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Priority issues: Agreements reached


Photo : Emmanuèle Garnier

If it took a lot of work to reach a satisfactory General Agreement last summer, as much effort was required on our part with respect to a number of measures associated with it. More specific agreements were therefore signed with the government regarding the economic recognition of the versatility of general practitioners in Québec, bonuses granted on the basis of the number of days worked and the volume of registered vulnerable and non-vulnerable patients, the electronic medical record, research and recognition of specific medical activities in private practice. The content of these agreements is summarized in this newsletter.

However, we cannot discuss the new General Agreement without talking about the new fees for the registration of "orphan" patients. Last fall, in the best interest of these patients, the FMOQ strongly advocated that these measures be implemented as soon as possible. As it could be expected, several adjustments and some fine-tuning were required in order to deal with a multitude of specific situations that presented themselves when the new agreement was implemented. Among other examples, there was the actual definition of an orphan patient and the application of self-referrals with regard to patients coming from the access registry. We also had to make numerous arguments to ensure that access registries for orphan clienteles will be operational and that coordinators will be allocated sufficient administrative resources for their proper functioning. Fortunately, based on information we received, things have improved in this area. However, do not hesitate to inform us about problems that were not resolved and we will inform the appropriate authorities.

The FMOQ and general practitioners consider access to a family doctor an undeniable priority. The views we regularly express and the content of the agreements we negotiate are eloquent examples of this position, while results obtained in the field over the past few months are an additional confirmation. Indeed, since Letter of Agreement No. 245 on the management of orphan clienteles came into effect November 1, 2011, thousands of Quebecers were taken on by family doctors. Thus, we have promptly "delivered the goods". In this context, it is reasonable to believe that if the government would really make front-line family medicine a priority by investing the sums required to offer family doctors more adequate professional and administrative support, these first encouraging results could be the beginning of better things to come.

In the months to come, the updating of the various measures that are part of the General Agreement will remain a priority. Everything should be put into place so that, among other issues, a new nomenclature for short-term and long-term care is developed. We will also continue to work on the development of new mixed remuneration systems in different sectors, particularly geriatrics, psychiatry, palliative care, home care, rehabilitation, public health and ongoing care in CLSCs. We must not lose sight of our main objective, which is to simply enable family doctors to offer the best possible medical care in optimal practice environments.

Dr. Louis Godin
President

August 14, 2012

Recognition of efficiency

These 3 measures are applicable as of the 2012 calendar year, with a first bonus payment in May 2013.

1. Number of significant practice days worked

Family doctors will be entitled to a bonus for days worked in excess of 180 days during each reference period (calendar year) as of 2012.

A day worked is defined as a day where the doctor's remuneration is equivalent to seven hours worked at the normal fixed fee rate or at the hourly rate or, for other methods of remuneration, at the equivalent of the hourly rate amount, i.e. $638.68 (7 X $91.24). The recording of days worked during a year will be automatically done by the RAMQ. Therefore, doctors do not have to submit a specific bill with regard to this measure.

The bonus is calculated as follows:

- $50 per day worked, from the 181st day to the 200th day
- $200 per day worked starting at the 201st day

For a given calendar day, a doctor may be remunerated for up to 1.5 days, providing that he or she billed for both the equivalent of more than 3.5 hours ($319.34) and 7 hours ($638.68) worked in two separate practice environments, i.e. in a front-line sector and in a second-line sector (institution).

Adjustments will be applied for certain sectors in order to take into account aspects that are particular to certain types of work. However, it should be noted that a doctor cannot logically be credited for more than 365 days worked in the same year. In addition, if a doctor takes maternity or paternity leave or extended sick-leave, threshold adjustments calculated on the pro-rata of days worked during a year will be applied.

The various equivalence and adjustment factors are as follows:

- The hours worked in Emergency at night (minimum 4 hours, maximum 8) are calculated separately and in lieu of remuneration for services, and are increased by 20% (number of days X 1.2). The same applies for on-site availability at night in a CHSLD, a CHSP and a rehabilitation centre.
- The lump sums paid for on-call availability on weekends and public holidays are added throughout the year and then converted into days worked on the basis of one day for $638.68.
- A delivery performed between 7:00 p.m. and 7:00 a.m. on a weekday is, at most, equivalent to one day worked.
- A delivery performed on a weekend or a public holiday is equivalent to one day worked. A doctor can be credited a maximum of two days worked on the same day for this purpose. However, a doctor who has front-line activities on the same weekend or public holiday when he or she performs a delivery may be credited an additional day or a half-day worked based on the remuneration billed on that particular day.
- In the case of work performed in intensive care or coronary care, separately from daily billable services, two hours are credited on an annual basis for each day on which the doctor takes on the responsibility of five patients or more and claims the bonuses provided for this purpose in the specific agreement. At the end of the year, the number of hours accumulated during the year is converted into days worked, according to the rules previously outlined.
- When there is a transfer between establishments, the doctor is credited four hours that are converted into days worked at the end of the year of reference, also according to the rules previously outlined.
- A day or half day of *perfectionnement, ressourcement* and continuing professional development is counted as such. A maximum of twenty days worked can be recognized for this purpose annually.
- For the purpose of daily remuneration for front-line services, the amount paid is increased by the percentage represented by all remuneration coming from the various fees paid for general registration, vulnerable patient management and management of primary health care nurse practitioners divided by all remuneration paid to the doctor for front-line services provided during the period of reference.
- Bonuses for responsibility provided for in certain specific agreements, which are added to 95% of professional hours, are converted and added to the remuneration of all hours of activities performed under the

specific agreement concerned. The same applies to bonuses for activities related to public health and workplace health.

- Finally, where medical-administrative activities are concerned, the remuneration paid in the form of a bonus during the period of reference is recorded and is then converted into days worked according to the rules previously outlined. A maximum number of recognized days is applicable to various medical-administrative activities as shown in the following table:

Professional function	Days credited
HEAD OF A DRMG	
Region 6	80
Region 03-16	65
Regions 01-02-04-05-07-08-09-11-12-13-14-15	55
Regions 10-17	45
MEDICAL COORDINATOR and the physician assisting him/her	
CSSS Group 1	40
CSSS Group 2	32
CSSS Group 3	27
CSSS Group 4	22
HEAD OF A CLINICAL AND GENERAL DEPARTMENT and the physician assisting him/her	
Group 1	30
Group 2	25
Group 3	20
Group 4	15
HEAD OF EMERGENCY and the physician assisting him/her	
Emergency group 1	30
Emergency group 2	18
Emergency group 3	12
HEAD OF A FMU and the physician assisting him/her	
FMU group 1	12
FMU group 2	17
HEAD OF A FMG OR NETWORK CLINIC and the physician assisting him/her	15
HEAD OF A FMG AND A NETWORK CLINIC and the physician assisting him/her	22.5

2. *Adjustment of bonus fees for taking on new patients*

This new measure stemming from the framework agreement aims at encouraging the management of new patients by giving doctors supplementary amounts on the basis of the number of active registrations of patients on December 31 of the reference year. To be entitled to this supplement, the doctor must reach a pre-set management rate (fidelity-building criteria) for vulnerable or non-vulnerable registered patients.

These rates and amounts, as they were presented at the time of the vote on the latest General Agreement, are as follows:

Vulnerable patients

- A $5 supplement for each active registration of a vulnerable patient, from the 201st patient to the 300th patient
- A $10 supplement for each active registration of a vulnerable patient, from the 301st patient to the 500th patient
- A $15 supplement for each active registration of a vulnerable patient, beyond the 500th patient

All registered patients (vulnerable and non-vulnerable)

- A $5 supplement for each active registration of a patient, from the 501st patient to the 750th patient
- A $10 supplement for each active registration of a patient, from the 751st patient to the 1000th patient
- A $15 supplement for each active registration of a patient, from the 1,001st patient to the 1,500th patient
- A $20 supplement for each active registration of a patient beyond the 1,500th patient

Management rate (fidelity-building criteria)

The management rate is the ratio between:

- The total number of examinations and consultations performed by doctors for their registered and active clienteles, in settings where patients can be registered, including those performed by one of the doctors in their group in premises where the group has its practice;
- And, the total number of examinations and consultations performed for the same clientele by any general practitioner (including the doctor and his/her group) in-practice, at the patient's home, in a CLSC, in a hospital-based FMU, in a FMG and in a hospital outpatient clinic, but excluding services offered in a hospital Emergency department or that of an on-call network CLSC

and, on weekends and holidays, in a network clinic. Examinations performed as part of temporary management in obstetrics and as part of the monitoring of a pregnancy by a doctor other than the family doctor are also excluded.

The management rate for 2012 is set at 61%. It will be progressively increased to reach 80% in 2016. Each year, the parties will need to agree on the appropriate management rate to be implemented for each of the years from 2012 to 2016.

Of course, these amounts are added to those allocated for the general registration bonus package and the annual fee for the management of a vulnerable patient. They are not taken into account in the calculation of days worked.

3. Increase with respect to multi-faceted practice

A physician who manages and monitors patients in a front-line environment can obtain a remuneration increase in the following sectors:

- Emergency service in a hospital centre or in a CLSC that is part of the on-call network
- Care units for patients admitted to a hospital centre, a CHSLD, an obstetrics department, a detention centre, a youth centre, a rehabilitation centre and to palliative care
- Services provided in public health when the physician participates in the on-call availability program in accordance with the specific agreement on public health

The increase of basic rate remuneration in those sectors is as follows:

- 2.5% if the doctor has between 700 and 999 active patient registrations
- 5% if the doctor has between 1,000 and 1,499 active patient registrations
- 10% if the doctor has 1,500 active patient registrations or more

For the **calculation of registered clientele,** each active registration of a **vulnerable patient** beyond 245 counts for **2.5 registrations.** For example, if a doctor has 300 vulnerable patients registered, this is in fact worth 245 + (55 × 2.5), or 382 registrations.

Adjustments for young doctors

It is, of course, difficult for a young doctor to register a great number of patients during the first years of practice especially if the doctor is active in a number of sectors. It was therefore agreed that there would be an adjustment in the number of registered patients required in the case of doctors who were issued their practice permit in 2008 and later in order for them to qualify for the increased rate for practice in an institution for the first four years.

First complete year of practice (and the portion of the preceding year)	
From 100 to 199 active patient registrations	+ 2.5%
From 200 to 299 active patient registrations	+ 5%
300 active patient registrations and more	+ 10%
Second year of practice	
From 250 to 399 active patient registrations	+ 2.5%
From 400 to 599 active patient registrations	+ 5%
600 active patient registrations and more	+ 10%
Third year of practice	
From 400 to 599 active patient registrations	+ 2.5%
From 600 to 899 active patient registrations	+ + 5%
900 active patient registrations and more	+ 10%
Fourth year of practice and last year for adjustments	
From 550 to 799 active patient registrations	+ 2.5%
From 800 to 1,199 active patient registrations	+ 5%
1,200 active patient registrations and more	+ 10%

Agreement concerning general practitioners' participation in the Québec Health Record (QHR) and the Québec EMR adoption program

The agreement to promote the adoption of electronic medical records (EMR) has finally been signed and has been in effect since August 1, 2012. A sum of $15.4 million per year has been set aside for this purpose. This agreement was merged with that for the Québec Health Record (QHR) and thus allows interested doctors to par-

ticipate in the QHR and in the Québec program for the adoption of electronic medical records. At the time of writing, the *ministère de la Santé et des Services sociaux* (MSSS) is making administrative preparations for the launch of this important program. The MSSS believes that it will be ready to receive and process physicians' applications for membership by November 15.

All general practitioners may benefit from this agreement if they so wish, according to the terms of their own practice setting. With regard to institutional FMUs and CLSCs, the MSSS will have a period of 24 months to choose an electronic record-keeping system for patients. At this time, the ministry is working to establish computer-based patient records (*dossiers cliniques informatisés* or DCIs) in institutions. According to the FMOQ's preferred scenario, EMRs could be used provided they are, obviously, compatible with or complementary to the DCI system.

As elsewhere in Canada, the program calls for a financial contribution by physicians to ensure the active adoption of EMRs. Also, the majority of reimbursements will be 70% of actual costs, according to the maximum amounts established by the program, with doctors assuming 30% of these costs.

Physicians must use the forms made available to them to claim the reimbursements to which they are entitled. These forms will be forwarded to the MSSS, which will first verify doctors' eligibility for the program. Subsequently, doctors will be able to send their claims to the ministry, which will send payment instructions to the *Régie de l'assurance maladie*. For QHR training and familiarization packages, as well as for packages to participate in the EMR program, billing codes will be created to facilitate the reimbursement process.

For participation in the QHR, the Agreement makes the following provisions:

For physicians practicing in private practice (other than a FMG)

- A maximum of $2,000 is provided for equipment costs and incidental expenses necessary for the use of the QHR. The physician is reimbursed for 70% of this investment, up to a maximum of **$1,400,** plus taxes.
- If the physician had invested in equipment during the six months prior to deployment of the QHR in the region, he or she is also eligible for this reimbursement.
- A private practice is eligible for reimbursement for an Internet switch up to a maximum of **$146,** plus taxes, and an Internet connection for a maximum value of **$1,200 per year,** plus taxes.
- A private practice may also be reimbursed for 70% of non-recurring costs for cables and wiring up to **$210** per doctor, plus taxes.
- A physician has a four-year cycle to be reimbursed again for equipment, including the Internet switch.
- A physician can claim a non-recurring flat fee for training and familiarization of **$600 per month for three months** for his or her participation in the QHR.

For physicians practicing in a FMG, CLSC and FMU

- A physician can claim a non-recurring flat fee for training and familiarization of **$600 per month for three months** for his or her participation in the QHR.

For participation in the Québec EMR adoption program, the Agreement makes the following provisions:

The conditions for participation in the Agreement regarding the EMR are the same for everyone.

- The physician must agree to adhere to the Agreement when the QHR will be deployed in his or her region.
- The physician must offer services insured by the RAMQ.
- The physician can benefit from the agreement on the EMR in just one practice setting of his or her choice, except for FMG doctors who must register within the FMG.
- The physician must take on the management and monitoring of a clientele of at least 300 patients, or work in a group where the average number of patients registered exceeds 300 patients per physician.
- At least half of the physicians in the group in question must adhere to the Agreement regarding the EMR.
- Only one certified EMR is permitted per clinical practice.

For physicians practicing in private practice other than a FMG

- **For those who have not yet acquired the EMR or acquired it since April 1, 2012**
  - The physician receives a reimbursement of 70% of the costs incurred for equipment and incidental expenses (e.g. computer, monitor, mouse, keyboard, server, printer and scanner, software, installation, UPS unit) up to **$3,500,** plus taxes.

- For each location, a private practice that is not a FMG will be reimbursed for up to 100% of the costs for an Internet switch (maximum of **$146,** plus taxes) and two Internet connections (maximum of **$2,400 per year,** plus taxes).
- A private practice will be reimbursed for 70% of non-recurring costs for cables and wiring up to **$210** per doctor, plus taxes.
- Obviously, if the physician has previously adhered to the Agreement on the QHR, certain amounts may be reduced to take into account reimbursements already received for equipment, incidentals and the Internet connection.
- The physician is reimbursed for 70% of the costs of implementing the EMR up to an amount of **$3,500** plus taxes (e.g. costs of data migration when changing EMR, scanning, training by EMR suppliers, technological and professional support for the implementation of the system).
- The physician is reimbursed for 70% of the investment made for the acquisition and exploitation of software licenses, updates, data hosting and support by the supplier up to **$1,400 per year,** plus taxes, per physician.
- A non-recurring amount of **$2,200, plus taxes,** is allocated to each physician to offset the costs of change management incurred to attend information days on the EMR program, customized workshops or for individual peer mentoring.
- To compensate for the time spent integrating an EMR into his or her practice, the physician will receive incentive packages for participation with a total value of **$3,600, at a rate of $600 per month, for six months**. These packages are halved if the doctor has already benefited from QHR familiarization packages.

■ **Those who acquired an EMR since January 1, 2011, but before April 1, 2012**
- These physicians are entitled to the same reimbursements as new members, **with the exception of** incentive packages for participation in the EMR program (**$3,600 at a rate of $600 per month for six months**) and the amount paid for change management (**$2,200**).

■ **Those who acquired an EMR before January 1, 2011**
These physicians have two options:

- **Option 1**
  - The physician is reimbursed for equipment, incidental and implementation expenses incurred before January 1, 2011.
  - The physician is reimbursed for the costs incurred for purchasing and operating licenses for this purpose starting on January 1, 2011.
  - The private practice is reimbursed for the Internet switch, cables, wiring and access to the Internet for the clinic (as of January 1, 2011 for the Internet connection).
  - The four-year cycle to qualify again for the program starts from time of the reimbursement.

- **Option 2**
  - Physicians who have already acquired their equipment and incidentals and believe that these are still adequate may defer their claims for reimbursement for equipment, incidental and implementation expenses until a later time.
  - In the meantime, physicians are reimbursed for the cost of acquiring and operating licenses incurred for this purpose starting on January 1, 2011.
  - The practice may also be reimbursed for the Internet switch, cables, wiring and access to Internet connections incurred for this purpose starting on January 1, 2011.
  - The four-year cycle to be entitled to claim reimbursements for equipment, incidental and implementation expenses starts from the time of the reimbursements.

For physicians practicing in FMG private practices

■ **Those who have not yet acquired an EMR**
- The physician is reimbursed for 70% of EMR implementation costs not exceeding the sum of **$3,500** (e.g. costs of data migration if there is a change of EMR, scanning, training by EMR suppliers, technological and professional support for the implementation of the system).
- The physician is reimbursed for 70% of the investment made for the acquisition and exploitation of software licenses, updates, data hosting and supplier support up to a maximum of **$1,400 per year**, per physician.
- A non-recurring amount of **$2,200, plus taxes,** is allocated to each physician to offset the costs of change

EMR – Summary table

	Per physician	Per year	Reimbursement	Eligibility		
				FMG	Non-FMG	CLSC
Implementation costs	$5,000	N/A	$3,500	yes	yes	no
Operating costs and licenses	N/A	$2,000	$1,400	yes	yes	no
Training and familiarization packages 6 X $600/month (100%)	$3,600	N/A	$3,600	yes	yes	yes (75%)
Change management (100 %)	$2,200	N/A	$2,200	yes	yes	yes (75%)
Equipment and incidental costs	$5,000	N/A	$3,500	no	yes	no
Cables and wiring	$300	N/A	$210	no	yes	no
Internet switch, Internet connection (per site) (100%)	N/A	N/A	$2,546	no	yes	no

management incurred to attend information days on the EMR program, customized workshops or for individual peer mentoring.
- To compensate for the time spent integrating an EMR into his or her practice, the physician will receive incentive packages for participation with a total value of **$3,600, at a rate of $600 per month, for six months**. These packages are halved if the doctor has already benefited from QHR familiarization packages.

- **Those who acquired an EMR after January 1, 2011, and before August 1, 2012**
  - The physician is eligible for reimbursement of 70% of the investment made since January 1, 2011, for the acquisition and exploitation of software licenses, updates, data hosting and supplier support to a maximum of **$1,400 per year**, per physician.
  - Physicians who have incurred implementation costs to integrate an EMR and have not yet claimed a reimbursement to an FMG budget may submit a request to this end to the joint committee.

- **Those who acquired an EMR before January 1, 2011**
  - The physician is eligible for a reimbursement of 70% of the investment made **since** January 1, 2011, for the acquisition and exploitation of software licenses, updates, data hosting and supplier support up to a maximum of **$1,400 per year**, per physician.
  - Physicians who have incurred implementation costs to integrate an EMR and have not yet claimed a reimbursement to a FMG budget may submit a request to this end to the joint committee.

For physicians practicing in CLSCs and in FMUs within an institution

- When an electronic patient record-keeping system chosen by the Minister is installed within an institution, the physician will receive 75% of the cost of support mechanisms for change management (**$2,200**) as well as incentive packages for participation, as provided for in the Agreement (**$3,600, at a rate of $600 per month, for six months**).

Letter of Agreement No. 250 : Research in family medicine

In effect since April 1, 2012, Letter of Agreement No. 250 aims to foster the growth of research in family medicine in Québec by improving working conditions for researchers and by supporting the career development of aspiring researchers. Its content is summarized on www.fmoq.org > Union Affairs > From the President > Newsletter > Priority issues : Agreements reached.

Dear members,

The measures referred to in the Newsletter are summaries. You may read the full text of the agreements on the RAMQ website. The RAMQ will also inform you of the detailed rules for implementation, particularly in the RAMQ newsletters (*Infolettres RAMQ*). If you have any question, do not hesitate to contact us.

Reminder to physicians and to DRMGs regarding mixed AMPs

Created in October, 2011, after long negotiations with the government, mixed Specific Medical Activities (*activités médicales particulières* or AMPs) marked a new step in the recognition of the management and monitoring of vulnerable patients in front-line care. Indeed, the management and monitoring of patients was no longer undervalued, compared with certain other hospital tasks. So, we had finally raised this activity to the same level of priority as most of the activities carried out in institutions.

As part of their local management of AMPs, all DRMGs must now, **without exception,** provide for mixed AMPs in the list of AMPs available in their region.

It is important to remember that these AMPs are defined as a combination of management and monitoring of vulnerable patients and front-line activities performed in institutions. The choice of activity in institutions is left to the physician who can chose from among all those available in the region.

Furthermore, it is important to note that the part of mixed AMPs related to the management and monitoring of patients is not calculated by the number of registered patients, but in hours worked. The patients' provenance cannot be a criterion for recognition either. DRMGs that make their choice of mixed AMPs conditional on achieving a certain number of registrations or on the provenance of patients (e.g. access registries) would therefore be doing so in **violation of established and agreed upon rules.**

That said, the FMOQ cannot ignore the fact that, since the arrival of mixed AMPs last fall, implementation has been, unfortunately, slow to materialize in the field. There are many reasons for this, but the change of culture required is perhaps the greatest stumbling block. Some people still have difficulty recognizing that a shortage of medical manpower in front-line care should be considered, for example, just as important as similar shortages in other sectors of activity. Modifying the levels of activity associated with the enjoyment of privileges within institutions, as well as management methods for AMPs by DRMGs, are other significant challenges.

It is the FMOQ's view that all stakeholders involved in the implementation of mixed AMPs must work together to give this new category of AMPs the momentum it needs to stimulate a greater supply of front-line services.

We invite our members to contact us with any questions they may have regarding the implementation of mixed AMPs.

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