Made effective April 1, 2018 (Effective Date).

MEMORANDUM OF UNDERSTANDING (MOU)

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
AS REPRESENTED BY THE MINISTER OF HEALTH
(AH)

and

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)
(AMA)

and

ALBERTA HEALTH SERVICES
a regional health authority created under the *Regional Health Authorities Act*
(AHS)

WHEREAS:

A. AH and AMA are parties to an agreement made effective April 1, 2011 (AMA Agreement);

B. AH, AHS and AMA have engaged in good faith negotiations in 2018 to explore issues of common interest with the aim of managing the rate of growth with respect to the physician services budget, improving the effective health care to Albertans and jointly ensuring the sustainability of the health care system in Alberta (Negotiations);

C. The parties have reached consensus on a number of issues, some of which will be reflected in amendments to the AMA Agreement; and

D. Through execution of this MOU, the parties wish to document their consensus on those issues which are outside of the scope of the AMA Agreement.

NOW THEREFORE, AH, AHS and AMA understand as follows:

1. **Scope and term of MOU**

   a) This MOU is not intended to add to nor derogate from the parties' respective roles and responsibilities under the AMA Agreement.

b) In undertaking the commitments outlined in this MOU, the parties will, where possible, provide assistance and subject matter expertise to each other.

c) This MOU expires March 31, 2020.

2. Blended Capitation

a) The parties intend to form a Blended Capitation Model working group and, through it, intend to submit the plan outlined in Appendix A, attached hereto, to the Management Committee who may recommend options for implementation to the Minister of Health.

b) The Minister of Health retains decision-making authority on implementation.

3. Continuity of Care Compensation Strategy

a) The parties have a shared interest in promoting continuity of care.

b) The parties acknowledge that physician compensation plays an important role in promoting continuity in primary care and the Patient Medical Home model, as well as between primary care and specialists, and specialists to specialists.

c) The parties intend to consult on how physician compensation could be adjusted to maximize continuity of care.

d) The parties intend to provide the following reports to the Minister of Health:

i. an interim report by December 1, 2018;

ii. an interim report by August 2019; and

iii. a final report by March 31, 2020.

4. System and Market Impact Assessment

a) The parties intend to develop a System and Market Impact Assessment.

b) A System and Market Impact Assessment may ensure the parties remain responsive to changing health system needs. It would allow for monitoring of special initiatives including physician resource planning and changes to the Schedule of Medical Benefits.

c) The parties intend to provide advice to the Minister by March 31, 2019.

5. CPAR Collaboration

a) AH will continue to support the Centralized Patient Attachment and Provider Registry (CPAR).

b) The Primary Care Network Program Management Office grant will be amended to support CPAR implementation.

6. **Physician Workplace Leadership**

    a) AH will work with AMA, AH, the College of Physicians and Surgeons of Alberta (CPSA), and other partners, as system leaders to develop strategies to address disruptive behaviours in physician workplaces.

    b) Existing initiatives led by the CPSA may be used as a venue for collaboration.

7. **Government support for initiatives under the Appropriateness and Evidence-Based Improvements Committee**

    a) The Appropriateness and Evidence-Based Improvements Committee has identified 17 potential areas of focus for non-drug technologies. These activities will increase quality and reduce variation in services and outcomes. Implementation of these activities will require consultation with AMA sections and change management support.

    b) AH intends to prioritize working collaboratively with Strategic Clinical Networks and the Physician Learning Program, among others, to implement appropriateness activities.

8. **Opioid Education Program**

    a) AH commits to providing AMA with $500,000 to develop a provincial opioid education and awareness campaign based on Opioid Wisely as part of the provincial opioid response.

    b) AH intends to reflect this commitment in a grant agreement to the AMA provided no later than March 31, 2019.

9. **Choosing Wisely**

    a) AH and AMA intend to work with others in furthering the objectives of the Choosing Wisely initiative in Alberta.

10. **Integration**

    a) The parties intend to work on projects to improve integration of care in Alberta, including improving opportunities to examine current referral processes and develop strategies for improvement.

11. **Physician Resource Planning Census**

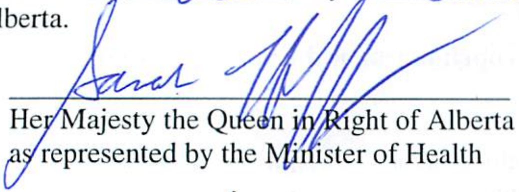
    a) AH, AMA and AHS intend to develop a better needs-based analysis of need for community physicians.

    b) The parties acknowledge that Primary Care Networks are ideally situated to collect information on the need for community physicians. AH intends to internally allocate funds to administer a census process to assess the current services and needs on a community by community basis.

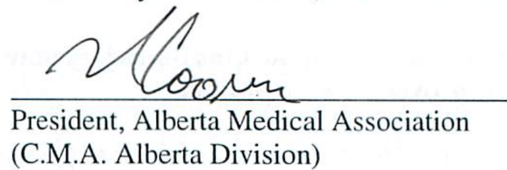
12. Amendments

a) This MOU may be amended only by written agreement signed by the parties hereto.

DATED this 22 day of June, 2018 at the City of Edmonton, in the Province of Alberta.



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



President, Alberta Medical Association
(C.M.A. Alberta Division)

Alberta Health Services

Appendix A

BLENDED CAPITATION RECOMMENDATIONS

The following recommendation on how to improve the Blended Capitation Model were developed jointly by AH, AHS and the AMA.

Model Elements & Financial Shift	Engagement & Communication Shift
Allow for comprehensive care clinics to provide episodic care to truly transient patients Amend 2 FFS limit per lifetime for in-basket claims for unaffiliated patient to 2 FFS visits per 2 years. System dependent **Facilitate comprehensive care provision by the most responsible physician** Allow only those physicians within the BCM ARP to bill certain comprehensive care SOMB codes for affiliated patients. System dependent **Allow for shifts in physician mental model without penalizing interested physicians** Allow clinic participation in BCM at 80% of physician involvement instead of 100% **Recognition of limitations in identifying special interests GPs** Negation forgiveness at 1% of negation during evaluation period **Assurance of formal patient affiliation at go-live** Clarify re-enrollment procedure Allow affiliation/form signature prior to Go- live date CPAR dependent **Ensure cashflow is not disrupted during FFS to BCM transition** Allow payment run one pay period prior to go-live date CPAR dependent **Commitment to prioritize modelling for rural BCM option**	**Engage in personal & specific conversations with potential BCM ready clinics** Targeted contact to potential clinics (Quality Improvement Involvement) **Acknowledge the monumental shift BCM requires in clinic practice** Mental Model focus in communication materials Philosophy of Care focus during initial clinics discussions Acknowledgment of massive level of change BCM requires of clinics 6 months lead time after decision to go ahead Possible re-branding (Care Based Model?) **Incorporate learnings from current BCM clinic** Including cashflow modeling in financial discussion