Summary Report

Royal College - National Specialty Societies’
Human Resources for Health Conference — December 7, 2010
*Back to basics: getting the record straight on the numbers and the story they tell*

and

National Specialty Societies’ Summit — December 8, 2010

Office of Health Policy
March 10, 2011
Introduction

Specialties face a number of challenges in planning their human resources for health (HRH) requirements to meet societal health and wellness needs. Many identify data and its analysis as crucial in workforce planning and forecasting but aren’t sure if the data is current, relevant or trustworthy; they would like a better understanding of data sources and the organizations that process, apply, analyze and interpret the findings.

By having modeling theories and techniques explained and contextualized in current practical applications (e.g., as demonstrated by the HealthForce Ontario model and case studies of cardiac surgery and gastroenterology planning scenarios), users can better appreciate the strengths and limitations of data and its throughputs.

In Ottawa on December 7 and 8, 2010, the Royal College hosted 63 delegates representing 26 specialties and seven stakeholder organizations at the Royal College - National Specialty Societies’ Human Resources for Health Conference and Summit.

On the first day, the conference titled, Back to Basics: Getting the Record Straight on the Numbers and the Story They Tell, was inspired from in-depth feedback from 75 per cent of national specialty societies (NSS) organizations and one of their biggest frustrations — data. It was an engaging event fuelled by research findings, expert opinions, HRH case studies and specialty interests. Conference participants reached consensus to move dialogue forward on data-gaps and analytic limitations affecting decision-making in specialty medical workforce planning.

Day two saw the NSS identify other areas for discussion in a specialties-led summit. Topics under the Maintenance of Certification (MOC) program covered a revised definition of unaccredited group learning, discussions on proposed changes to the MOC framework, and establishing reciprocal agreements with the College of Family Physicians (CFPC) and the European Accreditation Council for CME (EACCME). Sponsorship recognition at continuing professional development events was also discussed with the need to clarify parameters.

Day one — Royal College - NSS HRH conference — December 7, 2010

Back to basics: getting the record straight on the numbers and the story they tell

Background

- The 2010 Royal College - NSS HRH conference is the second such event.
- The 2010 program was based on findings from extensive consultations with the NSS, carried out between June and November 2010; input was received by 75% of NSS. A report on consultation findings are under attachment 1 (report) and summarized by Arun Shrichand, Royal College, under attachment 1a (PPT presentation).

Goal

The goal was to establish a course of action with the NSSs and other stakeholders for collecting and sharing comprehensive and accurate data, analysis and knowledge by

- understanding the data and analysis available,
- discussing gaps,
- identifying actions needed to ensure the provision of comprehensive and accurate data and analysis and
- agreeing to the way forward.
Specialties emphasize shortcomings: NSS views

Prior to the conference, key informants and survey respondents identified data, knowledge and workforce supply issues as their most prominent concerns.

Database managers and analysts cite the importance of data quality, standards and indicators — and the need to validate analytic outcomes.

Through online surveys and key informant interviews carried out between June and November 2010, NSS representatives were clear:

- Data, knowledge and supply issues are the most prominent concerns.
- The lack of quantitative and qualitative data, their integrity, collecting them consistently and applying findings correctly to have meaning in practice are issues.
- Standardization of data (e.g., wait times) needs further emphasis.
- The roles of specialties and their unique challenges in determining workload measurements, outcome and output measures and factors affecting specialty decisions need further expansion.
- Workforce research from several specialty societies identified undersupply/oversupply issues. Factors affecting shortages include
  - growing population health needs due to aging, complexity of cases and rural/remote versus urban health care requirements;
  - sustainability factors affected from decrease in government support to maintain and expand residency funding;
  - impact of physicians retirements;
  - shifts in specialty choice and practice locations; and
  - inability to better integrate international medical graduates in planning and education systems.

Issues symptomatic of “oversupply” include

- physicians unable to find work in their fields,
- reduced system capacity despite increasing population health needs,
- budget cutbacks in hospitals, and
- both medical and surgical specialties are affected despite growing patient needs.

Database keepers give their perspectives on collecting and analyzing data

There are a number of medical data holdings in the country. Conference participants heard from three major data holders to demonstrate what data is available and how it is used.

Canadian Institute for Health Information

Geoff Ballinger, Manager of Health Human Resources at the Canadian Institute for Health Information (CIHI), provided an overview of CIHI and CIHI’s Physician Data Holdings. CIHI is a not-for-profit corporation that works on behalf of stakeholders to create and maintain a broad range of health databases, measurements and standards. Its mandate is to promote sound health policy, effective management of the health care system and raise public awareness of health determinants through the management of 28 databases including 11 HRH datasets.

CIHI is strong proponent of data quality and standards. Its physician data holdings show that expenditure growth of physician services has exceeded or matched the growth in spending on hospitals and drugs over the last five years. CIHI is conducting a number of projects that look at national physician database indicators and it is very receptive to work more closely with specialties in terms of data and its analysis. Mr. Ballinger's presentation is under attachment 2.
**Canadian Collaborative Centre for Physician Resources (C3PR)**

The Canadian Collaborative Centre for Physician Resources (C3PR) of the Canadian Medical Association (CMA) conducts research to promote the appropriate supply mix and distribution of physicians to meet Canadian needs. It also provides national leadership in the development of standardized methodologies and approaches to describing and measuring physician resources in Canada.

The presentation by Lynda Buske, C3PR Director, highlighted C3PR’s extensive data holdings, notably the master file on all physicians, CMA student and resident member files and OECD Health Data. The CMA is also a partner in a number of initiatives, including the National Physician Survey, and it has also carried out a number of specialty-specific studies, as well as a number of province and specialty-specific projections. Ms Buske’s presentation is under attachment 3.

**National Physician Survey (NPS)**

Danielle Fréchette, Director of Health Policy at the Royal College, reminded delegates about the importance of the National Physician Survey (NPS), a partnership between the Royal College, CMA and College of Family Physicians of Canada. Conducted every three years, the NPS reaches all physicians in practice and training in Canada. Its goal is to address the education, training, recruitment and retention of physicians to ensure a sustainable workforce ready to meet the changing health needs of Canadians.

The NPS contains a wealth of longitudinal data and cycle-specific data addressing special areas of focus such as: changing scopes of practice, barriers to care, access to care, use of information technology and career selection. NSS are invited to query this unique and robust database that houses more than 50 million data units from responses from physicians, residents and students. Mrs. Fréchette’s presentation is under attachment 4.

**Demystifying HRH Forecasting and Planning**

Forecasting and planning is complex. Approaches are numerous and often elusive. This session provided participants insights into three approaches to HRH modeling and forecasting: an empirical overview, a provincial needs-based model and some key findings, and specialty-specific approaches.

Forecasting models help in patient and provider needs assessments, workforce planning, resource allocations and scenario simulations but they need to have good data inputs to generate useful outcomes for decision-making — and they require dedicated resources.

**Overview of forecasting and planning models**

Rick Cameron, Cameron Health Strategies Group, explained that the goal of HRH planning can be defined as achieving and maintaining an optimal and stable supply and distribution of appropriately trained, deployed, supported and motivated health workforce — with the capacity to respond to current and future population health care needs in a way that maximizes efficiency and effectiveness while being affordable and sustainable.
Key lessons noted by Mr. Cameron are that modeling does have strengths and weaknesses, theoretical/methodological biases and that no one size fits. He stressed that collaborating with other groups, developing data standards and performance indicators and continuously conducting research to feed in fresh data are keys to accurately forecasting patient needs and specialty workforce deployment and resource requirements to support both. Mr. Cameron’s presentation is under attachment 5.

Innovation in needs-based planning

Hussein Lalani, Manager, HHR Forecasting and Modeling Unit, Ontario Ministry of Health and Long-Term Care, described Ontario’s Population Needs-Based Physician Simulation Model. This planning tool can identify potential future trends and simulate the possible impact of policy changes of physician supply in Ontario. The model tool is based on supply and needs factors/inputs to arrive at HRH requirements that will fill the gap between supply of physician services and population need for those services. Mr. Lalani’s presentation is under attachment 6.

Specialty-specific HRH planning approaches:

Gastroenterology
Dr. Des Leddin of the Department of Medicine at Dalhousie University, on behalf of the Canadian Association of Gastroenterology Project, discussed how data and information were collected and used in the project, challenges and gaps, and how they were resolved.

Dr. Leddin highlighted novel approaches, including Practice Audit in Gastroenterology, also known as PAGE, which used personal digital assessments to facilitate data collection about specific procedures. A wealth of unique data and information never before available was collected including patient profiles, clinical approaches and practice variations. The Survey of Access to Gastroenterology in Canada, or SAGE, was presented as a useful approach to measure progress against recommended wait targets. Dr. Leddin explained that a more comprehensive image must also consider other dimensions including better understanding patient need, incidence and prevalence, health care team composition and the role of individual members, appropriateness and outcomes. Dr. Leddin’s presentation is under attachment 7.

Cardiac Surgery
Dr. Christopher Feindel, on behalf of the Canadian Society of Cardiac Surgeons, illustrated the use of “system dynamics” as another modeling approach which entails: determining supply (surgeons) and demand factors (patients), developing interactions (causal loops) and predicting outcomes (demand-supply gap) over time. Particularly troubling is that most scenarios predict a shortage of cardiac surgeons in the not too distant future.

Dr. Feindel also examined the recent and troubling trend of unemployment among some cardiac surgeons and various mitigating approaches, such as adjusting case numbers of high-volume surgeons to redistribute patients to surgeons currently unemployed. He emphasized that failure to curb unemployment trends will lead to a decline in recruitment and a likely crisis of surgeon shortages and weak specialty of cardiac surgery. Dr. Feindel’s presentation is under attachment 8.
Coalescing on issues and action

Conference objectives included identifying the actions needed to ensure the provision of comprehensive and accurate data and analysis, and agreeing to the way forward. Based on learnings from the day and ample discussion with presenters and plenary discussions, delegates agreed on:

- **establishing an HRH hub or consortium** to enhance knowledge exchange capacity in research, inter and intra-professionalism and data management and analysis;
- **refocusing connections with data holders** to better understand their areas of expertise, the data’s functionality and how best to share it;
- **collecting and utilizing pockets of data** including disease incidence and prevalence, impact of gender on practice profiles, different models of care, international medical graduates (including Canadian students studying abroad), medical student recruitment and retention and the impact of new information technology; and
- **promoting the importance of participating in HRH surveys** such as the National Physician Survey and demonstrating the contribution of such information towards addressing HRH issues.
- **creating a modeling system that is nimble** and can anticipate patient needs as well as provider supply and demand requirements.

Delegates also expressed a need for:

- **generating evidence-based and nimble forecasts** for post-graduate training positions, resource allocations, duty hours, etc. — using models of care which address both HRH challenges and patient needs;
- **using relevant and consistent data** that accurately reflects historical performance and current reality into trustworthy trend analyses; and
- **recognizing unique data needs of individual specialties** against the requirements of broader — cross-functional — segments.

Conclusion

Collecting, interpreting and using data require dedicated resources and disciplined approaches. This means that all sources need to be monitored for quality if outputs are to be trusted for planning purposes. Standards must be adopted to ensure cross-functional applications but they must also be flexible to reflect the unique challenges facing individual specialties, the growing complexities of practices and the diverse needs of patients. Key
performance indicators must also measure productivity while being sensitive to provider needs and the vast scopes of practice from team-based settings in large urban areas to rural and remote locations.

Finally, the reliance on modeling to forecast HRH resources should be recognized as an invaluable planning tool — that has limitations — to assist in decision-making. Common sense and verification of findings and simulations should always prevail as a test for quality.
List of attachments – HRH December 2010 Conference

Attachment 1:  Report on pre-Conference Consultations with the NSS
Attachment 1a: Pre-Conference Consultations with the NSS summary: “What you said”, Arun Shrichand – PPT presentation
Attachment 2:  CIHI in brief and CIHI’s Physician Data Holdings, Geoff Ballinger – PPT presentation
Attachment 3:  Canadian Collaborative Centre for Physician Resources (C3PR), Lynda Buske – PPT presentation
Attachment 4:  National Physician Survey, Danielle Fréchette – PPT presentation
Attachment 5:  Health Human Resources Forecasting Models in Canada, Rick Cameron – PPT presentation
Attachment 7:  Canadian Association of Gastroenterology HR Project, Des Leddin – PPT presentation
Attachment 8:  The Current Status of Cardiac Surgery Workforce in Canada, Christopher Feindell – PPT presentation
Maintenance of certification program discussion

Dr. Craig Campbell, Director, Office of Professional Affairs presented a revised draft framework for the Maintenance of Certification (MOC) program framework based on feedback received from Council (in October 2010) and other Fellows and organizations. Dr. Campbell developed a series of questions for participants to address through the use of an audience response system. The questions were intended to invite feedback from participants on a number of issues that had been raised through the consultation process. Examples of the issues raised and discussed included a revised definition of unaccredited group learning, removing credit maximums for Section 1, variable vs. standard credit ratings for scanning activities, as well as credit values for various standard setting activities. A rewards program recognizing Fellows who record more than 400 credits during their MOC cycle was also discussed and not supported by participants.

Concern was expressed about the time-consuming process of documenting learning outcomes for each recorded activity. Participants also expressed interest in establishing reciprocal agreements with the College of Family Physicians (CFPC) and the European Accreditation Council for CME (EACCME).

The feedback and results from the questions were slated for further discussion by the Professional Development Committee and at the next meeting of the Executive Committee of Council in January 2011.

Sponsorship recognition discussion

Dr. Andrew Padmos, Chief Executive Officer, moderated a discussion regarding the Royal College’s recent policy for recognizing the contributions of sponsors for accredited group learning. Dr. Andre Lalonde summarized the Federation of National Specialty Societies of Canada’s (FNSSC) disagreement with current Royal College policy. The FNSSC expressed concern about the financial viability of some National Specialty Societies if they are unable to recognize sponsorship funding in a manner different than restrictions the current policy requires. The discussion noted that the intent of the PDC recommendations was to prevent the perception of bias on the part of physicians who participate in activities that include links to names of sponsors who supported the development of these events.

The FNSSC recommended that tagging be permitted if the CPD provider organization is in control of the needs assessment, choosing of faculty, paying speaker honoraria and conducting content review (where necessary) to ensure the absence of bias. Other organizations supported the current policy as defined by the Royal College.

The participants recommended that the use of sponsor’s names to non-educational items (for example lanyards, kit bags, etc) and the limits / parameters for co-development relationships (particularly with commercial organizations) be clarified.

Since the ability to link the name of a sponsor to a specific educational session within an accredited group learning activity has been extended by the Professional Development Committee until June 30, 2012, this issue will be re-visited before the end of December 2011.
Thank you

The Royal College would like to thank all of the key informants, survey respondents, delegates and their respective organizations and presenters for their participation and valuable contributions to the conference and summit.

The two days were extremely productive and fruitful. We are moving ahead with the “hub”, tracking issues, conducting the “oversupply” study based on the findings from the mini-study and planning for the 2011 Royal College - NSS conference. It is also hoped that the NSS summit provided added clarity to Royal College program development and engaged the NSS.

Special thanks go to the following keynote speakers for their insights:

- Geoff Ballinger, Canadian Institute for Health Information, CHI
- Lynda Buske, Canadian Collaborative Centre for Physician Resources, Canadian Medical Association
- Rick Cameron, HRH Forecasting Models in Canada, Cameron Health Strategies Group
- Dr. Christopher M. Feindel, The Current Status of Cardiac Surgery Workforce in Canada, Canadian Society of Cardiac Surgeons
- Hussein Lalani, Health Force Ontario, Filling An Evidence Gap, The Ontario Population Needs-Based Physician Simulation Model, HHR Forecasting and Modeling Unit, HHR Policy Branch Ontario Ministry of Health and Long-Term Care
- Dr. Des Leddin, Canadian Association of Gastroenterology HR Project, Department of Medicine, Dalhousie University