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

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Will I have additional reporting requirements if I join a clinical ARP?
• 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.
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.
This program has not received any financial or in-kind support.
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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Opening Remarks:
Dr. Alison Clarke, AMA Past President
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
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
The Key Things You Need to Know About Clinical ARPs

Dr. Rick Ward
Family Physician, Crowfoot Village Family Practice ARP
Let’s simplify things

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

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

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 . . .

SPECIFIC CLINICAL SERVICES

IN A SPECIFIC LOCATION(S)

TO A SPECIFIC PATIENT POPULATION

- Narrow e.g., Pediatric anesthesia out-of-OR services
- Broad e.g., Office-based FP primary care services

- One small clinic
- All NICUs in Edmonton
- Patients with chronic wounds needing specialized treatment
- 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.)
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.

Voluntary participation
- Physician professional autonomy is maintained
- Partnerships between physicians, AHS and other health care organizations
- Clear eligibility criteria and terms of agreements
- Utilize best practice and high standards of care

Support for infrastructure and tools
- Fair and equitable payment rates

Monitoring and evaluation
- cARP Principles

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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
### 5. Four types of models

<table>
<thead>
<tr>
<th><strong>Annualized (FP or specialist)</strong></th>
<th><strong>Sessional (FP or specialist)</strong></th>
<th><strong>Capitation (FP primary care)</strong></th>
<th><strong>Blended Capitation (FP primary care)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>cARP funding is based on # of physician full-time equivalents (FTEs) required to deliver ARP services (determined through application) multiplied by rate per FTE</td>
<td>Funding rate per 1.0 FTE varies by specialty (e.g., FP = $364,582 per year)</td>
<td>cARP funding is based on an annual amount per patient to deliver ARP services (capitation rate) multiplied by the # of affiliated patients</td>
<td>Similar to capitation model. Key differences are:</td>
</tr>
<tr>
<td>FTE is a time-based unit of measure (e.g. FP = 241 days or 1928 hours/year)</td>
<td>Intended for small specialized programs</td>
<td>Different cap rates for 40 age/gender categories (avg ≈ $325/patient/year)</td>
<td>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)</td>
</tr>
<tr>
<td>Can participate part-time or full-time in ARP</td>
<td>Only allows for part-time participation up to 16 hours per week (832 hours annually)</td>
<td>“Negation” if physician outside the ARP provides ARP services (at FFS value up to cap rate)</td>
<td>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)</td>
</tr>
<tr>
<td>Can bill FFS for non-ARP services (outside of ARP time)</td>
<td>Can bill FFS for non-ARP services (outside of ARP time)</td>
<td>Can bill FFS for non-ARP services and un-affiliated patients (limits)</td>
<td>Negation at FFS value up to max of 85% of patient cap rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crowfoot: formal signed affiliation; office services only (91 codes)</td>
<td>No negation for first year of implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taber: geographic roster; office, ED, inpatient and LTC services (98 codes)</td>
<td>Office services only (59 codes)</td>
</tr>
</tbody>
</table>
Total current funding by model

Clinical ARP Approved Annual Funding by Model Type
($ millions, as of March 1, 2020)

- **Annualized**
  - 38 programs
  - $99.3
  - $78.3

- **Sessional**
  - 19 programs
  - $18.3
  - $4.5

- **Capitation**
  - 2 programs
  - $11.1

- **Blended Capitation**
  - 2 programs
  - $2.1

**Currently not available to new applicants**

**Demonstration project**

Total Funding: $130.8M + $82.8M = $213.6M

Total FTE: 347 + 177 = 524

Source: Conditions of Payment Ministerial Orders for each clinical ARP

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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.)
3. Performance measures & reporting requirements

- Performance goals and measures are developed during the application process

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

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**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
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
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

Dr. Richard Hanelt
Family Physician, Good Samaritan Seniors’ Clinic ARP
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:
  o provide community-based primary health care and specialized geriatric services to seniors with complex medical conditions requiring time-intensive assessment, treatment and management.
  o 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.
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 definition from our current program service day to a program service hour
• Recruitment
• Additional reporting requirements compared to FFS
Perspectives from experienced clinical ARP physicians

Annualized Model

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

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• 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.
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.
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.
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
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)
Perspectives from experienced clinical ARP physicians

Capitation Model

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

### Taber Clinic: Annual Per Patient Costs & Savings 2016-17

<table>
<thead>
<tr>
<th>Annual Costs</th>
<th>Taber</th>
<th>Alberta Rural</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE</td>
<td>$378</td>
<td>$366</td>
<td>$12 higher</td>
</tr>
<tr>
<td>OTHER PROVIDERS (e.g. specialists)</td>
<td>$326</td>
<td>$406</td>
<td>$80 lower</td>
</tr>
<tr>
<td>EMERGENCY DEPARTMENT VISITS</td>
<td>$162</td>
<td>$274</td>
<td>$112 lower</td>
</tr>
<tr>
<td>INPATIENT STAYS</td>
<td>$467</td>
<td>$736</td>
<td>$269 lower</td>
</tr>
</tbody>
</table>

### Crowfoot Village Family Practice (CVFP): Annual Per Patient Costs & Savings 2016-17

<table>
<thead>
<tr>
<th>Annual Costs</th>
<th>CVFP</th>
<th>Alberta Metro</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE</td>
<td>$343</td>
<td>$293</td>
<td>$50 higher</td>
</tr>
<tr>
<td>OTHER PROVIDERS (e.g. specialists)</td>
<td>$521</td>
<td>$510</td>
<td>$11 higher</td>
</tr>
<tr>
<td>EMERGENCY DEPARTMENT VISITS</td>
<td>$86</td>
<td>$110</td>
<td>$24 lower</td>
</tr>
<tr>
<td>INPATIENT STAYS</td>
<td>$298</td>
<td>$517</td>
<td>$219 lower</td>
</tr>
</tbody>
</table>

### Annual Savings:

- Per patient: **$449**
- For all patients at the Taber Clinic: **$7.2M**
- For all patients at the Crowfoot Village Family Practice: **$4.3M**

### 10-Year Savings:

- For all patients at the Taber Clinic (2007-08 to 2016-17): **$62.2M**
- For all patients at the Crowfoot Village Family Practice (2007-08 to 2016-17): **$57.3M**
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.
If you are interested in exploring a cARP, contact the AMA’s ARP Physician Services team to assist you with process.

1. Initial Inquiry
2. Expression of Interest
3. Consent Forms
4. Application
5. Conditions of Payment
6. Expansions / Renewals

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

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Q & A Session
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.
Thank you and please complete the post-session evaluation!
Evaluation