

**SGFP**

**Section of  
General &  
Family  
Practitioners**

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Dear Colleague:

Since my last letter of November 2006, there have been many developments and activities affecting family medicine practices across our province. In this letter, I intend to outline some of the economic gains flowing from the Agreement the majority of our members voted for last year as well as inform you of some of your SGFP Executive's initiatives.

**Financial Benefits:** Effective October 1, 2005 our fee-for-service based practices received increases to our General, Preoperative and Intermediate Assessment (A003, A903 and A007), Counseling (K030, K033, K041), Hospital Visit (Cxx2, Cxx7 & Cxx9), Concurrent Care (Cxx8), Supportive Care (C010), Palliative Care Consultations and Hospital Visits (A/C945 and C982) and Long Term Care Visit fees (W002, W882).

In terms of new fees, family physicians billing Intermediate (A007) or General Assessments (A003, C003, A903, C903, W903, W102, W109) on patients 70 years of age and older became eligible to receive a 15% premium (E070) on the billed fee. In addition, new fees include the Special Visit fee to the home of the palliative care patient (B998), Most Responsible Physician (MRP) fees for Day 2 & 3 plus day of discharge (C122, C123, C124 respectively).

For our Comprehensive Care Model colleagues, a new CCM monthly management fee was introduced on October 1, 2005. The initial monthly *average* CCM fee was \$1.00 per patient. With block coverage offered within six months of colleagues signing the CCM Agreement, this average monthly fee increases to \$1.42 per enrolled patient. Within one year of colleagues signing the CCM Agreement, the monthly fee increases to \$1.80. Furthermore, to encourage comprehensive care, our CCM colleagues can receive a new \$150 fee for the rostering of an acute care patient previously without a family physician, following the patient's discharge from an in-patient hospital visit. Our colleagues in FHGs and other harmonized models received a new complex care premium of 15% on comprehensive care capitation payments for patients 70+ years of age. This premium replaced the Q065 premium.

On April 1, 2006 a series of new fee increases were also introduced. Our Family Health Group (FHG) colleagues now receive a 20% premium for after hours work. Furthermore, two new fee codes – the absence of which had been a sore point with family physicians doing the unremunerated work in the past – were introduced. These codes are: K035 – Mandatory Reporting of Medical Condition to the Ministry of Transportation (MOT) form - \$34.85 and Kxxx – Completion of Northern Travel Grant form (K036) - \$10.25. Finally, our long term care colleagues are now eligible for a monthly (long term care) management fee (W010) - per patient per month - of \$85.70.

**Strategic Planning/SGFP Vision:** Following approval of the last Agreement, it became evident that the changing health care environment and needs of our members required a re-examination of our vision of the future of family medicine as well as our Section's 2001 Strategic Plan. To this end, your Executive met on September 17-18, 2005. The outcome of this was a revision of our Mission Statement in addition to our Goals & Objectives and Principles. Members are invited to visit our website ([www.familydoctorsofontario.com](http://www.familydoctorsofontario.com)) and view the changes under the tab "About SGFP" appearing at the top of our homepage.

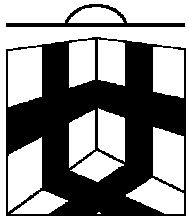
In addition to our Strategic Plan changes, your SGFP Executive recognized that, as a result of changes over the last two Agreements, our members' practices and preferred funding models have undergone profound changes. This is also reflected in your Executive members' own practices. Consequently, a more concerted and focused effort has been made to ensure that, to the extent possible, all our members' diverse practices and interests are represented in both our internal (within the OMA) deliberations as well as when representing family doctors externally.

It was precisely this recognition that led to two initiatives by your Executive:

- A Patient Enrolled Models (PEM) Working Group (chaired by Dr. Jon Johnsen, your Tariff Chair and a FHN physician) was set up to examine issues of implementation and member

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problems relating to PEMs. The Working Group intends to liaise with both OMA staff as well as relevant committees (e.g. Primary and Community Care Committee, Physician Services Committee, Central Tariff Committee, etc.) in an attempt to help members in their inquiries and to resolve practice difficulties related to the implementation of the Agreement. Members may wish to forward problems they face to our dedicated e-mail address [guidefeedback@hotmail.com](mailto:guidefeedback@hotmail.com). I only request that you clearly designate the questions to the SGFP PEM Working Group and that you take care to clearly explain the issue at hand. We will make every effort to find the answers for you. I ask that you understand that this effort is undertaken on a part-time basis by your elected Executive members and, as a result, a large volume of inquiries will unavoidably lead to delays in our Working Group’s responses. It is our intention to eventually post an inventory of *Frequently Asked Questions* along with the responses on our website.

- A concerted effort is being made to strengthen both the understanding and cooperation between your SGFP, the OMA Executive and the Ontario College of Family Physician’s Board. It is your Section’s intention to continue meeting with these groups on a regular basis. We also send a representative to OCFP Board meetings - which is reciprocated by having a member of the OCFP Board sitting on our Executive meetings.

**Remuneration for Workplace Safety and Insurance Board (WSIB) Forms**

Your Section Executive has had frequent contact with the OMA representative of the liaison committee with the WSIB. The issue at hand is the fact that, with the exception of the unsatisfactory increase to Form 8, there have been no increases to the amount WSIB is paying physicians to complete any of its forms since 2001. We are also pushing for recognition of the fact that premiums applied to OHIP fees in Patient Enrolled Models are awarded in lieu of general fee OHIP visit fee increases, to compensate family doctors for comprehensive care. The WSIB’s position, that it only pays for fees listed in the OHIP Schedule of Benefits (SOB), is unacceptable to us. Please stay tuned and watch for forthcoming SGFP communications on possible job action, if we are unsuccessful in convincing the WSIB of the merit and fairness of our position.

**Remuneration for Work Outside Publicly Funded Services**

Feedback received from members indicates that third party requested services (such as online or telephone surveys) continue to be challenging and frequent. I would like to point out that members should make every effort to value and price their services in accordance with recommended guidelines such as the OMA’s recommended part time employment hourly rate (net of associated expenses) which is \$266/hr for 2006. It does all our members – family doctors and consultants - a disservice when we undervalue our services. Doing so also creates a mindset that carries over into the comparatively undervalued OHIP/WSIB and other insured program fees we receive.

In closing, I would like to thank you and the members of the SGFP Executive for all of the support and encouragement I received as Chair of our Section over the past year. It has been a privilege to work for you and I am certain that the next SGFP Chair, Dr. John Ludwig, will do an excellent job in managing the evolution of our Section. I would also like to give special thanks to Ms Paddy Morton, our Section’s coordinator, and Mr. Jim Tsitanidis, our external consultant, without whose help and advice our Executive could not function as effectively as it has during my tenure as Chair.

Yours faithfully,

William Russell M.D  
Chair  
Section on General & Family Practice