Alberta College of Family Physicians

Advancing excellence in family practice

ALBERTA COLLEGE OF FAMILY PHYSICIANS RESPONSE TO PROPOSED FAMILY CARE CLINIC (FCC) APPLICATION KIT

JANUARY 2013

About ACFP

The Alberta College of Family Physicians (ACFP) is a provincial, professional voluntary organization, representing more than 3,500 family physicians, family medicine residents, and medical students in Alberta. Established over 50 years ago, the ACFP strives for excellence in family medicine for patients, families and communities through advocacy, continuing medical education, and primary care research.

The ACFP is a Chapter of the College of Family Physicians of Canada (CFPC), a nationwide organization with more than 28,000 members. The College strives to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

Executive Summary

The political landscape in Alberta today is squarely focused on the health care system. The introduction of Family Care Clinics in April of 2012 caused confusion among physicians, as well as patients, about physician access and the overall structure of the primary health system. The reaction by the physician community about FCCs highlighted an ongoing need to engage physicians and other health providers in future decisions about health care.

Given the political intensity of the health care agenda, the relationships between stakeholder groups that are impacted by changes to primary health care and how it is addressed at the policy and community level will be most crucial as primary health care evolves.

Going forward, it is important to consider that there are many primary health care models that have been designed and implemented successfully around the world, across Canada and more importantly, right here in Alberta. Whatever model is adopted, the foundation must be a set of values or principles that ground any decision making around form or function.

The ACFP will be a trusted partner in developing primary health care models that are cost-effective and patient-responsive. The role of family physicians is crucial and the ACFP provides the “voice of family medicine”. The ACFP has made it its vision to advance health for patients, their families and communities where every Albertan has a patient-centred medical home. Prior to the FCC Application Kit being released, the FCC Initiative, though not well defined, showed promise that this vision could be supported. Many physicians and their clinic teams were considering the transition. The FCC Application Kit was released and the optimism declined.

The Family Care Clinic Application Kit – Wave 1 describes something that is similar to the Patient’s Medical Home. The response overall is that, though the premise and goals and objectives of the Family Care Clinics

were very similar to the College of Family Physicians of Canada's vision of Family Practice: The Patient's Medical Home (PMH), there will be challenges with the implementation schedule, governance structure and accountability, remuneration issues for all providers, and a lack of understanding of the fundamental, longitudinal relationship between family physicians and patients. These challenges will need to be addressed in order for it to be acceptable to family physicians and potentially the communities that would support the FCC. The following outlines primary concerns of the ACFP in detail.

It is the desire of the ACFP that the input would be accepted as constructive and useful feedback that could be added to the stakeholder review process to ensure that the final product would be easily facilitated and the mandate of the FCC Initiative could be fully realized.

The CFPC Vision for Canada – Family Practice: The Patient's Medical Home (PMH)

The vision for the Patient's Medical Home (PMH) was released in September 2011 and outlined three objectives:

1. That every person in Canada will have the opportunity to be part of a family practice that serves as a PMH for themselves and their families.
2. PMH will produce the best possible outcomes for the patients, the practice populations and the communities they serve.
3. PMH will reinforce the importance of the Four Principles of Family Medicine for both family physicians and their patients. (The four principles are: the patient doctor relationship is central, the family physician is a skilled clinician, the family physician serves as resource to his or her practice population and family medicine is community-based)

The 10 Pillars of the PMH represent the goals which for the most part mirror the goals and objectives of the proposed Family Care Clinics (FCC). See Figure 1 for a visual representation of the PMH Pillars.

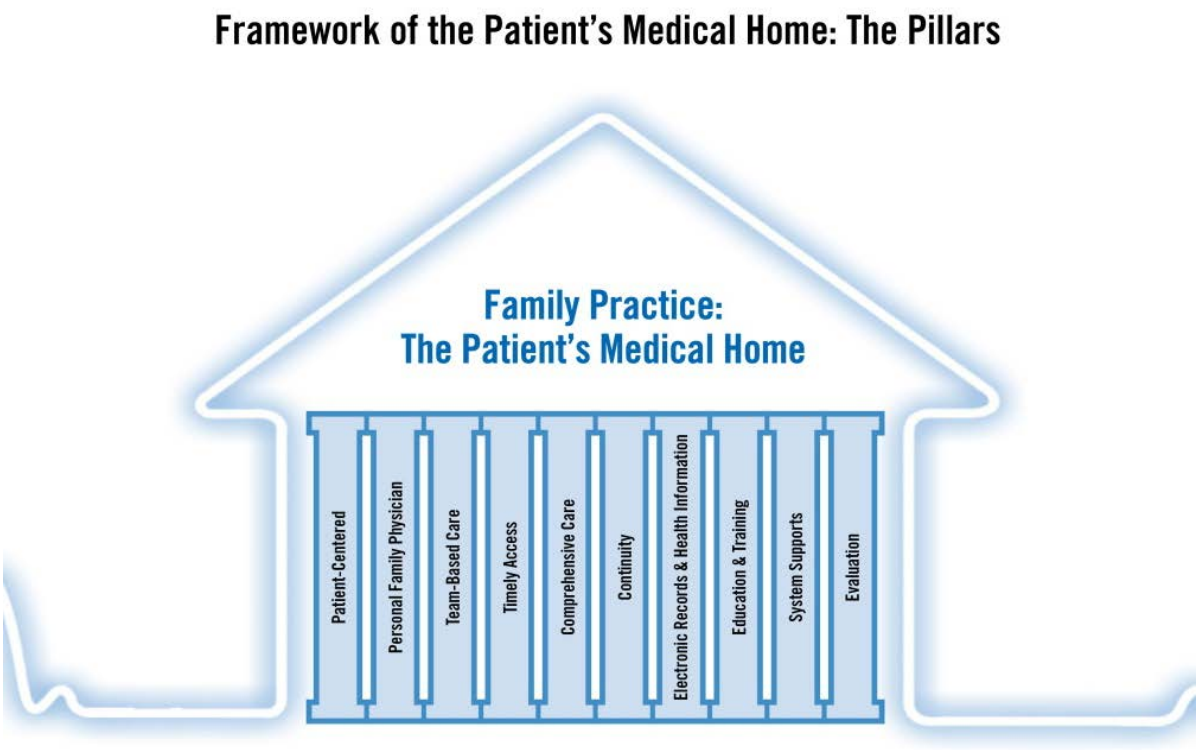

Figure 1: CFPC Patient's Medical Home – The Pillars

The diagram on the next page provides a mirrored description of the importance that the Government of Alberta has placed on the connection that the Family Care Clinics and the Primary Care Networks can provide to supports and programs within the home and community, to other health-related agencies, pharmacy, specialties, hospitals and continuing care facilities, laboratories and DI and public health.

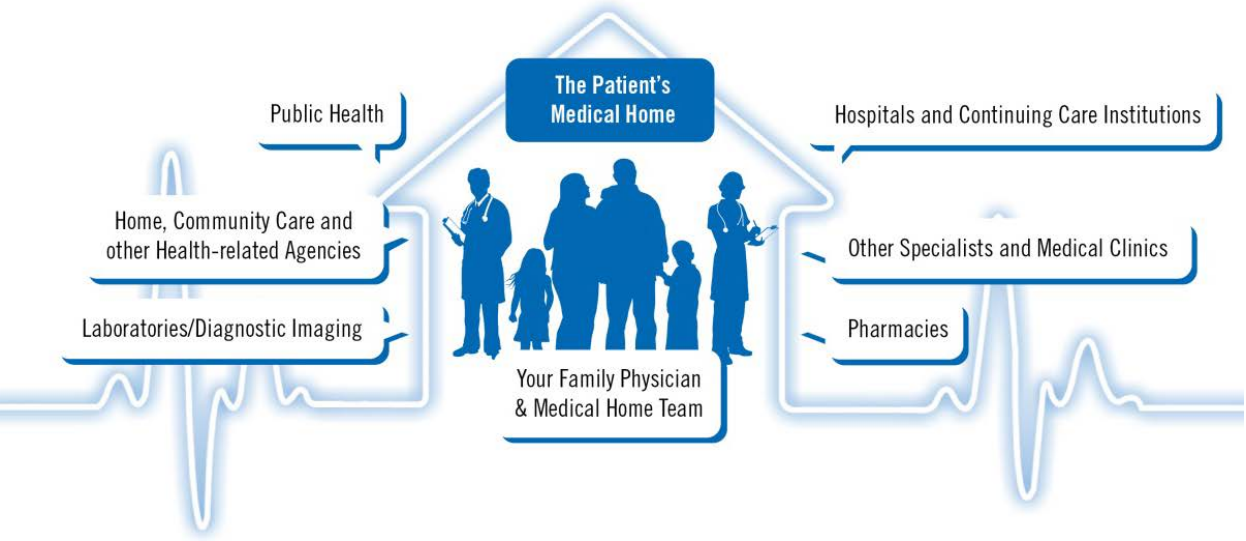

Figure 2: CFPC Patient's Medical Community

Tip:

The CFPC Vision for the PMH is supported by practice, research and evidence. Rather than developing a model that has not been proven, the Government of Alberta should adopt a model with principles, goals and objectives that are widely supported and that are evidence based.

Government of Alberta – Family Care Clinics Program Goal and Objectives	CFPC Patient's Medical Home Objectives and Goals
The FCC's primary goal: "Albertans have access to primary health care when they need it, where they need it, from the most appropriate service provider(s)." **FCC Objectives:** 1. Provide individual and family-focused comprehensive quality primary health care services across the lifespan based on population health needs. ***(See PMH Goal 1,5 and 6)*** 2. Manage timely access to primary health	**The PMH Objectives:** 1. Every person in Canada will have the opportunity to be part of a family practice that serves as a Patient's Medical Home for themselves and their families. 2. Patients' Medical Homes will produce the best possible health outcomes for the patients, the practice populations, and the communities they serve. 3. Patients' Medical Homes will reinforce the importance of the *Four Principles of Family Medicine* for both family physicians and their

care, including same day access. ***(See PMH Goal 4)*** 3. Increase emphasis on health promotion, disease and injury prevention, screening, self-management, and care of chronic disease and complex needs. ***(See PMH Goal 5)*** 4. Use a collaborative interdisciplinary team approach to service planning and delivery. ***(See PMH Goal 3)*** 5. Improve co-ordination, continuity and integration of primary health care services, including effective linkages with other Government of Alberta Ministries and community service providers and agencies. ***(See PMH Goal 6 and 10)*** 6. Maintain accessible and efficient information systems. ***(See PMH Goal 7)*** 7. Monitor quality and achieve positive outcomes, guided by evidence-informed practice. ***(See PMH Goal 9)*** **What is different or missing from the FCC Goals and Objectives?** PMH Goal 2 – Every patient should be attached to a personal family physician who will be the most responsible provider (MRP) and if not, who will be held responsible in the FCC model given the governance structure and vague definition for clinical responsibility and medical liability (Business Manager, Board, Clinical Lead?) PMH Goal 6 – Reference needs to be made regarding the valued patient/family physician relationsh PMH Goal 8 – FCCs ought to provide opportunities for training and education of medical students, residents, those in other health professions. PMH Goal 8 – FCCs should be considered family practice and primary care research sites	patients. **The PMH Goals:** 1. A Patient's Medical Home will be patient centred. 2. A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care. 3. A Patient's Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses, and others. 4. A Patient's Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice. 5. A Patient's Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs. 6. A Patient's Medical Home will provide continuity of care, relationships, and information for its patients. 7. A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients. 8. Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research. 9. A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI). 10. Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders,

PMH Goal 10 – FCCs should be strongly supported: i) internally, by governance and management structures defined by each practice and ii) externally, by all stakeholders.	including governments, the public, and other medical and health professions and their organizations across Canada.

The Government of Alberta's Primary Health Care Strategy – The Foreword

In the "Foreword" of the Application Kit Wave 1 – the description of Primary Health Care in Alberta was a thorough and refreshing change from the documentation that had been previously circulated about the Primary Care Networks failed to provide access to quality care for Albertans in the past. Primary Care Networks successfully recruited the support of 80% of Alberta's family doctors.

The Foreword acknowledges the successes in Primary Care Networks where collaborative teams have effectively provided comprehensive, team-based, continuity of care to their patients, their families and their communities.

There seems to be a recognition also that "A home in the health care system could be a PCN, FCC or a physician's office". The Minister also noted at a meeting recently, that there will be more than 140 points of access for Albertans to collaborative teams, and that FCCs are only one mechanism. He explained that FCC's most often will meet the need for access in un-served or underserved communities in Alberta.

There has to be recognition that existing PCNs and physician-owned clinics provide the most efficient and expedient way for the Government of Alberta to meet their objective of providing a health home for every Albertan. This is also stated in the vision of the Alberta College of Family Physicians (ACFP) and the College of Family Physicians of Canada (CFPC). We are in this together!

The challenges that the Foreword offers to family physicians and the existing primary health care systems is to reach beyond the health system into the community. There have been multiple examples of this "reaching beyond" in our existing PCNs in Alberta. Policy makers need only to seek them out and ask how the PCN teams and their communities worked together to resource additional programs. Examples that exist in Alberta currently support increased population health through improving access to sport and exercise equipment for all members of the community; support disease management for the homeless through creative fundraising efforts; or provide unique and coordinated programs and resources that promote aboriginal women's health and wellbeing.

The reference to governance of PCNs and FCCs being different and that one may exist alongside the other or that the FCC may even exist within a PCN is difficult to understand and seems redundant. Governance will be a challenge as it is currently spelled out in the FCC Application Kit.

Tip:

It would be refreshing if the language and support that is reflected in the Foreword regarding the success of Primary Care Networks, be consistently used throughout the FCC Application Kit.

MAJOR ISSUES IDENTIFIED AND POTENTIAL SOLUTIONS

Issue: FCC to PCN Relationship

As stated in the Foreword of the FCC Application Kit, leading and innovative work being done in Primary Care Networks (PCNs) will be taken and spread to other areas. It is now comforting to note that PCNs will remain an important part of our Primary Health Care System. The tone and approach seems to have shifted from a few months ago for the better.

When the description of the FCCs came out during the election as a new and innovative way to deliver better health care to Albertans, it created an immediate distaste for the initiative by family physicians and the teams that they work with. To discount the successes and innovative work that had been done in Primary Care Networks, despite the flaws and limitations put in place by government policy and funding models, was short sighted and did not promise to be a collaborative nor complimentary process to be a part of.

The resulting release of the FCC Application Kit immediately following an imposed settlement for Alberta's physicians, including a claw back on 2 fundamental funding programs that supported primary care delivery did not communicate a mutually agreeable, trusting and respectful relationship to enter into. Family Physicians were not even interested in looking at the document and in some cases were not willing to cooperate under any circumstances to move the FCC initiative forward.

Comments received:

- What is the need for FCC, if the PCN are doing a good job? Why not just expand and further add to PCN?
- They still don't seem to be clear that a PCN will have a difficult time "transitioning to an FCC" as it is made up of several clinics. It isn't until page 25 that they suggest that a PCN might "form an FCC". This should be discussed during the initial meeting of the advisory. Can a clinic within an existing PCN make this transition without the PCN being compromised? How will it then be governed and can it get funding from both AH and their PCN? There are likely other considerations. Hopefully they wouldn't have to pull out of that structure/support system.
- AMA's call for interested groups to become FCCs will likely have to backtrack to create a CWG that will meet their requirements before moving forward.
- There are scenarios that specify how a FCC might fit within the structure of a PCN. Not all questions are answered yet.
- It is very difficult to address the FCC Application Kit Wave 1 effectively from a physician's perspective when the physician-owned delivery model has been completely disregarded. What is

more of concern is that there is no mention or reference that the Second Wave will address a physician-led/owned FCC.

- It does not clearly demonstrate the transition of a PCN clinic to a FCC. In fact the kit erroneously refers to, or leaves the impression that a PCN and a FCC are similar entities when they clearly are not.
- The transition of a clinic that exists within a PCN to a FCC is very vague, and cannot be fully supported by physicians until it is.
- The Kit does not demonstrate clearly if the GoA has properly evaluated the effectiveness of existing PCNs in order to build upon and complement primary health care delivery with FCCs. More importantly, it has not communicated the **evaluation results for the three pilot FCCs in Alberta**.
- PCN will get no funding to transition to FCC, I suspect the transition will be expensive given all this 'new stuff'. What will be the motivation to transition? Or will they be forced?

Potential Solutions:

1. **Collect the success factors from the existing PCNs and support the implementation of these factors across the province.**

2. **Evaluate the 3 existing FCCs and circulate the results, even if they are not complimentary. This will effectively demonstrate the need to use evaluation for the purpose of gap identification and quality improvement.**

3. **Allow PCNs to contribute or propose a model for FCC that fits for a physician owned clinics and a physician led PCN.**

4. **Develop an inventory of the evaluations that have occurred in the PCNS and make these widely available.**

5. **Allow the existing PCNs to develop a common set of metrics for all primary care clinics in the province to use to evaluate both PCN clinics and FCCs.**

Issue: No Reference to Family Physician/Patient Relationship, Continuity of Care, Comprehensive Family Practice

More than 83% of Albertans currently have personal family physicians. Albertans have always turned to their family physician to be their first and ongoing medial contact for any health related concerns – to diagnose their problems, advise them regarding the need for investigations and treatments, provide care whenever possible and arrange referrals whenever needed. Because they come to know and understand one another over time, patients trust their family physicians to play a key role in administering and coordinating their care.

It is the personal family physician – providing and coordinating comprehensive basket of services for patients through a community-based family practice setting, and doing so over time – that family physicians

have proven their greatest value to our society. As shown in Starfield and Shi's research, populations with better access to continuing care over the years from the same personal physician have fewer hospitalizations and better health outcomes. The new survey released by the HQCA , "Satisfaction and Experience with Healthcare Services: A Survey of Albertans 2012", 84% of Albertans are satisfied with the care they received from their family physician. This is the highest satisfaction rate in the entire report and speaks to the value of these long term relationships.

In the FCC Application Kit - Wave 1, there is no reference to the patient and family physician relationship. No less, there is no reference to a patient and health care professional relationship that exists over the years. This relationship needs to be established in order to build an awareness of the person both when they are healthy and when they are failing. Subtle changes in mood, behavior and physical responses will often only be noticed by someone who has had a long term relationship with the patient. Following is a poem written by a primary care doctor that was shared at the ACFP Office that speaks to this very matter.

Keep Coming

They shuffle and saunter
Strut and stagger
Through my open door
Week after week.
They banter and bargain
Beg and bellow
Make promises and deals
Tell stories, most true.
They lay bare
Their deepest wounds
Like the abscesses
I sometimes drain.
I return their calls
Make more time
Write letters to lawyers
Challenge deceit.
I held one man's hand
"People are scared of me"
Salty sorrow coursed
Over tattooed teardrops.
I return handshakes and hugs
Say to him, to them
I will be here
Keep coming.

Published in the Journal of General Internal Medicine.
Sarah Wakeman[1]
Published online: 13 July 2012

Existing physician-owned family practice clinics in Alberta, often within a Primary Care Network, who have been building the PMH model, have found great success. There is improved access, convenience, coordination of care, family physicians collect and use data to identify gaps and make improvements to their clinics. By collaborating with these clinic owners and operators, the Primary Health Care Evolution that is long overdue, will find that there is a strong foundation that exists already that can be built on. The election promise of 140 FCC could be easily and cost effectively realized if there was an openness to involve existing clinics, with their autonomy intact, to offer the same basket of services that is being envisioned for brand new, ground up FCCs.

Some comments received:

- There is no "Physician Owned" option listed in this "first wave"! Is that coming in the next wave or is it off the table?
- There is NOTHING in here that is concrete about if you want to be a part of an FCC, have your patients cared for by an FCC team, that you must actually provide comprehensive services to your patient population as in within your FCC group or team–provide home visits, palliative visits, hospital care, LTC visits, etc. It's a concern that this is not fully and specifically addressed as it is patient care and primary care at its core.
- Page 21 talks of voluntary formal enrolment; this seems a bit contradictory in terms.

Potential Solutions:

1. **Create a new "Application Kit –Wave 2" that is solely reflective of a physician owned Family Care Clinic in order to take advantage of existing investments and infrastructure.**

2. **Include reference to the importance of the family physician/patient relationship. Refer to Starfield's work and the new HQCA survey that supports improved patient satisfaction and health outcomes when the patient has a medical home including a family physician and a collaborative team.**

3. **Incent urban physicians that offer comprehensive care within their clinics.**

4. **Incent physicians who remain in rural communities and provide comprehensive, continuity of care for the patients and the community population's health over a lifespan.**

5. **Incent patient enrolment/formal attachment.**

Issue: Governance

As a community based governance structure seems to be a large part of the change that the Government of Alberta is looking for, it would be helpful to describe the justification behind this extreme measure so that it could be understood by those that will have a major change in source of income and control of their investment that they have made over the years.

An evaluation process should include a strategy to identify and support individual clinics through changes that will put them on track to succeed. Initial risk assessment and thinking around mitigation strategies may be necessary in order to design a process that creates success and compliance to standards.

A PCN evaluation process apparently was discussed and planned but never fully implemented province wide. There were several PCNs that implemented their own evaluation, accreditation processes and accountability tools to manage the performance and results of their teams. The province fell short and now the primary care networks and new FCCs will shoulder the short fall with cumbersome and restrictive policy, structure and procedure in order to benefit from potential enhancement funding.

If the intent is to decrease physician control over primary health care delivery, would it not be necessary to involve all parties in a consultation or a collaborative decision making process. The transitions that governments drive from the top down will continuously be met with resistance. Alberta boasts an entrepreneurial spirit that regulates itself to a certain degree. If business practices do not create results, the bottom line will show it.

Physicians and the teams that they work with have had a business model that has been blended with public funding offered through fee for service and a PCN allotment at $62.00 per “attached/registered” patient. From those funds, the physician has to pay for overhead costs such as lease/mortgage, capital improvements, equipment, reception staff, nurses, social workers, nurse practitioners, Executive Directors, and more depending on the access to testing and diagnostics in their communities. Without good business sense and accountability to the organization and the teams within it, these clinics and primary care networks would never have lasted. The implication is that the primary care networks have not been effectively governing themselves and need to be controlled by a community board now.

Our communities are more and more being taxed with delivering public programs and services. This step to community governance puts one of the most foundational government funded services in the hands of the voluntary sector. Community leaders and volunteers that have time, willingness, skills and aptitude to run a health and medical service organizations such as a FCC or a PCN will be few and far between. It will be a challenge to maintain boards that will take on the fiduciary and legal responsibility for primary health care in their community delivering care for the people that they work, raise their families, socialize and live alongside.

In this governance model, who will take the responsibility? The government by way of the strict design and policy around FCC will be responsible if the issue can be traced back to one of its policies, guidelines or procedures within the application or governing documents. The FCC Board of Directors will be liable if a decision made at the local level about their FCC’s procedures and policies is identified as having an impact causing negative outcomes. The Business Manager who has only some control over the FCC but must be able to identify the fine line between clinical decisions and business decisions may be held responsible. The nurse, nurse practitioner or pharmacist that wrongly prescribes a medication that result in death or severe injury will be responsible. Conversely, does the clinical lead take full responsibility for any issues, charges or claims?

Physicians have taken an oath and have been the most responsible provider (MRP) for patients in their care. Whether the care is direct or coordinated by the physician with their nurse, a specialist or the laboratory; the buck stops with the physician. With the FCC model, this is not clear and seemingly lacks functional accountability. Physicians and collaborative teams working within the presented model will have very little accountability and responsibility, whether it be for financial efficiencies, improved patient health outcomes or population health outcomes. The result may produce disengaged and complacent teams and team members that do not have any reason to commit long term to a community and its population.

Some comments received:

- It would seem that the intent is for physicians not to have control, or even health care workers as a whole. I see where the government is coming from, some PCN's not to be named, have messed it up for the rest with greed and mismanagement and they have not been held accountable.
- The government does not want funds/decision making in the hands of docs to control. Instead the government is choosing to leave control of the FCC boards up to community members and patients - 60% of the board will be health care lay people.
- It is bold to give control of hundreds of millions of health care dollars to people with no knowledge of neither health care nor overarching understanding of the health care system.
- For us it creates conflict as there would only be one doc on the board, perhaps 2 if we have a 10 person board which would be a nightmare. Means someone is left out in the cold.
- The part about physicians not being able to chair seems a drastic measure.
- Physicians as a body will be very reluctant to buy in to this governance model.
- The FCC Program Goals do not address accountability and responsibility? Will the business manager take ultimate responsibility if there is a legal action taken against the FCC?
- Will the Business Managers have a standard job description and will they be paid by the Operating Grant?
- A Clinical advisor has to be appointed. There is no clarity around it being a physician. (page 23)
- The degree of control that the government is suggesting is going to be hard for physicians to accept for instance, the FCC's need branding that satisfies the government.
- Without strong leadership, I don't see how these teams will function very smoothly! Ideally this leadership needs to be at the physician level. The final responsibility will rest with the physicians. The buck stops with us, not nurses, NP's, dieticians, or the government.
- I have worked on multidisciplinary teams, (especially in global health, but even my own family practice). Without strong leadership, lots and lots of planning things, go FUBAR. And even with great planning, unforeseen situations come up, and to have quick, efficient responses, clear leadership must be in place.
- This governance model will create divisions and multiple FCC's where one would suffice because there cannot be adequate physician or health care professional representation from a PCN with 3 large clinics.
- Will create a lot of waste and unnecessary red tape.
- I am also not clear if a PCN morphs into an FCC, or if one clinic within a PCN does (see their examples) will then there be a PCN board, and a sub board that is different than the PCN board, or can it remain the same? It is confusing.

- The FCC concept invokes a very large and diverse number of stakeholders, many of which will have different goals and focus. All the different government, administrative, providers and communities will not be on the same page. Strong leadership will be needed to make this work. AT EACH FCC, plus at the government level, different organization level.
- The clinical advisor role is not defined…do they have ultimate accountability and responsibility for the clinical practice? What will their qualifications be, how are they regulated, and insured, who is liable for clinical decisions
- what criteria will be set for board membership qualifications, how will they receive the support and training they need

Potential Solutions:

1. **Look at existing PCN governance structures that are working and duplicate it around the province.**

2. **Let NFP Organizations meet requirements legislated by and reported to the Provincial Societies Act and the Federal Not for Profit Act instead of additional layers of accountability and reporting.**

3. **Design a model that will allow flexibility for a community that will have less capacity to build an adequate governance board.**

4. **Allow a physician owned structure, accountable to the province, with a team collaboration and decision making model that facilitates community involvement to provide input on client satisfaction, potential improvements to primary health care delivery as well as ways to augment the design of integration into community supports and programs.**

5. **Design evaluation processes for the governance models and share lessons learned with a Primary Care community of practice.**

6. **Research the issues of the community health centres in the USA and synthesize the lessons learned for the new board members and FCC staff.**

Issue: Access – Extended hours

There will need to be some public education around extended office hours and access to care. It has been traditionally acceptable to go to emergency rooms and medi-centres to access a physician after hours. The FCC initiative has seemingly created an AHS funded after-hours clinic that patients will go to when they cannot get in to see their own personal family physician. This new approach will take time for health care consumers to understand.

It is good to see that there is some flexibility built into the hours of operation depending on community needs. There are many PCNs that have created a clinic schedule that allows for weekends and extended weekday hours to accommodate a variety of patients and their work schedules. Each community may have a very different pattern needed based on the demographics, business and industries their patients work in and other social factors.

There are many strides being made in the delivery of health care through other means than the face to face traditional office visit. The primary health care evolution may want to consider creating legislation, support, education and funding other means such as email, telephone and web-based consultations.

Some comments received:

- There seems to be some flexibility around hours depending on community need. Who will decide ultimately if the long hours are not warranted?
- Will same day access for both scheduled and non-scheduled appointments be possible? Will the public expect that it be with the physicians? This may be difficult if not impossible to achieve.
- 7a.m.-9p.m in some areas these hours may be a huge waste outside of some form of emergency / urgent care service. Does a rural ER count? Is a small town, like Three Hills expected to fully staff an ER, plus somehow fully staff an FCC from 7 am-9pm when utilization will likely be poor and resources both physician and allied health stretched thin?
- How can we achieve continuity with extended access and not compromise the docs doing the work or the care our patients receive?
- The community needs are assessed very late in the planning process. Should not the needs of the community be established prior to even beginning the costly and time consuming process of planning and application?

Potential Solutions:

1. **See the *CFPC Primary Care Toolkit* for discussion and references relating to many aspects of new models of practice, including advanced access booking.**

2. **Training, education and change management will need to be supported to ensure wherever possible, patients are making appointments with their personal family physician and members of their collaborative health care team first, to improve continuity of care.**

3. **Education for patients and their family/care giver needs to be widely disseminated and supported so that they understand the importance of clarifying the reason for the visit so that adequate time can be allotted for the appointment, the appropriate team member(s) can be scheduled, and patient wait times and back logs are not created in the waiting rooms.**

4. **As appropriate supports are introduced (including resolution of privacy, liability and remuneration issues), patient interactions with their personal family physicians and other health professionals should be supported and carried out through more than face to face**

interactions in the family practice office setting (email, telephone and web based consultations).

5. **The hours of business in an FCC must be set to best serve the local population and the available resources. Having patient representation on the governing body would help to keep this a local issue. To make the "Hours of operation" meaningfully suited to the population the FCC must exist in an environment which integrates care in the community as a whole. I.e. urgent care, ER, hospice, hospital, home, LTC. At least the physician members of the team need to cooperate and be involved in the extensions of the office and the NPs, RNs, Midwives etc. should seek to participate in that comprehensiveness.**

6. **One patient - One record**

Issue: Funding – The Operating Grant

The requirements for funding through the Operating Grant to Alberta Health, adds to the complexity and heavy administrative functions required for the application and the reporting. If the FCC is to be run effectively utilizing its resources efficiently to serve the patients, their families and the community, adding the burden of multiple levels of reporting will be a resource draw.

The funding method seems to be counterintuitive. The reward for an FCC that operates efficiently is to withdrawal surplus funds rather than offering an incentive to improve efficiencies. Well thought through funding models and incentive programs will improve patient outcomes, happy employees and well-functioning teams.

With an emphasis on government cuts to funding for health care, what will the operating grant's sustainability be? If there is a provincial election or governments restructure and the new leadership does not see the value of the FCC system that has been fully funded through an annual grant program, how will that team, its infrastructure and its patients find a place in the system? FCC's that set up in communities where there are neighboring physician owned clinics, may have depleted their resources and weakened the pre-existing health care infrastructure. It is evident that there are financial and capital risks that haven't been fully assessed.

Some comments received:

- There will be an "Operating Grant" available to those that are applying. Is this sustainable? Will it last past another election? Is it part of the negotiated agreement? How will CWG know that they can sustain themselves if they build and resource this new structure.
- Where is this funding coming from? Will other programs be cut in lieu of this?
- The document suggests initiating staff recruitment before the operating grant is in place. That could be problematic given the supply and demand for health care professionals and support staff.
- Under Financial Management – if these NFP have to supply audited financial statements to AH, do they have to supply them to Revenue Canada as well? I haven't seen if NFP status has to be maintained through Revenue Canada or not.

- Physician compensation will be eligible for funding. Details to follow? After negotiations are complete?
- Page 44 talks of things previously funded by PCN's in terms of change management not being funded again. But if we are changing everything again why not? Who picks up the planning and opportunity costs?
- What about infrastructure dollars? I think we are fortunate we could probably make it work, but I have no idea how they are going to do this with no infrastructure money. This will certainly limit the pool of clinics/communities able to take this on.
- Page 32 I think talks of clawing back surplus year to year and then decreasing overall budgets by that amount. So I guess the expectation is that every position will be fully implemented and funded from go live to infinity and beyond? No one will ever quit, there will never be a changeover in staff. All programs will run at 100% capacity and never change or evolve? People will be too scared to change because the dollars will go seeing as it does not talk about increases to funding if more is needed, or programs change, or those positions that were difficult to fill becoming filled. Will create fear, stagnation and waste rather than innovation, cautious spending and responsibility in my opinion.
- Many unfunded costs of FCC, who pays if not the government/AHS. I doubt NP's or dieticians will pony up funds. I fear physicians will get stuck with costs. (contingency funds, termination of FCC costs, infrastructure costs)

Potential Solutions:

1. **Create a physician owned FCC that allows for a blended payment model.**

2. **Offer start up grant to offset application process and startup costs and then once approved, guarantee a long term funding agreement that allows for annual reporting and flexibility to build new programs and services into the FCC.**

3. **Clear and transparent information on funding source and implications for other programs with in the health services budget**

Issue: Administratively Awkward, Schedule is Unrealistic and Result is Not Sustainable

See also the comments under governance and funding.

This is a comprehensive and complex application process. In order to have a more successful uptake by health care professionals, it will have to be more compatible with the way that the health care business is running today. A complete change in governance, funding, planning, delivery and reporting all happening within 6 months is very unrealistic.

Utilizing existing structures that are already established with all of the foundational elements would be the most expedient way to get the job done. The FCC Application process assumes starting from square one

with the establishment of a CWG. This process will be a deterrent for existing organizations to consider the transition especially if they have gone through recent structuring or restructuring within their PCN.

Some comments received:

- Document is vague on detail, lots of positive ideas and plans, but little detail and practical steps on implementation.
- Whole thing sounds very administratively heavy. Lots of 'monitoring and achieving positive outcomes'. It sounds bureaucratic, expensive, slow decision making, and not physician or patient friendly.
- As the Community Working Groups (CWP) start working they will be facilitated by the senior level consultant from AH. Seems quite contrived and heavily controlled. Will community working groups be able to have any autonomy?
- On page 53 it acknowledges the possibility of the space being physician owned ("if the leased space is owned by the providers"). This could get complicated. Potential liability based on self-dealing by a physician(s) leaser on Board of Directors?
- The FCC Application Kit First Wave and FCCs in practice, as described, appears to be very administratively burdensome; it appears that there FCC administration will be burdened with a lot of administrative reporting - from a functional perspective, a budget perspective, a patient care perspective and population perspective. A LOT of money will be spent on administrators, reports, and numbers that may never help patient care. There is a fear that actual patient needs may get lost in numbers, and outcomes.
- All of these concerns question if this delivery model is even feasible and sustainable. More work and exploration needs to be done in gathering better information about the current FCC pilots; what working models are out there and how best to augment them into a working FCC.
- The AH staffed - FCC Implementation Team seems that it will be soon over-burdened and may cause a bottle neck.
- The time line for implementation is 3 months!! It will be impossible from submitting interest to achieve full implementation with all the requirements met? There will be some poorly thought out FCC's with dysfunctional team dynamics slapping things together like this. I think I have a very good handle on needs in the community I have full knowledge of our PCN, our clinic, AIM, a community working group, we have done surveys and such. A full turn around in 6 months is a stretch.
- There will surely be a lot of reporting going on. Sounds tedious, time intensive and who is going to be reading all of this data!?
- The main job of FCC seems to be to have committees meeting all the time. Then making reports. There will be lots and lots of reports. When will there be actual patient care?
- Lastly, this will truly be a re invention of the wheel… I fear it will be a very expensive, golden and not practical or functional.

Potential Solutions:

1. **Re-examine timelines for formation of working groups, business plans and community consultation.**

2. **Provide clear information on the resources available to facilitate the FCC development including resources from AH and consultants and what communities and their working groups can expect.**

3. **Consider a simpler, less time consuming reporting process so that it will be easier to implement with a potentially small FCC team or a large team with high patient volumes and/or complex care needs.**

Issue: Standards-Based

Standards based primary health care is reasonable to expect. It will now be necessary to establish what standards will be expected and the sooner that is introduced, the better.

There has been work done by professional health organizations (for instance, the AMA's Primary Care Alliance -Subcommittee on Practice Accreditation) that have included a number of stakeholders in a collaborative, literature review, highlighting evidence-based practice throughout the process. Research has been done and recommendations have been drafted. It would be in the government's best interest to engage the stakeholder organizations to assist in the establishment of the standards that they will be held to. Policy papers are likely to exist across the organizations that would inform this work. We need to work more collaboratively to get buy-in and moreover, a rapid uptake.

Some comments received:

- What primary care standards are they using? It is National but there is no mention except for, "Accreditation standards, such as Canada's Primary Care Standards are to be used to guide service planning, delivery and evaluation standards." There seems to be flexibility built in.
- The focus on standards is very vague and the statement is raises more questions and concerns unless specifically laid out. The standard should be whatever the best care is for the individual patient at the time.
- Page 22 talks about focus on outcomes and standards. I just hope they are the right outcomes and standards. Seeing as standards fail to apply to the standard patient and outcomes is very vague - I have seen some of the outcomes to be measured in a separate FCC document and I think they are on the right track, but this statement is scary unless specifically laid out. The standard should be whatever the best care is for the individual patient at the time.
- A big stick for me is that we are potentially going to spend tons of cash, etc., but we are not looking at a root issue of physician culture and patient care. There is NOTHING in here that is concrete about if you want to be a part of an FCC, have your patients cared for by an FCC team, that you must actually provide comprehensive services to your patient population as in within your FCC group or team provide home visits, palliative visits, HOSPITAL CARE, LTC visits, etc. I can't believe we are still going to leave ALL of this out. This is patient care and primary care at its core.
- I agree with the document when they say this is ambitious. There should be evaluative data to indicate this will work. Let's see the data on the 3 working FCC's! Their cost, patient, provider satisfaction, etc.

Potential Solutions:

1. **If thoughtful standards are chosen and established accreditation is utilized, the bureaucratic burden could be managed by leveraging existing models such as the primary care standards of Accreditation Canada or the Michigan Blue Cross Milestones of PMH. Use existing good work.**

2. **Provide current FCCs evaluation data now and use it to refine the design of subsequent models.**

3. **Provide accreditation standards to community working groups now so they develop a business plan that supports the standard of care.**

Issue: Information Management and Technology

System supports, including funding to support the transition from paper records, should be in place to introduce and maintain the new EMR. There are many strides made in the use to technology to facilitate patient care from communicating and sharing patient information, measuring progress, monitoring patient adherence to treatments and medication plans and secure online/email consultations. Medical home websites have been created that act as the first stop for patients and their care teams. Though this is possible and accessible to most, there needs to be recognition that certain socio-economic or demographic challenges still exist that will limit the full implementation of this technology across the board. Nonetheless, this evolution is widely supported however stakeholder consultation is absolutely necessary.

Some comments received:

- There will be Information Management and Technology (IMT) that must be used and will be at a minimal cost to the FCC through Shared Services. Not clear if this is provided through AHS or AH, but it is developed by AH. Have any physicians been involved in this development as of yet?
- What stakeholders are inputting the user-interface/ business analysis of this IMT/DM system? The system sounds too good to be true as there has been evidence of over two decades of IT issues? How will FCC systems be able to speak with existing systems – what kind of compatibility issues will it face when systems do not match?
- Is this interim solution going to be functional at all, we are going to teach everyone one way and then another way? It sounds very messy.
- The IT will be interesting and a nightmare, I love the concept of unified record, but we are not even close to that in this province. Plus, most providers (myself included) are not the most literate when it comes to computers, software etc.

Potential Solutions:

1. **IT solutions must meet standards of primary care records and mesh with institutional records.**

2. **Engage IT consultants now for a comprehensive plan including costs for the information needs of these clinics and fund separately, outside the operating grant.**

3. **IT Solutions must be user friendly and intuitive.**

Issue: Team Based

The primary concern is that the teams that are pulled together for the FCCs are new and will have to work through the stages of group development to become fully functional and complimentary. This process is often stressful and takes time. Given the short turn around for new FCCs to be ready for delivery of primary health care to their communities, the teams will have to be facilitated through formal team building and then work through their own informal team building that will follow. Calling the group a team will not necessarily guarantee that they will be high functioning right off the mark.

Role clarity tends to be the biggest struggle for new teams and team members. The clarity around roles and responsibilities will have to be defined in the planning stages based on the available professional staff, the experience of the business manager and any pre-existing team member roles and responsibilities. The support for utilizing existing PCNs and physician owned clinics and their teams will be the most expedient way to get to that level of performance that will be necessary to have an efficient FCC.

Some comments:

- There is very little about actual team dynamics. I have worked with different teams in AIM, worked and seen different team dynamics within the PCN and other PCN's. The biggest success stories in primary care usually involve great teams and not enough time is being spent laying out how to be an effective team in this document.
- The document describes the "clinical advisor" - but I am still not sure who that is, or what their role is. Who is going to champion these teams? Who is going to take the lead position of responsibility? When outcomes are bad, or chips are down, who is going to step up and make changes? It is not clear here.
- I can't believe that they left it open at a minimum of 2 extra providers. Wow, there could be some small FCC teams out there

Potential Solutions:

1. **Respecting the "Work to full licensed scope" principle must sensibly apply to the physician members of the team implying that the coordination, comprehensiveness and complex diagnostic skills of the physician must be available to every citizen of the FCC. <u>This translates into the necessity to have every person attached to a family physician</u> no matter how many other team members deliver care, first contact or not. Team care does**

not mean individuals possessing patients but does mean team sharing of the care with the corporate purpose to give the best care to the patient.

2. **Teams are built around patient needs, available personnel and cooperative purpose. A proven base is a family physician, a primary care Registered Nurse or Nurse Practitioner, and adds team members as needed from there. Successful PCNs have been using this evolution and I suspect teams starting with any other pattern will eventually include the same ultimate member mixes in order to comprehensively meet community needs.**

Issue: Compensation for FCC Team Members

It will be necessary for government to establish and support equitable salaries across the health care system. The competition for skilled and motivated health care professionals is going to continue to be a challenge. Physicians and the team members needed to fill the FCC teams will not be willing to leave secure positions and personal investments to sign on to something that is vague and lacks promise of a long term commitment.

Some comments:

- Physician compensation has not been addressed at all.
- They have skirted physician compensation obviously. My vote would be a blended model, fee for service but sessional or hourly rates for things like team meetings, collaborative team events, anything involved in patient care that would better patient care but we can't bill for like phone advice, e-mail, etc.
- Other option would be a modified capitation - I know Tobias Gelber in Pincher has been working on such a model with a health economist; you might want to talk to him.
- Am I missing compensation? How do you pay all these diverse groups? And the administrators? ?? Total cost??
- "FCCs must become familiar with locally available human resources and with opportunities to use regulated and non-regulated professions in new ways within their scopes of practice. Rather than designing job opportunities based on current common practice, FCCs should design jobs based on the service need in the community and available local health workforce resources, giving consideration to the full scope of practice of available providers." Sounds good. Now tell me who and how this will get done on a practical level in each community. They are diverse.

Potential Solutions:

1. **Ask Physicians who own private clinics, PCN Leads, PCN Executive Directors and existing team members how they think FCC team members should be compensated most effectively.**

2. **Consider blended models of compensation.**

3. **Address the need for competitive team member salaries and benefits across the whole health care system.**

4. **See "Access" solutions also.**

REFERENCES:

College of Family Physicians of Canada, A Vision for Canada: Family Practice – The Patient's Medical Home, 2011

ACFP website – Resources/Patient's Medical Home - http://www.acfp.ca/Resources/PatientsMedicalHome.aspx
Includes links to:

- CFPC's Patient's Medical Home Vision (September 2011)
- ACFP Medical Home Leadership Forum Synopsis (December 2011)
- CFPC's PMH Best Advice Articles (Panel Size, Enhancing Timely Access, Rostering) (2011-2012)
- CFPC's PMH Toolkit Link

AMA – Position Papers - Vision for FCC, Practice Accreditation, Formal Attachment

Research re: Primary Care Physicians, Satisfaction and Health Outcomes

Starfield B, Shi L, Macinko J. "Contribution of Primary Care to Health Systems and Health." Milbank Quarterly. 2005; 83(3):457–502 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

Health Quality Council of Alberta. "Satisfaction with Health Care Services: A Survey of Albertans." 2012 http://hqca.ca/index.php?id=68