REPORT CARD

STATUS OF THE

TRILATERAL MASTER AGREEMENT

BETWEEN

ALBERTA HEALTH AND WELLNESS

ALBERTA MEDICAL ASSOCIATION

ALBERTA'S REGIONAL HEALTH AUTHORITIES

MARCH 2005

Alberta
HEALTH AND WELLNESS

ALBERTA
MEDICAL
ASSOCIATION

Alberta's
Regional Health
Authorities

SUBJECT

MESSAGE FROM THE MASTER COMMITTEE

NOTES

In December 2003, a groundbreaking agreement was ratified by Alberta Health and Wellness (AHW), the Alberta Medical Association (AMA) and Alberta's Regional Health Authorities (RHAs). This much-anticipated agreement was heralded by the three partners as an opportunity to renew the health care system, supported with innovative investment and a unique approach to primary care, to attain the shared goal of improving access and patient care.

With an unprecedented eight-year term, the master agreement allows change for the better – the kind of change that takes time. The agreement represents a new way of advancing the health care agenda in Alberta and creates a competitive environment for attracting and retaining physicians. The success of this alliance will be driven by relationships among the parties based on mutual trust, respect, confidence, communication, collaboration and cooperation.

As we complete the first full year of implementing the agreement, much has been achieved and much more remains to be accomplished. The parties are pleased to report on the progress of the agreement and to highlight opportunities for the future – Together for Patient Care.

Paddy Meade, Chair
Deputy Minister, Alberta Health and Wellness

Michael Gormley
Executive Director, Alberta Medical Association

Sheila Weatherill
President and Chief Executive Officer, Capital Health

SUBJECT

MASTER AGREEMENT

NOTES

A BRIEF REVIEW

Term

- Eight years: April 1, 2003 to March 31, 2011
- Financial reopeners: March 31, 2006 and March 31, 2008

Components of the Master Agreement

Consists of:

- **Master Physician Budget (MPB)**
- Increases to the MPB: 2.7% October 1, 2003; 2.9% October 1, 2004; 3.5% October 1, 2005

- Management Structure

  Jointly managed by Alberta Health and Wellness, Alberta Medical Association and Alberta's Regional Health Authorities with decision-making by consensus (unanimous agreement)

  a) Master Committee: deputy minister of AHW; chief executive officer of AMA; a CEO representing the RHAs.

  b) Secretariat: nine members, three from each of the parties.

  c) Strategic Physician Agreement Committees (SPACs): Each of the four strategic physician agreements has its own management committee, with nine members, three from each of the parties.

- Budget Management and Adjustment Process

  Master Committee can:

  a) Move funds between elements of budget to balance the Master Physician Budget (MPB)

  b) Recommend adjustments to the MPB

  c) Determine use of surplus and address deficits

- Dispute Resolution

  Disputes are managed by Secretariat and, if necessary, the Master Committee. Arbitration is available in specific instances.

SUBJECT

REPORT CARD ON IMPLEMENTATION PROGRESS

NOTES

The first full year

The master agreement defines the relationship between the AMA, government and regional health authorities. It includes four strategic physician agreements, aligning the three parties with respect to

- Compensation for physician services (Physician Services Agreement)
- Primary care (Primary Care Initiative Agreement)
- Physician on-call programs (Physician On-Call Programs Agreement)
- Computerization of physician offices (Physician Office System Program Agreement)

The negotiations to reach the master agreement were involved and complex – and the task of implementing the agreement has been equally, or more, so! In the pages that follow, we highlight the activities and accomplishments of the first year, as well as emerging challenges and opportunities for the remaining term of the agreement.

We begin with an overview at the master agreement (Master Committee and Secretariat) level, then proceed to review the work of the four Strategic Physician Agreement Committees.

- Report Card: Master Agreement Page 4
- Report Card: Physician Services Agreement Page 7
- Report Card: Physician On-Call Programs Agreement Page 9
- Report Card: Physician Office System Program Agreement Page 11
- Report Card: Primary Care Initiative Agreement Page 14
- Glossary Page 17

We hope this information will make you feel more informed about the status of this very important master agreement.

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REPORT CARD: MASTER AGREEMENT

NOTES

Activities and accomplishments

Learning to work together

The fundamental distinction of the master agreement is that it represents a collaboration between government, physicians and regional health authorities. **Never before in Alberta** – or in other provinces, for that matter – have these groups been able to sit down under such a structure and work cooperatively with the collective goal of health system renewal and better patient care.

In terms of implementation, this has meant establishing **six trilateral committees**, each with distinct terms of reference, mandates, scopes of operation – yet requiring a common understanding of the master agreement and its goals and vision.

Four Strategic Physician Agreement Committees (SPACs) are overseen by the **Secretariat**, that coordinates SPAC activities and ensures their successful operations. Reporting to and working closely with the **Master Committee**, the Secretariat is responsible for overall implementation and management of the agreement itself with specific responsibilities for budget management, reviewing and approving physician agreements, approving consensus supplements and expanding the scope of the master agreement.

The first full year has been an overwhelming and successful exercise in developing processes and principles for **three-way collaboration and cooperation**.

One of the earliest tasks following the December 12, 2003 ratification of the master agreement was to organize a January 30, 2004 **orientation session** for the committees, followed immediately by inaugural committee meetings January 30, 2004.

Early in the year, the parties mutually recognized **conflict of interest guidelines** as a priority. Guidelines were completed in May and subsequently reviewed by the ethics commissioner.

The master agreement requires that decision-making be by consensus (unanimous agreement). An early accomplishment of the Secretariat, therefore, was conveying an understanding of the consensus process and the responsibility each party has to help the committee reach consensus. This has become the standard **decision-making process** throughout the committees of the master agreement structure as the three parties work together on issues and opportunities – with different implications for all, but a shared goal of better patient care.

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Seeing the big picture

On behalf of the Master Committee, the Secretariat has collected data regarding the payment arrangements between RHAs and physicians that existed at the time the master agreement was signed. The Secretariat has begun the process of analyzing and interpreting these arrangements in a coordinated fashion. By creating a big picture of the overall scope of **physician compensation** occurring outside the Master Physician Budget, this information can assist the parties to develop **principles and templates** for reporting physician agreements – existing and future.

Managing the budget

The Master Committee has overall responsibility for the Master Physician Budget (MPB) and has the ability to recommend adjustments and move funds within the MPB to address over-expenditures as well as determine the use of any surplus funds.

For 2003-04, the MPB was balanced by **reallocating funds** among programs. Subsequently, a deficit in the Physician Services Budget was addressed through automatic and discretionary adjustments. The Master Committee and Secretariat monitor the MPB on an ongoing basis.

Improving access

Health workforce planning – particularly physician resource planning – is critical to ensuring that Albertans receive timely access to the services they need. Recognizing this, the Secretariat contributed to reactivating the Physician Resource Planning Committee (PRPC), although the work of the committee will be outside of the master agreement. As PRPC begins work to update its major 2000 report on Alberta physician workforce issues, the Secretariat has approved a policy statement on relationship of the PRPC to the agreement structure and the use of PRPC reports.

Primary care renewal, through the Primary Care Initiative Program, is progressing to improve primary care delivery with managed 24/7 patient access to a comprehensive and coordinated basket of services (see details, page 14). To support the work of the Primary Care Initiative Committee, the Secretariat established a fund that ensures early stability for Local Primary Care Initiatives and helps resolve start-up issues.

NOTES

Future opportunities and challenges

Among the many tasks for the Secretariat in the year ahead are:

- Continuing to review and monitor **physician agreements** and initiatives while determining how the reporting information can improve management of the agreement.
- Assessing opportunities to expand the **scope of the agreements** to include other physicians not currently paid from the Physician Services Budget.
- Dealing with **25 legacy alternate payment plans** (APPs), beginning with neonatal and pediatric intensive care unit programs in Calgary and Edmonton. These APPs may be moved within the Master Physician Budget once Secretariat has resolved funding issues and ensured consistency with new alternate relationship plans (ARPs).
- Continuing to provide **day-to-day oversight**, management – and support when needed for the complex work of the four Strategic Physician Agreement Committees, discussed in the following pages.
- Reviewing new **alternate relationship plans** and requests for consensus supplements.
- Ensuring continued **progress** in implementing the agreement while the parties prepare for negotiations for the fiscal re-opener March 31, 2006.

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REPORT CARD: PHYSICIAN SERVICES AGREEMENT

NOTES

Activities and accomplishments

The monitoring and managing of the Physician Services Budget (PSB) is the responsibility of the Physician Services Committee (PSC). It deals with: expenditures and utilization of insured services and benefits; fees and conditions of payment for insured services; allocation of money for surcharges, premium rates, rules and fees; and input into the budget management and adjustment process for the overall agreement. Throughout this first implementation year the PSC focused on three main areas: **allocations, alternate relationship plans (ARPs) and Schedule of Medical Benefits (SOMB) redevelopment**.

- The first step for the Physician Services Committee was to begin implementation for a SOMB allocation April 1, 2004 (retroactive to October 1, 2003), followed by another allocation October 1, 2004. Sections and regions were consulted, and funding priorities for the allocations included some **targeted items** (e.g., complex care modifier), **overhead costs** and **general fee increases**.
- Substantial changes have been made to payment of **after-hour premiums**, including surcharges and special call-backs.
- A number of **fee-schedule innovations** have contributed to improving patient access, supporting expansion of the health workforce and supporting new medical procedures, including remuneration for:
  - Nurse practitioner referrals to physicians
  - Social worker, psychologist, occupational therapist and speech language pathologist referrals to psychiatrists
  - Managing patients on anticoagulant therapy without eye-to-eye contact
  - Telephone advice to long-term care workers
  - Pre-transplant assessments for islet cell transplants
- The Physician Services Committee provided input into the **budget management** and adjustment process of the master agreement structure by completing a *2003-04 Physician Services Budget and Expenditures Report.*

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- Throughout the past year, several strides have been made with respect to alternate relationship plans. An **application template and process** has been completed, and this included:
  - Establishing ARP models
  - Establishing ARP provincial payment rates
  - Developing ARP legal agreement template (near completion)
  - Establishing an ARP Unit to administer the ARP process on behalf of the Physician Services Committee
  - Establishing an ARP Subcommittee
  - Addressing policy issues related to the establishment of ARPs

  In addition, 12 new alternate relationship plans agreements were approved for implementation at the January 27, 2004 joint PSC/Secretariat meeting. Of these, 10 have been finalized and implemented. Work continues to move additional ARPs through the application process into the implementation phase.
- The PSC, with assistance from a consultant, also began work on a SOMB redevelopment project (**schedule redevelopment**). The committee has reviewed the goals and objectives of all three parties and is now developing a work plan for schedule redevelopment, including a prioritization of activities.

  The Rules Redevelopment Working Group is currently proceeding with a review of the SOMB rules, in order to simplify, modernize and streamline the **General Rules** to facilitate movement toward **fee equity**.
- A new **Parental Leave Program** for physicians, administered by the AMA, was also launched April 1, 2004.

Future opportunities and challenges

- The **alternate relationship plan** process implementation is still new. As use of the process increases, the PSC will be working to improve and perfect it.
- In the immediate future and as part of schedule redevelopment, the PSC will be working with the **Primary Care Initiative Committee** to address schedule issues to support the primary care initiative (e.g., multi-disciplinary teams, etc.).

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REPORT CARD: PHYSICIAN ON-CALL PROGRAMS AGREEMENT

NOTES

Activities and Accomplishments

The Physician On-Call Programs (POCP) Committee, responsible for the management and implementation of the Rural On-Call Program and the Specialist On-Call Program, has undertaken a great deal of work throughout the first year of the agreement's implementation. It has been a new and exciting opportunity to have all three parties working together in this area under the master agreement. Meeting the challenges that accompany any new process, the trilateral committee has successfully engaged in many activities including:

- Continuing to review and upgrade the **eligibility criteria** that apply to all regional on-call programs, in order to improve the evaluation process for program proposals and better optimize the match between available funding and required patient services (allocation efficiency)
- Clarifying both the **requirements** for, and **intent** of, on-call programs
- Discussing the establishment of a **reserve fund** with Secretariat and moving toward the implementation of a workable mechanism
- **Communicating** with RHAs and physicians across the province regarding new eligibility criteria and program parameters
- Developing a **new process and templates** for collecting and reviewing new program submissions and appeals
- Working jointly with other **Strategic Physician Agreement Committees** to discuss issues that affect all

This work has resulted in establishment and sign-off of **revised eligibility criteria**, reviews of requests for **new programs and program appeals** and development of new **financial report formats** to allow RHAs to document payments by individual on-call programs in a standard fashion.

The POCP Committee has also been working to address inequities in rates paid to physicians within various programs. **Equity** has been improved, particularly in providing an increase (April 1, 2004) to align on-call rates for rural general practitioners with special skills to those earned by urban physicians in specialist programs.

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Relationships have played a key role in the POCP Committee's success. **Relationship-based accomplishments** include:

- Developing RHA/Alberta Health and Wellness **on-call grant agreements** to reflect a new three-year funding timeframe, eliminating delays for funding transfers to RHAs and payments to physicians
- An increased working relationship with the **Rural Physician Action Plan** to promote understanding of rural issues for on-call
- A cost-sharing arrangement with Saskatchewan Health for on-call programs provided at **Lloydminster Hospital**

Future opportunities and challenges

The POCP Committee will continue to:

- Seek improvements to **payment equity** over the short- and long-term
- Conduct ongoing review of **program issues** related to design, eligibility criteria, payment rates and new on-call programs
- Identify an **evaluation mechanism** that will enable further refinement and shared understanding for support of necessary on-call services
- **Review** the current rural on-call program **criteria**, revise these criteria as appropriate and review individual programs for compliance with them
- Review existing specialist on-call programs for **compliance** with current criteria

SUBJECT

REPORT CARD: PHYSICIAN OFFICE SYSTEM PROGRAM AGREEMENT

NOTES

Activities and accomplishments

The master agreement continues and extends the first phase (2001-03) of the Physician Office System Program (POSP). POSP helps physicians providing insured services in the province to acquire the information technology tools they need for improvement of patient care and practice information.

Through a combination of 48 months of funding to cover partial costs of computerization, information technology services and change management services, POSP has helped 40% of Alberta's practising physicians to incorporate information technology into their practices. POSP is the **leading physician automation program** in the country.

Benefits for patient care are already emerging. Physicians using electronic medical records (EMRs) report better patient recall, easier management of lab test results, easier prescriptions, fewer pharmacy questions and better referral/consultation letters with complete information.

Along with the computerization of physician offices, POSP is an integral component of the province's **electronic health record (EHR)** strategy, collaborating on integration of physician electronic medical records and provincial and/or regional electronic health record initiatives, bringing information such as medication history and lab test results together with the physician's comprehensive EMR.

Since Phase Two of POSP began in January 2004, 810 physicians have joined the program:

- 110 physicians in Level 1: Computer in physician's office; browser access to the EHR; no EMR
- 66 physicians in Level 1.5: Computer at the point of care; browser access to EHR; no EMR
- 634 physicians in Level 2: Computer at the point of care; EMR integrated with provincial EHR and regional data.

This brings the overall program total to 2,194 participants

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POSP is working actively to bring physicians into the program with 40 physicians hosting demonstration clinics and mentoring colleagues who are considering POSP. Nearly 100 percent of those who attended demonstrations have enrolled in the program.

POSP has also worked to make such computer technology even more valuable for patient care:

- **Working closely** with Alberta Health and Wellness, the regional health authorities and Alberta Wellnet on the integration of the **electronic health record** with physicians' electronic medical records.
- **Developing solutions** to move **patient data** from one physician office system to another.
- Collaborating with Capital Health on a successful pilot to deliver community **diagnostic imaging text reports** to physicians' electronic medical records and developing a provincial data content standard.
- **Collaborating** with Capital Health to deliver lab test results directly into physician electronic medical records.
- **Reducing** the risk of **data loss** in physician offices caused by human, hardware or software failure. POSP's *System Management Guidelines* provide information and checklists on back-up and recovery, off-site storage of back-up tapes, virus management and protocols to ensure these procedures are working. The RHAs and POSP will be visiting clinics to assess these issues and provide guidance.
- Reviewing the **reference price** upon which POSP funding has been based. The reference price is an average, amortized cost for required hardware, software and network services.
- Working with vendors, health regions, Alberta Health and Wellness and other stakeholders to update the **Vendor Conformance and Usability Requirements** for physician office systems. These requirements are reviewed annually to ensure they continue to reflect the needs of all stakeholders.

POSP has helped physicians to manage the transition to using information technology through a variety of **Change Management Services**:

- **Required meetings**: Automation readiness assessment; a kick-off meeting (physician, vendor and Change Management Services); and the post-implementation review
- Assigning a **change management advisor** to each clinic to monitor progress and provide services on request
- **Physician workshops** on topics such as the *Health Information Act,* information and technology project management and contract management
- **Self-service tools** such as checklists and templates to help physicians plan for and manage the transition

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- **Supporting physician compliance** with the *Health Information Act* by providing resources to conduct privacy impact assessments

Future opportunities and challenges

- As electronic health records become available across the province, the value of computerization will increase for physicians, particularly as integrating EHR data becomes a regular part of the way physicians manage **patient health information and care**.
- POSP will continue to respond to the information technology needs of physicians in different settings, including **regional health authorities and universities**
- An evaluation of POSP's effectiveness in delivering services to physicians and the impact of the use of information technology will be used to shape the **future** of the program after March 2006
- The question of support for physicians who have received 48 months of funding is a future challenge
- POSP will work with the Primary Care Initiative, the AMA's Practice Management Program and Toward Optimized Practice to **coordinate services** provided to physicians and align the needs of the parties with respect to change management

SUBJECT

REPORT CARD: PRIMARY CARE INITIATIVE AGREEMENT

NOTES

Activities and Accomplishments

The Primary Care Initiative (PCI) promotes a team approach to providing comprehensive, integrated primary care services to patients. Primary care is a patient's first point of contact with the health care system. Under the PCI, Local Primary Care Initiatives* are formed through formal arrangements between groups of family physicians and their regional health authorities (RHAs).

This new model will lead the **future of primary care** in Alberta, a key focus of the recommendations from the Premier's Advisory Council on Health, and will be a major component of Alberta's innovative approach to health renewal. Objectives include:

- A greater proportion of Albertans have ready access to primary care
- Initiatives provide management of 24/7 access to appropriate primary care services
- Increased emphasis on health promotion, disease and injury prevention, care of the medically complex patient and care of patients with chronic diseases
- Improved coordination and integration with other health care services, including secondary, tertiary and long-term care by linking to specialty care
- Greater use of multi-disciplinary teams to provide comprehensive primary care services

The PCI has been developed in the first full year of the agreement through a phased approach, within which the Primary Care Initiative Committee has worked to:

- **Support the program**
  - Establishing a program management office with resources to promote and support development of Local Primary Care Initiatives
  - Developing policies and processes to guide development and operation of Local Primary Care Initiatives
  - Establishing communications mechanisms and support which includes:
    - Primary Care Initiative *in touch* newsletter
    - PCI website launched (Spring 2005) www.primarycareinitiative.ca

*As of late April 2005, Local Primary Care Initiatives will be known as Primary Care Networks.

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- **Generate interest**
  - Holding information sessions in every health region to introduce the Primary Care Initiative to interested physicians and RHA representatives (March – May 2004) as well as various conferences and meetings
  - Developing a letter of intent (LOI) template and called for letters of intent from all interested family physicians and RHAs (April 2004)
- **Support development**
  - Reviewing 26 LOIs to develop Local Primary Care Initiatives with representation from every health region
    - **Approving 12 initial groups** (Round One) that are now developing business plans for Local Primary Care Initiatives. (Almost 400 physicians)
      - Issuing change management funding to initial groups (July 2004)
      - Holding workshops in Calgary, Edmonton and Lethbridge to explain business planning process
      - Establishing a monthly Primary Care Initiative Forum to provide a venue for information sharing, program updates and networking among the 12 groups, including Local Primary Care Initiative project managers, physicians, RHA primary care leaders, representatives from AMA's Practice Management Program (PMP) and AHWs Primary Health Care Unit
    - Receiving business plans submitted to PCI committee February 2005
    - Developing **patient awareness and collateral materials** to help physicians and RHAs explain and launch Local Primary Care Initiatives
    - Establishing a **PCI Coordinating Committee** to integrate activities of representatives of the PCI, Physician Office System Program, PMP and Toward Optimized Practice for activities that overlap with family physician groups
  - Deferred groups (Round Two)
    - 11 letters of intent also approved, but groups deferred until later for business planning. These groups invited to begin business planning (February 2005). (Almost 400 family physicians)
    - Orientation meeting held in Edmonton to provide Round Two groups with all necessary information for business planning (March 15, 2005)

The master agreement also calls for "support of physician practices" to help physicians – primary care and specialist – to optimize their practice management in order to enhance the quality of patient care. The master agreement references the AMA's **Practice Management Program** that provides assistance for physicians with legal/liability issues, management and governance relationship issues, financial options, practice process and structure and change management. The PMP has assisted the first 12 Local Primary Care Initiatives to move forward in their business plan development as well as providing business consultation services to Round Two physician groups.

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Future opportunities and challenges

A fundamental culture shift is developing between physician and RHA groups as they work together on business plans and determine how to best provide primary care services.

- Round One: 12 initiatives "go live" over spring and summer 2005
- **Round Two:** Groups develop and implement business plans over the next six months
- **Second call** for letters of intent to be issued – date to be determined
- **Monitoring** and evaluation of Local Primary Care Initiatives
- Develop **policy** for Local Primary Care Initiatives including:
  - Specialist linkages
  - Formal enrollment
  - Accountability, monitoring, evaluation
  - Information sharing and management among providers
- **Public awareness** and education regarding the Primary Care Initiative

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GLOSSARY

ARP – Alternate Relationship Plan

A new term under the master agreement encompassing alternate payment plans (APPs) and the clinical component of alternate funding plans (AFPs). The purpose of an ARP is to provide payment options other than fee for service that allow innovation in clinical service and may enhance the following five dimensions: recruitment and retention; team-based approach; access; patient satisfaction; and value for money.

Consensus Supplements

Approved by consensus among the three parties, these supplements are made when "the parties recognize that other considerations may, in the overall best interests of Albertans, require a supplement from the Insured Services Element in respect of Physician Agreements or Alternate Relationship Plans" (Physician Services Agreement, article 5.6).

EHR – Electronic Health Record

The Alberta EHR was launched October 2003 by Alberta Health and Wellness. Available now in many parts of the province and coming soon to wider areas, the EHR already provides medication history, allergies, lab test result history and demographic/contact information. More applications will be available over time. The RHAs are also at work on their own regional variations of EHR and the parties are working toward integration of all such systems.

EMR – Electronic Medical Record

A computer application for capturing, managing and providing access to some or all of the information typically maintained in a physician's paper medical record/chart.

LPCI – Local Primary Care Initiative

A local contractual arrangement between an RHA and a group(s) of local physicians to deliver comprehensive primary care services to a defined population of patients.

Master Committee

The Master Committee consists of the deputy minister of AHW, CEO of the AMA and a CEO of the RHAs. It holds the highest authority to administer, manage and amend the master agreement and the relationships described therein.

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MPB – Master Physician Budget

Includes the combined value of all strategic physician agreements:

- Physician Services Agreement
- Primary Care Initiative Agreement
- Physician On-Call Programs Agreement
- Physician Office System Program Agreement

POCP – Physician On-Call Programs (Agreement)

Building on the success of a 2001 initiative, the master agreement acknowledges the need for programs to allow provision of emergency on-call services required by RHAs. Allowing physicians and RHAs to work closely on issues concerning the delivery of regional services, the program remunerates specialists and rural general practitioners for providing eligible on-call services in Alberta. Managed by the Physician On-Call Programs Committee.

POSP – Physician Office System Program (Agreement)

Originally created in 2001 by the AHW and AMA to support physicians who wish to improve the delivery of care by expanding the use of computer technology in their practices. The master agreement extends the program. Managed by the Physician Office System Program Committee.

Physician Services (Agreement)

Includes:

- Insured services (a budget base, rate increases and increases in case of population growth)
- Benefit programs (a budget base and increases)
- Managed by the Physician Services Committee

PSB – Physician Services Budget

The budget that includes funds to pay physicians for insured services, as well as for benefits provided to physicians. Formerly the Medical Services Budget.

PCI – Primary Care Initiative (Agreement)

Physician groups and RHAs have the opportunity to form Local Primary Care Initiatives to jointly provide comprehensive primary health care services to a defined population of patients, including linking patients to specialist services. Through various funding mechanisms, PCI initially supports physicians to plan and establish LPCIs with the RHAs (i.e., provide change management support), and then annually provide funds

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for their ongoing provision of comprehensive primary care services. Managed by the Primary Care Initiative Committee.

Primary Care Networks

As of late April 2005, Local Primary Care Initiatives will be known as Primary Care Networks.

Rural On-Call Program

The program that remunerates physicians to be available to provide emergency on-call services in emergency departments of approved rural facilities.

Secretariat

Consists of up-to-three representatives each from the AHW, AMA and RHAs. Provides support to the Master Committee and is responsible for managing the four strategic physician agreements.

SOMB – Schedule of Medical Benefits

The list of publicly insured services and corresponding fees, including general rules, surcharges and other associated payments.

Specialist On-Call Program

The program that remunerates specialists, rural general practitioners with special skills and other physicians for being available to provide eligible on-call services for RHA programs.

SPACs – Strategic Physician Agreement Committees

- Physician Services Committee
- Primary Care Initiative Committee
- Physician On-Call Programs Committee
- Physician Office System Program Committee

SPACs are managed by the Secretariat and, if necessary, the Master Committee.

TOP – Toward Optimized Practice

The Toward Optimized Practice (TOP) program succeeds the former Alberta Clinical Practice Guidelines program, and maintains and distributes Alberta Clinical Practice Guidelines. TOP is a health quality improvement initiative that supports physician practices, and the teams they work with, by fostering the use of evidence-based best practices and quality initiatives in medical care in Alberta. The program offers a variety of tools and services to help physicians and their colleagues meet the challenge of keeping practices current in an environment of continually emerging evidence.

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