6. GENERAL INFORMATION

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6. GENERAL INFORMATION

6.1 Overview

This general information section includes a list of the acts and applicable regulations that govern the majority of services rendered by physicians followed by an overview of other Ministry of Health and Long-Term Care Programs.

- Acts (Legislation)
- Alternate Payment Plans Program
- Ambulance Services Land and Air
- Assistive Devices Program and Home Oxygen Program
- Community Care Access Centres
- Community Health Centres
- Health Service Organization (HSO) Program
- Independent Health Facilities
- Laboratory Services
- Ontario Breast Screening Program
- Ontario Drug Benefit (ODB) Program
- Primary Care Reform
- Underserviced Area Program

6.2 Acts (Legislation)

Acts administered by the Ministry of Health and Long-Term Care are:

- Alcoholism and Drug Addiction Research Foundation Act
- Ambulance Act
- Cancer Act
- Charitable Institutions Act
- Community Psychiatric Hospitals Act
- Development Services Act (long-term care programs and services only)
- Drug and Pharmacies Regulation Act
- Drug Interchangeability and Dispensing Fee Act
- Drugless Practitioners Act
- Elderly Persons Centres Act
- Expanded Nursing Services for Patients Act
- Fluoridation Act
- Healing Arts Radiation Protection Act
- Health Cards and Numbers Control Act, 1991
- Health Care Accessibility Act
- Health Care Consent Act
- Health Facilities Special Orders Act
- Health Insurance Act
- Health Protection and Promotion Act
- Homemakers and Nurses Services Act
- Homes for Retarded Persons Act (long-term care programs and services only)
- Homes for Special Care Act
- Homes for the Aged and Rest Homes Act
- Human Tissue Gift Act (to be renamed Trillium Gift of Life Network Act)
- Immunization of School Pupils Act
- Independent Health Facilities Act
- Laboratories and Specimen Collection Centres Licensing Act
- Long Term Care Act, 1994
- Mental Health Act
- Mental Hospitals Act
- Ministry of Community and Social Services Act (Sections 11.1 and 12 re: long-term care programs and services only)
- Ministry of Health Act
- Ministry of Health Appeal and Review Board Act, 1998
- Municipal Health Services Act
- Nursing Homes Act
- Ontario Disability Support Program Act, 1997 (long-term care programs and services only)
- Ontario Drug Benefit Act

6.2 Acts (Legislation) (Continued)

- Ontario Medical Association Dues Act, 1991
- Ontario Mental Health Foundation Act
- Ontario Works Act, 1997 (long-term care and services act only)
- Physician Services Delivery Management Act, 1996
- Private Hospitals Act
- Public Hospitals Act
- Regulated Health Professions Act, 1991
- Audiology and Speech Language Act
- Chiropody Act
- Chiropractic Act
- Dental Hygiene Act
- Dental Technology Act
- Dentistry Act
- Denturism Act
- Dietetics Act
- Massage Therapy Act
- Medical Laboratory Technology Act
- Medical Radiation Technology Act
- Medicine Act
- Midwifery Act
- Nursing Act
- Occupational Therapy Act
- Opticianry Act
- Optometry Act
- Pharmacy Act
- Physiotherapy Act
- Psychology Act
- Respiratory Therapy Act
- Substitute Decisions Act
- Tobacco Control Act, 1994
- University of Ottawa Heart Institute Act, 1999

Major statutes relevant to the Ministry of Health and Long-Term Care but not administered by the ministry are:

- Canada Health Act
- Freedom of Information and Protection of Privacy Act

Copies of these and other Acts and Regulations are available on www.e-laws.gov.on.ca or you may purchase a copy from the Ontario Government Book Store.

6.3 Alternate Payment Plans Program

Introduction

The Ministry of Health and Long Term-Care (MOHLTC) has entered into over 300 Alternative Payment Agreements (APP) that provide global funding. These contracts include Alternative Payment Plans, Independent Health Facilities, Health Service Organizations and Ontario Family Health Network contracts. MOHLTC physicians participating in APP programs report their clinical services by submitting claims using a process known as 'shadow billing'. In addition, they follow other reporting requirements as negotiated under their APP.

Alternative payment programs were created to address specific needs within the communities. APPs have existed in Ontario for over 30 years.

An APP may fund a variety of physician services, including direct patient care, research, clinical education, indirect patient care and other related services.

APPs must serve and promote the interests of the health care system, which includes physicians, institutions, community agencies that use physician services, the government and the people of Ontario. More specifically, APPs may be used to achieve the following objectives:

- enhance physicians retention and recruitment
- enhance access in under-serviced areas and domains of practice
- protect services not adequately supported under fee-for-service
- support improved medical practice (e.g., adherence to guidelines, use of most appropriate provider, focus on preventive care and sharing of responsibility within groups of physicians)
- strengthen physician accountability to patients, other health care providers and facilities, and the community in respect to quality, availability and cost
- support and promote the effective and efficient restructuring of the health care system

6.3 Alternate Payment Plans Program (Continued)

Funding Methods

Over the years, a variety of compensation mechanisms have been used in alternative payment/funding arrangements. They included:

- capitation or blended funding models for group practice (e.g., Family Health Networks, Health Service Organizations and Primary Care Networks)
- bed utilization rate (e.g., chronic care)
- fee-for-service plus sessional payments (e.g., geriatrics and psychiatry)
- global/block funding of services at hospitals, Academic Health Science Centres and communities (e.g., Hospital for Sick Children, South Eastern Academic Medical Organization (SEAMO) in Kingston, Children's Hospital of Eastern Ontario (CHEO) and the Group Health Centre in Sault Ste. Marie)

Primary Care APPs in Underserviced Areas

The ministry offers alternative payment arrangements to help recruit and retain primary care physicians in eligible northern communities. Community Sponsored Contracts (CSC) for communities that require 1 to 2 physicians and Northern Group Funding Programs (NGFP) for physicians in communities requiring 3 to 7 physicians, provide a global payment for a full scope of primary care service delivery. The Scott Sessional Billing Program provides funding for physicians to ensure emergency department coverage on evenings, weekends and statutory holidays.

These groups of family physicians provide the community with reasonable access to a complete range of primary care including:

- primary care services during regular office hours
- emergency department coverage
- on-call emergency services
- hospital and nursing home rounds

6.3 Alternate Payment Plans Program (Continued)

Emergency Department Services

Emergency Department Alternative Funding Agreements (EDAFA)

In September 1999, the ministry offered Alternative Funding Agreements (AFA) to 88 community emergency departments that had emergency volumes less than 35,000 visits per annum. This initiative helped small and rural hospitals staff the emergency department.

In October 2000, the minister announced the expansion to include 62 hospital emergency departments located in urban centres and had emergency volumes greater than 35,000 visits per annum.

These funding agreements provide emergency department physicians with a global budget to ensure the provision of emergency medical services 24 hours a day 7 days a week. Such arrangements allow physicians to determine an appropriate level of remuneration and staffing in their emergency departments.

The AFAs have assisted with recruitment and retention of physicians in the emergency departments across the province.

Shadow Billing

Definition

The Ministry of Health and Long-Term Care (MOHLTC) has introduced automated service encounter reporting or shadow billing in order to collect and record the important client-based encounters provided by physicians receiving funding through Alternative Payment Programs (APP). Most APPs are now reporting service information in this manner. Providers are required to submit shadow billed claims to the ministry for insured services rendered to their patients.

Shadow billed claims are submitted to the appropriate ministry office of the Claims Payment Division using current Schedule of Benefits service codes and fees. After processing, the claims are reflected on the patient history file with the correct fee billed but are approved for payment at $00 dollars.

Purpose

Providers/Groups who shadow bill are paid through global funding from the ministry Alternative Payment Program as opposed to the traditional fee-for-service OHIP payments.

6.3 Alternate Payment Plans Program (Continued)

This process ensures the patient databases are populated with accurate payment and service information. It also ensures accountability under the APP contract while providing the ministry with the resources to monitor services rendered under the APP.

Registration of APP Shadow Billing Groups

All APP groups are registered with a unique four-character (alpha/numeric) group number. These specially assigned group numbers suppress OHIP payment while providing a facility to record the services rendered under the APP.

Technical Specifications

Shadow billing requires two changes to the claims submission technical specifications interface:

- software package must accommodate an alpha/numeric group billing number
- medical billing reconciliation software must reconcile the claims paid at $00 dollars

Exceptions

Providers who are registered under an APP shadow billing group number are permitted to bill permissible claims and receive payment at the appropriate fee-for-service amount. Examples of third party services for which the ministry acts as a payment agency are Workplace Safety and Insurance Board (WSIB) and Reciprocal Medical Billing (RMB); some "K" codes and negotiated permissible services. Where the ministry acts as a payment agency, the ministry receives reimbursement for such services directly from the third party.

Processing Rules for Shadow Billed Claims

Rules and regulations for Physician/Group shadow billing registration and shadow billing claim submissions apply equally to fee-for-service and shadow billed claims. Shadow billed claims are subject to all routine eligibility and validity checks. Manual review and Independent Consideration (IC) claims will continue to require the submission of supporting documentation.

Claims that reject onto the Claim Error Report must be corrected and resubmitted in order to populate the patient database and record services rendered under the APP. As in fee-for-service a Remittance Advice is produced following each processing cycle. Shadow billed claims need to be reconciled and claims outstanding for two payment cycles (remittances) should be re-submitted.

6.3 Alternate Payment Plans Program (Continued)

Other Report Requirements

Other reporting requirements may apply to APPs. Such requirements comply with ministry accountability standards or are the result of negotiated reporting requirements.

Examples of such reporting requirements may include:

- Financial reports
- Annual work/business plans, human resources plans, hospital operating plans
- Reports regarding uninsured services rendered within the scope of the contract
- (e.g., teaching, research and administration)
- Bed Utilization reports (Complex Continuing Care contracts)
- Canadian Triage Acuity Scale (CTAS) and National Ambulatory Care Reporting System (NACRS) data (e.g., Emergency Departments)
- Eligible Trauma Cases based on funding criteria as reported to the Ontario Trauma Registry (e.g., Trauma Team Leader Program)

6.4 Ambulance Services Land and Air

The Ministry of Health and Long-Term Care regulates and oversees the provision of land and air ambulance services in Ontario – a series of inter-related programs and services designed to provide timely response, prehospital emergency care and patient transport to those with immediate or urgent medical need, as well as transport of non-emergency patients to and from medical facilities.

Land Ambulance Program

Prior to 2000, a variety of providers delivered land ambulance services including private operators, hospitals, municipalities and volunteer agencies, as well as the Ministry of Health and Long-Term Care.

Following legislative changes to the *Ambulance Act R.S.O. 1990* as amended by the *Services Improvement Act 1997* (Bill 152), the funding responsibility for the delivery of land ambulance services shifted from the Ministry of Health and Long-Term Care to the province's upper-tier municipalities and designated delivery agents. The amended *Ambulance Act* also provides municipalities with the options of either assuming direct responsibility for providing land ambulance services, contracting with the existing operators, or selecting new service providers through the request for proposals process. In March 1999 the government announced that it would share in the approved costs of providing land ambulance services on a 50/50 basis with municipalities. At the same time, the government also extended the transition deadline for municipalities to assume the responsibility for delivering land ambulance services to January 1, 2001.

On January 1, 1998 the process of transferring operational and service delivery responsibilities to the municipalities began and by January 1, 2001 all 50 upper-tier municipalities and designated delivery agents had assumed the direct responsibility for the delivery of land ambulance services to their residents.

Today, through leadership, standard setting and performance monitoring, Emergency Health Services Branch ensures that the Ministry of Health and Long-Term Care continues to play a key role in sustaining the existence of a high-quality land and air emergency medical service system that is seamless, comprehensive, accessible, accountable, integrated, and responsive.

6.4 Ambulance Services Land and Air (Continued)

Air Ambulance Program

Established in 1977 and supporting the land ambulance system, the provincial air ambulance program is an integral component of the larger emergency health system in communities across the province.

Using both rotary and fixed wing aircraft made available through Critical Care Transport and Preferred Provider contracts and standing agreements with private air carriers and commercially scheduled airline services, the air ambulance system provides aeromedical transport to persons located in remote areas of the province, or in areas where land ambulance response or travel times are great. In addition, the air ambulance system provides transport for specialized medical teams and organs donated for transplant, as well as the transport of medically essential emergency and non-emergency patients to and from medical facilities. The air ambulance system also transports specially trained neonatal teams from facilities such as the Hospital for Sick Children and the McMaster University Medical Centre to outlying hospitals in order to provide emergency intervention and transportation for premature babies. Flight paramedics receive training at Sunnybrook Health Sciences Centre and take direction from doctors at local medical bases. Each year the air ambulance service transports approximately 17,000 patients.

All air ambulance transport is coordinated through the ministry's Medical Air Transport Centre (MATC). The MATC utilizes computer assisted call management, teleconference, radio/satellite communications, aviation weather and flight-tracking information systems, and airline reservation and flight planning software to provide its services, and monitors each flight's progress, coordinating any required land ambulance rendezvous. The MATC arranges the most appropriate aircraft meeting the needs of the transfer based upon aircraft suitability, availability and cost. MATC also arranges aircraft to transport the Multiple Organ Retrieval and Exchange (MORE) program's human organ teams.

6.4 Ambulance Services Land and Air (Continued)

Paramedic Education and Certification

Approximately 99% of the province's 11 million citizens have access to paramedic cardiac defibrillation. In addition, paramedics allowed to administer system relief drugs are available to approximately 95% of Ontario's population.

All paramedics must complete a two-year college course in paramedic prehospital care (or equivalent) and successfully complete a provincial qualifying examination in order to be eligible for full-time employment as a Primary Care paramedic. As of January 1, 2006 all part-time paramedics and full-time volunteers will also be required to hold these same qualifications and, beginning January 1, 2002 these paramedics and volunteers must have enrolled in paramedic pre-hospital care courses to achieve this goal.

For paramedics who have trained and worked outside Ontario, the Emergency Health Services Branch may grant reciprocity following completion of the ministry's equivalency challenge process. Once a paramedic's equivalency has been established, the candidate must successfully complete the provincial paramedic qualifying examination prior to employment in Ontario. The ministry has also been working with other provinces and territories to facilitate the interprovincial movement of paramedics along with a new and more open process for recognizing the qualifications of paramedics from other provinces.

The medical director of a ministry-designated local base hospital program is responsible for certifying the paramedic to perform controlled medical acts such as semi-automatic defibrillation and administering symptom relief medications (e.g., glucagon/glucose, nitroglycerin, epinephrine, ventolin and ASA) and for delegating the responsibility to perform such acts to the paramedics. Becoming an advanced care paramedic requires additional training and base hospital certification in such skills as endotracheal intubation, foreign body removal from the airway, needle thoracostomy, manual defibrillation and cardiac monitoring, intravenous infusion and administration of a variety of emergency drugs by various routes.

The Ontario Prehospital Advanced Life Support (OPALS) multi-year study is in its seventh year investigating the effects of rapid cardiac defibrillation and various advanced life support (ALS) procedures on cardiac patient survival and the reduction of morbidity and mortality among other critically ill patients. A number of the study's findings and conclusions have been reported in peer review journals.

6.4 Ambulance Services Land and Air (Continued)

Central Ambulance Communication Centres

Ambulance service in Ontario is a seamless, accessible and integrated program that crosses municipal boundaries without reference to residence or other demographic factors. By coordinating the deployment and movement of all ambulances within large geographic areas, the province's Central Ambulance Communications Centres (CACCs) facilitate this seamless access to service to all 447 municipalities of the province and the unorganized area of northern Ontario.

Computer-assisted, wide area central dispatching in the province's Central Ambulance Communications Centres ensures the closest available ambulance or emergency response vehicle is sent in an emergency. Modern interactive computer technology enables a CACC to link physicians, paramedics and other providers of emergency health services, as well as provide valuable information on the status of emergency departments and the availability of specialists and beds at tertiary care facilities.

Through coordination provided by CACCs, provincial land ambulance services respond to more than 1.4 million requests for land ambulance services per year, with over 810,000 resulting in emergency and non-emergency patient transport. Over 330,000 standby calls ensure the availability of service and the provision of balanced emergency coverage. In 2001, approximately 72% of all calls were for emergencies, with the remaining 28% for non-emergency calls, and the demand for essential ambulance services continues to grow – calls increased 10% in 2001 over 2000.

To assure CACCs remain able to respond to Ontario's increasing population, the Ministry of Health and Long-Term Care is in the process of upgrading the computer aided dispatch tools in all Central Ambulance Communications Centres to provide for improved, faster dispatching service – service that can include features such as integrated paging, automatic vehicle location technology and geographical information systems.

6.4 Ambulance Services Land and Air (Continued)

Ambulance Service Provider Certification

In 2000, because of amendments to the *Ambulance Act*, the legacy land ambulance operator-licensing scheme was replaced by a periodic quality based operator certification process. As part of the certification process, and a significant component of the initiative to monitor and ensure compliance with standards, the ministry employs a peer-orientated operational review program, combining some characteristics of accreditation with those of an inspection and a compliance review program. Land and air ambulance operators are required to participate in this review process in order to renew certification every three years. A similar review process is in place for Base Hospital Programs and Central Ambulance Communication Centres.

Land Ambulance Service Billing

The responsibility for determining whether ambulance service was medically necessary or unnecessary in transporting a patient from an accident or illness scene to a medical facility is at the sole discretion of the receiving hospital physician or designate, and is directly reflected in the co-payment charged to the patient by the billing institution.

For More Information:

Contact the Emergency Health Services Branch at:

6TH Floor, 5700 Yonge Street
North York ON M2M 4K5
Tel: 1 800 461-6431
Fax: (416) 327-7911

Or call the ministry INFOline at:

1 800 268-1154 (Toll Free in Ontario Only)
(416) 314-5518 (Toronto)
1 800 387-5559 (TTY service)

Access the Internet at:

www.health.gov.on.ca
or
www.amo-ehs.com

6.5 Assistive Devices Program and Home Oxygen Program

Objectives

The Assistive Devices Program (ADP) financially assists Ontario residents with long-term physical disabilities to obtain basic personalized assistive devices appropriate for the individual's needs and essential for independent living.

The Home Oxygen Program (HOP) financially assists Ontario residents with chronic illness requiring long-term oxygen therapy essential for independent living.

Both the programs are intended to give people increased independence and control over their lives. These programs may allow them to avoid costly institutional settings and remain in a community living arrangement.

Equipment Funded by ADP and HOP

ADP covers over 8,000 separate pieces of equipment or supplies in the following categories:

- Prostheses
- wheelchairs/mobility aids and specialized seating systems
- ostomy, and enteral feeding pumps and supplies
- needles and syringes for insulin-dependent seniors
- monitors and tests stripes for insulin-dependent diabetics (through agreement with the Canadian Diabetes Association)
- hearing aids
- respiratory equipment; orthoses (braces, garments and pumps)
- visual and communication aids

HOP pays for oxygen and oxygen delivery equipment, such as concentrators, cylinders, liquid systems and related supplies (e.g., masks and tubing).

6.5 Assistive Devices Program and Home Oxygen Program (Continued)

Accessing ADP and HOP

Initial access is often through a medical specialist or general practitioner who provides a diagnosis. In most device categories, an authorizer assesses the specific needs of the person and prescribes appropriate equipment or supplies. Finally, a vendor sells the equipment or supplies to the client.

In some device categories, such as adult hearing aids or prosthetic devices, the assessor is also the vendor.

Eligibility

Assistive Devices Program (ADP)

Any Ontario resident who has a valid health number issued in their name and has a physical disability of six months or longer. Equipment cannot be required exclusively for sports, work or school. Residents with a primary diagnosis of learning or mental disability are excluded from ADP, as are those receiving benefits from Workplace Safety and Insurance Board or Veteran's Affairs Canada, Group "A". There are specific eligibility criteria which apply to each device category.

Home Oxygen Program (HOP)

Any Ontario resident who has a valid health number issued in their name and has a chronic illness or dysfunction that requires long term oxygen therapy.

6.5 Assistive Devices Program and Home Oxygen Program (Continued)

Available Assistance

ADP pays up to 75 percent of the cost of equipment, such as artificial limbs, orthopaedic braces, wheelchairs, breast prostheses and breathing aids. For others, such as hearing aids, the ADP contributes a fixed amount. With regard to supply items, as ostomy, and needles and syringes for seniors, the ADP pays an annual grant directly to the person. HOP pays 100 percent of the cost of oxygen and related equipment for seniors and those on social assistance, home care or residing in a long-term care facility, and 75 percent for all others.

ADP pays up to 100 percent for disabled people receiving social assistance and eligible for ADP funding.

In most cases, the client pays a share of the cost at time of purchase and the vender bills ADP or HOP the balance.

For ADP supply categories where grants are paid, the client pays 100 percent of the cost of the vendor using funding provided by ADP.

All ages are eligible for devices except the needles and syringes grant which is restricted to insulin dependent seniors.

There are many sources of funding for the client's share of the cost including:

- clients
- voluntary/charitable organizations (e.g., March of Dimes, Easter Seals, Kiwanis)
- social assistance, Department of Veterans' Affairs (DVA)
- insurance companies
- relatives/friends
- waiver by vendor

6.5 Assistive Devices Program and Home Oxygen Program (Continued)

For More Information:

Call the Assistive Devices Program at:

(416) 327-8804 (Toronto)
(416) 327-8192 (Fax)
1 800 268-6021 (Toll Free)
1 800 387-5559 (TTY)

Write to:

Assistive Devices Program
5700 Yonge Street, 7TH Floor
North York ON M2M 4K5

6.6 Community Care Access Centres

People of all ages have simple one-phone-call access to community-based long-term care services through 43 Community Care Access Centres (CCACs) located across the province.

Community Care Access Centres:

- Provide up-to-date information on all community services (e.g., meals on wheels, supportive housing, attendant outreach)
- Conduct individual assessments
- Determine client's eligibility for CCAC services
- Plan a program of care for CCAC clients
- Arrange for services of CCAC clients
- Provide placement coordination services for admission to long-term care facilities

The ministry funds CCACs to purchase and arrange key community services on behalf of clients. Community services provided through CCACs include the following:

- nursing
- homemaking/personal support/respite
- physiotherapy
- occupational therapy
- speech-language therapy
- social work
- dietetics services
- case management/coordination
- medical supplies and dressings
- hospital and sickroom equipment
- laboratory and diagnostic services

Eligibility for services arranged by CCACs is based on a determination of need for the service. The CCAC case managers are responsible for assessing client needs, determining eligibility for services, developing service plans, authorizing the provision of services, coordinating the delivery of services, monitoring ongoing service needs and planning for discharge when services are no longer required.

CCACs determine eligibility and authorize admission to long-term care facilities (nursing homes and municipal and charitable homes for the aged). All persons requesting admission to a long-term care facility must apply to the CCAC placement coordination services to have their eligibility determined. CCACs manage the waiting list for admission to long-term care facilities.

6.6 Community Care Access Centres (Continued)

For More Information:

Call the Ministry INFOline at:

1 800 268-1154 (Toll free in Ontario Only)
(416) 314-5518 (Toronto)
1 800 387-5559 (TTY)

Access through the Internet at:

www.health.gov.on.ca
Or
www.oaccac.on.ca

6.7 Community Health Centres

Integrating Primary Care Across Ontario

Primary care with an emphasis on health promotion and disease prevention and a commitment to building community capacity are the defining characteristics of Ontario's 55 community health centres (CHCs). The CHC model provides comprehensive, coordinated care that identifies physical, social and emotional health issues and assists clients in addressing those issues. Priority is given to investing in individuals, families and communities to support them in building their capacity to take greater responsibility for their health.

Community health centres address a comprehensive spectrum of health needs and respond in a multi-faceted, holistic way. Care in community health centres is coordinated horizontally within the organization and across a range of community partners as well as vertically through the health sector.

Physician services are a core component of an efficient, inter-disciplinary primary care team within CHCs. Efficiency is achieved, in part, by ensuring that patient care is provided by the most appropriate caregiver. This approach allows physicians the necessary time to focus on more medically complex and challenging cases.

The inter-disciplinary teams of providers ensure that clients have ready access to a range of services. Access to the "right" service provider on-site means internal referrals are easily made and barriers to care are reduced. Typical CHC primary care teams include physicians, nurse practitioners, nurses, social workers, health promoters, community health workers and often chiropodists, nutritionists or dieticians. The health needs and priorities of each community determine the mix of professionals on the team. The inter-disciplinary model has proven to be a valuable tool in the recruitment and retention of health professionals in northern and rural communities as it significantly reduces professional isolation.

The CHC funding model provides each centre with a secure annual budget. This funding gives each centre the predictable revenue necessary to provide their clients with a consistent level of primary care and access to health promotion programs. All CHC staff positions are salaried. CHC physician salaries and benefits compare favourably with average incomes for fee-for-service physicians in Ontario.

Volunteer boards made up of community members and clients govern community health centres. In the more than 25 years since their inception, community health centres have developed a tradition of working effectively with all sectors of society. As CHCs create strong links with their communities, they are well positioned to ensure that cultural, economic and language differences do not become barriers to accessing health care.

6.7 Community Health Centres (Continued)

Community health centres are located in rural, northern and urban communities across the province. Innovative services and programs for diverse populations include:

- prenatal/postnatal support programs for high-risk clients
- piloting best practices (e.g., for asthma and arthritis)
- traditional aboriginal healing programs
- support services for older clients
- nutrition and food security programs
- home visits
- self help groups related to family violence
- tuberculosis management
- early child development screening and programs
- community action on environmental health issues
- primary care services for people who are homeless
- immunization programs

For more information:

Call the Community and Health Promotion Branch at:

(416) 327-7547

Access the Internet at:

www.health.gov.on.ca

6.8 Health Service Organization Program

Definition

The Health Service Organization (HSO) Program was initiated in the early 1970s as an alternative payment program for primary care practices. HSOs are funded on a capitation basis to provide primary health care services to roster members and are intended to encourage a multidisciplinary approach to care with an emphasis on health promotion and illness prevention.

HSOs operate under the terms of a contract with the Minister of Health and Long-Term Care. Each HSO signs its own contract and all contracts are based on the same template.

Program Size and HSO Locations

At present there are over 50 HSOs. Approximately 180 physicians are engaged in the HSO Program serving a population of close to 276,000 enrolled patients. These numbers are expected to decrease as many HSOs have expressed interest in transferring to Family Health Networks.

The number of physicians in an HSO range between 1 and 15 with over 70 percent of HSOs consisting of 3 physicians or less. HSOs are primarily found in more urban areas with nearly 70 percent located either in the Hamilton-Wentworth and Kitchener-Waterloo areas. Other locations include Toronto, Burlington, London, Ottawa, Brockville, Niagara Falls and Guelph.

Rostering

HSOs are paid a monthly amount based on the number of patients on their roster for that month. Patients wishing to belong to an HSO must sign a roster enrollment form. The number of patients an HSO may have on its roster is limited according to the terms of the contract the HSO signs with the Minister. Therefore, if the HSO is at its roster limit maximum, they may not be able to accommodate the wishes of a new patient until there is a space available on the roster. The average roster size for HSOs is approximately 1,491 members per physician.

6.8 Health Service Organization Program (Continued)

Funding

- Capitation: The amount that the HSO receives monthly for each roster member depends upon the age and sex of the roster member. The current average amount that HSOs receive in capitation payments is $11.00 per member per month. HSOs are paid roster specific capitation amounts each month whether or not roster members receive services from their HSO.

- Chargeback: If a roster member receives services from a GP outside the HSO, the HSO is charged 50 percent of the cost of the service. This is called a chargeback or negation and is subtracted from the monthly capitation amount.

- Fee-for-Service to Roster Members: Certain services are not included within the HSO capitation rate. HSO physicians may bill OHIP when providing these services to their members. These services include anesthesia, labour and delivery, surgical assists and physiotherapy.

- Fee-for-Service to Non-Roster Members: Each HSO physician may bill OHIP up to an average of $30,000 for services rendered to non-roster members.

- Program Grants: Most HSOs receive program grant funding for enhanced primary care services provided by non-physician health care workers. Examples of these programs include nutrition counseling, mental health services and health promotion programs.

For More Information:

Contact Health Service Organizations Program:

(416) 325-5309

6.9 Independent Health Facilities

The *Independent Health Facilities Act* (IHFA) provides a mechanism for funding, regulating and ensuring the quality of certain kinds of services in community-based facilities. It also provides for the coordinated and planned development of these facilities with the participation of District Health Councils. Licensing of facilities began in 1991 and licence renewal for five-year periods continues as a regular operation.

Independent Health Facilities (IHFs) are either diagnostic facilities funded by the ministry to provide specific classes of diagnostic tests or ambulatory care facilities licensed to provide surgical and therapeutic procedures.

Licenses have been issued to 25 ambulatory care IHFs. These provide surgical and other physicians' services that were historically performed only in hospitals (e.g., cataract and laser eye surgery, dialysis, laser dermatologic surgery, plastic surgery and gynaecologic surgery). The IHF program funds the costs of carrying out the procedures that are not included in the OHIP fee paid to physicians.

Diagnostic IHFs perform diagnostic imaging and a number of other tests on patients. There are approximately 1,000 such facilities licensed to provide diagnostic radiology, ultrasound, nuclear medicine, sleep studies and pulmonary function tests.

Facilities are funded for costs associated with the provision of licensed services, either on a fee-for-service basis, or under an approved annual budget. It is illegal to charge patients for any overhead expenses in connection with insured services, incurred in an IHF, either licensed or unlicensed, as these costs can only be funded through the IHFA. Further, it is illegal to operate an IHF except under the authority of a license issued under the IHFA.

Assessors are appointed by the College of Physicians and Surgeons of Ontario to perform regular assessments of licensed facilities and to ensure that the quality of care they provide meets or exceeds clinical practice parameters developed by the College for licensed services.

6.9 Independent Health Facilities (Continued)

For More Information:

Alternative Payment Programs Branch, IHF Program:

(613) 548-6637 (phone)
(613) 548-6734 (fax)

Access through Internet at:

www.health.gov.on.ca

Forward correspondence to:

Ministry of Health and Long-Term Care
Alternative Payment Programs Branch
Independant Health Facilities Program
49 Place d'Armes, 2ND Floor
Kingston ON K7L 5J3

6.10 Laboratory Services

The Ministry of Health and Long-Term Care, through the Laboratories Branch, regulates medical laboratory services in Ontario. The *Laboratory and Specimen Collection Centre Licensing Act* and Ontario Regulations 682 and 683 govern licensing, inspection and proficiency testing of licensed laboratories. To monitor and improve the proficiency of laboratories, the ministry funds the Quality Management Program - Laboratory Services (QMP-LS), which is operated by the Ontario Medical Association (OMA). All licensed laboratories are subject to this mandatory program.

Medical laboratory services in Ontario are currently provided by:

- Hospital based laboratories
- Community (private) laboratories
- Public Health Laboratories

Physicians can access these services across the province.

Hospital Laboratories

There are currently 199 hospitals with licensed laboratories and 18 hospital operated active specimen collection centres. Hospital laboratories primary work is associated with testing to meet in-patient and outpatient needs. Some of these laboratories are situated in rural areas where they are the sole providers of medical laboratory services. Physicians may collect the samples and send them to the laboratory for testing or, alternatively, direct the patient to the hospital outpatient specimen collection facility. In addition, some hospitals operate off-site specimen collection centres serving their communities.

Funding for laboratory services on hospital in-patient and out-patient services are included in the hospital’s global budget.

6.10 Laboratory Services (Continued)

Community (Private) Laboratories

There are 95 private laboratory facilities operated by the private sector across Ontario. In addition, the private sector operates 285 active specimen collection centres in various communities.

The Schedule of Benefits for Laboratory Services lists the insured laboratory tests for which community laboratories can bill OHIP on a fee-for-service basis. These laboratory tests are insured services only when ordered by physicians, nurse practitioners and midwives on community patients.

In order to submit specimens for examination or testing by a private laboratory, the physician, nurse practictioner, midwife must complete the Ministry of Health and Long-Term Care Laboratory Requisition (form 300-84). These forms may be obtained from Data Business Forms by either calling the claim card order desk at 905 791-3480 or by faxing a request to 905 793-4192.

No other requisitions or ordering materials are to be used for ordering laboratory examinations.

Public Health Laboratories

The Ministry of Health and Long-Term Care operates twelve Public Health Laboratories in Ontario. They are located in Toronto, Hamilton, Kingston, London, Orillia, Ottawa, Peterborough, Sault Ste Marie, Thunder Bay, Timmins, Sudbury and Windsor.

The Public Health Laboratories, part of the Laboratories Branch, provide specialized diagnostic and reference services in microbiology. A major portion of the work is related to public health, assisting physicians, medical officers of health and epidemiologists in the identification and control of infectious disease. In addition, the Public Health Laboratories operate public health screening programs. Examples include a neonatal screening program which tests all newborns in the province for congenital hypothyroidism and phenylketonuria and a prenatal program for detection of Hepatitis B and HIV in expectant mothers.

Details on the tests and specimen requirements are outlined in the Guide to Specimen Collection, (www.health.gov.on.ca/english/pub/labs/specimen.html) published by the branch. Details and contacts for the branch can be obtained from the Web site.

6.10 Laboratory Services (Continued)

For more information:

Contact the Public Health Laboratory at:

1 800 640-7221

Access the Internet at:

www.health.gov.on.ca

Physicians' Office Testing

A physician who carries out tests in his or her own office may require a licence under the *Laboratory and Specimen Collection Centre Licensing Act* unless the physician personally "performs laboratory tests for the exclusive purpose of diagnosing or treating his or her own patients in the course of his or her medical practice" (Regulation 682, section 13). Physicians considering office-testing necessary should check with the Laboratories Branch of the ministry prior to proceeding by telephone (416) 235-6054 or fax (416) 235-6282.

6.11 Ontario Breast Screening Program

The Ontario Breast Screening Program (OBSP) is an organized breast screening program administered by Cancer Care Ontario. It provides:

- Mammography
- Physical examination by a nurse examiner (in most sites)
- Result letters are sent to both women and their physicians
- Upon request explaining pros and cons of breast self examination
- Automatic recall letters
- Key materials are translated into French and 16 other languages including Spanish, German, Italian, Portuguese and Chinese

As of April 1, 2002 there are over 88 OBSP sites in operation, including a mobile van that travels throughout northwestern Ontario to bring screening to women in their own communities. The Ontario Breast Screening Program is aiming to screen over 350,000 Ontario women every year, or 70 percent of eligible women age 50-69.

Women over 50 years of age can be referred to the program by their family physician or can make an appointment on their own. Once in the program women are automatically recalled to be rescreened every two years until age 74. After age 74, women can continue to be screened on request.

The screening sites have a warm, comfortable atmosphere. Staff are trained to be sensitive to the needs of the women being screened.

For More Information:

Contact the Ontario Breast Screening Program at:

1 800 668-9304

Access the Internet at:

www.cancercare.on.ca/obsp

6.12 Ontario Drug Benefit Programs

Eligibility

Through the Ontario Drug Benefit (ODB) program, the Ministry of Health and Long-Term Care covers most of the cost of prescription drug products listed in the Ontario Drug Benefit Formulary/Comparative Drug Index (Formulary). The following people who are Ontario residents and have valid Ontario Health Insurance (OHIP) are eligible for drug coverage under the ODB program.

- people 65 or over
- residents of long-term care facilities
- residents of Homes for Special Care
- people receiving professional services under the Home Care Program
- social assistance recipients
- recipients of the Trillium Drug Program

Drug Coverage

The ODB program will pay for the following drug products for people eligible for ODB coverage if the drugs are prescribed by an authorized Ontario prescriber and dispensed by an Ontario pharmacy that is online with the ministry's Health Network:

- over 3,200 quality-assured prescription drug products
- over 300 limited use drug products
- some nutrition products
- some diabetic testing products

Co-payments and Deductibles

ODB eligible individuals may be asked to pay some portion of their prescription drug costs. They may pay up to $2.00 per prescription toward the dispensing fee if they are:

- single seniors with an annual net income of less than $16,018
- senior couples with a combined annual net income of less than $24,175
- receiving social assistance
- receiving professional services under the Home Care Program
- residents of a nursing home or Home for Special Care
- Trillium Drug Program beneficiaries

Seniors with higher annual net income levels will each pay their first $100 in ODB eligible prescription drug costs. After that they will pay up to $6.11 towards the dispensing fee for each prescription.

6.12 Ontario Drug Benefit Programs (Continued)

Trillium Drug Program

The Trillium Drug Program helps people who have high drug costs in relation to their income. Once an application is approved, the program covers:

- over 3,200 quality-assured prescription drug products
- over 300 limited-use drug products
- some nutritional products
- some diabetic testing products

Trillium Eligibility

Residents of Ontario can apply to the Trillium Drug Program if they have:

- valid Ontario health coverage
- are not eligible for drug coverage under the Ontario Drug Benefit (ODB) Program

Trillium Deductible

The program has a deductible that is based on net income and family size. Each year starting August 1, you must pay your drug costs up to your deductible level before you are eligible for drug coverage. The program runs from August 1 of one year to July 31 of the following year.

On August 1, 1999, the annual up-front deductible previously paid by Trillium recipients changed to a deductible that is paid in four installments over the Trillium program year (August 1 to July 31 of the following year). For example, a family with an annual deductible of $500 will pay $125 for prescriptions purchased at the start of each quarter on August 1, November 1, February 1, and May 1. After the deductible is paid in each quarter, the family will receive benefits for that quarter, and may be asked to pay up to $2 per prescription each time they purchase a covered drug product. Any unpaid deductible in a quarter will be added to the next quarter's deductible.

A prorated deductible for families who come into the program part way through the program year was also introduced. New applicants to Trillium can choose the date on which they wish to be enrolled in the program. The deductible they pay will be based on the number of days left in the program year. Please note that proration of the deductible will apply only for the first year that a family is enrolled in the program.

6.12 Ontario Drug Benefit Programs (Continued)

Trillium Drug Costs

Only certain drug costs count towards the Trillium deductible. Check with a pharmacist or the program to make sure the prescriptions are:

- listed in the ODB Formulary/Comparative Drug Index – Parts III and IX (drug products listed as Limited Use will require a physician to complete a Limited Use form)
- on the Facilitated Access List of HIV/AIDS drugs – Part VI
- requests for non-ODB drugs must be pre-approved by the ministry before the costs can count towards the Trillium deductible.

Section 8 Process

Under the Ontario Drug Benefit (ODB) Program, the Ministry of Health and Long-Term Care covers the cost of prescription drug products listed in the Ontario Drug Benefit Formulary/Comparative Drug Index (Formulary). In some cases, the ministry may consider requests for coverage of drug products not listed in the Formulary on a case-by-case basis for people who are eligible for ODB. This process is known as Section 8.

The individual's physician is required to write to the Drug Programs Branch providing the rationale for requesting the unlisted drug. All requests are reviewed by the Drug Quality and Therapeutic committee (DQTC), which recommends to the ministry whether coverage should be provided in each case. If the request is approved, coverage of the drug starts from the date ministry approval is granted. Requests may be approved for a period of up to one year. Coverage is not retroactive.

Limited Use

Some ODB products are listed in the Formulary as 'Limited Use'. Limited Use products are products that the ministry will reimburse only when a physician completes a Limited Use form for ODB eligible recipients who meet the criteria/conditions outlined for each product. The patient must take the form to the pharmacist.

6.12 Ontario Drug Benefit Programs (Continued)

Revised Limited Use Form

A new LU prescription form for prescribing LU drugs was introduced on July 1, 1999, and replaces the two LU forms (LU General and LU Proton Pump Inhibitors) that were introduced on December 31, 1998. The new prescription form has been streamlined and simplified to make it easier to complete.

For more information about LU drug products, please contact the Drug Programs Branch at (416) 327-8109. Physicians wishing to reorder additional *Limited Use Prescription Booklets*, may fax their requests to 1 888 234-1365.

Trillium application kits are available from local pharmacies or by calling the:

Ministry INFOline at:

1 800 268-1154 (Toll free in Ontario only)
(416) 314-5518 (Toronto)
1 800 387-5559 (TTY)

6.13 Primary Care/Family Health Networks

The Ontario Family Health Network is responsible for overseeing primary care expansion in Ontario. Its goal is to expand primary care services by providing opportunities for eligible family doctors to move voluntarily to family health networks over the next four years.

Participation in primary care networks and family health networks is voluntary for patients and providers.

Primary Care Networks (PCN)

PCNs are a network of physicians, including other health care providers at some locations, who enroll patients for the provision and coordination of primary care services. Participation in the reform is voluntary for patients and providers.

As of September 2002, 176 physicians have formed PCNs and over 270,000 patients have enrolled. PCNs have been created in Hamilton, Paris, Chatham, Ottawa, Parry Sound, Niagara Falls and rural Kingston.

Primary Care Networks are based on the concept of a network of physicians, which include other health care providers at some locations, who enroll patients for the provision and coordination of primary care services. Participation in the reform is voluntary for patients and providers.

Family Health Networks (FHN)

In 2001, the Premier of Ontario and the Minister of Health and Long-Term Care announced the creation of the Ontario Family Health Network (OFHN), an Ontario government agency charged with the task of helping physicians create FHNs across the province. OFHN assists physicians who have expressed an interest in establishing a network in their community by providing details of payment models, potential revenue analyses, and assistance with patient rostering.

As of September 2002, 40 physicians are in the process of forming FHNs and enrolment kits are being mailed out to their patients.

A FHN consists of at least five family physicians, who may work with other health care professionals to provide accessible, coordinated care to their patients and create a better working environment for themselves. Patients enrol with their FHN doctor by signing an enrolment and consent form.

6.13 Primary Care/Family Health Networks (Continued)

FHNs operate under a contract with the Ontario Ministry of Health and Long-Term Care and OFHN. Each FHN signs its own contract and all contracts are based on one of four template agreements. Physicians can choose from either the blended or reformed fee-for-service model. There are two versions of each of these models: one for physicians in rural and northern Ontario, and another for urban physicians.

The blended model is a population-based funding model that offers physicians greater flexibility in treating their patients according to the physician's preferred practice style and needs (including telephone advice and home visits), while receiving a more predictable income.

The reformed fee-for-service model is a more traditional model based on fee-for-service and offers greater flexibility for physicians with larger or more transient patient populations.

Both models feature:

- payments for service enhancement codes: preventive care bonuses and premiums for providing comprehensive care
- compensation for continuing medical education
- funding for improved clinical and practice management software and technology

For More Information:

Contact:

Ontario Family Health Network
1075 Bay Street, 9TH Floor
Toronto ON M5S 2B1
(416) 327-8443

or

Regency Court Building
80 Queen Street, 3RD Floor
Kingston ON K7K 6W7
(613) 544-7700

Access the Internet:

www.ontariofamilyhealthnetwork.gov.on.ca

6.14 Underserviced Area Program

History

The Underserviced Area Program (UAP) was established by the Ministry of Health and Long-Term Care in 1969 to respond to the need for more health professionals in northern Ontario. It has gradually expanded its role to also address the issue of health human resources in rural southern communities.

The program is administered by the North Region, Health Care Programs to enhance access to health care services in designated northern and rural areas of the province which have difficulty attracting and retaining health care providers.

It offers a variety of components aimed at attracting and retaining health care providers in northern, rural and remote areas of the province.

Designation

Communities (i.e., municipalities and townships) may apply to be designated as "underserviced" by completing a community-led designation process. UAP then determines if the community needs support to recruit required health care providers. Designation allows physicians relocating to those communities to receive the benefits outlined below.

Communities across the province may be designated for General Practitioners/Family Practitioners (GP/FPs) if they are experiencing a severe shortage of physicians. However, only northern communities may be designated as "underserviced" for specialists.

Factors considered include:

- health care professional data (how many service the community)
- local resident population and physician-to-population ratios
- previous recruitment efforts
- local demand for services
- additional health service needs and resources
- support of local health care professionals
- a letter indicating District Health Council (DHC) support or recommendation

6.14 Underserviced Area Program (Continued)

Designated communities are added to the appropriate List of Areas Designated as Underserviced (LADAU). These lists are widely distributed and made available to all health professionals inquiring about openings in their field of work. Current vacancies in underserviced areas for GP/FPs are also available from the Ontario Medical Association (OMA) Physician Job Registry.

Access the OMA Web site on the internet at:

www.oma.org

Financial Incentives

Incentive Grant Programs

Health care professionals relocating to designated underserviced communities may be eligible for one of the following incentive grants. Application must be made before relocating.

Incentive grants of up to $40,000.00 paid over four years to GP/FPs and psychiatrists who relocate to designated northern communities and up to $15,000.00 to GP/FPs who relocate to eligible designated southern communities.

Incentive grants of up to $20,000.00 paid over four years to physician specialists who relocate to designated northern communities plus a grant of up to $20,000.00 paid over four years under the Northern Medical Specialist Incentive Program (NMSIP), if the specialist also provides a minimum of 12 days of outreach services per year.

Incentive grants of up to $15,000.00 paid over three years to audiologists, chiropodists, occupational therapists, physiotherapists and speech-language pathologists who relocate to fill positions in UAP-approved vacancies in northern Ontario.

Practice Supports

Locum Tenens Programs

Locum programs assist northern and small rural communities experiencing shortages of physician services by providing temporary medical services to replace physicians on holidays, educational leave or temporary coverage for a vacant position, etc.

6.14 Underserviced Area Program (Continued)

Enhancing Access to Medical Services

Visiting Specialists Clinic Program

Approved northern communities not able to support resident physician specialists may access these services through outreach clinics.

Nursing Station Program/Medical Clinics

In 23 remote, rural and northern communities not able to support a physician, primary care services are provided through UAP Nursing Stations/Medical Clinics (staffed with a nurse or nurse practitioner).

Physician Outreach Program

Regularly scheduled primary care clinics may be provided to remote communities which have UAP-funded Nursing Stations and to provide telephone back-up to the nurse/nurse practitioner working at the Nursing Station.

Recruitment Initiatives

Community Sponsored Contracts (CSC)

Community Sponsored Contracts provide income stability for GP/FPs in eligible northern communities which have been designated as requiring a complement of one or two family physicians. The key feature of the CSC is that physicians are guaranteed an income, rather than being on fee-for-service.

Community Development Officer (CDO)

Community Development Officers facilitate and coordinate the independent recruitment initiatives of physicians, communities, government agencies and other stakeholders to address regional physician health resources issues. CDOs are located in Thunder Bay, Sudbury, Timmins, Goderich, Kingston and Goderich. Six CDOs provide service to the entire province.

Community Visit Program

Health care professionals and spouses may be reimbursed for travel and accommodation expenses to visit a designated underserviced community to assess practice opportunities.

6.14 Underserviced Area Program (Continued)

Free Tuition Program

The Free Tuition Program offers applicants up to $40,000.00 (or $10,000.00 per year) in exchange for a three or four year return-of-service commitment.

The program has two components: the reimbursement of medical undergraduate tuition fees and a location incentive fund. The Free Tuition Program will compensate medical students and postgraduate trainees for actual medical tuition payments (to a maximum of $10,000.00 annually), in exchange for a return-of-service in a community identified as underserviced. The Location Incentive Fund may provide tuition grant candidates with additional financial incentives to locate to approved communities.

Recruitment Tour

The Health Professionals Recruitment Tour is an annual recruitment activity which visits all five medical schools in the province. The tour, in the fall of each year, provides an opportunity for communities to market themselves to current and future health care professionals.

For More Information:

Contact the Underserviced Area Program at:

(705) 564-7280

Write to the following address:

Ministry of Health and Long-Term Care
North Region, Health Care Programs
Underserviced Area Program
159 Cedar Street, Suite 406
Sudbury ON P3E 6A5