clinical ARP

4. Funding rate ≠ internal payment rate

- cARP funding rates are intended to reflect average FFS payments
  - As with FFS, rates are adjusted by macro sectional allocation rate changes
- As with FFS, cARP funding rates are inclusive of overhead
  - you still need to pay your overhead expenses out of this funding
  - ARP overhead expenses vary by type of program / service / clinic
  - depending on the program, AHS or other partners may provide some staff, space or admin support
- cARP physician groups have flexibility to determine how best to distribute the funding internally amongst participants
- After covering overhead, the cARP physician group may want to vary internal payment rates with remaining funds. e.g.,
  - pay higher amounts for less desirable work or shift times
  - internally pay for certain things that don't generate external funding (e.g., travel time, admin, research, etc.)

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3. Performance measures & reporting requirements

- Performance goals and measures are developed during the application process

Type of Reporting	Funding Model	Frequency	By Whom
Performance Reporting	All	Quarterly	Physician Authorized Rep (AR)
Performance Reporting	All	Annual	AR
FTE Reports	Annualized	Monthly	AR
Service Event Reporting (Shadow Billing)	All	Daily/Weekly (on a regular basis)	All physicians

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2. Effective internal governance & change management are key

Internal Governance

Develop a physician practice agreement to guide the group

- Financial management: overhead, internal payments, banking, etc.
- How to distribute workload; shift scheduling; holiday schedules.
  - Requires partnership / collaboration with AHS or others, if working in their facilities
- Ensure all physicians are meeting cARP terms, accountability and reporting requirements
- Specify how the group is going to make decisions and resolve disputes

Change Management

It's not like flicking a switch

- Opportunity to innovate & change
- Change is often greater than we think
  - Service delivery
  - Cultural
  - Working differently across teams
  - Different financial incentives & risk
- Invest the time to make changes
- AMA supports are available to help
- Learn from others who have been there
- You will get frustrated at times
- Keep the bigger picture in mind
- Enjoy the journey

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1. Clinical ARPs are not perfect . . .

AMA Proposals to Government During Negotiations

1. Implement contractual agreements, with fair dispute resolution mechanisms (instead of Ministerial Orders)
2. Utilize "Quadruple Aim" as the overall objectives for cARPs
3. Implement a multi-stakeholder governance structure for cARPs
4. Honour the original cARP program principles
5. Update cARP rates and FTE definitions with current data
6. Expedite the cARP application and approval processes

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Summary

The top 10 things you need to know about clinical ARPs are …

10. Government wants more of them
9. AMA can help you make an informed decision
8. Funding is for clinical services only
7. Purpose and guiding principles
6. Legally governed through Ministerial Orders
5. Four types of models
4. Funding rate ≠ internal payment rate
3. Performance measures and reporting requirements
2. Effective internal governance & change management are key
1. They are not perfect

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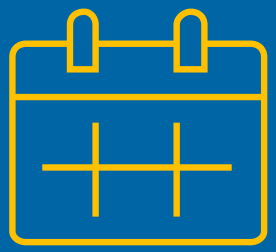

Perspectives from experienced clinical ARP physicians

Annualized Model

Dr. Richard Hanelt

Family Physician,
Good Samaritan Seniors' Clinic ARP

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Annualized Model
Good Samaritan Seniors Clinic (GSSC)

- Implemented in 2004.
- Primary care and geriatric consults to frail older adults, generally over the age of 65 via an interdisciplinary team of participating physicians and health care professionals.
- Focus on chronic disease management, health promotion, disease and injury prevention, and maximizing healthy community living for complex vulnerable seniors.
- Goal is to support seniors to live at home and thrive in their communities for as long as possible. We provide excellence in seniors care in the community embracing complexity and optimizing wellness.
- Our cARP enables our participating physicians to:
  - provide community-based primary health care and specialized geriatric services to seniors with complex medical conditions requiring time-intensive assessment, treatment and management.
  - work closely with other providers at the GSSC to offer comprehensive medical, social, and psychological support for this high-needs population.
- We currently have nine participating physicians (including two authorized representatives) who work a mix of full- and part-time.

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Annualized Model
Good Samaritan Seniors Clinic

Benefits:

- Patient-centred care (e.g., more time for vulnerable and complex seniors)
- Access for an underserved population including primary care for orphaned/unattached patients
- Multi-disciplinary teamwork and culture (collaboration, innovation – including home visits and urgent care)
- Stability of funding
- Support (e.g., ARP PSS, indirect patient care service codes)
- Ability to determine distribution of the approved FTEs to accommodate full and part time work

Challenges:

- Lengthy application process for an expansion application
- Stalled FTE and rate review
- Approval of a 1.0 FTE expansion for our program is contingent on a change in in definition from our current program service day to a program service hour
- Recruitment
- Additional reporting requirements compared to FFS

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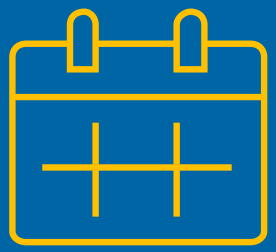

Perspectives from experienced clinical ARP physicians

Annualized Model

Dr. Catherine Ross

Pediatric Critical Care Medicine,
Calgary PICU ARP

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Annualized Model
PICU Calgary

- The Pediatric Intensive Care Unit (PICU) at Alberta Children's Hospital (ACH) in Calgary was implemented in 2005 due to difficulty recruiting and issues with retention, this allowed us to go from 2.5 to 8 FTE
- The program manages a 15-bed inpatient PICU and five PICU alternate care beds. We provide care and expertise to the critically ill infants and children of southern Alberta, southeastern British Columbia, and southwestern Saskatchewan. The PICU at ACH operates as a closed unit, where the participating physicians are responsible for the management of patients 24 hours a day, 7 days a week, 365 days per year.
- The program currently has 13 participating physicians, made up of 11 Critical Care Specialists and 2 Clinical Assistants

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Annualized Model
PICU Calgary

The PICU Calgary cARP enables our participating physicians to:

- Structure an internal compensation framework that enables the provision of high quality and innovative care with 24/7 onsite physician specialists
- Stable funding allows for recruitment and retention, which ensures a stable critical mass of attendings, this prevents burnout and allows for innovation and program development.
- Modify traditional work models to ensure appropriate coverage of multiple programs to ensure quaternary level patient care; e.g., STEP, ECLS, Pediatric transport, CRRT, Code Blue
- Participate in multiple indirect patient care activities such as developing clinical practice guidelines, simulation team training, patient safety and quality assurance, research

PICU Calgary has continually demonstrated success in providing high quality care and has been ranked as one of the top PICUs in North America.

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Annualized Model
PICU Calgary

Benefits:

- Stable workforce of critical care physicians 24/7 365 days/year.
- Recruitment and retention of specialist physicians to distribute workload and prevent physician burnout in high acuity speciality.
- Stability of funding, and group control of funding.
- Flexibility for internally managing funding and operations.
- Multi-disciplinary teamwork environment that enhances patient safety and quality of care.
- Innovation and program development, research development which impacts career satisfaction and longevity.

Challenges:

- Lengthy application process for application and expansion. Definition of 1.0 FTE in hours of work?
- Additional reporting requirements vs FFS – reporting of shadow billing and hours, emphasis not on quality of care or meaningful and measurable deliverables.
- Unilateral end to contract and change to MO and no legal recourse for dispute resolution or change to services agreement with augmented services
- No negotiation ability for new programs and responsibilities, and no increase in pay for new programs, or changes to FFS codes that initial fees based on – e.g., CMX30, after hour differential fees
- Physician representation and input into the overall cARP framework
- No built in hours or compensation for overhead or administration of the ARP

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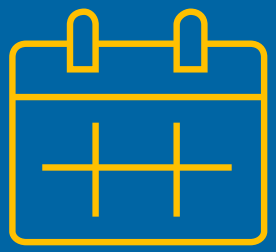

Perspectives from experienced clinical ARP physicians

Sessional Model

Dr. Julia Carter

Family Physician, Sexual and Reproductive Health ARP

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Sessional Model
Sexual and Reproductive Health

- Implemented in 2010
- Utilizes:
  - innovative and collaborative model to meet the sexual and reproductive health care needs of a complex population
  - multidisciplinary, team-based approach
  - drop-in services and specialized services by appointment
- Allows participating physicians to see high volumes of complex patients without compromising the program's ability to provide comprehensive preventative counseling and vigilant follow-up
- 25 participating physicians (including one authorized representative)
- Maximum number of program services hours is 5,580
- Have gone through two expansions due to adding services to the program

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Sessional Model
Sexual and Reproductive Health

Benefits:

- Patient-centred care (e.g., access to drop-in patients and adequate counselling time)
- Access for an underserved population including at risk patients (e.g., youth, vulnerable populations, patients seeking HIV PrEP without referral, telephone/telehealth follow-up appointments)
- Provides stable, accessible, high-quality, evidence-based clinical services
- Indirect patient care service codes (e.g., no limitation on telephone calls, collaborative care, documentation, referrals, etc.)
- AMA support (e.g., ARP PSS)

Challenges:

- Lengthy process for initiation or expansion applications
- Additional reporting requirements versus FFS
- Difficult reconciliation with AH statements
- Time modifier tracking (5-minute increments)

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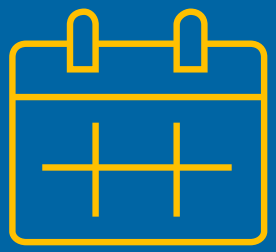

Perspectives from experienced clinical ARP physicians

Capitation Model

Dr. Rick Ward

Family Physician, Crowfoot Village Family Practice ARP

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Capitation Model
Crowfoot Village Family Practice

- Implemented in 1999.
- Comprehensive primary care in a patient-centred medical home
- Model helps remove barriers to providing optimal care.
- Multidisciplinary team-based approach.
  - High ratio of allied health care professionals to physicians
  - Allied staff work to full scope
- 16 participating physicians.
- Approximately 23,000 affiliated patients
- Great patient outcomes.

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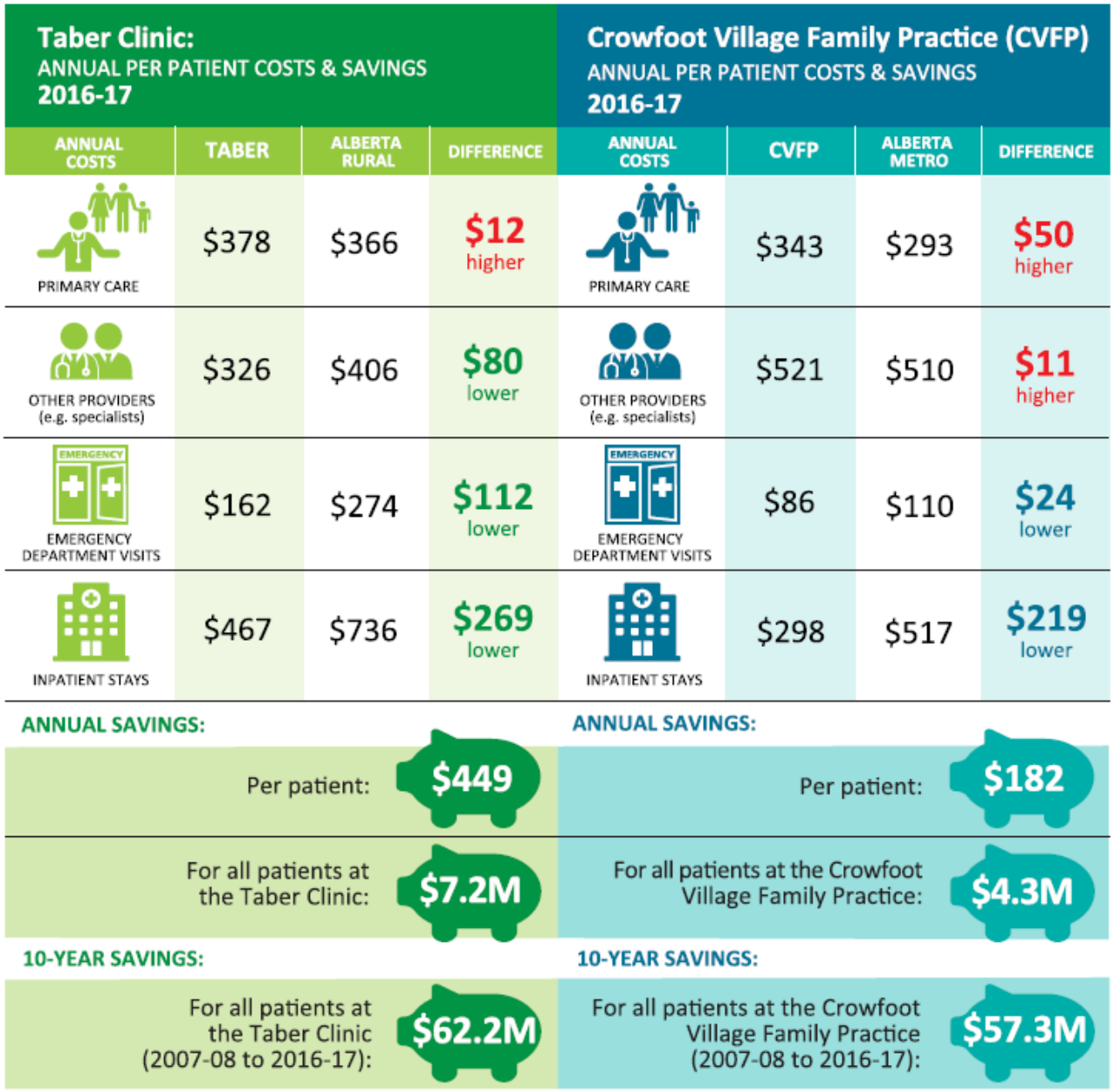

Key Findings

- Enables the design and delivery of a team-based practice model consistent with the principles of the Patient's Medical Home (PMH)

- Provides comprehensive, cost-effective care that creates value for the health-care system

Capitation Model
Crowfoot Village Family Practice

Benefits:

- Comprehensive patient-centred care (e.g., more time for vulnerable and complex population).
- Improved access for patients through use of multi-disciplinary team to their full-scope of practice.
- Physicians have larger patients panels than FFS average.

Challenges:

- Lengthy change management process.
- Additional office support required to manage ARP processes.
- Negation.

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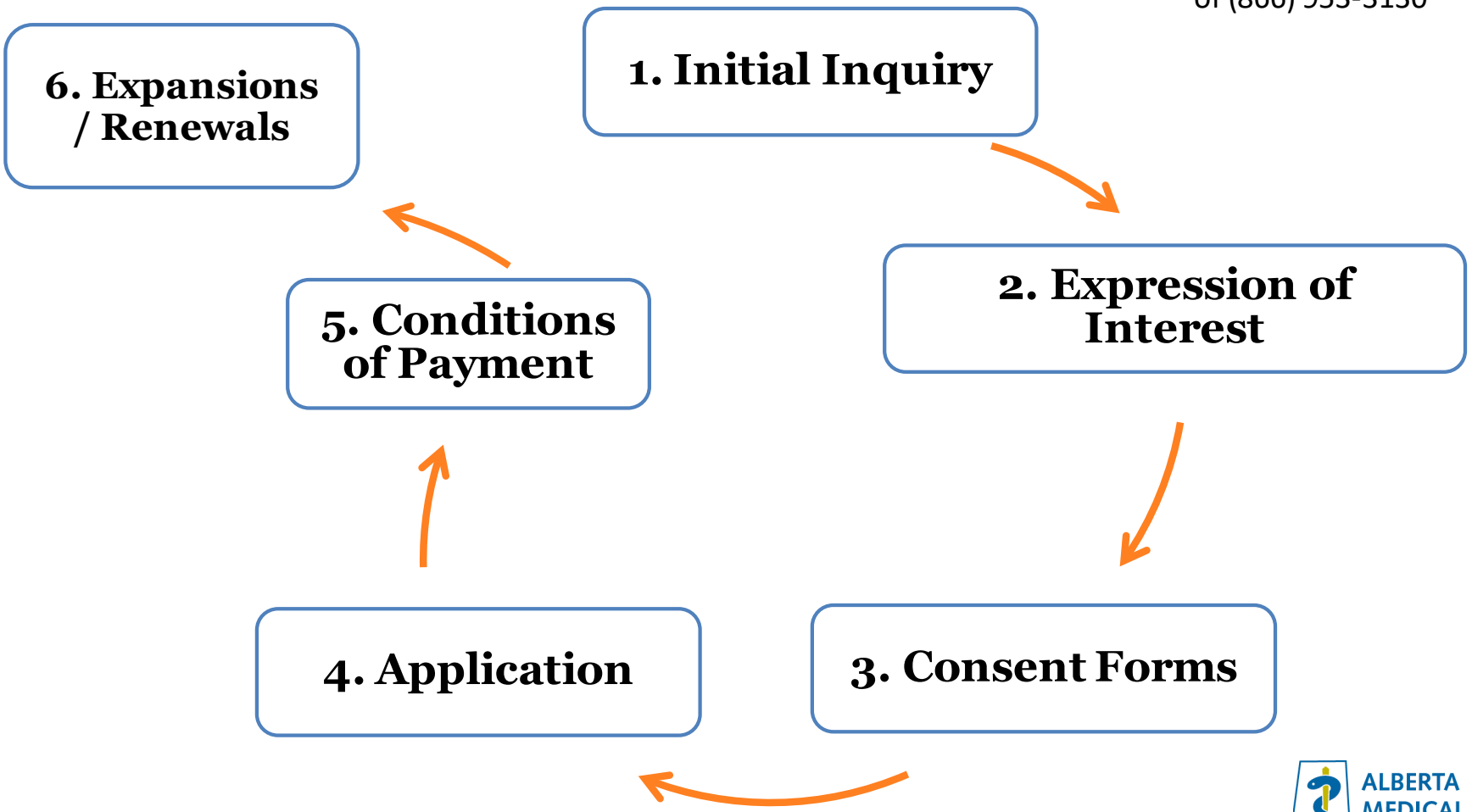
If you are interested in exploring a cARP, contact the AMA's ARP Physician Services team to assist you with process

Alternative Relationship Plan
Physician Support Services

arpinquiries@albertadoctors.org
or (866) 953-3130



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Q & A Session

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Do you have another question you would like a specific speaker to address?

Send to webinar@albertadoctors.org and state the speaker's name and we will forward your question to them for a response.

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Thank you and please complete the post-session evaluation!

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Evaluation

https://interceptum.com/s/en/RC05292020

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