

AMENDING AGREEMENT, dated [DATE]

FAMILY HEALTH NETWORK AGREEMENT

AMONG

**HER MAJESTY THE QUEEN, in right of Ontario, as represented by the Minister of
Health and Long-Term Care**

- and -

THE FAMILY HEALTH NETWORK

- and -

**THE ONTARIO MEDICAL ASSOCIATION, a corporation established under the
Corporations Act (Ontario)**

WHEREAS section 16.2 of the Family Health Network Agreement (the "Agreement") allows the OMA and the Ministry to negotiate amendments to the Agreement and to provide notice to the FHN Physicians of such amendments;

AND WHEREAS section 17.17 names the Lead FHN Physician, having the authority to act on behalf of all FHN Physicians, as the appropriate individual to whom any notice for the FHN should be addressed;

NOW THEREFORE, the OMA and the Ministry hereby notify the FHN and its FHN Physicians of the following amendments to the Agreement:

1. Article 1.1(i) (iii) is hereby replaced with the following:

“a Medicine Professional Corporation consisting of FHN Physicians who are all voting shareholders of the corporation, and of which no non-FHN Physician is a voting shareholder, unless otherwise agreed to by the OMA and the Ministry in writing; or”

2. Article 1.1(i)(iv) is hereby replaced with

“an unincorporated association consisting of any combination of:

- FHN Physicians as natural persons; and/or
- Partnership or partnerships of which only FHN Physicians are partners; and/or
- A Medicine Professional Corporation or Medicine Professional Corporations of which only FHN Physicians are voting shareholders and of which no non-FHN Physician is a voting member, unless otherwise agreed to by the OMA and the Ministry in writing.

3. Article 1.1(j) is hereby replaced with the following:

“FHN Physician” means a signatory to either this Agreement or a FHN Physician Declaration who falls into one of the following categories of persons:

- (i) a Physician in his/her personal capacity; or
- (ii) a Medicine Professional Corporation whose voting shareholders are all Physicians providing FHN Services pursuant to this Agreement, unless otherwise agreed to by the OMA and the Ministry in writing;”

4. Article 1.1(l) is hereby replaced with the following:

“FHN Contracted Physician” means a Physician or a Medicine Professional Corporation:

- (i) who is not a FHN Physician;
- (ii) who has been engaged under section 8.3 to provide services under this Agreement; and
- (iii) who has signed a FHN Contracted Physician Declaration;”

5. Article 1.1(o) is hereby replaced with the following:

““Framework Agreement” means the current Physician Services Framework Agreement between the OMA and the Ministry or such other revised, amended or any new agreement which the OMA and the Ministry may enter into from time to time during the term of this Agreement”;

6. Article 1.1(t.1) is hereby add to the Agreement as follows:

“Medicine Professional Corporation” has the same meaning ascribed to the term Physician Corporation under O.Reg 665/05 made under the Business Corporations Act R.S.O., c.B.16;

7. Article 2.1 is hereby replaced with the following:

A FHN shall consist of a minimum of three (3) FHN Physicians who are able to demonstrate to the satisfaction of the Ministry that they will be able to enrol a minimum of the following number of Enrolled Patients:

(a) For groups of 3 FHN Physicians: 2,400 patients;

(b) For groups of 4 FHN Physicians: 3,200 patients; and

(c) For groups of 5 & more FHN Physicians: 4,000 patients.

Notwithstanding the foregoing, in the event that a FHN Physician is a Medicine Professional Corporation, each voting shareholder of the Medicine Professional Corporation shall be counted separately for the purposes of fulfilling the minimum group size requirement.

8. Article 3.3 is hereby amended by the addition of the following:

“In the event that the FHN Physician is a Medicine Professional Corporation, patients shall be assigned to an individual voting shareholder designated by that corporation to act as its agent for the purposes of enrolment, including completing with the patient the Enrolment Form.”

9. Article 3.4 is hereby replaced with the following:

“Enrolment Funding

(a) For Physicians who become FHN Physicians on or after March 30, 2005:

Each FHN Physician shall receive an incentive in the amount of five dollars (\$5.00) on a per patient basis for the initial enrolment of patients in accordance with the provisions contained herein for a twelve (12) month period beginning on his/her effective date of registration as a FHN Physician.

(b) For Physicians who become FHN Physicians before March 30, 2005:

Each FHN Physician shall receive an incentive in the amount of five dollars (\$5.00) on a per patient basis for enrolling patients in accordance with the provisions contained herein for a twelve (12) month period beginning on March 30, 2005.”

10. Article 5.2 is hereby replaced with the following

(a) Except for Recognized Holidays, the FHN Physicians shall ensure that a sufficient number of Physicians are available to provide the FHN Services during reasonable and regular office hours from Monday through Friday sufficient and convenient to serve Enrolled Patients.

(b) Unless otherwise agreed to by the Ministry in writing, except for Recognized Holidays, and subject to Articles 5.2(iv) and 5.2(v), at least one FHN Physician office staffed by a FHN Physician or a FHN Contracted Physician shall be open outside of regular office hours for scheduled and unscheduled Enrolled Patient appointments/visits, according to the following minimum requirements (“Evening and Weekend Hours”):

- i. If the FHN consists of only three FHN Physicians, at least one FHN Physician office staffed by a FHN Physician or a FHN Contracted Physician, shall be open for a minimum three hour block of time on at least three of the following occasions: Monday to Thursday night after 5:00 p.m., or for a minimum three hour block of time on a weekend.
- ii. If the FHN consists of only four FHN Physicians, at least one FHN Physician office staffed by a FHN Physician or a FHN Contracted Physician, shall be open for a minimum three hour block of time on at least four of the following occasions: Monday to Thursday night after 5:00 p.m., or for a minimum three hour block of time on a weekend.
- iii. If the FHN consists of five or more FHN Physicians, at least one FHN Physician office staffed by a FHN Physician or a FHN Contracted

Physician shall be open for a minimum three hour block of time on at least five of the following occasions: Monday to Thursday night after 5:00 p.m. and for a minimum three hour block of time on a weekend.

- iv. If more than fifty percent (50%) of the FHN Physicians provide: (A) public hospital emergency room coverage, (B) public hospital anaesthesia services on a regular, ongoing basis, (C) obstetrical deliveries outside of regular office hours, or (D) any combination of services stated in (A), (B), and (C), then the obligation to provide Evening and Weekend Hours may be waived by the Ministry, at the written request of the Lead FHN Physician.
- v. Notwithstanding any other provision in the Agreement, nurse practitioners shall be permitted to equitably contribute to the fulfillment of Evening and Weekend Hours coverage and bonuses on the following basis. Nurse practitioners are permitted to fulfill the obligation for one of the 3 hour blocks of Evening and Weekend Hours coverage per week for the FHN and shall submit valid claims for those services rendered to FHN Enrolled Patients in accordance with section 6 of Appendix I.
- vi. During Evening and Weekend Hours, the FHN Physicians shall provide the FHN Services at appropriate locations of their choice, provided that they shall advise the Ministry of such locations. FHN Physicians providing services in an Emergency Room of a Public Hospital shall use best efforts to ensure that non-emergency services provided to Enrolled Patients are not counted by the Public Hospital as a visit to the Emergency Room. FHN Services provided by FHN Physicians in a Public Hospital must be offered separate and apart from the Public Hospital's Emergency Room services.
- vii. The FHN may provide a 3 hour block of coverage on Saturday, in place of one of the weekday Evening Hours blocks. The FHN may also provide a 3 hour block of coverage on Sunday, in place of one of the weekday Evening Hours blocks. If a 3 hour block of coverage is provided on both Saturday and Sunday, two of the weekday Evening Hours blocks will be considered to have been met.

Notwithstanding the foregoing, in the event that a FHN Physician is a Medicine Professional Corporation, each voting shareholder of the Medicine Professional Corporation shall be counted separately for the purposes of determining the minimum requirements for Evening and Weekend Hours.

11. Article 6.3 is hereby replaced with the following:

"The Ministry shall make a monthly payment of two thousand dollars (\$2,000) to each FHN which has at least five (5) FHN Physicians. The Ministry shall make a monthly payment of

four hundred dollars (\$400) multiplied by the number of FHN Physicians per month to FHNs with 3 - 4 FHN Physicians. These payments are in consideration of the FHN Physicians:

- (a) ensuring that a FHN Physician is available on call during the THAS Hours of Delivery;
- (b) ensuring that the THAS provider is informed of which FHN Physician is on call and how to reach that FHN Physician;
- (c) in conjunction with the Ministry, promoting the THAS among the FHN's Enrolled Patients and for encouraging the proper and appropriate use of THAS by Enrolled Patients;
- (d) providing the THAS provider with information about available local services to which the THAS Provider's staff can direct callers and
- (e) participating in on-going reviews and an overall evaluation of THAS.

The monthly payment shall be made at the end of each month through direct deposit to the FHN's bank account or through such other arrangements as may be made between the FHN and the Ministry.

Notwithstanding the foregoing, in the event that a FHN Physician is a Medicine Professional Corporation, each voting shareholder of the Medicine Professional Corporation shall be counted separately for the purposes of determining the THAS on-call block of coverage and payment."

12. Article 13.1 is hereby replaced with the following:

"Except as set out in Sections 3.4, 6.3 and 7.1, the payment provisions of this Agreement are contained in Appendix I and are only payable to the FHN for services rendered on and following the Commencement Date, unless otherwise specified in Appendix I.

13. Article 13.8 is hereby amended by replacing the reference to section 15.6 with the reference "section 21.3" of the 2004 Physician Services Framework Agreement.

14. Article 17.17 is hereby amended by the deletion of the notice address for the Ministry of Health and Long-Term Care and replaced with the addition of the following:

“Manager West and Capitated Models Unit, Primary Health Care Team, 1075 Bay Street, 10th Floor, Toronto, ON M5S 2B1, Fax: (416) 326-4684.

- 15.** Article 17.19 is hereby replaced with the following:

FHN Physicians shall be entitled to participate in the Physician IT Program in accordance with the provisions of Appendix “F”, attached hereto as Schedule 5.

- 16.** Appendix “A” is hereby replaced by the amended “Patient Enrolment and Consent to Release Personal Health Information”, which is attached hereto as Schedule 1.

- 17.** Appendix “B” is hereby replaced by the amended “Family Health Network Physician Declaration”, which is attached hereto as Schedule 2.

- 18.** Appendix “C” is hereby replaced by the amended “Family Health Network Contracted Physician Declaration”, which is attached hereto as Schedule 3.

- 19.** Appendix “E” is hereby replaced by the amended “Family Health Network Legal Structures and Governance Requirements”, which is attached hereto as Schedule 4.

- 20.** Appendix “I – as Amended July 1, 2003 (Payment)” is hereby replaced by “Appendix I – as Amended March 30, 2005 (Payment)” which is attached as Schedule 6 hereto.

- 21.** Appendix “K” is hereby amended as follows:

21.1 The phrase “new to practice”, found in the first paragraph of the Appendix, is hereby deleted.

21.2 The following is hereby added at the conclusion of the Appendix:

“Notwithstanding the above-noted, a separate undertaking applicable to new graduates who qualify for Income Stabilization is attached. The phrase “new graduate” pertains to a physician, including an International Medical Graduate, who graduated no more than three years prior to the date that he/she signed the FHN agreement.”

21.3 Undertaking K-1 (Undertaking and Acknowledgement), which is attached hereto as Schedule 7, is hereby added to the Agreement.

21.4 New Graduate Income Stabilization Undertaking K-2 (Undertaking and Acknowledgement), which is attached hereto as Schedule 8, is hereby added to the Agreement.

22. All words used in this Amending Agreement shall be deemed to have the same meaning that they have in the Agreement.

23. In all other respects, the terms and conditions of the Agreement shall continue to apply.

IN WITNESS WHEREOF, the OMA and the Ministry have signed this amendment on the day of , 2006.

**HER MAJESTY THE QUEEN, in right of
Ontario, as represented by the Minister
of Health and Long-Term Care**

The Ontario Medical Association

**Per: _____
Name:
Title**

**Per: _____
Name:
Title:
Authorized Signing Officer**

SCHEDULE 1

Patient Enrolment and Consent to Release Personal Information (please use official form provided by the Ministry)

Please **PRINT** using black or blue ballpoint pen

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsections 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s. 4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1- I want to enrol myself with the family doctor identified in Section 4

Last name		First name		Second name	
Health Number <div style="border-bottom: 1px solid black; width: 100px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div>	Version code <div style="border-bottom: 1px solid black; width: 100px;"></div>	Mailing Address	Apartment #	Street no. and name or P.O. Box, Rural Route, General delivery	
Date of birth (yyyy/mm/dd) <div style="border-bottom: 1px solid black; width: 100px;"></div>	Sex M F		City/Town	Postal Code	
Send notices from my family doctor's office to me by: regular mail email (if possible)		Residence Address	Apartment #	Street no. and name or lot, concession and township	
Email address:		Or same as mailing address	City/Town	Postal Code	

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A	Last name		First name		Second name	
	Health Number <div style="border-bottom: 1px solid black; width: 100px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div>	Version code <div style="border-bottom: 1px solid black; width: 100px;"></div>	Mailing Address Or same as	Apartment #	Street no. and name or P.O. Box, Rural Route, General delivery	

<div> <div></div> <div></div> </div>		Sex M F	Section 1	City/Town	Postal Code
Date of birth (yyyy/mm/dd)					
I am this person's		Residence Address	Apartment #	Street no. and name or lot, concession and township	
parent					
legal guardian					
attorney for personal care		Or same as Section 1	City/Town	Postal Code	
B	Last name	First name	Second name		
Health Number	Version code	Mailing Address	Apartment #	Street no. and name or P.O. Box, Rural Route, General delivery	
<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> </div>	Or same as Section 1	City/Town	Postal Code	
Date of birth (yyyy/mm/dd)	Sex M F				
I am this person's		Residence Address	Apartment #	Street no. and name or lot, concession and township	
parent					
legal guardian					
attorney for personal care		Or same as Section 1	City/Town	Postal Code	

Section 3 - Signature Family doctor information

Section 4 -

I have read and agree to the Patient Commitment, the Consent to Release of Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.	
I am signing on behalf of (check all that apply)	
<input type="checkbox"/> myself	<input type="checkbox"/> child(ren)
<input type="checkbox"/> dependent adult(s)	

My name			
last name		first name	
Signature		Date (yyyy/mm/dd)	
X			
(Include Billing no. and Group no.)			
Home telephone no.	Work telephone no.	Family doctor's signature	Date(yyyy/mm/dd)
()	()	X	

Patient Enrolment and Consent to Release Personal Information

Patient Commitment

I agree to contact my family doctor, the Group to which my family doctor belongs or the designated Telephone Health Advisory Service, when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm his or her enrolment with the family doctor.

Consent to Release Personal Health Information

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Group and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Group.

I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, Health Number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or phoning the ministry (see box below)

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will end when:

- (a) I cancel my enrolment by writing my family doctor or by writing or phoning the ministry (see box below)
- (b) I no longer qualify for health care services under the *Health Insurance Act (Ontario)*;
- (c) the Group to which my doctor belongs no longer exists
- (d) my family doctor chooses to discontinue acting as my doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines
- (e) I enrol with another alternatively-funded family doctor; or
- (f) The ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

- (g) I consistently fail to meet the obligations to which I agreed in the Patient Commitment (*above*)
- (h) my family doctor leaves this Group. If this happens, I may be able to enrol with my family doctor in another Group or I may be able to enrol with another family doctor in this Group
- (i) I become a resident of a nursing home or chronic care facility
- (j) I am imprisoned in a provincial or federal correctional institution; or
- (k) I move outside the geographic area where the Group provides services.

Contact Information:

Ministry of Health and
Long-Term Care

P.O. Box 48, Station
Main

Kingston ON K7L 9Z9

Call: INFOline 1 888
218- 9929

TTY 1 800 387-5559

SCHEDULE 2

APPENDIX B, as amended January 1, 2006

FAMILY HEALTH NETWORK PHYSICIAN DECLARATION

TO: THE MINISTRY OF HEALTH AND LONG-TERM CARE (the “**Ministry**”)

AND TO: THE GENERAL MANAGER OF THE ONTARIO HEALTH INSURANCE
PLAN (the “**General Manager**”)

SECTION ONE: FHN PHYSICIAN DECLARATION	
In the event the FHN Physician is a natural person, please complete the box below:	In the event the FHN Physician is a Medicine Professional Corporation please complete the box below:
IN CONSIDERATION of the Ministry and the Family Health Network (the “ FHN ”) entering into the Family Health Network Agreement (the “ Agreement ”) under which the Ministry shall remunerate the undersigned physician and the FHN for the services to be provided as set out under the Agreement, the undersigned physician, [insert name of physician] hereby declares and acknowledges as follows:	IN CONSIDERATION of the Ministry and the Family Health Network (the “ FHN ”) entering into the Family Health Network Agreement (the “ Agreement ”) under which the Ministry shall remunerate [insert name of Medicine Professional Corporation] and the FHN for the services to be provided as set out under the Agreement, [insert name of Medicine Professional Corporation], a body corporate duly incorporated under the laws of the Province of Ontario, hereby declares and acknowledges as follows:

1. The undersigned has received a copy of the Agreement and reviewed and fully understand the terms of the Agreement. The undersigned agrees to be bound by all of the terms of the Agreement.
2. Upon the Ministry confirming the undersigned’s status as a FHN Physician, the undersigned, with the support of the Ministry and in accordance with a timetable to be agreed to between the Ministry and the FHN, hereby agrees to offer each patient in his/her practice or, in the practice of each voting shareholder of the [insert name of Medicine Professional Corporation], as applicable, the opportunity to become an Enrolled Patient, provided that he or she meets the criteria set out in subsection 3.1.1 of the Agreement.

3. Other than as provided for in the Agreement, the undersigned shall not claim, directly or indirectly, or accept payment, or authorize any person to claim for or accept payment from the Ontario Health Insurance Plan (the “Plan”) or from any other person, for any FHN Services provided to Enrolled Patients.
4. In the event that the undersigned breaches any of the claim, payment or funding provisions set out in the Agreement, or where the undersigned owes a debt to the Minister for any other reason,
 - (a) the Ministry may retain, by way of deduction or set-off, out of any money that is due and payable to the undersigned by the FHN under the Agreement, all or part of such money as the Ministry sees fit in the circumstances; and
 - (b) the General Manager may retain, by way of deduction or set-off, under the Health Insurance Act, out of any money that is due and payable to the undersigned by the FHN or by the Plan, all or part of such money as permitted by that Act and the Agreement.

If the Ministry or the General Manager does retain by way of a deduction or set-off any money due and payable to the FHN as a result of such debt of the undersigned, the FHN shall be entitled to deduct such amounts from any amounts payable to the undersigned by the FHN.

5. The undersigned has executed all FHN Governance Documents either in my personal capacity or, if applicable, as a shareholder in my professional corporation, and consent to the disclosure to the Ministry of all documentation pertaining to the governance of the Family Health Network as may be required to demonstrate compliance with the Governance Requirements as defined and as set out in the Agreement.
6. The undersigned acknowledges and agrees that all payments to be made under the Agreement shall be made to the bank account specified by the FHN Physicians in accordance with the Governance Requirements as defined and as set out in the Agreement.
7. The undersigned confirms that Dr. _____, as Lead FHN Physician, and Dr. _____ as Associate FHN Physician, have the authority to act on my/our behalf in accordance with the Governance Requirements as defined and as set out in the Agreement.

Dated at _____ this _____ day of _____, _____.

Name	_____
Billing Number	_____
Office Address	_____

Fax Number	_____
Phone Number	_____
Name of FHN	_____

In the event the FHN Physician is a natural person:

Signature: Physician

Witness

OR

In the event the FHN Physician is a Medicine Professional Corporation:

The [insert name of corporation] hereby further represents, warrants to and covenants with the Ministry as follows:

1. The [insert name of corporation] is a corporation duly incorporated and validly subsisting pursuant to the laws of Ontario;
2. The [insert name of corporation] has full power and authority to enter into this Agreement and to observe, perform and comply with the terms and conditions of this Agreement, and all necessary action and procedures have been taken in order to enter into and authorize this Agreement; and
3. The [insert name of corporation] holds and shall continue to hold all registrations and certificates necessary to carry on business in Ontario and to perform its obligations under this Agreement.

Signature: Authorized Signing Officer

Witness

Name and Title: _____

I have the authority to bind the [insert name of Professional Corporation]

AND

SECTION TWO: SHAREHOLDER ACKNOWLEDGEMENT

To be completed in the event the FHN Physician is a Medicine Professional Corporation by each voting shareholder of that corporation:

Name of Voting Shareholder:

Office Address:

Billing Number:

Phone Number:

Fax Number:

Name of Voting Shareholder:	Office Address:
Billing Number:	Phone Number:
	Fax Number:
Etc. for each voting shareholder of the corporation	

We, the undersigned physicians, being all of the voting shareholders in the [insert name of professional corporation], hereby acknowledge and agree that the Ministry's rights as set out in sections 3 and 4 of this Declaration, and sections 13.3 and 13.4 of the Agreement, shall apply to each one of us in our personal capacities.

List Names of each voting shareholder:

Name:

Witness

Name:

Witness

Etc.

AND

SECTION THREE: LEAD PHYSICIAN DECLARATION

I, _____ (Lead Physician), confirm that _____ (Physician) has received a copy of the Agreement and the FHN Governance Documents and by the signing of this Appendix has agreed to be bound by them. I agree on behalf of the FHN to provide to the Ministry such information as may be reasonably required for the purposes of this Appendix.

Signature: Lead Physician

SCHEDULE 3

APPENDIX C, as amended January 1, 2006

FAMILY HEALTH NETWORK CONTRACTED PHYSICIAN DECLARATION

TO: THE MINISTRY OF HEALTH AND LONG-TERM CARE (the “**Ministry**”)

AND TO: THE GENERAL MANAGER OF THE ONTARIO HEALTH INSURANCE
PLAN (the “**General Manager**”)

SECTION ONE: FHN CONTRACTED PHYSICIAN DECLARATION	
In the event the FHN Contracted Physician is a natural person, please complete the box below:	In the event the FHN Contracted Physician is a Medicine Professional Corporation please complete the box below:
IN CONSIDERATION of the Ministry and the Family Health Network (the “ FHN ”) entering into the Family Health Network Agreement (the “ Agreement ”) under which the Ministry shall remunerate the undersigned physician and the FHN for the services to be provided as set out under the Agreement, the undersigned physician, [insert name of physician] hereby declares and acknowledges as follows:	IN CONSIDERATION of the Ministry and the Family Health Network (the “ FHN ”) entering into the Family Health Network Agreement (the “ Agreement ”) under which the Ministry shall remunerate [insert name of Medicine Professional Corporation] and the FHN for the services to be provided as set out under the Agreement, [insert name of Medicine Professional Corporation], a body corporate duly incorporated under the laws of the Province of Ontario, hereby declares and acknowledges as follows:

1. The undersigned has received a copy of the Agreement and have reviewed and fully understand the terms of the Agreement. The undersigned agrees to be bound by all applicable terms of the Agreement.
2. As long as the undersigned is a FHN Contracted Physician the undersigned shall not claim directly or indirectly, or accept payment, or authorize any person to claim for or accept payment from the Ontario Health Insurance Plan (the “**Plan**”) or from any other person, for any FHN Services provided to Enrolled Patients other than as provided in the Agreement.

3. The undersigned acknowledges and agrees that all payments to be made under the Agreement shall be made to the bank account specified by the FHN Physicians in accordance with the Governance Requirements as defined and as set out in the Agreement.
4. In the event that the undersigned breaches any of the claim, payment or funding provisions set out in the Agreement, or where the undersigned owes a debt to the Minister for any other reason,
 - (a) the Ministry may retain, by way of deduction or set-off, out of any money that is due and payable to the undersigned by the FHN under the Agreement, all or part of such money as the Ministry sees fit in the circumstances; and
 - (b) the General Manager may retain, by way of deduction or set-off, under the Health Insurance Act, out of any money that is due and payable to the undersigned by the FHN or by the Plan, all or part of such money as permitted by that Act and the Agreement.

In the event that the General Manager does retain by way of a deduction or set-off any money due and payable to the FHN as a result of such debt of the undersigned, the FHN shall be entitled to deduct such amounts from any amounts payable to the undersigned by the FHN.

5. The undersigned confirms that Dr. _____, as Lead FHN Physician, and Dr. _____ as Associate FHN Physician, have the authority to act on my/our behalf in accordance with the Governance Requirements as defined and as set out in the Agreement.

Dated at _____ this _____ day of _____, _____.

Name	_____
Billing Number	_____
Office Address	_____

Fax Number	_____
Phone Number	_____
Name of FHN	_____

In the event the FHN Contracted Physician is a natural person:

Signature: Physician

Witness

OR

In the event the FHN Contracted Physician is a Medicine Professional Corporation:

The [insert name of corporation] hereby further represents, warrants to and covenants with the Ministry as follows:

1. The [insert name of corporation] is a corporation duly incorporated and validly subsisting pursuant to the laws of Ontario;
2. The [insert name of corporation] has full power and authority to enter into this Agreement and to observe, perform and comply with the terms and conditions of this Agreement, and all necessary action and procedures have been taken in order to enter into and authorize this Agreement; and
3. The [insert name of corporation] holds and shall continue to hold all registrations and certificates necessary to carry on business in Ontario and to perform its obligations under this Agreement.

Signature: Authorized Signing Officer

Witness

Name & Title: _____

I have the authority to bind the [insert name of Professional Corporation]

AND

SECTION TWO: SHAREHOLDER ACKNOWLEDGEMENT	
To be completed in the event the FHN Contracted Physician is a Medicine Professional Corporation by each voting shareholder of that corporation:	
Name of Voting Shareholder: Billing Number:	Office Address: Phone Number: Fax Number:
Name of Voting Shareholder: Billing Number:	Office Address: Phone Number: Fax Number:
Etc. for each voting shareholder of the corporation	

We, the undersigned physicians, being all of the voting shareholders in the [insert name of professional corporation], hereby acknowledge and agree that the Ministry's rights as set out in

sections 3 and 4 of this Declaration, and sections 13.3 and 13.4 of the Agreement, shall apply to each one of us in our personal capacities.

List Names of each voting shareholder:

Name:

Witness

Name:

Witness

Etc.

AND

SECTION THREE: LEAD PHYSICIAN DECLARATION
--

I, _____ (Lead Physician), confirm that _____ (Physician) has received a copy of the Agreement and the FHN Governance Documents and by the signing of this Appendix has agreed to be bound by them. I agree on behalf of the FHN to provide to the Ministry such information as may be reasonably required for the purposes of this Appendix.

Signature: Lead Physician

SCHEDULE 4

APPENDIX E, as amended January 1, 2006

FAMILY HEALTH NETWORK LEGAL STRUCTURES AND GOVERNANCE REQUIREMENTS

1. Unincorporated Association – Natural Persons:

Where the FHN is composed entirely of natural persons, all FHN Physicians shall enter into a Contract of Association consistent with these Governance Requirements.

2. Partnership – Natural Persons as Partners:

Where the FHN is a partnership composed entirely of natural persons, all FHN Physicians shall enter into a Partnership Agreement consistent with these Governance Requirements.

3. Medicine Professional Corporation – Shareholders:

Where the FHN is a Medicine Professional Corporation, all voting shareholders shall enter into a Shareholders' Agreement and shall adopt Corporate Bylaws that shall both be consistent with these Governance Requirements.

4. Unincorporated Association – Natural Persons, Partnerships, Medicine Professional Corporations:

Where the FHN is composed of one or more of:

- (i) natural persons;
 - (ii) partnerships;
 - (iii) Medicine Professional Corporations;
- all such legal entities shall enter into a Contract of Association consistent with these Governance Requirements.

Notwithstanding anything else contained in this Agreement, non-FHN Physicians may not be either partners in a partnership or voting shareholders in a corporation where such partnership or corporation is a Party to this Agreement.

The FHN Physicians agree that they shall ensure that their respective Contracts of Association, Partnership Agreements, Corporate Bylaws and Shareholder Agreements, as the case may be, shall include provisions that address the following matters:

- (i) the admission of new FHN Physicians;
- (ii) the withdrawal of current FHN Physicians;
- (iii) the expulsion of current FHN Physicians;
- (iv) an approval process for FHN Contracted Physicians;

- (v) the selection of the Commencement Date for the FHN;
- (vi) where the FHN Physicians are in an unincorporated association, modifications to the Contract of Association;
- (vii) any decision of the FHN Physicians to terminate the FHN Agreement;
- (viii) a process for determining after-hours and on-call service by FHN Physicians;
- (ix) how the FHN Physicians share financial information received from the Ministry;
- (x) how the FHN Physicians shall determine individual payments to the FHN Physicians from payments deposited to the FHN's bank account; and
- (xi) a process to provide notification from each FHN Physician's malpractice insurer of any change or cancellation of such insurance.

FHN – OPERATIONAL REQUIREMENTS

The FHN Physicians further agree that, regardless of the legal structure of the FHN, they shall:

- (a) establish a bank account in the name of the FHN, with the naming of at least two appropriate signing officers, one of whom shall be the Lead FHN Physician, as defined in (d) below;
- (b) establish a framework for managing the FHN Physicians' rights and interests in property specially and separately funded by the Ministry. For greater clarity, such property shall not include any property purchased with any funding provided by the Ministry in consideration of the FHN Services;
- (c) adopt and implement information management protocols that give due regard to appropriate patient confidentiality and are consistent with this Agreement and applicable law; and
- (d) establish explicit authority for a minimum of two elected officers, of whom one shall be known as the "Lead FHN Physician", and one shall be known as the "Associate FHN Physician", who must all be FHN Physicians, and who, acting alone or in combination, are able to bind all of the members of the FHN collectively and personally, for a minimum of the following purposes:
 - for execution of all amendments, extensions or renewals of the FHN Agreement;
 - for execution of subsequent or supplementary agreements, as may be required, relating to the receipt, disbursement and use of public funds, other than funds provided in consideration of the FHN Services, in support of FHN activities and operations; and
 - to enter into agreements with such other persons, health care providers, health organizations, and institutions, as may be required or desired, for the purpose of supporting FHN activities and operations.

Schedule 5

APPENDIX F

Physician IT Program

1. The Physician IT Program will be available for a period of 3 years from the commencement of the Program.
2. Information technology will be provided to FHN Physicians through the Physician IT Program. The Physician IT Program will be managed by and delivered by the OMA or its agents.
3. The Physician IT Program includes the following elements:
 - 3.1 OntarioMD.ca – Provides FHN Physicians with free access, for the term of this Appendix, to an internet portal that contains healthcare-related information and access to services.
 - 3.2 Approved Clinical Management System Products (“CMS”) – Provides FHN Physicians with a list of Clinical Management System products, either Local Solution or Application Service Provider (ASP), that create electronic medical records (“EMR”) and integrate billing and scheduling functionality. The CMS list will be periodically updated to add new information technology products or to remove current products.
 - 3.3 Transition Support Program – Provides FHN Physicians with free access, for the duration of the Physician IT Program, to change management products and tools and a Transition Support Program Specialist to support the acquisition, implementation, and adoption of information technology.
 - 3.4 Secure Network Connectivity – Provides FHN Physicians with free access to the Smart Systems for Health Agency (“SSHA”) network or a network provider approved by SSHA.
 - 3.5 Secure eMail Communication – Provides FHN Physicians with free access to a SSHA secure eMail account.

3.6 Primary Care IT Funding Plan – Provides FHN Physicians who elect to participate (“Participating Physicians”) with a funding subsidy towards the acquisition, implementation and adoption of information technology. The amount of the funding subsidy will be dependent on the information technology option selected by a Participating Physician. Participating Physicians must apply for the Primary Care IT Funding Plan during the 3 year period the Physician IT Program is available and agree to the Terms and Conditions of the Primary Care IT Funding Plan.

3.6.1 Comprehensive Package - Under the Comprehensive Package option, Participating Physicians will receive funding to acquire, install and implement an Approved CMS Product.

3.6.1.1 A one-time site readiness grant of \$4500, per Participating Physician, to be used to prepare the office environment(s) for the installation and use of the Approved CMS Product.

3.6.1.2 A \$600 monthly funding subsidy, per Participating Physician, for a period of 36 months for the acquisition, implementation and maintenance of a CMS.

3.6.1.3 A one-time performance recognition bonus of \$2500 per Participating Physician on establishment of an EMR for either two-thirds (2/3) or 600, whichever is less, of their rostered patients. For the purposes of the performance recognition bonus, the EMR is expected to contain demographic profile, current prescriptions, current immunizations, details of any allergies, and a patient problem list.

3.6.2 Physician Desktop Package – Under the Physician Desktop Package, Participating Physicians will receive a one-time funding grant of \$2000 to be used to purchase a personal computer that includes an office productivity suite, an Internet browser, and a printer.

4. Primary Care IT Funding Plan Terms and Conditions

4.1. To receive funding through the Primary Care IT Funding Plan, Participating Physicians must agree to the following Terms and Conditions that remain in effect for the period during which Primary Care IT Funding Plan payments are made to the FHN.

4.2. Participating Physicians in the Comprehensive Package must:

- 4.2.1. Acquire and implement a CMS.
- 4.2.2. Acquire the same CMS within their FHN.
- 4.2.3. Have ready access to a CMS from their examination room(s) and/or office environment including the ability to access the Internet and print confidential information.
- 4.2.4. Have installed the necessary server/network infrastructure to support their technology environment.
- 4.3. Participating Physicians in the Physician Desktop Package must acquire equipment that meets or exceeds minimum standards available through the Transition Support Program Scope of Work document.
- 4.4. Participating Physicians selecting a CMS (Local Solution) must install the CMS on a computer located in the office of each Participating Physician or on a server located in the office of one Participating Physician on behalf of all Participating Physicians or on a server located in a hospital at the request of all Participating Physicians. Each Participating Physician must retain exclusive ownership and control of his or her EMR.
- 4.5. Each Participating Physicians is responsible for any tax obligations that arise from his or her receipt of funding from the Primary Care IT Funding Plan.
- 4.6. The Participating Physicians must enter into an agreement governing the ownership of the information technology acquired through the Primary Care IT Funding Plan.
- 4.7. Participating Physicians must implement and use the SSHA network or, if SSHA is unable to provide a network connection to a Participating Physician, a network connection provided through a network provider approved by SSHA.
- 4.8. Participating Physicians must implement and use a SSHA secure e-mail account.
- 4.9. Participating Physicians will register with the SSHA Registration Management System. Such registration can occur through various mechanisms including the OMA or its agents. OMA or its agents may register physicians and their staff for use of all services provided by OMA or its agents. OMA or its agents may also act as a registration agent for SSHA.

4.10. Participating Physicians and/or their authorized Lead FHN Physician must complete the following documents available through the Transition Support Program. The documents have been approved by the Ministry and the OMA. Changes to the documents will be subject to review and approval by the Ministry and the OMA.

- Letter of Intent v1.0
- Notice of Change v1.0 (when applicable)
- Vendor Contract Declaration Form v1.0
- Electronic Funds Transfer Form v1.0
- Scope of Work Document v1.0 for each Participating Physician Location
- Go-Live Declaration v1.0
- Performance Recognition Declaration v1.0

4.11. Primary Care IT Funding Plan payments will be made to the FHN. The FHN will make appropriate arrangements with Participating Physicians with respect to the disbursement of the Primary Care IT Funding Plan payments.

4.12. Primary Care IT Funding Plan payments will be made by electronic bank deposit.

4.13. Primary Care IT Funding Plan payments for the Comprehensive Package will be made as follows:

4.13.1. Payment of the site readiness grant will be issued to the FHN with 30 days of the OMA's receipt and acceptance of the Vendor Contract Declaration form.

4.13.2. Payment of the monthly subsidy will commence within 60 days of OMA's receipt and acceptance of the Go-Live Declaration form.

4.13.3. Payment of the performance recognition bonus will be issued within 60 days of OMA's receipt and acceptance of the Performance Recognition

Declaration form.

- 4.14. Primary Care IT Funding Plan payments for the Physician Desktop Package will be made within 60 days of the OMA's receipt and acceptance of a Go-Live Declaration form.
- 4.15. In the event that there are changes within the FHN that affect the Primary Care IT Funding Plan payments, the FHN must complete and submit a Notice of Change as set out below.
- 4.15.1. The FHN is required to notify OMA within 30 days of a Participating Physician's departure from the FHN. It is recognized that in accordance with Schedule H of the FHN Agreement, the Lead FHN Physician must also provide notice to the OMA and the Ministry in the event of the death or maternity or disability leave of a FHN Physician within 30 days of such event. For the purposes of the Primary Care IT Funding Plan, the FHN is entitled to replace a Participating Physician and may be entitled to continued funding from the Primary Care IT Funding Plan for a replacement Participating Physician.
- 4.15.2. A physician replacing a Participating Physician funded under the Physician Desktop Package is not eligible to receive funding under the Physician Desktop Package.
- 4.15.3. A physician replacing a Participating Physician funded under the Comprehensive Package, is eligible to receive any remaining monthly subsidy payments associated with the departing physician. The replacement physician is not eligible to receive additional site readiness funding.
- 4.15.4. Where a departing Participating Physician selected the Comprehensive Package, the OMA reserves the right to reduce the FHN's monthly subsidy payment if a replacement Participating Physician is not found within 6 months of the departure date.
- 4.15.5. New FHN Physicians are entitled to apply for funding from the Primary Care IT Funding Program.
- 4.15.6. Where a Participating Physician elects to upgrade from the Physician Desktop Package to the Comprehensive Package, the FHN may apply for funding from the Primary Care IT Funding Program. The FHN is eligible to receive the site readiness grant, less the \$2000 payment already provided under the Physician Desktop Program, the monthly subsidy, and the performance recognition grant.

- 4.16. The Participating Physicians and their staff must participate in appropriate training on the use and functionality of the information technology they select.
- 4.17. The Participating Physicians will be required to agree to develop a disaster recovery plan and a business continuity plan for their Approved CMS Product.
- 4.18. The Participating Physicians will be required to authorize OMA and/or its representatives at all reasonable times, and with reasonable notice, to audit any information technology installations, invoices, and documents related to the Primary Care IT Funding plan that are in the possession or under the control of the Group.
- 4.19. Participating Physicians acknowledge that the OMA may discontinue Primary Care IT Fund payments for a Participating Physician who has either not implemented or ceased to use the EMR.
- 4.20. Participating Physicians acknowledge that the OMA may terminate Primary Care IT Fund payments, if the FHN breaches any of the Primary Care IT Funding Plan Terms and Conditions.
5. Liability – None of the OMA, OMAeS, the Ministry, nor any of their directors, officers, employees or agents shall be liable to the FHN or FHN Physicians for any damages, injury, claims, costs or losses of any kind arising out of or in any way related to the Physician IT Program.
6. Amendments
- 6.1. In recognition of the changing information technology environment and the government's commitment to an eHealth Strategy, changes may be needed to the Physician IT Program to take advantage of new opportunities. Changes to the Physician IT Program elements or to the Primary Care IT Funding Plan Terms and Conditions will be reflected through an amendment to this Appendix prior to implementation.

Schedule 6

APPENDIX I - As Amended March 30, 2005

PAYMENT

Note: The payments set out in sections 5, 6, 7 and 8 apply as of the Issuance Date.

1.1 Base Rate Payment

(a) The Ministry shall pay to the FHN on behalf of each of its FHN Physicians for each of their Enrolled Patients, an amount equal to the daily Base Rate for the Enrolled Patient's age and sex category as set out in Schedule 1 of this Appendix for each day the patient is an Enrolled Patient. Payment will be made monthly in arrears for Core Services rendered on and following the Commencement Date.

(b) For FHNs with a Commencement Date prior to April 1, 2006:

Effective on the later of January 1, 2004 and the Commencement Date, the Base Rate Payment on and following the Commencement Date for Enrolled Patients who reside in Long-Term Care Facilities shall be \$416.28 per annum and shall not be age and sex adjusted. As of April 1, 2006, this Base Rate Payment shall be increased to **\$941.16 (net)** per annum per Enrolled LTC Patient and shall be conditional on the FHN Physician meeting the additional service obligations as set out in subsection 1.1(c) of this Appendix.

For FHNs with a Commencement Date on and following April 1, 2006:

Effective on the later of April 1, 2006 and the Commencement Date, the Base Rate Payment on and following the Commencement Date for Enrolled Patients who reside in Long-Term Care Facilities shall be **\$941.16 (net)** per annum (not sex and age adjusted) and shall be conditional on the FHN Physician meeting the additional service obligations as set out in subsection 1.1(c) of this Appendix.

Periodic Revisions to Base Rate Payment for Enrolled Patients in Long Term Care Facilities:

Following April 1, 2006, the value of the Base Rate Payment for Enrolled Patients who reside in Long-Term Care Facilities shall be revised periodically in accordance with the appropriate fee-for-service increases set out in, and over the term of, the Framework Agreement. The subsequent revisions to the value of this Base Rate Payment shall be confirmed and agreed to by the OMA and the Ministry and notice of the resulting new value shall thereafter be communicated to the FHN Physicians.

(c) Additional Service Obligations as of April 1, 2006:

In addition to the service obligations contained herein, the FHN Physician shall meet the following further obligations relating to the care of an Enrolled LTC Patient:

1. Completing a medication review every three months;

2. Conducting all discussions relating to the Enrolled LTC Patient with the care staff of the Long-Term Care Facility;
3. Except for Recognized Holidays, participating in all telephone calls from the Long Term Care Facility in respect of the Enrolled LTC Patient during reasonable and regular office hours from Monday through Friday; and
4. Performing on average two assessments per month per Enrolled Patient.

(d) Blended Fee-For-Service Payment for Services Provided to Enrolled Patients in Long Term Care Facilities:

The Ministry shall pay to the FHN on behalf of each of its FHN Physicians and FHN Contracted Physicians 10 percent (10%) of the value of valid claims in accordance with the Health Insurance Act for Core Services included in the Base Rate that are provided to such Enrolled LTC patients.

1.1.1 Comprehensive Care Capitation Payments

Effective on the later of October 1, 2005 and the Commencement Date, a FHN Physician shall be entitled to the following average monthly comprehensive care capitation rates for each Enrolled Patient:

- a. An average monthly capitation rate of \$1.42 per Enrolled Patient;
- b. Twelve (12) months thereafter the average monthly capitation rate will increase to \$1.80 per Enrolled Patient; and
- c. On January 1, 2008 the average monthly capitation rate in paragraph (a) will increase to \$1.50 and the average monthly capitation rate in paragraph (b) will increase to \$2.15.

The actual age and sex adjusted capitation rates may be calculated by multiplying the rates listed in Schedule 1A of this Appendix by the dollar amount quoted above.

1.1.2 Seniors Care Premium

As of October 1, 2005, a FHN Physician shall be entitled to a complex care premium of 15% on the Comprehensive Care Capitation Payments set out in section 1.1.1 of this Appendix for Enrolled Patients 70 years of age and older. As of January 1, 2008, this premium will apply to Enrolled Patients 65 years of age and older.

1.2 Core Services

Core Services shall mean the FHN Services that are included in the Base Rate, as set out in Schedule 2 of this Appendix.

1.3 Blended Fee-For-Service Payment

The Ministry shall pay to the FHN on behalf of each of its FHN Physicians and FHN Contracted Physicians ten percent (10%) of the value of valid claims in accordance with the

Health Insurance Act for Core Services included in the Base Rate that are provided to Enrolled Patients.

1.4 Excluded Services to Enrolled Patients

The Ministry shall pay to the FHN on behalf of each of its FHN Physicians and FHN Contracted Physicians valid claims in accordance with the Health Insurance Act for Excluded Insured Services provided to Enrolled Patients.

1.5 Insured Services Provided to Non-Enrolled Patients

The Ministry shall pay to the FHN on behalf of each of its FHN Physicians and FHN Contracted Physicians valid claims in accordance with the Health Insurance Act for Insured Services provided to patients other than Enrolled Patients. In the case of Insured Services that are Core Services in Schedule 2 provided to these patients, the valid claims shall be paid annually up to a total maximum payment of \$40,000 multiplied by the number of FHN Physicians (the "Multiplier"). As of April 1, 2005, the \$40,000 Multiplier shall be increased periodically in accordance with the appropriate fee-for-service increases set out in, and over the term of, the Framework Agreement. The new values, as agreed to by the OMA and the Ministry, are set out below:

Fiscal Period	Multiplier
April 1, 2005 – March 31, 2006	\$45,000
April 1, 2006 – March 31, 2007	\$47,500
April 1, 2007 – March 31, 2008	\$48,500

1.6 First Year Exemption

The maximum payment set out in Section 1.5 shall not apply to payments to the FHN in the case where the payments result from FHN Physicians who are changing from fee-for-service to the method of payment under this Agreement during the twelve (12) month period beginning on the Commencement Date.

1.7 Special Payment

1.7.1 The FHN shall be entitled to a Special Payment based on the success of the FHN and its FHN Physicians in providing to their Enrolled Patients all the FHN Services required by the Enrolled Patients. The Special Payment will be calculated and paid semi-annually for each Enrolled Patient based upon the complete claims data available to the Ministry for the semi-annual period.

1.7.2 The amount of each semi-annual Special Payment shall be determined as follows:

- (a) multiply the sum of all eligible Enrolled Patients' Base Rate for six (6) months by 0.2065. The resulting number will be referred to as the "Maximum Special Payment" (MSP);
- (b) subtract from the MSP the total value of all claims paid by the Ministry to physicians other than specialists, FHN Physicians for Insured Services described as Core

Services in Schedule 2 provided to Enrolled Patients during the semi-annual period, and general practitioner specialists who provide:

- (i) oculovisual assessments (A110, A112); and
- (ii) Effective the later of April 1, 2005 and the Commencement Date, GP Psychotherapy, as defined for the purposes of the Agreement as a Physician whose annual billing amounts for the following codes has totalled 50% or greater of their total annual fee-for-service billings in the preceding twelve (12) months: K004, K006, K007, K010, K011, K012, K024, and K025.

The resulting amount is the Special Payment payable to the FHN for that period. Where the amount is either zero or negative there is no Special Payment for the period.

1.8 Rosters Over 2400

In the case where the average number of Enrolled Patients per FHN Physician exceeds 2400, the average Base Rate payment for the FHN shall be reduced by fifty percent (50 %) for the number of Enrolled Patients of the FHN which is in excess of the 2400 multiplied by the number of FHN Physicians.

1.9 Payments are Pro Rata

All payments, unless otherwise specified in this Agreement, are based on a fiscal year of April 1 to March 31 and are prorated, wherever appropriate, with respect to all variables, including, without restricting the generality, time, amount and number of physicians.

2. Service Enhancement Codes

Each FHN Physician may submit claims for the following Service Enhancement Codes pursuant to the terms set out below. All references to an Enrolled Patient are intended to include an Enrolled Patient's parent or guardian where appropriate.

2.1 Preventive Care Management Service Enhancement Codes

A Service Enhancement Fee of \$6.86 is payable to a FHN Physician for each Enrolled Patient he or she contacts for the purpose of scheduling an appointment for one of the following Preventive Care Management tests / procedures:

2.1.1 Pap smear: Q001A

The Service Enhancement Fee may be claimed biennially for each Enrolled Patient, between 35 and 70 years of age and at risk of cervical cancer and who is not excluded from the target population (as set in section 2.3.2 of this Appendix), who is contacted for the purpose of scheduling a Pap smear.

2.1.2 Mammogram: Q002A

The Service Enhancement Fee may be claimed biennially for each female Enrolled Patient, between 50 and 70 years of age and at risk of breast cancer and who is not excluded from the target population (as set in section 2.3.3 of this Appendix), who is contacted for the purpose of scheduling a mammogram.

2.1.3 Influenza Vaccine for Enrolled Patients over 65: Q003A

The Service Enhancement Fee may be claimed annually for each Enrolled Patient, over the age of 65, who is contacted for the purpose of scheduling an influenza vaccination.

2.1.4 Immunizations for Enrolled Members under Two Years: Q004A

The Service Enhancement Fee may be claimed once for each Enrolled Patient, between 18 months and 2 years of age, whose parent or guardian is contacted for the purpose of scheduling an appointment for Ministry supplied immunizations pursuant to the guidelines set by the National Advisory Committee on Immunization.

2.1.5 Colorectal Screening: Q005A

Effective the later of April 1, 2006 and the Commencement Date, the Service Enhancement Fee may be claimed biennially for each Enrolled Patient, between 50 and 74 years of age (inclusive), at risk of colorectal cancer and who is not excluded from the target population (as set in section 2.3.5 of this Appendix), who is contacted for the purpose of scheduling a fecal occult blood test.

2.2 Conditions for claiming

A valid claim for one of the above Preventive Care Management Service Enhancement Fees is subject to the following conditions:

2.2.1. the FHN Physician may only claim the Service Enhancement Fee once one of the following has occurred:

- (a) the Enrolled Patient has responded to the FHN Physician's efforts to contact said Enrolled Patient by appearing for a scheduled appointment with the FHN Physician for the recommended test or procedure; or
- (b) the Enrolled Patient has responded to the FHN Physician's efforts to contact said Enrolled Patient by declining the recommended test or procedure, either verbally or in writing; or
- (c) the FHN Physician has provided two written notices to the Enrolled Patient (with the exception of a claim made under Code Q003A: Influenza Vaccine for Enrolled Patients over 65, in which case only one written notice is required) and telephoned the Enrolled Patient.

For the purposes of subsections (a), (b) and (c) above, the written notices and the telephone call must meet the following requirements:

- (i) The written notices shall be sent via regular mail, e-mail or facsimile. The FHN Physician shall address the written notices to the Enrolled Patient and use the address provided by the Enrolled Patient in the Enrolment Form.
- (ii) The first written notice shall include the following information:
 - the specific test or procedure that is recommended;
 - the material risks and benefits of the test or procedure, and the recommended frequency of such test or procedure;
 - the date of when the test or procedure of the kind recommended was last received by the Enrolled Patient, if applicable; and
 - the name of a FHN contact person and telephone number for scheduling an appointment.
- (iii) The second written notice must be delivered one to three months after the first written notice and shall include the following:
 - an offer to schedule an appointment for the specific test or procedure that is being recommended;
 - a description of the medical benefits of the test or procedure that is being recommended; and
 - the name of a FHN contact person and telephone number for scheduling an appointment.
- (iv) Telephone Call

The telephone call shall be made to the Enrolled Patient at the phone number the FHN has on record for the patient. The telephone call shall be made by a FHN Physician, a FHN nurse practitioner, or a member of the FHN staff in order to convey the medical benefit of the recommended test or procedure.

2.2.2 The FHN Physician must retain written records of all correspondence with the Enrolled Patient, including copies of the written notices, dates of delivery of the written notices and the date and a detailed description of the telephone call;

2.2.3 The Enrolled Patient who is contacted shall not already have had the test or procedure being recommended in the past two years, in the case of claims for codes Q001A, Q002A and Q005A; or one year, in the case of claims for code Q003A;

2.2.4 If the written notice and telephone call made to an Enrolled Patient include a recommendation for more than one of the tests and procedures only one claim for a Preventive Care Management Service Enhancement Fee may be made.

2.2.5 The Preventive Care Management Service Enhancement Fee shall cover all costs associated with performing the requirements necessary to make a claim for codes Q001A, Q002A, Q003A, Q004A and Q005A.

2.3. Cumulative Preventive Care Management Service Enhancement Codes

A FHN may claim the following Service Enhancement Codes on behalf of a FHN Physician who has administered a high cumulative level of preventive care to his or her roster of patients.

A FHN may make one claim per year for each FHN Physician under each of the following five headings per year:

2.3.1 Influenza Vaccine for Enrolled Patients over 65

This Service Enhancement Fee is payable to the FHN and calculated annually on an individual FHN physician basis based on the percentage of Enrolled Patients rostered to the FHN Physician who are over the age of 65 and who have received the influenza vaccine appropriate for that influenza season and before December 31st of that fiscal year.

<u>Percentage of Enrolled Patients</u>	<u>Fee Payable</u>	<u>Service Enhancement Code</u>
60%	\$220	Q100
65%	\$440	Q101
70%	\$770	Q102
75%	\$1100	Q103
80%	\$2200	Q104

2.3.2 Pap smear

This Service Enhancement Fee is payable to the FHN and calculated annually on an individual FHN physician basis based on the percentage of female Enrolled Patients rostered to the FHN Physician who are between 35 and 70 years of age, are not excluded from the target population (as set out below) and who have had a Pap smear in the previous 24 months as of March 31, 2004 or in the previous 30 months as of March 31, 2005 and every subsequent March 31 thereafter.

The following Enrolled Patients are excluded from the target population for pap smears:

- (i) Female Enrolled Patients who have had a hysterectomy; and

(ii) Female Enrolled Patients who are being treated for cervical diseases that preclude regular screening for pap testing.

The applicable exclusionary code for pap smears is Q140.

<u>Percentage of Enrolled Patients</u>	<u>Fee Payable</u>	<u>Service Enhancement Code</u>
60%	\$220	Q105
65%	\$440	Q106
70%	\$660	Q107
75%	\$1320	Q108
80%	\$2200	Q109

2.3.3 Mammogram

This Service Enhancement Fee is payable to the FHN and calculated annually on an individual FHN physician basis based on the percentage of female Enrolled Patients rostered to the FHN Physician who are between 50 and 70 years of age, are not excluded from the target population (as set out below) and who have had a mammogram in the previous 24 months as of March 31, 2004 or in the previous 30 months as of March 31, 2005 and every subsequent March 31 thereafter.

<u>Percentage of Enrolled Patients</u>	<u>Fee Payable</u>	<u>Service Enhancement Code</u>
55%	\$220	Q110
60%	\$440	Q111
65%	\$770	Q112
70%	\$1320	Q113
75%	\$2200	Q114

The following Enrolled Patients are excluded from the target population for mammograms:

- (i) Female Enrolled Patients who have had a mastectomy; and
- (ii) Female Enrolled Patient who are being treated for clinical breast disease.

The applicable exclusionary code for mammograms is Q141.

2.3.4 Immunizations for Enrolled Patients under Two Years

This Service Enhancement Fee is payable to the FHN and calculated annually on an individual FHN Physician basis based on the percentage of Enrolled Patients who are between 18 months and two years of age and are rostered to the FHN Physician and who have received all of the Ministry supplied immunizations recommended by the National Advisory Committee on Immunization in the previous 24 months as of March 31, 2004 or in the previous 30 months as of March 31, 2005 and every subsequent March 31 thereafter.

To claim this Service Enhancement Fee, the FHN Physician must retain detailed records, including the name of the vaccine, lot number, manufacturer, date of immunization, and route of administration.

<u>Percentage of Enrolled Patients</u>	<u>Fee Payable</u>	<u>Service Enhancement Code</u>
85%	\$440	Q115
90%	\$1100	Q116
95%	\$2200	Q117

2.3.5 Colorectal Screening

This Service Enhancement Fee is payable to the FHN and calculated annually on an individual FHN Physician basis based on the percentage of Enrolled Patients who are between 50 and 74 years of age (inclusive), are not excluded from the target population (as set out below) and who have had a fecal occult blood test in the previous 30 months as of April 1, 2006 and every subsequent March 31 thereafter.

<u>Percentage of Enrolled Patients</u>	<u>Fee Payable</u>	<u>Service Enhancement Code</u>
15%	\$220	Q118
20%	\$440	Q119
40%	\$1,100	Q120
50%	\$2,200	Q121

In order to be eligible for this Service Enhancement Fee, the FHN Physician's evaluation will include a review of the Enrolled Patient's family history and fecal occult blood test, where appropriate. The current Cancer Care Ontario guidelines will apply for ambiguous or positive results. To claim this Service Enhancement Fee, the FHN Physician must retain detailed records documenting the provision of this service, his/her evaluation and the results of the same.

The following Enrolled Patients are excluded from the target population for colorectal screening:

- (i) Enrolled Patients with known cancer being followed by a physician;
- (ii) Enrolled Patients with known inflammatory bowel disease;

- (iii) Enrolled Patients who have had colonoscopies within five (5) years;
- (iv) Enrolled Patients with a history of malignant bowel disease; and
- (v) Enrolled Patients with any disease requiring regular colonoscopies for surveillance purposes.

The applicable exclusionary code for colorectal screening is Q142.

2.4 Targeted Medical Education Service Enhancement Codes Q555

A Service Enhancement Fee of \$100.00 per hour is payable annually to a FHN Physician for each hour that he or she spends at a continuing medical education conference or seminar, subject to the following condition:

- a) the conference/seminar must have been approved by a joint committee of the OMA, the Ministry, Institute of Clinical Evaluative Sciences, and the Ontario College of Family Physicians;
- b) a FHN Physician may claim a maximum of 24 hours per year; and
- c) the FHN Physician must retain proof of attendance at the conference/seminar.

3. Special Payments

Effective the later of April 1, 2005 and the Commencement Date, a FHN Physician is eligible to qualify for each of the special payments described below in any fiscal year. Special payments will not be paid for both obstetrical deliveries and prenatal care. The provision of any services listed in sections 3.4, 3.5, and 3.6 by a nurse practitioner will count towards the FHN Physician's fulfillment of the obligations to qualify for each of these Special Payments provided that the nurse practitioner submits valid claims for these services on behalf of the FHN Physician in accordance with the provisions of this Appendix.

3.1 Special Payment For Obstetrical Deliveries

A FHN Physician shall receive an additional \$3,200.00 after submitting valid claims for five (5) or more services from the list set out in Schedule 3 (attached) to five (5) or more patients in any fiscal year.

3.2 Special Payment For Hospital Services

A FHN Physician shall receive an additional \$5,000.00 after submitting valid claims for services totalling \$2,000.00 in any fiscal year from the list of services set out in Schedule 4 (attached).

Effective the later of April 1, 2005 and the Commencement Date, the amount payable shall be increased from \$5,000.00 to \$7,500.00 for FHN Physicians who are located in either:

- (i) an area with a score on the OMA Rurality Index of Ontario (“OMA RIO”) greater than 45 (the “Designated RIO Area”); or
- (ii) one of the following five (5) Northern Urban Referral Centres: Sudbury, Timmins, North Bay, Sault Ste Marie or Thunder Bay, or such other northern community that may be agreed to in writing by the OMA and the Ministry.

In order to be eligible for the \$7,500.00 payment, either the office the FHN Physician regularly provides FHN Services (as registered with the Ministry) or the hospital in which he/she regularly provides hospital services will be located in the Designated RIO Area or the Northern Urban Referral Centre (as the case may be).

3.3 Special Payment For Palliative Care

A FHN Physician shall receive an additional \$2,000.00 after submitting valid claims for fee schedule code K023 for four (4) or more palliative care patients in any fiscal year.

3.4 Special Payment For Office Procedures

A FHN Physician shall receive an additional \$2,000.00 after submitting valid claims for services to FHN Enrolled Patients totalling \$1,200.00 or more in any fiscal year from the list of services set out in Schedule 5 (attached).

3.5 Special Payment For Prenatal Care

A FHN Physician shall receive an additional \$2,000.00 after submitting valid claims for fee schedule codes P003 and/or P004 for prenatal care during the first 28 weeks of gestation for five (5) or more FHN Enrolled Patients in any fiscal year.

3.6 Special Payment For Home Visits (Other Than Palliative Care)

A FHN Physician shall receive an additional \$2,000.00 after submitting valid claims for fee schedule codes A901 and/or A902 for one hundred (100) or more home visits to FHN Enrolled Patients in any fiscal year.

4. Payments To FHN

4.1 All payments, except those set out in Sections 2.4, 3, 5, 10, 11, 12, and 13 of this Appendix and Section 3.4 of the Agreement shall be made to the FHN and not to individual physicians.

Notwithstanding any other provision contained herein, effective the later of April 1, 2006 and the Commencement Date, the FHN Physicians may elect as a group to have the Base Rate Payment and Comprehensive Care Capitation Payments made to the individual FHN Physician instead of to the FHN. The Lead Physician shall advise the Ministry in writing of the election made by the FHN Physicians in the form agreed to by the OMA and the Ministry.

4.2 The Base Rate Payment, together with payments under Sections 1.3, 1.4, 1.5, and 2.1 of this Appendix as well as payments under Sections 6.3 and 7.1 of the Agreement

shall be made by the Ministry on a monthly basis by electronic deposit to the FHN bank account, established in accordance with the Governance Requirements.

4.3 Payments under Section 3 of this Appendix shall be paid in the month following the month in which the last claim for a service required to be made in order to be eligible for such payment was submitted to the Ministry by the FHN.

5. Premiums for Primary Health Care of Patients with Serious Mental Illness

A FHN Physician shall receive an additional \$1,000 per fiscal year when during that fiscal year, at least five patients with diagnoses of bipolar disorder or schizophrenia are rostered with the FHN Physician. Fee Schedule codes for services provided to these patients must be accompanied by tracking code Q021 for schizophrenia and tracking code Q 020 for bipolar disorder, and the patient must be rostered in order for the premium to be paid.

A FHN Physician shall receive an additional \$1,000 (\$2,000 in total) for the Mental Health Care premium for at least an additional 5 patients (ie. at least 10 patients in total) subject to the rules provided above.

Note: The Mental Health Premium will be paid to the FHN Physician by the claims payment system based on claims data.

6. After Hours Premium

The Ministry shall pay the FHN a 10% premium on the full value of fee codes A001, A003, A004, A007, A008 and A888 for valid claims for Evening and Weekend Hours Services provided to Enrolled Patients in accordance with Section 5.2.

As of April 1, 2005, the value of this premium shall increase from 10% to 20% in two phases:

1. On April 1, 2005 the premium shall increase to 15%; and
2. On April 1, 2006 the premium shall increase to 20%.

On April 1, 2005 the following will be added to the menu of fee codes to which this premium applies: K005, K013, and K017.

A shadow billing code Q012 must accompany each submitted claim in order for the premium to be paid.

A FHN Physician who provides services on Recognized Holidays shall be entitled to receive payment of the After Hours Premiums for such services to Enrolled Patients.

7. New Patient Fee

The Ministry shall pay the FHN \$100 for each New Patient that is enrolled up to a maximum of 50 patients per fiscal year. For each such enrolment a shadow billing code, Q013, must be billed in order for payment to be made. In addition, a 10% premium shall be added to

this payment for those New Patients between 65 and 74 years of age and a 20% premium shall be added for those patients 75 and over.

Note: In order for this fee to be paid, the FHN Physician must, in addition to enrolling the patient, complete with the patient a “New Patient Declaration Form” as set out in Schedule 6 of this Appendix. The Patient Declaration form requires the FHN Physician to agree to provide ongoing Comprehensive Care to the enrolled patient. Please note that the Ministry will undertake periodic reviews of claims for new patients and may request access to the New Patient Declarations, or contact the Physician, or contact the patient to verify the accuracy of the claims.

7.1 New Graduate-New Patient Fee

Effective the later of July 1, 2005 and the Issuance Date, a FHN Physician who qualifies as a New Graduate shall be eligible to receive the New Patient Fee of \$100.00 for each New Patient that he/she enrolls up to a maximum of 150 patients during his/her first year of comprehensive primary care practice.

For the purposes of this Agreement, a New Graduate is a physician, including an International Medical Graduate, who graduated no more than three (3) years prior to the date that he/she signs the FHN Agreement.

For each such enrolment a shadow billing code, Q033A, must be billed in order for payment to be made. In addition, a 10% premium shall be added to this payment for those New Patients between 65 and 74 years of age and a 20% premium shall be added for those patients 75 and over.

Note: In order for this fee to be paid, the FHN Physician must, in addition to enrolling the patient, complete with the patient a “New Patient Declaration Form” as set out in Schedule 6 of this Appendix. The Patient Declaration form requires the FHN Physician to agree to provide ongoing Comprehensive Care to the enrolled patient. Please note that the Ministry will undertake periodic reviews of claims for new patients and may request access to the New Patient Declarations, or contact the Physician, or contact the patient to verify the accuracy of the claims.

8 Newborn Care Episodic Fee

The FHN shall receive an additional payment of \$12.50 for approved claims for up to 8 well baby visits (A007) to Enrolled Patients in the first year of life (“Newborn Fee”). The add-on code, Q014 must accompany each submitted claim in order for the premium to be paid.

As of April 1, 2004 and periodically thereafter, the value of the Newborn Fee shall be revised in accordance with the appropriate fee-for-service increases set out in, and over the term of, the Framework Agreement. The subsequent revisions to the value of the Newborn Fee shall be confirmed and agreed to by the OMA and the Ministry and notice of the resulting new value shall thereafter be communicated to the FHN Physicians.

9. Unattached Patient Fee

Effective the later of October 1, 2005 and the Issuance Date, an incentive in the amount of \$150.00 will be paid to the FHN on a per patient basis for the enrolment of the acute care patient previously without a family physician, following the patient's discharge from an in-patient hospital visit. The payment of this incentive is subject to the FHN Physician enrolling the patient within three months of accepting responsibility for providing for the patient comprehensive care. This fee is not payable in addition to the New Patient Fee set out in sections 7 and 7.1 of this Appendix.

For each such claim, a shadow billing code Q023 must be submitted in order for payment to be made.

Note: In order for this fee to be paid, the FHN Physician must, in addition to enrolling the patient, complete with the patient a “Unattached Patient Declaration Form” as set out in Schedule 7 of this Appendix. The Unattached Patient Declaration Form requires the FHN Physician to agree to provide ongoing Comprehensive Care to the enrolled patient. Please note that the Ministry will undertake periodic reviews of claims for new patients and may request access to the Unattached Patient Declarations, or contact the Physician, or contact the patient to verify the accuracy of the claims.

10. Diabetes Management Incentive

Effective the later of April 1, 2006 and the Commencement Date, a FHN Physician shall receive an annual fee of \$60 per Enrolled Patient for coordinating, providing, and documenting all required elements of care for diabetic patients.

In order to be eligible for this fee, the FHN Physician shall complete a flow sheet in respect of the diabetic Enrolled Patient that includes required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association 2003 Clinical Practice Guidelines.

In order for this incentive to be paid, a shadow billing code, Q040A, must be submitted either separately or in combination with other fee-for-service codes once all elements of the flow sheet are completed.

11. Add-on Initial Smoking Cessation Fee

Effective the later of April 1, 2006 and the Commencement Date, a FHN Physician shall receive an annual incentive fee of \$15 added to the normal visit fee for dialogue with an Enrolled Patient who smokes.

The FHN Physician shall document the smoking cessation dialogue by either referring to the Smoking Cessation Guidelines for Physicians and completing the Smoking Cessation Flow Sheet developed by the Ministry and the OMA or, alternatively, documenting the completion of the 5A model of the Clinical Tobacco Intervention program.

In order for this fee to be paid, a FHN Physician must submit a shadow billing code, Q041A, with one of the following fee-for-service codes with the same service date:

A001A, A003A, A004A, A005A, A006A, A007A, A008A, A903A, K005A, K007A, K013A, K017A, P003A, P004A, P005A, P008A, W001A, W002A, W003A, W004A, W008A, W010A, W102A, W104A, W107A, W109A and W121A.

The Ministry shall pay a FHN Physician a maximum of one Add-on Initial Smoking Cessation Fee per Enrolled Patient per year.

12. Smoking Cessation Counselling Fee

Effective the later of April 1, 2006 and the Commencement Date, a FHN Physician shall be entitled to an incentive for each of a maximum of two (2) follow-up counselling sessions in the twelve (12) months following the service date of a valid Add-on Smoking Cessation Fee (Q041A) for the Enrolled Patient who has committed to quit smoking. This incentive will be equal to the adjusted value of A007 over the term of the Framework Agreement plus \$1.50

In order for this incentive to be paid, the FHN Physician shall submit a shadow billing code, Q042A, for \$1.50 in conjunction with an intermediate assessment (A007) with the same service date.

The FHN Physician shall document each of the two counselling sessions by either utilizing the Smoking Cessation Guidelines for Physicians and completing the Smoking Cessation Flow Sheet developed by the Ministry and the OMA or, alternatively, shall use other guidelines and flow sheets that reflect similar elements and document accordingly.

13. Rurality Gradient

Effective the later of April 1, 2006 and the Commencement Date, FHN Physicians shall be eligible to qualify for a rurality premium on the basis of their score on the OMA RIO. Beginning at a score of 45 on the OMA RIO, a FHN Physician shall be eligible to receive a payment of \$5,000 per fiscal year. This payment shall be increased by \$1,000 for each further score of 5 on the OMA RIO.

For the purposes of determining eligibility for this payment, the FHN Physician's score on the OMA RIO shall be based on the location of the office in which the FHN Physician regularly provides FHN Services (as registered with the Ministry).

14. Office Practice Administration

Effective the later of April 1, 2007 and the Commencement Date, the FHN shall be entitled to partial funding to support the cost of administrative functions of the FHN. These administrative functions will include, but will not be limited to, group administration, group on-call and extended hours organization, assistance with Information Technology implementation and planning for interdisciplinary teams.

The FHN's entitlement to funding shall be conditional on the FHN Physicians hiring an administrator to perform these functions and determined on the basis of the number of FHN Physicians who comprise the FHN in accordance with the scale set out below.

The Lead FHN Physician shall notify the Ministry in writing within twenty-one (21) days of any change in the number of FHN Physicians who comprise the FHN or if the FHN Physicians no longer employ an administrator. The Lead FHN Physician shall submit to the Ministry on an annual basis a written statement confirming the engagement of an administrator, the total number of hours worked and the administrative functions performed by the administrator.

<i>Number of FHN Physicians</i>	<i>Eligible Funding</i>
5-7	\$12,500
8-14	\$17,500
15-25	\$25,000

Appendix I Schedule 1: Ratio for Payment of Base Rate Payment and Special Payment by age and sex

	AGE CATEGORY	MALE	FEMALE	TOTAL		
	00-04	1.06	1.01	1.04		
	05-09	0.55	0.54	0.55		
	10-14	0.44	0.46	0.45		
	15-19	0.46	0.82	0.64		
	20-24	0.46	1.04	0.74		
	25-29	0.50	1.07	0.79		
	30-34	0.58	1.08	0.83		
	35-39	0.72	1.17	0.95		
	40-44	0.80	1.20	1.01		
	45-49	0.88	1.30	1.11		
	50-54	1.02	1.46	1.25		
	55-59	1.16	1.48	1.33		
	60-64	1.28	1.51	1.41		
	65-69	1.44	1.59	1.53		
	70-74	1.67	1.70	1.70		
	75-79	2.01	2.03	2.02		
	80-84	2.10	2.10	2.10		
	85-89	2.35	2.39	2.38		
	90+	2.65	2.71	2.69		

Note: The value of the multiplier for the base rate payment is as follows:

May 1, 2005 – September 30, 2005	\$105.42
October 1, 2005 – March 31, 2006	\$107.24
April 1, 2006 – September 30, 2006	\$108.36
October 1, 2006 – December 31, 2006	\$110.01
January 1, 2007 – March 31, 2007	\$110.74
April 1, 2007 – December 31, 2007	\$111.84
January 1, 2008 and thereafter	\$112.94

Note Senior's Premium: as of October 1, 2005, a FHN Physician shall be eligible for a complex care premium of 15% on the Base Rate Payment set out in this Schedule for Enrolled Patients 70 years of age and older. As of January 1, 2008, this premium will apply to Enrolled Patients 65 years of age and older.

Appendix I Schedule 1A

CAPITATION RATE CALCULATOR – COMPREHENSIVE CARE CAPITATION PAYMENTS

Average Enrolment with Estimated Monthly Comprehensive Care Fee Calculation (1)		
Monthly Comprehensive Care Fee per Enrolled Patient		
Age Range	Male	Female
	Monthly Rate (4)	Monthly Rate (4)
0-4	1.06	1.01
5-9	0.56	0.54
10-14	0.44	0.46
15-19	0.46	0.82
20-24	0.46	1.04
25-29	0.50	1.08
30-34	0.58	1.08
35-39	0.72	1.17
40-44	0.80	1.20
45-49	0.88	1.30
50-54	1.02	1.46
55-59	1.16	1.47
60-64	1.27	1.51
65-69	1.44	1.59
70-74	1.67	1.70
75-79	2.01	2.03
80-84	2.11	2.10
85-89	2.35	2.39
90+	2.65	2.70

		Appendix I Schedule 2
<u>Core Services:</u> Fee Codes included in the base rate payment		
	Fee code	Fee Code Description
o	A001	Minor Assessments
o	A003	General Assessments
o	A004	General Reassessment
o	A007	Intermediate Assessments
o	A008	Mini Assessment
o	A110	Periodic Oculo-visual Assessment aged 19 years and below
o	A112	Periodic Oculo-visual Assessment - additional assessment
o	A903	Pre-dental General Assessment
o	A990	Daytime Premium - Monday to Friday
o	A994	Evenings (17:00h - 24:00h) Saturdays, Sundays, Holidays
o	A996	Nights (00:00h - 7:00h)
o	E070	Geriatric General Assessment Premium – patient aged 70 or older
	E071	Geriatric Intermediate Assessment Premium – patient aged 70 or older
o	G001	Cholesterol test - in office
o	G002	Lab. Medicine in Private office - Glucose, quantitative or semi-quantitative
o	G004	Occult blood/lab med. in office
o	G005	Pregnancy test in office
o	G009	Urinalysis (in office)

o	G010	Urinalysis, routine -- in office
o	G011	Fungus culture incl. KOH & smear
o	G012	Wet preparation (fungus etc.) - in office
o	G014	Streptococcus test in office
o	G197	Skin testing (allergy) - professional fee
o	G202	Allergy Hyposensitization (incl. Assessment)
o	G205	Insect venom desensitization
o	G212	Hyposensitization/sole reason
o	G271	Cardiovascular/anticoagulant supervision
o	G365	Pap Smear
o	G372	Intramuscular injection with visit
o	G373	Injection - infants (sole reason for visit)
o	G375	Intralesional infiltration
o	G377	Intralesional infiltration
o	G379	Injection intravenous/child/adult
o	G384	Injection/infants infiltration – tissues
o	G385	Intralesional infiltration - each additional site
o	G420	Otolaryngology/ear syringing/curettage
o	G435	Tonometry
o	G462	Polio vaccine – oral
o	G481	HB/Hc screening in office
o	G482	Cardiovascular/ venipuncture child
o	G489	Venipuncture/adolescent, child

o	G525	Diagnostic Hearing Test
o	G538	Active immunization
o	G539	Immunization - sole reason for visit (1st visit)
o	G590	Active immunization - Influenza agent - with visit
o	G591	Active immunization - Influenza agent - sole reason
o	K004	Family Psychotherapy
o	K005	Counselling - Individual Care
o	K006	Individual hypnotherapy (per 1/2 hour)
o	K007	Individual Psychotherapy
o	K008	Diagnostic interview/counselling, child, parent
o	K013	Counselling (per 1/2 hr)
o	K015	Counselling relatives
o	K017	Annual Health Exam - Child after 2nd birthday
o	Z101	Skin - inc. abscess/haem.
o	Z176	Skin suture/laceration < 5cm

Note: the addition of E070 and E071 to the menu of fee codes is effective October 1, 2005.

Appendix I Schedule 2a: Fee codes included in the Long-Term Care Base Rate Payment

Fsc	Desc
A001A	Minor Assess. - F.P./G.P.
A003A	Gen. Asses. - F.P./G.P. Annual Health with Diag. Code 917
A004A	Gen. Re-Assess. - F.P./G.P.
A007A	Intermed. Assess./Well Baby Care - F.P./G.P./Paed.
A008A	Mini Assessment - F.P./G.P.
A110A	GP Periodic oculo-visual assessm. ages 19 or below
A112A	GP Periodic oculo-visual assessm. ages 65 and over
A903A	Pre-dental Gen. Assess. FP/GP
A990A	Spec. visit Each daytime (Mon. to Fri.)
A994A	Nights Sp. Visit Office(5 pm to 12 mn), Sat/Sun/Hol First Pt.
A996A	Spec. Visit Nights (12 mn to 7 am), First Pt.
E070A	Geriatric General Assessment Premium – patient aged 70 or older
E071A	Geriatric Intermediate Assessment Premium – patient aged 70 or older
G001A	Lad.med.in office – Cholesterol total
G002A	Lab.med.in office -glucose quant/semi-quantitative
G004A	Lab.med.in office -occult blood
G005A	Lab.med.in office- pregnancy test
G009A	Lab.med.in office -urinalysis routine
G010A	Lab.med.in office-one/more parts of G009 w/out microscopy

G011A	Lab.med.in office-fungus culture incl.KOH & smear
G012A	Lab.med.in office-wet prep'tion (fungus,trichm.parasites)
G014A	Lab.Med. - Streptococcus in office
G197A	Allergy-skin tests prof.comp.to G209
G202A	Allergy-hyposensitization 1/more inj (incl. assess)
G205A	Insect venom desensitization
G212A	Allergy-hyposens inj.(G700+G202) (sole reason visit)
G271A	Cardiov/Anticoag supervision - telep. advice - per mth
G365A	Gynaec.Papanicolaou smear
G372A	Inj/inf.intramusc/subcut/intraderm.with visit
G373A	Inj/inf.as G372 but sole reason for visit 1st inj.
G375A	Intrales.infil.one/two lesions
G377A	Intrales.infil.3/more
G379A	Inj/inf.intravenous-child/adult
G384A	Inj/inf.infiltration tissues,trigger point
G385A	Inj/inf.each add'l site add to G384(max 2)
G420A	Otolaryng - ear syringing/curettng (not with Z907)- unilat/bilat.
G435A	Ophthal – Tonometry
G462A	Polio vaccine—oral
G481A	Lab.med.in office -Hb./Hct.screen any method/instr.
G482A	Cardiovasc. - Venipuncture - child
G489A	Cardiovasc. - Venipuncture - adolescent/adult
G525A	Otolaryng - Diagnostic Hearing Tests - prof comp to G440
G538A	Inj/inf immunization per visit each injection or additional Flu inject.
G539A	Immunization sole reason first injection Flu injection vaccine
G590A	Active Immunization influenza agent with visit

G591A	Active Immunization influenza agent sole reason
K004A	Family - Psychotherapy - (2 or more) per 1/2 hr
K005A	Primary Mental Health Care
K006A	Individual - Hypnotherapy - per 1/2 hr
K007A	Individual - Psychotherapy - per 1/2 hr./GP
K008A	Diag. Interview/counselling child/parent, per 1/2 hr
K013A	Counselling - per 1/2 hr Limit 3 per year per phys only Educ Dial
K015A	Counselling - Catastrophic on behalf of pt see para B20(c)
K017A	Ann. Health Exam. - Child after second birthday no Diag.req'd.
Z101A	Skin - Inc. Abscess/haematoma Subcut. Local anaes - one
Z176A	Skin-Suture/lac-up to 5 cm
W001A	General Practice-Subseq. visits per mth. - Chr/Conval Hosp/LTIC
W002A	General Practice-First four visits per mth. - Chr/Conval Hosp/LTIC
W003A	General Practice-First two visits per mth. - Nurs. Home/Aged
W004A	Gen. Pract.-Gen. Re-Assess. in Nurs. Home/covered by Ext. Care Legisl.
W008A	Subseq. Visits - Nurs. Home/Aged - Covered by Ext. Care Leg
W102A	Adm. Assess. Type 1 - Chr/Conval Hosp - LTIC - GP
W104A	Adm. Assess. Type 2 - Chr/Conval Hosp - LTIC - GP
W105A	Consult. - Chr/Conval. Hosp - LTIC – GP
W106A	Repeat Consult. - Chr/Conval Hosp - LTIC – GP
W107A	Adm. Assess. Type 3 - Chr/Conval Hosp - LTIC - GP
W109A	Ann. Phys. Exam - Chr/Conval Hosp - LTIC – GP
W121A	LTIC Ac. Intercurrent illness, in excess of monthly max
W777A	Visit for Pronouncement of Death LTIC
W872A	Terminal Care N.H/G.P. Family Pract.

W882A	Terminal Care - Chron. Hosp/N.Homes etc.,G.P./Fam. Pr.
W903A	Pre-dental/pre-surg. Gen. Assess.

Note: As of April 1, 2006 the following fee codes shall be added to the Long Term Care Base Rate Payment: W010, E430, G003, G006, G007, G008, W771, W972, G394, K070, K071, and K072.

Note: The addition of E070 and E071 to the menu of fee codes is effective October 1, 2005.

Appendix I Schedule 3

The following codes are used to determine whether a physician has met the threshold for the special payment for Obstetrical services:

P006 OBS-vaginal delivery

P009 Attend at labour/delivery by phys other than obstetrical consultant

P018 OBS Caesarean section – procedure only

P020 OBS Op Del other than Caesarean section

P038 Attend labour patient transferred to another centre for delivery

P041 OBS Delivery Caesarean section with tubal interruption

Appendix I Schedule 4

The following codes are used to determine the threshold for payment of the special payment for hospital services:

A933 On-call general assessment

C002 Subsequent visits to 5 weeks

C003 General assessment

C004 General re-assessment

C005 Consultation

C006 Re-consultation

C007 Subsequent visits 6th to 13th week

C008 Concurrent care

C009 Subsequent visits after 13th week

C010 Supportive care

C121 Further fees for visits due to intercurrent illness

C777 Pronouncement of death

C905 Limited consultation in hospital

C933 On-call admission general assessment

H001 Newborn Care

Appendix I Schedule 5

The following codes are used to determine whether a physician has met the threshold for the special payment for office procedures. The procedures must have been done in the physician's office.

G420 Ear syringing and or extensive curetting or debridement

Incision: Abscess or Hematoma

Z101 Local anaesthetic – subcutaneous – one

Z173 - two

Z174 - three or more

Z103 Palmar or plantar spaces

Z106 Ischiorectal or pilonidal

Z104 perianal

Z114 Foreign body removal local anaesthetic

Z118 Aspiration of superficial lump for cytology

Z116 Biopsy(s) - any method when sutures are used

Z113 - any method when sutures are not used

Excision (with or without Biopsy) with the following fee schedule codes:

GROUP 1 - E.G. VERRUCA, KERATOSIS, PYOGENIC GRANULOMA

Z156 Removal by excision and suture – single lesion

Z157 two lesions

Z158 three or more lesions

Z159 Removal by electrocoagulation and or curreting -single lesion

Z160 two lesions

Z161 three or more lesions

GROUP 2 NEVUS

Z162 Removal by excision and suture – single lesion

Z163 two lesions

Z164 three or more lesions

GROUP 3 – PLANTAR VERRUCA

Z166 Removal by excision and suture – single lesion

Z167 two lesions

Z168 three or more lesions

Removal by electrocoagulation and/or curetting

Z169 single lesion

Z170 two lesions

Z171 three or more lesions

GROUP 4 –CYST, HEMANGIOMA, LIPOMA

Face or neck

Z122 Local anesthetic –single lesion

Z123 two lesions

Z124 three or more lesions

Other areas

Z125 Local anesthetic – single lesion

Z126 two lesions

Z127 three or more lesions

GROUP 5 – OTHER LESIONS

Z096 Lipoma – 5-10 cm

Malignant Lesions including biopsy of each lesion – single or multiple sites

Face or Neck – simple excision

R048 single lesion

R049 two lesions

R050 three or more lesions

Other areas – simple excision

R094 single lesion

R040 two lesions

R041 three or more lesions

Face or neck – curettage, electrodesiccation or cryosurgery

R018 single lesion

R019 two lesions

R020 three or more lesions

Other areas - curettage, electrodesiccation or cryosurgery

R031 single lesion

R032 two lesions

R033 three or more lesions

TREATMENT OF NASAL HEMORRHAGE

Z314 cauterization (IOP) –unilateral

Z315 anterior packing - unilateral

Z316 posterior packing – uni- or bilateral

Injection – Joint

G370 Bursa, joint, ganglion or tendon sheath and/or aspiration

G371 each additional site or area (to a max of 3)

OPERATION ON THE MUSCULOSKELETAL SYSTEM

Reduction - Fractures

F004 Phalanx – no reduction, rigid immobilization

F005 closed

E558 Each additional

F006 Intra-articular - closed

F008 Metacarpal – no reduction, one or more, rigid immobilization

F009 closed

E504 Each additional

F012 Bennett's – no reduction, rigid immobilization

F013 closed

F102 Carpus – no reduction, rigid immobilization

F016 closed, one or more

F017 open, one or more

F018 Scaphoid – no reduction, rigid immobilization

Reductions- Dislocations

D001 Finger – closed – one

E576 Each additional

D004 Metacarpal/phalangeal – closed –one

E577 Each additional

D007 Carpal - closed

D012 Radial head – closed , pulled elbow

Casts

Z200 application of Unna's paste

Z201 finger

Z202 hand

Z203 arm, forearm, or wrist

Z204 removal of plaster (not associated with fractures or dislocation) within 2 weeks of initial treatment

Z211 whole leg

Z213 below knee, knee splints

Suture of Lacerations (IOP)

Z154 Up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers

Z175 5.1 to 10 cm

Z177 5.1 cm – 10 cm if on face and/or requires tying of bleeders and/or closure in layers

Z179 10.1 to 15 cm

Z190 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers

Z191 more than 15.1 cm – other than face

Z192 more than 15.1 cm – on face

Finger or Toe-nail (IOP)

Z110 Extensive debridement of onychogryphotic nail involving removal of multiple laminae

Simple, partial or complete, nail excision requiring anaesthesia

Z128 one

Z129 multiple

Z130 radical, including destruction of nail bed - one

Z131 multiple

Chemical and/or cryotherapy treatment of minor skin lesions

Z117 one or more lesions, per treatment

OPERATIONS ON THE BREAST

Z141 Needle biopsy – one or more (IOP)

Z139 Aspiration of cyst – one or more (IOP)

ENDOSCOPIES (IOP)

Z515 Esophagoscopy, with or without biopsy(ies) (IOP)

Z567 Subsequent procedure by same physician (within three months following previous endoscopic procedure) (IOP)

STOMACH – ENDOSCOPIES (IOP)

Z527 Gastroscopy (may include biopsies, photography and removal of polyps = or < 1cm

Z547 Gastroscopy with removal of foreign body

Z528 Subsequent (within three months following previous gastroscopy)

Intestines (except rectum) – Endoscopy (IOP)

Z580 Endoscopy (using 60 cm. flexible endoscope)

Endoscope:

Z555 of sigmoid to descending colon

E740 to splenic flexure

E741 to hepatic flexure

E747 to cecum

E705 into terminal ileum

Endoscopic Sigmoidoscopy (with rigid scope) with or without anoscopy (IOP)

Z535 not to be billed with Z555 or Z580

Z536 with biopsy(ies)

VULVA AND INTROITUS - INCISION

Z714 Abscess of vulva, Bartholin or Skene's gland (IOP) – incision and drainage: Local anaesthetic

Vulva and Introitus – Excision – Condylomata – single or multiple (IOP)

Z733 chemical and/or cryosurgery – one or more

Z736 local anesthetic

CORNEA – INCISION

Removal imbedded foreign body (IOP) – local anaesthetic

Z847 one foreign body

Z848 two foreign bodies

Z845 three or more foreign bodies

EYELIDS - INCISION

Z854 Drainage of abscess (IOP) – local anesthetic

EYELIDS - EXCISION

Z874 Chalazion – single or multiple (IOP) – local anesthetic

EXTERNAL EAR - ENDOSCOPY

Z915 Removal of foreign body - simple

EXTERNAL EAR - EXCISION

Z904 Local excision, polyp – office (IOP)

GYNECOLOGY

G378 Insertion of intrauterine contraceptive device

G361 Endometrial flushing

Z770 Endometrial sampling

Appendix I Schedule 6

NEW PATIENT DECLARATION FORM

(please use official form provided by the Ministry)

I, _____ (Patient Name) declare that I currently do not have a family physician due to one or more of the following circumstances:

(Please mark applicable boxes)

- ☐ My family physician has moved to another community.
- ☐ I have moved to another community.
- ☐ My family physician is no longer available due to illness/death.
- ☐ My family physician is no longer available due to change of practice type.
- ☐ Up to now I have not had, or felt I needed a family physician
- ☐ I am signing on behalf of: *((check all that apply))*
 - ☐ myself
 - ☐ the children listed below of whom I am the parent or guardian
 - ☐ the dependent adult (s) listed below of whom I have a power of attorney for personal care

Children and Dependent Adults *(complete if applicable)*

- | | |
|---|---|
| 1. _____
Print Name Health Number | 2. _____
Print Name Health Number |
| 3. _____
Print Name Health Number | 4. _____
Print Name Health Number |

My Health Number

Patient Signature

Date

Print Patient Name

I, _____ (Physician Name) declare that the above patient is not a patient of mine or, to the best of my knowledge, of any other physician in the Family Health Network of which I am affiliated. I also declare that no child listed above (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the Family Health Network of which I am affiliated.

I agree to accept the above-noted patients into my practice and to provide ongoing health care to these patients from the date of the document forward. I will keep this documentation available on file in my primary office location and will provide copies of the same to the Ministry of Health and Long-Term Care as and when required for verification purposes.

Physician Signature

Date

Appendix I Schedule 7

UNATTACHED PATIENT DECLARATION

(please use official form provided by the Ministry)

Please complete this form if you were an in-hospital patient, previously without a family physician, have been discharged from hospital and you have been accepted into the practice of a primary care physician and have signed a *Patient Enrolment and Consent to Release Personal Health Information* form. If you are signing on behalf of a child or dependent adult and have completed a *Patient Enrolment and Consent to Release Personal Health Information* form on their behalf, complete the applicable sections below.

I am signing on behalf of (check the applicable boxes)

- ☐ myself (complete sections A and D)
- ☐ the child listed below of whom I am the parent or guardian (complete sections B and D)
- ☐ the dependent adult listed below for whom I have a power of attorney for personal care (complete sections B and D)

I hereby declare that the patient named below does not have a family physician due to one or more of the following circumstances (check applicable boxes)

- ☐ The patient's family physician has moved to another community
- ☐ The patient has moved to another community
- ☐ The patient's family physician is no longer available due to illness/death/retirement
- ☐ The patient's family physician is no longer available due to change of practice type
- ☐ Up until now the patient has not had or felt the need for a family physician

Section A: Patient Information (Sections A to D to be completed by patient/parent/guardian)

First Name	Last Name	Health Number

OR

Section B: Child and Dependent Adult Information

First Name	Last Name	Health Number

Section C: Hospital Stay Information

Name of Hospital	Discharge Date
------------------	----------------

Section D: Patient/Guardian Signature and Date

Signature	Date (yyyy/mm/dd)
-----------	-------------------

Section E: Physician Signature and Date

(Section E to be completed by physician)

I declare that to the best of my knowledge the above patient is not a patient of mine or of any other family physician.

I also declare that the only newborns listed are those that were admitted to a Neonatal Intensive Care Unit (NICU) within the last three months and are not a newborn of any existing enrolled or non-enrolled patient of mine or of any other physician.

I declare that the patient was an acute care patient in hospital, previously without a family physician and I accepted the patient into my practice, by enrolling the patient with the *Patient Enrolment and Consent to Release Personal Health Information* form within three months of his/her discharge from an in-patient hospital visit.

I agree to accept the above-noted patient into my practice and to provide ongoing primary health care to the patient from the date of this document. I will keep this document available on file in my primary office location and will provide copies of the same to the Ministry of Health and Long-Term Care as required for verification purposes.

Physician Last Name (print)	Physician First Name (print)
Physician Signature	Date (yyyy/mm/dd)

Schedule 7

UNDERTAKING K-1

UNDERTAKING AND ACKNOWLEDGEMENT

TO: The Ministry of Health and Long-Term Care

Re: Family Health Network Agreement Dated _____(as amended).

In consideration of my entering into the above-noted Agreement and my decision to opt for Income Stabilization as defined in the Agreement, I, the undersigned physician hereby acknowledge and undertake as follows:

1. I will continue to be available to patients for care during the Income Stabilization period;
2. I will continue to provide a similar mix of services and hours to those which were provided during the Income Stabilization calculation year (if applicable);
3. I will use all reasonable efforts to roster a minimum of 70% of my projected roster during the 12 month Income Stabilization period;
4. I agree not to bill OHIP for services rendered during the Income Stabilization period; and
5. I intend to bring my current practice into a FHN (noted exemption where applicable regarding re-location from a different geographic area or new physician).
6. In the event that I wish to discontinue my participation in the Income Stabilization option, I will provide at least 15 days notice of my intention to do so, in accordance with the notice provisions set out in the Agreement (as amended) and my entitlement to receive Income Stabilization Payments will end upon the sooner of:
 - (a) the effective date set out in the notice made and received in compliance with this paragraph 6; and
 - (b) the date on which I discontinue providing the FHN Services described in the Agreement and paragraph 2 of this undertaking.

DATED THIS ____ day of _____, 200__

In the event the FHN Physician is a natural person:

Signature: Physician

Witness

OR

In the event the FHN Physician is a Medicine Professional Corporation:

Signature: Authorized Signing Officer

Witness

Name & Title: _____

I have the authority to bind the [insert name of Professional Corporation]

Schedule 8

NEW GRADUATE INCOME STABILIZATION UNDERTAKING K-2

UNDERTAKING AND ACKNOWLEDGEMENT

TO: The Ministry of Health and Long-Term Care

Re: Family Health Network Agreement Dated _____

 (as amended).

In consideration of my entering into the above-noted Agreement and my decision to opt for Income Stabilization as defined in the Agreement, I, the undersigned physician hereby acknowledge, undertake and agree as follows:

1. I have signed the Agreement and will be bound by the service obligations set out therein.

2. I will be responsible to the Ministry and the FHN to provide FHN Services. I will devote time to such Services (rostering obligations included) which is at least equivalent to the average weekly hours of practice of new graduates working in full-time fee-for-service practices.

3. Subject to paragraph 7 of this undertaking, notwithstanding the payment provisions in the Agreement, I agree that my compensation for Income Stabilization period shall be \$155,000.00 (urban) or \$170,000.00 (rural) as defined by the Ministry and payable by 12 equal monthly installments commencing following the first month of services;

4. I will actively enroll patients during the 12-month Income Stabilization period. A roster of not less than 1,100 patients will be established for the purpose of payment of enrolment compensation.

5. I agree not to bill OHIP for services rendered during the Income Stabilization period but will submit shadow bills in accordance with Ministry reporting requirements for all such services;

6. In the event that I have a current practice in the same geographic area as the Family Health Network that I have joined, I will bring that practice into the Family Health Network.
7. In the event that I wish to discontinue my participation in the Income Stabilization option, I will provide at least 15 days notice of my intention to do so, in accordance with the notice provisions set out in the Agreement (as amended) and my entitlement to receive Income Stabilization Payments will end upon the sooner of:
 - (a) the effective date set out in the notice made and received in compliance with this paragraph 7; and
 - (b) the date on which I discontinue providing the FHN Services described in the Agreement and paragraph 2 of this undertaking.

Dated at _____ this _____ day of _____, 200_____.

Name _____

Billing Number _____

Office Address _____

Fax Number _____

Phone Number _____

Name of FHN _____

Date of Commencement of FHN Services _____

In the event the FHN Physician is a natural person:

Signature: Physician

Witness

OR

In the event the FHN Physician is a Medicine Professional Corporation:

Signature: Authorized Signing Officer

Witness

Name & Title: _____

I have the authority to bind the [insert name of Professional Corporation]