WHEREAS the OMA and the MOHLTC are parties to an agreement which covered the period from April 1st, 1997 to March 31st, 2000 (the "1997 Agreement");

AND WHEREAS The Physician Services Committee, established under the 1997 Agreement, has recommended to the parties several initiatives during the term of the Agreement which were implemented during such term;

AND WHEREAS the Government of Ontario has historically consulted and negotiated with the OMA as the representative of the medical profession in Ontario;
AND WHEREAS the MOHLTC is the Minister of the Government of Ontario charged with health care in the Province of Ontario;

AND WHEREAS the parties wish to continue to work together in order to improve health care in the Province of Ontario;

NOW the OMA and the MOHLTC have come to the following Agreement:

1.0 GENERAL

1.1 The MOHLTC acknowledges the OMA as the representative of the medical profession for the purpose of these negotiations and this Agreement. For its part, the OMA acknowledges the responsibility of the MOHLTC to manage the Ontario health care system. Both the OMA and the MOHLTC acknowledge the on-going responsibility of the MOHLTC, the OMA and the medical profession it represents to ensure that reasonably accessible medical services are provided to all insured persons in Ontario requiring medical services.

1.2 The parties acknowledge that major and rapid changes are occurring in the way in which health care is delivered in Ontario. Changes are necessary in order to meet the demands and needs of a changing Ontario population requiring health care services. The parties acknowledge that changes must be attained within appropriate budgets established by the Government of Ontario for the MOHLTC. The parties also acknowledge that the continued representation of the medical profession by the OMA during this time of rapid change will require further clarification and the parties agree to discuss this issue in accordance with the terms set out in this Agreement.

2 PHYSICIAN SERVICES COMMITTEE

2.1 The parties agree to continue the Physician Services Committee ("PSC") which is charged with the responsibility of developing a strong relationship between Ontario's physicians and the MOHLTC. The PSC will continue to provide a broad and structured process for regular liaison and communication between the MOHLTC and the medical profession, through its representation by the OMA. The mandate and terms of reference of the PSC are as set out in Appendix "A" to this Agreement.

3 REVISIONS TO THE SCHEDULE OF BENEFITS - PHYSICIAN SERVICES ("Schedule
3.1 The parties agree to the following revisions to the Schedule of Benefits:

   a) 1.95% effective April 1, 2000,
   b) 2% effective April 1, 2001,
   c) 2% effective April 1, 2002, and
   d) 2% effective April 1, 2003.

The parties agree that they will meet in March, 2003 to negotiate whether the 2% revision effective April 1, 2003 shall be increased and for this purpose may take into consideration the prevailing economic conditions.

4 INCORPORATION

4.1 The MOHLTC agrees to recommend to the Government of Ontario that it introduce legislation as soon as possible to allow Ontario physicians to incorporate and to further recommend that the Government of Ontario consult with the OMA.

5 ACADEMIC HEALTH SCIENCES CENTRES

5.1 The MOHLTC and the OMA agree that physicians working at Academic Health Sciences Centers ("AHSC") need to be funded in innovative ways in order for these institutions to fulfil their important patient service and academic activities. The MOHLTC intends to make physician alternative payment plans available to the individual AHSCs on a voluntary basis. Implementation issues with respect to such AHSCs are apart and separate from this Agreement. However, the parties acknowledge that conversion of the actual value of services provided by physicians from the fee-for-service pool or pools will take place. The manner in which such conversions out of the fee-for-service pool or pools shall be calculated shall be agreed between the parties prior to such conversion. The MOHLTC acknowledges that it will incur additional costs to implement these alternative payment modalities.

6 PRIMARY CARE
6.1 The OMA and the MOHLTC have jointly established seven pilot sites across the Province to investigate the feasibility and effectiveness of the primary care reform models in place at each of these sites. The OMA and the MOHLTC are committed to continuing these efforts. The parties therefore agree to continue with primary care reform based on the following principles:

1. There will be freedom of choice for both physicians and patients as to whether they wish to participate in primary care reform, and
2. Evaluation of primary care reform shall continue in order to inform the parties of the preferred direction with respect to further implementation.

6.2 The issue of physician and patient accountability shall be determined after an evaluation of the PCR pilot sites.

6.3 The MOHLTC will contribute funding for the acquisition of Primary Care Reform ("PCR") information systems.

6.4 Pending an evaluation to the contrary, no limit shall be set on roster sizes in future Primary Care Network ("PCN") contracts, provided that the physician to whom the patient is rostered personally and directly provides the majority of primary care medical services to the patient.

6.5 Physicians choosing to participate in new PCNs shall be eligible to do so subject to the conditions established in the template agreements governing such sites and subject to the availability of sufficient funds in any given fiscal year of this Agreement. The template agreements to cover physicians participating in primary care reform are separate and apart from this Agreement. However, the parties acknowledge that conversion of the actual value of services provided by physicians to rostered patients from the fee-for-service pool or pools will take place. The parties further agree that the method of calculating such conversions shall be agreed prior to any further implementation. The MOHLTC acknowledges that it will incur additional costs to implement primary care reform.

6.6 The parties agree that the final form of the agreements for physicians participating in primary care reform shall be available for consideration by physicians in advance but will not be offered for implementation prior to April 1st, 2001.

7 PATIENT CARE ENHANCEMENTS

7.1 The parties agree to several initiatives that are designed to enhance the delivery of certain needed services to the patients of Ontario and to provide appropriate incentives to those physicians prepared to provide such services. Some of these initiatives will be provided through hospitals under the advice and supervision of the hospital Medical Advisory Committee. Other initiatives shall be provided for by changes to the Schedule of Benefits. The initiatives to be provided through changes to the Schedule of Benefits shall be effective July 1st, 2000, and the initiatives to be provided through hospitals shall be effective September 1st, 2000.
7.2 The initiatives to be provided through hospitals are:

- GP hospital on-call coverage;
- Specialist hospital on-call coverage;
- Rurality premium; and
- GP anaesthesia premium,

and are more fully described in Appendix G to this Agreement.

7.3 The initiatives to be provided through changes to the Schedule of Benefits are:

- low volume obstetrics incentive;
- admission assessments;
- home care application;
- home care supervision;
- complex care of the elderly; and
- after-hour premiums.

and are more fully described in Appendix G to this Agreement.

7.4 Mental Health Sessional Payments
The parties agree to increase the current number of mental health sessional payments as more fully described in Appendix G to this Agreement.

7.5 Hospital On-Call Coverage Committee ("HOCC")
The manner by which each hospital shall be funded for on-call coverage (GP and Specialist) and the extent of such funding will be established through a joint hospital on-call coverage committee of the MOHLTC and the OMA in consultation with the Ontario Hospital Association.

7.6 It shall be the function of the HOCC to ensure that appropriate mechanisms are in place in each hospital to which such funds are flowed to ensure that the funds are used only for the purposes outlined and in the manner specified herein and to develop a template agreement dealing with the funding and service obligations for hospital on-call coverage. The HOCC shall also ensure that appropriate steps are taken at eligible hospitals to provide reasonable coverage in each specialty area for which funding is provided as a condition of such funding. It is recognized that some hospitals require a different mix and supply of priority medical programs and consideration may be given to changes in the categorization of specialties set out in Appendix "G" to this Agreement to accommodate such needs.
8.1 The parties agree that there is an on-going need to manage the growth in the cost of the physician services system caused by factors such as an aging and increasing population, the addition of new physicians to the system, new technology and physician and patient behaviour.

8.2 The parties agree to establish a sub-committee of the PSC, the System Management Committee, to advise the PSC in connection with system management.

8.3 The MOHLTC acknowledges that resources separate and apart from any fee increases will be required to address these system management factors. The PSC may make recommendations to the MOHLTC with respect to the need for additional system management resources.

8.4 For the purpose of system management, the MOHLTC agrees that it will not introduce any clawbacks from payments during the term of this Agreement with respect to services rendered before or during the term of this Agreement, it being understood that the MOHLTC reserves its customary rights with respect to taking steps in relation to system growth.

9.0 TECHNICAL FEES

9.1 The parties recognize that utilization increases in technical fees are influenced by factors which are different, or of a different magnitude, from the factors which influence physician services generally, such as new technologies and the increasing demand for these technologies.

9.2 During the 1997 Agreement, the parties in conjunction with the Ontario Hospital Association established the Committee on Technical Fees ("COTF") to study technical fees and utilization and to report back to the three parties involved. Although an Interim Report has been prepared, no final recommendations have been made. The Interim Report recommended that effective April 1st, 2001, the technical fees from the fee-for-service pool be combined with the amount spent by hospitals to provide similar in-patient services to form a combined technical fee pool to be jointly managed by the three parties.

9.3 Accordingly, the parties have agreed that no final decisions should be made at this time with respect to technical fees. However, on a temporary basis, the parties are agreed that in the interim they will segregate technical fees from professional fees, and that the COTF will investigate and make recommendations to the PSC concerning system growth and controls, fees and related matters with respect to technical fees. It is further agreed that the COTF will report back to the PSC its recommendations with respect to system growth and controls for the fiscal year 2000/2001 by July 31st, 2000.

9.4 The parties agree to segregate technical fees into a Technical Fees Pool ("T-Fees Pool") as of March 31st, 2000. The T-Fees Pool shall comprise all payments by OHIP for technical fees for diagnostic services provided in hospitals, independent health facilities and physician offices in fiscal year 1999/2000. The parties agree that for fiscal year 2000/2001, the T-Fees Pool will be augmented by an amount equal to 1.95% of the amount of the T-Fees Pool on March 31st, 2000.
9.5 The funding of the T-Fees Pool shall not be adjusted in fiscal year 2000/2001 in any other way until such time as the COTF investigates and makes recommendations to the PSC concerning system growth and controls, fees and related matters with respect to technical fees.

9.6 The recommendations of the COTF will be taken into consideration when deciding how to apply the percentage increases set out in sub-sections 3.1(b), (c) and (d) of this Agreement for technical fees in future fiscal years.

10.0 MALPRACTICE INSURANCE COVERAGE

10.1 Since the recent announcement by CMPA of coverage on a regional basis, and the very large increases in the cost of coverage that CMPA asserts would result, the parties agree on the urgent need to examine all available alternatives for the provision of malpractice insurance coverage to the physicians of Ontario.

10.2 The MOHLTC and the OMA agree to establish a Physician Malpractice Insurance Expert Committee to urgently evaluate all available options for the supply of malpractice insurance coverage to Ontario physicians, the anticipated cost of providing such coverage and how risk management and case management practices could be provided in conjunction with such coverage. The terms of reference of this committee stipulate that the coverage to be provided must be essentially equivalent to the malpractice insurance coverage currently provided by CMPA.

10.3 The parties agree that this expert committee will report to the parties no later than June 15th, 2000 with their recommendations. The parties agree to review these recommendations and to agree on the manner by which this coverage is to be provided and funded by July 15th, 2000. If the parties are unable to agree, they shall enter into negotiations to deal exclusively with this issue. The terms of reference of this committee are set out in Appendix "C" to this Agreement.

10.4 The Committee shall be cognizant of the potential negative impact of any increased financial burden upon the Government of Ontario and physicians of Ontario.

11.0 PHYSICIAN HUMAN RESOURCES

11.1 The parties agree to continue the Physician Human Resources Committee to report to and advise the PSC with respect to the following mandate:

i. to report to the PSC on the recommendations of the Expert Panel on Health Human Resources ("Expert Panel");
ii. to assist in the implementation of the Expert Panel recommendations pertaining to physician human resources;

iii. to monitor programs that have been established or are established during the operation of this Agreement to deal with problems of oversupply or undersupply; and

iv. to review the need for physician recruitment and retention in underserviced areas and to make recommendations to the PSC. The initial sites to be considered include the northern urban referral sites.

11.2 Elimination of New Entrant Discounts

Notwithstanding the provisions of the 1997 Agreement, the differentiated fees in effect in designated oversupplied areas shall cease to apply as of January 1, 2000.

12.0 NORTHERN AND RURAL RECRUITMENT AND RETENTION

12.1 The OMA and the MOHLTC agree to review the urgent need for physician recruitment and retention in underserviced areas. This task shall be given priority by the PSC and it shall make recommendations to the parties by November 30, 2000. The initial sites to be considered include the northern urban referral sites.

13.0 SCHEDULE OF BENEFITS

13.1 The parties agree that by December 31, 2000 they shall identify changes in the existing Schedule of Benefits which will result in annual savings of at least $50 million. This will be accomplished by a mix of tightening and modernization. The process for identifying and making the changes will be agreed upon by the parties.

14.0 GENERAL MATTERS

14.1 Thresholds

The parties agree that for fiscal year 2000/2001, the physician thresholds shall be:
### 14.2 Service Retention Initiative

The parties agree to establish a Service Retention Initiative to replace the existing SRI program and shall ask the Physician Human Resources Committee to investigate and make recommendations to the PSC with respect to this initiative and its implementation and monitoring.

### 14.3 Maternity Benefits

The parties agree to establish a Maternity Leave Benefits Program which will pay 50% of the fee-for-service billings or APP remuneration up to a maximum of $880 per week for 17 consecutive weeks to commence no later than two months following the date of birth of the child or date of the hospital discharge of the child. The details of this program, including its administration, will be developed by PSC for recommendation to the parties.

### 15.0 ALTERNATE PAYMENT PLANS/INTEGRATED HEALTH CARE SYSTEMS

15.1 The MOHLTC agrees that the OMA will be notified of all expressions of interest made to or by the Ministry to establish an Alternate Payment Plan "APP"), a health services organization, an integrated delivery system or integrated health care system or any other non-fee-for-service delivery model.

15.2 The MOHLTC further agrees that the OMA will be notified of any intention to commence negotiations or re-negotiations with respect to any of the foregoing non-fee-for-service arrangements.

15.3 The OMA will be recognized as the representative of those physicians participating in a non-fee-for-service arrangement that request the OMA to represent them for the purpose of the negotiation or re-negotiation of the terms and conditions of
their contractual relationship.

15.4 The MOHLTC agrees that the OMA shall be a participant in its own right in all AHSC APP negotiations.

15.5 The MOHLTC agrees that the OMA shall be the representative of all physicians converted to Primary Care Reform for the purposes of negotiating the template agreements that apply to all primary care sites.

15.6 The MOHLTC agrees that all agreements that it enters into, amends or renews, with any third party that provides for, or funds, in whole or in part, the compensation of physicians, shall contain a provision requiring all such physicians, whether a member of the OMA or not, to pay the OMA dues and assessments that the OMA would charge each such physician, if he or she were a member of the OMA and requiring the third party to deduct such amounts from the compensation owed to each physician and remit such amounts to the OMA. The MOHLTC further agrees that it shall require that the OMA be made a party to all such agreements with third parties with respect to the provisions regarding enforcement of OMA dues and assessments.

16.0 RESOURCE BASED RELATIVE VALUE SCHEDULE COMMISSION

16.1 The parties agree to continue the Resource Based Relative Value Schedule Commission "RBRVSC"). The mandate and terms of reference of the RBRVSC are as set out in Appendix "E" to this Agreement. The role of the RBRVSC is to determine the relative value of services provided by physicians on a revenue neutral basis. The parties agree that the process shall proceed as expeditiously as possible and that a full indivisible RBRV Schedule is to be produced as soon as possible.

16.2 The parties may agree that the implementation of the RBRVS be taken into consideration in deciding how to apply the percentage increases set out in Article 3 of this Agreement.

17.0 INCENTIVE FUNDING FOR RURAL STUDENT CLERKSHIP ROTATION

17.1 The MOHLTC will provide funding to encourage students to perform clinical rotations in a northern or rural area during their clerkship. This program will supplement any existing funding to a total maximum of $1,500 per month per student for transportation and accommodation. The funding is for a minimum of 4 weeks and a maximum of 12 weeks. The details of this program shall be established by the parties.
18.0 GUIDELINE ADVISORY COMMITTEE

18.1 The parties agree to continue the Guideline Advisory Committee “GAC”) to advise the PSC with respect to practice, prescribing and referral guidelines for physicians. The mandate and terms of reference for the GAC are as set out in Appendix “F” attached to this Agreement.

19.0 MEDICAL REVIEW COMMITTEE

19.1 The parties previously agreed to changes made to the regulations regarding the Medical Review Committee “MRC”) under the Health Insurance Act and established a pre-screening process to review complaints prior to the referral to the MRC.

19.2 The parties agree to examine the manner in which physicians’ billings are reviewed by the MOHLTC and by the MRC and to consider whether an alternative approach would be more appropriate.

19.3 Accordingly the parties agree to establish a joint committee with equal representation from the OMA and the MOHLTC to review the MRC process and make recommendations to the parties.

19.4 The committee will be instructed to prepare its report and recommendations for delivery to the parties during the first year of this Agreement.

20.0 ONTARIO GOVERNMENT FORMS

20.1 The OMA and the MOHLTC agree to establish a committee to review the present list of government forms and any new proposals for forms and consider the need and payment for completion of such forms.
21.0 TERM AND RENEWAL

21.1 This Agreement will terminate at the end of March 31, 2004. Negotiations to establish the next Physician Services Agreement will begin no later than January 10, 2004. The MOHLTC recognizes the OMA as the representative of the medical profession for the purpose of these negotiations.

The undersigned representatives of the parties hereby agree to unanimously recommend acceptance of this Agreement to their respective principals.

FOR THE OMA

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FOR THE MOHLTC

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APPENDIX "A"

PHYSICIAN SERVICES COMMITTEE

1. The PSC will consist of five members appointed by the OMA and five members appointed by the MOHLTC, all of whom will be expected to remain on the Committee for a minimum of two years and adopt roles of leadership in the performance of the PSC mandate.

2. The PSC will be chaired by a professional facilitator chosen by the parties.

3. The PSC will continue training in conflict resolution and relationship-building as the parties may deem appropriate.

4. The agenda of the PSC will be as determined by the facilitator in consultation with the co-chairpersons.
appointed by each party.

5. Each party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the cost of the facilitator.

6. The PSC will meet at least twice per month.

7. The mandate for the PSC is as follows:

(i) to build and sustain a strong positive working relationship between the Government of Ontario and the medical profession;

(ii) to receive and consider reports and recommendations as set out in this Agreement;

(iii) to advise the MOHLTC and the OMA in connection with the changing role of physicians within the health care system, including possible improved models of delivery of and compensation for services;

(iv) to develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to MOHLTC leading to the enhancement of the quality and effectiveness of medical care in Ontario;

(v) to work together toward identifying efficiencies and maximizing return on the funding provided for medical services;

(vi) to review utilization on a monthly basis and recommend to the MOHLTC and the OMA appropriate and effective steps to be taken to deal with utilization changes;

(vii) to develop and recommend patient education programs;

(viii) to review any disagreement arising out of this Agreement referred to it by either party and make recommendations to the parties regarding the resolution of the disagreement. However, the parties need not make such a referral as a pre-condition to commencing any other dispute resolution mechanism;

(ix) to study the report of the Physician Malpractice Insurance Expert Committee and to make recommendations to the parties as to how malpractice insurance for Ontario physicians should be provided effective January 1st, 2001; and

(x) to monitor the impact of hospital restructuring on utilization and the cost of physician services.
8. The PSC is committed to giving appropriate opportunity to affected parties to provide timely input to the PSC before making recommendations to the MOHLTC and the OMA.

APPENDIX "B"

AFTER HOUR PREMIUM CODES

Special Visit to Hospital In-Patient

C994—Evenings, Saturdays, Sundays, Holidays—first patient seen $43.70
--for each additional patient requiring a special visit and seen during the same special visit, add 40% to consultation or visit—minimum premium $20.63

C995—Nights—first patient seen $65.58
--for each additional patient requiring a special visit and seen during the same special visit, add 62.5% to consultation or visit—minimum premium $31.20

Special Visit to Office or Other Similar Facility: use the appropriate listing above but substitute the prefix "A" for "C".

Special Visit to Patient’s Home or a Multiple Resident Dwelling: Use the appropriate listing above but substitute the prefix "B" for "C". Applies only to B994 and B996.

Special Visit to Emergency Department or Out-Patient Department: Use the appropriate listing above but substitute the prefix "K" for "C".

Special Visit to Long-Term Care Institution: Use the appropriate listing above but substitute the prefix "W" for "C". Applies only to W994 and W996.

C998B—Special Visit to Assist at Non-Elective Surgery—evenings, weekends, holidays...
C999B—Special Visit to Assist at Non-Elective Surgery—nights...
E400B—surgical assist—evenings, weekends, holidays...
E401B—surgical assist—nights...
C998C—Special Visit, anaesthesia, Non-Elective—...
C999C—Special Visit, anaesthesia, at Non-Elective—...
E400C—anaesthesia—evenings, weekends, holidays—By 45%
E401C—anaesthesia—nights—By 62.5%

E409—non-elective surgical procedure premium—evenings, weekends, holidays—40%
E410—non-elective surgical procedure premium—nights—62.5%

NOTES:

1. C99x codes will be limited to a maximum of 3 per physician per day.
2. Evenings are defined as 18:00h to 24:00h.

APPENDIX "C"

PHYSICIAN MALPRACTICE INSURANCE EXPERT COMMITTEE

1. The Physician Malpractice Insurance Committee will consist of ten members appointed by the parties, and an expert chair acceptable to both parties.

2. The MOHTLC will fund the costs of the committee.

3. The mandate for the Physician Malpractice Insurance Expert Committee shall be:

   (i) to investigate on an urgent basis the options by which physician malpractice insurance coverage essentially equivalent to the physician malpractice insurance coverage currently provided by CMPA could be made available to Ontario physicians;

   (ii) to examine the cost of providing such insurance coverage;

   (iii) to determine how risk management and case management practices could be provided in conjunction with such coverage;

   (iv) to report its findings and recommendations to the parties by no later than June 15th, 2000; and

   (v) to perform other related functions as may be requested by the PSC.
APPENDIX "D"

IN-HOSPITAL AFTER-HOURS SERVICES EXEMPTED FROM THRESHOLDS

Special Visit to Hospital In-Patient: C994, C995, C996, C997 and associated services

Special Visit to Emergency Department or Out-Patient Department: K994, K995, K996, K997 and associated services

C998B and C999B: Special Visits to Assist at Non-Elective Surgery and associated services

E400B and E401B: surgical assist premiums and associated services

C998C and C999C: Special Visits, anaesthesia, at Non-Elective Surgery and associated services

C109 and C110: Special Visits, Non-Elective Diagnostic and Therapeutic Procedures and associated services,

E400C and E401C: anaesthesia premium and associated services

E402 and E403: Special Visits, epidurals and associated services,

E409 and E410: non-elective surgical procedure premium and associated services

Emergency Department—Physician on Duty: H151 to H154, H121 to H124, H112, H113 and associated services

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APPENDIX "E"

RESOURCE BASED RELATIVE VALUE SCHEDULE COMMISSION

MANDATE AND TERMS OF REFERENCE

Mandate:

1. To produce a complete and indivisible Resource Based Relative Value Schedule for recommendation to
AGREEMENT

both the OMA and the MOHLTC.

2. To receive submissions from the MOHLTC, the OMA and other appropriate parties as determined by the Commission, prior to producing such schedule.

Terms of Reference:

1. The Commission will consist of two appointees from each of the OMA and the MOHLTC and a neutral chair to be agreed upon by both parties.

2. The MOHLTC will pay for the Chair of the Commission and such expenses of the Commission as agreed upon between the OMA and the MOHLTC.

3. All payments to and expenses incurred by the appointees of the MOHLTC and the OMA will be the responsibility of the MOHLTC and the OMA respectively. Similarly, all expenses incurred by the MOHLTC, the OMA or any other appropriate party in relation to making submissions to the Commission will be borne by the party making the submissions.

4. The Commission will produce the complete and indivisible schedule as soon as possible.

5. The Commission will continue to provide an adequate opportunity to all appropriate parties to make submissions at all remaining stages of its mandate.

6. The Commission will continue to establish its own procedure and rules.

7. The MOHLTC and the OMA agree to assist the Commission by providing to it available information on RBRVS. All information supplied by either party will be made available by the Commission to the other party on the explicit understanding that such information will be used only for the purposes of making submissions to the Commission.

8. The Commission will report its findings and recommendations, together with a complete and indivisible RBRV Schedule, to the OMA and the MOHLTC simultaneously. If the Schedule so produced is implemented by the MOHLTC, it will be implemented in its entirety.

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APPENDIX "F"

GUIDELINE ADVISORY COMMITTEE

1. The Guideline Advisory Committee ("GAC") will consist of three members appointed by the OMA, three
AGREEMENT

persons appointed by the MOHLTC and a chair to be selected by the parties.

2. The GAC will be aided in its work by the appointment of a person from the Institute for Clinical Evaluative Sciences.

3. Each party will fund its own members and the MOHLTC will fund the administration costs of the Committee.

4. The mandate for the GAC is:

   (i) to develop and recommend to the PSC appropriate strategies for the implementation and monitoring of practice and referral guidelines;

   (ii) to make recommendations for assisting in the implementation of prescribing guidelines; and

   (iii) to consult widely with the profession in the development of its recommendations.

5. All information concerning physician practices and procedures obtained by the GAC shall be maintained confidentially by it and used only for the purpose of developing appropriate guidelines.

APPENDIX "G"

PATIENT CARE ENHANCEMENTS

A. HOSPITAL INITIATIVES

(1) General Practice Hospital On-Call Coverage

For the purpose of General Practice hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section (1) are provided except federally funded hospitals and those within an AHSC that has an alternate funding plan covering these services.

General and family practitioners shall be reimbursed for being available to provide after-hours hospital services such as surgical assisting, emergency department back-up coverage and in-patient care.

The following will be used to determine the amount payable for full coverage per eligible hospital per 12 month period.
(a) All Hospitals Except Level A, B, 1, 2 or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

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<thead>
<tr>
<th># of Participating Physicians</th>
<th>Payment per Hospital</th>
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<tr>
<td>5 or more</td>
<td>$75,000</td>
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<tr>
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<td>$45,000</td>
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(b) Level A, B, 1, 2 or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

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<th># of Participating Physicians</th>
<th>Payment per Hospital</th>
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<td>$25,000</td>
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(2) Specialist Hospital On-call Coverage

For the purpose of specialist hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section (2) are provided except federally funded hospitals and those within an AHSC that has an alternate funding plan covering these services.

This initiative is being undertaken to address on-call specialist coverage in Ontario. Coverage less than full coverage shall be prorated on approval by HOCC.

(a) Level II Specialists

The parties agree that funding will be provided for specialists being available to provide on call hospital services in the specialties of Anaesthesia, General Surgery, Orthopaedic surgery, Psychiatry, Internal Medicine, Obstetrics and Gynaecology, and Paediatrics.
The following will be used to determine the amount payable to eligible hospitals for full coverage per specialty per 12-month period.

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<th># of Participating Physicians</th>
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<td>$45,000</td>
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(b) Level III Specialists

Funding will also be provided to specialists being available to provide on-call hospital services in the specialties of Cardiothoracic Surgery, Neurosurgery, Cardiology, Emergency Medicine, Gastroenterology, Haematology/Oncology, Neurology, Ophthalmology, Otolaryngology, Plastic Surgery, Respiratory Medicine, Diagnostic Radiology, and Urology.

The following will be used to determine the amount payable to eligible hospitals per specialty per 12-month period.

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<th># of Participating Physicians</th>
<th>Payment per Hospital</th>
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<tr>
<td>5 or more</td>
<td>$15,000</td>
</tr>
<tr>
<td>4</td>
<td>$14,000</td>
</tr>
<tr>
<td>3</td>
<td>$13,000</td>
</tr>
<tr>
<td>2</td>
<td>$12,000</td>
</tr>
<tr>
<td>1</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

(c) Level IV Specialists

Funding will also be provided to eligible hospitals for specialists being available to provide on-call hospital services in the specialties of Immunology, Dermatology, Physical Medicine and Rehabilitation, Rheumatology, Nuclear Medicine and Radiation Oncology.

Where one of the above specialists, in an eligible hospital, performs a special visit in the evening, night, on weekends or holidays, the hospital shall receive, a call-in fee of $100 in addition to any other fee-for-service amounts which may be billed. The physician will be limited to 2 call-in fees per calendar day.
(3) Rurality Premiums

Each hospital set out in Appendix “H” to this Agreement shall receive a $15,000 per annum financial incentive for GP on-call funding. This incentive is in addition to the on-call funding as set out in this Appendix.

(4) GP Anaesthesia Premium

This premium is intended to assist in retaining GP anaesthetists within rural communities.

Each eligible hospital as determined by the HOCC that does not have a Royal College certified anaesthetist associated with it and where general practitioners provide a minimum of $10,000 of anaesthetist services per year will receive an additional $15,000 per annum. This incentive is in addition to the on-call funding as set out in this Appendix.

B AMENDMENTS TO THE SCHEDULE OF BENEFITS

(1) Low Volume Obstetrics Incentive

It is important to maintain family physician involvement in obstetrical services.

Where a physician has only one delivery in a calendar day, there shall be a 50% premium applied to such delivery, to a maximum of 25 deliveries in any fiscal year per physician. This premium will apply only to the following codes as set out in the Schedule of Benefits: P006, P009, P018, P020 and P038.

(2) Admission Assessments

General Practitioners who are on-call and admit a non-elective patient through an emergency room or as a transfer from another institution will receive an admission assessment fee of $75.00. This fee compensates the physician for performing a complete history and physical examination. It cannot be billed within 30 days of any other admission assessment for that patient and is available only to the most responsible physician dealing with that patient in the hospital.

(3) Home Care Application: $16.50

This fee will be payable to the most responsible physician for personal completion and submission of a home care service request form to the Community Care Access Centre ("CCAC") on behalf of a patient for whom the physician provides on-going primary care. The service may be claimed in addition to an appropriate assessment.

(4) Home Care Supervision: $10.40
This fee will be payable to the most responsible physician for providing advice, direction or information in response to an inquiry from staff of a CCAC or CCAC contractor on behalf of a patient for whom the physician provides on-going primary care. The physician must record the date, question, response and identity of the CCAC staff in the patient's medical record.

(5) Complex Care of the Elderly: $10.30

A 20% premium will be added to the general assessment code (A003) for services provided to patients who are 75 years of age or older. This general assessment premium can be charged only once per patient per year.

(6) Mental Health Sessional Payments

Effective April 1, 2000 the number of psychiatry sessions for patients will increase by 13,500 per year.

(7) After Hour Premiums

To compensate physicians who perform after hours work, there will be an increase in the following after hour premium codes and special visit premium codes:

a. Evening and night in-patient services;
b. Special visits to the office;
c. Special visits to the emergency room or out-patients department;
d. Special visits to long term care institutions;
e. Special visits to patient's home;
f. Anaesthetics or surgical assists; and
g. After hour obstetrical and non-elective surgical procedures, which are more specifically described in Appendix B. Notwithstanding sub-section 3.1a), these premium codes shall be the amounts listed in Appendix B. Thereafter, the System Management Committee will consider the feasibility of making further revisions to the premium codes listed in Appendix B and make recommendations in that regard to the PSC.

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APPENDIX "H"

HOSPITALS ELIGIBLE FOR THE RURALITY PREMIUM

Bruce Peninsula Health Service – Lions Head
Bruce Peninsula Health Service – Wiarton
AGREEMENT

Campbellford Memorial Hospital
Centre Grey General Hospital, Markdale
Chapleau General Hospital
Deep River and District Hospital
District Health Centre, Sioux Lookout
Dryden District General Hospital
Durham Memorial Hospital
Espanola General Hospital

Four Counties General Hospital, Newbury
Glengarry Memorial Hospital, Alexandria
Haliburton Highlands Health Services - Haliburton
Haliburton Highlands Health Services – Minden
Kirkland and District Hospital
Mattawa General Hospital
Meaford General Hospital
MICS Group of Hospitals – Cochrane
MICS Group of Hospitals – Iroquois Falls
MICS Group of Hospitals – Matheson

Notre Dame Hospital, Hearst
Palmerston and District Hospital
Quinte Healthcare Corporation – Bancroft
Riverside Health Care Facilities – Fort Frances
Saugeen Memorial Hospital, Southampton
Sensenbrenner Hospital, Kapuskasing
Smooth Rock Falls Hospital
South Grey Bruce Health Centre - Chesley
South Grey Bruce Health Centre - Kinardine
South Grey Bruce Health Centre – Walkerton

South Huron Hospital – Exeter
St. Francis Memorial Hospital, Barry’s Bay
St. Joseph’s General Hospital, Blind River
St. Joseph’s General Hospital, Elliot Lake
Temiskaming Hospitals, New Liskeard
West Nipissing General Hospital, Sturgeon Falls
West Parry Sound Health Centre
Wingham and District Hospital

LETTER OF UNDERSTANDING
April 26, 2000

Dear Dr. Wexler:

**Re: Data from the Minister of Health and Long-Term Care**

This will confirm our understanding with respect to the provision of data required by the OMA or the PSC and its reporting committees.

1. **Negotiations**

   The OMA will continue to provide the MOHLTC with a list of all data it seeks for negotiation or other agreed to purposes. In return, the MOHLTC will provide the OMA with all requested data that it believes it can legally so provide. In the event there is disagreement over whether specific data so requested can be made available, the issue will be referred to the Privacy Commissioner for determination. All information obtained by the OMA shall be maintained confidentially by it and used solely for the purpose of negotiations or other approved purposes.

2. **PSC and Constituent Committees**

   The PSC will continue to provide the MOHLTC with a list of all data it seeks for the purposes required by it or its constituent committees. In return, the MOHLTC will provide the PSC with all requested data that it believes it can legally so provide. In the event there is disagreement over whether specific data so requested can be made available, the issue will be referred to the Privacy Commissioner for determination. All information obtained by the OMA shall be maintained confidentially by it, the PSC and its constituent committees and used solely for the purposes of the PSC and its constituent committees.

3. **OMA Monitoring Information**

   The MOHLTC agrees that the OMA requires certain data in order to meet its obligations to its members and pursuant to the Agreement. The OMA will provide the MOHLTC with a list of all data it seeks for monitoring purposes. In return, the MOHLTC will provide the OMA with all types of data reasonably available and that it believes it can legally provide. In the event there is disagreement over whether specific data so requested can be made available, the issue will be referred to the Privacy Commissioner for determination.

Yours truly,

Elizabeth Witmer
Minister of Health and Long-Term Care
Dear Dr. Wexler:

Re: Meetings with the Minister of Health and Long-Term Care

This will confirm our understanding with respect to regular meetings between the Ontario Medical Association and the Minister of Health and Long-Term Care.

As part of our intent to strengthen the relationship among the medical profession, the Ontario Medical Association and the Minister of Health and Long-Term Care, the Minister of Health and Long-Term Care will meet with the President of the OMA and the CEO of the OMA at least once every two months for the purpose of discussing matters of mutual concern and interest.

It is acknowledged that these meetings are not intended to be in place of the meetings of the Physician Services Committee.

Yours very truly,

Elizabeth Witmer
Minister of Health and Long-Term Care