MEMORANDUM OF AGREEMENT

BETWEEN

NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION

AND

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Date Signed: May 3, 2022 Expires: September 30, 2023

THIS AGREEMENT made this 3rd of May Anno Domini 2022.

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF NEWFOUNDLAND AND LABRADOR, represented herein by the President of the Treasury Board and the Minister of Health and Community Services (hereinafter referred to as the "Government")

of the one part

AND:

THE NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION, a body organized and existing under the laws of the Province of Newfoundland and Labrador and having its Registered Office in the City of St. John's (hereinafter referred to as the "NLMA")

of the other part

Together, the "Parties"

THIS AGREEMENT WITNESSETH that for and in consideration of the premises, covenants, conditions, stipulations, and provisos herein contained, the parties hereto agree as follows:

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SECTION A – GENERAL CONSIDERATIONS

Article 1 Purpose of Agreement

1.01 **WHEREAS**

a) Government and physicians share responsibility for the provision of medical services to the public;

b) Both parties agree that the delivery of medical services must take into full consideration:

(i) reasonable and fair compensation and working conditions for physicians providing insured medical services;

(ii) the need for sufficient physician resources to provide adequate medical care in Newfoundland and Labrador; and

(iii) the financial circumstances of Government; and

c) Government and the NLMA, on behalf of physicians, wish to establish a working relationship based on cooperation and good faith;

The parties have negotiated this Memorandum of Agreement with respect to levels of compensation, employment-related benefits and service coverage.

Article 2 Interpretation

Under this Agreement the following definitions will apply.

"Agreement" means this Memorandum of Agreement.

"Alternate Payment Plan (APP)" means an agreement between Government, a Regional Integrated Health Authority (RHA), and the NLMA, that provides remuneration in a format other than salary or fee-for-service (FFS) to a group of physicians in a specialty, including family medicine, in return for the provision of medical services.

"Consensus" means general agreement, characterized by the absence of sustained opposition to substantial issues by any of the voting members of a committee established under this Agreement, and by a process that involves seeking to take into account the views of all voting members and to reconcile any conflicting arguments. Consensus does not

require unanimity.

"Geographic Full-Time (GFT) physician" means a physician with clinical responsibilities who also has an academic teaching appointment at Memorial University. The compensation for the academic component is separate from the compensation for clinical work.

"Maritime Weighted Parity" means the weighted average formula agreed upon by the parties, the outcomes of which are used in this agreement.

"Fee-For-Service (FFS)" means the submission of accounts by and payment of fees to physicians for insured medical services in accordance with the MCP Payment Schedule under the Medical Care Plan, pursuant to the *Medical Care Insurance Act, 1999*, SNL 1999, C. M-5.1 ("*Medical Care Insurance Act, 1999*").

"Health and Community Services (HCS)" means the department or branch of the Government of Newfoundland and Labrador which provides leadership in health and community services programs and policy development for the Province.

"MCP Payment Schedule" means the schedule of fees payable, and the rules and conditions for payment of insured services provided by licensed physicians to beneficiaries under the *Medical Care Insurance Act, 1999* and the *Regulations* made thereunder.

"Newfoundland and Labrador Medical Association (NLMA)" means the medical association representing, advocating for, and negotiating on behalf of Newfoundland and Labrador physicians pursuant to the *Medical Act, 2011*, SNL 2011, c. M.-4.02.

"Physician" means a person who is lawfully entitled to engage in the practice of medicine in the Province pursuant to the *Medical Act, 2011*, SNL 2011 c. M.-4.02, and includes a person who, under the regulations, is entitled to provide insured services.

"Province" means the Province of Newfoundland and Labrador.

"Regional Health Authority (RHA)" means a Regional Health Authority for each health region of the Province established under the *Regional Health Authorities Act*, SNL 2006, c. R-7.1 to provide for the delivery and administration of health and community services in the health region.

"Salaried Physician" means a physician who is an employee of an RHA and who provides medical services as required by the RHA.

"Specialist" means a physician who is recognized as a specialist by the *College of Physicians and Surgeons of Newfoundland and Labrador* or a physician practicing outside the Province who is recognized as a specialist by the appropriate regulatory body in the

jurisdiction where the physician practices.

Article 3 **Term of Agreement and Interest Arbitration**

3.01 Notwithstanding the date of execution hereof and except as otherwise provided herein, this Agreement shall be effective from October 1, 2017 and shall remain in full force and effect until September 30, 2023.

3.03 Either party to this Agreement may at any time within the one hundred and eighty (180) calendar day period immediately preceding the September 30, 2023 expiration date of this Agreement, give written notice to the other party to commence negotiations for a new agreement.

3.04 Within thirty (30) days following the receipt of the notice referred to in Article 3.03 or a further time that the parties may agree upon, the parties hereto shall enter into good faith negotiations and use reasonable efforts to negotiate a new Agreement.

3.05 If at the expiration date of this Agreement a new agreement has not been negotiated replacing this Agreement, this Agreement shall continue and remain in full force and effect until a new agreement has either been negotiated replacing this Agreement or the terms and conditions of a new agreement have been determined by a combination of negotiation and arbitration as provided for in this Agreement.

3.06 The parties agree to the terms of interest arbitration as articulated at Schedule "N", Interest Arbitration.

Article 4 **Parties to the Agreement**

4.01 The parties to this Agreement are Government and the NLMA.

4.02 The parties recognize that, where applicable, the interests of Government may be represented by the President of Treasury Board and/or the Minister of Health and Community Services or any Minister as may be designated by Government from time to time.

Article 5 **Physicians' Negotiator**

5.01 The NLMA is recognized as the sole and exclusive negotiator on behalf of physicians licensed by the College of Physicians and Surgeons of

Newfoundland and Labrador to practice in this Province for matters which fall within the scope of this Agreement save and except physicians employed in the following positions:

(i) Vice President, Medical Services – Eastern RHA
(ii) Vice President, Medical Services – Central RHA
(iii) Vice President, Medical Services – Western RHA
(iv) Vice President, Medical Services – Labrador-Grenfell RHA
(v) Medical Director – Eastern RHA
(vi) Medical Consultant – HCS
(vii) Director of Physician Services – HCS
(viii) Assistant Director of Physicians Services – HCS
(ix) Chief Medical Examiner – Department of Justice and Public Safety
(x) Chief Medical Officer of Health – HCS

Article 6 Government Negotiator

6.01 The President of Treasury Board and/or any Minister as may be designated by Government from time to time is recognized as the sole and exclusive negotiator on behalf of Government for matters that fall within the scope of this Agreement.

Article 7 Subsidiary Agreements

7.01 All subsidiary agreements currently in effect between physicians, RHAs, the NLMA and Government shall be null and void effective the date of signing by all parties of the new Agreement and shall be replaced with the following:

(i) Waterford Physicians "On-duty, on-site" Payment Policy – Schedule "A"
(ii) Facility Workload Disruption Payment Policy for Fee-For-Service Physicians – Schedule "B"
(iii) Salaried Physician Retention Bonus Categories – Schedule "C"
(iv) Specialty Corrections Fund – Schedule "D"
(v) Alternate Payment Plans (APPs) – Schedule "E"
(vi) FFS Increases, By FFS Specialty Group – Schedule "F"
(vii) Approved Category 'A' Facilities (24-Hour On-Site Emergency Department Coverage) – Schedule "G"
(viii) Approved Category 'B' Facilities (24-Hour Emergency Department Coverage) – Schedule "H"
(ix) Obstetrical Bonus Policy for Salaried and Fee-For-Service Family

Physicians – Schedule "I"
(x) Family Practice Renewal Program – Schedule "J"
(xi) Physician Services Liaison Committee (PSLC) Terms of Reference – Schedule "K"
(xii) MCP Payment Schedule Review Committee (PSRC) Terms of Reference – Schedule "L"
(xiii) On-Call and Internal Locum Rates – Schedule "M"
(xiv) Interest Arbitration – Schedule "N"
(xv) Cataract Surgery Fees in Non-Hospital Designated Facilities – Schedule "O"
(xvi) Dispute Resolution – Schedule "P"
(xvii) Rural Community Comprehensive Care (RCCC) Bonus – Schedule "Q"

Article 8 **Government Rights**

8.01 All functions, rights, powers, and authorities, which are not specifically abridged, delegated or modified by this Agreement, are recognized by the NLMA as being retained by Government or its delegated authorities.

Article 9 **Effect of Legislation**

9.01 The parties acknowledge that legislation takes precedence over any provision of this Agreement. It is also acknowledged that should any legislation render null and void any provision of this Agreement, the remaining provisions shall remain in effect during the term of this Agreement.

Article 10 **Agreement to Amend**

10.01 It is agreed by the parties to this Agreement that any provision of this Agreement may be amended by mutual written consent of Government and the NLMA during the term of this Agreement.

Article 11 **Service Coverage**

11.01 Physicians commit to provide, in accordance with the negotiated MCP Payment Schedule and/or negotiated salary, insured services which have traditionally been funded through MCP and which the public might reasonably expect to be available, subject to resources and skill limitations.

11.02 The NLMA will make best efforts to encourage all practicing physicians providing clinical services in the Province to be credentialed and privileged with a RHA.

Article 12 Physician Services Liaison Committee (PSLC)

12.01 The parties agree to maintain the PSLC, through which medical issues of mutual concern may be addressed collaboratively and to act as an oversight body for the administration of this Agreement. The operation and mandate of the PSLC is described in Schedule "K".

Article 13 Dispute Resolution

13.01 In the event that a disagreement arises regarding the interpretation of this Agreement:

(i) Either party may refer the matter to the Physician Services Liaison Committee (PSLC) for resolution;

(ii) Should the PSLC be unable to resolve the matter, either party may refer the matter to mediation in accordance with the procedure outlined in Schedule "P". The mediator shall assist the parties in reaching a resolution. If resolution is not achieved the mediator will recommend a resolution for consideration by the parties. The cost of mediation shall be equally borne by the parties; and,

(iii) The parties may, at any time, by mutual agreement, engage the services of an arbitrator(s) in accordance with the *Arbitration Act, RSNL 1990 cA-14,* the cost of which arbitration shall be equally borne by the parties.

Article 14 Provincial Locum Recruitment Program

14.01 The Department of Health and Community Services will establish and resource a provincial physician locum recruitment program. This program will be funded by the Department and commence within six (6) months of the date of signing the MOA.

The program's mandate will be to match locums with locum opportunities, including the establishment and maintenance of a provincial physician

locum roster. The program objective is to bring about improved access to locums by community-based physicians and Regional Health Authorities and a more equitable distribution of locum assignments.

The implementation of the program will be monitored by the PSLC and will be evaluated by the PSLC for continuation after two (2) years of operation.

SECTION B - COMPENSATION ISSUES

Article 15 Fee-For-Service Compensation

15.01 Fee-For-Service Increases

Fee-For-Service (FFS) physician groups shall receive increased remuneration as follows:

(i) FFS physician groups identified as being under Maritime Weighted Parity using 2019-20 units and October, 2019 rates, will attain 100% of Maritime Weighted Parity, as of December 30, 2021. The 2019 – 2020 analysis requires overall funding of $22,618,949 (organized by Family Physicians ($12,149,564) and Specialists ($10,469,385)) to attain Maritime Weighted Parity. The percentage increases to attain 100% Maritime Weighted Parity, by physician group, derived from the 2019-2020 analysis are included in Schedule "F".

(ii) Family Physicians as a group will maintain access to funding under the Primary Care Renewal Program, as detailed in Schedule "J", attached.

(iii) A further amount will be allocated for increases to other items not considered under the Maritime Weighted Parity methodology. These include, but are not limited to, APP payments, sessional payments, FFS Intensive Care Unit (ICU) payments, surgical assisting payments, premiums for surgery fee codes, Category B payments, and Specialty Corrections in accordance with Schedule "D".

(iv) The funding identified in paragraphs 15.01(i) through (iii), above, will be distributed effective December 30, 2021.

(v) The $170,000 funding commitment for Psychiatry consultants from the former Clinical Stabilization Fund will continue to be

allocated annually, through the established methodology used during the term of the 2013-2017 MOA, and this allocation will be in addition to funding on which Maritime Weighted Parity is achieved.

(vi) The Maritime Weighted Parity formula will be reviewed by the parties prior to the next negotiation and any future use will be based on an agreed methodology.

15.02 Schedule of Payments

Until such time as the MCP Payment Schedule fee code allocation process is completed:

(i) FFS Physicians will continue to claim for services using MCP Payment Schedule rates in effect.

(ii) The applicable increase for each group will be paid as an adjustment in each pay period until such time as the Fee Code Allocation Process outlined below in Articles 15.03 and 15.04 is completed.

15.03 FFS Fee Code Allocation

Government and the NLMA will collaborate in the allocation of new funds to specific fee codes and rates for each specialty (the "FFS Fee Code Allocation Process").

The FFS Fee Code Allocation Process will be based on the following principles:

1. no fee code shall exceed the Ontario Health Insurance Plan rate for a comparable service unless mutually agreed;
2. there shall be no fee code allocation to offset overhead costs; and
3. there shall be no fee code allocation for currently non-insured services.

15.04 FFS Fee Code Allocation Process

The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine fee code allocation jointly and collaboratively by consensus. Any fee code allocation which has not been established through this collaborative process will be determined as outlined in steps (i) and (ii) below:

(i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

(ii) Within thirty (30) days of receipt of the information from the NLMA as referred to in 15.04 (i) HCS shall allocate the remaining 50% of the FFS increase.

15.05 MCP Payment Schedule Review Process

The parties agree to review the MCP Payment Schedule in accordance with the terms of reference of the MCP Payment Schedule Review Committee as set out in Schedule "L".

15.06 Category 'A' Designated Facilities – Emergency Department

With the exception of arrangements made under the Alternate Payment Plan for Adult Emergency Department (Health Science Centre/St. Clare's Mercy Hospital) as set out in Schedule "E", all FFS Physicians providing on-site coverage at Category 'A' designated emergency facilities, which are identified in Schedule "G", Approved Category 'A' Facilities (24-Hour On-Site Emergency Department Coverage), shall be compensated at an hourly rate as follows:

	December 30, 2021
Payment Rate	**$232.07**

15.07 Category 'B' Designated Facilities – Emergency Department

FFS Physicians providing emergency department (ED) services coverage at Category 'B' designated facilities, as more particularly set out in Schedule "H", shall be compensated as follows:

1. Payment for daytime ED coverage, 8 a.m. to 6 p.m., Monday – Friday:

   a) FFS Category 'B' Physicians:
      - $56.65 per hour (plus Fee-For-Service claims) as per the MCP Payment Schedule.

2. Payments for after-hours ED coverage, 6 p.m. to 8 a.m. Monday to Friday, all- day Saturday, all- day Sunday, and statutory holidays:

a) FFS Category 'B' Emergency Physicians may bill, at their discretion, either:
   - $78.84 per hour (no FFS claims); or
   - $56.65 per hour (plus Fee-For-Service claims) as per the MCP Payment Schedule.
   - The method of payment chosen by the physician must apply to the entire shift or period of coverage provided.

3. There are no additional payments available under the on-call program described in Article 15.12.

15.08 Retention Bonus – Rural FFS Specialists (excluding physicians on APPs)

FFS Specialists, who practice outside St. John's/Mount Pearl, will be eligible to receive an annual retention bonus based on accumulated service time, as follows:

After 12 Eligible Months	After 24 Eligible Months	After 36 Eligible Months
$5,000	$10,000	$15,000

Rules on eligibility have been determined by the parties and may be amended from time to time where appropriate.

15.09 Rural Community Comprehensive Care (RCCC) Bonus – Rural FFS Family Physicians

FFS Family Physicians, including physicians who transition to the Blended Capitation Model, will be eligible to receive the Rural Community Comprehensive Care (RCCC) Bonus as set out in Schedule "Q".

15.10 Canadian Medical Protective Association (CMPA) reimbursement for FFS Physicians

The parties agree that, for the term of this Agreement, the HCS's calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate. All other aspects of the payment policy in effect on the date of signing of this Agreement will remain unchanged.

15.11 Obstetrical Bonus

FFS Family Physicians are eligible for the Obstetrical bonus policy as outlined in Schedule "I", Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians.

15.12 Recognition of On-Call

(i) The rates for on-call billing and internal locum payments are set out in Schedule "M", On-Call and Internal Locum Rates.

(ii) General Obligations

a. On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency department;
- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

b. Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

c. The on-call services will operate from designated facilities.

d. Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients and make FFS claims related to them during the period they are also on-call for unattached patients.

e. Only on-call rotations recommended by a RHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

f. Physicians on APPs who have on-call payments factored

into their APP budget are not eligible to claim the on-call payment.

15.13 Surgical Assist - Dedicated time method Surgical Assistance

Until such time as the FFS Fee Code Allocation Process is completed:

- FFS Physicians should continue to claim for services using the rates in the MCP Payment Schedule in effect as of October 1, 2019. These payments will be increased based on the percentage increase being applied to all FFS Physicians;
- Retroactive payment to December 30, 2021 will be paid as expeditiously as possible after signing of this Agreement based on the percentage increase applicable; and,
- Following the retroactive payment, the applicable increase will be paid bi-weekly as required until such time as the FFS Fee Code Allocation Process is completed and new fees are implemented.

Article 16 Salaried Physician Compensation

16.01 Salary Scales

The salary scales for Family Physicians in Category 'B' Facilities, all other Family Physicians, Hospitalists, and Specialists are as follows:

December 30, 2021 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3
Family Physicians (Category 'B')	$163,812	$170,572	$177,333
Family Physicians	$198,724	$206,911	$215,097
Hospitalists	$217,525	$226,530	$235,535
Specialists	$263,672	$274,637	$285,596

Effective December 30, 2021, physicians will move to the new salary scales as follows:

(i) Physicians on Step 1, Step 2 and Step 3 of the October 1, 2016 Salary Scale will be placed on Step 1 of the December 30, 2021 Salary Scale;

(ii) Physicians on Step 4 of the October 1, 2016 Salary Scale will be placed on Step 2 of the December 30, 2021 Salary Scale; and

(iii) Physicians on Step 5 of the October 1, 2016 Salary Scale will be placed on Step 3 of the December 30, 2021 Salary Scale.

(iv) Notwithstanding the above, Oncologists and Pathologists on Step 3 or Step 4 of the October 1, 2016 Oncologist/Pathologist Salary Scale will advance to Step 2 or Step 3, respectively, of the December 30, 2021 Specialist Scale.

(v) Physicians will advance to next step on the Salary Scale on the anniversary date of their hiring. Physicians working less than full time hours will advance to the next step on a prorated basis.

16.02 Per Diem Locum Rates

Locum rates paid under this Agreement shall be as follows:

	December 30, 2021
Family Physicians (Category 'B')	$825
Family Physicians	$995
Hospitalists	$1,090
Specialists	$1,335

16.03 Category 'B' Designated Facilities – Emergency Department

Salaried physicians providing emergency department (ED) services coverage at Category 'B' designated facilities, as more particularly set out

in Schedule "H", shall be compensated as follows:

1) Payment for daytime ED coverage, 8 a.m. to 6 p.m., Monday – Friday:

   a) Salaried Category 'B' Physicians:
      - Included in the bi-weekly salary

   b) Salaried Locum Category 'B' Physicians:
      - Included in the daily locum rate

2) Payments for after-hours ED coverage, 6 p.m. to 8 a.m. Monday to Friday, all- day Saturday, all -day Sunday, and statutory holidays:

   a) Salaried Category 'B' Physicians:
      - $78.84 per hour (no FFS claims permitted)

   b) Salaried Locum Category 'B' Physicians;
      - $78.84 per hour (no FFS claims permitted)

   c) Salaried Family Physicians at Category 'B' facilities:
      - Remain eligible for their annual Retention bonus;
      - Are not eligible for the annual after-hours coverage payment; and
      - Are not eligible for participation in the provincial on-call program.

16.04 Geographic Retention Bonuses

The geographic locations encompassed by the categories outlined below are set out in Schedule "C", Salaried Physician Retention Bonus Categories, and are to be paid on the salaried physician's anniversary date.

a) Retention Bonuses – Salaried Family Physicians

Retention bonuses will be paid to Salaried Family Physicians including those at Category 'B' Facilities as follows:

	Level 1 After12 Eligible Months	Level 2 After 24 Eligible Months	Level 3 After 36 Eligible Months
Category 0	$12,500	$25,000	$37,500
Category 1	$7,500	$15,000	$22,500
Category 2	$5,000	$10,000	$15,000

b) Retention Bonuses – Salaried Specialists

Retention bonuses will be paid to Salaried Specialists, including Oncologists/Pathologists, as follows:

	Level 1 After 12 Eligible Months	Level 2 After 24 Eligible Months	Level 3 After 36 Eligible Months
Category 0	$14,000	$28,000	$42,000
Category 1	$8,000	$16,000	$24,000
Category 2	$4,000	$8,000	$12,000

16.05 Obstetrical Bonus

Salaried Family Physicians are eligible for the Obstetrical Bonus Policy as outlined in Schedule "I", Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians.

16.06 Oncology and Pathology Bonus

The Oncology and Pathology Bonus is paid out on the physician's anniversary dates as follows:

Step	1	2	3
Amount	$50,000	$56,250	$60,000

16.07 Recognition of On-Call

(i) The rate for on-call billing and internal locum payments for each physician group is included in Schedule "M", On-Call and Internal Locum Rates.

(ii) General Obligations:

(a) On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, or treating, or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency department;
- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

(b) Approved on-call rotations must follow a defined on-call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

(c) The on-call services will be based from designated facilities.

(d) Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients during the period they are on-call for unattached patients.

(e) Physicians shall not accrue a responsibility to perform call duties for any call rotations occurring during periods of annual or other forms of leave. This provision will take effect ninety (90) days following the date of signing this Agreement.

(f) Only on-call rotations recommended by a RHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

(g) Physicians on APPs who have on-call payments factored into their APP budget are not eligible to claim the on-call payment.

16.08 Critical Escort Duty

The hourly rate for critical escort duty is $115.56.

16.09 University Physicians (Geographic Full-Time - "GFT")

(i) The compensation for GFT physicians working at 0.8 clinical FTE will be at 90% of the applicable salary scale. Compensation for GFT physicians working at less than 0.8 clinical FTE will be proportionate to their clinical FTE status. For example, a GFT physician working at 0.5 clinical FTE will be remunerated as follows: 0.5/0.8 x 90% of applicable salary scale.

(ii) Whereas the parties have agreed to incorporate the relative value of the After-Hours/On-Call Bonus and the Category 3 Geographic Retention Bonus into the salary scales, the parties agree that these bonuses will be incorporated into GFT compensation at 100% of their value, except where a GFT physician works at less than 0.8 clinical FTE in which case the bonus will be proportionate to their clinical FTE status as set out in 16.10(i).

16.10 Registered Retirement Savings Plan (RRSP)

(i) Government commits to maintaining an employer-sponsored salaried physician RRSP.

(ii) As a condition of employment all salaried physicians, except those participating in the Public Service Pension Plan pursuant to an election made prior to November 30, 2000, are required to participate in the employer-sponsored RRSP.

16.11 Market Adjustment Policy

The Treasury Board Secretariat, Market Adjustment Policy is applicable to Salaried Physicians and may be used by a Regional Health Authority where it determines that it is unable to recruit salaried physicians in specific positions at a particular geographic site. Subject to the approval of the Treasury Board Committee of Cabinet, the Regional Health Authority may approve and provide benefits to salaried physicians beyond those benefits outlined in the MOA.

The relevant policy and guidelines are posted on the Treasury Board website and the parties acknowledge that any policy modifications are within the sole purview of the Treasury Board Secretariat.

Article 17 Other Compensation Issues

17.01 Transitioning of Hospital Services

(i) The parties agree to establish a committee (consisting of two members appointed by the NLMA and two members appointed by HCS) to consider the options available for the potential to have FFS Physicians perform in private medical offices, surgical, diagnostic or therapeutic procedures that at present are non-insured services unless they are provided in facilities listed in the *Hospital Insurance Regulations* Schedule under the *Hospital Insurance Agreement Act*. The following issues will be reviewed:

a) Timeliness of care and follow-up;
b) Appropriateness of the service;
c) Cost-effectiveness of the service;
d) Identification of a quality assurance program for the service; and
e) Monitoring of the service.

(ii) The Committee's sole responsibility will be to make recommendations to the Minister of HCS related to the issues stated above, once per annum. Decisions regarding recommendations made to the Minister will be made by consensus. Such recommendations will not impact the Minister's discretion in determining which, if any, hospital-based services may be insured when provided within private offices by FFS Physicians.

17.02 Blended Capitation Program

The parties commit to establishing a Blended Capitation model of payment as a new Schedule to the MOA, using the following processes:

a) The parties will use their best efforts to negotiate a complete program design for Blended Capitation within six (6) months of signing the MOA. The parties' proposals used in the negotiation of this MOA will be part of the information considered in the Blended Capitation negotiations.

b) If after six (6) months the parties are making progress on establishing a Blended Capitation model, the negotiations may continue if both parties agree. At any time after the six (6) month anniversary of signing the MOA, either party may refer the outstanding matters to mediation in accordance with Article 13. To

the extent any part of this Article differs from Article 13, this Article will prevail.

c) If the parties cannot agree upon a mutually agreeable mediator within ten (10) calendar days, then either party may request the Atlantic ADR Institute in writing, to name a mediator from the roster of arbitrators established by the Labour Management Arbitration Committee of the Labour Relations and Standards Division.

d) The mediation process will commence on the date the mediator is appointed and will be conducted for up to six (6) weeks unless otherwise extended by mutual agreement of the parties. After six (6) weeks, the mediator will have ten (10) calendar days to submit their report with recommendations.

e) The parties will have ten (10) calendar days to consider the mediator's report and recommendations, after which either party may refer any outstanding matters to arbitration.

f) If the parties cannot agree on the selection of an arbitrator within ten (10) calendar days from the date of referral to arbitration, then either party may apply under the *Arbitration Act, RSNL 1990, c. A-14* for judicial appointment of a single arbitrator.

g) The arbitration shall be governed by the provisions of the *Arbitration Act, RSNL 1990, c. A-14.*

Unless the parties agree otherwise, the decision of the arbitrator will, along with any matters previously agreed upon, constitute the new Blended Capitation program and will be placed in a Schedule to the MOA.

17.03 Sessional Hospitalist Daily Rate

The Sessional Hospitalist Daily Rate is $1,236 per 8-hour shift.

The requirements for a Family Physician working under a Sessional Hospitalist Daily Rate arrangement are:

(i) Enter into a contractual arrangement with a Regional Health Authority in order to be rostered and/or assigned a schedule.

(ii) Participate in the hospitalist on-call service at the respective site which will be compensated by the Family Physician on-call per diem and FFS billing for services provided after-hours.

(iii) Provide comprehensive medical care to hospitalized patients. The Physician will normally be responsible for 15-20 patients, but the workload may vary periodically, up or down, within a site based on the health status and complexity of the patients presenting, and after consultation with the physician about the ratio of "medically active" versus "alternate level of care" patients.

Physicians who receive the Sessional Hospitalist Daily Rate are eligible to receive payments under the Internal Locum Policy.

17.04 Virtual Care

The PSRC will consider data with respect to the trends and patterns in the utilization of virtual care. Best efforts will be made by the PSRC to complete a final set of virtual care fee codes within six (6) months of the date of signing the MOA.

SECTION C - SALARIED PHYSICIANS - TERMS AND CONDITIONS OF EMPLOYMENT

The terms and conditions of employment for salaried physicians under this Agreement supersede all other conflicting terms and conditions within employer human resource policies.

Article 18 Definitions

18.01 (a) Probationary Period

All newly hired salaried physicians shall be required to serve a twelve (12) month probationary period during which time the performance of the salaried physician shall be reviewed by RHA designate and, if unsatisfactory, the employment of the salaried physician shall be terminated. If successful, the salaried physician shall be given a letter by the RHA confirming the completion of the probationary period.

(b) Month of Service
Means a calendar month in which the salaried physician is in receipt of full salary for that month and includes any month in which the salaried physician is on approved leave of absence without pay, which leave shall not be in excess of twenty (20) days.

(c) Scale Definitions
The scale definitions contained in the Terms and Conditions of Employment for Salaried Physicians shall continue to apply until such time as amended by the mutual consent of the parties to this Agreement.

Article 19 Termination

19.01 A salaried physician is required to give the Employer three (3) months written notice of resignation and the Employer is required to give a salaried physician three (3) months written notice of termination of employment, except for just cause where no notice is required.

Article 20 Advertising of Vacancies

20.01 Physicians may apply for vacant publicly-funded salaried physician positions within Newfoundland and Labrador, as advertised by the Employers.

Article 21 Part-Time Salaried Physicians

21.01 Salaried physicians working less than a full schedule are considered part-time and are covered by this Agreement for the purpose of benefits outlined in this Agreement, which they shall receive on a prorated basis based on the work week and the specific arrangements they have with their Employer. The method of prorating will be defined in the letter of appointment from the Employer.

Article 22 Statutory Holidays

22.01 There shall be a total of nine (9) paid statutory holidays for salaried physicians. The Employer shall define the days on which those nine (9) paid statutory holidays will be observed. Whether or not a salaried physician is required to work on a paid statutory holiday shall be determined in consultation with the Vice President of Medical Services or designate where

the salaried physician works.

22.02 If a salaried physician is required to work and works on a paid statutory holiday, they shall be scheduled to take another day off with pay in lieu of that holiday within ninety (90) days of the holiday. If the day off is not scheduled by the Employer within ninety (90) days, the day off with pay in lieu of the holiday will be taken at a time before the end of the fiscal year, as mutually agreed upon between the salaried physician and authorized in writing by the Vice President of Medical Services or designate. The day off with pay in lieu of the holiday will not be carried forward more than one fiscal year. It is the responsibility of the Employer to schedule this leave. If leave is carried over to the next fiscal year and is not taken in that fiscal year, it will be paid out in April of the following fiscal year.

22.03 A salaried physician required to provide on-call for a portion of the paid statutory holiday shall be deemed to have worked during the holiday. A paid statutory holiday shall be the twenty-four (24) hour period commencing at 00:01 on the day designated by the Employer as the paid statutory holiday.

Article 23 Annual Leave

23.01 Salaried physicians shall be entitled to annual leave as follows:

(a) Twenty (20) days per year for salaried physicians with one (1) year to ten (10) years of service as a salaried physician.

(b) Twenty-five (25) days per year for salaried physicians with more than ten (10) years of service but less than twenty-five (25) years of service as a salaried physician.

(c) Thirty (30) days per year for salaried physicians with twenty-five (25) years of service or more as a salaried physician.

(d) A year of service is equivalent to twelve (12) months of service as a salaried physician.

(e) Annual leave is an accumulative benefit and any unused annual leave is payable on termination of employment.

(f) A physician may carry forward to another year any portion of annual leave not taken by them in previous years until, by doing so they have accumulated a maximum of:

(i) twenty (20) days annual leave, if the physician is eligible to receive twenty (20) days in any year;

(ii) twenty-five (25) days annual leave, if the physician is eligible to receive twenty-five days in any year; and

(iii) thirty (30) days annual leave, if the physician is eligible to receive thirty (30) days in any year.

Each of the above accumulations is in addition to the physician's current annual leave entitlement. Physicians with additional accumulated time as of May 15, 2003 will have that time "grandparented". However, these physicians will be subject to this policy for any future year's accumulated annual leave.

Article 24 Approval for Leaves of Absence

24.01 All leaves of absence, paid or unpaid, require the prior approval of the Vice President of Medical Services or designate. Salaried physicians shall submit requests for leave in writing and give as much notice as possible.

Article 25 Bereavement or Compassionate Leave

25.01 A salaried physician shall be entitled up to three (3) days paid compassionate leave upon the death of the salaried physician's mother, father, brother, sister, child, spouse, common-law spouse, grandmother, grandfather, grandchild, father-in-law, mother-in-law. If the salaried physician is required to travel outside the Province, one (1) additional day with pay shall be granted. In extraordinary circumstances, the Employer may grant additional unpaid leave. This leave is not cumulative and is not payable on termination or resignation.

Article 26 Compensatory Leave

26.01 All salaried physicians (excluding Casualty Officers) employed by the Employer will be entitled to one (1) week (five (5) working days) of compensatory leave once the salaried physician completes one (1) year of service with that Employer. Salaried physicians maintain eligibility for compensatory leave if their area of employment changes, (i.e. RHA). Such leave is cumulative and payable on termination of employment.

Article 27 **Deferred Salary Plan**

27.01 With the approval of the Employer, salaried physicians shall be eligible to access the deferred salary plan with those Employers who have made the arrangements with Canada Revenue Agency.

Article 28 **Family Leave**

28.01 A salaried physician who is required to attend to the temporary care of a family member living in the same household, or to attend to needs relating to the birth of the salaried physician's child, or to attend to matters relating to a home or family emergency, shall be allowed up to three (3) days paid family leave in any calendar year provided that no other person was available to attend to these needs and provided that the salaried physician gave the Employer as much notice as possible. This leave is non-cumulative and is not payable on termination of employment.

Article 29 **Maternity Leave, Adoption Leave and Parental Leave**

29.01 A salaried physician is entitled to a maximum of fifty-two (52) weeks unpaid maternity, adoption or parental leave.

29.02 A salaried physician may request maternity leave without pay which may commence prior to the expected date of delivery.

29.03 Adoption leave shall be granted to a salaried physician who legally adopts a child and upon presentation of proof of adoption.

29.04 A salaried physician may return to duty after two (2) weeks' notice of their intent to do so.

29.05 A salaried physician shall resume their former salary upon return from leave, with no loss of accrued benefits.

29.06 Periods of leave of up to fifty-two (52) weeks without pay for maternity, adoption, or parental leave(s) shall be counted for accumulation of annual or paid leave entitlement, sick leave, severance pay, and step progression.

29.07 Salaried physicians on maternity, adoption or parental leave will continue to pay their portion of group insurance premiums to a maximum of fifty-two (52) weeks, unless they provide proof of alternative coverage and sign a waiver declining continued coverage. When a salaried physician opts to

continue to pay their portion of group insurance premiums, the Employer shall also pay its share of the group insurance premiums.

29.08 Neither the salaried physician nor the Employer will be required to contribute to the Employer group RRSP plan during the period of maternity, adoption or parental leave.

29.09 A salaried physician may be awarded sick leave for illness that is a result of or may be associated with pregnancy.

29.10 The Employer may grant a leave of absence without pay when a salaried physician is unable to return to duty after the expiration of this leave.

Article 30 Education Leave

30.01 (a) After applying in writing, and upon receiving approval from the Employer, each salaried physician is entitled to take up to five (5) days paid leave per calendar year to attend educational sessions such as conventions or refresher courses.

(b) The five (5) days paid education leave, which are non-cumulative, are in addition to Study Leave benefits.

(c) Education leave is not payable on termination of employment.

(d) A salaried physician is to apply to their Employer for education leave as far in advance as possible.

Article 31 Paid Leave Program

31.01 Physicians who have been participating in the paid leave program since September 1, 2002 will remain eligible for the program under the same conditions as all other entrants; however, no further entrant will be permitted. A list of the current physicians participating under this program has been provided to the NLMA.

31.02 Salaried physicians who are under the paid leave program will continue to receive the benefit of the paid leave program as long as the program stays in place with that Employer, or until the salaried physician leaves that Employer. Salaried physicians who are on a paid leave program will not be entitled to annual leave or sick leave under this Agreement.

Article 32 Sick Leave

32.01 (a) The total amount of sick leave which may be awarded to a salaried physician is calculated by multiplying the number of months of service by two (2) to a maximum of four hundred and eighty (480) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

(b) Notwithstanding Article 32.01(a), the total amount of sick leave which may be awarded to a salaried physician hired after October 1, 2005 is calculated by multiplying the number of months of service by one (1) to a maximum of two hundred and forty (240) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

32.02 At any occasion if the Employer feels the salaried physician is either excessively using sick leave or misusing sick leave, the Employer may request a medical certificate.

32.03 Sick leave is an accumulative benefit, but it is not payable on termination of employment.

Article 33 Unpaid Leaves of Absence

33.01 With the approval of the Employer, a salaried physician may be granted leaves of absence without pay provided that the salaried physician has no annual or paid leave available.

Article 34 Study Leave

34.01 Salaried physicians are entitled to study leave provisions as follows:

(a) Study leave is available to prepare for and write the licensing and certification exams.

(b) Study leave may also be used for select courses that enhance a particular physician skill set. The skills required and corresponding courses must be based on patient needs in a particular region, as deemed appropriate and approved by the Employer.

(c) Study leave may not be used for any other purpose than described above. Excluded purposes include Maintenance of Certification (Royal College) and Maintenance of Proficiency Program (College of Family Physicians)

requirements, conferences, research, reading reports and publications, and activities for which education leave is applicable.

(d) A salaried physician taking study leave is entitled to ten (10) days paid study leave per year. A salaried physician who does not take study leave in year one (1) and year two (2), but who wishes to take accumulative study leave in year three (3), would be entitled to take up to sixty (60) days paid study leave.

(e) A salaried physician who does not take study leave in years one (1) to three (3), but who wishes to take accumulative study leave in year four (4), would be entitled to take up to eighty (80) days paid study leave.

(f) A salaried physician who does not take study leave in years one (1) to four (4), but who wishes to take accumulative study leave in year five (5), would be entitled to take up to one hundred twenty (120) days paid study leave.

(g) Accumulative study leave may be taken in respect to any three (3) year, four (4) year, or five (5) year period in accordance with the above.

(h) A salaried physician's study leave entitlement is reduced by the actual number of days of study leave that are taken in a particular year.

E.g., In the case of a salaried physician who has accumulated three (3) years of entitlement, this physician may use the sixty (60) days during year three (3) as a single block or on separate occasions. Once the physician uses all or a portion of their entitlement in a particular year, no balance can be carried to the following year. In the year following, the physician's entitlement will reset to ten (10) days. If the entitlement is not used, accumulation may continue, and the entitlement will be available, until the year in which all or a portion of the entitlement is used.

(i) Study leave must be requested in writing at least three (3) months prior to the beginning of such leave and must be approved by the Employer.

(j) A salaried physician will be paid full salary during study leave, assuming that the salaried physician is receiving no additional remuneration. The salaried physician is required to declare any additional remuneration received. Salary while on study leave will be reduced proportionately to any additional remuneration received, unless otherwise approved by the Employer.

(k) A salaried physician taking study leave must agree that following the conclusion of the study leave they will provide salaried service with the

same Employer for a period that is twice the length of the study leave.

(l) Study leave is not payable on termination of employment.

Article 35 Additional Billings

35.01 Billing for Non-Insured Services

Salaried physicians may direct bill for any services not insured under provincial legislation. Salaried physicians are entitled to bill WorkplaceNL for services provided to persons covered by the WorkplaceNL plan, insurance companies for routine medical examinations of insured people, and other provincial medical care plans in respect of services provided to non-residents covered by such plans. Salaried physicians may submit bills to individual residents of the Province who are not covered by the Province's Medical Care Plan, including those covered by legislation of the Government of Canada, such as, war veterans with disabilities, and members of the Canadian Armed Forces.

35.02 Billing for Insured Services

Salaried physicians can bill Fee-For-Service when they are on an approved leave of absence from the Employer. This arrangement requires the approval, in writing, of the Physician Services Division of the Department of Health and Community Services.

Article 36 Professional Liability Insurance

36.01 Before commencing practice, every salaried physician must obtain professional liability insurance. Salaried physicians are responsible for paying their own professional liability insurance.

36.02 Notwithstanding Article 36.01, the parties agree that, for the calendar year 2017 (rebate paid out in 2018) and until the end of the term of this Agreement, the RHAs' calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate.

Article 37 **Severance Pay**

37.01 A salaried physician who has one (1) or more years of continuous employment with any employer covered under these Terms and Conditions of Employment is entitled to be paid, or in the event of their death, the employee's estate is entitled to be paid, severance pay equal to the amount obtained by multiplying the number of completed years of continuous employment with the Employer(s) by the salaried physician's weekly salary to a maximum of twenty (20) weeks.

37.02 Continuous service shall not be deemed to have been broken where a salaried physician is on approved unpaid leave. However, the time spent on such approved unpaid leave shall not be counted as a part of the time worked in the computation of the entitlement to severance pay, except as specifically provided for in this MOA (maternity, adoption, or parental leave).

37.03 Effective June 30, 2019, there shall be no further accumulation of service for severance pay purposes and severance pay will be calculated at weekly salary rates that were in effect on June 30, 2019.

37.04 Salaried physicians may elect which of the last three quarters of the 2022/23 fiscal year to receive their severance entitlement. The weekly salary, the length of service used for calculating severance entitlement, and the position used shall be that in effect on June 30, 2019. The last three quarters of the fiscal year 2022/23 are; July 1, 2022 to September 30, 2022; October 1, 2022 to December 31, 2022; and January 1, 2023 to March 31, 2023. A physician shall notify their employer in writing no later than June 30, 2022 in which of those quarters they wish to receive their severance entitlement. Furthermore, a physician shall indicate in their written notification if they wish to have all or a portion of their severance entitlement paid into an RRSP. Where a physician fails to indicate same, they shall be paid their full severance entitlement by March 31, 2023.

Article 38 **Meal Rates and Kilometre Rates for Use of Own Vehicle**

38.01 Salaried physicians who are authorized by the Employer to travel on employer business shall be reimbursed the appropriate meal and mileage rates in accordance with Government's Treasury Board approved Meal Rates and Transportation policies, which policies may be amended from time to time.

Article 39 Relocation Expenses

39.01 A salaried physician who is required by the Employer to relocate from one geographical location to another shall be compensated by the Employer for expenses that are legitimately and directly associated with this move. Such compensation shall be in accordance with Government's Treasury Board approved relocation expense policy, which may be amended from time to time.

Article 40 Damage or Loss of Personal Property

41.01 Where a salaried physician in the performance of their duties suffers a loss of any personal property, and it can be determined that the salaried physician would reasonably be expected to have such property in their possession during the performance of their duties, such loss shall be reported in writing by the salaried physician to the Employer within two (2) days of the loss, and if such loss was not due to the salaried physician's negligence, the Employer may compensate for such loss up to a maximum of three hundred dollars ($300.00) per incident.

Article 41 Workers' Compensation

42.01 The *Workplace Health, Safety and Compensation Act* applies to all salaried physicians.

Article 42 Health Benefits

43.01 Salaried physicians are eligible for the group insurance benefits as outlined in Government of Newfoundland Group Insurance Plan, which may be amended from time to time. A summary of the Plan in effect at the date of signing will be attached as an Appendix to the Terms and Conditions of Employment for Salaried Physicians.

IN WITNESS WHEREOF the parties hereto have executed this Agreement the day and year first before written.

SIGNED on behalf of Treasury Board representing Her Majesty the Queen in Right of Newfoundland by the Honourable Siobhan Coady President of Treasury Board, and the Honourable Dr. John Haggie, Minister of Health and Community Services, in the presence of the witness hereto subscribing:

Witness

Minister of Finance
President of Treasury Board

May 3, 2022
Date

May 3, 2022
Date

Witness

Minister, Health and Community Services

May 3/22
Date

May 3 2022.
Date

SIGNED on behalf of the Newfoundland and Labrador Medical Association by its proper officers in the presence of the witness hereto subscribing:

Donna Osmond
Witness

President, NLMA

May 2, 2022
Date

May 2/22
Date

Schedule "A"

Waterford Physicians "On-duty, on-site" Payment Policy

Salaried Family Physicians employed at the Waterford Hospital (Eastern RHA) are required to remain on-site when designated to provide On-duty services, including emergent In-patient services and Emergency Department Coverage. In general, the GP designated as being "On-duty" provides 24 hours of coverage.

The GP designated as being "On-duty, on-site" will be eligible to receive this payment in addition to the provincial On-call per diem fee in effect at the time. The On-duty, on-site per diem rates are:

Weekdays – Monday to Friday	$676
Weekends – Saturday and Sunday (includes statutory holidays)	$1,287

In addition to the payment rates noted above, after a physician provides three (3) weekday shifts and one (1) weekend or statutory holiday shift in a month, the per diem rates will be $1,436 and $2,160 for weekdays and weekends/statutory holidays respectively.

This payment model may be changed, by mutual agreement of the parties, upon redesign of the service, after moving to the new Mental Health and Addictions facility.

Schedule "B"

Facility Workload Disruption Payment Policy for Fee-For-Service Physicians

Definitions:

"Facility" means a publicly funded, Regional Health Authority-operated hospital/site

"Group" means any specialty or subspecialty working in a "Facility" that maintains a distinct on-call rota as per the Department of Health and Community Services *On-Call Payment Program* or a group that is unable to work due to the Emergencies Only Status.

"Daily salary rate of pay" (DSRP) means the top of the appropriate salary scale divided by 240.

Policy:

In the event that a Facility is forced to:

a) adopt an Emergencies Only Status, which is any mandatory closure that results in the delivery of only essential and emergency service; or

b) unexpectedly close all or a portion of a Facility (e.g., weather event, non-physician labour disruption, maintenance issue, etc.),

the following arrangement can be invoked which will provide an optional payment arrangement based on the DSRP for groups of facility-based, Fee-For-Service (FFS) physicians.

General:

1. To receive payment under this policy a physician must:
   i. be part of a Group which has opted to invoke the DSRP in lieu of FFS payment; and
   ii. be available to work as required by the VP Medical Services (or designate) during the Emergencies Only Status; and
   iii. be willing to provide those services, as reasonably requested by the VP Medical Services (or designate), that may be outside of their normal scope of practice but within their competency.

2. Physicians may remain FFS at a facility where the remainder of the Group have invoked the DSRP, and to do so shall require the written authorization of the VP Medical Services (or designate).

3. Physicians who do not meet the requirements of this policy are not eligible

for payment under this policy.

Principles:

1. Any Group of physicians can invoke the DSRP in lieu of FFS. Specialties that provide city-wide on-call can be divided into groups by facility, provided the normal on-call rotation is maintained. To invoke the DSRP, it is necessary that all members of the Group who remain during either the Emergencies Only Status or "facility closure" period, accept the DSRP with the exception noted in Principle #2 below.

2. A physician who is part of a Group affected by b) above may apply to remain FFS in situations where the facility closure is partial, and some routine services are maintained or when start up is partial. When choosing to do so, it is for the duration of the partial or complete facility closure (see rules related to this outlined in Implementation #3 below).

3. It is understood that physician groups who accept DSRP will be on site during normal working hours. A physician who is receiving DSRP will not be eligible for education leave or vacation time.

4. Notwithstanding the requirement that a physician is required to be "physically present", the VP Medical Services may authorize work off site via virtual care when appropriate and safe to do so.

5. Normal on-call coverage must continue to be provided during the Emergencies Only Status or the "facility closure" period.

Application:

Physician groups who invoke the DSRP will receive payments directly from MCP.

1. Payments will be bi-weekly, based on current MCP FFS payment dates, prorated for the applicable time period.

2. For those physicians who accept the agreement above, no FFS or sessional claims will be accepted for services rendered while this arrangement is in effect (except as permitted under Principles #4 above). Following termination of this arrangement, billings will be monitored to ensure that stockpiling of claims has not occurred.

3. If the work disruption event allows for the gradual restarting of services FFS and sessional claims may be permitted, at the discretion of the VP of

Medical Services, in consultation with the Department of Health and Community Services. The DSRP amount paid will be adjusted to reflect billings received in such cases. If a physician bills MCP an amount above the DSRP then no work disruption payment is necessary.

Implementation:

1. To initiate this policy, it is required that written notice be sent by the VP of Medical Services of the Regional Health Authority to the HCS Director of Medical Services, stating the date the Emergencies Only Status or "facility closure" status was activated. Such notice is to normally be provided within 24-hours of the start of the event.

2. Written acceptance of the payment arrangement for the duration of the Emergencies Only Status or "facility closure" period must be received in writing from every member of any eligible physician group. The Chief of Staff/designate at the Facility will coordinate the collection of signatures and submit them to the VP of Medical Services of the Regional Health Authority.

3. For a physician or physicians who apply to remain FFS but is/are part of a group that has chosen to accept the DSRP, such approval will only be granted when there is conclusive evidence that the work/on-call schedules have been maintained as would have occurred prior to the work disruption. The Regional Health Authority's VP of Medical Services will request such information and provide it to the HCS Director of Medical Services. The HCS Director of Medical Services will review the information and decide whether approval will be granted.

4. This arrangement will stay in effect for physicians who accept DSRP until written notice of the earlier of:

    a. discontinuation of the Emergencies Only Status or "facility closure" by the administration of the Facility to the HCS Director of Medical Services; or

    b. written agreement by all Group physicians to discontinue the arrangement.

Schedule "C"

Salaried Physician Retention Bonus Categories

The categories for retention bonuses shall be as listed below, or as modified according to the mutual agreement of the parties. If additional communities are identified, they shall be assigned to Category 2 unless otherwise agreed to by all the parties.

Salaried Family Physician Retention Bonus Table:

Category 0
Labrador

Category 1

Baie Verte	Buchans	Burgeo	Cow Head
Flowers Cove	Fogo	Hampden	Harbour Breton
Hermitage	Jackson's Arm	La Scie	Mose Ambrose
Norris Point	Port Saunders	Ramea	Roddickton
St. Alban's	Trepassey	Woody Point	

Category 2

Bay L'Argent	Bell Island	Bonavista	Botwood
Brookfield	Burin	Cape St. George	Carmanville
Centreville	Codroy Valley	Ferryland	Gambo
Glovertown	Grand Bank	Hare Bay	Lewisporte
Lourdes	Marystown	Musgrave Harbour	Musgravetown
Old Perlican	Placentia	Port aux Basques	Springdale
St. Anthony	St. George's	Stephenville Crossing	St. Lawrence
Terrenceville	Trinity	Twillingate	Virgin Arm
Western Bay	Whitbourne	Jefferies	

Salaried Specialist Retention Bonus Table:

Category 0
Labrador

Category 1

Burin	St. Anthony

Category 2

Carbonear	Clarenville	Corner Brook	Gander
Grand Falls-Windsor	Stephenville		

Schedule "D"

Specialty Corrections Fund

The Parties agree that the following amounts for each specialty will be allocated into the MCP Payment Schedule through micro-allocation according to the following procedure:

Specialty Group	Dollar Allocation	Fund Remaining After Fee Code Micro-Allocations
Orthopedics	$2,529,608	$1,769,094
Plastic Surgery	$260,525	$0
Neurology	$265,997	$33,545
Psychiatry	$143,870	$0

1. Under the 2017-2023 MOA:

    a) for each of the four specialties, if the amount is insufficient for the specialty to reach Maritime Weighted Parity, the whole allocation will be used in fee code micro-allocations for those specialties;

    b) if the allocation for a specialty is more than sufficient for the discipline to reach Maritime Weighted Parity, the amount that is sufficient to reach Maritime Weighted Parity will be used in fee code micro-allocations for those specialties; and,

    c) any surplus funding not required for Maritime Weighted Parity under the 2017-2023 MOA will be allocated to members of the relevant specialties each year according to the same administrative practices in place prior to the signing of the 2017-2023 MOA.

2. In the future, when there is a general adjustment to the MCP Payment Schedule for purposes of Maritime Weighted Parity, the surplus funding noted in 1. (c) above will be allocated into the fee schedule consistent with 1. (a) and (b) above, and any remaining surplus will be managed in accordance with 1. (c) above. The funding will be fully depleted when the total amount of $3.2M is allocated to fee codes.

Schedule "E"

Alternate Payment Plans (APPs)

The following is a list of APPs in effect as of December 30, 2021:

Eastern Health

a) Adult Critical Care
b) Adult Emergency Department (Health Sciences Centre/St. Clare's Mercy Hospital)
c) Adult Haematology/Oncology
d) Anaesthesia (Carbonear General Hospital)
e) Anaesthesia Neurocoiling
f) Cardiac Surgery Anesthesia
g) Cardiac Surgery
h) Medical Oncology Services
i) Neonatology Services
j) Obstetrical Anaesthesia Services
k) Obstetrical/Gynaecology (Non-elective) Services
l) Otolaryngology Services (Dr. H. Bliss Murphy Cancer Centre)
m) Paediatric Anaesthesia Services
n) Paediatric Ophthalmology
o) Paediatric Ophthalmology (Premature Infant) Services
p) Paediatric Orthopaedic Services
q) Paediatric Surgery and Urology Services
r) Thoracic Surgery Services
s) Vascular Surgery

Central Health

a) Anaesthesia Services – (James Paton Memorial Regional Health Centre)
b) Anaesthesia Services (Central Newfoundland Regional Health Centre)
c) General Surgery – (Central Newfoundland Regional Health Centre)
d) Orthopedic Surgery Services (James Paton Memorial Regional Health Centre)

Western Health

a) Anesthesia (Western Memorial Regional Health Centre)
b) ICU Adult Critical Care (Western Memorial Regional Health Centre)
c) Acute Care Surgery (Western Memorial Regional Health Centre)

During the term of this Agreement, both parties agree to continue a review of the general principles and current issues being experienced with APPs, based on the experiences in

this Province and other provinces. Of particular note, productivity, accountability, reporting, termination dates, funding, and the impact on recruitment are some of the issues to be reviewed. As part of the review, a document will be produced detailing the new principles and practices.

All existing APPs will be reviewed, and for those where agreement by all parties exists to continue, the APPs must be rewritten to conform to the new principles and policies. For those where agreement to continue is not received, appropriate notification to the signatories of the APP will occur and the proper processes, as outlined in the APP agreement(s), will be followed for the termination of same.

Schedule "F"

FFS Increases by FFS Specialty Group

The table below shows the percentage adjustment effective December 30, 2021 for each specialty, for purposes of fee code allocation. These percentage increases will be applied to the total bi-weekly payments to FFS Physicians until such time as the micro-allocation process is completed.

Specialty	Percentage Adjustment
Family Medicine	13.31%
Anaesthesia	10.46%
Radiology	-
Nuclear Medicine	-
Medical Specialties:	
Dermatology	-
Internal Medicine	8.28%
Critical Care	10.00%
Neurology	0.28%
Paediatrics	-
Psychiatry	16.74%
Surgical Specialties:	
Obstetrics and Gynaecology	15.04%
Ophthalmology	9.22%
Otolaryngology	8.03%
General Surgery	7.72%
Orthopedics Surgery	-
Neurosurgery	-
Plastic Surgery	12.45%
Urology	10.41%
TOTAL NEW FUNDING	**$22,618,949**
As noted in Article 15.01(iii) a further amount will be allocated for increases to other items not considered under the Maritime Weighted Parity methodology.	

Schedule "G"

Approved Category 'A' Facilities
24-Hour On-Site Emergency Department Coverage

This schedule is provided for information only.

Hospital Number	Hospital Name
0302	Burin Peninsula Health Care Centre, Burin
0230	Carbonear General Hospital, Carbonear
0213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0205	James Paton Memorial Hospital, Gander
0175	Western Memorial Regional Hospital, Corner Brook
0256	General Hospital, Health Sciences Centre, St. John's
0281	Janeway Children's Health and Rehabilitation Centre, St. John's
0264	St. Clare's Mercy Hospital, St. John's
0159	Labrador West Health Centre, Labrador City
0183	Sir Thomas Roddick Hospital, Stephenville
0167	Labrador Health Centre, Happy Valley-Goose Bay
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony

Schedule "H"

Approved Category 'B' Facilities
24-Hour Emergency Department Coverage

This schedule is provided for information only.

Facility Number	Facility Name
0051	Baie Verte Peninsula Health Centre, Baie Verte
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0345	Bonavista Community Health Centre, Bonavista
0442	Bonne Bay Health Centre, Bonne Bay
0451	Dr. Hugh Twomey Health Care Centre, Botwood
0299	Brookfield/Bonnews Health Care Centre, Brookfield
0434	A.M. Guy Memorial Health Centre, Buchans
0388	Calder Health Care Centre, Burgeo
0329	Fogo Island Hospital, Fogo
0016	Grand Bank Community Centre, Grand Bank
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0200	North Haven Emergency Centre, Lewisporte
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0418	Placentia Health Centre, Placentia
0191	Dr. C.L. LeGrow Health Centre, Port aux Basques
0396	Rufus Guinchard Health Care Centre, Port Saunders
0426	Green Bay Community Health Centre, Springdale
0022	U.S. Memorial Health Centre, St. Lawrence
0221	Notre Dame Bay Memorial Health Centre, Twillingate
0400	Dr. William Newhook Community Health Centre, Whitbourne

Schedule "I"

Obstetrical Bonus Policy for Salaried and Fee-for-service Family Physicians

Under this policy, there is dedicated funding for a bonus payable to Salaried Family Physicians (FPs) and FFS FPs that provide labour and delivery obstetrical services.

Eligibility

Fee-For-Service

FFS FPs who provide obstetrical services billable as either fee code 80004 (*Delivery)* or 80014 (*Attendance at labour)* are eligible to receive a bonus payment after the end of each fiscal year. The bonus is paid in addition to the MCP Payment Schedule obstetrical fees 80004 and 80014.

Salaried

Salaried FPs who provide obstetrical services where they either: (i) perform the delivery; or (ii) attend the patient during labour but transfer the patient to a Specialist because of complications during labour and/or delivery, are eligible to receive a bonus payment after the end of each fiscal year.

Calculation of the Bonus

Fee-For-Service

The bonus amount for an individual FFS FP will be calculated after the end of the fiscal year by multiplying the total number of delivery and attendance at labour events (codes 80004 and 80014) times $100, and adding the result to the applicable figure from the following table:

Total Units 80004 + 80014	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Salaried

The bonus amount for an individual salaried FP will be calculated after the end of the fiscal year by adding the total number of eligible services and multiplying it by $100 and adding

the result to the applicable figure from the following table:

Total Units	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Example:

A FP provided 24 eligible labour and delivery services in the one-year period. The bonus payment will be 24 x $100 plus $7500 = $9900.

Applying for the Bonus

Fee-For-Service

FFS FPs must submit an application for the bonus within ninety (90) days of the end of each fiscal year (March 31st). The application form can be printed from the MCP website.

Salaried

Salaried FPs who wish to apply for the bonus for the first time must complete the *Application for Salaried General Practitioner Obstetrics Bonus* form. The Department of Health and Community Services will open an Obstetrics Bonus file for each salaried FP who completes and returns the form. If an application was submitted in a previous year, a secondary application is not required.

On an ongoing basis, each salaried FP who has a file opened must submit copies of their patient records for the eligible services. Copies of actual patient labour and delivery record should be submitted as soon as possible after the eligible service has been provided.

Schedule "J"

Family Practice Renewal Program

This Schedule to the Agreement outlines the principles, structure, physician and broad program areas for a Family Practice Renewal Program. This Schedule addresses matters of unique interest and applicability to Family Physicians.

GUIDING PRINCIPLES FOR PRIMARY CARE RENEWAL

The parties agree that improved population health and health system sustainability in Newfoundland and Labrador will require a renewed focus on primary health care reform. The parties acknowledge that Family Physicians have an important role to play in the improvement and full integration of primary care and primary health care services and supports.

In alignment with the Province's new Primary Health Care Framework/Action Plan, the Family Practice Renewal Program shall incorporate the following principles, which the Family Practice Renewal Committee will convert into priorities and targets as specific programs and initiatives are designed and implemented.

Patient-Centered Services and Supports

Primary health care services should be provided in the manner that works best for patients and their families. Family Physicians and other primary health care providers should partner with patients, their families, and the local community to meet a range of health care needs and preferences.

Collaborative Multi-Disciplinary Teams

Processes must be developed to enable inter-professional communication and decision making that brings together the separate and shared knowledge of various providers to achieve the best possible patient outcomes.

Multi-Disciplinary Teams should include each patient's Family Physician or family practice group and a variety of other primary health care professionals all working together and at their full scope of practice to improve patient outcomes. This should include providers collaborating to increase continuity of care and improve the integration of community-based services and supports with secondary, tertiary, home, and long-term care services.

Increased collaboration among physicians, and between physicians, regional health authorities, and other health professionals to solve health system and population

health issues, to improve health outcomes, and to increase patient and provider satisfaction must be encouraged.

Coordination of Care

Highly coordinated services and supports at the primary health care level are essential to effective treatment plans that maximize the health and wellness of individual patients. Coordination of care requires awareness of available supports and clear communication between patients, providers, community stakeholders, and across the spectrum of primary, secondary, long-term, and tertiary health care.

Comprehensiveness of Care

Comprehensive care encompasses the provision and organization of a full range of services and supports across the spectrum of the patient's health and wellness needs. It is a patient-centered approach to care that acknowledges an individual's physical and mental health needs throughout their entire life and does not focus on the episodic treatment of specific diseases or illnesses. Comprehensive care includes the provision of a range of primary care services within the Family Physician's scope of practice or the organization of services provided by other physicians and primary health care providers.

Access to Appropriate Services and Supports

Appropriate access centres on the patient's ability to receive the right care, from the right provider, at the right time, and in the right place. It includes an approach to service delivery that aligns with the patient's needs for health care services and supports available in her or his local area or within a reasonable distance. It includes improved access to primary care physicians and increased availability of physicians outside of traditional business hours and on weekends.

Attachment and Longitudinal Relationships

Primary health care providers should be supported to build long-term patient-provider relationships that foster the development of trust and respect between the patient, the Family Physician or practice, and other health care professionals providing services and supports to the patient. Physicians should be encouraged to act as the most responsible provider for their patients and ensure that care is coordinated, consistent, and the patient's long-term needs are considered.

Communities of Practice

Communities of practice should include Family Physicians coming together in a physical or virtual way to share information and experiences and learn from each other and the

other health care professionals they work with. Communities of practice support the identification of local primary health care solutions, recognize the need for each provider to participate in ongoing personal and professional development, and encourage innovative means to improving patient care. They enable faster response to emerging health issues at both the community and regional levels.

Continuous Evaluation and Evidence-Based Decision Making

Ongoing monitoring and evaluation of primary care services is essential to the process of continuous quality improvement. Greater use of evidence-based and cost-effective approaches to management of the common conditions encountered in primary care must be encouraged. Improving the effectiveness of primary health care services and supports, the satisfaction of providers, and the health outcomes of the population requires ongoing evaluation and continuous improvement of service delivery models. Public investments in primary health care must help to achieve better care, better health, and better value.

Community Engagement and a Local Focus

Local communities have an important role to play in working with Family Physicians, other primary health care providers, and regional health authorities to improve the health of their residents. No community is the same, and improving population health and wellness may require solutions tailored to individual communities and regions.

ARTICLE 1 - DEFINITIONS AND INTERPRETATION

1.1 "**Schedule**" means this document, as amended from time to time as provided within the Agreement.

1.2 "**Attachment**" means ensuring citizens of Newfoundland and Labrador have access to a Family Physician with whom they develop a long-term relationship.

1.3 **"Family Practice Renewal Program (FPRP)"** is the renewal program including governance, funding, and evaluation structures described within this Schedule.

1.4 **"Family Practice Renewal Committee (FPRC)"** means the governance committee for the Primary Care Renewal Program.

1.5 **"Practice Improvement Program"** means a jointly sponsored program of the Department of Health and Community Services (HCS) and the NLMA through the FPRC. The program offers continuing professional development for physicians and their staff, as appropriate, to help them improve practice efficiency, support change management, and to enable enhanced delivery of patient care.

1.6 "**Family Practice Networks (FPN)**" means the initiative created and supported by the FPRC to organize physicians at the sub-regional or regional level in order to address common health care goals in their communities. Each FPN will participate in a Collaborative Services Committee (CSC) with the relevant RHA. Each FPN will be a not-for-profit corporation constituted by the physicians within their sub-region or region.

1.7 **"Collaborative Services Committee (CSC)"** means the joint committee of the FPN and the RHA, with membership shared equally between FPN representatives and RHA representatives with decision-making authority. The CSC may also choose to invite patients and local community representatives to participate as ex-officio members. The mandate of the CSC is to identify and respond to primary health care needs of the community. The partners work to co-design programs to improve local primary health care. Decisions of the CSC are made by consensus and both FPN and RHA participation is mandated.

1.8 "**Comprehensive care**" is the delivery of a full range of primary health care services including the following:

(a) Health and health risk assessments
(b) Coordination of patient care across the spectrum of primary, secondary, and tertiary care, including making referrals, and acting upon consultative advice
(c) Longitudinal care of patients across the spectrum of their medical needs
(d) Diagnosis and management of acute ailments
(e) Guidelines-based chronic disease management
(f) Primary reproductive care including the organization of appropriate screening
(g) The provision of or the arrangement with another provider for the provision of prenatal, obstetrical, postnatal, and newborn care
(h) Mental health care and counselling
(i) End of life planning / advanced care directives
(j) Palliative and end of life care
(k) Care and support of the frail elderly
(l) Support for hospital, home, rehabilitation, and long-term care facilities
(m) Patient education and preventative care, including support and education for ongoing patient self-management
(n) The maintenance of a longitudinal patient record

ARTICLE 2 – Family Practice Renewal Committee

2.1 The FPRC is hereby established under this Agreement as a mechanism for representatives of HCS, the NLMA, and RHAs to work together on matters affecting the provision of insured primary care services by Family Physicians in Newfoundland and Labrador.

2.2 The mandate of the FPRC is to:

(a) Within available funding, design program initiatives that seek to improve primary care in the Province consistent with the principles outlined in the preamble of this Schedule and the goals identified in Article 3 of this Schedule.
(b) Build a culture of collaboration and innovation between HCS, the NLMA, RHAs, and other stakeholders as appropriate.
(c) Identify gaps in care and address population health needs.
(d) Work with stakeholders to identify changes in primary health care delivery, including physician services, which could result in improvements in patient care and health outcomes.
(e) Work to identify and implement initiatives that will result in more effective utilization of physician and other health care resources, and a more fiscally sustainable health care system.
(f) Establish clear metrics for the evaluation of primary care and primary health care services as per Article 5 of this Schedule.

2.3 The FPRC shall be composed of three (3) members appointed by HCS and three (3) members appointed by the NLMA.

(a) Committee members are to be appointed on staggered terms of two (2) and three (3) years to ensure continuity.
(b) Representatives of the RHAs may be HCS appointees and/or participate in the FPRC as ex-officio members.
(c) A patient or citizen representative will be jointly selected by the appointed members to participate as non-voting ex-officio member.
(d) From time to time appointed committee members may agree to invite relevant stakeholders, including physicians, allied health care professionals, government representatives, citizens, and R H A employees to participate in FPRC meetings and discussions.
(e) Quorum for all FPRC meetings will require at least two (2) appointed members from HCS and two (2) appointed members from the NLMA.
(f) Within its mandate, the FPRC has authority to establish rules and procedures for the orderly conduct of business.

2.4 The FPRC shall be co-chaired by a member chosen by the HCS members and a member chosen by the NLMA members.

2.5 The FPRC will develop annual work plans and ensure that evaluations to measure outputs and outcomes are an integral part of the plan.

2.6 The FPRC will establish communication protocols to allow the co-chairs to communicate information about the business and/or decisions of the FPRC to physicians, Government, and other stakeholders including the public.

2.7 The cost of evaluation and administrative and clerical support required for the work of the FPRC will be paid from the funds to be allocated to the PCRP pursuant to this Schedule.

(a) Spending on auditing or evaluation activities is not to exceed 5% of total FPRP funding allocated during the fiscal year in which the evaluation activities occur.
(b) Spending on administrative and clerical support is not to exceed 15% of total FPRP funding allocated during the fiscal year in which it is spent.
(c) Program development, implementation, and operating costs will not be included in the spending limits described in Articles 2.7 (a) and (b) of this Schedule.
(d) Physician participation in the FPRC will be compensated at a rate to be determined by the FPRC.

2.8 Decisions of the FPRC shall be by consensus.

ARTICLE 3 – GOALS OF FAMILY PRACTICE RENEWAL PROGRAM

3.1 Improved health outcomes, particularly among high-needs populations and those living with chronic disease(s).

3.2 Improved coordination of patient care across the continuum of care, and between providers and community-based services and supports.

3.3 Increased collaboration between local Family Physicians, and between Family Physicians and other primary health care providers.

3.4 The establishment of collaborative, community-based multidisciplinary teams.

3.5 Greater collaboration between Family Physicians and RHAs leading to improved alignment on priority issues.

3.6 Improved recruitment and retention of Family Physicians, particularly in rural and underserviced communities.

3.7 Enhanced access to primary care services, such as through the provision of more flexible and conveniently scheduled after-hours clinics and improved access to same-day or next-day urgent appointments.

3.8 Improved patient-physician longitudinal attachment, particularly for those living with chronic disease(s).

3.9 Improved patient and provider satisfaction including greater work-life balance for Family Physicians.

3.10 Measurable improvements in system sustainability including reduced demand on secondary and tertiary emergency departments and other acute care services.

ARTICLE 4 – FAMILY PRACTICE RENEWAL PROGRAM FUNDING

4.1 The FPRC will allocate funding for FPRP initiatives at an annual rate of $4.5M.

4.2 The FPRC will use the FPRP funds available pursuant to section 4.1 for the following purposes:

(a) To design and fund new condition-based fee code initiatives for the support of comprehensive care delivery, including:
  (i) Increased coordination and collaboration with other primary health care providers.
  (ii) Improved patient access.
  (iii) Improved identification and management of a full range of Comprehensive Care services.

(b) To fund the development and implementation of FPNs as a means to organize Family Physicians at the sub-regional or regional level in order to address common health care goals in their communities.

  (i) FPNs will participate in a Collaborative Services Committee (CSC) with the relevant RHA, as well as other committees or projects that result from the work of the CSC.
  (ii) FPNs will organize and promote the participation of physicians in their region in activities that improve the delivery of Primary Health Care services.
  (iii) FPNs will be supported and funded within a program framework and funding formula, to be developed by the FPRC, with funds to be used for management, honoraria, administrative expenses and other expenses relevant to the mandate of the program. The program framework will also specify accountability requirements of the FPNs.
  (iv) FPNs will not engage in labour relations or advocacy activities regarding compensation and benefits of salaried physicians.
  (v) The establishment of a CSC does not preclude or limit an RHA's right to consult or work collaboratively with physicians outside of the formal CSC structure.

(c) To fund the development and operation of a Practice Improvement Program designed to support evidence-based change management aligned with initiatives described in Articles 4.2(a) and (b) of this Schedule and the following target areas:
  (i) Primary care best practices and guidelines-based care

(ii) Clinical and practice efficiency
(iii) Adoption of new technology (exclusive of electronic medical records program)
(iv) Practice reorganization
(v) Multi/interdisciplinary collaboration and coordination
(vi) Health prevention and promotion
(vii) Mental health and addictions
(viii) Other target areas as agreed by the FPRC.

4.3 Any funds identified in Article 4.1 of this Schedule that remain unexpended at the end of any fiscal year will be available to the FPRC for use as one-time allocations to improve the quality of primary health care. One-time allocations will require FPRC consensus.

ARTICLE 5 – Accountability and Evaluation

5.1 The FPRC will regularly monitor, review, and evaluate all initiatives implemented and/or funded under the FPRP.

5.2 The FPRP goals identified in Article 3 of this Schedule will serve as the basis for developing all PCRP evaluation metrics. Specific indicators and output and outcome targets will be defined by the FPRC for each individual initiative.

5.3 Funding for newly approved FPRP initiatives, including one-time allocations, will not be released prior to the FPRC approving an evaluation plan that will include the following elements:

(a) defined evaluation objectives;
(b) defined and measurable output and outcome indicators;
(c) ongoing and continuous collection of relevant data;
(d) dissemination of relevant data or monitoring results to stakeholders involved in the initiative;
(e) regular progress reports to the FPRC;
(f) explicit reporting deadlines with a minimum of one formal written status report per fiscal year;
(g) an evaluation budget and work plan describing evaluation activities, deliverables, timeframes, and responsible parties; and
(h) a clear communications plan that describes how evaluation findings will be reported to physicians, government, and relevant stakeholders, including the public.

5.4 The FPRC may employ evaluation staff or enter into agreements with third parties, including academics, research organizations, and evaluation professionals to ensure proper and timely evaluation of all initiatives.

5.5 The results of all formal written status reports will be public records, accessible under the *Access to Information and Protection of Privacy Act*, SNL2015 c. A-1.2, and will be communicated publicly. This will include the public release of annual evaluation summaries and, when appropriate, publication of evaluation findings in academic journals.

5.6 The FPRC will review evaluation results on an annual basis. In cases where the FPRC deems a PCRP initiative has underperformed or was unsuccessful, the FPRC will be responsible for amending or ending the initiative.

5.7 All FPRP initiatives that do not demonstrate progress in reaching the goals identified in Article 3 of this Schedule within 3 (three) years will be discontinued unless otherwise agreed by FPRC consensus.

(a) Funding previously allocated to unsuccessful or cancelled initiatives will be returned to the FPRP budget and re-administered by the FPRC.

(b) Article 5.7(a) of this Schedule applies to all FPRP initiatives, including all physician payments and remuneration initiatives within the FPRP.

Schedule "K"

Physician Services Liaison Committee (PSLC) Terms of Reference

Purpose of PSLC

To maintain an ongoing mechanism through which medical issues of mutual concern may be addressed collaboratively between the NLMA and HCS, and to act as an oversight body for the administration of the Agreement.

Membership of PSLC

The membership shall consist of four (4) members selected by the NLMA and four (4) members selected by HCS. The Chair shall be appointed for a one-year term and shall alternate between the NLMA and the HCS representatives. The Deputy Minister of the HCS and the NLMA Executive Director shall agree on the Chair.

Frequency of Meetings

Meetings shall be held at least quarterly, or at the call of the Chair for urgent issues that may arise between regular meetings.

Quorum

Two members from the NLMA and two members from the HCS shall constitute a quorum. Decisions will be made by consensus.

Record of Discussions and Action Items

A record of discussions and action items shall be kept for all meetings. All discussions at the meetings shall be confidential. These records shall be available to the Minister, Deputy Minister, and the Executive of HCS, and the Executive and Board of Directors for the NLMA. These records shall also be made available to the CEOs of the RHAs where appropriate.

Location

The time and location of the meetings shall be at the call of the Chair.

Mandate

1) To provide information and advice to the HCS on medical issues from a policy, systemic, and strategic perspective.

2) To oversee the administration of the Agreement.

3) To generally explore options that would contribute to a sustainable health care system that maintains and/or enhances quality of service that is reasonably accessible to all.

4) To create sub-committees and establish, where necessary, terms of reference for these committees, to address issues such as:

    a) Improving efficiency;
    b) Developing clinical practice guidelines;
    c) Exploring standards related to such issues as wait times and hospital lengths of stay;
    d) Physician recruitment and retention;
    e) Interdisciplinary primary care delivery models;
    f) Primary health care;
    g) Clinical stabilization;
    h) MCP Payment Schedule review;
    i) Others, at the discretion of the PSLC.

5) To liaise with other professional groups, RHAs, or other organizations when both parties consider it necessary or useful;

6) Upon the request of the Minister of HCS, to review and provide timely advice on issues that may be directed to the Committee by the Minister of HCS.

Costs

The costs of participation in the PSLC will be borne by the parties separately.

Schedule "L"

MCP Payment Schedule Review Committee Terms of Reference

The MCP Payment Schedule Review Committee (PSRC) will be responsible for the ongoing review, editing, and drafting associated with maintaining the integrity of the MCP Payment Schedule.

Scope:

The PSRC will consider and make recommendations to the Minister of HCS regarding:

I. MCP Payment Schedule Review Process
II. MCP Payment Schedule Fee Code Allocation Process
III. MCP Payment Schedule Fee Code Addition Process

Composition of the Committee:

The PSRC will consist of four members:

- Two (2) HCS representatives, and,
- Two (2) NLMA representatives.

Alternate and/or additional members may attend PSRC meetings.

Frequency of Meetings:

The PSRC will meet a minimum of four (4) times a year, otherwise on an as-needed basis. Meetings shall be held at least quarterly or by mutual agreement for urgent issues that may arise between regular meetings.

Work of the Committee:

I. MCP Payment Schedule Review Process

The PSRC is responsible for reviewing the MCP Payment Schedule in order to identify areas for change to ensure that public expenditure on insured medical services yields high quality patient care and high value for money. In this regard the PSRC will:

1. Develop a methodology to analyze physicians' FFS billings in order to identify fee codes or groups of fee codes, and billing rules for review.
2. Establish a process to review and adjust fee codes and billing rules to reflect changes in time, technology, direct cost, market comparison, and other such factors

as may be determined by the parties from time to time, for the purpose of adjusting such fees and rules appropriately.

3. Identify fees that are no longer necessary, for elimination.
4. Fee codes may have funding increased or decreased, via valuation change or via rule modification, but in any event, no new fee codes will be introduced via the review.
5. In cases where fee codes are reduced, ensure that no discipline will have its overall funding adjusted to less than parity with Maritime Weighted Average (MWA), notwithstanding instances where money has been added to a code that is not in the MWA comparison.
6. Fee codes and billing rules will be adjusted on an overall cost-neutral basis only. No new funding will be allocated to support the MCP Payment Schedule Review process.
7. Consult with affected discipline(s) on any recommended adjustments to fees.
8. Provide ninety (90) days' notice of any adjustments to affected discipline(s).
9. Re-allocate any savings as a result of adjustments to fee codes firstly within the discipline and secondly in another discipline to respond to unmet needs.
10. After the process is complete, HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
11. Promote the initiatives of *Choosing Wisely Canada* to optimize value and minimize waste in medical care.
12. Decisions of the PSRC shall be made by consensus and shall be subject to the approval of the Minister of HCS.

II. MCP Payment Schedule Fee Code Allocation Process

Increases awarded by agreement between HCS and the NLMA shall be allocated to individual fee codes in the MCP Payment Schedule by the PSRC in accordance with the following FFS fee code allocation process:

1. The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine funding allocation jointly and collaboratively by consensus.

2. Fee code funding not allocated by consensus via this collaborative process will be determined as outlined in i) and ii) below:

    i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

    ii) HCS will then allocate the remaining 50% during the next thirty (30) day period.

3. Following allocation in accordance with (1) and/or (2), above, HCS representatives will seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.

III. MCP Payment Schedule Fee Code Addition Process

The PSRC is responsible for receiving applications for new fee codes in order to ensure that the MCP Payment Schedule includes appropriate fee codes for new physician services that become available in the Province, and for the overall maintenance of the integrity of the MCP Payment Schedule, in accordance with the following:

1. The PSRC will receive applications for new fee codes from physicians or from HCS and will review them jointly and collaboratively and work toward a consensus-based response.
2. The PSRC will develop and use a MCP Payment Schedule Request form that must be completed by HCS or the physician (or discipline) making the proposal. From time to time the PSRC may review and revise the form to ensure suitability.
3. The PSRC will consider such things as insurability, the site of the proposed service and the rate and terms and conditions of payment with reference to Maritime parity.
4. Where reference to Maritime parity is not possible, by consensus, the PSRC may make reference to the rates and/or terms and conditions established by another province/territory outside of the Maritime Provinces.
5. After the process is complete HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
6. In the absence of consensus, HCS representatives will make a recommendation to the Minister of HCS and the NLMA may also advise the Minister of HCS regarding their separate recommendation.
7. Revisions to the MCP Payment Schedule that have been approved by the Minister of HCS will take effect ninety (90) days following the date of approval by the Minister of HCS.

Schedule "M"

On-Call and Internal Locum Rates

On-call service shall be remunerated according to the following four-tiers, and the rules as published from time to time in the MCP On-Call Payment Information Manual:

Tier 1:	$326.20
Tier 2:	$289.95
Tier 3:	$253.71
Tier 4:	$217.47

Internal Locum payments shall be remunerated according to the following rates:

Salaried Specialist	$43.55
FFS Specialist	$18.73
Salaried Family Physician	$30.13
FFS Family Physician	$12.92
Salaried Hospitalist	$34.09

Schedule "N"

Interest Arbitration

1. (a) This amendment replaces the Schedule N originally included in the 2013-2017 Agreement. This Schedule N shall come into force upon signing by the Parties of the 2017-2023 MOA. To clarify, the Parties agree that Schedule N shall not give rise to any retroactive entitlements arising from actions by either party which occurred prior to the date of signing the 2017-2023 MOA.

   (b) Should the parties fail to enter into a new Agreement to replace this Agreement within twelve (12) months following the date of the receipt by any party of the written notice referred to in Article 3.03 of this Agreement, any party may give written notice to the other party of its intention to invoke the arbitration provisions set forth in this Schedule.

2. Where a party has given notice under section 1 of its intention to invoke the arbitration provisions, the parties agree to submit all matters in dispute to a three (3) member Arbitration Board, which shall be constituted and shall proceed as follows:

   (a) Within ten (10) days following the receipt by any party of the notice referred to in section 1, each of the parties shall nominate an arbitrator to be its nominee on the Arbitration Board and shall give written notice to the other party of the name and address of the person so nominated.

   (b) Within seven (7) days following the nomination of the persons to the Arbitration Board referred to in section 2(a), the two persons so nominated shall together select a third person who shall be the Chairperson of the Arbitration Board, and the three persons so nominated and selected shall together constitute the Arbitration Board for the purpose herein set forth.

   (c) Within thirty (30) days following the selection of the Chairperson of the Arbitration Board as provided in section 2(b), or within such other period as may be mutually agreed by the parties, the Arbitration Board shall convene a hearing to arbitrate the matters in dispute.

   (d) Not later than ten (10) days prior to the day set for the commencement of the hearing referred to in section 2(c), each party shall submit to the Arbitration Board, in writing, a statement of its respective positions on the matters in dispute together with all relevant documentation in support thereof, and shall serve a copy on the other party. Subject to section 2(e), no matter may be submitted to the Arbitration Board as a matter in dispute unless:
      (i) within one hundred and eighty (180) days following the date of the receipt by any party of the written notice referred to in Article 3.03 that

matter has been the subject of a written proposal by one party towards settlement of the matter and which written proposal has been delivered to the other party within that 180 day period; or

(ii) both parties consent in writing to that matter being submitted to the Arbitration Board as a matter in dispute.

(e) Unless both parties explicitly consent in writing, no matter may be submitted to the Arbitration Board that involves a decision or decisions by Government as to: (i) the allocation of human resources, including without limitation, the number and allocation of salaried positions and the location of services; (ii) the allocation of fee codes (i.e. fee code allocations); (iii) new services to be compensated; (iv) new programs, new benefits, new bonuses and new incentives; and (v) determination of what are insured services. Other than the foregoing, the Arbitration Board shall be able to determine any matter in dispute concerning compensation and benefits, including the rules and terms that define the entitlement of physicians to such compensation and benefits, that are contained in the Agreement under which the referral to arbitration has been made, including, subject to section 2(f), the duration of the Agreement.

(f) The arbitration referred to section 2(c) shall be governed by the provisions of the *Arbitration Act, RSNL 1990, c. A-14*. In conducting the arbitration and making its decision or award, the Arbitration Board shall give due consideration to the purposes of the Agreement set out in Article 1.0l(b). The Arbitration Board shall not have jurisdiction to make a decision or award for a period covering more than three (3) years unless the parties agree otherwise. The Arbitration Board shall give full opportunity to the parties to present evidence and make submissions.

(g) The Arbitration Board shall use conventional arbitration principles and, in making its decision, shall consider and take into account any matter(s) or factor(s) which it judges to be relevant, including the following factors:

(i) Evidence relating to comparable groups in Atlantic Canada;

(ii) Reasonable and fair compensation and working conditions for physicians in rendering professional services;

(iii)The ability of Government to pay in light of its current and projected fiscal position, including levels of taxation, expenditures and debt levels; and

(iv)Recent general economic increases provided to the provincial public sector unions in Newfoundland and Labrador.

(h) The Arbitration Board shall, should it determine that either party has failed to bargain in good faith to conclude a new agreement, refer the parties back to bargaining for a period of sixty (60) days with a view to resolving, clarifying, or otherwise addressing one or more matters in dispute.

(i) The Arbitration Board shall deliver its decision or award by majority decision in writing within forty-five (45) days from the conclusion of the hearing referred to in section 2(c), and the decision or award of the majority shall be the decision of the Arbitration Board and shall be final and binding on the parties with respect to the matters in dispute and shall not be subject to any appeal. Should there be no majority decision or award, the decision or award of the Chairperson of the Arbitration Board shall be the decision or award of the Arbitration Board. The decision or award of the Arbitration Board shall be implemented in the manner provided in the decision or award. The Arbitration Board shall have jurisdiction to provide clarification to the parties concerning the decision or award, provided, however, that the Arbitration Board shall not change its decision or award in any substantive way.

(j) Each party shall bear its own costs and expenses of the arbitration, including the costs and expenses of its nominee to the Arbitration Board, and shall share equally the costs and expenses of the arbitration including those of the Chairperson of the Arbitration Board.

(k) The Arbitration Board shall not have jurisdiction to amend or vary the terms of any part of Article 1.0l(b), Article 3.03 or this Schedule N of the Agreement.

(l) Judgment upon the decision or award of the Arbitration Board may with leave of the Court be entered in the Supreme Court of Newfoundland and Labrador and, if so registered, be enforced subject to those restrictions, if any, ordered by the Court.

(m)Nothing in this Agreement prohibits, limits or restricts the right of either party to seek judicial review of the award or decision of the Arbitration Board or of a component thereof on a matter of law or jurisdiction.

3. During the life of this Agreement the parties agree that:

(a) The NLMA shall not declare, organize, authorize, encourage, support, participate in, or sanction in any way action by a physician acting alone or in concert with other physicians that would breach the obligations imposed in subsection 3(b); and

(b) A physician, acting alone or in concert with other physicians, shall not engage in a cessation or refusal to work or to continue to work, including, without limitation, a resignation, slow-down of work or other such concerted activity, or threat thereof, in respect of the provision of an insured service, for the purpose of exerting economic influence on either Government or the NLMA to achieve personal economic gain or to achieve a benefit in excess of those

determined pursuant to the terms of this Agreement.

4. (a) (i) Where the Government reasonably believes that there has been a breach of the obligations imposed by subsection 3(a), the Government may provide written notice to the NLMA stating the sources and grounds for its belief and may declare this Schedule to be of no force or effect.

(ii) Where the Government reasonably believes that there has been a breach of the obligations imposed by subsections 3(b), the Government may provide written notice to the NLMA stating the sources and grounds for its belief and require the NLMA to remedy the breach within two (2) working days of such notice. If the breach is not remedied to the reasonable satisfaction of Government within two (2) working days of such notice, the Government may declare this Schedule to be of no force or effect.

(b) If the NLMA disputes that there has been a breach as identified in any notice provided by Government under subsection 4(a) the NLMA may, within fifteen (15) calendar days of receiving such notice, refer the matter to arbitration in accordance with Article 13(iii) of this Agreement. Such referral will be deemed by the parties as mutual agreement to engage the services of an arbitrator in accordance with Article 13 (iii).

(c) Where an arbitrator appointed pursuant to subsection 4(b) determines, on a balance of probabilities, that there has not been a breach of the obligations imposed by subsections 3(a) or 3(b) or that any such breach of 3(b) was remedied by the NLMA to a level that should reasonably have satisfied Government within two (2) working days, this Schedule shall continue in full force and effect as though the declaration issued by Government under subsection 4(a) had not occurred. The findings of an arbitrator, as to whether a breach occurred or whether the NLMA failed to remedy the breach to a level that should reasonably have satisfied Government shall be final and binding.

(d) Following the referral to arbitration in accordance with subsection 4(b), no notice shall be given pursuant to section 1 and, where any such notice was given prior to such reference and the proceedings have not concluded, such proceedings shall be suspended unless and until an arbitrator has made a determination in accordance with subsection 4(c).

(e) Where a declaration by Government has been issued in accordance with subsection 4(a) and there has been no referral to arbitration in accordance with subsection 4(b), any proceeding initiated pursuant to section 1 shall cease.

5. The parties hereby agree that:

(a) Any judicial or quasi-judicial determination, including, without limitation, a determination by an arbitrator appointed pursuant to Article 13 of this Agreement, which has the effect, directly or indirectly, of bringing within the scope of this Agreement any matter, compensatory or otherwise, that was not explicitly contained in this Agreement prior to such determination, that matter shall be specifically excluded from the jurisdiction of an interest arbitration board, unless agreed between both parties.

6. This Schedule shall cease to be of any force or effect on the earlier of either:

   (a) The parties' written agreement;

   (b) A determination made pursuant to section 4 that there has been a breach of the obligations imposed by subsections 3(a) or 3(b).

7. Notwithstanding any other provision of this Agreement, and for further clarity, if this Schedule ceases to be of any force or effect in accordance with sections 4 or 6 of this Schedule, the parties hereby agree and confirm that this Schedule shall not form part of any subsequent agreement unless the parties explicitly agree otherwise in writing.

8. The following Schedules are not subject to interest arbitration:

   1. Schedule "B" Facility Workload Disruption Payment Policy for Fee-For-Service Physicians
   2. Schedule "C" Salaried Physician Retention Bonus Categories
   3. Schedule "E" Alternate Payment Plans (APPs)
   4. Schedule "G" Approved Category "A" Facilities: 24-Hour on-site Emergency Department coverage
   5. Schedule "H" Approved Category "B" Facilities: 24-Hour Emergency Department coverage
   6. Schedule "K" Physician Services Liaison Committee Terms of Reference
   7. Schedule "L" MCP Payment Schedule Review Committee Terms of Reference
   8. Schedule "N" Interest Arbitration
   9. Schedule "O" Cataract Surgery Service Fees in Non-Hospital Designated Facilities
   10. Schedule "P" Dispute Resolution

   The following Schedules are subject to interest arbitration:

   1. Schedule "D" Specialty Corrections Fund
   2. Schedule "F" FFS Increases, By FFS Specialty Group
   3. Schedule "M" On-call and Internal Locum Rates
   4. Schedule "Q" Rural Community Comprehensive Care (RCCC) Bonus

The following Schedules are subject to interest arbitration in part, as indicated:

1. Schedule "A" Waterford Physicians On-Duty, on-site Payment Policy: rates only
2. Schedule "I" Obstetrical Bonus Policy for Salaried and FFS Family Physicians: rates only
3. Schedule "J" Primary Care Renewal Program: clause 4.1 ("Funding") only

Schedule "O"

Cataract Surgery Service Fees in Non-Hospital Designated Facilities

1. The purpose of this Schedule is to outline the agreement reached between the Department of Health and Community Services (HCS) and the Newfoundland and Labrador Medical Association (NLMA) with respect to service fees for cataract surgeries carried out in a facility designated by the Lieutenant-Governor in Council. Service fees do not include professional fees for insured services as specified in the Medical Care Plan (MCP) Medical Payment Schedule.

2. Designated facilities will be those facilities designated by the Lieutenant-Governor in Council as meeting the established criteria as set by the Department of Health and Community Services.

3. A service fee will be payable to the operator of a designated facility on a per-procedure basis to be invoiced to the Regional Health Authority of the region in which the facility is located.

4. The service fee will be $945.41.

5. The service fee may be reviewed at the request of the NLMA or HCS on a frequency no greater than annually. Upon request, both parties will undertake good faith discussions based on actual changes in the cost of insured cataract surgery services. During a review, HCS has the right to request verification of costs related to consumables, including rarely used consumables, staff compensation, and specific contracts.

6. The service fee represents the total compensation for the provision of cataract surgery in a designated facility and no additional compensation, except for the list of rarely used consumables attached hereto as Exhibit "A" and the MCP professional fee, is payable.

7. Rarely used consumables as identified in Exhibit "A" do not form part of this service fee and will be provided by the relevant Regional Health Authority.

8. This Schedule shall remain in effect for ten (10) years. The parties agree to review the Schedule at five (5) years.

9. Any designated facility may cease provision of cataract surgery at any time by providing six (6) months' written notice to the appropriate Regional Health Authority.

10. Commencing in 2020/2021, and prorated for any portion of 2019/2020 in which a

designated facility is in operation, there shall be an annual provincial cap of 3,500 cases to be performed in designated facilities, comprising a regional cap of 1,231 procedures within the eastern region and a regional cap of 2,269 procedures within the western region. HCS acknowledges that any procedures performed in a hospital facility at the request of HCS or a Regional Health Authority will not be deducted from the regional or provincial cap.

11. Commencing in 2021/2022, the number of procedures comprising the annual provincial cap and the corresponding regional caps shall be adjusted annually. Changes shall be based on demographic projections of the Department of Finance, and a calculation of total predicted regional demand based on factors derived from relevant peer-reviewed evidence. The factors are the rate of cataract surgeries for the population 65 and over, plus the ratio of surgeries performed for people under the age of 65 to the total number of cataract surgeries.

12. This Schedule is not subject to interest arbitration.

Exhibit A

Infrequently used hospital provided items:

- Malyugin ring
- Iris hooks
- Vision blue
- Capsular tension rings
- Capsular segments
- 10-0 nylon suture
- 10-0 vicryl suture
- Centurion vitrectomy kits
- Myostat
- Myochol
- Healon
- Implantable glaucoma devices
- Kenalog/triesence
- Cartridges for rarely used lenses
- Anterior chamber lenses for rare complicated cases
- And other rarely used consumables not included in a standard cataract surgery, to be provided on an as-needed basis, for complex cases.

Schedule "P"

Dispute Resolution

1. The purpose of Schedule "P" is to establish a mediation process so as to facilitate the early and fair resolution of disputes between the parties regarding the interpretation of this Agreement, other than any dispute that is subject to Interest Arbitration.

2. In this Schedule, the following words and phrases shall have the following meanings:

   "mediation" means a process of discussion between the parties or their representatives or both the parties and their representatives under the direction of a neutral third party ("the mediator") with a view to facilitating communication among the parties to assist them in reaching a mutually acceptable resolution of some or all of the issues in dispute.

3. If within ten (10) calendar days following the delivery of a written notice of a reference to mediation the parties do not in writing agree upon and appoint a mediator, then either party may in writing request the Atlantic ADR Institute to name a mediator from the roster of arbitrators established by the Labour Management Arbitration Committee of the Labour Relations and Standards Division.

4. A mediation shall be conducted by the mediator appointed by written agreement of the parties, or by appointment in accordance with section 3.

5. The parties agree that the representatives selected to participate in the dispute resolution process will have either the authority required to settle the dispute or a ready means of obtaining the requisite authorization to do so.

6. The mediation may be conducted for a period of up to six (6) weeks after appointment of the mediator ("the mediation period"), unless the mediation period is extended by written agreement of the parties.

7. Unless otherwise agreed by the parties in writing, a mediation session shall commence within twenty (20) calendar days of the appointment of the mediator.

8. Following the appointment of a mediator, the parties shall expeditiously contact the mediator to schedule the mediation session(s).

9. Unless the parties and the mediator agree otherwise, at least seven (7) calendar days before the first scheduled mediation session each party shall provide to the mediator

and each other party a brief statement of factual and legal issues in dispute, a summary of that party's position, and copies of all documents relevant to the mediation.

10. The parties shall attend the mediation session(s) unless the mediator directs otherwise.

11. The procedure and methodology to be followed at a mediation session may vary according to the particular style and approach of the mediator who shall, after consultation with the parties, adopt an approach which in their opinion is best calculated to facilitate the purposes of the mediation and otherwise complies with the requirements of the mediation.

12. The mediator may deliver to a party a notice of non-compliance if it is not practical to conduct a mediation session because a party has failed to comply with section 9, or because a party has failed to attend at the time scheduled for the session, unless the party in attendance agrees otherwise. Where a mediator delivers a notice of non-compliance, the other party may ask the mediator to schedule a further mediation session.

13. Unless otherwise agreed by the parties and the mediator, within fifteen (15) calendar days after the date of the final mediation session, the mediator shall deliver to each of the parties a report: (i) identifying the issues on which agreement has been reached; (ii) identifying the remaining issues in dispute and the points of difference, if any; and (iii) containing recommendations that the mediator considers appropriate as to how the remaining issues in dispute and points of difference might be resolved.

14. The mediator will develop their report based on the information submitted pursuant to section 9 and any other information supplied by the parties in face-to-face mediation sessions.

15. All communications during a mediation session:

    (a) shall constitute without prejudice settlement discussions;
    (b) shall be privileged from disclosure; and
    (c) shall not be admissible as evidence in a legal proceeding.

In this context, communications include, but are not limited to, the following:

(a) the mediator's recollections of a mediation session;
(b) the mediator's notes and records relating to a mediation session; and
(c) anything said or written down during a mediation session.

16. For greater certainty, a mediator shall not be a compellable witness regarding any aspect of a mediation session relating to the issues in dispute being mediated or the results of the mediation, including any discussions relating thereto.

17. A mediator may stipulate that they are not liable for loss or damage suffered by a person by reason of an action or omission of the mediator in the discharge of their duties under this Schedule.

18. If there is an agreement by the parties resolving all or any of the issues in dispute, it shall be in writing and signed by the parties. Notwithstanding section 15 above, an agreement resolving all or any of the issues in dispute shall be admissible in evidence for the purpose of enforcing that agreement. Where a party to a signed agreement fails to comply with its terms, another party to the agreement may apply to the Supreme Court of Newfoundland and Labrador for judgment in the terms of the agreement or with those modifications as subsequent circumstances may require to ensure that the applying party receives that to which the applying party is substantially entitled under the agreement.

19. Unless the parties otherwise agree, the mediator's fees and expenses shall be borne equally by the parties.

Schedule "Q"

Rural Community Comprehensive Care (RCCC) Bonus

The start date for the Rural Community Comprehensive Care (RCCC) Bonus program will be September 30, 2022.

The RCCC Bonus amount is $10,000 per annum to all eligible physicians, as opposed to the current tiered bonus structure of the FFS Rural Retention Bonus.

Eligibility Criteria

Eligible physicians are FFS Family Physicians who cross a set of predetermined thresholds that demonstrate they are providing comprehensive community care. These thresholds will align with the Family Practice Renewal Program's criteria established for participation in its fee code program, unless otherwise amended by the parties to this Agreement. In instances where a physician's qualifying criteria cannot be assessed via fee codes, the matter will be referred to the relevant FPN/RHA Collaborative Services Committee (CSC) to gather relevant information.

To be eligible to receive the RCCC Bonus, a physician must have billed $100,000 in the applicable year and must have billed for services provided on a total of one hundred and fifteen (115) or more days within a twelve (12) month period.

A physician will be eligible after twelve (12) months of practice in the province if criteria are met. New physicians entering partway through an eligibility period will receive a prorated amount.

The physician must practice in a community outside of the Northeast Avalon (the Northeast Avalon being defined as all communities north of and including Holyrood and Witless Bay, with the exception of Bell Island).

Any physician eligible for a payment under the previous program will receive a prorated bonus up to the start date of the new program.

The parties will jointly develop other transition and administrative rules as necessary.

Date of Signing: May 3, 2022

Letter of Understanding – Salaried Family Physician Remoteness Bonus

The parties agree to work expeditiously on a new program for addressing recruitment challenges for Salaried Family Physicians in remote sites. The program framework will include, but not be limited to, the following elements:

1. The parties will agree on a list of eligible communities.
2. An isolation index for communities with Regional Health Authority facilities in NL will be developed. The index will consider factors such as
    a. distance from facilities with specialty support;
    b. number of Family Physicians close to the community;
    c. distance from a Category A ER;
    d. whether the community is connected to the Island of Newfoundland by ferry;
    e. distance from the TCH;
    f. population of the community;
    g. distance from the tertiary centre; and,
    h. any other factors as mutually agreed in writing by the parties.
3. Additional compensation or benefits will be assigned based on the index.
4. The Salaried Physician Remoteness Bonus for Family Physicians will be deployed upon adoption of the new program. The new program will include the budget for the Geographic Retention Bonus, and an additional $1 million per annum to be allocated based on the isolation index.
5. The new program will be effective the date of signing the MOA.
6. The Geographic Retention Bonus, as set out in Article 16.05, will continue as part of the new program. Sites where the Geographic Retention Bonus is now applied, and the value of the site's Geographic Retention Bonus, will continue under the new program. Sites may receive additional dollars allocated through the isolation index.
7. Upon the implementation of the new program, any physician who would have received a higher amount than that provided via the Geographic Retention Bonus will receive the prorated difference retroactive to the date of signing the new MOA.
8. The new program will form part of the MOA.

Lisa Curran

Lisa Curran
Director, Medical Services

R. Thompson

Robert Thompson
Executive Director, NLMA

END OF SCHEDULES AND LETTER OF UNDERSTANDING TO THE AGREEMENT