OMA ARBITRATION POSITION ON PRIMARY CARE ISSUES

1. ACCESS

(a) **Minimum Group Size**:

This proposal is conditional on Managed Entry

(i) Minimum size for new FHOs be 5 physicians as in the original FHN model;

(ii) Reasonable notice to be provided to all affected groups with less than 5 physicians to require implementation no later than 12 months following the resolution of all outstanding primary care issues or the final determination of the Board of Arbitration on all outstanding primary care issues,

(iii) Notwithstanding (ii), existing FHOs of less than 5 physicians will be permitted to be grand-parented provided the FHO agrees to implement and maintain the same "after hour requirements" as FHOs with 5 physicians as set out below and provides such agreement no later than 12 months following the resolution of all outstanding primary care issues or the final determination of the Board of Arbitration on all outstanding primary care issues,

(iv) Guidelines will be agreed to by the parties or, failing such agreement, determined by the Kaplan Board of Arbitration, permitting FHOs of fewer than 5 physicians in northern, rural, remote or underserviced communities. The Guidelines will also establish the circumstances under which these FHOs can switch their compensation model to the RNPGA model, where requested by physicians.

(v) This proposal is conditional on allowing new entrants as outlined in Proposal 7 – Managed Entry.

(b) **After Hours Service (block) Requirements**:

The following changes in (b) to (e) are all effective six months following the resolution of all outstanding primary care issues or the final determination of the Board of Arbitration on all outstanding primary care issues:

After hours block service obligations are amended as follows:

Group MD Size	Current Requirement (base plus enhanced)	New Total Requirement
0		0

1		1
2		2
3	3	3
4	4	4
5-7	5	5
8-9	5	6
10-14	7	8
15-19	7	9
20-24	8	10
25-29	8	11
30-39	10	14
40-49	10	15
50-59	10	16
60-74	10	17
75-99	15	22
100-199	20	30
Over 200	25	35

The FHO must provide 1 block on each weekday (Monday to Thursday) and at least one additional block on any of Friday evening, Saturday or Sunday unless the individual exemptions in 1(d) apply.

A888 will be billable for physicians providing services to their groups' enrolled patients for both scheduled and unscheduled visits on Friday evenings, Saturday, Sunday or Holidays.

(c) **After Hours Exemption**:

(i) The group exemption from the after-hours coverage for physicians in a FHO, where more than 50% of physicians provide specified services, will be replaced as follows:

(ii) Individual exemption from after-hours coverage (weekdays after 5 pm Monday through Thursday and weekends from Friday 5 pm to Sunday 5 pm) will apply where more than 50% of physicians in a group provide the following "Exemption Services" after 5 pm weekdays and/or on weekends:

a. Regular public hospital emergency room coverage; and/or;
b. Public hospital anaesthesia on-call services on a regular basis; and/or;
c. Obstetrical deliveries outside of regular office hours; and/or
d. Regular after-hours care of hospital in-patients; and/or

e. Provision of palliative care as indicated by at least 4 palliative care patient home visits per week averaged over a 3 month period (tracking mechanism to be jointly developed); and/or
f. Provision of services in a LTC/nursing home (for non-enrolled patients) as demonstrated by at least 10 patient visits per week averaged over a 3 month period (tracking mechanism to be jointly developed);
g. complex continuing care on-call as established by a call schedule in a complex continuing care facility; and/or

(iii) In addition to the exemptions set out above, Northern and Rural FHO groups are contractually required to have at least 50% of their physicians maintain active in-patient hospital privileges; as a result, Northern and Rural FHO groups are required to provide no more than 5 after-hours blocks.

(iv) The FHO will be required to provide the total after-hours and weekend coverage for the group, based on the FHO group physician size after removing the exempt physicians, as per the requirements set out in the after-hours and weekend chart in paragraph 1(b).

(v) In order to qualify for the after hours exemption the individual physician must be engaged in the services listed above in (a), (b), (c), and (d) for at least 6 hours per week or provide service as specified in (e) and (f) or be on call as specified in (g) above.

(d) **Weekly Office Hours for FHOs**

Each FHO group will have regular office hours for no less than 35 hours a week, between the hours of 8 am and 5 pm Monday to Friday, pro-rated for weeks with a statutory holiday.

To ensure that patients are aware of the hours of service of their physician's group, the hours of service (daytime and after hours) will be posted in the office, on telephone answering machines, on-line (if available) and shared with the Local Health Integration Network (including so that it can be made available on the LHIN website).

The Ministry will provide to Ontario patients who are enrolled to FHO physicians, information regarding access and availability of FHO physicians, and expectations and commitments of patients as described on the patient enrolment and consent form. Any dispute over the accuracy of information regarding FHO physician access and availability will be resolved summarily and expeditiously by William Kaplan.

(e) **Establish a Multi-Stakeholder FHO Access Working Group:**

The OMA proposes:

(i) The establishment of a Multi-Stakeholder FHO Access Working Group, reporting to the PSC, and composed of an equal number of OMA and MOHLTC members. The PSC may also appoint stakeholder representatives to the Committee. Any

dispute with respect to the composition of the Committee will be determined by Arbitrator William Kaplan on an expedited basis

(ii) The Working Group will make specific recommendations in relation to the following access issues:

- Identifying and assessing evidence-informed measures of timely access for patients;
- identifying evidence-informed benchmarks for achieving timely access for patients;
- identifying data collection and reporting mechanisms for the measures and benchmarks determined above;
- establishing best practices to monitor and report on the timely access for patients;
- causes and management of outside use

(iii) The Working Group will review and make recommendations on the operation and practices of walk-in clinics and similar episodic care models such as companies and practices that are solely mobile service and virtual visits as outlined in 5 below.

The parties intend that the Working Group recommendations related to access issues will be implemented by January 1, 2021

2. ACUITY MODIFIER, COMPLEXITY AND CAPITATION RATES

(i) Effective April 1, 2017, until such time as a permanent acuity modifier is implemented, the MOHLTC will restore the previously established interim payment methodology acuity modifier;

(ii) Effective April 1, 2019, A007 be paid at a 50% premium for complex intermediate assessments, payable to a non-capitated comprehensive family physician who provides an intermediate assessment to a patient with at least four (4) chronic conditions as defined in the E078 criteria, where the service is provided in relation to one of those conditions;

(iii) The establishment of an OMA/Ministry Capitation Rate Working Group, reporting to the PSC, composed of an equal number of OMA and MOHLTC members. The parties may also agree to include stakeholders or consultants as required appoint stakeholder representatives in the Committee's work. The Working Group will review and revise the FHO base capitation rate, in accordance with the total amount of funding available as determined by the Phase 1 decision of the Board of Arbitration and subject to allocation at Phase 2. More specifically, the Working Group will:

- review the FHO basket to consider the codes to be included or excluded from the basket including addition of A002A (18 month well baby visit) to basket and applicable amount;
- establish the methodology for a permanent acuity modifier to the FHO capitation rates using funding identified in (i);
- any other issues related to the establishment of the capitation rates as the parties may jointly agree.

Beyond these areas the working group may address other such access issues as the OMA and MOHLTC members of the committee jointly agree.

The parties intend that the Committee recommendations will be implemented by January 1, 2021. In order to accomplish this objective, any issue which has not been resolved by June 30, 2020 will be determined by the Board of Arbitration.

3. QUALITY IMPROVEMENT

The Parties will collaborate in developing a plan to establish and implement a Primary Health Care Quality Agenda including develop and implement an annual quality improvement plan structure and process appropriate for non-FHT FHOs.

The QIP should include:

- identification of quality issues across the six domains of quality;
- development of indicators;
- development of goals for improvement;
- development of targets for improvement;
- development of change ideas or plans to implement improvements; and
- annual submission of a report on progress achieved and the above elements to be publicly posted by HQO with other primary care QIP initiatives.

Level of data published will be consistent with all other QIPs currently posted.

Following agreement of the QIP structure and process for these groups, the OMA will be engaged in the current annual process to establish QIP priority issues and indicators.

The parties intend that the working group recommendations regarding QIPs will be implemented by September 30, 2019. In order to accomplish this objective, any issue which has not been resolved by July 1, 2020 will be determined by the Kaplan Board of Arbitration.

Effective April 1, 2019, new funding for payment of a QI stipend of $5,000 per physician in the FHO groups up to a maximum of $100,000 per group. The QI funds will be utilized in accordance with the group's governance arrangements and only for the purposes of achieving the goals of the QIP and/or building physician skills and knowledge to support quality improvement.

To further support improvement, in 2019/20 and 2020/21, the Ministry will provide new incentive funding to FHO physicians to effectively use the EMR and an EMR Dashboard to implement the annual QIP and other improvement efforts. The proposed funding amount is $400 monthly per FHO physician, which is equal to standard EMR licensing/maintenance fees in the province.

The enhanced-use funding stream would start April 1, 2019. Funding would not be available retroactively for any period of time prior to an individual joining a FHO during the period of this program.

This funding will continue during the next round of negotiations until there is a successor agreement and may be repurposed as agreed or arbitrated for other uses for FHO groups.

To be eligible for this funding, all physicians in the same FHO must be able to digitally access all rostered patients' electronic medical records from any location. The Ministry will facilitate a data migration program for those FHOs that do not currently have a shared common certified electronic medical record. For each FHO with more than 1 existing EMR the ministry will support data migration to an inter-operable EMR. This data migration will be based on a model that allocates new funding of $2500 for the first physician data set and $1000 for each subsequent physician data set (payment to vendor) within a FHO.

The province agrees to not use the data gathered through EMR Dashboard use for performance management purposes.

The above funding is available to both non-FHT and FHT FHOs.

4. GP FOCUSED PRACTICE EXEMPTION:

The OMA proposes to make the process for GP Focused Practice Designation more efficient and responsive to the needs of the primary care patient community. More specifically:

a) The focus areas of Sports Medicine, Pain Management, Sleep Medicine, Addiction Medicine, Palliative Care and Care of the Elderly will be automated, using billings in a manner similar to the implementation of the Focused Practice Psychotherapy designation.
b) Where a minimum of 20% of the billings of eligible physicians are in the specific GP focused practice area, the physician will be designated.
c) Eligibility would be determined through an automatic review of fee codes, not application based, with the fee codes specific to each focus area as set out in the current GP Focus Designation document;
d) In addition, Hospitalists will be recognized as an area of Focussed Practice designation, but the billings threshold will be 20%, based on C prefix codes;
e) Applicants in other practice areas would notify the OMA and MOHLTC of their desire to be considered for eligibility in a particular focus area. Where a proposed focus area is not a Royal College specialty/subspecialty, or an area previously approved by the PSC, the area will be not designated unless approved by the PSC.

5. WALK-IN CLINIC REVIEW:

1) Add to the workplan of the Multi-stakeholder FHO Access Working Group (Proposal 1(f)) a review of the operation and practices of walk-in clinics and similar episodic care models such as companies and practices that are solely mobile service and virtual visits.

2) The Working Group's mandate will include:

- developing an appropriate definition of a walk-in clinic and the provisions of services provided within an environment of PEM providers;
- developing recommendations with respect to the registration of walk-in clinics including the establishment of a unique identifier for the provision of walk-in clinic services and the use of OHIP card verification to enable the point of care identification of patients rostered to FHOs and other PEM providers;
- establishing methodologies for obtaining and analyzing data on services provided in walk-in clinics including using OHIP card verification that will include information on patient rostering to comprehensive care groups; and
- recommendations on changes to improve services provided by walk-in clinics and to better promote their integration with primary care providers, particularly those in PEMs, including:

    - exploration, in partnership with Ontario MD, of the ability for walk-in clinics to communicate back to the patient's primary physician (and eventually a requirement to do so);

    - communicating with patients who regularly use the same walk-in clinic to suggest connecting them with a more conveniently located primary care provider;

    - communication with patients who regularly use walk-in clinics to understand why they do so and how they could be best encouraged to engage in a continuity or care environment; and

    - exploration of the possibility of PEM groups working in networked ways to provide walk in services to each other's patients with timely communication, ideally with access to a patient's chart.

6. PRIMARY CARE TRACKING CODES AND PATIENT SMART CARDS

The OMA proposes that the parties develop jointly and implement primary care tracking codes to identify such matters as (i) multiple issues addressed by physicians in a single patient visit; (ii) non-face-to-face encounters by physicians; (iii)

time of day encounters; (iv) no-show patients; and (v) provision of allied health professional services in support of comprehensive patient care.

The purpose of the tracking codes will be to provide a better understanding of the extent of the services provided by physicians in non-fee for service primary care models and to support the work of the Access Committee and Capitation Rate Working Group in 1 and 2 above. Incentives for tracking codes to be discussed, developed and implemented, and failing agreement to be determined by the Kaplan board of arbitration effective April 1, 2020.

The OMA also proposes that the parties study the use of smart health cards to enable the identification of patients rostered to FHOs and other PEM providers. With the smart card:

- a patient rostered to a FHO or other PEM would be identified at the time of their registration for service with a different provider;

- The patient would be advised to seek care at the organization in which they have been rostered.

- If that organization is not open, patients would be seen at the other providers' clinic and negation would be accessed.

- If the organization was open and reasonably available, the service at the non-PEM location would be exempted from negation.

- Appropriate mechanisms would need to be established to address issues such as geography, emergency service and other exceptional circumstances in which patients would not be required to pay for the service and the PEM would not be negated.

7. MANAGED ENTRY

Effective April 1, 2019 the Ministry agrees to increase FHO complement by up to 500 physicians per year.

Registration of 40 new physicians into FHO models each month in two streams:

- 20 physicians per month in a prioritized stream for those seeking to practice in an area of high need, for FHOs with less than 5 physicians, and for physicians currently in their first 3 years of practice (definition of high need and the prioritization of other factors determining entry into the FHO model will be negotiated by the parties, Kaplan to remain seized)
- 20 physicians per month in the regular stream (all applications not prioritized) which will be processed on a first come, first served basis;
- Any unused spots from one stream will shift to the other stream;

- Any unused spots can be rolled over to subsequent months for the term of the agreement until March 31, 2021; and
- Replacement physicians will be processed outside the Managed Entry process.

Income stabilization will be made available on same terms as previously bilaterally agreed.

8. ENFORCEMENT AND ACCOUNTABILITY [NTD: paragraph references below not yet updated]

X.0 Non-Application of this Article

The failure to meet the parameters of [Cross-reference to B1(1), B1(2), B4 and B5(4)] will form no part of any decision under sections X.1 or X. 4, and such failure is not an Event of Default for the purposes of section X.3(a).

X.1 Termination by Either Ministry or Group.

Either the Ministry or the Group may, in their sole discretion, at any time and for any other reason, terminate the Agreement upon giving three months Notice to the other Parties.

X.2 Termination by Group.

The Group may, in its sole discretion, terminate the Agreement immediately upon giving Notice to the Ministry if the Ministry fails to provide Funds in accordance with Article 6, unless the failure was caused by a circumstance of Force Majeure as provided for in Article 16.

X.3 Event of Default.

Each of the following events shall constitute an Event of Default:

(a) the Group or a Group Physician breaches any representation, warranty, covenant or other material term of the Agreement, including failing to provide Reports in accordance with Article 8;

(b) Where the number of Group Physicians falls below the minimum number of Group Physicians required under the Agreement and the Group is not otherwise grand-parented in accordance with the provisions of [Cross reference to A3];

(c) the Group ceases to operate;

(d) a Group Physician or a Contracted Physician no longer meets the requirements set out in section 5.2; and

(e) an event of Force Majeure that continues for a period of 60 days or more.

X.4 Consequences of Event of Default.

If an Event of Default occurs, the Ministry may, at any time, in proportion to the Event of Default, and in relation to the Defaulting Party, take one or more of the following actions:

(a) initiate any action the Ministry considers necessary in order to facilitate the continued provision of the Services, including demanding the removal of a Group Physician or Contracted Physician who has defaulted under subsection 11.3(d) above;

(b) provide the Defaulting Party with an opportunity to remedy the Event of Default;

(c) suspend the payment of Funds for such period as the Ministry determines appropriate;

(d) reduce the amount of the Funds;

(e) cancel all further installments of Funds;

(f) demand the repayment of any Funds remaining in the possession or under the control of the Group or a Group Physician;

(g) demand the repayment of an amount equal to any Funds the Group or a Group Physician used, but did not use in accordance with the Agreement;

(h) demand the repayment of an amount equal to any Funds the Ministry provided to the Group or a Group Physician; and/or

(i) terminate the Agreement at any time, including immediately, upon giving Notice to the Parties.

X.5 **Opportunity to Remedy**.
If in accordance with section X.4(b) the Ministry provides the Defaulting Party with an opportunity to remedy the Event of Default, the Ministry shall provide Notice to the Defaulting Party of:

(a) the particulars of the Event of Default; and

(b) the Notice Period.

X.6 **Not Remedying**.
If the Ministry has provided the Defaulting Party with an opportunity to remedy the Event of Default pursuant to section X.4(b), and:

(a) the Defaulting Party does not remedy the Event of Default within the Notice Period;

(b) it becomes apparent to the Ministry that the Defaulting Party cannot completely remedy the Event of Default within the Notice Period; or

(c) the Defaulting Party is not proceeding to remedy the Event of Default in a way that is satisfactory to the Ministry,

the Ministry may extend the Notice Period, or initiate any one or more of the actions provided for in sections X.4(a), (b), (c), (d), (e), (f), (g), (h) and (i).

X.7 **Dispute Resolution**

Any dispute with respect to the interpretation or application of the provisions of this Agreement including the enforcement provisions may be referred by the Group or a Group Physician to the Physician Services Committee (PSC) for consideration. Any matter that is not resolved by the PSC may be referred by either the OMA or the Ministry to the Referee in accordance with the provisions of Section 39 of the Binding Arbitration Framework of June 2017.

X8 **When Termination Effective**.
Termination under this Article shall take effect as set out in the Notice.

X.9 **Funds on Termination**.
If either the Ministry or the Group terminates the Agreement pursuant to section X.1, or the Group terminates the Agreement pursuant to section X.2, the Ministry:

(a) shall cancel all further instalments of Funds;

(b) may demand the repayment of any Funds remaining in the possession or under the control of the Group or a Group Physician; and/or

(c) may demand the repayment of an amount equal to any Funds the Group or a Group Physician used but did not use in accordance with the Agreement.

9. GENERAL

In addition to what is specifically provided above, the Kaplan Board of Arbitration shall remain seized of all disputes with respect to the implementation of any of these proposals, which disputes shall be determined on an expedited basis.