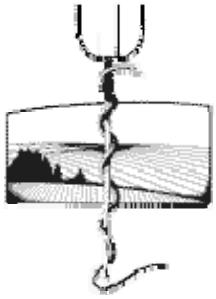

Society of Rural Physicians of Canada
Société de la médecine rurale du Canada

The ER APP - The History

Starting October 1st 1999, 27 hospitals in Ontario are getting an Alternate Payment Plan to provide ER coverage, costing about $37 million dollars. The communities include: Alliston, Bancroft, Barry's Bay, Bracebridge, Campbellford, Chatham, Exeter, Fergus, Georgetown, Grimsby, Hagersville, Hanover, Huntsville, Ingersoll, Leamington, Napanee, Owen Sound, Parry Sound, Petrolia, St. Mary's, Simcoe, Stratford, Tillsonburg, Trenton, Wallaceburg, Winchester and Woodstock. The SRPC-ON was understandably concerned that the smallest and most remote hospitals were not covered (see press release at www.srpc.ca/librarydocs/media.htm)

An additional 58 hospitals, generally smaller and more isolated, were offered the plan December 22, 1999 at another $60 million. The newer group of hospitals are Almonte, Alexandria, Arnprior, Blind River, Bowmanville, Brockville, Carleton Place, Chapleau, Chesley,Clinton, Cochrane, Collingwood, Deep River, Dryden, Dunnville, Elliot Lake, Espanola, Fort Erie, Fort Frances, Goderich, Haliburton, Hearst, Iroquois Falls, Kenora, Kemptville, Kincardine, Kirkland Lake, Kapuskasing, Listowel, Mattawa, Matheson, Markdale, Meaford, Minden, Mount Forest, Milton, Markham, Newbury, New Liskeard, Orangeville, Palmerston, Pembroke, Picton, Port Colbourne, Port Perry, Renfrew, Seaforth, Smooth Rock Falls, Sioux Lookout, Southhampton, St. Catharines, Sturgeon Falls, Strathroy, Uxbridge, Walkerton, Welland, Wiarton, and Wingham.

While SRPC-ON has worked with the rural section of the OMA to put pressure on for this APP to be at least expanded to include the rest of the small hospital sector, and most of this sector now is covered, some of the smallest and most isolated hospitals are still not covered including Englehart, Atikokan, Emo and Red Lake.

In 1999 the total contract offers an average hourly rate, 24 hours a day, 365 days a year, of

$100	for less than 10,000 visits	Out of hospital call with 15 min response time in these three levels
$110	10,000 -15,000	
$120	15,000 - 20,000	
$130	20,000 - 25,000	These three levels require the physician to be on-site in the ER
$140	25,000 - 30,000	
$150	30,000 - 35,000	

Visits are determined by 97/98 "MIS" volumes and ohip reported emergency volumes (yes its important to shadow bill correctly). Local medical staffs may distribute the moneys as they see fit - offer more on weekends, less throughout the week, more in the summer etc. -a positive touch.

Also $45,000 for admin. purposes, to be distributed as seen fit - suggested $20,000 for secretarial and $25,000 for emerg director plus an allowance for billing for second on call call-backs varying between $10,000 per year for the smallest hospitals up to $35,000 for the largest.

Most of the funding comes from the MOH, but part of it (approx. 10%) comes from the local hospital (this is a problem with the less affluent rural hospitals, who have trouble keeping nurses hired). Some services are billable in addition - WSIB, obs, anaesthesia, certain scheduled visits including chemo, iv infusions. Part of the MDs obligations are to keep the emerg open and maintain the standards of emergency care. Of course, in most hospitals, this is already provided, but reporting obligations are potentially another difficulty for rural hospitals, and there is an out with 60 days notice if the APP is not working out. Also there is a commitment to shadow bill.

The contract was changed in 2002 to include many more tiers of volume, which may be inappropriate for rural settings where maintaining services to the community and availability of physicians to do the service should be more important than volume as a driver. The hospital in the new deal does not contribute to the agreement, but is required to submit CIHI ER data or is subject to fine of apprx 10% of the contract. There is no ER director fee but $20,000 of the contract is designated for administrative expenses.

There was a 2.5% increase in the base amount April 1, 2005 and the following table relects these numbers. There was an attempt ot put future increases as a percentage of shadow billing (ie volume) which was strongly, and successfully defended by the Section on Rural Practice and rural ED directors.

Hospital Volume	Level	2nd on Call Cap	yearly contract value	on site/on call
<3,500 visits	A	$5,000	$637,978	on call
3,500-5,000	B	$7,500	$729,185	on call
5,000-7,500	1	$10,000	$910,959	on call
7,500-12,500	2	$15,000	$1,101,899	on call
12,500-17,500	3	$20,000	$1,093,105	on call
17,500-20,000	4A	$22,500	$1,257,060	on site
20,000-22,500	4B	$25,000	$1,301,955	on site
22,500-25,000	5A	$30,000	$1,346,850	on site
25,000-30,000	5B	$35,000	$1,369,296	on site

On call means you can perform OHIP insured non-emergency (no call ins or H's) services elsewhere as long as you are available on call with 15 minutes notice to the ER for Emergency Services.