SCHEDULE A

SESSIONAL MODEL CLINICAL ARP CONDITIONS OF PAYMENT

1. Capitalized words not defined herein have the meaning given to them in the Clinical ARP Program Parameters.

2. The terms and conditions of this Ministerial Order are subject to the overriding provisions outlined in the Clinical ARP Program Parameters. In the event of any conflict between the provisions of this Schedule and the Clinical ARP Program Parameters, the provisions of the Clinical ARP Program Parameters shall be paramount.

3. "**Program Service Hour**" means 60 minutes of Program Services provided by Participating Physicians in accordance with the requirements of the Ministerial Orders as applicable to this Clinical ARP. A Program Service Hour shall not include a Participating Physician's on call availability to provide Program Services, but may include the Participating Physician's time spent at the Centre waiting for Patients who fail to attend scheduled appointments, each unattended appointment being deemed equivalent to the Participating Physician having provided 0.25 of a Program Service Hour hereunder.

SECTION 1

APPENDICES

The following appendices are incorporated into and form part of this Ministerial Order:

Appendix	**Description**
1.0	Compensation
2.0	Program description
3.0	Claims for Benefits
4.0	Performance reporting

APPENDIX 1.0

COMPENSATION

1. Compensation

(a) The maximum annual Compensation payable to the Participating Physicians who provide and submit Claims for Benefits for Program Services in accordance with the Clinical ARP Program Parameters and this Ministerial Order during the year to which the Compensation relates (or pro-rated for a portion of a year) shall not exceed the lesser of (i) the annual payment rate per FTE multiplied by the number of Participating Physicians on the Clinical ARP Physician List and (ii) the annual payment rate per FTE multiplied by the maximum number of FTEs, as set out in Table 1 below:

Table 1
Pay period: April 1, XXXX – March 31, XXXX

Specialty	Maximum number of Program Service Hours per annum	Hourly rate	Maximum annual Compensation
Family medicine/General Practice			
Psychiatry			

(b) Participating Physicians shall report all FTEs provided in accordance with the FTE reports attached hereto; however, subject to paragraph (a) and to prior approval by the Minister, any Program Services provided by a Participating Physician over 1.5 FTEs worth of Program Services annually is not compensable by the Minister as part of this Clinical ARP or otherwise.

(c) The Compensation shall be reduced by any applicable deductions identified in the Clinical ARP Program Parameters and this Ministerial Order.

(d) Subject to receipt of Claims for Benefits, the Minister may pay the Compensation described hereunder in monthly instalments.

(e) The Minister may, at any time, adjust Compensation payments to ensure Compensation paid to Participating Physicians accurately reflects the actual FTEs of Program Services provided and reported hereunder.

(f) Subject to paragraph (a) and notwithstanding the allocation of FTEs between Specialties, if any, in Table 1, the Participating Physicians may distribute FTEs between the Specialties indicated in Table 1 at their discretion.

2. Other funding provisions specific to this Clinical ARP

All funding sources for the Clinical ARP are identified in the tables below. The term FTE, when used in Table 2, is as defined by AHS or other employer. Support provided through AHS Funding is subject to AHS' annual budgeting and planning process.

Table 2
Current and proposed professional and support staffing

Staff by type	FTEs Fiscal or operating year[1] 2015-2016	Proposed FTEs per Fiscal or operating year[2] 2016-2018	% Responsibility[3]	
			Physician Funding	AHS Funding
Non-Physician clinical				
Nurse coordinator (early risk assessment)			%	%
Registered nurse			%	%
Genetics counselors			%	%
Ultrasound sonographers			%	%
Administrative			%	%
Clerical			%	%
Clerical support genetics			%	%
Secretary (early risk assessment)			%	%
Service worker			%	%

[1] Last complete operating year (April 01-March 31).
[2] Operating year (April 01-March 31).
[3] Actual dollars not required.

Table 3
Expense responsibility sharing by major expense category

Expense category	% Responsibility[1]	
	Physician Funding	AHS Funding
Operating expenses		
Space and associated costs	%	%
IM/IT (Clinibase, Supply Chain Management, Astraia, Picture Archiving & Communication System, Netcare)	%	%
Other[2]:	%	%
Service Event Reports	%	%
Data analysis for performance reporting	%	%
Pagers	%	%
Cell phones	%	%
Professional fees	%	%
Capital improvements (Minor renovations for ultrasound reporting stations)	%	%

[1] Actual dollars not required.
[2] Typical items might include costs of collecting and calculating data for reporting, moving costs, recruitment costs, or travel costs.

APPENDIX 2.0

THE PROGRAM

Key criteria and details of the Program are set out below.

This Appendix details:

(a) an overview of the Program;

(b) the goals of the Program and any proposed changes in practice that support Clinical ARP principles/purposes;

(c) the Centre;

(d) the type of services to be provided, including the scope of the services and proposed changes from current services;

(e) the Patients to be served;

(f) the service delivery model including any intended allocation of FTEs among Participating Physicians, Program hours, services, and any other levels and parameters within which the Program is to operate;

(g) the management of the practice and any proposed changes;

(h) the roles of non-Physician professional staff on the Program team;

(i) the information technology support services and resources needed to support the Program; and

(j) the quality management program activities for the Program.

The Program particulars are:

A. Overview:

The Program facilitates the development and coordination of high-risk population in Edmonton. The Program improves quality and safety of care and enables consistent recruitment and retention efforts, which improves Patient access. The Program encourages opportunities for multidisciplinary collaboration by enhancing consistency and improvement in the delivery services.

B. Goals:

The overall goal of the Program is to improve the quality and safety of care for patients with high-risk conditions. Through the Program, Participating Physicians will demonstrate success in the following ways:

- Enhance Patient satisfaction related to Participating Physicians working closely with a multidisciplinary team;
- Enhance continuity and quality of care by enabling Participating Physicians to collaborate with antenatal Physicians and access the latest innovations in treatment;
- Improve Participating Physicians' satisfaction by enabling a critical mass of expertise and a secured compensation package that encourages innovation and provides for a balance of clinical work and personal life.

C. The Centre:

Notwithstanding the buildings, facilities, locations, or geographic areas that may be described in this Appendix as the site(s) for the provision of Program Services, the Centre for this Clinical ARP is deemed to be the list of all buildings, facilities, locations, or geographic areas, as the case may be, as approved by the Minister in accordance with Section 3.2 of the Clinical ARP Program Parameters.

D. Program Services:

Program Services include:

- Coordination of clinical services including tertiary care and referral services;
- Determining the priority of Patients' treatments;
- Coordination of transport to appropriate facilities;
- Supporting the treatment of Patients;
- Supporting labour and delivery services;
- Supporting the treatment of postpartum complications;
- Health promotion and education services including immunizations;
- Comprehensive Patient assessments;
- Management and treatment of gynecological and obstetrical conditions;
- Provision of contraceptive services, including intrauterine device insertions;
- Treatment examinations and form completion;
- Chronic disease diagnosis and treatment;
- Management and treatment of gastrointestinal conditions;
- Management and treatment of respiratory conditions;

Program Services as described in this Appendix include all health services codes related to the provision of those services.

E. Patients:

The target Patient population is people with all ages who live in the inner-city surrounding area, and who may have medically, socially, and psychologically complex issues, and may include:

- Seniors;
- Immigrants;
- High-risk youth;
- Homeless population.

Service delivery model

Program Services are delivered through a multidisciplinary team that functions in an integrated manner. The multidisciplinary team consists of Participating Physicians, nurses, addictions counsellors, pharmacists, social workers, and other allied health care workers who have experience in dealing with this population and provide Program Services in a culturally sensitive fashion.

This group functions as an integrated team in that they see Patients together and conference around the Patient with each team member having equal say in planning for Patient care. The Patient participates in decisions about harm reduction services and contracts regarding outcomes of care. The core team brings expertise from their professional backgrounds, and jointly through their experience in dealing with this population. Each can, and do, call on other professions, as the service requires.

Patients present with multiple needs, including both medical and social issues. They often seek care for their addictions; physical and mental illness issues are often present. The presence of all three elements complicates a Patient's assessment and treatment.

Participating Physicians provide Program Services at the Centre to provide continuity of care for Patients. With this hard-to-treat and hard-to-locate Patient population, the Participating Physicians sometimes travel to the Patient. The Program provides Program Services at the Centre Monday to Friday.

When appropriate, Participating Physicians, nursing staff and addictions counsellors meet with the Patient. Care plans are developed through case conferences that are Patient-centred and involve the team equally, including the Patient who participates in decisions regarding harm reduction. Care plans are documented in a team contract that outlines expected outcomes, which the Patient signs.

F. Practice management

The multidisciplinary support team, with team members operating together, ensures that Program Services are in accordance with evidence-based clinical practice guidelines and best models of care.

G. Roles of non-Physician professional staff

Non-Physician professional staff and their roles include:

Licensed practical nurses: responsibilities include immunizations, dressing changes, wound care, and transfer of care.

Registered nurses: responsibilities include coordinating patient services, case management and follow up, performing physical assessments, and counselling and education.

Contact with the following AHS roles are facilitated by the Participating Physicians for the Patients.

Pharmacists: responsibilities include management of medication distribution for Patients, and education for Patients and the multidisciplinary team.

Social workers: responsibilities include consultation, assessment, counselling, education, support, and links with other community providers.

H. IT support services and resources

The Participating Physicians and other funding organizations will arrange and fund the IT support services and resources between themselves.

I. Quality management program

- The quality management program is through coordinated and planned activities and includes:
- Implement clinical practice guidelines;
- Report on performance measures on a quarterly and annual basis; and
- Discuss quality management topics and reports during management meetings.

APPENDIX 3.0

CLAIMS FOR BENEFITS

1. Program Service Hours reports

Participating Physicians shall submit Program Service Hours reports to the Minister via Alberta Health's electronic invoicing application. These Program Service Hours reports shall be submitted at least once per month (if Program Service Hours were provided during that month) during the term of this Ministerial Order, and must be submitted not later than 180 days from the date that the Program Service Hours were provided.

Program Service Hours reports shall include the minutes worked by that Participating Physician during Program Service Hours, reported in 15-minute blocks of time.

2. Service Event Reports

Participating Physicians shall submit to the Minister Service Event Reports within 90 days of having submitted the Program Service Hours report or 180 days following the Program Service event, whichever is earlier. Service Event Reports shall be submitted via Alberta Health's electronic submission application (H-Link).

For any Program Services which do not have a corresponding SOMB code to facilitate reporting via H-Link, the Participating Physicians shall submit to the Minister at the address provided in the Clinical ARP Program Parameters a supplementary written report of these Program Services provided.

APPENDIX 4.0

PERFORMANCE REPORTING

Participating Physicians shall report on performance measures to demonstrate Clinical ARP outcomes. The Authorized Representative and a representative from AHS shall review and sign each performance report.

Quarterly performance reports and annual performance reports, in the form and manner established by the Minister and attached hereto as Attachment 1 to Appendix 4.0 of this Schedule shall be submitted to the Minister, using the address identified below:

Policy Analyst
Alternative Compensation Delivery Unit
Provider Compensation and Strategic Partnerships Branch
Health Workforce Planning and Accountability Division
Alberta Health
11th floor, 10025 Jasper Avenue
Edmonton AB T5J 1S6

In order to allow flexibility in identifying performance measures as necessary to support Program goals and priorities, the form and manner of quarterly or annual performance reports as set out in this Appendix 4.0 of this Schedule shall be deemed to be updated immediately upon the Minister providing written notice of any reporting changes to the Authorized Representative and AHS.

APPENDIX 4.0, ATTACHMENT 1

QUARTERLY AND ANNUAL PERFORMANCE REPORTS

a) Quarterly reports

Participating Physicians shall submit quarterly performance reports to the Minister according to the following schedule:

Quarter	Report due date
1: April-June	July 31
2: July-September	October 31
3: October-December	January 31
4: January-March	April 30

Quarterly reports shall be submitted to the Minister substantially in the following form:

Category	Indicator	Indicator data source	Data responsibility	Actual results				Comments
				Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Performance Measure								
Performance Measure								

b) Annual reports

Participating Physicians shall submit annual performance reports based on the fiscal year (April 1 to March 31), by June 30th of each year during the term of this Clinical ARP.

Annual performance reports shall include the measures reported on in quarterly performance reports and shall be submitted substantially in the following form:

Category	Indicator	Indicator data source	Data responsibility	Fiscal year end		Variance	Explanation of variance
				Proposed results	Actual results		
Performance Measure							
Performance Measure							

Discussion of variance:

Action plans to meet targets (if required):