

**PRIMARY CARE INITIATIVE AGREEMENT MADE EFFECTIVE THE 1ST DAY OF
APRIL, 2003**

AMONGST:

**HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA**

As represented by the
MINISTER OF HEALTH AND WELLNESS
(the "Department")

And

**THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. ALBERTA DIVISION)**

(the "Association")

And

**THOSE REGIONAL HEALTH AUTHORITIES
IDENTIFIED IN SCHEDULE "A"
ATTACHED TO THE MASTER AGREEMENT**

(the "Authorities")

RECITALS:

- A. The parties have entered into a Master Agreement regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements (the "Master Agreement") dated for reference the 1st day of April, 2003; and
- B. The Master Agreement contemplates that the parties will enter into this Strategic Physician Agreement respecting the Primary Care Initiative.

THEREFORE the Parties promise and agree with each other as follows:

**ARTICLE 1
DEFINITIONS AND INTERPRETATION**

1.1 In this Agreement terms with initial capitals and defined in Schedule "J" to the Master Agreement have the meanings ascribed to such terms therein and the following terms have the meanings set out herein, unless there is something in the subject matter or context inconsistent therewith:

- (a) "**Agreement**" means this Primary Care Initiative Agreement, and any appendices annexed hereto;

- (b) “**Annual Per Capita Amount**” means the annual amount provided to an LPCI on a per capita basis for those members of a specific Patient Population;
- (c) “**Business Plan**” means a document submitted by a Participating Physician and an Authority in a manner, form and content prescribed by the Committee and substantially meeting the criteria defined in Article 6;
- (d) “**Change Management Funding**” means the funding established by the Committee as referred to in Article 10;
- (e) “**Committee**” means the Primary Care Initiative Committee formed pursuant to paragraph 4.1(c) of the Master Agreement with responsibility for the management and administration of this Agreement and the Primary Care Initiative Budget as more particularly set out in Schedule “C” to the Master Agreement;
- (f) “**Encounter**” means the unit of measure, determined by the Committee, for the provision of Service Responsibilities through an LPCI, to be used in determining eligibility of Patients to be included in an Enrolment List;
- (g) “**Enrolment Agreement**” means a document signed by or on behalf of a Patient, in form and content satisfactory to the Committee, which evidences that the person or persons named in the document have chosen to be Formally Enrolled with and obtain Services from an LPCI;
- (h) “**Enrolment List**” means the list of the Patient Population in respect of which an LPCI is obligated to provide the Service Responsibilities and to receive LPCI Funding based on the Annual Per Capita Amount;
- (i) “**Formal Enrolment**” or “**Formally Enrolled**” means that a Patient has signed an Enrolment Agreement with an LPCI;
- (j) “**Formal Enrolment List**” means the Patients on the Enrolment List of an LPCI who are Formally Enrolled;
- (k) “**Informal Enrolment**” or “**Informally Enrolled**” means that a Patient is eligible to be included on an Enrolment List, but has not signed an Enrolment Agreement;
- (l) “**Informal Enrolment List**” means the Patients on the Enrolment List on an LPCI who are Informally Enrolled;
- (m) “**Initiative**” means the primary care initiative contemplated under this Agreement and to be funded from the Primary Care Initiative Budget or any Element thereof;
- (n) “**LPCI**” means the contractual arrangement between a Participating Physician and an Authority acting together to provide the Service Responsibilities;

- (o) **“Majority Care Provider”** means an LPCI, that in respect to a Patient, provides fifty (50%) percent or greater of the Encounters relating to the provision of primary care services with that Patient;
- (p) **“Patient”** means a Resident who receives or is entitled to receive Insured Services;
- (q) **“Participating Physician”** means a Physician who has signed an approved Letter of Intent or an approved Business Plan or both;
- (r) **“Patient Population”** means those Patients who are Formally or Informally Enrolled and receiving or entitled to receive Services from an LPCI;
- (s) **“Services”** means, in respect of a Patient, the receipt or ability to receive those Service Responsibilities to be provided by an LPCI in respect of its Patient Population;
- (t) **“Service Responsibilities”** means, in respect of an LPCI, those services defined from time to time by the Committee to be provided by every LPCI as initially set out in Article 8 hereof;

1.2 The interpretive provisions set out in Article 13 (except the provisions of paragraph 13.8) and the general provisions set out in Article 14 (except the provisions of paragraph 14.8) of the Master Agreement are incorporated and form part of this Agreement.

1.3 The recitals are incorporated into and form part of this Agreement.

ARTICLE 2 TERM OF THE AGREEMENT

2.1 The term of this Agreement shall commence on the Effective Date and shall, notwithstanding any notice to reopen negotiations served pursuant to paragraph 11.2 of the Master Agreement, remain in full force and effect only until twelve (12) o'clock midnight, March 31, 2011.

ARTICLE 3 ACKNOWLEDGEMENTS

3.1 The Parties acknowledge and confirm that:

- (a) Alberta has taken a leadership role relative to other provinces in many key aspects of health care improvement, including information management and technology;

- (b) relationships among government, regional health authorities and providers are recognized as being among the best in the country;
- (c) A number of areas for improvement to the health care system have been identified, including:
 - (i) access to many providers, including finding a family Physician, is becoming more limited as the population grows;
 - (ii) fewer medical students are choosing to practise in family medicine for a variety of reasons; and
 - (iii) while many of the individual system components are excellent, there is a need for better co-ordination and integration, for example, between regional programs and Physician offices;
- (d) A strong patient-Physician relationship is a fundamental building block for primary care improvement and every Albertan should be encouraged to establish a relationship with a family Physician;
- (e) The key objectives of the Initiative are to:
 - (i) increase the proportion of Residents with ready access to primary care;
 - (ii) provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services;
 - (iii) increase the emphasis on health promotion, disease and injury prevention, care of the medically complex Patient and care of Patients with chronic disease;
 - (iv) improve coordination and integration with other health care services including secondary, tertiary and long-term care through specialty care linkages to primary care; and
 - (v) facilitate the greater use of multi-disciplinary teams to provide comprehensive primary care;
- (f) A number of reports, such as the report of the Premier's Advisory Council on Health in Alberta (Mazankowski report) and the federal reports from the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report) and the Commission on the Future of Health Care in Canada (Romanow Report) have reinforced the need for primary care improvement and the general directions of that improvement;
- (g) Family Physicians are specially trained in the coordination of primary care services, are skilled at providing information that empowers Patients to take charge of their own health care and are able to develop a comprehensive approach to the management of disease and illness; and

- (h) Innovation and delivery must occur at the local levels regarding the cooperative efforts and sharing of resources between Authorities and Physicians.

**ARTICLE 4
PRIMARY CARE INITIATIVE COMMITTEE**

4.1 The Committee shall deal with the expenditure of monies comprising the Primary Care Initiative Budget and all matters related to the Initiative, including but not limited to:

- (a) Support the development of LPCIs involving Participating Physicians and Authorities for the provision of primary care to a defined population;
- (b) Structure and administer LPCIs to optimize all opportunities for financial contribution from any federal funding program;
- (c) Day-to-day administration and support of the Initiative;
- (d) Establish (and amend as required) province-wide standards for LPCIs including:
 - (i) defining the criteria to be included in a Letter Of Intent as initially set out in Article 6;
 - (ii) developing standardized Change Management Funding amounts for Business Plan development;
 - (iii) defining the criteria to be included in a Business Plan as initially set out in Article 7;
 - (iv) defining the Service Responsibilities substantially as initially set out in Article 8;
 - (v) determine the process to select among the initial submissions of Letters of Intent;
 - (vi) developing mechanisms and incentives to recognize the value-added services in specialist linkages to LPCIs;
 - (vii) developing descriptions and suggested rates for value-added services provided by Participating Physicians not funded from the Insured Services Element including supervision of alternate providers, administration, travel and 24-hour, 7-day-per-week management of access;
 - (viii) developing contractual templates for primary care initiatives and specialist care initiatives;

- (ix) developing standardized forms and criteria for the enrolment of members to a Patient Population; and
 - (x) developing or refining Encounter, and proration amount definitions related to the enrolment of and payment for the Patient Population.
- (e) Receive and approve Letters of Intent submitted by a Physician and an Authority and determine and allocate Change Management Funding for Business Plan development;
 - (f) Establish and fund a provincial change management program to assist Physicians and Authorities in developing their Letters of Intent or Business Plans and to assist in the re-evaluation of Business Plans, where necessary;
 - (g) Review and make recommendations, from time to time, regarding the Annual Per Capita Amount;
 - (h) Receive and approve Business Plans and amendments thereto submitted by a Participating Physician and an Authority;
 - (i) Provide information to LPCIs through Department information systems to assist them in determining the service needs of their Patient Population and to assist in ongoing management;
 - (j) Authorize funding to LPCIs upon approval of their Business Plan in accordance with Article 9 or cessation of such funding if the LPCI does not fulfill its Service Responsibilities;
 - (k) Develop templates of service delivery models or other tools to promote primary care initiatives and specialist care initiatives;
 - (l) Establish accountability mechanisms;
 - (m) Develop and oversee all evaluation activities and review programs;
 - (n) Establish and maintain remedies for non-compliance with the Service Responsibilities;
 - (o) Develop a dispute resolution mechanism to handle any disputes that may arise between an LPCI and the Committee including but not limited to the achievement of the Service Responsibilities;
 - (p) Establish a communications directorate;
 - (q) Establish linkages with health information research organizations including, without restriction, the Health Services Utilization and Outcomes Commission;
 - (r) Recommend longer-term strategies to advance the objectives of primary care improvement in order to support LPCIs and the Initiative; and

- (s) Provide input to the budget management and adjustment process set out in Article 8 of the Master Agreement or any other matter as requested or directed by the Secretariat or Master Committee from time to time.
- (t) Prioritize receipt and approval of a Letter of Intent, Business Plan, commencement of LPCIs and timing of funding in respect thereof in accordance with paragraph 13.2.

4.2 The Committee shall, in accordance with the provisions of paragraph 4.3 of the Master Agreement, prepare a Mandate, having due regard for the provisions of paragraph 4.1 above, recommending its terms of reference, roles and responsibilities.

4.3 In the event that the Committee is unable to reach Consensus on any matter properly to be considered by it, that matter shall be forwarded to the Secretariat for consideration.

4.4 Notwithstanding the provisions of paragraph 4.3, any member of the Committee shall be permitted, at any time and from time to time, to require that a matter presently before the Committee be referred to the Secretariat for consideration without the requirement that such matter be brought to a formal vote by the Committee.

ARTICLE 5 PRIMARY CARE INITIATIVE BUDGET

5.1 In order to advance the objectives of the Initiative, the Parties have established a Primary Care Initiative Budget in the amounts, subject to adjustment, initially set out in Schedule "C" to the Master Agreement.

5.2 The amounts set out below will be provided from the Primary Care Initiative Budget to the Association to be used for the Association's Practice Management Program respecting the Initiative, as more particularly described in Article 11 hereof; namely:

- (a) in the 2003/04 Fiscal Year, forthwith upon signing this Agreement, the sum of \$1,320,000;
- (b) For the 2004/05 Fiscal Year, on or about April 1, 2004, the sum of \$1,250,000; and
- (c) For the 2005/06 Fiscal Year, on or about April 1, 2005, the sum of \$1,400,000.

5.3 The Committee shall use the monies in the Primary Care Initiative Budget from time to time, after the payments to the Association contemplated in paragraph 5.2, to support the Initiative and fulfill its responsibilities and obligations as more particularly set out in Article 4 above.

5.4 The Association shall be entitled to carry forward to future fiscal years any unused portion of the funding referred to in paragraph 5.2.

5.5 In the event there is unused or non-accrued funding remaining at the end of the term of this Agreement, the Master Committee shall determine how the remaining funding shall be used. Under no circumstances shall the Master Committee allow the funds to be forfeited.

ARTICLE 6 LETTER OF INTENT

6.1 A Physician and an Authority may submit to the Committee a Letter of Intent to form an LPCI.

6.2 Each Letter of Intent shall be in form and content satisfactory to the Committee and include:

- (a) A general description of the LPCI and how the LPCI intends to meet the Service Responsibilities;
- (b) A commitment that the Physician and the Authority intend to participate in the LPCI and develop a Business Plan that will meet the requirements prescribed from time to time by the Committee;
- (c) Details of the amount of Change Management Funding requested by the applicants and details of the intended use of any such funding allocated by the Committee and a commitment to utilize any such funding allocated to that LPCI only for the intended purposes;
- (d) A binding direction to pay, detailing where any Change Management Funding so allocated may be paid; and
- (e) such other information as the Committee may from time to time require.

6.3 Each Letter of Intent must be signed by an authorized officer of the Authority and all Physicians intending to participate.

6.4 All Letters of Intent shall be in form and substance satisfactory to the Committee. The Committee shall forthwith review each Letter of Intent and may request further information or clarification it requires before making a decision. The Committee shall approve or reject any Letter of Intent, once in satisfactory form, within fourteen (14) business days of receipt of the last information required.

6.5 The Committee shall notify the applicants within the time set out in paragraph 6.4 if the Letter of Intent has been approved and the date on which it is intended that the initial fifty (50%) of Change Management Funding will flow. If the Letter of Intent has been rejected the reasons for the rejection shall also be stated.

ARTICLE 7 BUSINESS PLAN REQUIREMENTS

7.1 Upon acceptance of the Letter of Intent, the Participating Physicians and the Authority shall be required to develop and agree to a Business Plan for ensuring 24/7 management and delivery of the Service Responsibilities to the intended population.

7.2 The Committee shall develop the requirements for a Business Plan that shall substantially include the following items:

- (a) A statement indicating joint agreement between the Participating Physicians and the Authority on the contents of the Business Plan;
- (b) The length of the agreement and the provision for continuance;
- (c) Renegotiation provisions;
- (d) Termination provisions including individual Participating Physician termination;
- (e) A dispute resolution process;
- (f) The location of the LPCI;
- (g) The defined population described in a manner acceptable to the Committee;
- (h) The name of each of the Physicians involved;

- (i) The roles and responsibilities of the Participating Physicians and the Authority in providing each of the Service Responsibilities;
- (j) Identification of all sources of funding flowing to the LPCI, including, without limitation from the Master Physician Budget and Authority budgets;
- (k) Specify the allocation of funds between the Participating Physicians and Authority;
- (l) An implementation strategy;
- (m) A method for approving amendments to the Business Plan, including any specified changes that must be approved by the Committee;
- (n) An agreement to adhere to accountability mechanisms developed by the Committee;
- (o) Annual financial reporting respecting the operations of the LPCI in form and content satisfactory to the Committee;
- (p) The account information which has been established for the purposes of receiving funding; and
- (q) Such other matters as may be prescribed by the Committee or which the Participating Physicians and the Authority may consider appropriate and the Committee approves.

7.3 Each Business Plan must be signed by an authorized officer of the Authority and all Participating Physicians.

7.4 Each Business Plan shall be in form and substance satisfactory to the Committee. The Committee shall forthwith review each Business Plan and may request further information or clarification it requires before making a decision. The Committee shall approve or reject any Business Plan, once in satisfactory form, within twenty-one (21) business days of receipt of the last information required.

7.5 The Committee shall authorize payment of the remaining fifty (50%) percent of the allocated Change Management Funding to the LPCI upon approval of the Business Plan.

ARTICLE 8
SERVICE RESPONSIBILITIES

8.1 The Committee shall define the Service Responsibilities, which initially shall include the following, namely:

- (a) Those services directly related to the provision of primary care services to the Patient Population:
 - (i) Basic ambulatory care and follow-up;
 - (ii) Care of complex problems and follow-up;
 - (iii) Psychological counselling;
 - (iv) Screening/chronic disease prevention;
 - (v) Family planning and pregnancy counselling;
 - (vi) Well-child care;
 - (vii) Obstetrical care;
 - (viii) Palliative care
 - (ix) Geriatric care;
 - (x) Care of chronically ill patients;
 - (xi) Minor surgery;
 - (xii) Minor emergency care;
 - (xiii) Primary in-patient care including hospitals and long-term care institutions;
 - (xiv) Rehabilitative care;
 - (xv) Information management; and
 - (xvi) Population health.

- (b) Those services that relate to linkages within or between Primary Health Care and other areas:
 - (i) 24-hour, 7-day-per-week management of access to appropriate primary care services;
 - (ii) Access to laboratory and diagnostic imaging; and

- (iii) Coordination of:
 - A. Home care;
 - B. Emergency room services;
 - C. Long-term care;
 - D. Secondary care;
 - E. Public health; and

- (c) Acceptance into the LPCI's Patient Population and provision of the Service Responsibilities to an equitable and agreed upon allocation of unattached Patients.

8.2 The Services Responsibilities will be provided and adhered to by each LPCI and delivered by the Participating Physicians and the Authority according to their agreement as set out in the approved Business Plan.

8.3 Any change to the Service Responsibilities must be approved by the Master Committee and, when so approved, shall be included in all subsequently approved Business Plans. Any LPCI in existence at the time of such a change shall amend its Business Plan to include the changed Service Responsibilities no later than at the next regularly scheduled renewal or any amendment of such Business Plan.

ARTICLE 9 LPCI ENROLMENT AND PAYMENT

9.1 As at the Effective Date, the Annual Per Capita Amount shall be up to fifty (\$50) dollars per person subject to allocation and adjustment from time to time, as set out in this Article.

9.2 The Enrolment List of an LPCI may include those Patients who are Formally Enrolled or Informally Enrolled.

9.3 A Patient will initially be eligible to be included on an LPCI's Enrolment List if that Patient has had two or more Encounters with a Participating Physician in the LPCI and included facilities over the previous three-year period.

9.4 The LPCI's Formal Enrolment List will be comprised of all Patients who have signed an Enrolment Agreement with the LPCI and who continue to meet the criteria for remaining Formally Enrolled, namely:

- (a) The Patient remains a Resident;
- (b) The Patient has not Formally Enrolled with another LPCI; and
- (c) Any Patient on a Formal Enrolment List will be automatically excluded from all Informal Enrolment Lists.

9.5 LPCI's that choose to formally enrol Patients must commit to using best efforts to have all their Patients sign an Enrolment Agreement. Patients must be provided the opportunity to terminate an Enrolment Agreement on the conditions specified therein, which termination provisions must be satisfactory to the Committee.

9.6 LPCIs with Formal Enrolment Lists may have a portion of its Patient Population that is Informally Enrolled under the following circumstances:

- (a) During the development phase of an LPCI, while the Formal Enrolment List is being built, as determined by the Committee;
- (b) Patients who were a long-standing part of a Participating Physician's practice prior to the creation of the LPCI, but who are unwilling to sign an Enrolment Agreement; and
- (c) New patients to the LPCI will have an interim period to become Formally Enrolled with the LPCI.

9.7 The LPCI will receive Fifty (\$50) dollars per annum for each Patient on the LPCI's Formal Enrolment List.

9.8 Patients entering into an Enrolment Agreement with an LPCI for the first time will remain on the Formal Enrolment List for a minimum of three years, subject always to continuing to meet the eligibility requirements set out in paragraph 9.4 above;

9.9 Following the first three years of Formal Enrolment of a given Patient, and each year thereafter, there will be a retrospective review of the Patient's utilization for the immediately preceding three year period to determine whether or not the LPCI is the Majority Care Provider to that Patient:

- (a) If the Patient had two or more Encounters with the LPCI:
 - (i) and the LPCI is the Majority Care Provider, the Patient will remain on the Formal Enrolment List and the LPCI will continue to receive the Annual Per Capita Amount;
 - (ii) but if the LPCI is not the Majority Care Provider, the Patient will remain on the Formal Enrolment List and the LPCI will receive a prorated amount of the Annual Per Capita Amount, based on the portion of Encounters received within the LPCI divided by the Patient's total number of Encounters;
- (b) If the Patient had less than two Encounters with the LPCI:
 - (i) but no Encounters outside the LPCI, the Patient will remain on the Formal Enrolment List and the LPCI will receive the Annual Per Capita Amount;
 - (ii) but had Encounters outside the LPCI, the Patient will remain on the Formal Enrolment List and the LPCI will receive a prorated amount of the Annual Per Capita Amount, based on the portion of Encounters received within the LPCI divided by the Patient's total number of Encounters;
- (c) In the circumstances described in 9.9(a)(ii) and 9.9(b)(ii), the LPCI will have one year to demonstrate that it is the Patient's Majority Care Provider. If during that year the LPCI is successful in again becoming the Patient's Majority Care Provider and the Patient signs a new Enrolment Agreement the Patient may (subject always to the eligibility requirements in paragraph 9.4) remain on the Formal Enrolment List for one (1) further year; failing either of which the Patient shall be removed entirely from the LPCI's Enrolment List.

9.10 For the purposes of paragraph 9.9, the Committee may more completely define or refine the meaning of "Encounter", but initially:

- (a) An Encounter within an LPCI will include the provision of any of the Service Responsibilities outlined in paragraph 8.1(a) by any of the Participating Physicians in the LPCI, other health care providers within the LPCI or other health care providers outside the LPCI who have made contractual or other written arrangements with the LPCI to deliver some part of the said services; and
- (b) An Encounter outside an LPCI will include the provision of any of the Service Responsibilities outlined in paragraph 8.1(a) by other LPCIs or other Physicians.

9.11 For the purposes of paragraph 9.9 the prorated amount will be more fully defined by the Committee, but initially will be determined by the ratio of the number of Encounters for a given Patient provided within the LPCI divided by the aggregate number of Encounters respecting any one or more of the Service Responsibilities received both

inside and outside the LPCI. The prorated amount will be calculated every six months, in conjunction with the semi-annual payment of the Annual Per Capita Amount.

9.12 An LPCI Informal Enrolment List will include all persons who meet the Enrolment criteria identified in 9.3, who are not on a Formal Enrolment List of any LPCI, and who are not on the Enrolment List of a practice that is funded out of the Insured Services Element under an Alternate Relationship Plan for any primary health care service.

9.13 An LPCI that does not wish to formally enroll Patients may solely maintain an Informal Enrolment List, but payment of the Annual Per Capita Amount will be prorated according to the calculation described in paragraph 9.11.

9.14 The Department shall pay to the LPCI, in the manner identified in the Business Plan, the amount allocated based on the Enrolment List and payment calculations included in this Article 9.

9.15 Payments under this Article shall be made on a prospective basis and paid semi-annually at the time prescribed by the Committee.

ARTICLE 10 CHANGE MANAGEMENT FUNDING

10.1 The Committee will establish Change Management Funding from the Primary Care Initiative Budget, in an amount to be determined, in support of the Committee responsibilities identified in Article 4, including but not limited to:

- (a) Day-to-day administration and support of the Initiative;
- (b) Funding to support, directly or indirectly, Business Plan development by the Participating Physicians and Authorities;
- (c) Funding a communications directorate, in an amount up to \$2 million;
- (d) Funding through the Department for improvements to information technology and information management systems needed for administration of the primary health care initiatives, in an amount up to \$1 million; and
- (e) Funding through the Association to support a Practice Management Program, in the amount set out in paragraph 5.2 to be used as set out in Article 11.

10.2 The Change Management Funding referenced above, except that referred to in subsection 10.1(d) will be administered by the Association and be provided by a grant agreement to be entered into with the Department. The grant agreement shall be consistent with the provisions of the Master Agreement and this Agreement, and in a form satisfactory to the Department, acting reasonably.

ARTICLE 11
ALBERTA MEDICAL ASSOCIATION
PRACTICE MANAGEMENT PROGRAM

11.1 The Association shall be provided funding as defined in paragraph 5.2 to carry out the following deliverables in a manner reasonably determined by the Association including:

- (a) Primary Care Initiative Workshop
 - (i) The Association shall host a workshop designed to build support for the Initiative and to begin development of Physician and Authority leaders;
 - (ii) The Association shall invite participants that will represent Physician practices and Authorities from across Alberta; and
- (b) Support of Physician Practices
 - (i) The Association, in consultation with the stakeholders the Association deems necessary, will provide assistance to individual Physician practices that are interested in developing a Business Plan with an Authority. In performing this role, the Association will work closely with the Committee to ensure integration with the Committee's change management program;
 - (ii) The Association will assist Participating Physicians by providing support in respect of issues such as group formation, practice governance, relationship issues, taxation, financial projections, liability issues, and any other issues the Association deems necessary;
 - (iii) The Association's Practice Management Program is intended to support primary care Physicians and specialists on a practice/group specific basis and is not intended to provide those services more appropriately dealt with by the Committee including but not limited to those responsibilities referred to in Article 10; and
 - (iv) To better represent Physicians in Alberta, the Association shall establish a Calgary office to support and assist primary health care and specialist care initiatives.

11.2 The Association shall, no later than thirty (30) days after the end of each quarter of each Fiscal Year during the term of this Agreement, provide the Department with internal financial statements respecting the Practice Management Program, prepared in accordance with Generally Accepted Accounting Principles, and certified to be complete and accurate in all respects by the Assistant Executive Director (Corporate Affairs) of the Association.

ARTICLE 12

SPECIALIST LINKAGES TO THE PRIMARY HEALTH CARE INITIATIVE

12.1 The Parties shall allocate ten million (\$10,000,000) dollars from the Primary Care Initiative Budget to establish mechanisms and incentives to recognize the value-added services in specialist linkages to the primary care initiative.

ARTICLE 13

PRIORITIZATION WITHIN THE INITIATIVE

13.1 The Parties intend to have LPCIs broadly available to Albertans, but recognize that this will take time to develop and that some staging of the development and creation of LPCIs will be required.

13.2 From the date the Master Agreement is signed through and until June 30, 2004 the Parties anticipate that the Committee will only be able to approve up to twelve (12) Letters of Intent from across the Province. It is anticipated that these potential LPCIs will assist the Committee in developing the experience and expertise required to expedite a more general rollout of LPCIs across the Province. The process for selecting these projects will be the responsibility of the Committee.

13.3 The Committee shall establish and communicate to Physicians and Authorities any criteria for receiving, reviewing and approving Business Plans and for implementing same, which will include consideration of the following:

- (a) Size of the LPCIs defined population in relation to the characteristics and size of the general population of the region;
- (b) Commitment of the local Physicians and Authority to establish and maintain the LPCI; and

- (c) Ability of the local Physicians and Authority to clearly define and establish within the Business Plan the population they intend to serve.

ARTICLE 14
OTHER RELATED MATTERS

14.1 Nothing in this Agreement shall limit:

- (a) a Physician or an Authority from accessing funding from the Primary Care Initiative Element based on a Physician's choice of remuneration from the Insured Services Element; or
- (b) a Physician from accessing any other funding source.