SCHEDULE "G"

Memorandum of Agreement regarding the Community Hospital Inpatient Program

This **MEMORANDUM OF AGREEMENT**, dated this _____ day of October, 2019, BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA, as represented in that capacity by the Minister of Health and Wellness (the "Minister")

OF THE FIRST PART

- and –

DOCTORS NOVA SCOTIA, a body corporate constituted by the *Doctors Nova Scotia Act*, SNS 1995-96, c 12, on behalf of duty qualified medical practitioners in Nova Scotia

OF THE SECOND PART

- and -

NOVA SCOTIA HEALTH AUTHORITY, a body corporate established by the *Health Authorities Act*, SNS 2014, c 32 ("NSHA")

OF THE THIRD PART

WITNESSETH THAT:

(a) WHEREAS Doctors Nova Scotia is the sole bargaining agent for medical practitioners in Nova Scotia, for the purpose of entering into agreements with the Minister that bind its members;

(b) AND WHEREAS the Minister and Doctors Nova Scotia are currently negotiating a new Master Agreement (the "**new Master Agreement**") to provide for physician compensation for insured professional services;

(c) AND WHEREAS the Minister wishes to implement the Community Hospital In-Patient model outlined in the attached schedules (the "**Community Hospital In-Patient Model**") for physician professional services delivery and compensation in certain community hospitals in advance of the new Master Agreement;

(d) AND WHEREAS the Minister and Doctors Nova Scotia agree that during the term of this Memorandum of Agreement and the new Master Agreement the Community Hospital In-Patient Model will not be implemented in facilities other than those listed in section 1 of this Memorandum of Agreement, that Category 1 on-call rates will not be increased, and that Category 1 on-call rates will not be expanded to other sites except where demonstrably justified

according to the requirements for Category 1 on-call described herein;

NOW THEREFORE, in consideration of the mutual covenants made herein, and other consideration the receipt and sufficiency of which is acknowledged by the Parties, the Parties hereby agree as follows:

1. The Minister and NSHA will make the Community Hospital In-Patient Model available to physician groups only at the following community hospitals:

    1.1. Inverness Consolidated Memorial Hospital;
    1.2. Strait Richmond Hospital;
    1.3. New Waterford Consolidated Hospital;
    1.4. Northside General Hospital;
    1.5. Fishermen's Memorial Hospital;
    1.6. Soldiers Memorial Hospital;
    1.7. Queens General Hospital;
    1.8. Hants Community Hospital; and,
    1.9. Roseway Hospital;

(each a "**Community Hospital**"; together, the "**Community Hospitals**").

2. A physician group which is eligible pursuant to Article 1 may opt into the Community Hospital In-Patient Model by delivering notice from its Representative Physician, as identified in its Service Delivery Plan, to the Minister and the NSHA in writing.

3. The Parties agree that the facility stipends and the compensation rate methodology as set out in Appendix "B" of this Memorandum of Agreement will be the sole funding for physicians under the Community Hospital In-Patient Model for the provision of all in-patient care services (other than LTC) as specified in Appendix "A" of this Memorandum of Agreement.

4. Where a physician group at a Community Hospital which has adopted the Community Hospital In-Patient Model pursuant to Article 2 has had its site delivery plan approved by NSHA and the Minister as required by Appendix "A" on or before 15 February 2020, then upon implementation of the site delivery plan in accordance with Appendix "A":

    4.1. each physician in the physician group who provided inpatient services at the Community Hospital from 1 July 2019 to the date when the Community Hospital adopted the Community Hospital In-Patient Model (the "retroactivity period") shall be entitled to retroactive compensation in accordance with Article 5 of Appendix "B"; and,

    4.2. each physician in the physician group who provided on-call services at the Community Hospital prior to the physician group adopting the Community Hospital In-Patient Model shall be entitled to retroactive on-call compensation for the retroactivity period, calculated as the difference between:

4.2.1. the amount claimed by the physician as compensation for being on-call during the retroactivity period; and

4.2.2. the amount of compensation that would have been paid to the physician in on-call rates under the Community Hospital In-Patient Model for the on-call days worked by the physician during the retroactivity period.

5. The Community Hospital In-Patient Model will not be made available other than in the Community Hospitals.

6. Category 1 On-Call rates shall be $300/day for weekdays, and $400/day for all weekends and holidays for the provision of call for a 24-hour period from 08:00 through to 08:00 the next day.

7. This Memorandum of Agreement shall be effective from the date when it is executed by the last of the Parties to do so, and shall remain in force until the termination or expiry of the new Master Agreement.

8. A physician group that participates in the Community Hospital In-Patient Model may terminate its participation by giving three months' prior written notice from its Representative Physician to the Minister and the NSHA. Upon termination, the members of the physician group shall:

   8.1. revert to fee for service for their inpatient care; or

   8.2. for physicians who are on an alternate payment plan, revert to their full alternative payment plan FTE allotment and provide inpatient services as required by their alternative payment plan agreement, as immediately prior to the physician group enrolling in the Community Hospital In-Patient Model.

9. The Minister, or NSHA with the Minister's prior written approval, may terminate the participation of one or more physician groups in the Community Hospital In-Patient Model upon three months' prior written notice to the group's Representative Physician, and the other Parties to this Memorandum of Agreement.

IN WITNESS WHEREOF the Parties hereto have executed this Agreement by their duly authorized representatives:

	HER MAJESTY THE QUEEN in the right of the Province of Nova Scotia
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____
	DOCTORS NOVA SCOTIA
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____
	NOVA SCOTIA HEALTH AUTHORITY
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____

Appendix "A"

Community Hospital Inpatient Program
General Program Guidelines

1. General Requirements

Physician groups participating under the program must provide:

- on site comprehensive care for all inpatients (attached and unattached) in the hospital that include:
  - physician support 7 days a week to meet patient care needs and system flow requirements;
  - on site presence to align with timing of daily bed management decisions by other hospital staff (as pre-arranged and mutually agreed);
- comprehensive on call coverage and response for all hours where physicians are not on site for all inpatients;
- collaborative care with other providers;
- effective discharge planning in concert with inter-professional team;
- participation in quality improvement and patient safety reviews, programs and activities;
- best practice documentation in the clinical record for all visits, admissions, and discharges as well as best practice physician daily 'hand-off' structure and process;
- assistance to site leads to support bed utilization management including supporting the timely transfer patients, when the level of acuity is appropriate, from Regional Hospitals, including orphan and/or unattached patients.

All physicians at an eligible Community Hospital must participate in the program and all beds, other than LTC, at that facility must be covered by the program.

Quality patient care and safety is the overall goal of the Community Hospital In-Patient Model. In the event the physician group believes it is unable to sustain services as required by this Schedule without undue burden on the providers or undue risk to patient care and safety the physician group may terminate its participation in the Community Hospital In-Patient Model in accordance with Article 8 of the Memorandum of Agreement, or, with the prior written agreement of the NSHA and the Minister, temporarily suspend its participation in the Community Hospital In-Patient Model.

2. Daily Services

The daily stipend for inpatient coverage at Community Hospitals is intended to be inclusive of the provision of inpatient care for all patients, whether attached or unattached and any and all patients transferred into the facility through the regional network of care. It covers:

- required clinical care of all inpatients (acute, ALC, restorative care, transitional care, attached and unattached) other than LTC, admitted in the facility;

- time spent supporting indirect patient care (e.g. collaboration with other members of the hospital health care team);
- time spent delivering clinical support services (e.g. admission and discharge planning, working with in-hospital multidisciplinary team, participation in quality improvement and patient safety reviews, programs and activities, supporting bed utilization decisions and inter-hospital transfers);
- time spent building local inpatient care capacity (e.g. mentoring new physicians and trainees).

3. Site Delivery Plan

Physicians from each participating Community Hospital will develop a site-specific delivery plan to ensure that all inpatients at the facility are covered 24/7/365. This includes:

- the names of the participating physicians;
- the name of a Representative Physician who is authorized by all of the physicians in the group to deal with the Department and the NSHA on their behalf in regard to inpatient care and the Community Hospital In-Patient Model;
- confirmation that physician remuneration is consistent with the daily stipend and will not exceed the overall site budget and level 1 Facility On-Call payment rates;
- the approach to providing quality care to all inpatients across the different units of the hospital, including attached and unattached patients – the approach may be a hospitalist model (i.e. single physician coverage on a daily basis), or a model whereby physicians follow their own patients with clarity of who will provide coverage on off hours, weekends and holidays, or a mixed model (i.e. physicians following their own patients throughout the week, but having single coverage on the weekends/holidays). The plan for coverage must include:
    - the proposed model for on-site presence of participating physicians;
    - the proposed approach to on-call coverage and response;
- the process for ensuring a quality physician "hand-off" for physicians taking over call from call or coverage from another physician;
- The process for and commitment to ensuring collaborative care with other members of the hospital health care team;
- the process for timely admission and discharge planning in concert with hospital multidisciplinary team, the patients family/support network, and community-based staff, agencies and supports;
- planned participation in quality improvement and patient safety reviews, programs and activities;
- A clear commitment to engagement in and facilitation of bed utilization and inter-hospital transfers in collaboration with site lead;
- A clear commitment to participation in the Community Hospital In-Patient network/collaborative (if one exists) dedicated to enhancing skills and mentoring new physicians and trainees in quality in patient care; and,
- An internal plan and methodology for allocation among participating physicians of compensation provided under the Community Hospital In-Patient Model.

All physicians providing inpatient services at a Community Hospital are expected to participate in the program and contribute to the site delivery plan. Site delivery plans must be approved by the Zone

Head for Family Medicine, the Zone Medical Executive Director, and the Senior Medical Director of Medicine and must be consistent with NSHA Policies and Procedures. A copy of the site delivery plan will be provided to DHW for review and sign off prior to implementation.

The site delivery plan must be signed by all participating physicians. Each physician added to the group after the initial plan is approved will be required to sign a Declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program.

4. Cash Flow and Disbursement

The physician group will be responsible for submitting claims for both retroactive compensation in accordance with article 4 of the Memorandum of Agreement and the daily stipend as provided in Appendix "B". Funds will be disbursed to the group or to individual physicians as identified by the group's Representative Physician. Decisions on distribution of funds will be the sole responsibility of the physician group provided the plan and methodology is clear in the site delivery plan as required above.

MSI will establish monthly transfers of funding to the physician group or individual physicians according to the invoices received as outlined above.

5. Reporting Requirements

Physicians are required to shadow bill for 100% of services provided and are responsible for any and all costs associated with the submission of shadow billings.

On a quarterly basis, the physician group must provide to the Minister a summary of all program financial disbursements to individual physicians, including disbursement of the Category One On-Call stipend according to the reporting protocols currently in place for the Facility On-Call Program;

NSHA will provide the physician group a monthly report on key metrics regarding inpatient care at each facility.

NSHA will prepare and provide to the DHW a quarterly report on key metrics on quality and safety of patient care, and key utilization indicators (LOS, readmissions within 30 days, transfers in and out, etc). Examples of quality indicators may include:

- hospital standardized mortality rate;
- C. Difficile infection rates;
- patient falls;
- re-admission rates 7 days, 30 days;
- rate of connection with community family physician within 1 week of discharge;
- number of attached and unattached patients.

A process will be established to develop other relevant metrics which will be tracked by all participating facilities across the province.

Appendix "B"

Facility Stipends and Compensation Rate Methodology

1. Daily Stipends

The daily stipend for each Community Hospital will be established using the following formulae:

Daily Stipend Formula:

Admission $ + Discharge $ + Ongoing Care Beds $ = daily stipend at each site

	Admission $	Discharge $	Ongoing Care Beds $
Rate	$89.47 per avg daily admission at each site	$99.82 per avg daily discharge at each site	$47.12 per ongoing care bed at each site
Based on	Average admission MRP inpatient billing per admission, assuming 75% are billed as geriatric admissions, based on 18/19 FY data	Average discharge MRP inpatient billing per admission, assuming 75% are billed as comprehensive discharges, based on 18/19 FY data	Assumes amount paid for 03.03 Subsequent Daily Hospital Visit billed for inpatient days 4-7

Ongoing Care Bed Count formula:

Physician Resource Weighted beds – average daily admissions – average daily discharges = ongoing care bed count for each site

Physician Resource Weighted Bed Count formula:

[(# of medical unit beds multiplied by medical unit bed occupancy rate multiplied by # visits required per week for medical unit beds)
+
(# of RCU and TCU unit beds multiplied by RCU and TCU unit bed occupancy rate multiplied by # visits required per week for RCU and TCU unit beds)
+
(# of ALC unit beds multiplied by ALC unit bed occupancy rate multiplied by # visits required per week for ALC unit beds)]

divided by 7 days = weighted bed count for each site

The Physician Resource Weighted Bed formula and the Ongoing Care Bed Count formula will be used in the annual review of the daily stipend described below.

As at September 30, 2019, the weekly visit assumptions for each unit/bed type are:

Average visits required per bed type	
Unit Type	MD Visits per patient per week
Medical Unit	7
RCU and TCU Units	2.5
ALC units	1.5

As at September 30, 2019, the following data was used to calculate the Community Hospital In-Patient Model daily rates:

Site	Physician Resource Weighted Beds	Avg Daily Admissions	Avg Daily Discharges	Avg Daily Ongoing Care Beds	Daily Stipend Funding	Daily Category 1 On-Call Payments*	Daily Site Total Funding	Annual Site Total Funding (including on-call)
Inverness	28.0	2.06	2.08	23.85	$1,515	$332	$1,847	$674K
Strait-Richmond	14.6	1.72	1.75	11.10	$852	$332	$1,184	$432K
Northside	45.4	2.51	2.52	40.36	$2,378	$332	$2,710	$989K
Fisherman's	18.0	0.88	0.88	16.23	$932	$332	$1,263	$461K
Soldiers	20.5	1.91	1.97	16.62	$1,151	$332	$1,483	$541K
Queens	22.7	1.94	1.96	18.76	$1,253	$332	$1584	$578K
Hants	25.9	1.82	1.86	22.18	$1,393	$332	$1,725	$630K
Roseway	11.0	0.79	0.78	9.41	$592	$332	$924	$337K
New Waterford	19.9	0.90	0.91	18.09	$1,024	$332	$1,356	$495K

* This is the average daily call rate, calculated based on $300 for weekdays and $400 for weekend days and holidays, provided that Category 1 requirements described below are met.

The daily stipend will be reviewed in the event of any permanent changes to either the number or the designation of beds at a particular facility. Any changes to the daily stipend as the result of planned changes in bed number of designations will be implemented effective the date of the bed change. Notice of change will be provided to physicians and all signatories of this MOA 3 months in advance.

The daily stipends will also be reviewed annually by DHW and adjusted as required, based on utilization data provided to the DHW by the NSHA and using the formulae above. The analysis and decision(s) arising from the review of the daily stipends will be shared with DNS and the physicians participating in the Community Hospital In-Patient Model in advance of the end of each fiscal year. Funding changes are aligned to the April-March Fiscal year.

2. On-Call Stipends

The Community Hospital In-Patient Model provides a daily stipend of $300/day for weekdays, and $400/day for all weekends and holidays for the provision of call availability for a 24-hour period from 08:00 through to 08:00 the next day.

Physicians receiving this payment are expected to adhere to the guidelines defined for Category 1 call coverage as defined under the Facility On-Call Program, specifically:

- the physician group is required to provide 24/7/365 coverage;
- a written on-call schedule must be provided in advance to the Zone Medical Director;
- physicians must respond to calls within 10 minutes by phone and be able to be on site within 20 minutes if called in;
- physicians who have been called back to a facility to attend to a patient are eligible to bill fee-for-service for any services delivered outside of standard working hours, which for the purpose of this program is defined as 1700h through to 0800h the following day.

For the purposes of Community Hospital In Patient Model, any physician seeking to take on more than one call shift per day must have the prior written approval of the NSHA and must, as determined by the NSHA in the NSHA's sole discretion, be able to adhere to the criteria associated with category 1 on call.

3. MSU Funding Adjustments

The daily stipends will be increased each year based on the MSU increases as defined in the Physician Master Agreement. The MSU increase effective April 1, 2019 will be applied to the daily stipends.

4. Remuneration Principles

a. Fee-for-service physicians will not submit fee claims for inpatient services provided between 0800h and 1700h. Instead, these services will be shadow billed as outlined in Appendix A.

b. Services provided during the hours of 1700h through to 0800h the following day, when on call, can be claimed fee-for-service for all physicians, in addition to the daily stipend and on-call stipend.

c. Physicians on an alternative payment plan (APP) will see a reduction in their APP contract FTE equivalent to the lesser amount of:

   i. The portion of APP deliverables relating to inpatient services outlined in their APP deliverables, or

   ii. The total amount of shadow billing for inpatient services offered by that physician at the Community Hospital during the year prior to enrollment in the Community Hospital In-Patient Model.

5. Retroactive Compensation

a. For physicians who delivered inpatient care at the Community Hospital pursuant to an alternative payment plan during the retroactivity period:

$$Retro\ Payment = [Stipend\ in\ Retro\ Period] * [APP\ billing\ share] - [APP\ Inpatient\ \$]$$

- **Stipend in Retro Period** = Daily (non-call) stipend calculated at site multiplied by # days in retro period

- **APP billing share** = % of total inpatient billings (shadow & FFS) made by APP group in retro period
- **APP inpatient $** = Sum of each APP physician's APP FTE dedicated to inpatient work. This is the FTE amount that will be reduced from their contract when they join CHIP.
- **Retro Payment** = the amount that the APP group of physicians gets to divide amongst themselves.

b. For physicians who delivered inpatient care at the Community Hospital on a fee for service basis during the retroactivity period:

$$Retro\ Payment = [Stipend\ in\ Retro\ Period] * [FFS\ billing\ share] - [FFS\ Inpatient\ \$]$$

- **Stipend in Retro Period** = Daily (non-call) stipend calculated at site multiplied by # days in retro period
- **FFS Billing Share** = % of total inpatient billings (shadow & FFS) made by FFS physicians who will be part of the physician group in the retro period.
- **FFS Inpatient $** = Sum of all the FFS inpatient billings made by the FFS physicians who are part of the physician group during the retro period.
- **Retro Payment** = the amount that the FFS group of physicians gets to divide amongst themselves.

c. Once a physician group has implemented a site delivery plan as provided by article 4 of the Memorandum of Agreement, the Department of Health and Wellness will calculate the retroactive payment as noted above. The Department will provide its calculations to the physician group and the physician group will be responsible for submitting a claim for retroactive compensation to MSI as per Appendix A, clause 4.