

**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 through 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.

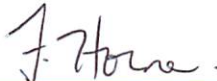
## 4. REPORTING

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
<b>Primary Care</b>			
Mixed Payment Model	Alternate payment arrangement incorporating elements of population (capitation), service, and performance incentives.	S.T.	<ul style="list-style-type: none"> <li>Stabilize funding</li> <li>Enhance population health and resources management incentives.</li> </ul>
Enrollment	Formal attachment of patients to family physicians.	S.T.	<ul style="list-style-type: none"> <li>Studies have demonstrated improvement in quality, decreased utilization, and decreased overall costs that are directly related to the degree of attachment.</li> <li>A necessary precursor to most elements of advancing primary care: e.g. population focus and quality measurement/reporting.</li> <li>Several regulative and administrative supports required.</li> <li>Patient concerns and incentives for enrollments need to be considered.</li> </ul>
Accreditation	Move forward with PCN Accreditation as proposed by the AMA PCA.	S.T.	<ul style="list-style-type: none"> <li>Begin process of establishing, achieving and maintaining standards.</li> </ul>

Initiative	Description	Timing	Comments
<p><b>Primary Care cont'd</b></p> <p>At Risk Patients</p>	<p>Focus resource management and support on 'at-risk' patients: the 5% of the population that accounts for 60% of health resource utilization.</p>	<p>M.T.</p>	<ul style="list-style-type: none"> <li>• 'At-risk' includes: <ul style="list-style-type: none"> <li>○ Chronic conditions</li> <li>○ Low primary care access with high specialist usage</li> <li>○ Complex, acute inpatient on discharge from acute</li> </ul> </li> <li>• Important support programs include Home Care, CHOICE, and potentially FCCs.</li> <li>• FCCs aligned with PCNs and aimed towards at-risk populations or low primary care access populations offer significant opportunity.</li> <li>• Aligns AH, AHS and AMA activities.</li> <li>• Potential to offer improved quality of care and quality of life at a lower cost.</li> </ul>
<p>System Objectives and Integration</p>	<p>Explore opportunities and develop a long-term direction with primary care as the foundation for overall system efficiency and effectiveness.</p>	<p>L.T.</p>	<ul style="list-style-type: none"> <li>• Models discussed include: <ul style="list-style-type: none"> <li>○ Triple AIM (population health; cost per patient; patient experience)</li> <li>○ Accountable Care Organizations (shared savings; quality measurement and reporting)</li> </ul> </li> <li>• Necessary framework to align the short-term and medium-term initiatives: payment, accreditation and enrollment.</li> <li>• Aligns AH, AHS and AMA</li> </ul>



Initiative	Description	Timing	Comments
<p><b>Appropriateness</b></p> <p>Decision Support</p>	<p>Educational tools and supports for physicians and teams on appropriate diagnostic testing.</p>	<p>S.T. to L.T.</p>	<ul style="list-style-type: none"> <li>• Initial focus should be on lab, DI, and medication management but could be broadened to other aspects of medicine</li> <li>• Opportunity to build on Canadian Association of Radiology (CAR) guidelines with assistance of Alberta Society of Radiologists (ASR)</li> <li>• CoF CPGs provide a priority listing</li> <li>• 'Choose Wisely' program should be considered</li> <li>• Clinical decision support systems integrated with EMRs are needed.</li> </ul>
<p>Drug Utilization</p>	<p>Undertake a review of opportunities to improve clinical decision making respecting specific pharmacology</p>	<p>S.T. to L.T.</p>	<ul style="list-style-type: none"> <li>• Information systems support</li> <li>• Some specific opportunities are available, e.g., drug management related to macular degeneration</li> <li>• Clinical decision support systems integrated with EMRs are needed</li> </ul>

Initiative	Description	Timing	Comments
<b>Improve Efficiency and Reduce Waste</b>			
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.	<ul style="list-style-type: none"> <li>• Communication with the public is needed</li> <li>• Information systems support needed, e.g., access to real-time data to manage time limits</li> </ul>
Working with Sections	Work with AMA Sections to identify opportunities for: <ul style="list-style-type: none"> <li>• Fee schedule improvements</li> <li>• System efficiencies</li> <li>• Appropriateness</li> </ul>	S.T.	<ul style="list-style-type: none"> <li>• SCNs and sections need to work more closely</li> <li>• Several SCN proposals require an alignment of physician compensation with the initiative</li> <li>• Shared savings should be considered</li> </ul>
<b>Physician Compensation</b>			
Relativity	Improve relativity in physician payments: <ol style="list-style-type: none"> <li>1. Initial opportunity for sections to address challenges with their schedules</li> <li>2. Physician Compensation Committee will have the authority to move funds between fee items</li> </ol>	S.T.  S.T. to L.T.	<ul style="list-style-type: none"> <li>• Improved intersectional relativity important to ensure appropriate incentives for medical decision-making</li> <li>• Initial opportunity for sections to adjust their schedules seen as an important precursor to the work of the Physician Compensation Committee</li> </ul>
Overhead	Review of measurement and payment for overhead in conjunction with fair cost recovery and the incentive structure	M.T.	<ul style="list-style-type: none"> <li>• Cost recovery is an important consideration for fee relativity and is a component of the incentive structure.</li> <li>• Improved measurement of costs required</li> </ul>

Initiative	Description	Timing	Comments
<b>Physician Compensation</b> 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.	<ul style="list-style-type: none"> <li>• Can improve efficiency within the bundled care</li> <li>• Combined with appropriateness criteria and shared savings, can also improve system efficiencies and capture savings</li> <li>• SCNs can serve to identify opportunities. Several proposals are already in early development</li> <li>• Aligns AH, AHS, and AMA</li> </ul>
Practice Improvements	Examples: <ul style="list-style-type: none"> <li>• Review group visits</li> <li>• E-visits and consultations</li> <li>• Home visits</li> </ul>	S.T. to L.T.	<ul style="list-style-type: none"> <li>• Needs to align with other strategies, e.g., chronic care</li> <li>• Mostly aimed at system efficiencies and improved access</li> </ul>
Physician On-call programs	Harmonize after-hours and on-call payments	S.T. to L.T.	<ul style="list-style-type: none"> <li>• Several Sources: On-call Program, SOMB and AHS payment</li> <li>• Will require greater transparency and sharing of information between all payers</li> <li>• Work can be undertaken by the Physician Compensation Committee</li> </ul>
<b>Program and Benefits</b>  Reduce Rates	Potential savings through rate adjustments or program elimination.		<ul style="list-style-type: none"> <li>• Direct impact on physician compensation</li> <li>• No consensus reached</li> </ul>

## **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.