ECOMMENDATIONS FOR A NEW RURAL ON-CALL REMUNERATION PROGRAM

- Consensus Statement -

Preamble

Whereas the provision of emergency on-call services in rural locations poses significant lifestyle and economic challenges for the physicians providing this important service, and

Whereas the recognition of and compensation for the provision of emergency on-call services is a significant measure to enhance the recruitment and retention of physicians in rural Alberta, and

Whereas such a new on-call program represents an important component of a broad array of measures to address rural physician issues as contained in the Rural Physician Action Plan,

Therefore the Minister of Health has committed to the development and implementation of a new rural emergency on-call remuneration.

To ensure an effective and efficient program design, implementation and administration, Alberta Health and the Alberta Section of Rural Medicine (ASRM) of the Alberta Medical Association (AMA) formed a working group mandated to develop, on a consensus basis, recommendations to the Minister on such a new program. The following represents the consensus recommendations achieved by the working group on how the new program will achieve specific objectives. It is understood that this program is an initiative of the Minister of Health, and that he is exclusively responsible for setting the terms and conditions of this program.

Objectives

- To give recognition to and compensate physicians for the unique lifestyle and economic circumstances of providing emergency on-call in rural areas and to provide an incentive to increase the number of physicians who provide rural emergency on-call services.

- To ensure that Albertans living in rural and remote locations of the province receive comprehensive and continuous emergency on-call services.

- To provide opportunities for physicians and Regional Health Authorities to work together more closely on issues concerning the delivery of medical and physician services to their populations.

Recommendation 1

- That the emergency on-call remuneration be paid in addition to income earned by a physician during an on-call shift, either through fee-for-service or alternative payment arrangements, without affecting the fee schedule or governing rules.

Recommendation 2

- That the Minister of Health provide funding at a fixed hourly rate per eligible facility to cover the following annual emergency on-call hours:
    - All annual hours with the exception of the hours of Monday to Friday, 8 a.m. to 5 p.m.
    - Where a statutory holiday falls on a weekday (Monday to Friday), the hours from 8 a.m. to 5 p.m. of that statutory holiday are also eligible for this program.

- The hourly rate will be $17 from the date of implementation to March 31, 2000. As of April 1, 2000, the hourly rate will increase to $21.

- The on-call funding per facility is to be shared among the physicians who provide on-call services at an eligible facility, based on the number of hours of on-call service provided by each physician. Where two or more physicians share on-call hours at the same eligible facility, only one payment covering the hours provided at that facility will be made.

- To provide a meaningful lifestyle improvement, it is recommended that, where possible, a physician should be on call not more than one day in four as long as this does not compromise the objective of providing full on-call coverage.

- To avoid excessive on-call provision by individual physicians, it is recommended that the Chiefs of Staff of the Regional Health Authorities review on-call schedules with the physicians providing this service in their jurisdiction.

Note: A cost estimate for the program is attached.

Recommendation 3

- That the funding be provided for emergency on-call services provided in eligible facilities which meet the following criteria:
    - acute care facilities, which offer to the general public emergency on-call coverage 24 hours per day, 365 days per year,
    - where the emergency department is not staffed by geographic full-time physicians practicing emergency medicine, and
    - where there are 25,000 or fewer unscheduled visits annually to the emergency department.

- A Regional Health Authority may apply to have included in the schedule of eligible facilities non-hospital facilities, which hold themselves out to the general public as providing emergency on-call coverage 24 hours per day, 365 days per year, or, where appropriate, for a specified period of time in a year. The Regional Health Authority will need to demonstrate how such a non-hospital facility fits into its overall service delivery plan, be satisfied that the facility has the necessary equipment to provide emergency services, and ensure that full on-call coverage is provided by the facility.

- The eligible facilities will be determined by the Regional Health Authorities, in consultation with physicians, and listed on a schedule. Any change to this schedule of eligible facilities will require the approval of the Minister of Health.

Recommendation 4

- The administration of the program budget will be with Alberta Health until March 31, 2001. Effective April 1, 2001, the administration of the program budget will be transferred to the Regional Health Authorities. The program funds will be transferred to the Regional Health Authorities and their use will be limited to the rural on-call program, which will remain a provincial program.

Recommendation 5

- That, as a transition from the terminated Incentive Payment Program (IPP) to the new rural on-call program, physicians who applied for IPP payments for the first quarter of 1998 will make a

choice between joining the new rural on-call program upon the implementation date, or continuing to apply for IPP payments up to and including the first quarter of 1999, ending March 31, 1999.

- Where a physician does not make an explicit choice to continue to receive payments based on the former IPP, he will be deemed by Alberta Health to have chosen participation in the new rural on-call program.

Recommendation 6

- That the program be evaluated two years after implementation. The Rural Physician Action Plan Coordinating Committee will present an evaluation report to the Minister of Health no later than March 31, 2001.

Recommendation 7

- That the program be implemented effective October 1, 1998.

Undertakings and Common Understandings

- The AMA and the ASRM agree that this program is designed to facilitate the recruitment and retention of rural physicians, and to address the lifestyle issues caused by rural on-call service provision. It is recognized that the valuable on-call services provided by rural physicians during the hours of 8 a.m. to 5 p.m., Monday to Friday, are not included in the rural on-call remuneration program at this time. This is not intended to diminish the recognition of the value of these services.

- The AMA, ASRM, and rural physicians will make their best efforts to work with the Regional Health Authorities to ensure full and adequate rural on-call coverage in eligible facilities throughout Alberta.

- Between the implementation date of this program and March 31, 2001, the rural physicians, supported by the AMA and the ASRM, will make every effort to work with the Regional Health Authorities to identify and resolve issues, which present barriers to integrated and cooperative service delivery.

- It is understood that any deletions of eligible facilities from the schedule will occur as a result of a Regional Health Authority's strategies for delivering effective and efficient services, and not due to the implementation of this new program.

- It is also understood that physician input into the process of changing the schedule of eligible facilities will be based on considerations of patient needs, as well as the adequacy, effectiveness and efficiency of on-call service delivery, and that the final determination of eligible facilities lies with the Regional Health Authorities and requires approval by the Minister of Health.

- The Minister of Health will establish the features, terms and conditions of the rural on-call remuneration program as of April 1, 2001 in consultation with the AMA and the ASRM.RURAL PHYSICIAN ACTION PLAN

- Consensus Statement -

The Rural Physician Action Plan (RPAP), in place since 1990, has played an important role in responding to critical shortages in the number of rural physicians and in co-ordinating programs aimed at rural

physician recruitment and retention. The introduction of a new major program, rural on call, provides an opportunity to review RPAP to ensure its continued effectiveness. The Working Group believes that RPAP should be restructured so as to:

- emphasize the role of RPAP as the policy advisory body to the Minister of Health on issues of rural physician recruitment and retention;
- enhance the role of rural physicians, both as the key program recipients and for their expertise and experiences in the issues of rural medical practice;

- streamline membership and administrative procedures.

The following outlines the recommendations of the Working Group.

Composition of the RPAP Committee

Representatives from:

- Alberta Health (1)
- Alberta Medical Association (1)
- Alberta Section of Rural Medicine (2)
- Regional Health Authorities (2), one of whom shall be a Regional Medical Director
- College of Physicians and Surgeons of Alberta (1)

Committee members and alternates shall be named in the Deputy Ministerial Order establishing the membership of the RPAP Committee. Alternates shall attend Committee meetings only when the regular representative cannot attend due to an emergency situation.

The committee shall select a chair from amongst its members.

The administrative support to the RPAP Committee will be provided under the current terms and conditions.

Roles and Functions

The primary role of the RPAP Committee will be to provide policy advice to the Minister of Health on all issues related to the recruitment and retention of rural physicians including the following:

- establishment of provincial goals, objectives and strategies;
- introduction of new programs;
- policy, goals, objectives and performance criteria for each RPAP initiative;
- evaluations of RPAP and RPAP initiatives on a regular basis;
- allocation of the RPAP budget.

In carrying out its role, RPAP will ensure that it maintains appropriate linkages with the representatives of key RPAP programs, such as the universities.

With respect to the Rural On Call Program, the responsibilities of the RPAP Committee shall, in addition to those outlined above, include the following:

- recommending criteria for any changes in the list of eligible facilities included in this report, including non-hospital facilities;

- provide recommendations to the Minister, upon his request, on specific applications for changes to the facility list from the regional health authorities.

The RPAP Committee should continue to have the responsibility and accountability for the following existing programs:

- Enrichment
- Rural Rotation
- Continuing Medical Education
- Signing Bonus - Practice
- Signing Bonus - Special Skills
- Weekend Locum Program
- Recruitment Fairs
- Information/Communications

The Committee shall also recommend to the Minister of Health, as appropriate to maintain the effectiveness and efficiency of RPAP, whether the balance among existing programs should be changed, or existing programs should be deleted, or new programs should be added.

While several of the administrative aspects of other programs will remain outside the direct purview of the RPAP Committee, the Committee shall have the responsibility of advising the Minister on all matters related to the efficient and effective administration of all programs and the co-ordination of administration between programs.

Reporting

The RPAP Committee will report to the Minister of Health on a regular basis. All Committee recommendations will be on a consensus basis.

On call Hours: 5 p.m. to 8 a.m. Monday through Friday,

8 a.m. to 8 a.m. Saturdays, Sundays, and stat. Holidays.

# of Facilities	Weekday Hours	Weekend/Stat Hours	Total Call	On Rate	Hourly	Total Facility	Per
	per year	Hours per year	per year	($)	($)	($)	

85 3,900 2,586 6,486 17 9,372,2 110,262
Total 365 24 8760
70

Hours in a year

85 3,900 2,586 6,486 21 11,577, 136,206
office 260 9 2340
510

hrs.

stats 10
9 90

Balance of 2250 2250 98-99 Start date Oct 1 98.

sep 30 sub

oct 31

# of Covered Facilities	Weekday Hours	Weekend/ Holiday Hours	Total Hours Stat. On Call	Hourly Rate	Total Facility	Per
Remaining	Hours Remaining	Remaining	($)	($)	($)	

nov 30

dec 31

6486

85 1,950 1,293 3,243 17 4,686,1 55,131
35

feb 28

150

Phase-in Scenario

Fiscal Year	Coverage	Rate	Total Cost ($)	Per Facility
1998-1999	Off Hours 4 hrs. or $17/hr.	$400/2	4,686,135	55,131
1999-2000	Off Hours 4 hrs.	$400/2	9,372,270	110,262

or
$17/hr
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