DRAFT

DISCUSSION PAPER

A Vision for Family Care Clinics

Alberta Medical Association

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ALBERTA
MEDICAL
ASSOCIATION

Physicians want the very best primary care system for their patients.
To do so, we need to have everyone working together, doing what they do best.
Primary care networks (PCNs) have an excellent track record and now
we have the potential that family care clinics (FCCs) bring.

Let's explore how we can use the FCCs and PCNs
to provide the very best care possible,
to give Albertans the care they expect and deserve,
to offer each and every Albertan a medical home.

As we move forward, this paper is intended to provide
a starting point for further discussion and consultation.
We hope it will continue to evolve
as we receive broader feedback and input.

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EXECUTIVE SUMMARY

This discussion paper has been developed to propose a vision for how family care clinics (FCCs) could successfully be implemented in Alberta.

The premise for this discussion paper is that FCCs are not new or separate entities. Really, they can be seen as a new form of traditional family practices, funded and enhanced by the robust presence of a team of allied health professionals.

The key principles for FCCs are:

1. **Patient centered**: Programs and services are designed around patient needs.

2. **Continuity of care:** Patients receive the bulk of their primary care through a primary care team with whom they have an ongoing relationship from "cradle-to-grave."

3. **Service integration**: A consistent and responsible care team ensures patient care (across the entire health system) is as coordinated and seamless as possible.

4. **Service enhancement**: Services will enhance, not duplicate, existing programs and services.

5. **Multiple points of access**: Patients can access primary care through the most appropriate member of the team.

6. **Patient attachment**: Each patient has the opportunity to be attached to a family physician[1], supported by a primary care team.

In our vision, FCCs could be based on several business models, including Alberta Health Service (AHS)-operated or primary care network (PCN)-operated clinics. The majority would likely arise from physician-owned-and-operated family practices.

New funding mechanisms would allow each clinic to create a primary care team to meet the specific, local needs of their patient population. The primary care team would be co-located and work in a highly collaborative model in which each discipline works to full scope of practice. The primary care team includes allied health professionals such as nurse practitioners, registered nurses, licensed practical nurses, pharmacists, behavioral health consultants, social workers, and dieticians, working with family physicians.

Patients receive comprehensive care through their FCC, which becomes their medical home. This includes screening for disease and illness, early intervention and management of risk factors, illness prevention, health promotion and chronic disease management. All care the

[1] There is significant good evidence internationally that patient attachment should remain to an individual physician. Source: Starfield B, Shi L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics.* 2004; 113 (Supplement 4):1493-1498.

patient receives is coordinated by the FCC. This includes referral to specialist care, or managing the patient's passage through programs and services provided within the primary care neighborhood (consisting of the PCN linked to AHS and other agencies).

PCN funding and supports have allowed for the first steps to be taken from traditional family practice to fully-resourced, interdisciplinary FCCs. Patients, particularly those with chronic diseases, are already seeing the benefits of interaction with other health professionals including improved access and better quality, comprehensive care.

Primary care in Alberta is ready to evolve! For proof, look no further than alignment on many of the FCC concepts among both the nursing professions and physicians. There is good physician buy-in and the desire to work with allied health professionals across the province. Through the development of PCNs there are healthy new working partnerships between AHS and primary care physicians. Finally, we can ensure accountability for the investment required to successfully implement and operate our vision of FCCs province-wide by using the governance structure that PCNs have in place today.

This is important, because fully achieving the vision of FCCs calls for long-term commitment and stable funding. This includes:

- New funding options for hiring allied health professional team members.
- Capital investment to create spaces for teams.
- Investment in team training and development.
- Engagement of front-line health providers.
- Patient engagement and education.

I. Introduction

This discussion paper has been developed to propose a vision of how family care clinics (FCCs) could most successfully be implemented in Alberta and how they relate to the current comprehensive family practices aspiring to the "medical home"[2] model of team care and to the primary care networks (PCNs)[3] that have made that possible.

The premise for this discussion paper is that FCCs are not new or separate entities but, in large part, are the existing traditional family practices funded and enhanced by the integration of a robust team of allied health professionals (AHPs). The traditional model of physician as "gatekeeper" is evolved to a model in which patients have access to a coordinated and collaborative primary care team that includes physicians, nurses (RNs, LPNs), nurse practitioners (NPs) and, as appropriate, other health care professionals.

This requires an evolution from current-state family practices to enhanced FCCs that are able to deliver the best possible care to Albertans in an efficient and effective manner. That evolution has begun in many family practices through funding support of PCNs, but needs to be enhanced to realize the full vision of an FCC. (See diagram in Appendix A, page 19.)

II. Background

One of Premier Redford's campaign proposals is to develop FCCs as a means of increasing access for Alberta families to primary care. Our understanding of the premier's vision is that FCCs feature the characteristics of:

a. Timely access to primary care, including appropriate after-hours care.
b. Multidisciplinary team care.
c. New funding options for multidisciplinary team members.
d. Multiple access points to a primary care team.
e. Comprehensive, "cradle-to-grave" care.
f. Local, community-based decision-making.

[2] The term "medical home" is widely used in international literature and incorporates the principles of the FCC concept including interdisciplinary care. For many PCN-affiliated family practices in Alberta, this evolved model of primary care has been the goal.

[3] Primary care networks are formalized collaborations between groups of family physicians and AHS to address some of the local primary care service gaps. Programs and services are delivered by family physicians and allied health professionals employed by physicians, AHS and, in some cases, PCNs directly. In addition, hundreds more AHS staff have reconfigured to work better with community physicians in meeting patient needs. Each PCN has developed the most appropriate model to enhance primary care for maximum impact in their community.

III. Key principles of family care clinics

The following key principles are the foundation for the vision of FCCs to achieve the intended outcomes and ensure successful and timely implementation.

1. **Patient-centered**
   Neither patients nor health care providers want to see the creation of more disconnected "silos" of care. The future of primary care lies in the concept of a "primary care home" which is designed around patients; not around diseases or programs or providers or separate funding streams. Family care clinics should be the "one-stop" centers where patients receive the vast majority of their comprehensive primary care over their lifetime from birth to end-of-life.

2. **Continuity of care**
   One of the key tenets underlying high quality and cost-effective health care is continuity of care.[4] Research clearly demonstrates that continuity of care is critical to improved health outcomes, to reduction of errors and duplication or re-utilization of services, and to decreased specialist visits.[i, 5] Access to a primary care team, where patient and team members have a trust relationship and the patient is confident that the team is working together in a coordinated and collaborative fashion, correlates with reduction of service redundancy and costs, and with improved health outcomes.

   Expedient, episodic care with other health care providers who are not part of that "primary care home" does not achieve better quality care or value for the health system in the long term. Pragmatically, patient access must be balanced against patients receiving continuity of care for optimal health outcomes.

3. **Service integration**
   Coordination of the patient's care and appropriate patient information flow by a collaborative, consistent and responsible team in the FCC will ensure that whether the patient is receiving services in the family care clinic, their "medical home,"[6] through

[4] A key premise of the Access, Improvement, Measures (AIM) initiative that government has invested in and promoted province-wide is that "continuity is king" and that lack of continuity of care results in service duplication, less efficient and effective care and actually deteriorates access to primary care in the longer term.
[5] Starfield et al 2009 pointed out that lack of primary continuity increased costs of specialist services. It is estimated that 40% of new problems in primary care practices are undifferentiated which are best managed by "watchful waiting" involving minimal investigation or referral. (Starfield 1994; Rosser and Shafir 1998) "Watchful waiting" as a care strategy only works where there is a strong trust relationship and familiarity. (Rosser and Kasperski 1999) Numerous other studies found evidence that supported continuity care resulted in better preventive care (Lieu et al 1994), patients feeling more able to care for themselves (Howie et al 1999), better recognition of problems (Gulbrandson et al 1997), less recourse to medication as a first-line treatment (Hjortdahl and Borchgrevink 1991), fewer hospitalizations (Weiss and Bluestein 1996), lower total costs (Flint 1987), fewer emergency department visits and fewer tests ordered.
[6] A 2007 survey comparing health care experiences in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States found that "having a 'medical home' that is accessible and helps coordinate care is associated with significantly positive experiences." (Schoen et al 2007)

AHS programs, through a PCN program in their "medical neighborhood," or other primary care health service providers, care is as seamless as possible.

4. **Service enhancement**
   Family care clinics with a co-located, robust and effective interdisciplinary team will enhance current primary care services. They will not duplicate but, rather, enhance what is already in place in existing traditional family practices, AHS programs and services, or specialized primary care initiatives of local PCNs. PCNs further augment the patient experience by enhancing core primary care within the local "health care neighborhood," utilizing economies of scale or pooling expertise unavailable to the individual FCC.

5. **Multiple points of access**
   In traditional models of primary care the family physician has been the key entry point to accessing health care services. Funding systems and health care policies traditionally have developed that assign the role of "gatekeeper" to family physicians. Family care clinics feature the ability of the patient to access primary care directly through the most appropriate member of a primary care team, be that a doctor, a nurse, a nurse practitioner or other allied health provider.

6. **Patient attachment**
   Health outcomes and a healthy population are strongly correlated to a patients' longitudinal relationship with a family physician.[ii,iii] Attachment to a family physician is also correlated to lower systems costs and greater patient satisfaction.[7] Ensuring each Canadian and each Albertan has his/her own family physician is a stated goal of a number of key stakeholder organizations, including the Canadian Medical Association, the Alberta Medical Association and Alberta Health Services.

[7] Forrest and Starfield (1996) found that care episodes that begin with a visit to an individual's family doctor had a 50% reduction in ambulatory episode-of-care costs.
Menec and colleagues found that greater continuity of care with a family physician was associated with reduced ambulatory care-sensitive hospitalizations. (Menec et al. 2006:196)
Ionescu-Ittu and colleagues found that, after age, gender and co-morbidity adjustment, increased rate of emergency department use was associated with a lack of a primary physician. (Ionescu-Ittu et al 2007; 1362)
The 2009 study in British Columbia on higher-care-needs patients with diabetes and congestive heart failure found that a 1% increase in attachment to practice is associated with an average decrease in the total cost of care of $80-$323. This represented a cost decrease of 50% to 55%, factoring in hospital, specialist and pharmaceutical costs. In fact, patient attachment was significantly more highly inversely correlated to cost than the correlation to patient age. (Hollander, Kadlec, Hamdi and Tessaro 2009)
Ipsos-Reid polls conducted for the Canadian Medical Association (CMA) have shown that Canadians with a family physician were more satisfied with all other aspects of health care in Canada than those without a family doctor.
A CMA survey, Decima Research, as well as the experience in Ontario, found that patient acceptance of interdisciplinary team care is predicated by their family physician remaining their main provider and coordinator of care. This same research illustrated the importance of a strong patient-physician long-term relationship has in terms of greater patient engagement. Patients were more likely to adhere to agreed-upon treatment plans and recovered more quickly. In addition, they chose less testing and fewer specialist referrals.

The importance of the local family doctor's office is also reflected in Alberta's 5-Year Health Action Plan[8] that includes the goals of better connecting Albertans to family doctors and other health care providers and providing that care locally in doctors' offices. Perhaps most importantly, the majority of Albertans are concerned about having a family doctor and being able to see that doctor quickly when required.

The designation of a most responsible provider is important in the care of the patient and to the primary care team for clinical accountability and patient advocacy. There is significant good evidence internationally[9] that patient attachment should remain to a family doctor providing care in conjunction with the primary care team. In some instances, the most responsible provider could be a nurse practitioner where a physician is not available. This is already the case in some remote, underserviced communities.

IV. What does a family care clinic look like?

Working from the key principles identified, the FCC would have several broad characteristics.

1. **Builds on existing community-based family practices**
   To ensure FCCs are not a passing fad or a mere pilot project, but instead truly transform the delivery of primary care in Alberta the concept needs to be implemented in a practical and sustainable way to have widespread impact.

   The vision is that FCCs leverage existing community-based family practice clinics, where patients currently receive the vast majority of their primary care, by their ability to provide primary care through collaborative multidisciplinary teams co-located in those family practices. While physician-owned-and-operated clinics provide the majority of primary care delivered in Alberta today, the concept of the FCC need not exclude other business models or delivery venues (e.g., AHS-operated health centers, PCN-operated clinics, academic practices, etc.).[10]

2. **Interdisciplinary primary care teams**
   The configuration of health professionals may vary based on the needs of the patient population of a given FCC. Each member of the primary care team would work to their full scope of practice to provide appropriate care for their patients, be they nurse practitioners, registered nurses, licensed practical nurses, pharmacists, behavioral health consultants, social workers, dieticians, physicians or other allied health professionals.

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[8] *Becoming the Best – Alberta's 5-Year Health Action Plan 2010–2015* developed by Alberta Health and Alberta Health Services.

[9] Starfield B, Shi L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics.* 2004; 113 (Supplement 4):1493-1498.

[10] In communities where there are no, or limited, primary care services through family physician practices, AHS-operated FCCs could help meet the needs of an underserviced population. Also, there are many academic practices affiliated with our medical faculties that would benefit from the additional resources of FCC funding.

Members of the interdisciplinary team would ideally be co-located in the FCC or located as a shared resource off-site through local PCNs. Co-location does not simply refer to physical proximity as "neighbors." It requires instead that they truly operate as a unified system with continuous and ongoing interaction, consultation and collaboration. The patient is always their focus.

3. **Coordinated and collaborative team care**
   Not only does the primary care team encompass multiple health disciplines, but the team members work in a highly collaborative and participative team environment. Each discipline has clear roles and responsibilities and contributes their unique skills and expertise. Additionally, each member of the team is well informed of the activities of other team members and hand-offs occur in a manner that is seamless to the patient.

   While administrative team leadership may be provided by a team member from any of a number of disciplines, clinical leadership would continue to be provided by a family physician who, as team "coach," remains the most responsible provider with the broadest scope of clinical practice.

4. **Multiple points of access for the patient**
   Patients may initiate contact with any member of the primary care team, or vice versa, within established guidelines of clinical expertise and appropriateness of the encounter. Services are not provided in a fragmented way to the exclusion of other team members; rather the entire team shares information to provide the best possible care for the patient. With every member of the team understanding the role of every other member, the patient is directed to the right provider at the right time without the barrier of a "gatekeeper." Patients will still require a way-finding/routing mechanism to help them determine who can best meet their needs.

5. **Seamless flow of information**
   Appropriate patient information and interdisciplinary communication is supported by team collaboration and co-location where possible, and a single-shared electronic medical record with multiple layers of security to ensure privacy. Regardless of where team members are physically located, robust communication strategies are required to ensure all team members operate with the most current and complete patient information. Further, patient privacy and custodial responsibilities are clearly delineated through information-sharing agreements ensuring compliance with the *Health Information Act* and professional standards of practice.

   New communication conduits are available to allow for two-way direct interaction between the patient and the primary care team. These may include phone, electronic communication, patient portals and patient access to their own medical record.

6. **Integrated with other parts of the health system**
   While the majority of primary care is delivered in FCCs in the local community, they will not operate as unconnected entities. FCCs will function in the context of, and in coordination with, the entire local primary care delivery system which includes other FCCs, NPs, PCNs, other primary care providers and AHS programs and services (including local acute care infrastructure). (See diagram in Appendix B, page 20.)

   The local PCN provides access to pooled resources and services in the primary care neighborhood, meeting specific needs of a patient population or local primary care community that cannot be practically delivered by each individual FCC in an efficient manner. In some communities without sufficient (or any) physicians or nurse practitioners available to provide essential primary care, PCNs may serve to link those high-need communities with primary health care resources outside of the immediate area.

   Alberta Health Services continues to provide programs and services across a wider geographic area within zones and provincially, including connections to the broader health system; secondary and tertiary care hospitals, continuing care, public and population health, etc.

7. **Locally governed and responsive to each unique community**
   The development of PCNs has allowed AHS zones and primary care physicians to form better working relationships and offered a new mechanism to dialogue, engage in joint problem solving and planning at a grassroots level in the context of the unique needs and realities of each community. This governance model (Model 1) through the joint venture structure between local not-for-profit corporations and AHS can be capitalized upon to ensure the accountability and value of the investment in community FCCs.

8. **Measurement and evaluation**
   A comprehensive evaluation strategy ensures efficacy and value for money of the investment made in FCCs. These strategies need to be robust and evidence-based, balance short-term and longer-term impacts and reflect both the micro- and macro-impact of FCCs.

V. Key outcomes of family care clinics

A thoughtful evaluation strategy is required to measure the successful implementation of FCCs and their ability to deliver both long-term and short-term benefits to the citizens of Alberta, including:

1. **Timely access to primary care**
   Increased access is achieved on a number of levels:

   - Increased capacity of family physicians, supported by a team, to interact with patients for both acute and chronic primary care needs.

- Direct access to non-physician members of the expanded primary care team.
- Increased access through local PCNs to additional specialized or intensive shared primary care services and supplemental allied health professionals already in place (e.g., chronic pain clinics, mental health navigators, geriatric assessment teams, etc.).
- Virtual linkages created through local PCNs that leverage and connect multiple FCCs to meet the specific needs of each community (e.g., on-call availability, after-hours clinics, linkages with HealthLink, etc.).
- Enabling better access and care of patients with a fortified primary care team addresses some of the root causes of inappropriate emergency department (ED) visits that result in increased ED wait times. Team-based care also decreases the number of patients seeking after-hours care.
- Care is delivered as close as possible to the patient at the right time by the right provider.

2. **Every Albertan attached to a family doctor**
   Through the support of the collaborative multidisciplinary care team, physicians would be able to accept new patients who currently do not have a family physician but wish to have one.

3. **Comprehensive cradle-to-grave care**
   In addition, a team approach refocuses care in family physician practices from primarily "illness care" to promoting healthy lifestyles, disease prevention and screening. The collaborative multidisciplinary team provides patients with the appropriate lifelong support to better manage their chronic diseases and to maintain and improve their overall health status.

4. **Value for the health system**
   Taxpayers, government, AHS and physicians share the desire to achieve real value for health care dollars spent. Creating value and being cost-effective in primary care models includes decreasing costs by increasing continuity of care, improving coordination of care, avoiding service duplication,[iv] emphasizing health promotion, and proactively identifying and managing risk factors for chronic diseases.

   The value extends to increasing the capacity of primary care physicians and nurse practitioners to see and manage patients with undifferentiated illness that otherwise result in emergency department visits and hospital admissions. These events increase costs to the system and decrease access for those who truly require emergency treatment or hospitalization.

VI. What is the status quo?

The seeds of FCCs have already been planted in Alberta. The success and benefits of a multidisciplinary team approach to primary care have already been demonstrated in many family practice clinics, supported by PCN funding, across the province.

1. **Primary care networks**
   PCNs continue to strive to improve service coordination, reduce duplication, coordinate information sharing, and break down traditional silos in health by addressing their communities' most pressing primary care gaps. PCNs represent the most significant shift in thinking in our health system and certainly in primary care of the last decade or more. Programs and services provided by PCN funding are varied, including after-hours clinics, complex-care clinics, shared mom-care within the "medical neighborhood' and the utilization of patient navigators and nursing staff within family practices, the "medical home."

2. **Allied health professionals in existing family practices**
   Investment has been made over the last six years through the introduction of PCN funding, laying the foundation for collaborative care in the community family practice clinics.

   Since 2005, allied health professionals, funded through PCNs, have provided collaborative primary health care to patients both in physician-owned-and-operated family practices and in PCN-operated centralized models.[11] Integrated primary care teams are also in place in a number of academic sites and AHS-operated health centers funded through other mechanisms, particularly in remote or severely underserved communities.

3. **Funding limitation for teams**
   Despite the many successes of team-based primary care in improving access and the patient experience in Alberta today, the full potential has not yet been realized.

   Current PCN funding, which has increased only $12 per patient (inflationary costs only) since 2005, limits the ability to hire more nurses, pharmacists, dieticians, etc., to increase access for both acute and chronic primary care needs. The current funding through PCNs for teams in family practices supports a ratio of 0.25-0.50 registered-nurse-equivalent positions per physician. In other health jurisdictions where interdisciplinary care is supported and practiced, the ratio ranges from 1.0-3.0 nurse positions per physician.

4. **Infrastructure-related restrictions on building teams**
   Further, budget and physical infrastructure limitations have driven many PCNs to adopt centralized models by creating virtual teams or centralized programming instead of placing allied health professionals directly in family practices. However, the ideal is for primary care teams to be co-located to allow for robust and highly effective teams, promoting direct communication and collaboration, and to provide a "one-stop shopping" experience that is truly patient-centered.

[11] Almost 600 FTE allied health professionals are employed in PCN-affiliated family practices, PCN programs and hundreds more remain employed by AHS but work integrally with the PCNs.

Some PCNs have tried to do both, placing nurses and other allied health professionals in clinics while also trying to deliver other needed centralized programs, but find it difficult to adequately resource either.

5. **Existing family practice infrastructure**
   The vast majority of primary care is currently delivered in physician-owned-and-operated family practice clinics. This represents a private investment of several hundreds of millions of dollars in physical infrastructure, and significant business operating costs. The development of FCCs can leverage this massive investment by using any and all suitable existing infrastructure of these community-based family practices.

   The most cost-effective approach to achieve this vision for better health care delivery is to build on what is already in place and to avoid fracturing care by developing new, stand-alone entities disconnected from family practices, AHS, and PCNs.

VII. What will it take to realize the full potential?

There are five critical components that need to be put in place to realize the full potential of the FCC concept for Albertans and to promote the spread of collaborative team-based primary care.

1. **New funding options for AHP participation in collaborative team models**
   Current funding runs counter to the objective of efficient team-based care as it requires that allied health professionals be funded primarily through physician fee-for-service billings along with all the other expenses of running a business. Currently, typical family practice clinic overhead is generally in excess of 40% of gross billings.

   Further, the "whites-of-the-eyes" rule requiring a physician-patient face-to-face visit discourages allied health professionals practicing to full scope of practice and impedes efficient team care since no revenue (e.g., billings) are generated unless the patient is also seen by the physician.[12] This business model dictates that the physician must see each patient in order to remain financially viable as a privately owned practice. This also further hampers other efficient means of communication between the patient and primary care team, which could include telephone or electronic interaction.

   New, innovative funding options, such as incentives for provision of after-hours care, will need to be in place to allow for the expansion and spread of collaborative interdisciplinary team care in Alberta. These funding options need to be long-term to give all members of the primary care teams some assurance of stability and ongoing viability. Currently, the uncertainty of funding is a significant barrier to recruiting qualified allied health professionals.

[12] These funding barriers to full scope of practice and efficient collaborative care is also cited in the vision paper developed by the College & Association of Registered Nurses of Alberta (CARNA). See source in footnote 13.

2. **Capital investment to create spaces for teams**
   Many existing physician clinics were not designed with larger teams in mind and limited space makes the co-location of other professionals impractical or impossible. Capital investment is required to expand existing clinic infrastructure or, where expansion is not feasible, to build new infrastructure. A substantial savings to Alberta taxpayers is achieved by using all suitable physical infrastructure currently in use, rather than building all new FCCs across the province.

3. **Investment in training and team development**
   While there are many highly skilled nurses, pharmacists, and other providers, they are not easily transplantable from other parts of the acute care health system to primary care clinics. Similar to family physicians, allied health professionals need to have a broad skill set and training specific to primary care. Family physicians and PCNs have made a considerable investment in the education and training of professional staff and this investment will need to continue as teams expand throughout the province.

   Creating a high-functioning team requires more than co-locating professionals. Family practice clinics and PCNs have learned that reframing and "out of box thinking" is required to enable a group of professionals to truly work as a team for patients that have complex and unique requirements. This includes development of interactive team care protocols and change management to build high-functioning teams. It also requires provider education on the respective scopes of practice of various team members.

4. **Engagement of front-line allied health professionals and physicians**
   The physicians and allied health professionals who will be working in FCCs need to be engaged in the planning and implementation in order for FCCs to be successful and to have widespread impact. As well, the medical, nursing, and pharmacy professions, among others, will need to examine their training strategies to ensure primary-care qualified professionals are available to fill these new or expanded roles in FCCs.

5. **Engagement of patients and all Albertans**
   Evolving primary care to achieve the benefits must be accompanied by engagement of patients and the population, in general through comprehensive communication strategies. Patients are a great untapped resource in primary care, and involving and empowering patients in maintaining and improving their own health and quality of life is critical. This includes: educating Albertans on why attachment and continuity of care are important; how and where to appropriately access care; the distinctions between episodic care and comprehensive primary care; why continuity of care is in their best interest; and in providing them with reassurance that the right care will be available from the right provider at the right time.

VIII. Readiness

Collaborative interdisciplinary team care for primary care is not a new concept. Physicians, nurse practitioners, RNs, LPNs, pharmacists, dieticians, and patients have had positive experiences in collaborative models of primary care. PCN funding presented the initial opportunity and PCNs currently welcome the opportunity to facilitate additional allied health professionals working alongside physicians. What is needed now is whole-hearted commitment, coupled with the right incentives and funding, to further expand this highly effective model of collaborative team-based care.

1. **Partnership with Alberta Health Services**
   PCNs have demonstrated the net positive result of the relationship and trust that has emerged between family physicians and AHS. This has resulted in greater collaboration that would not have occurred without the governance framework PCNs provided to engage in joint planning and problem solving. PCNs also have a local presence and have the ability to plan and consult with a representative body of physicians, AHS, other local care providers – and the communities themselves.

2. **Alignment of philosophy**
   Both the AMA and the College & Association of Registered Nurses of Alberta (CARNA) support the concept of the "family medical home" in which cradle-to-grave care is provided by an integrated interdisciplinary team. The FCC has the hallmarks of this concept heretofore constrained by traditional professional attitudes and funding systems. The experience of professionals working within and through PCNs has broken down many of those barriers, generated new understanding, and created an appetite for more meaningful engagement in that evolution.

   In a vision document developed by CARNA in January 2011, there is significant alignment on key principles of primary care delivery.[13] These principles include patient-centered care, access to interprofessional teams, coordination and case-management, evidence-based models responsive to local needs and funding mechanisms that are dedicated to team development and are designed to facilitate interprofessional care.

3. **Physician buy-in**
   Just as primary care can no longer be provided solely by physicians, neither can new models exclude the role and skill set of family physicians and their current interdisciplinary teams.

   Over a period of six years, approximately 80% of family physicians have become participants within PCNs,[14] which feature the integration of allied health providers in ways previously not envisioned in primary care. Given that the vast majority of the

[13] Primary Care: Vision, Roles and Opportunities. College & Association of Registered Nurses of Alberta, January 2011.

[14] Source: Primary Care Initiative Program Office – September 2011 Statistics, prepared by AH Primary Health Care Unit.

existing primary care delivery system is owned and operated by physicians in the traditional family practice clinic, full and meaningful engagement is essential to the success of any proposed new models of primary care.

4. **Proven governance model**
   Accountability for use of public funds invested in FCCs could leverage the existing governance and accountability structures already in place for PCNs. In PCNs, governance and oversight responsibility is enacted through a joint venture agreement between a local not-for-profit corporation of family physicians and AHS. Regardless of the exact mechanism to flow funds, this structure could continue to ensure that the investment to create FCCs from existing family practices would provide value and deliver the outcomes delineated above.

IX. Conclusion

The vision for family care clinics is one that is evolutionary. It is a vision that builds on existing traditional family practices and enhances their ability to provide comprehensive primary care through integration of interdisciplinary primary care teams. Physicians, patients and allied health providers are ready to embrace more collaborative interdisciplinary teams and those who have experienced primary care teams would like to see more robust teams in place.

What is required from government is long-term commitment, cooperation, and funding to continue to spread and build team-based primary care. PCN funding has allowed family practices to take initial steps to move to an interdisciplinary team care model. In fact, many existing practices already embody the key attributes of an FCC. However, to fully realize the benefits of collaborative care and meet the needs of patients, there needs to be appropriate funding to allow for further development and expansion of primary care teams.

Both development of the "medical home" model of primary care, also called a family care clinic, and PCNs are an essential part of evolving primary care. PCNs engage in a variety of strategies to increase patient access and improve primary care at a local level. FCCs align well as one of those strategies. Funding the co-location of team members in family practices through FCC funding will allow PCNs to focus on shared resources and broader programs and strategies that span multiple FCCs.

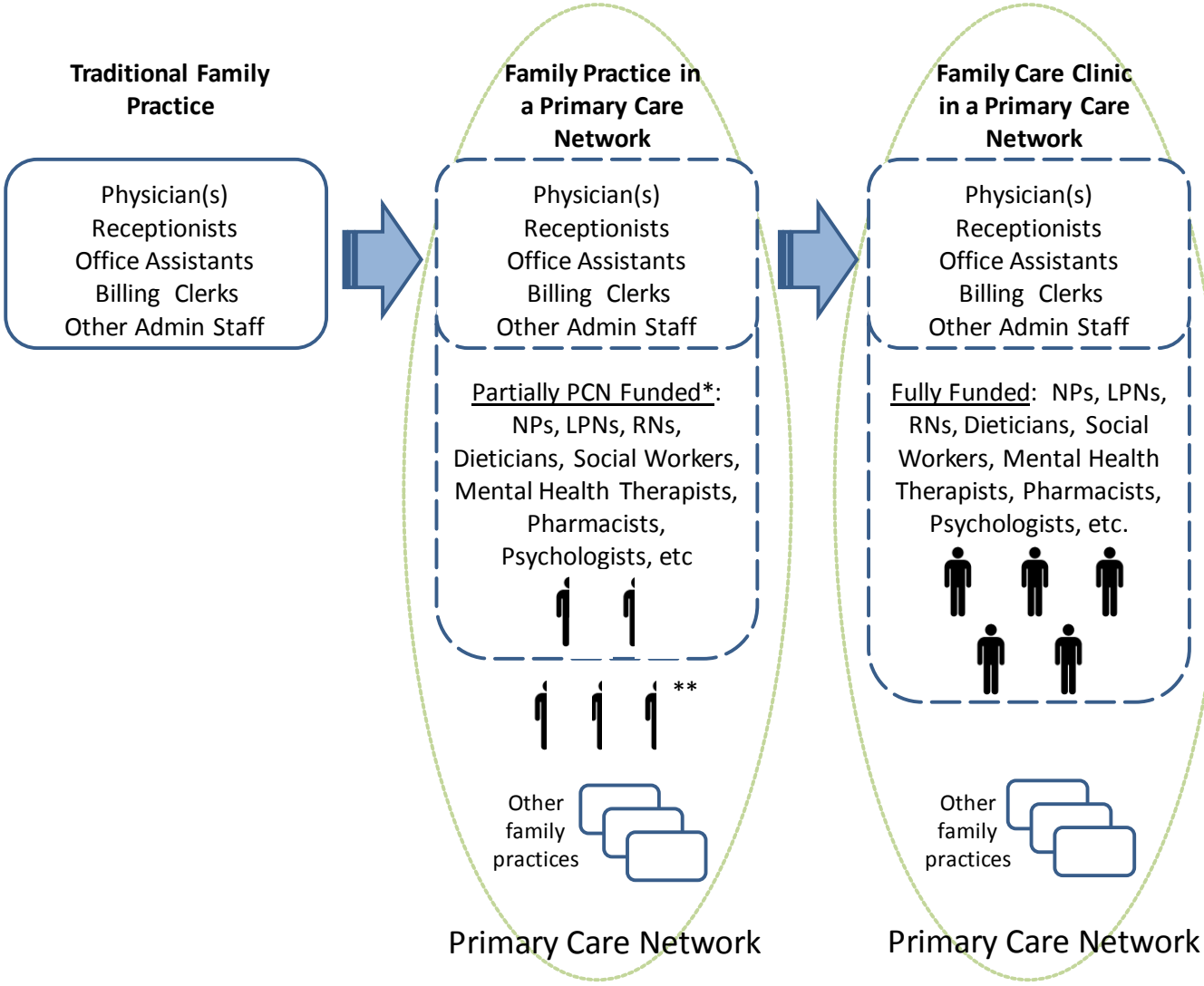
A fitting analogy might be that if the family care clinic is the "medical home" then the primary care network is the "medical neighborhood" in which the family care clinics reside.

X. Next Steps

Some of the next steps include:

- Engagement of AH, AHS, and AMA representatives to further develop the details around family care clinics.
- Vetting of the concepts of this discussion paper to a broader physician group.
- Engagement of other allied health professionals.
- Engagement of the public.

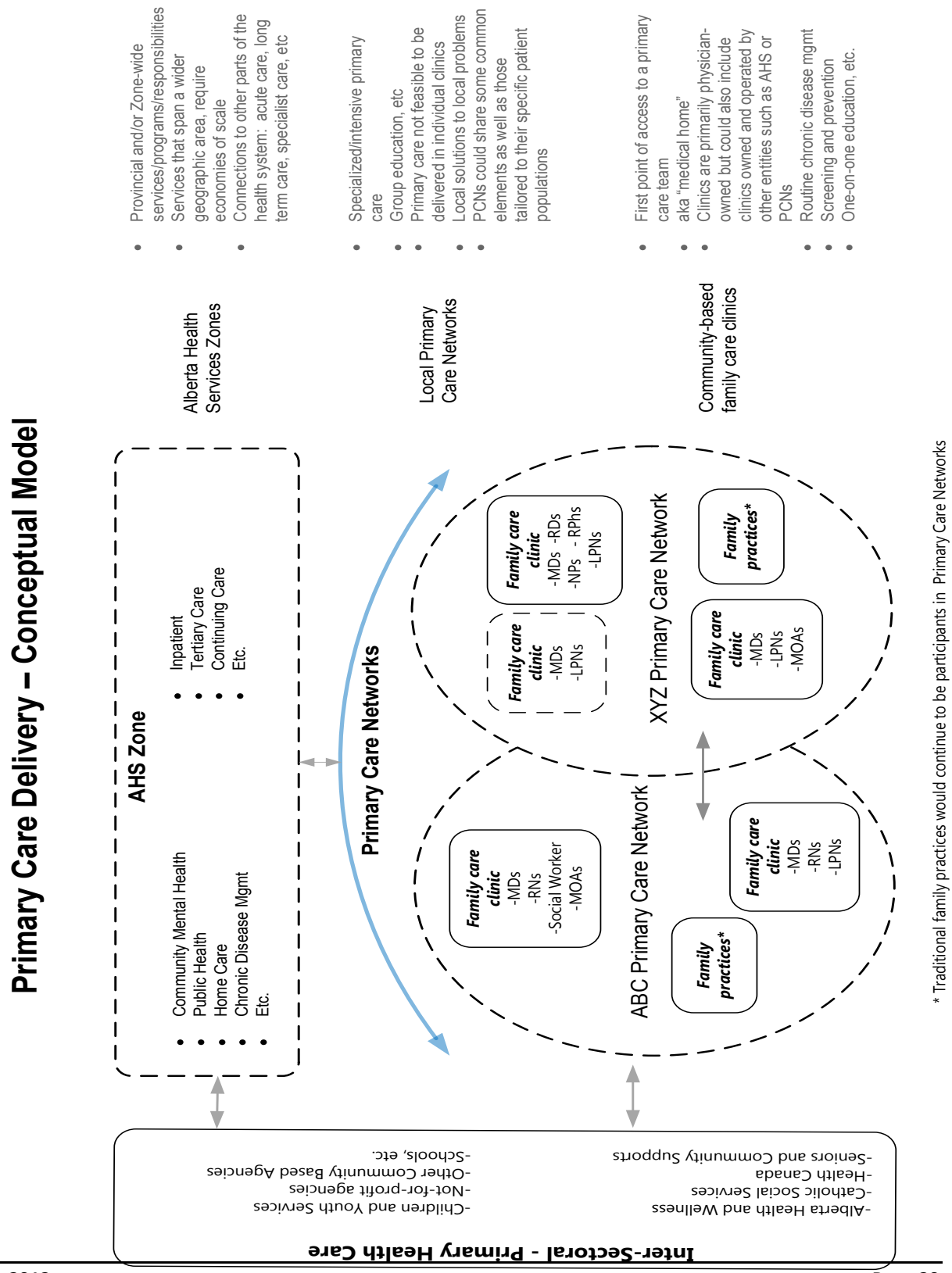
XI. APPENDIX A – Evolution of Family Practice



* Current PCN funding limits the number and breadth of Allied Health Professionals patients can access.

** Access to some services is currently only via a centralized team. In the fully evolved family care clinic model, AHPs would be co-located in the family practice clinic where feasible and warranted by volume/patient needs.

XII. APPENDIX B - Primary Care Delivery – Conceptual Model



Endnotes

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