

MEMORANDUM OF AGREEMENT

BETWEEN:

THE ONTARIO MEDICAL ASSOCIATION

(The “OMA”)

- and -

**HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
AS REPRESENTED BY THE
MINISTER OF HEALTH AND LONG-TERM CARE
(The “MOHLTC”)**

WHEREAS the OMA and the MOHLTC are parties (the “Parties”) to a Physician Services Agreement in effect until March 31, 2008 (the “2004 Agreement”), a Reassessment Agreement made pursuant thereto in 2007, and had previously been Parties to Agreements in 1996, 1997 and 2000 and a Memorandum dated April 8, 2003;

AND WHEREAS the Government of Ontario consults and negotiates with OMA as the representative of the medical profession in Ontario;

AND WHEREAS the MOHLTC is charged with the responsibility for health care in the Province of Ontario in a stewardship role;

AND WHEREAS over the past four years the Parties have demonstrated that a focus on measurable outcomes can transform the health system and foster renewal while delivering results for patients;

AND WHEREAS the Parties wish to continue to work together in a relationship based upon mutual respect, trust, consultation and co-operation in order to improve health care in the Province of Ontario;

AND CONSIDERING the following principles of the Parties that support this Agreement and the delivery of health care:

- Patients first
- Innovation and the need for ongoing flexibility to meet public needs
- Performance – a focus on results including quality and access
- Transparency and accountability to the taxpayer
- Sharing risks for controllable results and being able to show returns on the Government’s investments.

Now the Parties have come to the following 2008 Physician Services Agreement (the “Agreement”).

1. RELATIONSHIP

1.1 As stated in the recitals, the Parties acknowledge the importance of our ongoing relationship based on mutual respect, trust, consultation and co-operation. The MOHLTC acknowledges that the OMA is the representative of physicians in Ontario for the purpose of this relationship, these negotiations and this Agreement.

1.2 The Parties also understand that the significant changes to the Ontario health care system require new multilateral and collaborative approaches.

1.3 The Parties expect this Agreement to deliver clear and measurable change in two priority areas: access to family health care for all Ontarians, and reducing congestion in Emergency Departments. To support these and other goals the MOHLTC has made a wide range of investments across the profession to improve patient care throughout the health care system.

1.4 The Parties also acknowledge that the results achieved from these investments will need to be measured and evaluated at regular intervals during the term of this Agreement.

1.5 The Parties agree to continue the Physician Services Committee (“PSC”). The Parties agree that matters arising from this Agreement and the continuing development and strengthening of our relationship will be considered at the PSC. 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 for the PSC are more completely set out in Appendix “A” of this Agreement.

1.6 To implement and oversee the achievement of results under this Agreement, the Parties have or will establish a number of committees in addition to the PSC, as set out in Appendix “A”.

1.7 The Parties agree to establish a Financial Planning and Oversight Committee (FPOC), as set out in Appendix “B”.

1.8 The Parties agree to continue the Physician – LHIN Tripartite Committee (PLTC), as set out in Appendix “C”.

2. DISPUTE RESOLUTION

2.1 The Parties believe that a clear dispute resolution process is important both with regard to disagreements between the Parties concerning the interpretation and application of this Agreement and issues of fair representation that may arise as a result of actions taken by the Parties during the term of this Agreement. The dispute resolution process is set out in Appendix “G”.

3. GENERAL FEE INCREASE

3.1 For professional services rendered during the period October 1, 2008 to September 30, 2009, the monthly remittance advice payment will be increased by 3% of the value of services provided within this service period. Effective October 1, 2009, the 3% will be allocated by the Physician Services Payment Committee (PSPC) to the OHIP Schedule of Benefits, in addition to a 2% fee increase effective October 1, 2009.

3.2 The Parties agree to the following global increase to the OHIP Schedule of Benefits, based upon the fee-for-service payments for services rendered in the year ending March 31, immediately preceding the effective date below:

Effective October 1, 2009; 5% (five)

Effective October 1, 2010; 3% (three)

Effective September 1, 2011; 4.25% (four decimal two five)

3.2.1(a) One-half of the increase each year will be allocated on an equal percentage basis to each OHIP Specialty.

3.2.1(b) One-half of the increase each year will be allocated to OHIP Specialties by the Physician Services Payment Committee (PSPC), based upon a relativity methodology agreed to by the Parties. The PSPC is defined in Section 5.4 of the Health Insurance Act.

3.2.2 The amount of increase allocated to each Specialty by 3.2.1 (a) and (b) will be allocated by the PSPC to fee codes billed by that Specialty or in the form of other payments agreed to by the Parties.

3.2.3 The PSPC in making its recommendations, especially for 2009/10, will take into consideration the work done by the Medical Services Payment Committee (MSPC) prior to this Agreement, in identifying codes as deserving change. The MSPC is a committee established under the 2004 Physician Services Agreement.

3.2.4 The MSPC shall carry out the mandate assigned to the PSPC until the PSPC is operational.

3.3 The rate of increase provided for in 3.1 and 3.2 shall flow through to the following contractual payments, excluding administrative and other non-clinical payments, made directly or indirectly by the Ministry to physicians (excluding civil servants):

- Funding agreements for clinical services entered into by the Ministry of Health and Long-Term Care including Alternate Payment Plans and Alternate Funding Plans

- Primary care models, salaries, sessionals, capitation and Monthly Comprehensive Care Fee payments
- Mental Health Sessionals, Sessional Fee Supplement, Psychiatric Stipend, Physicians compensation in Divested Provincial Psychiatric Hospitals, Physicians compensation in Assertive Community Treatment Teams, OPOP sessionals, Visiting Specialist Program and Urgent Locum Tenens Program for Specialists sessionals, and the Hospital Pediatric Stabilization Program
- Fees for medical services listed in the OHIP Schedule of Benefits that are paid by Ministries other than the MOHLTC,

on a basis that achieves comparable economic increases as the physicians paid fee-for-service receive under s.3.1 and 3.2 for such practice. Where there is no corresponding OHIP Specialty, the flow through shall be the unadjusted increases provided for in 3.1 and 3.2.

Non-clinical payments include payments for teaching, research, the Academic Health Sciences Centre (AHSC) AFP Innovation Fund, recruitment, mentoring, honoraria, Hospital On Call Payments and HealthForceOntario (HFO) stipends.

Where a contract does not distinguish between clinical and administrative or non-clinical payments, the Parties will agree to a flow through to be calculated upon no less than 80% of the total contract value.

The PSC will adjust on an annual basis the maximum allowable OHIP billings for non fee service contracts to reflect general fee increases in this contract.

4. DIAGNOSTIC SERVICES

- 4.1 The Ministry agrees to segregate technical fees from the Physician Services budget into a Diagnostic Services budget and to establish a new supporting structure both by April 1, 2009 involving the OMA and other key stakeholders.
- 4.2 A fund of \$15 million for technical fees will be provided, with the method of allocation to be determined by the PSC. Any future funding increases will be determined through a separate process.

5. PRIMARY CARE

Unattached Patient Bonus and Registry

5.1 The Parties share a common goal that all Ontarians should have access to high quality family health care and agree that using a systematic approach to identify unattached patients will assist in achieving this goal. The Parties share the commitment to work together to a target of attaching a minimum of 500,000 unattached patients to a family physician within three years of ratification of this Agreement, while ensuring the stability

of current patient rosters. The parties agree that approximately 400,000 patients at any one time are in transition between family health care providers. An Unattached Patient Collaboration Initiative will be established as described in Appendix “D”.

In Office Service Bonus

5.2 The PSC will develop a payment to PEM physician and physician groups who provide a broad range of in-office services. A recommendation will be made to the parties for implementation by April 1, 2010. A fund of \$5 million will be set aside in the first year of the program and \$10 million will be set aside on an annual basis thereafter.

Out of Office Service Bonus

5.3 To compensate those family physicians that provide services outside of their offices that are required by the public for effective and timely access to health care, the Parties have agreed to the programs set out at Appendix “E” as follows:

- Individual Incentive Bonuses for Aging at Home/End of Life Care, and Maternity and Newborn Care.
- PEM Group Bonus Payment for Out-of-Office Care.

PEM Group Bonus Payment for After Hours Care

5.4 (a) A bonus program will be established for physician groups who reduce their rostered patient use of EDs. Up to \$2.5 million dollars will be available in 20011/12 for this program.

(b) If a physician group meets the determined target for CTAS IV and V visits to the ED by their rostered patients they will be eligible for a bonus paid to the group. The targets will be based on NACRS data and be sensitive to rurality. Advice on targets will be received from the ED Expert Panel and the PSC will make recommendations to the Parties.

Locum Programs and Service Bonus Calculations

5.5 Effective April 1, 2009, the services provided by a physician working as a “locum” shall count toward the entitlement to all service-related premiums and bonus thresholds on behalf of the physician for whom the “locum” is standing in for patient service. The Parties shall establish a simple reporting procedure to support this process.

Chronic Disease Management - Diabetes

5.6.1 All family physicians will be eligible to bill Q040A for the Diabetes Management Incentive (DMI). Those not already eligible for the DMI will be eligible effective April 1, 2009.

5.6.2 With the establishment of the MOHLTC Diabetes Registry, a new DMI will be paid to all family physicians who fulfill the incentive criteria based on the current Canadian Diabetes Association Practice Guidelines, including registration of each patient on the Diabetes Registry and provision to the patient of MOHLTC information resources on how to access the Registry for the self-care component. The fee will be established by the Parties.

5.6.3 In the interim, in order not to disrupt the chronic disease initiative established in 2004 with respect to diabetes care, the current DMI fee (Q040) will be available to all family physicians.

5.6.3.1 Effective April 1, 2009, Q040A will be paid at \$75.00.

5.6.3.2 Phasing out of this incentive will be considered by the Parties based on physician participation in the Diabetes Registry.

5.6.4 To encourage the adoption and use of the Diabetes Registry by physicians and their patients, a new bonus will be awarded to physicians who register their patients. This is a one-time program that will only apply to patients registered within the first 12 months after the Diabetes Registry is active. The thresholds and bonus amounts for this one-time program are described below.

Threshold	Bonus amount per physician
Between 15 and 49 patients	\$500.00
50 patients or more	Additional \$500.00

5.6.5 To continue promotion of Chronic Disease Management, effective April 1, 2009, existing after hours codes Q012 and Q016 will also be eligible to be billed with K030A and any other applicable CDM codes.

G.P. Focused Practice

5.7.1 In recognition of specialized services provided by GP Focused Practice physicians and their possible impact on the access bonus of physicians participating in Harmonized Model agreements, the Parties agree to extend the focused practice self-identification process as follows:

5.7.1(a) Through the PSC, the Parties may identify specific focused practice areas for exemption.

5.7.1(b) Any focused practice family physician may apply for a full exemption to access bonus impact as originally identified in the 2007 Reassessment through the Program Eligibility Review Committee as set out in Appendix "C.1".

5.7.2 Recognizing that there will continue to exist other focused practice physicians not covered by the preceding options, effective October 1, 2009, the Parties agree that focused practice physicians will be eligible to bill two assessments in follow-up to a focus practice consultation without any impact on an access bonus when a patient has been referred from a harmonized physician. Harmonized physicians may refer up to 6 patients per year per 1,000 rostered patients (pro-rated for average size of rostered practice during the year) to any such self identified focus practice physician.

5.7.3 FHG and CCM Agreements

The Parties agree to extend the term of existing FHG and CCM agreements to the end of the term of this Agreement.

The current Term of Agreement provision in the FHG and CCM agreement will be deleted and replaced with,

“This Agreement will remain in effect until March 31, 2012, but notwithstanding any other provision contained herein; this Agreement may be terminated before that date by either the Physicians or the Ministry giving the other 90 days written notice of their intention to so terminate”.

Inter-Professional Shared Care

5.8.1 Beginning in 2009/10, the MOHLTC will provide full salary support for up to 500 currently licensed nurses to be added to eligible practices. Access will be expanded to currently licensed nurses for non-harmonized Patient Enrolment Model (PEM) practices (FHGs and CCMs) to support three key priority areas: Aging at Home Strategy, End of Life Care, and mental health and addictions.

5.8.2 The Parties will develop a simple application process and an eligible practice may apply for financial support from the program based on the following criteria:

- a) Demonstrated focus on one or more of three priority areas: aging at home (CDM, home visits, LTC visits), End of Life care, mental health and addictions.
- b) A commitment by a practice to attach 200 to 400 patients per nurse as a result of the program.
- c) Partnering or co-ordination arrangements with a local Community Care Access Centre, mental health organization, or LTC facilities.
- d) Demonstrated alignment to the health needs of the population in the community served by a practice.

The application may provide for a reasonable administration cost in its budget.

5.8.3 An application may be made to cover the full salary cost of a nurse in any of the pre-existing nurse pilot projects pursuant to 5.8.2. This will apply to harmonized models that took part in a pilot project.

Capitation Rate

5.9 In the last fiscal year of this Agreement the PSC shall strike a Working Group to consider expert advice and submissions toward updating the capitation methodology, possibly to incorporate the burden of illness of patients. The Working Group shall report to the PSC by December 1, 2011.

Student Health Clinics

5.10 The Parties agree that the PSC shall appoint an agreed upon person to provide a review and analysis of the services provided by Student Health Clinics no later than January 1, 2011. The review will identify any shortfall in service to the unique communities served by such clinics and the appropriateness of current compensation arrangements for physicians serving in such clinics including availability of primary care models and rostering.

Hospital Services Payments

5.11 Effective October 1, 2008, the Parties shall amend the existing list of codes used to determine the threshold for payment of the special payment for hospital services in harmonized models to include C122, C123, C124, C142, C143 and any Cxxx enhanced MRP codes created pursuant to s.6.1.1.

Northern and Rural Harmonized Models

5.12.1 Effective April 1, 2009, Appendix "D" of the Family Health Network (FHN) Agreement shall be amended as follows:

"In northern and rural areas, at least 50% of the FHN Physicians must have active in-patient hospital privileges and involvement, where appropriate, with discharge planning, rehabilitation services, out-patient follow-up and home care services. In the categories of in-patient hospital privileges and involvement with discharge planning, physicians 65 years of age and older will not have to be counted in the preceding requirement."

5.12.2 Any Harmonized Model agreement shall also be amended to be consistent with section 5.12.1.

5.12.3 Effective April 1, 2009, in northern and rural areas where at least 50% of the FHN Physicians must have active in-patient hospital privileges, each FHN Physician shall be eligible for a new special payment for hospital services where a physician shall receive a revised payment of \$12,500 after submitting valid claims for services totalling \$6,000 in

any fiscal year from the list of services set out in Schedule 4 of the FHN contract. The basket of services will be modified to reflect the changes outlined in 5.11.

Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs)

5.13 The Physician - LHIN Tripartite Committee (as described in Appendix “C”) will review the alignment of CHC physician compensation with CHC service profile and accountability within their LHIN. Compensation models, including a fully salaried model, will be considered during the review. Consideration of the impact on the AHAC model will be undertaken by the PSC. The review will be completed no later than October 1, 2009.

6. HOSPITAL CARE

Enhanced Funding for MRP Physicians Admitting Unscheduled Patients

6.1.1 Effective October 1, 2009, a 30% increase will be targeted to key fee codes for MRP care (codes include: admission assessment codes C933, C122, C123, C124, C142, C143; subsequent visit codes Cxx2, Cxx7, Cxx9; and Cxx5 consultation codes). The increased codes will be billable by MRP physicians caring for patients admitted to hospital. Routine admissions for labour and delivery (including routine newborn assessments) will not be eligible for the enhanced MRP codes. The increased codes will reflect the importance and scope of the MRP role.

6.1.2 Access to the enhanced fee codes for MRP care by a physician will require an annual declaration by the physician’s hospital that there is no top-up or financial subsidies provided to that physician for direct or indirect MRP care.

6.1.3 The MOHLTC commits funding to provide peer support and best practice guidelines for hospitals and their hospitalists to reorganize their MRP program to meet the program requirements.

6.1.4 The Parties will examine the progress of hospitals that are not part of the enhanced program.

6.1.5 A further \$33 million will be available for an incentive payment through the MRP Collaboration Initiative fund (Section 9.3) to recognize MRP physician groups at the hospital and LHIN level that receive enhanced fee codes for meeting established targets related to effective management of hospital patients. Key indicators: average length of stay, “may not require hospital” rate, and readmission rates. The incentive will be split to recognize both physician contributions at the LHIN level and at the hospital level (proposed 25/75 ratio).

Hospital On Call Programs

6.2 The Parties agree that an effective HOCC program with appropriate participation by LHIN-based hospital networks is important to the provincial health care system.

6.2.1 The MOHLTC will undertake responsibility for the administration of the HOCC program as of March 31, 2009, or such earlier date as is agreed upon by the Parties.

6.2.2 A Working Group reporting to the Physician-LHIN Tripartite Committee will be appointed to conduct a detailed review of HOCC and the Physician-LHIN Tripartite Committee will report to the three parties. The Working Group will consist of representatives from the MOHLTC, LHINs and the OMA. The Working Group will receive expert advice and will complete its work by October 1, 2010. The review will consider the effectiveness of HOCC, including:

- A methodology for providing data regarding the use of HOCC funds to allow for appropriate audit.
- The participation of doctors in Criticall Ontario.
- An enhanced premium for physicians required to stay in house on call.
- The use of Regional Call networks.
- Enhanced coverage for long-term care, sexual assault centres, chronic care facilities and palliative care programs.
- The role of LHINs and hospitals.
- Permitting physicians to register for on call at more than one hospital or facility for different shifts.
- Establishing a common payment per on call shift.
- Such other priorities as the Parties may request.

6.2.3 The Parties agree to work together on an appropriate physician compensation plan required to address any policy changes brought forward as a result of the review. To facilitate this, the MOHLTC has reserved \$20 million annually commencing April 1, 2011. Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

6.2.4 An On Call Coverage Collaboration Initiative fund of \$22 million will be established as set out in Section 9.3 to recognize physicians in each LHIN where following implementation of recommendations pursuant to 6.2.2, a comprehensive regional on-call coverage program is in place and aligned to the needs of that community.

Emergency Department Funding

6.3.1 Ensuring timely access to ED services 24/7 is a goal shared by both Parties. To recognize the importance of this goal, the ED Collaboration Initiative fund (Section 9.3)

of up to \$14 million will pay an incentive initiative to recognize ED physicians at the LHIN level whose LHIN hospitals meet the following goals:

- (a) All the EDs at hospitals in a LHIN did not close for any period of time over the course of the year due to physician staffing issues.
- (b) All the EDs at hospitals in a LHIN achieved the wait time benchmarks established by the ED expert panel for CTAS IV and V patients. (This assumes the establishment and functionality of the Emergency Department Information System.)

6.3.2 For MOHLTC-designated urgent care clinics (UCCs), there will be no reduction in the access bonus for patients that use the UCC. The Parties will monitor the effect of this initiative on ED volumes.

AHSC AFP – Northern Ontario School of Medicine

6.4.1 The Parties agree to establish a Northern Ontario School of Medicine (NOSM) alternate funding program (AFP) involving NOSM participating physicians, participating hospitals and the universities, with a target to have it in place April 1, 2009. This agreement will be based on and aligned with, wherever applicable, the provincial AHSC AFP template agreement.

6.4.2 The participating physicians, hospitals and university will be required to establish a governance organization within the applicable parameters of the provincial AHSC AFP template agreement. Accountability and reporting requirements included in the provincial AHSC AFP template agreement, wherever applicable, will apply.

6.4.3 Funding provisions for the NOSM AFP are set out at Appendix “F”.

7. MENTAL HEALTH

Divested Provincial Psychiatric Hospitals

7.1.1 Effective April 1, 2009, the MOHLTC will provide funding to applicable LHINs to bring the compensation for divested psychiatric hospital services provided by FRCPC psychiatrists (psychiatrist 2) to a target range of \$206,690 to \$239,269; psychiatrist 1 (non FRCPC psychiatrist) \$169,894 to \$196,674; pediatrician/developmental specialist \$206,690 to \$239,269; and general physician \$150,995 to \$174,796 (FY2007/08) per full-time equivalent per year (at the appropriate percentage of a FTE depending on service commitment). Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

Assertive Community Treatment Programs

7.1.2 Effective April 1, 2009, the MOHLTC will provide funding to LHINs to bring the compensation for services provided by psychiatrists working on Assertive Community Teams (ACT) aligned with the applicable ranges in section 7.1.1 per full-time equivalent per year at the appropriate percentage of a FTE. Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

Ontario Psychiatric Outreach Program

7.1.3(a) Effective April 1, 2009, in regard to the Ontario Psychiatric Outreach Program, the sessional rate paid to psychiatrists participating in the Northern Ontario Francophone Psychiatry Program (NOFPP), the University of Toronto Psychiatry Outreach Program (UTPOP) and the University of Western Ontario Psychiatry Outreach Program (UWOPOP) will be aligned with the current mental health sessional rate of \$459/3-4 hour session. Any increases in this rate pursuant to Section 2 of this Agreement will flow through to said rate.

(b) A maximum of three sessions can be billed per day.

(c) A program honorarium of \$300 will be paid for any scheduled day of work as travel to reflect the extra effort required to provide care pursuant to this program, and the disruptive impact on the physician's practice. If approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

(d) Reasonable travel expenses, including meals and lodging, are covered at cost.

(e) Travel time will be remunerated at the sessional rate provided in (a) above and, if approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

Mental Health Sessional Payments and the Sessional Fee Supplements

7.1.4 Mental Health Sessional Payments and the Sessional Fee Supplements paid via community mental health agencies, addiction agencies and non-Schedule 1 hospitals, will be expanded by increasing the number of allowable sessionals by 40% in two stages:

a) Stage 1, 20% increase effective 2009/10.

b) Stage 2, 20% increase effective 2010/11.

The goal of this investment is to strengthen access to community mental health services for high-risk individuals. The funding will be aligned with current provincial goals of

unattached patients, emergency department congestion, and the provincial strategy on mental health and addictions.

7.1.5 The MOHLTC agrees to harmonize its current mental health funding programs. The MOHLTC will establish a technical advisory group to advise on the recommended actions to achieve this result. The goals of said harmonization are to:

a) Combine mental health sessional, sessional fee supplements, and psychiatric stipend funding currently paid to Schedule 1 hospitals and centralize these in one area of the MOHLTC for distribution and tracking.

b) Combine current mental health sessional and sessional fee supplements paid via community mental health agencies, addiction agencies and non-Schedule 1 hospitals and flow them from one area in the MOHLTC to the LHINs.

8. ENHANCED CARE FOR FRAIL ELDERLY

8.1 As part of the Aging at Home Strategy, the Ministry will put in place an enhanced interdisciplinary team-based care model for the provision of specialized health services to the frail elderly, including LHIN-based outreach. The target date for this model will be April 1, 2009.

8.2 Geriatricians participating in the enhanced model will be compensated at a fiscal year 2008/2009 FTE rate of \$330,000 annually.

8.3 The MOHLTC will invest to support the recruitment of an additional 10 FTE Geriatricians to participate in the enhanced model.

9. LHIN PHYSICIAN COLLABORATION INCENTIVE FUND

9.1 The Ministry will establish a new LHIN Physician Collaboration Incentive Fund to recognize and reward the local efforts of physician groups who work together and in collaboration with other service providers to support the needs of patients in targeted areas of care.

9.2 The establishment of targets and the implementation of these incentive funds will be the responsibility of the Physician – LHIN Tripartite Committee.

9.3 A total of \$100M will be available to support four LHIN Physician Collaboration Incentive Fund initiatives:

- \$33M for a MRP Collaboration initiative (Section 6.1.5) to recognize MRP physician groups at the hospital and LHIN level for meeting established targets related to effective management of hospital patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the

following fiscal year. Key indicators are: average length of stay, “may not require hospitalization” rates, and readmission rates.

- \$14M for an ED Collaboration initiative (Section 6.3.1) to recognize ED physician groups at the hospital and LHIN level meeting established targets related to effective management of ED patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the following fiscal year. Key indicators are: Wait time benchmarks, 24/7 ED access.
- \$31M for an Unattached Patients Collaboration initiative (Appendix “D”) to recognize physicians who work together at the local and LHIN level to achieve established targets for rostering unattached patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the following fiscal year.
- \$22M in 2011/12 for an On Call Coverage Collaboration initiative (Section 6.2.4) to recognize HOCC physician groups in those LHINs where a comprehensive regional on-call coverage program is in place and aligned to the needs of that community.

10. RECRUITMENT AND RETENTION INITIATIVES

Student Loan Interest Relief

10.1 In order to support the attraction and retention of new graduates, the MOHLTC will implement the following program in 2009/10 regarding student debt relief:

- (a) Eligible debt is that incurred through any Canadian government (Federal or Provincial) student loan program;
- (b) Eligible trainee physicians are those in an Ontario government funded post-graduate medical training program;
- (c) The Ministry will pay the full interest on the eligible debt through the end of the residency training program;
- (d) Ontario residents will not be required to make any payments on the principal of the eligible debts during their training; and
- (e) To qualify for this program, the physician must make a commitment at the time of enrolling in the program to stay practicing in Ontario for five years after successful completion of the residency program. If the physician leaves practice in Ontario, they will reimburse the Government the full cost of the amounts paid under this program.

Alternate Funding Agreement Recruitment

10.2 The MOHLTC will provide new funding to support AFP and APP recruitment or Specialty Review funding up to the following amounts:

2009/10 - \$ 4.5 million
2010/11 - \$ 8.0 million
2011/12 - \$15.0 million

11. INCORPORATION

11.1 The MOHLTC will recommend to the Government any necessary amendments to the regulations under the *Business Corporations Act* and the *Regulated Health Professions Act* to expand the definition of “family member” for the purpose of holding non-voting shares in a Medicine Professional Corporation (MPC) to include; common law spouses, adopted children, stepchildren and step-parents. Subject to appropriate legislative drafting of the definitions, stepchildren shall mean children of a current or former spouse or common law spouse in regard to whom the physician has had a relationship of “in-loco-parentis” at some time, and step-parent shall mean the spouse or common law spouse of a parent of the physician who is not a natural or adoptive parent of the physician.

11.2 MPCs shall be entitled to sign any APP, AFP or similar agreement with the MOHLTC and there shall not be any special requirements for physician shareholders in the MPCs who do not provide services under the agreements. Existing requirements will continue for participating or designated physicians, including the execution of declarations and consents.

11.3 The Parties agree to explore options for simplifying the College application/renewal process for MPCs. The review process will involve all affected Parties.

12. BENEFITS

12.1 Pursuant to S. 14.1 of the 2004 Framework Agreement between the parties the MOHLTC has agreed to contribute \$25 million annually to the OMA health related insurance program. The MOHLTC will pay the entire amount to the OMA annually for this purpose. The nature of an insurance program means that the actual annual expenditure will vary depending upon such considerations as registration numbers, variance from actual assumptions and utilization. Recognizing therefore that actual fund expenditure will vary from year to year, the OMA will make appropriate fiscal arrangements to hold the payments received from the MOHLTC solely for the insurance program. It is acknowledged that the OMA may, in any given year, make a program expenditure that is to be recovered from future MOHLTC payments for this program. The OMA agrees that the fiscal records of the insurance program will be available for audit by the Government of Ontario. Should the OMA accumulate a surplus exceeding

\$25 million in this account, the Parties shall discuss an adjustment to the MOHLTC obligation to make future contributions.

13. CLERKSHIPS

13.1 The Clerkship Stipend program set out in S.19.1 of the 2004 Agreement is continued and is amended effective July 1, 2008 to provide a payment of \$750.00 per month.

13.2 The funding provided for clinical rotations as set out in S.19.2 of the 2004 Agreement shall be continued and effective April 1, 2011, will be available for all training more than 100 kilometres from the border of the student's home community, within Ontario subject to eligibility criteria to be developed by the PSC.

14. TELEMEDICINE

14.1 Increases provided in this Agreement, including Section 3, shall flow through to corresponding relevant fee codes, including any unique codes for Telemedicine.

14.2 The MOHLTC confirms its recognition of the OMA as the representative of physicians in any consideration of compensation matters relating to Telemedicine.

15. VISITING SPECIALIST CLINIC PROGRAM AND URGENT LOCUM TENENS PROGRAM FOR SPECIALISTS

15.1 (a) Effective April 1, 2009, the sessional rate paid to Specialists participating in the Visiting Specialist Clinic program or Urgent Locum Tenens Program for Specialists will be aligned with the Ontario Psychiatric Outreach Program (OPOP) at a sessional rate of \$459 per 3-4 hour session. Any increases in the OPOP rate pursuant to Section 7.1.3(a) of this Agreement will flow through to said rate.

(b) The physician may choose to bill fee-for-service to OHIP or claim a stipend as outlined above. Physicians are encouraged to bill fee-for-service rather than the stipend on days where FFS billings are expected to exceed the sessional rate.

(c) A maximum of three sessions can be billed per day.

(d) A physician may either bill fee-for-service or stipend on any approved clinic day, but claiming both types of payment for the same clinic day is prohibited. This does not apply if a physician has provided office or on call services in his/her home community prior to providing service at the clinic site.

(e) A physician is allowed a \$300 honorarium per day of clinical service and/or travel. If approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

(f) Travel time will be remunerated at the sessional rate provided in (a) above and, if approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

16. HEALTH CARD VALIDATION

16.1 The MOHLTC commits to make “real-time” health card validation accessible to office-based providers by March 31, 2011.

17. ALTERNATE PAYMENT PLANS

Genetics

17.1 The MOHLTC will provide a funding contribution to support the compensation for services provided by CCMG and FRCP geneticists to a target rate to be agreed to by the Parties, effective October 1, 2010. The Parties expect to be informed by the compensation currently paid to geneticists across institutions in Ontario.

Infectious Diseases

17.2 The Parties agree to negotiate an APP for Infectious Diseases specialists (both Pediatric and Internal Medicine subspecialists) engaged in infectious disease prevention and control, to be in place by October 1, 2010.

17.3 LABORATORY PHYSICIANS

17.3.1 The MOHLTC shall make the following investments to assist hospitals to recruit new laboratory physicians and expand capacity for laboratory medicine:

- \$1M in 2009/10
- \$3M in 2010/11
- \$5M in 2011/12

A payment of up to \$100,000 per new recruit will be made to bring the laboratory physician up to the Uniform Minimum Level of Compensation. Payment will be made once the recruit is on-site and licensed in Ontario.

Recruitment funding will reflect a regional/provincial approach to rationalization of lab physician distribution, be aligned with public need, and reflect advances in quality of care and benefits of technology.

17.3.2 Laboratory physicians will receive the additional payment based on the percentage set out in Section 3.1.

17.3.3 The Uniform Minimum Level of Compensation will increase by the percentages stated in Section 3.2.1a). The Parties agree to consider a relativity adjustment for laboratory physicians to be applied to the Uniform Minimum Level of Compensation.

17.3.4 The Parties agree to establish a Laboratories Physician Committee to report to the PSC to provide guidance on initiatives currently underway as per the 2004 Laboratory Physicians Agreement.

18. INTERPROFESSIONAL HEALTH CARE — SPECIALISTS

18.1 The Parties are committed to the development of collaborative care models that will improve patient access to needed health care services. The PSC will evaluate the effectiveness of existing pilots and will consider options to move effective pilots into programs with ongoing funding and will report to the Parties. The Parties will address physician compensation related to these programs.

19. NORTHERN AND RURAL PROGRAMS

19.1 Subject to consultation with affected physicians, the Parties intend to align the following programs with RIO 2008-BASIC methodology:

- Rural CME
- Rural Medicine Investment Program (RMIP)
- Hospital Rurality Premium Top-Up
- Rurality Premium

The Parties will discuss the impact on physician compensation.

19.2 The MOHLTC will continue the Northern Physician Retention Initiative.

20. DATA SHARING

20.1 Following ratification, the Parties will review and revise their current data sharing agreement as necessary. The provision of this information will be subject to the compliance with all applicable privacy legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act, 2004*, as amended.

21. TERM AND RENEWAL

21.1 This Agreement will begin on April 1, 2008, and will terminate at the end of March 31, 2012. Negotiations to establish the next Physician Services Framework Agreement will begin no later than January 10, 2012. The MOHLTC recognizes the OMA as the representative of the medical profession for the purposes of these negotiations. The Parties may mutually agree to utilize the services of the “Independent

Facilitator” set out in Appendix “A” Physician Services Committee to assist the Parties in negotiations for a new agreement in 2012.

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

DATED AT TORONTO, ONTARIO THIS ____ DAY OF _____, 200 ____.

FOR THE OMA

FOR THE MOHLTC

Appendix A

PHYSICIAN SERVICES COMMITTEE

Membership

Each Party will appoint a core membership supplemented from time to time as needed by temporary members with particular expertise or authority.

Co-Chairs

Each of the Parties will appoint a co-chair.

Facilitator

The PSC will have an independent facilitator chosen by the Parties and subject to an annual review or a review at the request of either Party.

Relationship-Building

The PSC will continue training in relationship building and conflict resolution, as the Parties consider necessary.

Agenda Setting

The agenda of the PSC will be set by the co-chairs appointed by the Parties, in consultation with the facilitator. In the event of a dispute, the facilitator will set the agenda.

Funding

Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

Meetings

The PSC will normally meet twice a month.

Mandate

The mandate for the PSC is to make recommendations to the Parties as follows:

- To build and sustain a strong positive relationship between the Government of Ontario and the medical profession;
- To receive and consider reports and recommendations as set out in this Agreement;
- To advise the Parties in connection with the changing role of physicians within the health care system, as it pertains to the Agreement, including possible improved models of delivery of and compensation for services;
- To develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to the MOHLTC and the OMA leading to the enhancement of the quality and effectiveness of medical care in Ontario;
- To develop and recommend patient education programs;

- To participate in the Dispute Resolution Process in accordance with its requirements as described elsewhere in this Agreement;
- To consider matters referred to it by either Party.

Committees

1. *The Parties plan to rely on ad hoc working groups to work on various mutual initiatives*
 - Issue-specific, time-limited
 - Established by PSC or FPOC
2. *The following ongoing committees will report to PSC:*
 - Laboratory Physicians Committee
 - Academic Medicine Steering Committee
 - Third Party Implementation Advisory Committee
 - Program Eligibility Review Committee
 - Forms Committee

Appendix B

FINANCIAL PLANNING AND OVERSIGHT COMMITTEE

Membership

Each Party will appoint individuals with senior decision-making authority.

Co-Chairs

Each of the Parties will appoint a co-chair.

Reporting

The FPOC will report to the Parties.

Agenda Setting

The agenda of the FPOC will be set by the co-chairs.

Funding

Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

Meetings

The FPOC will meet once monthly.

Mandate

The mandate for the FPOC is to make recommendations to the Parties as follows:

- To track Agreement-related expenditures;
- To review utilization reports on a monthly basis;
- To realign and adjust within budget the initiatives under this Agreement to achieve their objectives;
- To negotiate any outstanding compensation matters arising from the Agreement;
- To identify efficiencies and maximize return on funding provided under this Agreement;
- To track expenditures from the LHIN Physician Collaboration Incentive Fund and the PEM Group Bonuses on an ongoing basis, and make any recommendations for adjustments to the fund and bonuses;
- **If** funding for any one component of the LHIN Physician Collaboration Incentive Fund and the PEM Group Bonuses has not been fully distributed, make recommendations for changes within the parameters of the Incentive Fund and bonuses;
- To recommend to the Parties appropriate and effective steps to be taken to deal with system management issues.

2008 Priorities

- To consider approaches to review the appropriate use of the fee schedule, including expert reviews.
- Collection of physician level compensation data across all government funded programs.

Appendix C

PHYSICIAN - LHIN TRIPARTITE COMMITTEE

Mandate

The Parties understand that the significant changes to the Ontario health care system require new multilateral and collaborative approaches. The Physician – LHIN Tripartite Committee (PLTC) will provide a forum for the OMA, the MOHLTC and representatives of the LHINs to meet regularly to discuss, review, and respond to matters of mutual interest for the benefit of the health care system.

Areas of Responsibility

The PLTC will:

- Provide a mechanism through which the parties can obtain input from each other about proposed planning, funding and service delivery decisions that affect physicians;
- Provide a mechanism through which the parties can receive early notice about activities/initiatives that involve physicians and may have implications for the other Parties;
- Establish and monitor programs and targets for the LHIN Physician Collaboration Incentive Funds established in Section 9 of this 2008 Physician Services Agreement;
- Discuss effective strategies for communicating with physicians and engaging physicians in LHIN initiatives;
- Collectively identify and address issues of provincial significance;
- Address any specific issue directed to it by the parties;
- Conduct reviews identified in the 2008 Agreement: HOCC; CHC.

Membership

Each party will appoint 3 representatives, for a total of 9 members. Each party will identify a Co-Chair.

Co-Chairs

Meetings of the Committee will be facilitated by an agreed upon neutral facilitator. The Co-Chairs will set the agenda.

Reporting

The PLTC reports to the parties.

Frequency of Meetings

The Committee will meet every 2 months or more often as agreed to by the parties.

Budget:

The parties will be responsible for the honoraria and expenses of their respective members.

Appendix A.1

PROGRAM ELIGIBILITY REVIEW COMMITTEE

Core Membership

Core membership will be composed of staff from each Party supplemented with other representatives as needed.

Facilitator

The PSC will provide facilitation support to this Committee.

Funding

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

Reporting

The Program Eligibility Review Committee will report to the PSC. Reports will be presented to the PSC as requested.

Mandate

To review requests and appeals and make physician eligibility decisions on physician payment programs including but not limited to:

- Clerkship Stipend Program
- Continuing Medical Education
- GP Focused Practice
- GP Psychotherapy
- Mental Health Stipend Program
- Northern Physician Retention Initiative
- Hospital Pediatric Stabilization Program
- Pregnancy and Parental Leave Benefit Program
- Service Recognition Payment
- Rural Medicine Incentive Program

Appendix D

UNATTACHED PATIENTS

1. Principles

1.1 The Parties share a common goal that all Ontarians should have access to high quality family health care and agree that using a systematic approach to identify unattached patients will assist in achieving this goal. Once an unattached patient information system is in place and functioning, an appropriate goal will be to establish an acceptable timeframe which is considered an acceptable wait to find a family doctor when moving, a doctor retires, upon arriving in the province, and in other circumstances that result in a resident not having a family doctor.

1.2 The Parties share the commitment to work together to a target of attaching a minimum of 500,000 unattached patients within three years of ratification of this Agreement, while ensuring the stability of current patient rosters. The Parties agree that approximately 400,000 patients at any one time are in transition between family health care providers. Attaching new patients will be supported by new fees and fee enhancements as set out below.

2. Fees and enhancements for rostering unattached patients

2.1 New Unattached Patient payments for family physician:

2.1.1 A new Complex/Vulnerable New Patient fee, a one-time payment of \$350 for attaching the patient, will be introduced effective April 1, 2009.

(a.1) The Minister's Expert Panel on Unattached Patients will recommend to government identification criteria of this patient group. The OMA and others will provide input on the definition to this Expert Panel.

(a.2) The Parties will decide how to apply the \$350 fee to this group of patients.

(b) If the MOHLTC unattached patient information system is not ready on April 1, 2009, this fee will apply to "complex or vulnerable" hospital inpatient or ED patients pursuant to a methodology agreed to by the Parties. If required, the identification of patients will be updated on an annual basis at the hospital level.

2.1.2 Unattached mother and newborn(s) within 2 weeks of birth:

Effective April 1, 2009, physicians taking on as new patients an unattached mother within two weeks of giving birth, will be eligible for a \$350 fee for attaching both the mother and newborn. Complete care for the newborn should be provided within two

weeks of birth and rostering of the mother and newborn must occur within three months of being attached.

Physicians taking on as new patients an unattached woman after 30 weeks of pregnancy will be eligible for the \$350 new patient fee providing the newborn is attached at birth and receives appropriate care within two weeks of birth and both are rostered within three months.

In the case of multiple births, the new patient fee for each additional newborn of an unattached mother will be \$150.

2.1.3 The new fee codes for all patients listed above will not be subject to any billing maximums.

2.2 Expanded access to unattached patient codes

2.2.1 All family physicians in PEM models can bill both existing and new fees applicable to New Patients (from the unattached patient information system or through other mechanisms).

2.2.2 Fee codes for patients attached from the unattached patient information system will not be subject to any billing maximums.

2.2.3 Payment of all new patient fees is subject to current requirements (i.e. patient must be rostered and Unattached Patient Fee Form completed).

2.3 Enhanced payments for caring for complex/vulnerable patients

2.3.1 For physicians in harmonized models, an annual payment of \$500 will be added to the existing capitation rate for any complex/vulnerable patients rostered through this initiative. One year after the patient's enrolment this annual payment will end and the physician will then receive the appropriate capitation rate according to the current schedule. For salaried and blended salaried model physicians in harmonized models, a \$500 capitation payment will flow for one year following rostering. At the end of the year, this payment will cease.

2.3.2 For physicians in non-harmonized models, the rostering physician will receive 150% of the value of all fees billed applicable to these patients during the first year of care. At the end of the first year of care, fees billed will be paid at the regular rate.

3. Unattached Patients Collaboration Initiative

3.1 A new "community-level" incentive of up to \$31 million will be introduced that will reward all PEM family physicians in LHIN-defined geographic sub-regions if community-specific targets for attaching new patients are achieved.

3.2 Once the unattached patient information system is in place for a period of time, the target will be a timeframe to “being attached to a primary care physician”.

3.3 Over the course of the Agreement, the specific targets may change from the community level to the level of the LHIN.

3.4 Twenty-five percent (25%) of the bonus available will be allocated for greater recognition of those who make a significant contribution to attaching patients.

3.5 The bonus will be payable on a pre-determined timeframe when the target is achieved within each community/LHIN.

Appendix E

OUT OF OFFICE INCENTIVE BONUSES

1.1 Bonus Categories

- Aging at Home/End of Life Care: three bonus categories – LTC Homes, Palliative Care, Home Visits
- Maternity & Newborn: One bonus category – Labour & Delivery

2.1 The bonus initiative is structured around two or three levels of bonuses depending on the activity and is based on yearly volume of activity in each area. Bonuses can be earned by providing services to both rostered and non-rostered patients and payments begin in 2009/10.

2.1.1 “A” or “B” level bonuses will be applicable to all family physicians.

2.1.2 “C” level bonuses will be applicable to physicians in patient-enrolled models only.

2.1.3 Eligibility for a yearly bonus in a given category will be based on the number of persons (for home visits: patients and services combined) served by a physician as identified by key billing codes in that category (see Schedule A).

Schedule A – Bonuses

Bonus Level	Home Visits		
	A	B	C
Necessary annual criteria	3 or more patients served <u>and</u> 12 or more encounters	6 or more patients served <u>and</u> 24 or more encounters	17 or more patients served <u>and</u> 68 or more encounters
Annual Bonus	\$1,000	\$2,000	\$5,000

Bonus Level	Long-Term Care		Labour and Delivery		Palliative Care	
	A	C	A	C	A	C
Necessary annual criteria	12 or more patients served	36 or more patients served	5 or more patients served	23 or more patients served	4 or more patients served	10 or more patients served
Annual Bonus	\$2,000	\$5,000	\$5,000	\$8,000	\$2,000	\$5,000

3. PEM Group Bonus Payment for Out of Office Care

3.1 This special bonus will reflect the extent to which rostered patients reflect population demographics in the physician's community. In 2011/12, it will reward top performing groups who have a rostered population reflective of their community and who provide the broad range of out of office services which meet the needs of their rostered patients. The Parties will design together the methodology for awarding this group bonus at year three of the Agreement.

Appendix E Schedule A List of Billing Codes

Long Term Care	
W010A	LTC Management
W102A	LTC Assessment
W002A	Subs. visit (Chronic)
W008A	Subs. visit (Nurs., Aged)
W121A	Add'l visits (Nurs., Aged)
W003A	Subsequent Visit
W001A	Additional Subs. Visit
W109A	Annual physical exam
W107A	Admis. Assess, type 3
W777A	Pronouncement of death
W903A	Pre-operative assess.
W004A	General Reassessment
W104A	Admis. Assess. Type 2
Home Visits	
A901A	House Call
A902A	Home Visits
B990A	Spec. Visit Premium
B992A	Spec. Visit Premium
B994A	Spec. Visit Premium
B996A	Spec. Visit Premium
B910A	Special Visit
B914A	Special Visit
B916A	Special Visit
Palliative Care	
K023A	Palliative Care
C882A	Palliative Care
A945A	Palliative Care Consult
C945A	Palliative Care Consult
W882A	Palliative Care Subs. Visit
W872A	Palliative Care Subs. Visit
B998A	Spec. visit Premium

Labour & Delivery	
P006A	Vaginal Delivery
P007A	Post-natal Care
P009A	Attendance at L&D
P020A	Operative Delivery
P018A	Caesarean Section

Appendix F

NORTHERN ONTARIO SCHOOL OF MEDICINE (NOSM) FUNDING ARRANGEMENTS

1. The government agrees to make available funding to establish an AFP to support teaching, research, recruitment, leadership and innovation, and AFP administration. Funding is based on applying the provincial AHSC AFP methodology in consideration of the proportional number of students at NOSM.

Academic Support:

\$2,620,932 in annual funding to support teaching and research.

AHSC AFP Administration Funding:

\$218,411 in annual funding to support the NOSM PCTA AFP administrative costs.

Recruitment Funding:

Up to \$436,822 will be made available annual to support the recruitment of clinical teachers to NOSM.

Innovation Funding:

\$436,822 will be added to the \$10 million AHSC AFP Leadership and Innovation Fund to recognize the NOSM PCTA AFP's eligibility to participate in this initiative.

AHSC AFP alignment:

An additional \$3.3 million will be used to address any further alignment issues with the AHSC AFP initiative.

The use of all of the above funds is subject to the requirements around governance, principles, accountabilities and reporting contained within the provincial AHSC AFP framework.

Appendix G

DISPUTE RESOLUTION

1) If the OMA and the MOHLTC have a disagreement regarding the interpretation and/or the application of this Agreement, the matter will first be referred to the PSC for consideration. The PSC will make recommendations to the Parties regarding the resolution of the disagreement and may enlist the support of an agreed upon mediator to assist it. Failing settlement of the matter, either Party may then use any other available dispute resolution process.

2) a) During the operation and administration of this Agreement, the Parties may be called upon to make decisions which may adversely affect the specific interests of a particular group of physicians represented by the OMA. If that occurs, and bearing in mind that the OMA has an obligation to represent all physicians for the purpose of this Agreement, and the affected group believes that the OMA has not fulfilled its representation obligation, the matter will first be referred to the PSC for consideration. If the matter is not resolved, it will be referred to a qualified person appointed by the PSC after consultation with the affected group, as a fact finder and mediator to assist the Parties.

b) Failing resolution through fact-finding and mediation, the mediator will prepare a written recommendation for resolution that will be provided to the Parties and the affected group for their consideration. If the matter remains unresolved after two weeks from the date the recommendation was provided, the recommendation will be made public and the affected group may then use any other available dispute resolution process.

Letter of Agreement

Public Health Physicians

Effective April 1, 2009, the MOHLTC will use its best efforts, funding the additional costs, and working with the local Board of Health, to achieve salaries for Medical Officers of Health and Associate Medical Offices of Health within the following ranges. Benefit levels will be maintained with additional costs funded by the MOHLTC:

Medical Officers of Health: \$235,000 to \$275,000

Associate Medical Officers of Health: \$200,000 to \$240,000

Effective October 1, 2010, there will be a three percent (3%) increase to the above salary grid. Effective September 1, 2011, there will be a four decimal two five percent (4.25%) increase to the resulting salary grid.

Side Letters to Agreement

[Date]

Mr. Jonathan Guss
Chief Executive Officer
Ontario Medical Association

RE: Segregation of Technical Fees

Dear Jonathan,

As you know, the Diagnostic Services Committee (“DSC”) was established as part of the 2004 Physician Services Agreement. A tripartite committee with Ministry of Health and Long-Term Care (“MOHLTC”), the Ontario Medical Association (“OMA”) and the Ontario Hospital Association (“OHA”) representation, the DSC’s mandate was to provide advice to the Minister on the planning and coordination of an efficient and effective diagnostic service system. The DSC reported its findings and recommendations in March 2008.

One recommendation of this committee is the segregation of the diagnostic funding envelope. The DSC report states: “A separate envelope for the compensation of diagnostic technical services and equipment will enable a more sustained focus on the needs of diagnostic services and facilitate broader system improvements.”

To support this direction, the Ministry agrees to segregate technical fees from within the Physician Services budget into a Diagnostic Service budget and establish a new supporting structure by April 1, 2009.

We will keep you apprised of progress and next steps involving OMA. I want to thank your representatives for their contribution to this initiative.

Sincerely

Ron Sapsford
Deputy Minister

Copy OHA, IHF, LHINs

Date

Mr. Jonathan Guss
Chief Executive Officer
Ontario Medical Association

RE: Mental Health Sessional Payments

Dear Jonathan,

I am writing to confirm that the MOHLTC will work with the Ministry of the Attorney General and Ministry of Children and Youth Services to align sessional payments and salaries for mental health providers (psychiatrists, paediatricians and family physicians) that are paid by those two ministries with rates negotiated under the 2008 Physician Services Agreement.

We will keep you apprised of progress and next steps involving OMA. I want to thank your representatives for their contribution to this initiative.

Sincerely

Ron Sapsford
Deputy Minister

Copy MAG/MCYS