



# Primary Care Initiative Policy Manual

Version 10.1

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# 1. Introduction

The Primary Care Initiative (PCI) policy manual was developed by the Primary Care Initiative Committee (PCIC) to provide the foundation on which Primary Care Networks will be developed, implemented and evaluated. Policy and principles will be developed for those components where provincial direction is required to ensure that PCI objectives are achieved. It is understood that the PCI policy framework and associated guidelines will evolve as all parties learn from the initial phase.

The Primary Care Initiative (PCI) Agreement (Schedule G to the Master Agreement) defines local primary care initiatives as the contractual arrangement between one or more participating physicians and a regional health authority acting together to provide designated service responsibilities. The Primary Care Initiative Committee (PCIC) has approved the name “Primary Care Network” for use by local primary care initiatives. Therefore, for the purpose of the Primary Care Initiative Program, and more specifically, for this document, a local primary care initiative will be referred to as a “Primary Care Network.”

Any words or phrases used in this document that are defined in the Master Agreement or the PCI Agreement, whether or not they are capitalized, shall have the same meaning as set out in the Master Agreement or PCI Agreement, unless they are used in a different context than that in the Agreements.

## **2. PCI Objectives**

The key objectives of the Primary Care Initiative are to:

- Increase the proportion of residents with ready access to primary care
- Provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services
- Increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient and care of patients with chronic diseases
- Improve coordination and integration with other health care services including secondary, tertiary and long-term care through specialty care linkages to primary care
- Facilitate the greater use of multi-disciplinary teams to provide comprehensive primary care

### **3. PCIC Principles for Primary Care Network Development**

- (a) All parties to the Master Agreement will enable the effective implementation of the Primary Care Initiative by establishing supporting policies and removing policy and regulatory barriers, where practical.
- (b) Every resident of Alberta will be eligible to receive primary care services from a Primary Care Network, contingent on development and availability.
- (c) Albertans will still have the freedom to choose their physicians.
- (d) Physicians will remain free to choose their method of remuneration for insured services (i.e., fee-for-service, alternate relationship plan, etc.).
- (e) Participation by physicians in a Primary Care Network is voluntary.
- (f) Primary Care Networks will define the respective roles and responsibilities of each party.
- (g) A physician group may appeal to the PCIC if a regional health authority (RHA) unreasonably and/or arbitrarily rejects a proposal to establish a Primary Care Network.
- (h) Primary Care Networks will be defined by a number of criteria including geographic parameters, natural referral patterns and existing patient populations.
- (i) Primary Care Networks will provide primary care services to formally and informally enrolled patients and a reasonable and equitable allocation of unattached patients (unattached patients may be referred to a Primary Care Network based on the patient's residence or work location). Primary Care Networks will not be expected to provide services to a disproportionate number of unattached patients.
- (j) Primary Care Networks will be of sufficient size to effectively fulfill the service responsibilities specified in Article 8 of the PCI Agreement and as further defined by the PCIC.
- (k) RHAs and physician groups will have the flexibility to develop a Primary Care Network that meets their region's unique needs, within provincially established standards and guidelines.
- (l) Primary Care Networks will ensure that the size of their enrolled population is aligned to their service delivery capacity.
- (m) Primary Care Networks may have an unlimited number of fee-for-service, alternate relationship plan and RHA physicians, other health care providers and service delivery locations. However, a Primary Care Network cannot be owned by another Primary Care Network or any other corporate entity.
- (n) All Primary Care Networks will have the same service responsibilities. These may be changed from time to time by the PCIC. However, existing Primary Care Networks will not be required to deliver newly added services until the Primary Care Network's renewal date, and until the global service responsibility list is updated.

- (o) Primary Care Network performance measures and evaluative processes will be developed by the PCIC in collaboration with the physicians and RHAs that are developing and implementing Primary Care Networks.

## 4. Service Responsibilities

Article 8 of the PCI Agreement itemizes the service responsibilities and categorizes them into direct services, and linkages to services within and between primary care and other areas. As well, it is the responsibility of a Primary Care Network to accept into its patient population, and provide service responsibilities to, an equitable and agreed-upon allocation of unattached patients.

### **Services directly related to the provision of primary care services to the patient population**

- Basic ambulatory care and follow-up
- Care of complex problems and follow-up
- Psychological counseling
- Screening/chronic disease prevention
- Family planning and pregnancy counseling
- Well-child care
- Obstetrical care
- Palliative care
- Geriatric care
- Care of chronically ill patients
- Minor surgery
- Minor emergency care
- Primary in-patient care including hospitals and long-term care institutions
- Rehabilitative care
- Information management, and
- Population health

### **Services related to linkages within and between primary care and other areas**

- 24-hour, 7-day-per-week management of access to appropriate primary care services
- Access to laboratory and diagnostic imaging, and
- Coordination of:
  - Home care
  - Emergency room services
  - Long-term care
  - Secondary care, and
  - Public health

## 4.1 Service Responsibility Policy

The following policies apply to service responsibilities as set out in Article 8 of the PCI Agreement:

- (a) A Primary Care Network must demonstrate it can provide the full range of primary care services either directly or through other formal arrangements.
- (b) The Primary Care Network business plan should demonstrate how arrangements with other health care providers and coordination with other health services will be established.
- (c) Although all Primary Care Network service responsibilities must be delivered by a Primary Care Network, individual physicians do not need to personally provide each service.
- (d) Primary Care Network service responsibilities should be consistent with health system policy and standards, and recognize the constraint of availability of resources.
- (e) The specific roles and responsibilities of the respective parties will be defined jointly by the participating physicians and the RHA and recorded in the formal (contractual) arrangement between them.
- (f) The Primary Care Network will coordinate and integrate the existing resources of the respective parties, as well as develop formal arrangements that coordinate and deploy new resources.
- (g) An individual physician may not be a core provider in more than one Primary Care Network. However, the PCIC recognizes there may be circumstances where a physician may be a core provider in one Primary Care Network and provide specific services as an Associate Provider in another Primary Care Network (i.e., where the Primary Care Networks serve mutually exclusive populations and potential for a conflict of interest is minimal). The PCIC must be made aware of these situations. When a family physician/general practitioner decides to leave a PCN, s/he cannot be registered in another PCN as a core provider until first ending registration in the original PCN.
- (h) An individual physician may provide services to more than one Primary Care Network as an associate provider through a formal arrangement with each of the respective Primary Care Networks.
- (i) Service arrangements in a Primary Care Network are not meant to replace existing services that have been provided by physicians and regional health authorities, but are services that are provided collectively.

## 4.2 Service Responsibility Definitions

PCIC has further defined the Primary Care Network service responsibilities, as set out in Article 8 of the PCI Agreement to ensure a common understanding of the major components and characteristics of each service element (see *Appendix A – Service Responsibility Definitions*).

## **5. Letters of Intent**

- (a) The PCIC will consider all letter of intent submissions that have been jointly developed and signed by an authorized official of the RHA and all participating physicians.
- (b) Letter of intent evaluation criteria will be communicated to RHAs and physicians and will be applied in a transparent and fair manner.
- (c) The PCIC will provide reasons for its determination to accept or defer all submitted letters of intent, and will identify deficiencies if submissions do not meet the requirements.

## **6. Business Plan**

### **6.1 Business Plan Parameters**

- (a) Article 7 of the PCI Agreement defines the primary parameters to be included in each business plan including the required signing authorities.
- (b) When preparing their business plans, Primary Care Networks should use the business plan templates developed by PCIC, to ensure that all components and requirements identified for a business plan are addressed.

### **6.2 Business Plan Principles**

- (a) Business plans will address all components outlined in Article 7 of the PCI Agreement, and service delivery issues identified by the PCIC.

## **7. Enrolment**

### **7.1 General Enrolment Policy**

- (a) Initially, all Primary Care Network Enrolments will be informal.
- (b) Subject to a tripartite decision to implement Formal Enrolment, patients shall have the option of being formally or informally enrolled.
- (c) Primary Care Networks may not discriminate amongst existing Primary Care Network patients with respect to whether they offer formal or informal Enrolment.
- (d) Subject to a tripartite decision to implement Formal Enrolment, Primary Care Networks may offer either informal enrolment or formal enrolment to new patients.
- (e) Enrolment is with the Primary Care Network, not the individual physician.
- (f) Primary Care Networks may compete for patients but they must fairly represent the services they provide to current and prospective patients.
- (g) Core providers can initiate and maintain enrolments by providing services. Core providers are family physicians / general practitioners and other health care providers as approved by PCIC. Core providers may also be registered at another PCN as an Associate Provider. Further policy related to Associate Providers is under development.
- (h) There will be one Enrolment list for a Primary Care Network. Practices, providers and facilities will use the same Primary Care Network Enrolment list.
- (i) There will be two “payment details” lists for each Primary Care Network. 1) An aggregated list of enrollees by age and sex and 2) a detailed patient list for each provider by individual clinic (access to the latter will be managed in accordance with HIA requirements).
- (j) Access to the Primary Care Network Enrolment lists and operational reporting information will be through an established access process, for custodians and their affiliates as requested by a Primary Care Network.

### **7.2 Informal Enrolment Policy**

- (a) The first group of Primary Care Networks will initially operate under informal Enrolment, which is the default method of enrolling patients in a Primary Care Network. Informal Enrolment is based on patient encounters with a Primary Care Network health care provider, in a Primary Care Network service delivery location, for services included in the list of Primary Care Network service responsibilities (Article 8 of the PCI Agreement).
- (b) A patient is “automatically” informally enrolled with a Primary Care Network when s/he has had one or more Encounters over the previous three year period and has been assigned to a Patient panel in accordance with the four cut funding methodology:
  - (i) Patients whose Encounters are with a single provider are assigned to the Patient panel of that provider;

- (ii) Patients not assigned to a panel after step (a) are assigned to the Patient panel of the provider with whom they have had the most Encounters;
  - (iii) Patients still not assigned to a panel after steps (a) and (b) are assigned to the Patient panel of the provider who completed the last physical exam on that Patient; and
  - (iv) Remaining Patients are assigned to the Patient panel of the provider with the last recorded Encounter for that Patient;
- (c) Informal Enrolment lists are determined by AHW through historical patient utilization.
  - (d) Informal Enrolment lists are updated semi-annually by AHW.

### **7.3 Formal Enrolment Policy**

- (a) Formal Enrolment includes an acknowledgement by the patient and the physician of an ongoing relationship which includes:
  - (i) The patient's commitment to seek primary care services from the physician and the Primary Care Network.
  - (ii) The physicians' /core providers' and the Primary Care Network's commitment to provide primary care services to the patient.
- (b) Formal Enrolment includes a document signed by both parties that incorporates the above commitments (described as an Enrolment Agreement in Article 9.5 of the PCI Agreement).
- (c) Formal Enrolment will become an option for all Primary Care Networks once PCIC is confident that all Primary Care Networks have a fair opportunity to use this approach.
- (d) Once formal Enrolment is approved by PCIC, an active Primary Care Network may change its Enrolment from informal to formal or vice versa through an established process as defined by the PCIC.
- (e) Patients should be fully informed of the services and programs provided by the Primary Care Network so they can make an informed choice and understand the mutual obligations associated with formal Enrolment.
- (f) Subject to a tripartite decision to implement formal enrolment, Primary Care Networks should establish a formal mechanism and a communication package to ensure a consistent approach to the formal enrolment process. This could include designating specific staff, who are familiar with the enrolment process and procedures, to support physicians to enrol patients.
- (g) Patients may terminate their formal Enrolment.
- (h) Primary Care Networks may terminate the formal Enrolment of a patient if the physician/patient relationship has been terminated in accordance with CPSA guidelines.

## 8. Encounters

### 8.1 Definition of Encounter

The definition of an encounter will be consistent with the Schedule of Medical Benefits Rules Redevelopment Working Group definition as follows:

*“The term encounter means each separate and distinct time a health service provider provides services to a patient in a given day (defined as a period of 24-hours, starting at midnight). To be recorded as separate encounters, multiple services provided to a patient may not be initiated by the health service provider or may not be a continuation of a service which began earlier in the day.”*

### 8.2 Encounters Objectives

Encounters are the means by which Primary Care Network Enrolments will be generated and maintained. Primary Care Network funding is determined by patient Enrolment, and encounters are a means of tracking Enrolment. Specifically, encounters are used to:

- (a) Quantify the service populations (formally or informally enrolled) of Primary Care Networks for the purpose of allocating per-capita payments.
- (b) Quantify the number and type of services provided and by whom on behalf of the Primary Care Network for performance monitoring, measurement and evaluation purposes.
- (c) Allocate per-capita payments in a fair and timely manner by assigning the eligible patients to each networks enrolment list in accordance with the four cut funding methodology and based on historic utilization.
- (d) Provide service delivery information for local and provincial planning purposes.

### 8.3 Encounters Policy

An encounter will only be considered a Primary Care Network encounter if it includes all of the following:

- (a) Provision of any of the service responsibilities outlined in Article 8, section 8.1(a) of the PCI Agreement. The Service Responsibilities, as outlined in Article 8 of the PCI Agreement, are expressed through a list of health service codes. There will be one common list of health service codes for all Primary Care Networks, therefore, a Primary Care Network cannot have a unique set of service responsibilities or health service codes.
- (b) By any of the participating physicians or other health care providers in the Primary Care Network through direct participation in the network or by contract or service agreement
- (c) At a designated Primary Care Network service delivery location
- (d) To a patient who is an Alberta resident insured under the Alberta Health Care Insurance Plan with an Alberta Personal Health Number (PHN)

- (e) Encounters will be tracked relative to either informally or formally enrolled patients in the Primary Care Network. Payments made to each Primary Care Network will be based on this Enrolment.
- (f) When applying the fourth level in the four cut funding methodology, where a patient has been seen by more than one provider in a 24 hour period, the encounter will be deemed un-assignable.
- (g) For the purpose of calculating per-capita payments, core locum encounters will be attached to the Primary Care Network as long as there is a formal arrangement between the Primary Care Network and the core locum, and the Primary Care Network provides AHW with the dates during which that core locum was practicing in the Primary Care Network.
- (h) Primary Care Networks will not receive funding for encounters that are provided by a non-Primary Care Network provider.
- (i) The costs associated with collecting and submitting encounter information at a local level will be borne by the Primary Care Network. Encounter information must be submitted in an approved format.
- (j) The cost of monitoring and evaluating the encounter information at a provincial level will be borne by the PCI program.
- (k) Primary Care Networks will be responsible for collecting, monitoring and evaluating data they may require for specific local purposes.
- (l) All services provided by physicians and other health care providers within the construct of the Primary Care Network will be treated the same with respect to whether or not they are an encounter.

### 8.3.1 Encounters Policy for Other Health Care Providers

In their business plans, Primary Care Networks mention other health care providers – they identify which ones they plan to include in their service delivery; what roles these professionals will play; and how their inclusion in the Primary Care Network will contribute to the objectives of the Primary Care Network and the PCI program. These encounters are covered by the Encounters Policy. PCNs may register their Other Health Care Providers (OHCPs) with Alberta Health & Wellness and submit encounter data through an accredited submitter. Encounters with OHCPs can assist with initiating and maintaining Enrolments if they have been approved as core providers by PCIC.

Encounters with core other health care providers will be used to generate patient Enrolments. Encounters with associate other health care providers will count towards maintaining already existing patient Enrolments (in other words, encounters with associate other health care providers will not count towards patients meeting/maintaining Enrolment criteria).

Encounter measurement is how many encounters each service delivery event will generate. Encounters will **not** be measured by the amount of time they take (e.g., 15 minute intervals)

**Rule 1:** Single patient and single provider = single encounter

Example: 1 patient and 1 provider = 1 encounter

**Rule 2:** Single patient and multiple providers = multiple encounters

Example: 1 patient and 5 providers = 5 encounters

**Rule 3:** Multiple patients (identifiable) and single provider = multiple encounters

Example: 3 patient and 1 provider = 3 encounters

**Rule 4:** Multiple patients (identifiable) and multiple providers = multiple encounters

Example: 2 patient and 5 providers = 10 encounters

**Rule 5:** Single/multiple patients (non-identifiable) and single/multiple providers = 0 encounters

Example: 2 providers speaking to 100 unidentifiable patients (cannot be identified by their PHNs) = 0 encounters

The following table gives examples of these rules:

Service type	Description and examples	Recipient type	Single or multiple providers	Encounter measurement	Rule used
Screening/ case finding	Determining type of further action; triage	Individual patient	Single	One	1
Assessment or reassessment	Examine, observe, diagnose, evaluate	Individual patient	Single	One	1
Intervention to individual patient	Treatment	Individual patient	Single	One	1
Telephone conversation	Consultation with patient or family, including parents	Individual patient	Single	One	1
Client family conference	Consultation with those closely associated with the patient (e.g., family, custodian)	Individual patient	Single	One	1
			Multiple	Multiple	2
Education to patient	Follow-up to treatment or ongoing care (e.g., chronic disease self-management)	Individual patient	Single	One	1
			Multiple	Multiple	2
Consultation between providers	Provider consulting with another provider (core to core or core to associate; not associate to associate)	Individual patient	Multiple	Multiple	2
Case management/ team conferences	Professional interview relating to care and treatment of a patient with other physicians, family, other health care providers or community agencies	Individual patient	Multiple	Multiple	2
Intervention to groups	For example, immunization	Group of identifiable patients	Single	Multiple	3
			Multiple	Multiple	4
Education to groups of patients/clients	Classroom session ( e.g., well-baby clinic, diabetes clinic)	Group of identifiable patients	Single	Multiple	3
			Multiple	Multiple	4

## 9. Payments

### 9.1 Payment Policy

- (a) Primary Care Networks cannot be established retroactively. However, services, service delivery locations and providers can change from time to time after a Primary Care Network is established (i.e., as providers are added or choose to exit and as service delivery locations are added or removed).
- (b) Primary Care Networks must begin operating on the first of the month.
- (c) Primary Care Networks will receive two semi-annual per-capita payments of \$25. A Primary Care Network may identify up to two payees.
- (d) Semi-annual payments periods are scheduled for each April and October.
- (e) Primary Care Networks will receive an initial payment for the number of months the Primary Care Network is in operation before the next semi-annual payment period. (For example, if the effective date for the Primary Care Network is May the Primary Care Network will receive a payment for the five months between May and the next payment date of October.)
- (f) The amount of the prospective semi-annual payment shall be based on the PCN's Informal Enrolment List as defined by historic encounters with core providers during the three year period preceding the payment.
- (g) Subject to a tripartite decision to implement Formal Enrolment, payments for formally enrolled patients will be based on whether or not the Primary Care Network meets the criteria for being designated as the Major Care Provider for the patient.

## 10. Business Plan Development Funding

### 10.1 Purpose

Business Plan development funding is advanced to support proposed Primary Care Networks (PCNs) to create their initial business plan. Funding is also intended to support transitional activities occurring prior to receipt of the first per-capita payment.

Business Plan development funds are intended to defer some but may not cover all of the costs associated with the development of Primary Care Networks. Each party may incur costs that are not recoverable from the PCI program.

### 10.2 Business Plan Development Funding Process

The maximum amount of Business Plan development funding for which a Primary Care Network may qualify depends on its size, namely the number of clinics involved and the number of participating physicians. The following chart provides the maximum allowable funding ('cap') for PCNs of various sizes.

PCN Size	Number of Physicians		Funding Cap
	If Single Clinic	If Multiple Clinics	
Small	14 or less	< 10	\$100,000
Medium	15 or more	10 - 40	\$150,000
Large	n/a	> 40 - 70	\$200,000
Super	n/a	Over 70 (managed on a case by case basis)	\$250,000

Upon approval of its LOI, a proposed PCN will receive an initial disbursement of \$30,000 to support development of a project plan which estimates the resources required until per-capita funding is received.

Proposed PCNs will estimate and justify their requests for business plan development funding in their project plans. The PO will evaluate these requests in light of local factors affecting each PCN and issue disbursements accordingly.

Allocation and disbursement of Business Plan development funding is linked to specific deliverables and scaled appropriately for the size of the proposed PCN and its anticipated activity levels. Disbursements will be determined and issued according to the following chart:

<b>Disbursement</b>	<b>To be Issued</b> Upon Notice of Approval of:	<b>Purpose</b>	<b>Amount</b>
1	LOI	Development and submission of <b>Project Plan</b>	\$30,000
2	Project Plan	Development and submission of <b>Clinical Service Plan</b>	Based on the resource requirements identified in the project plan as validated by the PO based on established expenditure patterns and in consideration of local factors affecting each Primary Care Network
3	Service Plan	Development and submission of full <b>Business Plan</b>	
4	Business Plan	Support of the PCN through <b>transition</b> to the receipt of operational funding	

- Financial updates accounting for expenditures related to business planning must be provided to the PCI Program Office by PCNs with their project plan, clinical service plan, and business plan submissions.
- The second, third, and fourth disbursements will be reduced by any funds remaining unspent at the conclusion of the project plan, service delivery plan, and business plan stages, respectively.
- Any funding remaining at the conclusion of transition (or if business plan is discontinued at any earlier stage) must be returned. PCNs are required to return any remaining funding to PCIC within 90 days of operation start up.

Business Plan development funds must be used only for business planning purposes, and are advanced to recipients on the understanding that PCNs will adhere to this policy and any other policies in the information provided to them.

## 11. Per-Capita Funding

Article 9 of the PCI Agreement outlines the Enrolment rules and the payment to the Primary Care Network of \$50 per annum for each patient on the Enrolment list.

### 11.1 General Per-Capita Funding Policy

- (a) The primary objective of the up to \$50 per patient annual payment is to substantially improve the provision of primary care to all Albertans, as described in Article 3, section 3.1(e) of the PCI Agreement.
- (b) The \$50 per patient payment may be used to fulfill the PCI objectives by:
  - Adding value through the provision of new services and or service enhancements including support for other providers (i.e., provide incentives to expand the comprehensiveness of an existing service or fill service gaps)
  - Paying for physician services for which there is currently no remuneration (fee-for-service or other programs) from the Physician Services Budget (PSB) or RHA
- (c) PCI monies will not fund existing services provided currently by RHAs, PSB or other initiatives like POSP (i.e., PCI monies are not intended to replace existing funding).
- (d) PCI monies may not be used for major infrastructure development including facility construction, etc.
- (e) PCI monies may not be used to support or operate physician office systems for individual physicians or physician clinics if there are situations where physicians:
  - Are eligible for Physician Office System Program (POSP) funding but have not yet received it, or
  - Have come to the end of their allocated POSP funding.
- (f) PCI monies may be used to operate systems for which the overall Primary Care Network is responsible (e.g., a system for an after-hours clinic).
- (g) At the local level, each Primary Care Network will determine how PCI monies will be allocated based on the application of approved principles and the approved business plan.
- (h) The retrospective review period will be three years. This will be monitored to ensure it is appropriate. Once Primary Care Networks are operational, AHW will monitor and trend the data to gather more evidence and understanding about patient utilization and provide this information, along with recommendations, for consideration by the PCIC.

### 11.2 Reimbursement Principles

- (a) Physicians and RHAs will be reimbursed for providing primary care services using new approaches to service delivery (e.g., supervision of other health care providers,

managing care, and case management) that fulfill the five objectives outlined in the agreement.

- (b) Physician and RHA services eligible for reimbursement will be defined by a provincial framework, which may establish minimum and maximum limits for various compensation types.
- (c) Physician and RHA services eligible for reimbursement may be adjusted from time to time by PCIC with appropriate notice to all parties.
- (d) RHAs and physician groups will establish locally, through their business plans, specific compensation elements for eligible services, within the provincial framework (see table below).
- (e) Primary Care Network monies will not be used to “top up” payment for currently remunerated services.
- (f) Physicians and RHAs will be reimbursed for at least a portion of the costs directly incurred as a result of implementing and operating the Primary Care Network.
- (g) Reimbursement will be designed to avoid “double dipping” with other payment and funding systems.

### **11.3 Reimbursement Components**

- (a) Evaluation of physician and RHA reimbursement proposals will be based on how the proposal addresses each of the following major components:
  - PCI program objectives
  - Systemic considerations
  - Economic considerations
  - Social/public Each of these major components will be further evaluated using a number of evaluative questions. This technique allows for a comprehensive assessment using a consistent set of evaluative elements.

### **11.4 Physician Reimbursement Policy**

- (a) Services/activities not currently funded from other funding pools (e.g., fee-for-service) are eligible for reimbursement from Primary Care Initiative monies. If other funding pools change the type of service/activity that is eligible for payment, then the eligibility for payment from Primary Care Initiative monies will change accordingly.
- (b) Physicians cannot be compensated for more than one service at the same time from Primary Care Initiative monies (e.g., team management and disease management).
- (c) Other non-Primary Care Initiative payments will be refunded to the Primary Care Network when a physician is being compensated by the Primary Care Network for that specific service or activity.
- (d) The types of proposed activities for which physicians may be compensated from PCI funds are outlined below. The objectives, desired activities and payment method are further described in the table below.

## 11.4.1 Compensable Activities

### Clinically-Related Activities

- (a) Where a physician is performing a specific role as clinical supervisor or managing a team of other health professionals such as:
- Supervision of other health care providers where the providers are performing supplementary functions on behalf of the physician as opposed to providers who are practicing independently and therefore, not directly accountable to the physician for the services they provide.
  - Managing multi-disciplinary team functions where the physician is the designated team lead (e.g., providing clinical and financial oversight of the operation of the team).

#### Recommended Payment Method

Activities related to clinical roles will be paid by a stipend as opposed to an hourly rate.

- (b) Where a physician is performing a clinical service for individuals or a specific group of patients such as:
- Managing the care of a discrete group of patients, who share common health needs, on behalf of the Primary Care Network.
  - Managing the individual care of patients with multiple and complex health needs, including the coordination of referrals, results and subsequent follow-up.
  - Providing care advice and case management after regular hours of operation utilizing a formalized triage system on behalf of the Primary Care Network

#### Recommended Payment Method

Services related to the care of an individual or group of patients may be paid by a standardized daily or hourly rate, whichever is most appropriate.

- (c) Where a physician is performing program development and/or research functions on behalf of the Primary Care Network they may be paid a daily or hourly rate.

#### Recommended Payment Method

Services related to program development and implementation and/or research functions may be paid through a time-limited stipend.

- (d) Where a physician incurs travel time as part of Primary Care Network activities they may be compensated.
- (e) Physician payments for clinically-related activities performed in direct support of the Primary Care Network objectives may include a component for travel, where this is incorporated into a recommended payment method (i.e., a stipend or an adjusted hourly rate). For example:

- If clinical supervision/team management involves a degree of travel, for example in a rural area, this could be built into the recommended payment rate (in this case, a stipend).
  - If clinical services to individuals or groups required travel, for example, among clinics or facilities, this could be a factor in establishing an adjusted hourly rate.
  - If program development or research involved travel, this could be incorporated into a time-limited stipend.
- (f) Travel costs (mileage, etc.) directly associated with Primary Care Network responsibilities may be recovered at cost. However, travel time is not allowable as a standalone cost recovery item. In particular, travel time for physician activities not directly associated with the Primary Care Network (e.g., that are solely remunerated under the Schedule of Medical Benefits) will not be eligible for Primary Care Network payment.
- (g) Hourly rates for physicians performing clinically-related activities in support of the Primary Care Network business plan are indexed to ARP sectional allocations.

### **Primary Care Network Administrative/Governance Services**

- (a) Governance and management of a Primary Care Network are compensable activities.

#### **Recommended Payment Method**

The above non-clinically related services will have a provincially standardized hourly rate or stipend with no maximum. Primary Care Networks are encouraged to adopt payment methods that are consistent with other governing bodies such as RHA and municipal boards. The rate is indexed with changes to the Alternate Relationship Plan sessional rates.

### **Cost Recovery Related to the Operation of the Primary Care Network**

- (a) Recoveries of costs directly related to the operation of the Primary Care Network are compensable. For example:
- Rent and lease costs
  - Equipment (refer to guidelines on allowable capital costs)
  - Medical and office supplies
  - Staffing
  - Specialized training
  - Evaluation costs
  - Recruitment
  - Innovative initiatives that add value to the Primary Care Network

#### **Recommended Payment Method**

- (b) Costs may be recovered at a standardized rate or a market rate where applicable.

- (c) It is the responsibility of the Primary Care Network to clearly define and describe the cost and how it is being measured
- (d) Costs that are already being paid through other means are not eligible for reimbursement and it is the responsibility of the Primary Care Network to establish that this will not occur.
- (e) "Recruitment" refers to the cost directly associated with recruitment activities and is not for signing bonuses or other incentives.

Objectives and Activities	Type	Description	Payment Method
<b>1. Clinically-related activities</b>			
<p>Improves access by expanding capacity while ensuring appropriate supervision and coordination.</p> <p>Enhances the Primary Care Network's capacity to provide effective and efficient care.</p>	Supervision	<p>A payment to a physician for supervising another health care provider who is performing supplementary functions on behalf of the physician. This role extends the efficiency of the physician by the other provider assuming part of the tasks, which are generally technical in nature.</p> <p>Key elements:</p> <ul style="list-style-type: none"> <li>• Other health care provider performing a supplementary role not other health care providers who are acting independently</li> </ul>	No limit, but a stipend
<p>Promotes teamwork amongst the group including the engagement of other health care providers to their full scope of practice.</p>	Team management	<p>A payment to a physician for leading a multi-disciplinary team supporting a discrete group of patients. This would include taking clinical and/or financial responsibility for the primary care functions assumed by the team (e.g., providing clinical and financial oversight of the operation of the team).</p> <p>Key elements:</p> <ul style="list-style-type: none"> <li>• Multi-disciplinary team</li> <li>• Discrete group of patients</li> <li>• On behalf of the Primary Care Network</li> </ul>	No limit, but a stipend

Objectives and Activities	Type	Description	Payment Method
<p>Encourage an organized, long-term approach to screening and preventive services.</p> <p>Encourage the comprehensive care of patients including the coordination of care and the appropriate completion of reports, problem lists, etc.</p>	Disease management	<p>A payment to a physician for managing the care of a discrete group of patients who share common health needs, on behalf of the Primary Care Network.</p> <p>Key elements:</p> <ul style="list-style-type: none"> <li>• Managing the care of a group of patients</li> <li>• On behalf of the Primary Care Network</li> </ul>	A standard hourly or daily rate but no limit
Encourage the care of patients with complex/multi-problem health issues.	Case management including coordination	<p>A payment paid for the case management of patients with complex/multi-health issues that may require specialist services (e.g., multiple specialist referrals).</p> <p>Key elements:</p> <ul style="list-style-type: none"> <li>• Providing direct individual care</li> <li>• Complex patient, who has multiple care providers</li> <li>• Coordinating clinical information from a variety of sources and is also receiving specialist services</li> </ul>	A standard hourly or daily rate but no limit
Improve timely and appropriate access.	Management of 24/7 access	<p>A fee paid for being available to provide and/or actually providing care advice and case management services after regular hours of operation, utilizing a formalized triage system as part of a program provided by the Primary Care Network, for example services provided to complement normal referrals to Health Link.</p> <p>Key elements:</p> <ul style="list-style-type: none"> <li>• Case management</li> <li>• Formalized triage system</li> </ul>	A standard hourly or daily rate but no limit
Promotes the development of new programs and their effective implementation.		A payment for program development and implementation and evaluation activities.	A time-limited stipend

Objectives and Activities	Type	Description	Payment Method
<b>2. Primary Care Network Administrative/Governance Services</b>			
Promotes the effective operation of the Primary Care Network.		A payment for governance and management-related functions of the Primary Care Network.	Standard hourly or daily rate or a stipend.
<b>3. Cost Recovery</b>			
Costs must be related to the provision of Primary Care Network services  (Examples are listed in the next column)	Rent and lease costs	Cost to acquire and maintain the space required to support Primary Care Network programs	Reasonable limits established and market rates applied
	Minor equipment and other approved capital expenditures	Cost to acquire and maintain the equipment required to support Primary Care Network programs	Reasonable limits applied within PCI Capital Expenditure Policy
	Specialized training	Payment to encourage and cover the costs of specialized training directly related to advanced primary care services	Limited to direct (e.g., travel and tuition) and indirect (e.g., compensation for physician's time) costs of obtaining the training
	Primary Care Network evaluation	Overall evaluation of the Primary Care Network and other related activities	Amount established per capita
	Medical and office supplies	Supplies related to Primary Care Network activity that are not covered by other payment systems	Reasonable limits established and market rates applied
	Staffing	Payments for Primary Care Network staff	Reasonable limits established and market rates applied
	Recruitment	Costs directly associated with recruitment activities (not for signing bonuses and other incentives)	Reasonable limits established and market rates applied
	Innovative initiatives that add value to the Primary Care Network	Initiatives that add value and are not already funded by other payment systems	Initiative-dependent (within reasonable limits)

## 11.5 RHA Reimbursement Policy

- (a) Services/activities for which RHAs are compensated must:
- Substantially improve the provision of primary care to Albertans
  - Add value through the provision of new services and/or enhanced services, including support for other health care providers
  - Not duplicate services for which RHAs are already funded
  - Not be major infrastructure development (must follow Primary Care Network capital expenditure guidelines)
- (b) PCIC will focus on assessing the impact of RHA reimbursement proposals within the context of achieving PCI objectives, rather than trying to address the shortcomings of other funding sources.
- (c) Primary Care Network funding cannot be used to replace and/or subsidize existing services provided by RHAs. However, some overlap may be allowed for a fixed period of time to allow for transition to new models.

## 11.6 Capital Expenditures Policy

- (a) PCI policy states that Primary Care Network per-capita funding may not be used for “major infrastructure development including facility construction, etc.” (i.e., funding of large capital projects). However, direction has been given that smaller capital items, such as renovations to accommodate a new services or additional health providers, would be allowed.
- (b) Primary Care Network decisions regarding whether a purchase is a capital or operating expenditure will be guided by generally accepted accounting principles, including the matching and materiality principles. Some criteria to help the decision include:
- If the use of a purchase can be reasonably applied to the current fiscal year, it should be an operating expense.
  - If a single purchase has a useful life exceeding one fiscal year, but is not of significant dollar value, it should be an operating expense.
  - If the sum total of several small purchases of the same type of product or service exceeds a large dollar value, there is a case for capitalizing the expenditure.
  - Capital expenditures made with Primary Care Network funds must directly enhance and support service delivery related to the Primary Care Network service delivery model.
  - A Primary Care Network may not expend more than \$100,000 in PCI funding annually on (the total set of) capital expenditures without prior approval from PCIC.
  - Expenditures totaling more than \$100, 000 annually require PCIC approval.

- Any individual item purchased for more than \$5,000 is considered to be a capital expense. This is consistent with AHW and RHA reporting limits. Approval for purchase of capital items would be made within the Primary Care Network.

### Capital Expenditure Types, Eligibility and Method of Depreciation

Type of Expenditure	Description	Allowed/ Not Allowed	Method of Depreciation
Information technology	Purchase and implementation of VCUR compliant physician office systems to support Primary Care Network business	Allowed <i>* PCIC to be informed of plans in these situations</i>	Straight line over 5 years for hardware Straight line over 1 year for software
Information technology	Acquisition of desktop hardware, software and services for Primary Care Network administration purposes: Includes: personal computers, printers, scanners, LAN, PDA, etc.	Allowed	Straight line over 5 years for hardware Straight line over 1 year for software
Information technology	Development of interfaces from physician office systems to RHA systems and/or the provincial EHR to support the delivery of laboratory, drugs, and diagnostic imaging information	<i>Subject to further guidance</i>	
Medical (or clinical) equipment	Minor equipment for diagnostic and treatment services that supplements existing equipment in support of the Primary Care Network service delivery model (e.g., blood cuff monitors, glucose monitors, examination tables)	Allowed	Straight line over 5 years
Office equipment and furnishings	Furniture and office equipment Upgrades to fixtures and furnishings	Allowed	Straight line over 5 years
Upgrades to physical infrastructure	Expansion/renovation of existing facilities (e.g., remodeling)	Allowed	Straight line over 5 years, or amortize over the period of the lease
Minor leasehold improvements other than upgrades to physical infrastructure (as above)	Accounting rules depend on the lease arrangements; otherwise, use the same accounting rules as with other capital assets. Excludes major physical infrastructure improvements, as in next row	Allowed	Straight line over 5 years, or amortize over the period of the lease

Type of Expenditure	Description	Allowed/ Not Allowed	Method of Depreciation
Major physical infrastructure	New facility construction Major expansion/ upgrades to existing facilities Leasing and/or mortgage financing of major physical infrastructure	Not allowed	N/A
Medical laboratory and diagnostic imaging equipment and services	Major equipment used in the provision of medical laboratory and diagnostic imaging services	Not allowed	N/A

## 11.7 Transition Policy

### 11.7.1 For All Primary Care Networks

- (a) A Primary Care Network, in its original application, will be expected to comply with the PCI policies in effect at the time of the approval of its Letter of Intent, and these policies will be in effect for its initial business plan period
- (b) Compliance with subsequent changes to policies will be expected at the time of the Primary Care Network's next business plan period. At the time of the renewal of the business plan, the Primary Care Network will be required to conform with the policy in place six months prior to the end of its business plan period.

### 11.7.2 For Round 1 and Round 2

- (a) **Round 1: The first twelve Primary Care Networks that had their Letters of Intent (LOIs) approved in the first round of business planning:**

The policy guidelines in existence at the time of the LOI approval will apply until the expiry of the Primary Care Network's first business plan. After that, the policy in effect six months prior to the expiry of the business plan will apply to the next business plan.

Rationale: Round 1 proposals were grandfathered to avoid retroactively applying policy guidelines. Round 1 Primary Care Networks will need to comply with the new guidelines upon expiry of their initial business plan period.

- (b) **Round 2: Those Primary Care Networks that had their LOIs approved for the second round of business planning but have not yet had their business plans approved:**

Round 2 Primary Care Networks will be expected to comply with the November 18, 2005 Guidelines for Use of Per-Capita Funding.

Rationale: Round 2 proposals will not be grandfathered because they have been advised that changes will be forthcoming. The PCI PO will meet with each proposed Primary Care Network to identify any issues associated with complying with the new guidelines.

### **11.7.3 For Round 3 and Subsequent Rounds**

- (a) Primary Care Networks in Round 3 and beyond will be expected to comply with the policies in effect at the time of their Letter of Intent approvals, as stated in the guidelines above.

## 12. Capacity-Building Grant Funding

To help address the challenges of smaller than anticipated patient populations and higher than anticipated rates of pro-ration, the Primary Care Initiative (PCI) will make available capacity-building grants to provide sufficient funding to allow those Primary Care Networks most in need to fully implement their business plans.

### 12.1 Capacity-Building Grant Policy

- (a) Capacity-building grants will be available to Primary Care Networks in the first and second set of approvals (Rounds 1, 2 and 3). This grant is not available for Primary Care Networks formed at a later period.
- (b) Funds for capacity-building grants will come from the existing Primary Care Initiative Budget within the Master Physician Budget. No additional funding is being made available.
- (c) Eligible Primary Care Networks will receive capacity-building grant funds on a semi-annual basis.
- (d) The grant amount requested is an application only. The amount actually disbursed is subject to evaluation and validation based on local factors affecting each Primary Care Network.
- (e) AHW will recalculate the grant amount at the time a network commences operation to accurately reflect participating physicians and Enrolment.
- (f) Six-month reconciliations will be completed, based on Enrolment and physician FTE at the “go live” date.
- (g) The grant amount will be a fixed amount with payments spread equally over two years and paid semi-annually.
- (h) An increase or decrease of 10% or greater in the number of physician core providers at one time will result in a change to the grant amount (either an increase or decrease) for the remaining period of the grant. Physician FTE changes must occur at a single point in time (i.e. within a 30-day time period) within the first 18 months of a network’s operation.
- (i) Building capacity within a Primary Care Network can include enhancing the ability for Primary Care Networks to increase their population of patients served, and increasing access for patients within a Primary Care Network.

## 13. Specialist Linkages Funding

As outlined in Article 12 of the Primary Care Initiative (PCI) Agreement, specialist linkages funding is available to support mechanisms and incentives for making value-added services provided by specialists available to Primary Care Networks.

### 13.1 Specialist Linkages Policy

- (a) The primary purpose of specialist linkages funding is to provide funding to allow operational Primary Care Networks to establish linkages with specialists at the local level.
- (b) For the purpose of this funding, a specialist is a medical professional with a specific skill set and level of training, designated and accredited by the Royal College of Physicians and Surgeons and licensed by the College of Physicians and Surgeons of Alberta.
- (c) The intent of specialists linkages funding is:
  - To directly remunerate specialists or to be used by a general practitioner to remunerate a specialist.
  - To support improved access to specialists by general practitioners.
- (d) Funding is to be used to support only the approved set of specialist linkages activities (see below).
- (e) Funding will be disbursed only to operating Primary Care Networks. However, networks may apply for specialist linkages funding prior to going live.
- (f) The amount of specialist linkages funding a network is eligible for will depend on its size, namely the number of clinics involved and the number of participating physicians (see below).
- (g) The specialist linkages funding amount requested is an application only. The amount actually disbursed is subject to evaluation and validation, based on local factors affecting each Primary Care Network.
- (h) Funding will be available to eligible networks for a two-year period (i.e. March 1, 2006 to March 31, 2008).
- (i) The total amount of funding for the network will be determined at the time of application approval. Within 30 days following each quarter the Grant Recipient will submit a funding request on the form contained in Appendix B for activities conducted in that period.
- (j) The PCI Program Office requires those networks receiving specialist linkages funding to report on use of the funds via the routine semi-annual reporting process. In this process, reporting periods are based on the per-capita funding dates of March 31 and September 30 each year, which matches the availability of per-capita funding and activity reporting information. Specialist linkages funding will be added to the roster of funds that are reported on the semi-annual report.

- (k) Networks will be requested to complete a baseline evaluation at the time of application and a final evaluation at the end of the funding term.

## 13.2 Amount of Specialist Linkages Funding

The amount of specialist linkages funding a Primary Care Network is eligible for will depend on its size, namely the number of clinics involved and the number of participating physicians, as follows:

Primary Care Network Size	Monthly Amount
<b>Small</b> <ul style="list-style-type: none"> <li>• Single clinic and less than 15 physicians</li> </ul> <i>OR</i> <ul style="list-style-type: none"> <li>• Multiple clinics and less than 10 physicians</li> </ul>	Up to \$2000
<b>Medium</b> <ul style="list-style-type: none"> <li>• Single clinic and more than 15 physicians</li> </ul> <i>OR</i> <ul style="list-style-type: none"> <li>• Multiple clinics and between 10 and 40 physicians</li> </ul>	Up to \$5000
<b>Large</b> <ul style="list-style-type: none"> <li>• Multiple clinics and more than 40 physicians</li> </ul>	Up to \$10,000
<b>Super</b> <ul style="list-style-type: none"> <li>• Multiple clinics and more than 70 physicians</li> </ul>	Up to \$14,000

## 13.3 Specialist Linkages Activities

Primary Care Networks may use specialist linkages funds in accordance with the following approved activities:

(a) **Knowledge Transfer, Learning Opportunities and Informal Relationship Building and Networking Opportunities**

Funding may be used to support some of the more formal aspects of knowledge transfer and learning. This includes, but is not limited to, continuing medical education, physician shadowing, and newly graduated specialists (or specialists that are new to the region) doing rounds in family practice settings. The common denominator is providing physicians with the opportunity to learn from each other and strengthen professional relationships in a trusting and supported environment.

1. Make specialist time available for telephone consultations with GPs
2. Support specialists to conduct education sessions for GPs
3. Support specialists to visit GP sites for shared care consultations and joint case conferencing
4. Establish referral relationships at GP sites

(b) **Collaborative Model**

Funding may be used to pay physicians for participation in a multifaceted environment, which incorporates specialty clinics and joint case conferences, chart reviews, shared care, dedicated consultation time via telephone conferencing, seminars and education sessions, other health professionals and/or other care enhancements.

- Provide opportunities for GPs to shadow specialists
- Support GP by providing dedicated mentoring time with specialist

(c) **General Support for Knowledge Transfer and Collaboration**

Funding may be used to pay for travel time and expenses (where applicable). This activity speaks to the need to remunerate specialists for travel and expenses that may be incurred when providing care relating to activities 1 to 6.

- Travel time and expenses for urban and rural environments for specialists and GPs, as a means of making specialists more accessible to GPs.

### **13.4 Specialist Linkages Funding Guidelines for Travel**

- (a) Travel time and expenses may be claimed by a specialist for activities 2, 3, 5 and 6 (see above). The rate per hour for a specialist is indexed to the Alternative Relationship Plans sessional rate.
- (b) Travel and expenses may be claimed by a general practitioner for activities 4 and 5. The rate per hour for a general practitioner indexed to the Alternate Relationship Plan's sessional rate.
- (c) Mileage will be reimbursed as per the AMA Guide for Honoraria and Expense Allowances. This rate is based on the Canada Customs and Revenue Agency maximum rate per kilometer and will be updated as the rate changes.

## 14. Network Accountability

As outlined in the Primary Care Initiative (PCI) Agreement, Primary Care Networks must agree to adhere to and follow accountability mechanisms developed by the Primary Care Initiative Committee (PCIC).

Primary Care Network accountability to PCIC is referenced in the PCI Agreement, as follows:

- (d) Article 6, paragraph 4.1(n) – establishing and maintaining remedies for non-compliance with the service responsibilities
- (e) Article 4, paragraph 4.1(o) – developing a dispute resolution mechanism to handle any disputes that may arise between a Primary Care Network and PCIC, including but not limited to the achievement of the service responsibilities
- (f) Article 6, paragraph 6.2(c) – expenditure of change management funding
- (g) Article 7, paragraph 7.1 – fulfilling the Primary Care Network business plan
- (h) Article 7, paragraph 7.2(m) – developing a method for approving amendments to Primary Care Network business plans
- (i) Article 7, paragraph 7.2(o) – expenditure of per-capita funding
- (j) Article 8, paragraph 8.2 – delivery of the service responsibilities

### 14.1 Monitoring and Reporting

Network accountability includes the requirement to report, mid-year and annually, to PCIC through the PCI Program Office, in a standard format approved by PCIC. The purpose of this reporting is to provide information on network progress relative to objectives, strategies and service responsibilities, as outlined in the network's business plan.

- (a) Primary Care Networks will report mid-year and annually. The reporting period is aligned with the six-month Primary Care Network payment cycle (i.e., March and September).
- (b) Mid-year and annual reporting will follow a standard format approved by PCIC and will include:
  - General information on network progress, including milestones, schedule and identification of key issues and challenges
  - Reporting against progress on the service delivery plan and objectives as set out in the business plan, including performance indicators defined by the network therein, and provincially by PCIC. Since results-based indicators are progressive, indicators related to inputs, process and outcomes are desirable, as measurable changes in outcomes will occur over time.
  - Financial information, including funding and expenditures (i.e., statement of operations) and financial status (i.e., statement of financial position). Financial information must be audited on an annual basis, respecting the operation of the network in a form and content satisfactory to PCIC.

- Progress information on increasing capacity and the expenditure of Primary Care Network capacity-building grant monies.

## 14.2 Business Plan Amendments

In accordance with the PCI Agreement, Primary Care Networks must identify an internal process to be used to amend their business plans and account for changes made. Minor changes are at the discretion of the Primary Care Network. Major changes to business plans must be documented, and submitted to and approved by PCIC.

### 14.2.1 Major Changes

Major changes require:

- (a) Summary documentation outlining the particulars of the change(s).
- (b) Evidence of agreement to the change(s) between the parties to the Primary Care Network, signed by the authorized representatives of the Primary Care Network.
- (c) Submission of a revised Business Plan to PCIC for approval (signed by a representative of the RHA and all participating physicians).
- (d) Approval for changes must be received from PCIC before any action can be taken. PCIC will review any changes to business plans as soon as is feasible.

Examples of major changes include, but are not limited to:

- An increase or decrease of more than 10% of core providers within a six month per capita payment period. If the Primary Care Network is smaller than 10 physicians, all changes in core providers must be reported.
- A change in revenue of more than 10%.
- A variation of more than 20% on the following planned expenditure items:
  - Physician remuneration
  - RHA remuneration
  - Remuneration to other health care providers
- Withdrawal of an entire clinic from the Primary Care Network.
- Significant changes to the service delivery model.
- Significant changes (additions or deletions) to service delivery locations.
- Forward or backward changes to timelines of more than one quarter of a calendar year.
- Any changes to the legal arrangement/agreement.
- Any administrative changes in the Primary Care Network that result in the requirement for changes to the Primary Care Network PIA. Requires evidence that the PIA has been amended and resubmitted to Office of the Information and Privacy Commissioner (OIPC).

### **14.2.2 Minor Changes**

Minor changes to the business plan do not require PCIC approval. However, they must follow processes set out by Alberta Health and Wellness (AHW) and/or the PCI Program Office. For example, when physician(s) or other health care providers join or leave a Primary Care Network, the appropriate forms must be completed, signed and submitted to AHW. Changes to core providers and service delivery locations will be directed to PCIC through the AHW reporting system.

Examples of minor changes are:

- (a) An increase or decrease of 10% or less of the Primary Care Network's core providers.
- (b) Minor changes to the service delivery model
- (c) Minor changes (additions or deletions) to service delivery locations.
- (d) Forward or backward changes to timelines of less than one quarter of a calendar year.

### **14.3 Support for Meeting Primary Care Network Responsibilities**

- (a) The Primary Care Initiative Committee (PCIC) is required, by the PCI Agreement, to develop mechanisms to ensure that Primary Care Networks are meeting their Service Responsibilities, as set out in Article 8 of the PCI Agreement. A set of processes has been developed to support Primary Care Networks to meet the Service Responsibilities they have committed to, and to work with them if they are not able to do so.
- (b) Primary Care Networks are advised of their accountability to ensure compliance with the PCI Agreement, and of PCIC's desire for collaboration and reasonableness in helping Primary Care Networks address deficiencies. The objective of publishing interventions to support Primary Care Networks is to provide support and encouragement to ensure Primary Care Networks are fully operational and able to meet their Service Responsibilities.
- (c) Primary Care Networks will have a reasonable period of time in which to establish programs and services to address the required Service Responsibilities, which may be specified in an approved business plan.
- (d) Primary Care Networks will submit semi-annual status reports to PCIC. The semi-annual status report will describe progress against the objectives, strategies and activities outlined in the approved Primary Care Network business plan, and, more specifically, how the Service Responsibilities are being met. Semi-annual reporting, within the agreed framework, is mandatory for Primary Care Networks.
- (e) Following review of the semi-annual Primary Care Network reports, PCIC will confirm whether a Primary Care Network has met its Service Responsibilities, or will, if required, initiate support for the Primary Care Network as follows:
  - 1. PCIC will notify the Primary Care Network that it has not met one or more of the Service Responsibilities within 30 days of receipt of the semi-annual report. A clear statement of what Service Responsibilities have not been delivered will be provided, in writing, to the Primary Care Network

PCIC will request that the Primary Care Network work to rectify the shortfall following receipt of notice from PCIC or, in those cases where immediate correction is not possible or practical, embark upon a process to correct the situation in a timely manner. The Primary Care Network will be required to submit a written work plan, including timelines and commitments, to PCIC within 30 days of receipt of the notice from PCIC.

PCIC will monitor and review the Primary Care Network's progress toward remedying the identified shortfall, and repeat Step 1 above, as necessary. This monitoring and review should span no more than two semi-annual reporting periods.

2. If it is determined that there is not sufficient progress towards meeting all Service Responsibilities:
    - At PCIC's direction, the PO will form and implement a resolution team as appropriate for the specific situation. PCIC will be responsible to determine the composition of the team, based on the issues and the skill sets required.
    - The team will work to assist the Primary Care Network to identify problems and develop plans for resolution, and will work jointly with the Primary Care Network to assess the situation and provide recommendations to PCIC within 60 days of receipt of the last semi-annual report.
    - Team members will report to PCIC (through the PO) with an assessment of the outstanding issues, an action plan, and associated timelines.
  3. If the resolution team and the Primary Care Network cannot come to a consensus:
    - PCIC will conduct a review of the situation, determine next steps, and act accordingly.
  4. If PCIC has gone through the entire range of support options and there are still outstanding issues, PCIC will recommend cessation of funding to the Primary Care Network:
    - Immediately, in extraordinary circumstances (e.g., evidence of mismanagement of funds)
    - With notice (perhaps 90 days), based on a set of criteria that must be met
- (f) PCIC reserves the right, in extraordinary circumstances (for example in the event of mismanagement of funds) to revoke funding without notice.

## 14.4 Resolving PCI-Primary Care Network Differences

- (a) Article 4 (o) of the PCI Agreement states that PCIC is responsible to develop a process to handle any differences that may arise between a Primary Care Network and the Primary Care Initiative Committee (PCIC), including but not limited to the achievement of the Service Responsibilities.
- (b) If a dispute or disagreement should arise between the PCIC and a Primary Care Network, either party can initiate following process for resolving differences:
  - 1. Where possible, the responsible officers of PCIC and the Primary Care Network will develop a “statement of dispute” and a mutually agreed upon action plan for resolution.
  - 2. If this process does not lead to resolution of differences, designated officers of the Primary Care Network will meet with the PCIC co-chairs to discuss the issue and reach a mutually acceptable resolution.
  - 3. If the issue still cannot be resolved, the parties will refer it to mediation, as follows:
- (c) The parties will, if possible, mutually agree on a mediator, based on suggestions from the Alberta Arbitration and Mediation Society (who will provide a list of candidates with suitable skills and knowledge), and failing agreement on a mediator, will accept the mediator recommended by the Alberta Arbitration and Mediation Society.
- (d) The parties will share the cost of the mediation equally.
  - 1. If the mediation process does not produce a resolution, the issue will be referred to Secretariat and Master Committee whose decision will be final.
  - 2. All parties should be reasonable in their dealings with each other and all steps and proceedings should be documented.

## 15. Appendix A – Service Responsibility Definitions

Service Responsibilities are defined in the Master Agreement as meaning “in respect of a local primary care initiative, those services defined from time to time by the [PCI] Committee to be provided by every local primary care initiative as initially set out in Article 8.”

Following are descriptions of the service responsibilities, as determined by PCIC. These are an extension of Article 8 and are intended to provide further information, clarification and guidance to Primary Care Networks.

Service Responsibility	PCI Definition
1. Basic ambulatory care and follow-up	<ul style="list-style-type: none"> <li>• Assessment, diagnosis, management and follow-up of simple episodic health concerns</li> <li>• Routine, periodic health assessments</li> <li>• Opportunistic prevention and health promotion services</li> </ul>
2. Care of complex problems and follow-up	<ul style="list-style-type: none"> <li>• Assessment, diagnosis, management and follow-up of complex health concerns</li> <li>• Duration of the problem may be short, medium or long-term. For purposes of Primary Care Network service delivery responsibilities, this excludes conditions that fall under the definition of chronic conditions.</li> <li>• Generally:               <ul style="list-style-type: none"> <li>– Involves more than one body system</li> <li>– Requires the involvement of more than one health professional</li> </ul> </li> <li>• May involve coordination and integration with services provided by other sectors (e.g., education, social services)</li> <li>• Opportunistic prevention and health promotion services</li> </ul>

Service Responsibility	PCI Definition
3. Psychological counselling	<ul style="list-style-type: none"> <li>• Identification and treatment of mental health problems at an early stage, prevention of relapse, assistance to individuals and families in maintaining good mental health, coordination of the health and mental health services an individual may require, encouragement of healthy lifestyle choices, and provision of support and information for the families of individuals with a serious mental or physical illness</li> <li>• Service examples include: <ul style="list-style-type: none"> <li>– Individual and family counselling and psychotherapy, diagnostic interviews, counselling of relatives of catastrophically or terminally ill patients</li> </ul> </li> </ul>
4. Screening/chronic disease prevention	<ul style="list-style-type: none"> <li>• Screening of patients at risk for disease, to attempt early detection and institute early intervention and counselling to reduce risk or development of harm from disease</li> <li>• Appropriate immunizations</li> <li>• Periodic health assessments</li> <li>• Organized population health screening targeted at the Primary Care Network population</li> <li>• Organized population health promotion targeted at the Primary Care Network population</li> </ul>
5. Family planning and pregnancy counselling	<ul style="list-style-type: none"> <li>• Counselling for birth control and family planning</li> <li>• Education, screening and treatment for sexually transmitted infections</li> </ul>
6. Well-child care	<ul style="list-style-type: none"> <li>• Screening, parent education and counselling re: infant/child health and development and health promotion</li> </ul>
7. Obstetrical care	<ul style="list-style-type: none"> <li>• Antenatal care to term</li> <li>• Labour and delivery including induction and augmentation of labour; vaginal delivery; low forceps and vacuum extraction assisted delivery; repair of perineal, vaginal and cervical tears; manual removal of the placenta; and neonatal resuscitation</li> <li>• Postpartum maternal and newborn care</li> </ul>

Service Responsibility	PCI Definition
8. Palliative care	<ul style="list-style-type: none"> <li>• Active compassionate care directed primarily towards improving the quality of life for the dying. The focus is on comfort, not cure, but where active care is required to alleviate or manage symptoms.</li> <li>• Includes the provision of other service responsibilities such as basic ambulatory care and follow-up, complex care and follow-up, psychological counselling, screening/minor surgery, minor emergency, primary inpatient symptom and pain management.</li> <li>• Frequently requires coordination between health providers, amongst health sectors and perhaps with other sectors.</li> </ul>
9. Geriatric care	<ul style="list-style-type: none"> <li>• Provision of primary care service responsibilities (e.g., basic ambulatory care and follow-up, complex care and follow-up, psychological counselling, screening/chronic disease prevention, etc.) to individuals 75 years of age and older taking their unique considerations/needs into account.</li> </ul>
10. Care of chronically ill patients	<ul style="list-style-type: none"> <li>• Provision of primary care service responsibilities (e.g., ambulatory care and follow-up, complex care and follow-up, psychological counselling, screening, etc.) to patients who have conditions that are continuous or persistent over an extended period of time and are not easily or quickly resolved.</li> <li>• Includes chronic disease management programs/approach.</li> </ul>
11. Minor surgery	<ul style="list-style-type: none"> <li>• Treatment and follow-up of those procedures identified in the fee code "basket of services."</li> </ul>

Service Responsibility	PCI Definition
12. Minor emergency care	<ul style="list-style-type: none"> <li>• Basic resuscitation and Canadian Emergency Department Triage and Acuity Scale - levels 3 and 4 , i.e.:               <ul style="list-style-type: none"> <li>- Level 3 (urgent): Conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affect ability to work or activities of daily living.</li> <li>- Level 4 (less urgent): Conditions that relate to age, distress or potential for deterioration or complications that would benefit from intervention or reassurance within 1 - 2 hours.</li> </ul> </li> </ul>
13. Primary in-patient care including hospitals and long-term care institutions	<ul style="list-style-type: none"> <li>• Support and/or provision of primary care to patients in hospitals and, where applicable, long-term care facilities</li> <li>• Discharge planning, rehabilitation services, out-patient community follow-up and home care services.</li> </ul>
14. Rehabilitative care	<p>Provision of community rehab services such as physical therapy, occupational therapy, speech language pathology, audiology and respiratory therapy to LPCI patients</p> <p>It is not a requirement of the LPCI to provide rehabilitative care above the current capacity of the system or that the LPCI assume rehabilitative care responsibilities that are already the responsibility of the regional health authority.</p>

Service Responsibility	PCI Definition
15. Information management	<ul style="list-style-type: none"> <li>• The policies, procedures and systems for collecting, using and sharing data and information required for: <ul style="list-style-type: none"> <li>– Patient care (includes patient data and clinical decision support systems; meets both individual patient and Primary Care Network population health needs)</li> <li>– Administration (e.g., scheduling, financial, reporting)</li> <li>– Communication (between providers and between providers and patients)</li> </ul> </li> <li>• The information management system must be compliant with the <i>Health Information Act and VCUR if POSP funding is being applied for</i>.</li> <li>• To realize the full benefits of Primary Care Networks, information management systems should support the rapid achievement of electronic medical records that are integrated with the electronic health record and allow for electronic connectivity between and amongst service providers and health authorities.</li> </ul>
16. Population health	<ul style="list-style-type: none"> <li>• The process of actively supporting and enabling people to increase control over and improve their health (WHO, 1998).</li> <li>• Delivery of services/programs that address the needs of the Primary Care Network patient population or a given unique/specialized sub-population within it, and the factors that contribute and determine health status. A population health approach facilitates the integration of services across the continuum (Canadian Council on Health Services Accreditation (CCHSA) (2002).</li> </ul>
<b>8.1 (b) Services that relate to linkages within and between primary care and other areas include:</b>	
17. 24-hour, 7-day-per-week management of access to appropriate primary care services	
18. Access to laboratory and diagnostic imaging	

Service Responsibility	PCI Definition
<b>Services that relate to the coordination with other health services include:</b>	
19. Home care	
20. Emergency room services	
21. Long-term care	
22. Secondary care	
23. Public health	
<b>8.1 (c) The agreement requires “Acceptance into the LPCI’s patient population and provision of services to an equitable and agreed upon allocation of unattached patients.”</b>	
24. Unattached patients	Individuals who require and/or desire a family physician for ongoing medical care but who currently do not have a therapeutic relationship with one.

## 16. Appendix B - Definition of Primary Care Network Provider

“Provider” as it relates to Primary Care Networks is explored by defining provider types and provider roles, and outlining example scenarios to illustrate the definitions.

### 16.1 Primary Care Network Provider Types

#### Family Physician/General Practitioner

A medical professional licensed as a family physician or general practitioner with the College of Physicians and Surgeons of Alberta.

#### Specialist Physician

A medical professional with a specific skill set and level of training, designated and accredited by the Royal College of Physicians and Surgeons and licensed by the College of Physicians and Surgeons of Alberta.

#### Other Health Care Provider

A health care professional, other than a physician, who is either regulated as a member of a profession included in the Health Professions Act (e.g., nurse, psychologist), or non-regulated (e.g., health aide, continuing care worker).

#### Locum

Designate a health care provider who delivers services for another provider who is temporarily away from work.

### 16.2 Primary Care Network Provider Roles<sup>1</sup>

#### Core Provider

A core provider is a physician or other health care provider who is committed to providing primary care services<sup>2</sup> to only one Primary Care Network unless otherwise approved by the PCIC. In certain situations identified to the PCIC, a core provider in one Primary Care Network may also spend a limited amount of time delivering a defined set of primary care services to another Primary Care Network.

Core providers can be family physicians/general practitioners that provide primary care services. Other Health Care Providers may be included as core providers when approved by PCIC. Core providers may be registered as a core provider with only one PCN.

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<sup>1</sup> In their business plans, Primary Care Networks will submit information on providers who will contribute to the provision of Primary Care Network service responsibilities in support of the Primary Care Network service delivery model. It is recognized that these providers will likely change over time, due to attrition and/or adjustments to the Primary Care Network service delivery model.

<sup>2</sup> For the purpose of this document, “primary care services” refers to those services outlined in Article 8 of the Primary Care Initiative Agreement.

Core providers are responsible for maintaining the ongoing relationship with a patient for providing the range of Primary Care Network primary care services, and dedicate the majority of their work time to the Primary Care Network. Core providers also generate and maintain Primary Care Network encounters and Enrolments for the purpose of determining Primary Care Network per-capita funding.

### **Associate Provider**

An associate provider is a provider who agrees to assist a Primary Care Network by delivering one or more of the required Primary Care Network primary care services. Associate providers may provide services to one or more than one Primary Care Network, but no one Primary Care Network takes up all of their time.

In contrast to a core provider, an associate provider is more likely to provide a smaller subset of primary care services for a particular patient for a limited period of time.

***Further policy related to Associate Providers is under review.***

### **Locum Provider**

A family physician/general practitioner contracted by a PCN to provide primary care services on a non-permanent basis. A locum will be considered a core provider when he/she is dedicated to just one PCN in Alberta. A locum will be considered an Associate Provider when he/she is providing service to more than one Primary Care Network. Further policy related to locum providers is under review.

***Further policy related to Associate Providers is under review.***

### **Other Health Care Providers**

Other Health Care Providers may be included as core providers when approved by PCIC. OHCPs approved as core providers may be registered as a core provider with only one PCN at a time.

***Further policy related to Associate Providers is under review.***

### 16.3 Primary Care Network Provider Role Combinations

Type	Core	Associate
Family Physicians/ General Practitioners	Yes - most family physicians/GPs would participate in a Primary Care Network as core providers.	Yes - could be family physicians/GPs who have a special area of interest, for example, routine obstetrics or sports medicine. Family physicians/GPs who are associates to a Primary Care Network may provide services to more than one Primary Care Network, and may also provide services not related to any Primary Care Network.
Specialist Physicians	Policy related to specialist involvement in PCNs is under review.	Policy related to specialist involvement in PCNs is under review.
Other Health Care Providers	Only OHCPs approved by PCIC to be a core provider may be registered as a Core Provider.	Policy related to Other Health Care Providers involved in PCNs is under review.

### 16.4 Determining Whether Providers are Core or Associate

*Currently under review*

#### 16.5 Scenarios

##### Family Physician/General Practitioner (Core)

*Currently under review*

##### Family Physician/General Practitioner (Associate)

*Currently under review*

##### Specialist Physician (Core)

*Currently under review*

##### Other Health Care Providers (Core)

*Currently under review*

##### Other Health Care Providers (Associate)

*Currently under review*

## **17. Appendix C - Definition of Enrolment**

Enrolment is used to associate patients with a Primary Care Network for the purpose of calculating per-capita payments to a Primary Care Network. Per-capita payment, according to the PCI Agreement, is an amount up to \$50 per enrollee per annum, divided into semi-annual payments. To be enrolled in a Primary Care Network, a patient must be an Alberta resident with active Alberta Health Care Insurance coverage.

### **17.1 Enrolment Type**

#### **17.1.1 Informal Enrolment**

The first group of Primary Care Networks will initially operate under informal Enrolment, which is the default method of enrolling patients in a Primary Care Network. Informal Enrolment is based on patient encounters with a Primary Care Network core provider, in a Primary Care Network service delivery location, for services included in the list of Primary Care Network service responsibilities (Article 8 of the Primary Care Initiative (PCI) agreement.

A patient is “automatically” informally enrolled with a Primary Care Network when he/she has had the majority of encounters with a Primary Care Network core provider, at a Primary Care Network service delivery location, for the services that are included in Article 8 of the PCI Agreement, during the past three years.

#### **17.1.2 Formal Enrolment**

(Definition in progress)

### **17.2 Enrolment Lists**

The AHW system prepares an informal Enrolment list for each Primary Care Network when semi-annual payments are calculated. Encounter history is viewed on a 36-month rolling basis.

## **18. Appendix D - Definition of Service Delivery Location**

Primary care can be delivered in a variety of locations including registered facilities such as a hospital or physician's office, and other more generic locations, such as at a patient's home or a seniors' drop-in centre. Service delivery location is used to ensure that appropriate primary care encounters are assigned correctly to Primary Care Networks.

### **18.1 Definition**

For the purpose of registering Primary Care Networks, a service delivery location is any location at which a Primary Care Network service is delivered. Delivery of Primary Care Network services can be provided in either registered facilities or generic locations.

Encounter lists are based on service delivery locations designated by the Primary Care Network as being associated with the Primary Care Network.

### **18.2 Registered Facilities**

A registered facility is each physical building registered with Alberta Health and Wellness (e.g., a physician clinic, hospital, public health centre or community health care centre) where delivery of health care services is provided on a regular/routine basis. Each registered facility is further defined by designated functional centre(s), for example, an examination room or diagnostic imaging site. Codes for the facility and functional centre are used in combination to identify specific Primary Care Network service delivery locations.

Each registered facility is assigned a facility number that must appear on all claim submissions. Claim submissions used for fee-for-service billing are also used for tracking Primary Care Network encounters. Like a postal code, the 'Facility ID' code is address-linked, non-transferable and remains the same no matter how many care providers (physician or other health care providers) work out of that physical location.

Examples of facility types that can be registered are:

- a) Active treatment general hospital
- b) Auxiliary hospital
- c) Nursing home
- d) Mental health regional clinic
- e) Jail
- f) Non-hospital surgical facility
- g) Physician office
- h) Community health centre
- i) Public health centre
- j) Locations such as recreational centres and schools that are used regularly for the delivery of primary care services.

If a facility code but no functional centre is entered in a claim, the system defaults to the functional center set up as the default in the registration of that facility.

### **18.3 Other Locations**

Primary care services can also be delivered at other locations. An “other location” is any location where Primary Care Network service is delivered outside of a registered facility on an irregular or random basis.

Other locations are designated by location codes. There are presently two location codes - “home” and “other.” “Home” is used when services are provided in a patient’s home. “Other” is used when services are provided at non-public, non-regularly scheduled locations (e.g., emergency services provided on the side of a road).

Additional location codes for unregistered schools and public centres are currently being created. For example, the “school” location code would be used for a one-time diabetes information session held in a school gymnasium. The “public centre” location code would be used for a flu immunization clinic held in a city hall.

## 19. Appendix E - Definition of Encounter

This definition expands on the explanation of “encounter” in the PCI Agreement, and attempts to clarify encounters as they relate to the services delivered by Primary Care Networks. The definition also contains examples and scenarios to illustrate and clarify what an encounter is and how it counts toward Primary Care Network Enrolment.

### 19.1 Background

Primary Care Network funding is determined by patient Enrolment, and encounters are a means of tracking Enrolment.

According to the PCI Agreement, information on encounters, as they relate to Primary Care Networks are tracked by the Alberta Health and Wellness fee-for-service claims system (CLASS), and will be used:

- a) To create and maintain informal Primary Care Network Enrolments
- b) To perform retrospective patient utilization by looking at patient visits within and outside the Primary Care Network over a given time period
- c) To determine Primary Care Network semi-annual payments
- d) To determine majority care provider for patients

### 19.2 Definition

The AHW system defines an encounter as “each separate and distinct time a physician or other service provider provides services to a patient in the Primary Care Network in a given 24-hour period, starting at midnight” (adapted from the AMA/AHW Rules Redevelopment Working Group).

An encounter **within** a Primary Care Network will include the provision of any of the Primary Care Network service responsibilities by any of the participating physicians in the Primary Care Network, other health care providers in the Primary Care Network, or other health care providers outside the Primary Care Network who have made contractual or other written arrangements with the Primary Care Network to deliver some part of the service responsibilities.

An encounter **outside** the Primary Care Network will include the provision of any Primary Care Network service responsibilities by other Primary Care Networks or other physicians who are not part of a Primary Care Network.”

#### 19.2.1 Services vs. Encounters

**One encounter may consist of more than one service.** For example, during an appointment with her family physician, Jan discusses her sore throat and also the need for a flu shot, which she receives. Although she is only seeing the physician once (a single encounter) the visit would include two services (each billed under a different health service code).

**One encounter may consist of more than one service event (visit) to the same health care provider for the same reason in the same 24-hour day, and at the same service delivery location.** For example, Harold presents to the office giving a history of having fallen on his arm earlier in the day. The physician examines Harold and indicates that he likely has a fracture, but wants to confirm by X-ray. Harold is sent next door for an X-ray, and is asked to return and wait in the waiting room until the physician has reviewed the film. After review of the x-ray, Harold is called in to see the physician who advises him that he does have a fracture and proceeds to cast the arm.

Although Harold has seen the physician on two separate occasions on that day, it is still considered one encounter since the second visit was a continuation of the first. One service is billed and one encounter recorded.

**There may be more than one encounter related to a condition.** For example, Judy sees her family physician on Monday because of an infected sinus. The physician refers her, on the same day, to another Primary Care Network physician in a different clinic who specializes in this type of condition. This would be considered two separate encounters, but for the same condition, and two services would be billed under two different health service codes.

### **19.2.2 Service Responsibilities vs. Service Codes**

The list of Primary Care Network service responsibilities, as outlined in Article 8 of the Master Agreement, details the services Primary Care Networks must agree to provide to their patients.

The list of primary care health service codes, as set out by the PCIC, contains the codes used to track patient encounters with Primary Care Network health care providers.

It should be noted that Primary Care Network service responsibilities do not necessarily correspond one-on-one to a specific health service code. Examples of Primary Care Network services where encounters are not tracked include information management and 24-hour, 7-day-per-week management of access to care.

### **19.2.3 Assigning Encounters to a Primary Care Network**

When claims are submitted, the AHW information system will determine which encounters should be assigned to a Primary Care Network, based on the following criteria:

- The patient must be an Alberta resident insured under the Alberta Health Care Insurance Plan with an Alberta Personal Health Number (PHN).
- The service provided must be on the list of approved health service codes for Primary Care Networks and must fall into one of the following categories:
  - a. **Insured services:** These services are currently reimbursed as fee-for-service health service codes (HSC), and meet eligibility criteria for Primary Care Network encounter tracking.
  - b. **Other health interventions:** Although these services meet eligibility criteria, they are not reimbursed as fee-for-service health service codes. This includes services that are outside of the typical Schedule of Medical Benefits and could be provided by a physician or other health care provider. These health service codes will be captured only for tracking encounters and do not relate to billing.

Currently, four codes (visit, consult, case-discussion and referral) have been created to accommodate these encounters with other health care providers. The manner in which physicians should bill for activity which is not remunerated through fee-for-service has yet to be determined.

- The service provider or provider type must be registered with the Primary Care Network and have a valid practitioner ID.
- The service must be delivered at a service delivery location that has been registered by the Primary Care Network as being for that Primary Care Network or can be recognized by the AHW registration system (e.g., home). (See “Definition of Service Delivery Locations” for examples of delivery sites).

### **19.3 Services Not Counted as Primary Care Network Encounters**

Services provided, for example, to members of the Armed Forces or RCMP, or out of province patients, are not captured as encounters. WCB claims are also not captured as encounters.

### **19.4 Encounters Applied to Determination of Per Capita Payments**

AHW shall allocate per capita payments in a fair and timely manner by assigning the eligible patients to each networks Enrolment list in accordance with the four cut funding methodology and based upon historical utilization by patients and end date for registration of providers. At this time only core providers are utilized in the determination of per capita payments however the policy remains under review.