

**Letter of Understanding
Between**

**THE MINISTER OF HEALTH
FOR THE PROVINCE OF SASKATCHEWAN
("minister")**

- and -

**THE BOARD OF DIRECTORS OF THE
SASKATCHEWAN MEDICAL ASSOCIATION
("board")**

This letter is a companion document to the Agreement dated May 4, 2011, and reflects the understandings and actions to be undertaken by the parties to the Agreement during the term of the contract.

A. Relationship

Both the minister and the board recognize the benefits to the health system and the people of the province in working together in a cooperative environment and focusing on the primary goal of improving the health of Saskatchewan people. Both parties support a financially sustainable, publicly funded health system and agree that to achieve this goal, providers, regional health authorities and the Saskatchewan Ministry of Health (Ministry) must create an environment which supports innovation, collaboration, research and technological advances.

While recognizing and respecting the mandate and role of the Saskatchewan Medical Association (SMA) and that of government, both parties agree to work cooperatively on activities/initiatives which support the common goal and objectives.

B. Joint Initiatives

1. Information Technology

The attached agreement dated March 27, 2008 sets out the terms and commitments to support the implementations of electronic medical records (EMR) and the integration with the provincial electronic health record (EHR).

2. Non-Fee-for-Service Physicians

The minister accepts that the SMA shall represent non-fee-for-service physicians individually or collectively.

Through the negotiation process resulting in the Agreement dated May 6, 2011 a bargaining framework was agreed to by the board and the minister. This framework is attached to the letter. The parties agree to continue work on a Memorandum of Understanding (MOU) for bargaining on behalf of non-fee-for-service physicians. This memorandum will define the roles of the SMA, regional health authorities and Saskatchewan Ministry of Health.

Every effort will be made to develop the MOU by May 31, 2011 or a date both parties can reasonably achieve. In the event that the parties cannot reach agreement, they may appoint a mutually agree to mediator to assist with the process. The MOU will identify the process for prioritizing the transition of physician specialty groups.

On completion of the MOU, the Management Committee will develop terms of reference, identify support requirements and develop a work plan.

3. Full-Service Family Physicians

The May 6, 2011 Agreement provides funding to recognize the value of family physicians who provide a full range of services to their patients and the continuity of care that results from this comprehensive service. Appendix 1 of the Agreement provides the initial concept and payment framework. The parties recognize that additional clarity is required to this Appendix in order to begin making payments beginning Fall 2011. This program will also include payments to Metro physicians for providing extended and comprehensive coverage for their patients.

The Ministry and SMA will work on the detailed criteria through a joint working group with costs to be tracked through the Payment Schedule Review Committee. The approved criteria must be managed within the negotiated funding level or funds brought forward from New Items funding or fee allocations by mutual agreement.

4. General Practitioner Specialists

The May 6, 2011 Agreement included funding to recognize that some general practitioners provide a broader range of services, such as anesthesia and surgical services. These services are of a considerable benefit, particularly in rural areas, as patients are not required to travel to get the services available locally because of the specialized skills of the local physicians.

The Ministry and the SMA agree to establish a small working group to work out the final details and program parameters in order that this program can be implemented by Fall 2011.

5. Premium payments for after-hours clinic work

The May 6, 2011 Agreement included funding of \$3.28M in year two (2010-11) of the agreement to provide a 50% increase in premium and surcharge rates effective October 1, 2010 (annualized to \$6.56M in 2011-12).

The agreement provides an additional \$6.56M in year four (2012-13) of the agreement to increase premiums and surcharges within this funding amount.

The SMA and Ministry agree a new 10% premium for scheduled or unscheduled after-hours clinic work and an Indirect Patient Care Fee will be funded using the uncommitted balance in the Discretionary Fund and any identified unallocated increases where retroactive payments have been issued to the SMA related to unexpended funds from the previous year.

The premium will be payable on weekends and statutory holidays, as well as on weekdays (including Friday) between 19:00 and 07:00. The premium will be restricted for physicians within Regina, Saskatoon, Prince Albert, and Moose Jaw initially.

The costs of these initiatives will be tracked and funded by the Payment Schedule Review Committee and fees will be adjusted to ensure costs fall within the budgeted amounts.

6. Quality and Access

The May 6, 2011 Agreement included funding of \$3M in year 3 (2011-12) of the agreement.

The Ministry proposes a process be established to determine the allocation and management of these funds by July 1, 2011. To do this it is proposed a joint committee be established with representatives from the Ministry and members of the physician community who are knowledgeable and have shown leadership on quality and access issues. Any agreed upon initiatives will need to be within the agreed upon funding level of \$3M. Where it is determined that an item can be addressed through the fee schedule, the Ministry and SMA agree it to be forwarded to the Payment Schedule Review Committee to be considered within the New Items Fund.

7. Chronic Disease Management (CDM) – Pay for Performance

The May 6, 2011 Agreement included funding of \$3M be provided in year three (2011-12) of the agreement.

It is agreed that \$1.5M balance of the funding may be allocated on a one-time basis to discretionary recruitment in 2011-12 and will be directed back to the CDM (Pay for Performance) initiative at the end of the third year.

Recognizing that the education of physicians who have not participated in the collaborative is critical, funding may be used to increase educational opportunities.

The Ministry and SMA agree that a joint committee of the SMA, Ministry, eHealth, and the Health Quality Council be established to establish specific details of the requirements to meet the CDM proposal.

The Ministry and SMA further agree to evaluate offsets at the Payment Schedule Review Committee table within the new CDM funding and return any savings realized within the new funding back to the fund. The Ministry and SMA agree to return unallocated expenditures from the 2011-12 CDM funding back to the CDM fund for use in future fiscal years.

8. Billing Information

The SMA and government agree that timely access to billing information is critical for effective program management, intersectional funding allocation, the review of existing fees and the establishment of new fees.

Prior to October 31, 2011, the Ministry and SMA will enter into discussions regarding an expanded role for the SMA in the use of de-identified billing data for allocation and fee review purposes.

9. Physician Dislocation/Relocation

There may be instances where the practising physician finds himself/herself negatively impacted financially by a decision of a regional health authority or government. The Ministry and the Board are in agreement that group/associate practice and a stable physician supply are important elements in creating a health system that has high public confidence. Both parties agree that where it is desirable to consolidate services and relocate or dislocate a physician, financial assistance may be required to facilitate such a move.

The parties agree to develop restricted criteria whereby physician relocation is considered as a cost of system reorganization (i.e. closure of small rural hospitals where it is clear that the physician will have to relocate to maintain a viable practice). The parties agree to work toward mutually acceptable criteria to assist in managing the intent noted with a target date of March 31, 2012. Until such time as a more formal policy is in place, situations will be handled on a case by case basis.

IN WITNESS WHEREOF the parties have set their hands and seals on the day written above.

Executed on behalf of the Minister this 5th day of May, 2011

Don McMorris
(Signature)

Don McMorris
Minister of Health

Assoc. Deputy Minister
(please print title)

W. A. ...
(Witness Signature)

Executed on behalf of the Board this 5th day of May, 2011

Ed ...
(Signature)

G. SRIPATH
President
Saskatchewan Medical Association

Ed ...
(please print title) ADMINISTRATOR

[Signature]
(Witness Signature)

Attachments:

- Non-fee-for service Bargaining Framework
- EHR contract - 2008

**ATTACHMENT 1
TO LETTER OF UNDERSTANDING**

Non-fee-for-service Bargaining Framework

Preamble

The parties (including the RHAs) agree that it would be beneficial to have a provincial structure to bargain and represent the interests of physicians who are paid on a non-fee-for-service basis. This process would initially include all physicians working under contract to RHAs.

Government and the Saskatchewan Medical Association (SMA) agree to establish a non-fee-service bargaining structure to formally transition representation/bargaining rights for non-fee-service physicians to the Saskatchewan Medical Association. It is believed that this can be achieved through a Memorandum of Understanding (MOU); however, this will have to be examined over time to ensure it meeting objectives.

This process will ensure consistency in compensation rates and work/service expectations across the Province for non-fee-for-service physician(s) (specialty groups) that transition to this structure. The compensation rates and policies established under this MOU will be binding on Ministry, the SMA, Regional Health Authorities (RHAs) and participating physicians.

Other agencies, including the University of Saskatchewan (College of Medicine), Northern Medical Services, Community Clinics and Saskatchewan Cancer Agency employ and contract physicians. These physician groups may be included in this process at the request of the governing agency. It is expected separate agreements will be established over time to ensure that the SMA can appropriately and effectively represent these physician groups.

Principles:

1. **Physician Resources** - The Ministry and Regional Health Authorities will retain ultimate responsibility for determining physician resource levels. The Ministry is currently developing a Provincial Health Human Resource Plan that will include physicians. This plan will guide and inform decisions with respect to physician resources. The Ministry and RHAs will seek input from the SMA (through the Management Committee) and others in regards to physician resource planning and appropriate physician resource levels.
2. **Predictability of Costs** - A process needs to be established to prioritize and transition physician (specialty) groups to a formalized non-fee-service bargaining structure. This process needs to be sensitive to the funding requirements and the

ability of the Ministry of Health to secure these resources from government. It is proposed that following specialties (in no specific order) be prioritized for inclusion in this process: Primary Health Care, Emergency Medicine, Medical Health Officers, Psychiatry and Pathology.

Other physician groups may be transitioned during the course of the agreement in accordance with established prioritization processes.

3. **Support** - It is recognized that the process of transitioning specialty groups to this formalized structure is resource intensive. Recognizing that this is a priority for all parties concerned, all parties will endeavor to complete requests within a timely fashion.
4. **Right to Representation** - There must be agreement from the SMA, the Ministry, the RHA (or any and all other relevant contractors/employers - e.g. University of Saskatchewan, Saskatchewan Cancer Agency), and any and all respective unions (eg. University of Saskatchewan Faculty Association) that a physician group will be included/represented under the proposed structure.

It is duly noted that all physicians have the right to SMA representation, whether it be through this process or independent of it.

5. **The Dispute Resolution Process** - will be established in accordance with the structure set out in *the Medical Care Insurance Act*, to deal with issues related to payment rates. In developing the MOU, the Management Committee will consider what other dispute resolution processes may be required.

Committees

Non-fee-service negotiations will involve a two level process:

- A **Negotiation Committee** will negotiate compensation rates and work/service expectations. Similar in function to the Medical Compensation Review Committee, it will have access to an appropriate dispute resolution process.
- A **Management Committee (MC)** - with equal representation from the Ministry (chair), the RHAs and the SMA, will be established to:
 - provide management of non-fee-for-service bargaining contracts;
 - receive and adjudicate submissions/proposals from the Negotiating Committee;
 - adjudicate contract disputes or directs disputes to the established dispute resolution mechanism (below);
 - establish a prioritization process to transition new physician groups beyond the 5 discussed below;

- approve contract templates and grids; and
- make recommendations to the Minister of Health.

In certain cases where an agency other than a RHA employs or contracts with a physician, they would be invited to attend Management Committee and participate on the Negotiating Committee.

All proposals and recommendations of the Management Committee are subject to the approval of the Minister of Health and the Board of the SMA.

Getting Started:

The Ministry proposes that the SMA and Government negotiate the terms of a formal Memorandum of Understanding by March 31, 2011. In the event that the parties cannot reach agreement by this date, they may appoint a mutually agreed to mediator to assist with the process. The MOU will identify the process for prioritizing the transition of physician specialty groups.

On completion of the MOU, the Management Committee will develop terms of reference, identify support requirements and develop a work plan.

**ATTACHMENT 2
TO LETTER OF UNDERSTANDING**

Electronic Medical Record Agreement

THIS AGREEMENT is made this 27th day of March, 2008

BETWEEN

**THE MINISTER OF HEALTH
FOR THE PROVINCE OF SASKATCHEWAN
(hereinafter called the "minister")**

- and -

**THE BOARD OF DIRECTORS OF THE
SASKATCHEWAN MEDICAL ASSOCIATION
(hereinafter called the "board")**

WHEREAS under *The Department of Health Act* the minister may enter into agreements with the board for the purposes of developing, coordinating and maintaining comprehensive health services in the province and for the education and training of health personnel;

AND WHEREAS the minister and the board have reached an agreement;

NOW THEREFORE this Agreement witnesses that the parties agree as follows:

1. INTRODUCTION

The minister and the board wish to support the adoption of electronic medical records in physicians' offices and the integration of these electronic medical records (EMR) with the provincial electronic health record (EHR).

The minister and the board believe that the implementation of EMR in physician offices will improve the quality and safety of patient care and acknowledge that there will be tangible benefits to the physicians as well as the health care system. The minister and the board agree that costs associated with EMR should be shared between physicians and government.

The spirit and intent of this agreement is to ensure long term financial support for physicians to offset the direct costs associated with successful implementation of an EMR integrated with the EHR.

2. TERM

- 2.1 This Agreement begins April 1, 2008 and shall continue unless terminated pursuant to article 10.
- 2.2 Notwithstanding 2.1, payments to physicians will begin when the approved EMR systems have been selected and physicians have implemented them, meeting the payment criteria below.

3. GRANTS AND PAYMENTS TO PHYSICIANS

- 3.1 Physicians providing insured medical services to Saskatchewan beneficiaries will receive payments to offset their cost of purchasing and maintaining the required qualifying software and the appropriate hardware to implement electronic medical records.
- 3.2 To qualify to receive payments, such physicians must maintain a qualifying EMR system and utilize it to provide a longitudinal patient record which integrates with the province's EHR through standard interfaces.
- 3.3 All Physicians, whether self-employed, contracted or salaried, who receive funding under this program will be required to disclose if any component of their medical record system is supported, either financially or technically, by a regional health authority, the minister or other publicly-funded agency. In cases where such support exists, eligibility to receive payments will be adjudicated on a case-by-case basis and may result in prorating of funding.
- 3.4 Payments are designed to ensure that the electronic medical record is effectively utilized, and shall include the following:
 - 3.4.1 Beginning when qualifying electronic medical record systems are approved, a fee of \$1.00 for each visit/consultation service documented in a qualifying EMR which contains sufficient information to meet the profession's generally accepted standard for medical records.
 - 3.4.2 A monthly fee of \$300.00 (paid quarterly) to commence once the physician successfully documents and maintains 50% of approved visits in a qualifying EMR will be paid for 12 months. After the first year of EMR operation, at least 95% of approved visits must be successfully documented and maintained on an on-going basis for the fee to continue.
 - 3.4.3 To encourage early adoption and to recognize that there are fewer benefits to the physician in the first years of the program due to fewer electronic health record services, bonus payments will be made available in the amount of:
 - a) \$200 per month (paid quarterly) during the initial 18 months of the list of qualifying EMR systems being approved to be paid to physicians who meet the criteria in clauses 3.4.1 and 3.4.2. If the electronic health record fails to have at least one clinical data interface (lab, diagnostic imaging, pharmacy) available to the qualifying electronic medical record systems within the 18 months of the systems being selected, this fee will be extended until such time as one clinical data interface is available or one year, whichever is sooner.
 - b) \$100 per month (paid quarterly) during the 12 month period following that period referenced in 3.4.3a) above to be paid to physicians who meet the criteria in clauses 3.4.1 and 3.4.2. If the electronic health record fails to have two clinical data interfaces available to the qualifying electronic medical record systems selected, this fee will be extended until such time as two clinical data interfaces are available or one year, whichever is sooner.

- 3.4.4 In the event approved EMR systems are not selected by April 1, 2008, physicians who, on the date EMR systems are approved, were using an approved system shall be eligible to receive a payment of \$500 per month. Such payment shall be retroactive to April 1, 2008 or the date the physician began using the approved system, whichever is later, will be discontinued once payment under 3.4.1, 3.4.2 and 3.4.3 begin and are subject to the physician consistently recording 50% of approved visits in the EMR during the retroactive period.
- 3.5 Payments to physicians shall be administered through the Physicians' Payment Schedule unless otherwise agreed by the parties. Costs for the other components of the program will be reimbursed at the agreed amounts from the funds administered by the board.
- 3.6 The minister and board will review the payment rates pursuant to clause 3.4.3 on a yearly basis to determine whether adjustments should be considered.
- 3.7 This agreement acknowledges Section 33 of the *Financial Administration Act, 1993*.

4. VENDOR SELECTION

- 4.1 The minister and board agree collaboratively to undertake a competitive process to identify EMR software products that are eligible for funding pursuant to this agreement.
- 4.2 Selection criteria will ensure that up to five qualified electronic medical record products will integrate with the Province's Electronic Health Record and meet the functional requirements of physician offices. A minimum of two of these systems must be available on a centrally hosted basis, a minimum of two requiring local servers and supporting infrastructure in physician offices and at least one must meet the specifications for Primary Health Care sites.
- 4.3 The EMR Program shall budget \$100,000 per year toward for the establishment and maintenance of EMR standards.
- 4.4 The EMR Program shall allocate up to \$100,000 per year for each qualifying EMR system for the conformance testing and certification services provided by Saskatchewan Health.

5. CHANGE MANAGEMENT SUPPORT

- 5.1 The board will establish a service to assist physicians in transitioning from paper to electronic medical records. Education and training services will include, but are not limited to:
- privacy impact assessments
 - computer literacy
 - EMR readiness assessments
 - contract management
 - electronic decision support

- team building
- workflow analysis
- dispute resolution between physicians and vendors.

5.2 The EMR Program shall fund this service according to physician demand, and will initially be set at \$150,000 per fiscal year, plus \$1000 per year per physician with newly adopting EMR systems and \$50 per year per physician with EMR systems implemented one year or more previously.

6. NETWORK CONNECTIVITY

- 6.1 The EMR Program shall fund the provision of high speed Internet connectivity to physicians adopting EMR systems, including necessary security and related support, with such services to be administered by the minister.
- 6.2 Physicians will be responsible for their own hardware, software, local network and implementation costs, as well as ongoing costs of upgrades, replacements and licensing. To qualify for payment under the program, physicians must undertake regular upgrades as agreed by the parties.
- 6.3 Physicians will be responsible for the safety and security of their electronic medical records including electronic and physical security and must comply with all applicable legislation, regulations, policies and guidelines respecting privacy and security of information.

7. INTEGRATION WITH THE PROVINCIAL ELECTRONIC HEALTH RECORD

- 7.1 The board and the minister agree to work together to plan and implement linkages between the electronic health record and physician electronic medical records.
- 7.2 Physicians will be expected to implement direct system-to-system integration between their electronic medical records and the electronic health record as the agreed upon system interfaces to/from the EHR are made available.
- 7.3 Physicians will be expected to access their patient's information on the electronic health record consistently, in the interest of improved patient care. Receipt of payments pursuant to this program shall be contingent on a physician's continued adherence to these utilization expectations.
- 7.4 The minister and the board agree that patient information contained in an electronic medical record may be critical to quality patient care throughout the system and, therefore, agree to develop mutually acceptable policies with respect to physicians sharing pertinent information contained in their electronic medical record with the electronic health record. These policies shall, at a minimum, set out the information to be shared, which shall include:

- (a) the patient's name, health services number, date of the encounter, diagnosis, service description including relevant clinical details; and
 - (b) relevant clinical details including patient care flow-sheets, where the physician is participating in provincially-sponsored quality improvement initiatives and/or participates in chronic disease management through utilization of chronic disease management payment codes.
- 7.5 The parties agree that such policies will be developed and implemented within the first year of the qualifying systems being approved.

8. SHARING OF PROGRAM COSTS

- 8.1 The board shall contribute \$2M to the Program for the fiscal year 2006/2007. The minister and the board shall each contribute \$2M to the program for the fiscal years 2007/2008 and 2008/2009.
- 8.2 The board and the minister shall thereafter share in the costs of the Program outlined in sections 3, 4, 5, and 6 on a 30/70 percentage basis respectively. Each party shall contribute to the Program Fund sufficient funds to meet this obligation. However, at no point shall the board contribute less than \$2M per annum to the Fund.

9 MANAGEMENT


- 9.1 An EMR Program Management Committee with representatives from the board and the minister will be established to oversee program administration. Its roles and responsibilities shall include but not be limited to:
- Review of processes, policies and program parameters and to recommend enhancements and amendments as necessary to the minister and the board
 - Review program eligibility criteria and propose changes as appropriate
 - Adjudicate cases where eligibility is unclear
 - Receive and review financial statements for the programs and oversee the accounting and distribution of funds as set out in clause 8.2
 - Other matters pertinent to the operation of the programs as agreed upon from time to time.

10. TERMINATION

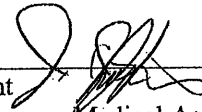
- 10.1 Upon mutual agreement, the parties may terminate this Agreement at any time with the understanding that, on the date of termination, any amount contributed to the Fund by each party shall be retained by that party for redistribution at their individual discretion.

- 10.2 Either party may, without cause or reason, terminate this Agreement by providing the other party at least 12 months written notice of its intent to terminate. Such notice shall not be given prior to April 1, 2010. The parties agree that, upon termination pursuant to this notice, the program will continue to support physicians who, on the date of termination, have a binding financial commitment related to an approved EMR product. Support, in such circumstances, will not extend beyond 3 years from the date the notice of termination was written or the expiry date of the binding financial commitment, whichever is sooner.
- 10.3 Either party may enter into discussions with the other party pertaining to major program adjustments (which does not include termination) by providing the other party with 90 days written notice of its intent to enter into discussions. If the parties are unable to reach agreement on the major program adjustments within 180 days following commencement of discussions, this agreement may be terminated in accordance with clause 10.1 or 10.2 or the parties may agree to enter into a conciliation process for the purposes of reaching an agreement.

IN WITNESS WHEREOF the parties have set their hands and seals on the day written above.



Minister of Health



President
Saskatchewan Medical Association