TENTATIVE AMA AGREEMENT 2011-2018 PACKAGE

Contents:

- AMA Agreement
- Three Consultation Agreements:
  - Provincial Electronic Medical Records Strategy Consultation Agreement
  - Primary Medical Care/Primary Care Networks Consultation Agreement
  - System-Wide Efficiencies and Savings Consultation Agreement

Please note that, while they have been signed, the three Consultation Agreements each contain a clause which makes them subject to the ratification of the AMA Agreement. **You cast one vote for the entire package.**

ALBERTA MEDICAL ASSOCIATION AGREEMENT
(“AMA Agreement”)

Made Effective April 1, 2011

BETWEEN:

Her Majesty the Queen
in Right of Alberta,
as represented by the Minister of Health
(“AH”)

- and -

Alberta Medical Association
(C.M.A. Alberta Division)
(“AMA”)

RECITALS:

A. AMA’s members comprise the vast majority of the practicing physicians in the Province of Alberta.

B. AMA and AH have a long history of collaboration and cooperation regarding health care matters in general and medical services in particular.

C. AMA and AH have completed extensive discussions concerning matters of significance to Alberta’s physicians including sources of revenue for physicians, physician compensation for the provision of Insured Medical Services and plans and programs which exist for the benefit of physicians.

D. AMA and AH now wish to create, through the provisions of this AMA Agreement, the principles, processes and agreements which will apply to and which will govern a long term financial and working relationship between AH and Alberta’s physicians, as represented by AMA.

THEREFORE each of AMA and AH promise and agree with the other as follows:

1. Definitions

   (a) “Agreement” or “AMA Agreement” means this Alberta Medical Association Agreement and all schedules attached, all as might be amended from time to time in accordance with the provisions hereof.

   (b) “ARP” means an Alternative Relationship Plan as defined in the *Medical Benefits Regulation* including the clinical Insured Medical Services component of an Academic Alternative Relationship Plan.

(c) “Effective Date” means 12:01 a.m. April 1, 2011.

(d) “Insured Medical Services” means insured services provided by the Alberta Health Care Insurance Plan and paid for directly by AH.

(e) "Physician" means a physician as defined in the *Alberta Health Care Insurance Act*.

(f) “Physician Assistance Programs” means those non-evergreen programs and benefits identified in Article 3(a)(iv) of this Agreement.

(g) “Physician Compensation Programs” means fee-for-service compensation under the SOMB and alternate funding under ARPs, both with respect to the provision of Insured Medical Services.

(h) “Physician Support Programs” means those evergreen programs and benefits identified in Article 3(a)(iii) of this Agreement.

(i) “Price” means the amount payable in Canadian dollars to or for a Physician under a Physician Support Program or a Physician Assistance Program.

(j) “Rate” means the amount payable in Canadian dollars established by the Minister for payment under Physician Compensation Programs.

(k) “SOMB” means the Schedule of Medical Benefits as defined in the *Medical Benefits Regulation.*

2. Recognition of AMA

(a) AMA is recognized as the sole and exclusive representative of all physicians who are authorized to practice medicine in the Province of Alberta for the scope, purposes and term of this AMA Agreement; and

(b) upon the written request of AMA, AH will work towards entrenching a general recognition of AMA within an appropriate legislative framework.

3. Scope and Purpose(s)

(a) This AMA Agreement will apply to:

(i) physician compensation for the provision of Insured Medical Services wherever those services are provided,

(ii) the Rates described in the SOMB and in ARPs,

(iii) Prices associated with any or all of the following Physician Support Programs:

- Continuing Medical Education,
- Medical Liability Insurance,
- Parental Leave,
- Physician and Family Support,
- Compassionate Expense,
- Physician Locums (Regular and Specialist),
- Practice Management,

(iv) Prices associated with any or all of the following Physician Assistance Programs:

- Physician On-Call,
- Physician Learning,
- Program Management Offices,
- Towards Optimized Practice,
- Business Cost,
- Retention Benefit,
- Rural Remote Northern;

(b) without limitation, this AMA Agreement does not apply to:

(i) the setting of health care policy which policy is within the sole discretion of the Government of Alberta to decide,

(ii) the setting of the annual budgets for expenditures relating to physicians including payments for the provision of Insured Medical Services (the Annual Budgets),

(iii) the management, from time to time, of the Annual Budgets,

(iv) the Electronic Medical Record completion program and any new approach or plan arising therefrom or thereafter,

(v) subject to paragraph 3(a)(i) hereof, Primary Care Networks, Primary Care Networks 2.0 and Family Care Clinics, and

(vi) any and all consultation agreements which arise out of Section 4 hereof (i.e. each of the consultation agreements will stand on its own, are not linked to and do not form part of this AMA Agreement and are not subject to Schedule 5 - Dispute Resolution); and

(c) the scope and purposes of this AMA Agreement may be added to or deleted from by subsequent written document agreed to and signed by both AMA and AH.

4. Consultation with AMA

For health matters which touch and concern physicians but which are not within the stated scope and purposes of this AMA Agreement, such as those matters referred to in paragraphs 3(b)(iv) and 3(b)(v) hereof, AH will consult with and will seek the advice of AMA, from time to time. In this regard, AMA and AH will initially negotiate and sign agreements describing the parameters of the consultation process for each of Electronic Medical Records, Primary Medical Care/Primary Care Networks and System-Wide Efficiencies and Savings.

5. Financial

(a) Funding for the following plans and programs (the "Grant Programs") will be provided by AH to AMA according to grant agreements, which grant agreements will include an administrative fee payable to AMA in consideration for services regarding the management of each Grant Program and which grant agreements will align, from time to time, with the provisions described in the attached Schedule 6 – Details of Grant Programs:

- Compassionate Expense,
- Parental Leave,
- Physician and Family Support,
- Continuing Medical Education,
- Medical Liability Insurance,
- Physician Locums (Regular and Specialist)
- Physician Learning,
- Practice Management,
- Towards Optimized Practice,
- Retention Benefit,
- Program Management Offices;

(b) (i) Rates described in the SOMB and in ARPs;

(ii) Prices associated with all Physician Support Programs (whether a Grant Program or not); and

(iii) Prices associated with all Physician Assistance Programs (whether a Grant Program or not) will be subject to the following increases (the "Agreed Increases"):

- effective April 1, 2011 to March 31, 2012 - 0%
- effective April 1, 2012 to March 31, 2013 - 0%
- effective April 1, 2013 to March 31, 2014 - 0%
- effective April 1, 2014 to March 31, 2015 - 2.5%
- effective April 1, 2015 to March 31, 2016 - 2.5%
- effective April 1, 2016 to March 31, 2017 - COLA
- effective April 1, 2017 to March 31, 2018 - COLA

(c) for the purposes of this AMA Agreement, "COLA" means a cost of living adjustment equal to the average annual percentage change in the Alberta All Items Consumer Price Index as determined by Statistics Canada and as published in the December 2015 Consumer Price Index Report for the 2016/2017 financial year and in the December 2016 Consumer Price Index Report for the 2017/2018 financial year;

(d) within 90 days (or such longer period of time as the parties agree to) following the final approval and/or ratification and signing of this AMA Agreement by AH and AMA, AH will make a payment of $68 million to AMA (or directly to Alberta's physicians at AMA's discretion) upon the following understandings:

(i) this payment is a one-time only payment and will not create any future or ongoing financial liability on the part of AH, and

(ii) after consulting with AH, AMA will determine how the funds are to be allocated and when the funds are to be paid to Alberta's physicians; and

(e) (i) AH acknowledges that it has the responsibility for the funding impact of increases in expenditures for all Insured Medical Services and plans and programs beyond the Agreed Increases, including utilization increases; and

(ii) AMA acknowledges that AH is not responsible for funding increases arising from errors made by the PCC in calculation for the pricing and introduction of new services or changes in description, rules and pricing.

6. Term

(a) (i) the initial term respecting the financial matters discussed in subsections 5(b) and 5(c) hereof is from April 1, 2011 until March 31, 2018 (the "Initial Financial Term"), and

(ii) the financial matters discussed in subsections 5(b)(i),(ii) and 5(c) hereof are subject to renegotiation according to the provisions of the attached Schedule 1 - Financial Reopeners and Article I of Schedule 5 - Dispute Resolution;

(b) the term respecting the matters discussed in paragraph 3(a)(iv) hereof (whether a Grant Program or not) is from April 1,2011 until March 31, 2018 unless extended according to the provisions of the attached Schedule 2 - Extensions/Amendments and Article II of Schedule 5 - Dispute Resolution; and

(c) (i) for all other matters within the scope and purposes of this AMA Agreement, the term is ongoing and will continue from April 1, 2011 until this AMA Agreement is ended by mutual written agreement of the parties or by operation of law (the "Evergreen Term"), and

(ii) for certainty, the Evergreen Term applies to the financial matters discussed in subsection 3(a)(i),(ii),(iii) notwithstanding the expiry of the Initial Financial Term (or any subsequent financial term).

7. Governance/Management Committee

The parties are of the opinion that it is essential to provide for a broad and general oversight responsibility and authority regarding the efficient and effective implementation and operation of the matters within the scope and purposes of this AMA Agreement. Accordingly:

(a) there will be an AMA Agreement Management Committee (the "Management Committee") comprised of the then Deputy Minister of AH and the then Chief Executive Officer of AMA. However, each of AH and AMA may, at its sole discretion and from time to time, designate another representative to fill their respective position;

(b) subject to the provisions of Article III of Schedule 5 - Dispute Resolution, the Management Committee will, amongst other things:

(i) have overall authority to manage those matters within the scope and purposes of this AMA Agreement including, without limitation, the roles, responsibilities and duties described in the attached Schedule 3 - Management Committee, and

(ii) operate and make decisions and recommendations by consensus.

8. Physician Compensation Committee

While the Management Committee has a broad and general oversight responsibility and authority over all the matters within the scope and purposes of this AMA Agreement, the parties agree to provide for a specific and focused authority regarding the physician compensation, plans and programs other than the Grant Programs which are within the scope and purposes of this AMA Agreement. Accordingly:

(a) there will be a Physician Compensation Committee (the "PCC") which is comprised of the members and which has the authority, roles, responsibility and duties all as described in the attached Schedule 4 - Physician Compensation Committee;

(b) the PCC will take general direction from and will report to the Management Committee. However, within its agreed scope of authority described in Schedule 4 - Physician Compensation Committee, the PCC has independent decision making/recommendation power and its decisions/recommendations are not subject to an appeal to the Management Committee;

(c) (i) decisions/recommendations of the PCC will be made by majority vote. Notwithstanding the number of members that the PCC may have from time to time, for each decision/recommendation of the PCC there will be only three (3) votes cast (i.e. 1 for AMA, 1 for AH and 1 for the Chair of the PCC); and

(ii) a quorum for the proper conduct of business by the PCC will be not less than one (1) AMA member, one (1) AH member and the Chair; and

(d) like the Management Committee, the PCC's authority and decision/recommendation making power is subject to the provisions of Article III of Schedule 5 - Dispute Resolution.

9. Entire Agreement

(a) The Recital clauses and all attached schedules are incorporated into and will form an integral part of this AMA Agreement; and

(b) it is acknowledged and confirmed that this AMA Agreement contains all of the promises and agreements of the parties regarding the scope and purposes of this AMA Agreement and that there are no other promises/agreements, oral or written between the parties regarding the provisions of this AMA Agreement.

10. Laws of Alberta

This AMA Agreement will be construed and will be interpreted according to the laws of the Province of Alberta, and, subject to the dispute resolution provisions of this AMA Agreement and specifically the provisions of Schedule 5 - Dispute Resolution, the Courts of the Province of Alberta will have exclusive jurisdiction regarding the interpretation and enforcement of this AMA Agreement.

11. Invalidity

The invalidity of any particular provision of this AMA Agreement will not affect any other provision and this AMA Agreement will be construed and enforced as if such invalid provision is deleted herefrom unless the invalid provision is a fundamental or material provision of this AMA Agreement.

12. No Waiver/Remedies

(a) The failure of a party at any time to require strict performance by the other party of any obligation described herein will in no way affect the right to enforce such obligation thereafter; and

(b) unless otherwise expressly stated in this AMA Agreement, a failure by a party to comply with or to perform its obligations described herein will entitle the other party, subject to the provisions of Article III of Schedule 5 - Dispute Resolution, to pursue all available remedies at law or in equity. Each party is able to pursue its available remedies either individually or in any combination.

13. Assignment

This AMA Agreement is not assignable in whole or in part by either party without the prior written consent of the other party, which consent may be arbitrarily and unreasonably withheld.

14. Enurement

This AMA Agreement will enure to the benefit of and be binding upon the parties and their respective successors and permitted assigns.

15. Amendment

This AMA Agreement may only be amended or altered in any of its provisions by written document signed and delivered by each party.

16. Words

(a) Wherever and whenever the singular, plural, masculine, feminine or neuter is used in this AMA Agreement, the same will be construed as meaning the plural, singular, feminine, masculine, neuter, body politic or body corporate as the case may be;

(b) a reference to an individual by his or her name of office means the individual appointed as the person holding that office from time to time or the successor of that office;

(c) a reference to a statute or regulation or a provision thereof means the statute or regulation or provision as amended or superseded from time to time, except where otherwise expressly stated herein;

(d) a reference to a person includes a body corporate and a reference to a Department includes the government of the Province of Alberta;

(e) a reference to dollars or amounts of money means lawful money of Canada;

(f) "herein" or "hereof" or "hereunder" and similar expressions when used in a Section will be construed as referring to the whole of this AMA Agreement and not to that Section only, unless otherwise expressly stated;

(g) provisions expressed disjunctively will be construed as including any combination of two or more of them as well as each of them separately; and

(h) any reference in this AMA Agreement, including Schedule 5 - Dispute Resolution, to dispute resolution, facilitation, mediation or any non-binding process shall not be construed as arbitration pursuant to Section 40 of the *Alberta Health Care Insurance Act*.

17. Minister of Health

In this AMA Agreement, except as otherwise expressly stated herein or as required by law, the Minister may, from time to time, perform, exercise, enforce or waive on behalf of the Department any of the rights, powers and privileges conferred on or enjoyed by the Department at law, in equity or by statue.

18. Interpretation

The headings of the Sections of this AMA Agreement are for reference purposes only and will not bear on the interpretation of the provisions herein.

19. No *Contra Proferentem*

The *contra proferentem* rule will not apply to the interpretation of this AMA Agreement.

20. Notices

Any notice required to be given pursuant to or under this Agreement shall be in writing and shall be deemed to have been well and sufficiently given if:

(a) personally delivered to the party to whom it is intended or if such a party is a corporation to an officer of that corporation;

(b) mailed by prepaid registered mail, to the address of the party to whom it is intended as hereinafter set forth; or

(c) sent by facsimile, to the facsimile number of the party to whom it is intended

to such address or facsimile number as a party may from time to time direct in writing.

21. No Fettering

Nothing in this AMA Agreement shall in any manner whatsoever fetter the legislative and regulatory power and authority of the Government of the Province of Alberta and/or the Minister of Health.

22. Signing/Delivery

(a) This Agreement is subject to approval by AH and ratification by the members of the AMA by May 30, 2013.

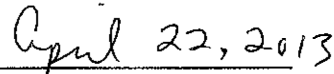
(b) This Agreement may be signed using one or more counterparts which together will constitute one original document. Once signed, including the use of counterparts, this Agreement may be delivered by facsimile transmission addressed to the other party. Such delivery will be as effective as if an originally signed document had been delivered.

23. Effective Date

Notwithstanding the date this AMA Agreement is signed, it will be effective from the Effective Date.

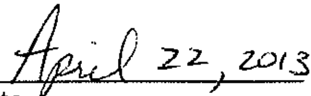
THIS AGREEMENT IS ENTERED INTO BY EACH OF THE UNDERSIGNED BY THEIR AUTHORIZED REPRESENTATIVE:

Her Majesty the Queen in right of Alberta as represented by the Minister of Health



Date

President, Alberta Medical Association



Date

SCHEDULE 1
FINANCIAL REOPENER(S)
(For Matters within the Evergreen Term)

The provisions of this Schedule apply to the financial matters discussed in subsection 5(b) and 5(c) of this AMA Agreement excepting those financial matters concerning the plans and programs described in paragraph 3(a)(iv) of this AMA Agreement (the “Financial Matters”):

1. The Initial Financial Term will expire as of the end of business on March 31, 2018 (the “Expiry Date”).

2. (a) Not earlier than one year prior to the Expiry Date and not later than six months prior to the Expiry Date, either party may serve notice upon the other party of its desire to commence negotiations (the “Notice”); and

   (b) The Notice must provide details of the Financial Matters to be negotiated.

3. The parties will conduct good faith discussions/negotiations for a period of not less than three months from the date the Notice is received. The period of three months may be extended by written agreement of the parties (the “Time for Negotiations”).

4. If the parties have not reached agreement on a new financial deal during the Time for Negotiations, then either party may activate the applicable provisions of Schedule 5 - Dispute Resolution.

5. The provisions of this Schedule will apply, from time to time, to all subsequent financial negotiations arising from the expiry of successive financial deals during the Evergreen Term of this AMA Agreement.

6. After all successful negotiations (if any) of a replacement financial deal as contemplated by this Schedule 1 or after the binding arbitration process described in Schedule 5 has been utilized and has been completed with the issuance of an award by the arbitral tribunal, AH will prepare and the parties will sign and deliver a written amending agreement which:

   (a) records the Annual Increase(s), the Financial Term and the fiscal/budget year(s) for the purposes of subsection 5(b) of this AMA Agreement;

   (b) records any changes to subsection 5(c) of this AMA Agreement; and

   (c) records the new “Expiry Date” for the purpose of paragraph of this Schedule 1.

SCHEDULE 2
EXTENSIONS/AMENDMENTS
(For Matters not within the Evergreen Term)

1. The provisions of this Schedule apply to:

   (a) the Physician Assistance Programs described in paragraph 3(a)(iv) of this AMA Agreement;

   (b) the Prices associated with any or all of the Physician Assistance Programs; and

   (c) the extension or extensions of the initial term described in subsection 6(b) of this AMA Agreement which initial term is to expire as of the end of business on March 31, 2018 (the "Expiry Date").

2. The Expiry Date and subsequent expiry dates may be extended by written agreement of the parties.

3. The payments, benefits and/or subsidies associated with any or all of the Physician Assistance Programs may be added to/deleted from or otherwise amended by written agreement of the parties.

4. (a) Not earlier than one year prior to the Expiry Date and not later than six months prior to the Expiry Date, either party may serve notice upon the other party of its desire to commence negotiations (the "Notice"); and

   (b) the Notice must provide details of the matters described in paragraph 1 of this Schedule which are to be negotiated.

5. The parties will conduct good faith discussions/negotiations for a period of not less than three months from the date the Notice is received. The period of three months may be extended by written agreement of the parties (the "Time for Negotiations").

6. If the parties have not reached agreement regarding some or all of the matters to be negotiated during the Time for Negotiations, then either party may activate the applicable provisions of Schedule 5 - Dispute Resolution.

7. The provisions of this Schedule will apply, from time to time, to all subsequent discussions/negotiations arising from the expiry of any subsequent extended terms.

8. For certainty, if the dispute resolution process of Schedule 5 applicable to this Schedule 2 is activated and utilized, and if at the completion of the dispute resolution process there is no agreement by the parties to continue a Physician Assistance Program upon agreed terms, then that Physician Assistance Program will be at an end.

9. After all successful negotiations (if any) as contemplated by this Schedule 2 and whether mediated/facilitated according to the provisions of Schedule 5, AH will prepare and the parties will sign and deliver a written amending agreement which:

    (a) records the Physician Assistance Programs which are included in the financial deal;

    (b) records the details of the financial deal including the agreed Prices associated with the affected Physician Assistance Programs;

    (c) records the new “Expiry Date” for the purpose of subparagraph 1(c) of this Schedule 2; and

    (d) records any other material matters forming part of the new financial deal.

SCHEDULE 3
MANAGEMENT COMMITTEE
(Roles, Responsibilities and Duties)

The Management Committee will:

1. Ensure that the scope and purposes of this AMA Agreement are followed and implemented as intended.

2. Provide broad general direction to the Physician Compensation Committee ("PCC") including, without limitation, providing guidance regarding the priorities of and the tasks and work to be undertaken by the PCC.

3. Ensure that the PCC has sufficient resources to undertake and complete its tasks and work.

4. Subject to the provisions of Section III of Schedule 5 - Dispute Resolution, provide direction and advice regarding the interpretation of the provisions of this AMA Agreement as requested or required by the PCC and/or the parties hereto, including issues touching and concerning the mandate, roles, responsibilities, duties or authority of the PCC.

5. Provide timely reports to both the Minister of Health and to AMA's President regarding the operation of the PCC, the operation of this AMA Agreement and any other matter deemed relevant by the Management Committee. For certainty, the Management Committee will keep the Minister of Health and AMA's President apprised of any concerns, disputes and/or issues which may develop into and/or have developed into matters that will activate the provisions of Section III of Schedule 5 - Dispute Resolution.

6. Not have the authority to overrule/set aside a properly made decision/recommendation of the PCC.

7. Recommend to the Minister of Health and to AMA's President for potential appointment as the Chair of the PCC not less than three (3) and not more than five (5) persons.

8. Establish the terms and conditions of the contract for the Chair of the PCC.

9. Consult with AH and AMA regarding the establishment of provincial strategic requirements for physician compensation, plans and programs.

SCHEDULE 4
PHYSICIAN COMPENSATION COMMITTEE
(Roles, Responsibilities and Duties)

The Physician Compensation Committee ("PCC") will:

1. Be comprised of not more than seven (7) and not less than three (3) persons. AH and AMA will each appoint up to three (3) representatives.

2. The Chair of the PCC will be appointed by consensus of the Minister of Health and AMA's President each acting reasonably and prudently. The Chair may be selected from a list of names provided to the Minister of Health and to AMA's President by the Management Committee; however, the Minister of Health and AMA's President may choose to appoint a person who is not on the list.

   If the Minister of Health and AMA's President are unable to agree on the appointment of the Chair, then either may by written notice given to the other activate the applicable provisions of Section IV of Schedule 5 - Dispute Resolution.

3. The PCC may deal with all elements of physician compensation, plans and programs (excepting the Grant Programs), subject to the provisions of this AMA Agreement. Therefore:

   (a) this AMA Agreement establishes increases during its term for prices, fees, rates and subsidies;

   (b) AH has responsibility and authority to set annual physician budgets from time to time;

   (c) subject always to the provisions of Section 5 of this AMA Agreement, the PCC will operate and deal with matters of physician compensation, plans and programs (excepting the Grant Programs) within the annual budgets set by AH. Accordingly:

      (i) the PCC has no ability to increase the average prices, rates, fees and subsidies for Insured Medical Services, plans and programs beyond the Agreed Increases,

      (ii) decisions that are determined to have a risk of going beyond the Agreed Increases must go to the Minister of Health for approval,

      (iii) any adjustments in prices, rates, fees and subsidies beyond those identified in paragraph 3(c)(ii) of this Schedule (i.e., arising through a reallocation) are to be expenditure neutral and therefore all savings and/or reductions arising from or through such reallocation cannot be transferred or used outside of the annual budget and when used, may be used anywhere within the annual budget, and

      (iv) the PCC will correct any errors made by it, including, in the calculation of pricing and the introduction of new services or changes in description, rules and pricing;

(d) (i) AH will establish the policy and legislative framework for Insured Medical Services and other physician services, plans and programs including, without limitation, establishing from time to time what is/is not an Insured Medical Service. AH will also, in consultation with AMA and the Management Committee, establish the provincial strategic requirements for physician compensation, plans and programs,

(ii) the PCC will develop a plan to implement the provincial strategic requirements established by AH in consultation with AMA and the Management Committee, including without limitation:

- align physician compensation with goals of delivery based initiatives such as primary care, strategic clinical networks and ARPs; and

- restructure physician compensation to provide the optimal support to those delivery models which are selected to deliver health care in Alberta, and

(iii) the PCC may make recommendations to the Minister of Health concerning the provincial strategic requirements for physician compensation, plans and programs; and

(e) The PCC will undertake tasks related to how Alberta's physicians are currently compensated, including without limitation:

(i) managing the allocation process for changes in Rates under the SOMB as it applies to the provision of Insured Medical Services in fee-for-service and ARPs including the clinical medical services component of AARPs,

(ii) reviewing and managing the distribution of funding among Insured Medical Services, plans and programs (excepting Grant Programs),

(iii) reviewing and potentially adjusting selected Rates for Insured Medical Services and ARP rates, including those for the clinical medical services component of AARPs, and

(iv) reviewing and determining Prices in the following programs:

- Rural Remote Northern

- Physician On-Call

- Business Costs, and

(v) reviewing, commenting upon and listing potential improvements to the programs described in paragraph 3(e)(iv) of this Schedule. The potential improvements may be recommended to the Management Committee.

4. (a) Generally the PCC will cooperate with and will communicate with the Management Committee and it will receive and consider advice and direction from the Management Committee concerning the operation of, the interpretation of and the implementation of the scope and purposes of this AMA Agreement; and

   (b) the PCC will determine its own procedures for its meetings and for accomplishing the tasks assigned to it. These procedures may include, without limitation:

      (i) establishing secretariat support, which may include AH and/or AMA staff and third party resources,

      (ii) establishing rules for the conducting of its meetings including who is eligible to attend (for example, support staff, invited guests and/or Alberta Health Services representatives),

      (iii) establishing sub-committees and/or working groups, and

      (iv) retaining a trusted third-party organization to gather and analyze information, from time to time, which information is relevant to the PCC's work;

   (c) the PCC will submit annually a written business plan and supporting budget to the Deputy Minister of Health (the "DM"). Upon receipt, the DM will consult with AMA's Executive Director regarding the requested support budget. After such consultation, the DM will establish the support budget;

   (d) AH and AMA will be jointly responsible for the costs associated with and expenses incurred by the Chair of the PCC; and

   (e) each of AH and AMA will be responsible for the costs associated with and expenses incurred by their respective members of the PCC.

SCHEDULE 5
DISPUTE RESOLUTION

I. BINDING ARBITRATION ARISING FROM SCHEDULE 1 OF THIS AMA AGREEMENT

1.1 This dispute resolution process of binding arbitration is available only when the parties have complied with the provisions of Schedule 1, have not reached agreement on a new financial deal within the Time for Negotiations and one (or both) of the parties has/have given written notice to the other that it wishes to activate and utilize this dispute resolution process of binding arbitration according to the following provisions.

1.2 This dispute resolution process of binding arbitration applies to only:

(a) annual percentage increases (the “Annual Increases”) for:

(i) Rates for Physician Compensation Programs, and

(ii) Prices associated with any or all of the Physician Support Programs (whether a Grant Program or not);

(b) the definition/determination of COLA, if and when applicable, as used in subsection 5(c) of this AMA Agreement; and

(c) the term (total length of time) of each replacement financial deal between AH and AMA (“Financial Term”) subject to the following:

(i) the Financial Term may be agreed to/set by the parties,

(ii) if the parties do not agree on the Financial Term, then it cannot be less than one (1) year and it cannot be more than three (3) years unless the parties otherwise agree, and

(iii) each Financial Term will be described as a fiscal/budget year or years commencing April 1 and ending March 31 of the following year. For example, a replacement financial deal having a two (2) year Financial Term will commence April 1, 2018 and will end March 31, 2020 and will encompass two (2) fiscal/budget years being April 1, 2018 to March 31, 2019 and April 1, 2019 to March 31, 2020.

1.3 For certainty, this dispute resolution process of binding arbitration does not and will not apply to the matters contemplated by and described within Schedule 2 attached to this AMA Agreement including:

(a) Prices associated with any or all of the Physician Assistance Programs (whether a Grant Program or not); and

(b) to subsection 6(b) of this AMA Agreement.

1.4 Additionally and for certainty, the right to arbitrate does not extend to, and is expressly excluded for, any other matter or dispute whatsoever other than the matters referred to in Article 1.2, and without limitation does not include, in any manner whatsoever, past, present or future Rates or Prices, any of the terms, conditions or parameters for any of the Physician Assistance Programs, the Physician Compensation Programs and the Physician Support Programs or any modifications made thereto, and any issue regarding the type of or description of Insured Medical Services.

1.5 For certainty, AH and the AMA expressly agree that:

(a) unless otherwise agreed by the parties, an arbitral tribunal shall only determine the Annual Increases for the one Financial Term in question and an arbitral tribunal's award with respect to any Annual Increase is only binding on the parties for the applicable Financial Term. No determination or award shall be made for or have any application to any previous or future Financial Term;

(b) in an arbitration proceeding the arbitral tribunal when determining an Annual Increase may consider prevailing and anticipated economic conditions in Alberta and generally may consider what is fair and reasonable compensation for physicians practicing in Alberta;

(c) the arbitral tribunal when determining an Annual Increase shall not review or otherwise analyze/comment upon Rates for Physician Compensation Programs, Prices associated with Physician Support Programs (whether a Grant Program or not) and the provisions/parameters of any Physician Compensation Program or any Physician Support Program (whether a Grant Program or not); and

(d) the reference to Annual Increases shall not preclude or restrict the arbitral tribunal from an award or decision that is, in fact, a negative adjustment which as a consequence results in a decrease or reduction of Rates and/or Prices.

1.6 The arbitration process is activated according to the provisions of Schedule 1. Accordingly if the parties have not reached agreement on a new financial deal during the Time for Negotiations, then either party may give the other party a request for arbitration (the "Request"), which request will, where applicable, describe:

(a) the Financial Term to be arbitrated;

(b) the Annual Increases(s) to be arbitrated; and

(c) the definition of COLA to be arbitrated.

1.7 Subject to Article 1.8, the arbitral tribunal shall be composed of a single arbitrator selected and agreed to by both AH and AMA.

1.8 If the parties cannot agree on a single arbitrator within fifteen (15) days of the date of the receipt of the Request, then the arbitral tribunal shall be composed of three (3) arbitrators, appointed and selected according to the following:

(a) AH and the AMA shall each appoint an arbitrator within thirty (30) days of the date of the receipt of the Request and the two (2) arbitrators so appointed shall then select a third arbitrator who shall act as the presiding arbitrator;

(b) if either AH or the AMA fails to appoint an arbitrator within the stated thirty (30) days, then such arbitrator shall, at the request of the other party, be appointed by the Court of Queen's Bench of Alberta ("the Court") pursuant to the provisions of the *Arbitration Act of Alberta* ("the Act"); and

(c) if the two appointed arbitrators are unable to agree on the presiding arbitrator within fifteen (15) days of the appointment of the second arbitrator, then the presiding arbitrator shall, at the request of either party, be appointed by the Court pursuant to the provisions of the Act.

1.9 The procedure to be followed during the arbitration shall be agreed to by the parties or, failing such agreement, will be determined by the arbitral tribunal subject to the following:

(a) the arbitral tribunal shall conduct the arbitration, hold hearings and determine the issues in private;

(b) the arbitral tribunal shall render an award in writing within thirty (30) days of the end of the hearings or such extended date agreed to by the parties, or failing agreement as determined by the Court, even if the thirty (30) days has expired;

(c) any award shall state the reasons on which it is based;

(d) AH and the AMA shall each bear their own legal expenses and each shall pay 50% of the fees and expenses of the single arbitrator. If there is a three (3) person arbitral tribunal, then each party will pay the fees and expenses of its appointed arbitrator and 50% of the fees and expenses of the presiding arbitrator;

(e) the place of the arbitration shall be Edmonton, Alberta; and

(f) if there is a three (3) person arbitral tribunal, then all decisions and/or awards will be determined by majority vote.

1.10 Nothing in this Article shall preclude the parties from reaching an agreement at any time.

1.11 Unless otherwise provided for in this Article, the Act does not apply to this AMA Agreement and specifically this Schedule 5, Article I.

II. NON-BINDING FACILITATION/MEDIATION ARISING FROM SCHEDULE 2 OF THIS AMA AGREEMENT

2.1 The dispute resolution process of non-binding facilitation/mediation is available only when the parties have complied with the provisions of Schedule 2, have not reached agreement regarding some or all of the matters described in the Notice within the Time for Negotiations and one (or both) of the parties has/have given written notice to the other that it wishes to activate and utilize this dispute resolution process of non-binding facilitation/mediation according to the following terms and conditions.

2.2 This dispute resolution process of non-binding facilitation/mediation applies to only:

(a) Prices associated with any or all of the Physician Assistance Programs (whether a Grant Program or not) as those Physician Assistance Programs are described in subsection 3(a)(iv) of the AMA Agreement;

(b) any other payments, benefits or subsidies associated with any or all of the Physician Assistance Programs; and

(c) the extension of the Initial Term (and any other extensions from time to time) as described in subsection 6(b) of this AMA Agreement. For certainty, the Initial Term will expire on March 31, 2018 unless the parties agree to an extension.

2.3 The facilitation/mediation process is activated according to the provisions of Schedule 2. Accordingly, if the parties have not reached agreement regarding some or all of the matters to be negotiated as described in the Notice during the Time for Negotiations, then either party may give the other a request for facilitation/mediation (the "Request"), which Request, subject to Article 2.2, will describe the matters to be discussed during the facilitation/mediation process.

2.4 Such facilitation or mediation shall take the following form:

(a) the parties shall agree on a facilitator. In the event no agreement is reached, either may apply to the Court of Queen's Bench of Alberta (the "Court") requesting the Court to make such appointment. If possible, preference in making the appointment should be given to a person having knowledge of the delivery of physician services in the Province of Alberta.

(b) the appointed facilitator shall hear representations as soon as possible after appointment and shall issue a report within fourteen (14) days, or such longer period as the parties agree, after completion of representations by the parties;

(c) the parties shall have fourteen (14) days to accept or reject the report in writing. If accepted by both parties, the report shall be formalized in an agreement by the parties;

(d) in the event the report is not mutually accepted, either party shall have fourteen (14) days to submit the matter to a mediator chosen in the same manner as the facilitator (see 2.4(a) hereof);

(e) the mediator shall hear representations by both parties as soon as possible and shall be given access to the report of the facilitator. The mediator shall issue a report within fourteen (14) days, or such longer period as the parties agree, after completion of representations by the parties;

(f) the parties shall have fourteen (14) days to accept or reject the mediator's report in writing. If accepted by both parties, the report shall be formalized in an agreement by the parties; and

(g) if the mediator's report is not accepted by both parties or is otherwise rejected, then this dispute resolution process is ended and the provisions of paragraph 8 of Schedule 2 are applicable.

III. INTERPRETATION AND SCOPE AND PURPOSES OF THIS AMA AGREEMENT AS REFERENCED IN SECTION 10 AND SUBSECTION 12(b) OF THIS AMA AGREEMENT AND IN PARAGRAPHS 4 AND 5 OF SCHEDULE 3 OF THIS AMA AGREEMENT

3.1 Disputes regarding the interpretation and/or the scope and purposes of this AMA Agreement will be resolved as follows:

(a) by reference firstly, to the Management Committee ("MC") for its consensus decision;

(b) if the MC is unable to reach consensus, then by reference to the Minister of Health and to AMA's President for their consensus decision; and

(c) if the Minister and the President are unable to reach consensus, then each party is at liberty to pursue its available remedies as generally described in Section 10 and subsection 12(b) of this AMA Agreement.

IV. SELECTION OF THE PHYSICIAN COMPENSATION COMMITTEE CHAIR ARISING FROM SCHEDULE 4 (PARAGRAPH 2) OF THIS AMA AGREEMENT

4.1 (a) If the Minister of Health and AMA's President are unable to agree on the appointment of the Chair of the Physician Compensation Committee (the "Chair"), then either, by written notice given to the other, may apply to the Court of Queen's Bench of Alberta (the "Court") requesting that the Court appoint the Chair; and

(b) when making an application to the Court, the applicant will provide to the Court for its consideration the list of names which was previously provided to the Minister of Health and to AMA's President by the Management Committee as referenced in paragraph 2 of Schedule 4.

SCHEDULE 6
DETAILS OF GRANT PROGRAMS

Generally, funding will be provided to pay for estimated spending within program parameters. For greater clarity, the basis for the annual budget for each Physician Support and Physician Assistance Program will be as follows:

<table>
<tr><th>Physician Support Programs – (Evergreen)</th><th>Description</th><th>Basis for the Budget</th></tr>
<tr><td>• Compassionate Assistance</td><td>To assist, on compassionate grounds, eligible physicians in need of temporary support, who have been referred by either the College of Physicians and Surgeons of Alberta or a consulting Physician of the Physician and Family Support Program.</td><td rowspan="4">• Base funding of:
o $400,000 for Compassionate Assistance
o $2,478,000 for Regular and Specialist Locum Programs
o $2,175,000 for Physician and Family Support Program
will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.
• Base funding will be readjusted each year if in accordance with a grant, funds are transferred from other programs as a result of a change, in the ordinary course, of physician uptake of that particular program.</td></tr>
<tr><td>• Regular Locum Program</td><td>To ensure that Residents living in communities with four or fewer Physicians (or other critical circumstances approved by the Minister) will have access to continuous medical coverage if a Physician is unable to provide Physician services due to short-term absences.</td></tr>
<tr><td>• Specialist Locum Program</td><td>To ensure that regional centers outside of Calgary and Edmonton (or other critical circumstances approved by the Minister) will have access to specialist coverage due to short-term absences of specialists in regional centers. Local specialists in consultation with the Authority agree on locum needs.</td></tr>
<tr><td>• Physician and Family Support Program</td><td>To provide eligible physicians and their qualified dependants with assistance in dealing with life management issues.</td></tr>
</table>

Physician Support Programs – (Evergreen)	Description	Basis for the Budget
• Parental Leave Program	To provide financial support to eligible physicians who are not practicing medicine as a result of the birth or adoption of a child.	• Estimated utilization (number of weeks * rate) • The base rate of $1,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.
• Continuing Medical Education	To reimburse eligible physicians for costs incurred with regard to the maintenance and enhancement of knowledge, skills, and competency. The annual allotment of shall be carried forward and accumulated for up to three years.	• Estimated number of participants * rate • The base rate of $2,500 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.
• Medical Liability Reimbursement	To reimburse eligible physicians for costs incurred in respect of medical liability insurance premiums as set by the Canadian Medical Protective Association. The annual deductible will be $1000 per Eligible Physician.	• Estimated number of participants * rates charged by the Canadian Medical Protective Association less deductible of $1,000/physician
• Practice Management Program	To assist Physicians with developing and implementing Primary Care Networks by providing support in respect of issues such as group formation, practice governance, relationship issues, taxation, financial projections, liability issues, and any other issues the Association deems necessary.	• Base funding of $2,174,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18. • Program parameters may be expanded to include support for other models beyond PCN's upon consensus decision of the AMA Agreement Management Committee.

<table>
<tr><th>Physician Assistance Programs –

(Non-Evergreen)</th><th>Description</th><th>Basis for the Budget</th></tr>
<tr><td>• Physician Learning Program</td><td>The Physician Learning Program supports and promotes continuous professional learning by Physicians in Alberta. The criteria, program details and operational parameters will be established and reviewed from time to time by the Association in consultation with University of Alberta and University of Calgary.</td><td>• Base funding of $3,475,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.</td></tr>
<tr><td>• Towards Optimized Practice Program</td><td>To support the development, implementation and evaluation of products and services that will facilitate evidence-based best practice and support quality initiatives in medical care in Alberta.</td><td>• Base funding of $1,066,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.</td></tr>
<tr><td>• Retention Benefit</td><td>Physicians will receive retention benefit amounts on an annual basis in recognition of past years of service contribution in Alberta. The level of retention benefit for Eligible Physicians in a specific year will be determined based on the number of years of practice in Alberta and the amount of payments for the provision of eligible services in a given year. Physicians with annual billings for eligible services of $80,000 or more in a given year will receive the full benefit. Those billing less than $80,000 for eligible services in a given year will have their payment prorated.

Base rates for the retention benefits for Fiscal Year 2013/2014 are as follows:

<table>
<tr><th>Years of Service</th><th>Benefit Amount</th><th>Physician Billing</th><th>Benefit Amount</th></tr>
<tr><td>1-5</td><td>$4,840</td><td>≥ $80,000</td><td>100%</td></tr>
<tr><td>6-15</td><td>$7,260</td><td>$60,000 - $79,999</td><td>75%</td></tr>
<tr><td>16-25</td><td>$9,680</td><td>$40,000 - $59,999</td><td>50%</td></tr>
<tr><td>26+</td><td>$12,100</td><td>$10,000 - $39,999</td><td>25%</td></tr>
<tr><td colspan="2"></td><td><$10,000</td><td>0%</td></tr>
</table></td><td>• Estimated number of participants * rate

• The base rates will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.

• The retention benefit income threshold of $80,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.</td></tr>
</table>

Physician Assistance Programs – (Non-Evergreen)	Description	Basis for the Budget
• Alternate Relationship Plan Program Management Offices	• Support the various aspects of the ARP program, including but not limited to, assisting with the development, implementation and accountability processes of individual ARP's	• Base funding of $1,800,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18. • PMO activities aligned with the Physician Compensation Committee implementation plan.
• Primary Care Network Program Management Offices	• Support the various aspects of the PCN program including but not limited to, assisting with the development, implementation, and accountability processes of individual PCN's.	• Base funding of $2,900,000 will increase by 2.5% in 2014/2015 and 2015/16, and COLA in 2016/17 and 2017/18.

1. AMA is responsible for managing the programs in accordance with AMA's policies, practices and procedures, including financial, human resources, information technology and related legal matters established by AMA from time to time.

2. The Association may allocate and apply for its own use in each year, $400,000 in recognition of the AMA's role as representative of physicians, which allocation shall survive this agreement in accordance with the evergreen provision.

3. The Association may allocate and apply for its own use in each year up to 4% of the total grant for costs associated with the administration of the grant programs, which allocation shall survive this agreement in accordance with the evergreen provision. For greater clarity, the 4% administration fee will only be calculated on those plans which continue beyond the initial financial term.

4. The Minister acknowledges that the Association charges non-members an administration fee as a condition of participation in the Physician Assistance and Physician Support Programs. The Association covenants that such administration fee shall not exceed the annual cost of membership charged by the Association to its members for full membership in the Association.

5. For the purpose of the Physician Support and Physician Assistance Programs, it is understood that the base funding amounts referenced in the table above constitute a Price.

6. If a program is discontinued, AH agrees to make funds available for all reasonable and direct costs and expenses actually incurred by AMA to terminate and wind down the program and fulfill AMA's obligations pursuant to this AMA Agreement.

7. AH is generally responsible for any increased costs in each program arising as a result of an increase in the number of physicians who utilize that program.

8. For the purpose of accessing Grant Programs a physician is, with reference to a medical service provided in Alberta to a Resident, a person who is a regulated member of the College of Physicians and Surgeons of Alberta under the Health Professions Act, who holds a practice permit issued under the Act (excluding physicians on the postgraduate provisional register), or a professional corporation registered with the College of Physicians and Surgeons of Alberta.

9. A physician is eligible for the Grant Programs if he/she is a resident of Alberta and is:
   (i) Providing publicly funded Insured Medical Services as defined under the Alberta Health Care Insurance Act, whether paid by Alberta Health, Alberta Health Services or any other party.
   (ii) Providing public health services funded by Alberta Health Services
   (iii) Otherwise approved by the Minister from time to time.

10. Notwithstanding the eligibility criteria above, the parties acknowledge that medical students and resident physicians are eligible for the services provided through the Physician and Family Support Program.

PROVINCIAL ELECTRONIC MEDICAL RECORDS STRATEGY

CONSULTATION AGREEMENT

BETWEEN

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
As presented by the
MINISTER OF HEALTH
("AH")

and

ALBERTA MEDICAL ASSOCIATION
(C.M.A. ALBERTA DIVISION)
("AMA")

1. Description

a) The Physician Office Systems Program (POSP) provided financial, change management and transitional support for physicians wanting to adopt electronic medical record (EMR) technology. In 2010, the parties agreed to an EMR Acceleration Plan that will be completed on March 31, 2014.

b) The parties have been successful in deploying electronic medical records to a substantial number of physicians and their practices.

c) An integrated and coordinated provincial EMR replacement strategy that meets the needs of patients, physicians and the health system is a critical component of our evolving health information system and a key enabler for many health system priorities and initiatives (such as primary care and strategic clinical networks).

d) AH agrees to consult with the AMA on the development of a new approach and an ongoing implementation plan for physician electronic medical records.

2. Provincial EMR Strategy Development

a) AH, AMA and Alberta Health Services (AHS) will develop a provincial EMR strategy that will define the future approach to EMR use, adoption and communication between health system providers in delivering care to the patients of Alberta.

b) The strategy will be focused on EMRs within community-based physician practices (both family physicians and specialists) and will consider such subjects as EMR standards and integration, clinical decision support needs, meaningful use, analytics for population health and linkages to other provincial IM/IT strategies. Additional subject areas will be determined as part of the strategy development process. The strategy will also include an implementation approach and consultation process that will include AMA involvement.

c) The development of the provincial EMR strategy will require a working group that will be chaired by AH and will have representation from AH, AMA and AHS and not more than three members from each. This working group will leverage existing Electronic Health Record governance structures and will provide a final report to the provincial Health Information Executive Committee, no later than February 15, 2014, to be recommended for approval by the Minister of Health prior to March 31, 2014.

3. Subject To

This Consultation Agreement is subject to AMA's members ratifying by May 30, 2013, the written AMA Agreement made effective April 1, 2011 between AH and the AMA.

Deputy Minister
Alberta Health

Executive Director
Alberta Medical Association

PRIMARY MEDICAL CARE / PRIMARY CARE NETWORKS
CONSULTATION AGREEMENT

BETWEEN

Her Majesty the Queen
in Right of Alberta,
As represented by the Minister of Health
("AH")

-and-

Alberta Medical Association
(C.M.A. Alberta Division)
("AMA")

1. DESCRIPTION

a) Primary Care Networks (PCNs) were established in the 2003 Trilateral Master Agreement to support the delivery of primary care in Alberta. Primary care delivery has continued to evolve, including PCNs.
b) Article 4 of the AMA Agreement provides for the parties to consult on Primary Medical Care/Primary Care Networks and to negotiate and sign an agreement describing the parameters of the consultation process.
c) The Primary Medical Care/Primary Care Networks Consultation Agreement is established pursuant to Article 4 of the AMA Agreement.
d) The AMA will work with others to achieve the goals defined in this agreement including the AMA's Primary Care Alliance and the AMA's Primary Care Network Lead Executive.

2. TERM

a) This Agreement is in force until March 31, 2018.

3. PRIMARY CARE NETWORK EVOLUTION

a) The parties acknowledge the work PCNs have done to date advancing primary health care in Alberta (e.g., improving access to primary health care services as well as improving continuity between physicians and patients). The parties also acknowledge that more work can be done to further improve and evolve the existing PCNs toward an improved and more accountable health care system in Alberta.

b) The parties acknowledge that the PCN evolution is part of an ongoing evolution in Primary Health Care which encompasses other health and social services providers.

c) The parties agree to develop a framework within which PCN evolution (e.g., PCN 2.0) can be developed and managed. This will include:

I. Establishing linkages to the broader provincial primary care strategy.
II. Understanding and taking into consideration the impact primary care has on the broader health system.
III. Contributing to a common accountability framework for Primary Health Care, including PCN 2.0

d) The parties will work together to identify and establish areas where standardization would be of benefit across all provincial PCNs (e.g., minimum outcome expectations). The parties will also review and advise on any necessary PCN specific policies it deems necessary to ensure high functioning PCNs consistent with those policies established by the Minister of Alberta Health.

e) Alberta Health agrees to consult with the AMA on primary health care strategy and policy development.

4. PRIMARY CARE NETWORK FUNDING

a) The current PCN per capita funding amount is $62.

b) The PCN Committee shall review and provide advice on the per capita funding amount for Primary Care Networks on an annual basis, subject to a non-binding dispute resolution processes.

c) Any Party may commence a non-binding facilitation or mediation process with respect to the matters set out in Article 4(b) provided:

(i) Notice of facilitation or mediation shall in all cases be in writing by one party to the other which notice shall contain details of the matters in impasse.

(ii) Such facilitation or mediation shall take the following form:

(1) The parties shall agree on a facilitator. In the event no agreement is reached, either may apply to the Court of Queen's Bench of Alberta (the "Court") requesting the Court to make such appointment. If possible, preference in making the appointment should be given to a person having knowledge of the delivery of physician services in the Province of Alberta;

(2) The appointed facilitator shall hear representations as soon as possible after appointment and shall issue a report within fourteen (14) days, or such longer period as the parties agree, after completion of representations by the parties;

(3) The parties shall have fourteen (14) days to accept or reject the report in writing. If accepted by both parties, the report shall be formalized in an agreement by the parties;

(4) In the event the report is not mutually accepted, either party shall have fourteen (14) days to submit the matter to a mediator chosen in the same manner as the facilitator (see 4 (c)(ii)(1) hereof);

(5) The mediator shall hear representations by both parties as soon as possible and shall be given access to the report of the facilitator. The mediator shall issue a report within fourteen (14) days, or such longer period as the parties agree, after completion of representations by the parties;

(6) The parties shall have fourteen (14) days to accept or reject the report in writing. If accepted by both parties, the report shall be formalized in an agreement by the parties; and

(7) If the mediator's report is not accepted by both parties or is otherwise rejected, then this dispute resolution process is ended.

d) The PCN Committee may, at its own discretion, review methodologies for PCN funding for recommendation to the Minister (e.g., 4-cut funding model, population-based funding model such as formal attachment, etc.)

e) Physician compensation for the provision of insured medical services within primary care models such as PCNs and FCCs which are paid for directly by Alberta Health will be managed according to the provisions of the AMA Agreement.

5. PRIMARY CARE NETWORK (PCN) COMMITTEE

a) To achieve the goals, a PCN Committee will be established.

i) The PCN Committee will be chaired by Alberta Health and will have five (5) representatives from the AMA's PCN Physician Lead Executive, three (3) representatives from Alberta Health Services and two (2) additional representatives from Alberta Health.

b) The PCN Committee will, when providing advice, ensure this advice is consistent with the policies established by the Minister of Health. Where there are identified gaps in policy the PCN Committee will provide that advice to the Minister of Alberta Health.

c) The PCN Committee is responsible for advising on policy and issues relating to PCNs.

   i) The PCN Committee will advise on the program management, policies and issues relating to PCNs and the development of PCN 2.0.

d) PCN Committee is an advisory body reporting to the Minister of Health.

e) AMA and AH will agree the PCN PMO will be used within the context of the Primary Care Network (PCN) Program. The AMA and AH will work together to determine the appropriate role of the PCN PMO. This work will be completed by December 31, 2013.

6. SUBJECT TO

This Consultation Agreement is subject to AMA's members ratifying by May 30, 2013, the written AMA Agreement made effective April 1, 2011 between AH and the AMA.

Deputy Minister
Alberta Health

Executive Director
Alberta Medical Association

SYSTEM-WIDE EFFICIENCIES AND SAVINGS

CONSULTATION AGREEMENT

Among

Her Majesty the Queen

in Right of Alberta,

as represented by the Minister of Health

("AH")

- and -

Alberta Medical Association

(C.M.A. Alberta Division)

("AMA")

- and -

Alberta Health Services

("AHS")

1. DESCRIPTION

Alberta Health (AH), Alberta Health Services (AHS) and the Alberta Medical Association (AMA) are all committed to a sustainable health care system from the perspectives of both quality and funding. Striving for both aspects requires the identification of opportunities for efficiencies and savings, ensuring that:

a. Resource allocations to health care are based on best evidence as to the contribution of these resources to a healthy economy and the health objectives of patients and populations

b. Resource allocations within health care are allocated on the best evidence as to what is most effective and efficient in meeting health care needs.

The parties, either jointly or separately, are currently engaged in a number of initiatives to identify and implement such savings and/or efficiencies. Parties recognize that effectiveness and success of these initiatives will be better served though improved communication and sharing of ideas, greater coordination and alignment of activity and, more ability to prioritize initiatives across organization, to ensure focus and adequate resourcing success.

2. STRUCTURE AND SCOPE

The parties shall establish a Working Group on system-wide efficiencies and savings. For the purposes of this agreement system-wide means proposals that are within a common -sphere of the three parties. This Working Group shall be comprised of: Deputy Minister, Alberta Health (chair); CEO, Alberta Health Service; Executive Director, Alberta Medical Association.

The purpose of the Working Group shall be to identify a prioritized list of proposals for system-wide efficiency and savings. Each proposal will include without limitation a description; the mechanism(s) for achieving efficiencies and savings: Implications for patients, especially in regard to quality of care and access; timelines for any necessary investment and returns; metrics; roles and responsibilities.

The Working Group will determine its own procedures for meeting and accomplishing its task.

While not intending to limit the Working Group in anyway, "Summary of Initiatives" found in the attached appendix describes the opportunities that came out of a one-day session of AH, AHS and AMA staff held on April 8, 2013. Items contained in the appendix are intended to be illustrative at this time.

3. TERM

The term of the Working Group shall be from April 1, 2013 to March 31, 2016 with an initial meeting to be held by June 2013.

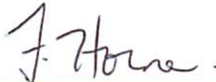
4. REPORTING

The Working Committee shall report to the Minister of Health who will consult with the Chair, Alberta Health Services and President, Alberta Medical Association on impact of the recommendations. Following that, the Minister may direct which, if any of the recommendations are to be pursued by the parties and *any* additional direction to the Working Group.

The first report of the Working Group will be due September 1, 2013 with subsequent reports presented in six month intervals over the term.

5. SUBJECT TO

This Consultation Agreement is subject to AMA's members ratifying by May 30, 2013, the written AMA Agreement made effective April 1, 2011 between AH and the AMA.



Hon. Fred Horne
Minister
Alberta Health

Mr. Stephen Lockwood
Chair
Alberta Health Services

Dr. R. Michael Giuffre
President
Alberta Medical Association

Appendix

Summary of Party efficiency finding of April 8, 2013

Note: Short Term (S.T).- under 1 year; Medium Term (M.T.) - 1-2 years; Long-term (L.T.). - 2+ years

Initiative	Description	Timing	Comments
Primary Care			
Mixed Payment Model	Alternate payment arrangement incorporating elements of population (capitation), service, and performance incentives.	S.T.	• Stabilize funding • Enhance population health and resources management incentives.
Enrollment	Formal attachment of patients to family physicians.	S.T.	• Studies have demonstrated improvement in quality, decreased utilization, and decreased overall costs that are directly related to the degree of attachment. • A necessary precursor to most elements of advancing primary care: e.g. population focus and quality measurement/reporting. • Several regulative and administrative supports required. • Patient concerns and incentives for enrollments need to be considered.
Accreditation	Move forward with PCN Accreditation as proposed by the AMA PCA.	S.T.	• Begin process of establishing, achieving and maintaining standards.

Initiative	Description	Timing	Comments
Primary Care cont'd			
At Risk Patients	Focus resource management and support on 'at-risk' patients: the 5% of the population that accounts for 60% of health resource utilization.	M.T.	• 'At-risk' includes: o Chronic conditions o Low primary care access with high specialist usage o Complex, acute inpatient on discharge from acute • Important support programs include Home Care, CHOICE, and potentially FCCs. • FCCs aligned with PCNs and aimed towards at-risk populations or low primary care access populations offer significant opportunity. • Aligns AH, AHS and AMA activities. • Potential to offer improved quality of care and quality of life at a lower cost.
System Objectives and Integration	Explore opportunities and develop a long-term direction with primary care as the foundation for overall system efficiency and effectiveness.	L.T.	• Models discussed include: o Triple AIM (population health; cost per patient; patient experience) o Accountable Care Organizations (shared savings; quality measurement and reporting) • Necessary framework to align the short-term and medium-term initiatives: payment, accreditation and enrollment. • Aligns AH, AHS and AMA

<table>
<tr><th>Initiative</th><th>Description</th><th>Timing</th><th>Comments</th></tr>
<tr><td>Appropriateness

Decision Support</td><td>

Educational tools and supports for physicians and teams on appropriate diagnostic testing.</td><td>

S.T. to L.T.</td><td>

• Initial focus should be on lab, DI, and medication management but could be broadened to other aspects of medicine
• Opportunity to build on Canadian Association of Radiology (CAR) guidelines with assistance of Alberta Society of Radiologists (ASR)
• CoF CPGs provide a priority listing
• ‘Choose Wisely’ program should be considered
• Clinical decision support systems integrated with EMRs are needed.</td></tr>
<tr><td>Drug Utilization</td><td>Undertake a review of opportunities to improve clinical decision making respecting specific pharmacology</td><td>S.T. to L.T.</td><td>• Information systems support
• Some specific opportunities are available, e.g., drug management related to macular degeneration
• Clinical decision support systems integrated with EMRs are needed</td></tr>
</table>

Initiative	Description	Timing	Comments
Improve Efficiency and Reduce Waste			
Service Protocols	Publicly funded services are done with protocols and timelines. Protocols in effect, define what is covered Limits to services may be instituted, e.g., changing annual screening to biannual.	S.T. to M.T.	• Communication with the public is needed • Information systems support needed, e.g., access to real-time data to manage time limits
Working with Sections	Work with AMA Sections to identify opportunities for: • Fee schedule improvements • System efficiencies • Appropriateness	S.T.	• SCNs and sections need to work more closely • Several SCN proposals require an alignment of physician compensation with the initiative • Shared savings should be considered
Physician Compensation			
Relativity	Improve relativity in physician payments: 1. Initial opportunity for sections to address challenges with their schedules 2. Physician Compensation Committee will have the authority to move funds between fee items	S.T. S.T. to L.T.	• Improved intersectional relativity important to ensure appropriate incentives for medical decision-making • Initial opportunity for sections to adjust their schedules seen as an important precursor to the work of the Physician Compensation Committee
Overhead	Review of measurement and payment for overhead in conjunction with fair cost recovery and the incentive structure	M.T.	• Cost recovery is an important consideration for fee relativity and is a component of the incentive structure. • Improved measurement of costs required

Initiative	Description	Timing	Comments
Physician Compensation Cont'd			
Bundled Payments (case rates)	A blend of FFS and capitation Bundling of payments around an episode of care	S.T. to L.T.	• Can improve efficiency within the bundled care • Combined with appropriateness criteria and shared savings, can also improve system efficiencies and capture savings • SCNs can serve to identify opportunities. Several proposals are already in early development • Aligns AH, AHS, and AMA
Practice Improvements	Examples: • Review group visits • E-visits and consultations • Home visits	S.T. to L.T.	• Needs to align with other strategies, e.g., chronic care • Mostly aimed at system efficiencies and improved access
Physician On-call programs	Harmonize after-hours and on-call payments	S.T. to L.T.	• Several Sources: On-call Program, SOMB and AHS payment • Will require greater transparency and sharing of information between all payers • Work can be undertaken by the Physician Compensation Committee
Program and Benefits			
Reduce Rates	Potential savings through rate adjustments or program elimination.		• Direct impact on physician compensation • No consensus reached

Appendix B

Examples of Savings and Cost Avoidance

- Drug utilization - up to $50 million cost savings
  - mainly through appropriateness criteria
  - provision of cost information for alternative therapies thought to be useful
  - major initiatives, e.g., alternative drug therapy treatment of macular degeneration

- Appropriateness management initially for lab/Diagnostic Imaging - up to $50 million cost savings
  - will work with AMA sections to help identify
  - real-time access to claims submission
  - opportunities represented by programs such as 'Choose Wisely'
  - Council of Federation initiatives related to CPGs and appropriateness

- Focus on 5% over two years of the high needs population - up to $60 million cost savings
  - Persons with chronic conditions utilize significant resources
  - Significant opportunity to work in collaboration between AMA and AHS to find system savings
  - Primary care enrollment and payments will be the key focus

- Introduce alternate payment models for primary care- cost savings unknown at this time
  - Alignment with population health incentives and care of chronic populations
  - Opportunity represented by ACO and triple AIM

Priorities:

Primary care in the near term:

- Enrollment of patients
- Accreditation
- Alternate Relationship Program for primary care physicians – capitation

Implementation of strategy towards high risk populations:

- Address vulnerable population or high volume system users.

To address appropriateness and other efficiencies:

- IT Clinical Support – Clinical Decision Support
- Introduce bundled care or case rate services

To address relativity Issues:

- AMA sections to have opportunity to address internal relativity prior to the fee relativity work of the compensation commission.