FAQs - Family Care Clinics - Wave 2

The first and most fundamental question you need to answer for yourself before pursuing or practicing in a FCC is one of philosophy: What practice model is best for your patients, your community and you personally?

In an FCC the level of autonomy and independence most physicians currently enjoy is significantly altered from both a clinical and business perspective.

Most current team-care models in PCNs recognize that there has to be a clinical leader to oversee the patient's care and the scope of the family physician makes him/her the appropriate anchor/leader for that team (the most responsible provider). The vision for the collaborative team model in an FCC is that joint decisions are made by the care team and no profession is identified as the clinical leader.

From a business model perspective, the FCC positions physicians as part of a team in a contractual model similar to any other health care professional. Furthermore, the governance structures indicate that physicians are intended to take a lesser role in both strategic and operational decision-making both through the prescribed composition of the Board(s) and lines of reporting for the FCC Business Manager.

The information in this document is summarized from the Alberta Health *Family Care Clinic Reference Manual – Wave 2* and accompanying Guidelines documents released June 4, 2013[1] and presented in a question and answer format.

Q1. Who is eligible to operate a Family Care Clinic (FCC) for Wave 2?

An FCC can be operated by a not-for-profit corporation (NPC) set up for that expressed purpose or Alberta Health Services (AHS). The not-for-for profit corporation can be an independent entity or a subsidiary to a parent PCN not-for-profit corporation.

In Wave 2 groups in the identified communities are invited to apply; there is no indication that they will all get an FCC.

Q2. What is the general process to apply and how long is it anticipated to take?

Alberta Health anticipates it will take approximately 11 months from the Expression of Interest to an operational FCC. At a high level, the steps are:

[1] Full documents are available at: http://www.health.alberta.ca/services/family-care-clinic-establish.html

- Receipt of an Expression of Interest to operate or participate in the planning of an FCC submitted to Alberta Health by June 21, 2013.
- Parties responding with an Expression of Interest will be contacted by an FCC Implementation team consisting of AHS and Alberta Health consultants who will provide information sessions and begin organizing a planning team and a Community Working Group.
- Community Working Group develops a Proposal and submits to Alberta Health for approval by September 30, 2013.
- Legal and Committee structures are setup and Business Manager is recruited.
- FCC Business Plan and the Financial Plan are developed and submitted to Alberta Health for approval.
- The operating grant agreement will be executed and remaining task to become operational occur (e.g. staff recruitment, business infrastructure, staff training, etc.)

Q3. Will participants in planning be remunerated for their time?

It appears not. The list of ineligible uses for FCC Development funds as noted on page 28 of the FCC Reference Manual includes "costs associated with completing Expressions of Interest of the FCC Proposal form" and "fees or honoraria to members of the FCC governing body or its committees".

Q4. What are the mandatory operational components of all FCCs?

- Hours of operation 7:00 AM to 9:00 PM, seven days per week unless community needs and circumstances indicate otherwise. It is unclear who has authority to make that determination. It is also unclear which health providers must be available during those hours.
- Same day access for scheduled and non-scheduled visits.
- Direct access to any member of the care team.
- Minimum team mix of 1 Nurse Practitioner or General Practitioner, at least 2 other health providers, 1 Business Manager, 1 Administrative Assistant and 1 Receptionist.
- Provide for teaching and mentoring of health care providers (students, residents, interns)
- Commitment to provide all mandatory FCC primary health care services and provide linkages to key social and community support programs.(see page 16-18 of the Reference Manual)
- Use the EMR and IMIT solution provided by Alberta Health accessible by all other FCCs and external health organizations (see Q19 to 21)
- Adherence to the FCC operating policy requirements (see page 20-22 of the Reference Manual)

Q5. What funding is available for operation of an FCC?

The documentation is silent on the specifics of the funding model or how much operating funding will be available to an FCC. There is also no overall operating funding budget provided for FCCs as a whole, however, $50 million has been earmarked for FCC development. It is not clear how

much of that $50 million is being spent on general FCC development as opposed to individual community FCC development.

There is a statement that "it is anticipated that Alberta Health will be moving to a client-based funding model". The wording is not clear whether the funding will be client-based from day one or if the intention is move to this model in the future.

Q6. At what point in the process will we know how much funding is available?

Our best understanding at this point is that an FCC won't know the funding amount until the Business Plan and Financial Plan are approved. Extensive thought and careful planning needs to be undertaken to fully understand all costs associated with operating an FCC and fulfilling all governmental requirements and obligations. Alberta Health's service delivery expectations are detailed on pages 16-18 and pages 20-22 of the Reference Manual.

Q7. For what purposes can the FCC operational funding be used?

A detailed guideline of eligible and ineligible expenditures is not yet available; however, we do know that the FCC can undertake leasehold improvements/renovations to accommodate FCC programs and services and that, with Alberta Health approval, FCCs can lease space or take over existing leases at fair market rates. Major capital purchases including purchasing or building net new space are not allowed.

Q8. Can the FCC seek other revenue sources or donations?

Yes; however, they must be approved in advance by Alberta Health.

Q9. What are the options for physician payment?

The reference manual states "a non fee-for-service approach to physician compensation is preferred in an FCC". Current FCC compensation is based on an hourly rate. Details of physician compensation are under negotiations with the Alberta Medical Association as part of the recently ratified *AMA Agreement 2011-18*. The AMA and AH will be meeting over the coming weeks to discuss the rate of remuneration under any payment model. It is our understanding that Alberta Health is strongly leaning toward an hourly rate.

Q10. How will physician contracts be negotiated?

As far as we understand, each FCC will negotiate a contract with the physician(s) in that FCC based on guidelines from Alberta Health.

If that is the case, it is important that you contact the AMA as there are significant issues that physicians need to be aware of prior to negotiating a contract for services. It is our understanding at this time that the only standard component is the rate of remuneration rate.

Q11. Who has decision-making authority at each of the following levels?

1) Strategic Direction - Depending on the option chosen it will be either be:
   a) a Not-for Profit Board consisting of either:
      i) A minimum of two different health care providers (note: one does not have to be a physician), one client representative and two community leaders (non-FCC staff), or,
      ii) Equal representation of physicians and AHS representatives plus the addition of a member from a Community Advisory Committee
   b) Alberta Health Services with input from a Community Advisory Committee
2) Business Operations - The Business Manager of the Family Care Clinic.
3) Clinic Operations - Can be determined by each FCC in the Business Plan; however, the reference manual states "the team model being implemented does not identify one profession as clinical lead. Instead various roles, such as care coordinator, may be filled by a range of professions as determined by the team and the Business Manager". Standard protocols and clinical practice guidelines will be used by all health providers.
4) Patient Care -The vision is that the health providers work to their full scope of practice and they operate as equal members of the care team. The vision of team collaborative care cites the team will make joint care decisions. There is no requirement that a physician has oversight over the team or over a patient's care.

Q12. To whom does the Business Manager report?

The Business Manager reports the Board, unless there is an FCC health provider on the Board. In this case, the Business Manager reports directly to the Chair of the Board, who cannot be a physician or a health provider within the FCC. This is in contrast to the PCN model where Executive Director reports to the PCN Board as a whole.

Q13. How can an FCC be operated under the umbrella of a Primary Care Network?

There are two primary models for a PCN to operate and FCC all of which require the creation of a new not-for-profit corporation.

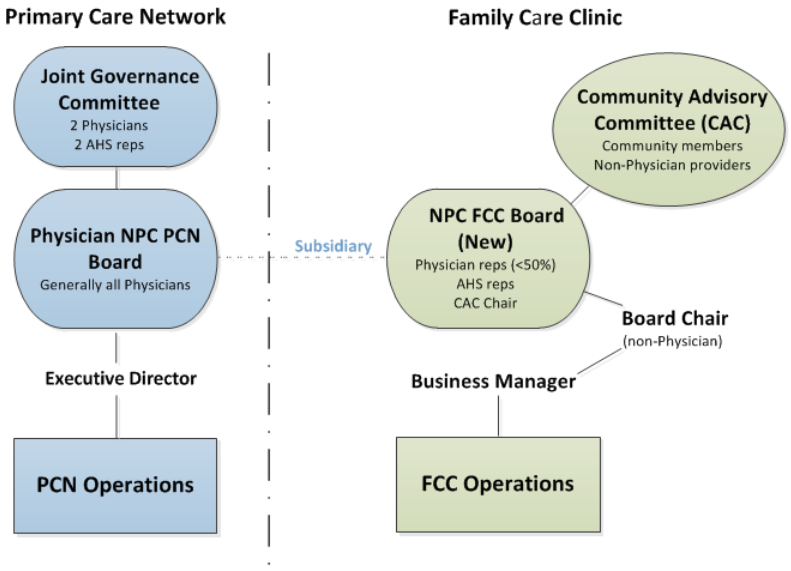
The models clearly create a separation between the PCN and FCC and the PCN would have no formal influence over the FCC. It is unclear in the "PCN mirrored FCC Board" whether the representatives can be the same individuals as those on the PCN governance committee. The legal structure of a parent-subsidiary relationship would dictate that the FCC Board has full independence

from the PCN parent organization. In all governance models, health care providers (physician or allied health professional) cannot make up more than 49% of the Board.

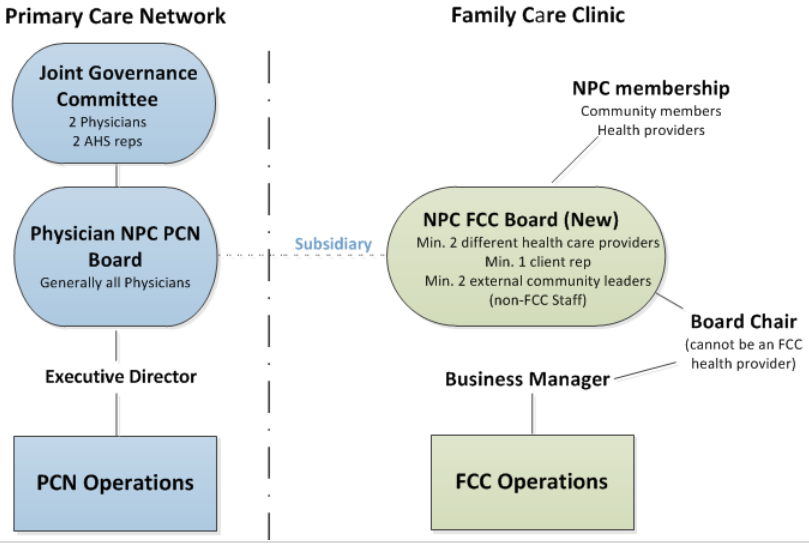
The 2 basic variations available for a PCN operated FCC are diagrammed below.

Note: The diagrams reflect the more common PCN Legal Model 1. For Legal Model 2 the physicians form an NPC and a second NPC is formed to operate the PCN made up of members of the Physician NPC and Alberta Health Services representatives. In this model there is no Joint Governance Committee.

PCN Mirrored Governance



FCC Community Board Structure



Q14. Are there additional options for a PCN Clinic?

Yes, a PCN Clinic can leave the PCN entirely and set up a separate FCC not-for-profit corporation or multiple PCN Clinics can become FCCs in an FCC Collaborative reporting to a single FCC Board as described in Q11 above under 1) a) i).

Q15. Can our PCN Executive Director also be the Business Manager of an FCC under the PCN umbrella?

Our understanding at this time is that this would not be allowed. The underlying philosophy of the document is to keep the PCN and FCC operations and management separate. The *Governance and Accountability Guidelines* document is very clear that due to a perception of a conflict of interest, the Business Manager cannot ever report to a physician. In fact, the Business Manager cannot report to any health care provider within the FCC. This is a very different model from PCNs.

Q16. How will PCN funding be impacted by FCCs?

Although the details aren't known the Reference Manual clearly states that "A family physician, nurse practitioner or pediatrician may be registered as a core provider in a PCN while also providing services in an FCC. In this instance, Alberta Health will adjust the PCN's per capita payment proportional to the care received to avoid duplicate payments." Thus, it appears there will be negation in some manner. Especially in a smaller community with a PCN and an FCC, careful consideration needs to be taken as there is a potential for significant PCN resources to be flowed into the FCC. This would lead to PCN program termination and staff reductions to maintain PCN operations within the budget were this to occur.

This suggests that an FCC may not result in "net new" funding to a community.

Q17. If our PCN operates the FCC doesn't that ensure any reduction in PCN funding is recovered through FCC funding?

While a PCN can prevent "a loss" of funding overall by owning and operating an FCC site (and therefore avoid a reduction in patient panels), the funding required to own and operate an FCC site will be extensive given the staffing, mandatory standards and other requirements. You may find that while you avoid reducing patient panels and keep overall funding within your PCN, the additional funding a PCN is given to own and operate an FCC will be needed to completely support the FCC service expectations and requirements. It is quite clear that FCC funding would not be available to support PCN operations.

Q18. Can a PCN refer patients to the FCC to make use of their supplemental services and vice versa? In other words, given that the two delivery models are intended to be complementary and not duplicate services, can a patient receive services from both an FCC and a PCN without restriction? (E.g. patient X attends the PCN's Weight Management Clinic and sees the FCC's physiotherapist for a frozen shoulder)

How, or if, this can occur is not clear from the documentation. Regardless, the funding implications will need to be considered.

Q19. Who is responsible for the EMR and IMIT infrastructure?

Alberta Health is developing a single EMR solution FCCs and a single IMIT infrastructure that must be used by all. Shared Services capability is being developed by Alberta Health and the costs of both are borne by Alberta Health.

Q20. What are the key considerations associated with the FCC EMR?

The physician's professional EMR-related obligations (see CPSA Standards of Practice, Patient Records Standard 21) must be acknowledged. In addition, the specific roles and responsibilities (e.g., physicians, Alberta Health, other providers, etc.) with respect to the FCC EMR need to be clarified, clearly articulated and documented. For example, physicians need to know what they are accountable for and what degree of control they may or may not have with regard to patient information access, use and disclosure to others.

Q21. Who can access the patient's medical record?

"FCC health providers will capture all charting information in electronic format and contribute to a shared health record (shared across FCCs, and between FCCs and partner organizations, including Alberta Health and Alberta Health Services."

Q22. What ongoing accountability reporting is required for each FCC?

The required reporting initially identified by Alberta Health includes:

- An annual business plan and financial plan approved by Alberta Health
- An annual health workforce plan approved by Alberta Health
- Quarterly financial report
- Annual report
- Performance reporting
- Service event/workload reporting
- Reciprocal billing

Q23. What are the standardized evaluation and performance measurement required for FCCs?

These are under development by Alberta Health.

Q24. What other guidelines must the FCC abide by?

- Operating Guidelines for each of the seven FCC program objectives are being developed by Alberta Health
- Handbook for Occupational Hazards and Controls for Community Clinics and Doctor's Offices
- The following guidelines are still under development by Alberta Health:
    - Policy to "rationalize funding for FCCs and PCNs in order to avoid funding overlap and ensure accountability between these separate streams of PHC service delivery"
    - Business Plan, Financial Plan and Reporting Guidelines
    - Board Orientation Guidelines
    - Facility and Infrastructure Reference
    - Standards and Guidelines for Information Management Technology and Data
    - Set of standardized performance measures and evaluation framework
    - Shared Services agreement
    - Privacy and Security Guidelines

Q25. What other business components are required of FCCs?

- FCCs must comply with Accreditation Canada Primary Care Standards
- Community Ambulatory Care Centre (CACC) certification with Alberta Health
- Privacy Impact Assessment approved by the Office of the Information and Privacy Commissioner
- Formal patient enrollment
- Provincial Organization Readiness Assessment (pORA) accepted by Alberta Health

Q26. Will there be collaborative team-based care training available?

Yes, Alberta Health will make training based on the *Inter-professional Competency Framework* model released by Canadian Inter-professional Health Collaborative (CIHC) and adopted by the Alberta Government Collaborative Practice and Education Steering Committee (CPESC) available to FCC staff through contracted services.

Q27. Given that the physician is no longer the team lead, how does that impact my liability?

This is not a typical physician office so in the first three pilot FCCs we have agreement from AHS to build in a legal "firewall" into the contract to minimize liability to the physician as it relates to any direct or indirect supervision or leadership. This requires further legal review.

Q28. There is no mention of AMA support in the documents. Does that mean AMA support is not available as part of the development process?

While the AMA and the ACFP was given an opportunity to review the FCC application documents like all other health care professional groups, we were NOT involved in any detailed planning or discussions on the development of the FCC framework, requirements or Reference Manual and Guideline documents.

Within the new Agreement, there are provisions for the AMA to work with the Government to establish compensation rates for any physicians that will work within an FCC.

The Government will be making some resources available (including support from AHS) to assist all communities that were targeted within this current FCC wave. While the AMA was not listed as an available resource within the Reference Manual, staff resources will be made available to any physician(s) that requests representation. While the AMA will not be in a position to actually draft business proposals or be involved to the extent it was with PCNs, it will provide advice and support to all interested physicians such that we ensure you can make the most informed business decision possible.

As in any new initiative there will be parties with vested interests prepared to offer assistance and assurances. It is important to ensure that as physicians you have a representative whose interest is in ensuring you ask the right questions and take the time you need so you can make rational and informed decisions for yourself, your patients and your community.

If you desire AMA support, please contact Linda Ertman at 780-733-3632.

Supplemental Questions for Consideration

- What happens if multiple groups submit to run an FCC in one of the 24 targeted geographies? Would one of the groups be denied? What are the selection criteria?
- What option is there to back out of the FCC process if, for example, a mutually acceptable Business Plan and Financial Plan cannot be agreed upon? (i.e., at what point are you committed beyond the "point of no return" given that significant commitment is required in the process before funding is known and the operational model is approved.)
- Given the separation of the governance and management structures of the FCC and PCN, what is the operation relationship between an FCC and a PCN? How will duplication be avoided and joint collaboration be encouraged?
- Will there be an option for a PCN to operate or transition to an FCC in the future? (i.e. beyond Wave 2)
- What are the implications for a family practice in a rural area, if an FCC is set up in competition with the private practice?
- What is the intent of the FCC in practical terms? Is it for unattached patients only? Is it a walk-in clinic for episodic care? Can any Albertan be seen in an FCC for episodic care?
- Where will FCC staff in your community come from? Will it impact private practice staff? Hospital and AHS staff? PCN staff?
- If an entire PCN transitions to an FCC would your existing staff need to reapply for their positions?
- In the NPC operated model who appoints the Board initially and on an ongoing basis?
- In the PCN operated model with an FCC NPC Board, who is the Board accountable to?
- If a PCN transitions to an FCC, how does it revert to back a PCN or cease operating the FCC if the FCC service model is not functioning well for the community?
- Will there be patient panel minimums or maximums for the FCC as a clinic and individual providers within the FCC?
- What does the hourly rate cover beyond directly interacting with patients? E.g. charting, mentoring and preceptorship, clinical protocol development, team meetings, etc. Is it consistent for all professionals on the team?
- How will third-party (e.g. WCB, military, medico-legal, etc.) be handled? Would these fees be paid in addition to the hourly rate?

- In an hourly model, will shadow billing be required?
    - Likely if not certain. It is in the existing FCC pilot projects, physicians are required to bill Fee-For-Service and assign the billings back to the FCC.
- What level of clinical autonomy will you have as a physician in an FCC?
- It is assumed that staff in an AHS operated FCC will be unionized. Is the same true of an NPC-operated FCC?
- Provided that direct access to all team members is envisioned, will there be a limit to the services the patient can access e.g. As a patient, can I visit the dietician as many times as I like?
- Will the funding be sufficient to meet the expectations and detailed requirements?
- Will the funding available be comparable to the Wave 1 Pilot FCC clinics in Slave Lake, northeast Edmonton and northeast Calgary?
- Since a funding methodology has not yet been identified and business plans must be approved on an annual basis what is the risk of downward budget adjustments in subsequent years? Also, what provision is there for future budget increases to reflect cost of living and expanded services?
- Given that any surplus will reduce the following year's funding, what incentives are there to become more efficient and provide greater value for money?

Keep in mind in addition to the FCC operational business, there will still need to be individual physician contracts negotiated that define the exit clauses, liability protection, terms of work, hours, days, employee versus contractor status, etc. in detail for the individual physician working in an FCC.

- How are your shifts determined and how much input do you have? This is one of the factors that impacts whether you are deemed by the courts or Canada Revenue Agency as to whether you are an employee or a contractor. This may have significant implications for you financially. We highly recommend having the AMA review and/or negotiate your contract.
- How will issues of physician liability be dealt with? If another health professional sees a patient in your FCC, what liability and obligations do you have?
- If there are disputes about anything (e.g., clinical decisions, administration, hours worked, remuneration, etc.) how will these be handled? Is there a dispute resolution mechanism in place? Does it follow the Alberta Arbitration Act or is it expensive and/or bureaucratically difficult, which could discourage you from pursuing this course of action?

- How will the physician contracts be negotiated? Will you be able to seek representation or will it be a take-it-or-leave-it type contract?
- If Canada Revenue Agency and the courts deem you to be an employee, will the FCC cover all costs and penalties applied to you, or are you at personal risk for this? Will the provincial government/FCC provide you with benefits retroactively (e.g., pension, health benefits, dental, payment of EI and CPP premiums, etc.) if it is ruled that you are considered and employee under Canada Revenue Agency guidelines? In other words will they indemnify you? If they do not, then you should give serious thought as to why they won't and why you would take on that risk? If you choose to take on that risk is the compensation higher to cover off the increased risk?