President's Letter

April 21, 2023

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Update on Family Care Teams

Dear Colleagues:

There is a significant amount of activity on the new Family Care Teams (FCTs), and I wish to update you on the involvement of the NLMA, and in particular the development of an "affiliation agreement" template that can be used by fee-for-service (and blended capitation) practices to link up with the FCTs.

Background:

The Health Accord recommended a province-wide roll out of about 35 FCTs to cover every part of the province and every citizen. Even before the Health Accord report, the government had started to fund Collaborative Care Teams, which are now renamed FCTs. All new teams will be FCTs.

The already established teams, mainly in St. John's, have not yet integrated any community-based family practices. Instead, new salaried FP positions were created in the teams, some of which were filled by doctors from existing community-based practices.

Parallel to the new teams, the government created a new registry of unattached patients called Patient Connect NL. This registry is being used as a source of patients to be attached to FPs and NPs within the FCTs. We understand that "complexity" of the patient was initially used as a priority-setting criterion to be accepted into an FCT, but now the criterion is "first come first served".

One of the features of the new FCTs will be the addition of allied health care providers to expand the range of professions working alongside physicians in the team model. We do not have any data yet on the number of allied health providers who have been hired.

The provincial government is in the final stages of preparing a provincial policy framework for FCTs. The NLMA has reviewed and commented on this framework, but at the current time we do not know the final content.

The Provincial Health Authority (PHA) Role:

The PHA, now known as Newfoundland and Labrador Health Services, has the responsibility for implementing the FCT strategy and will hire the necessary administrative and health professional staff, other than the personnel in FFS and Blended Capitation practices. There may also be other private health care providers, such as pharmacists and physiotherapists, who affiliate with the teams, but we do not know the PHA's specific plans in this regard.

The PHA will hire an FCT manager for each team, provide administrative support for team operations, and will be the employer of the salaried health professionals. Therefore, it will be the PHA, as represented by regional and local officials, who will partner with community-based physician practices, to round out the full FCT.

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The NLMA does not have any information on how the PHA intends to house its new team employees in each region, whether in existing PHA facilities, new accommodations, arrangements with community-based family practices. Family practices are not required to be co-located with PHA staff, and in general will continue in their own existing offices. However, we expect opportunities will arise within each team to discuss the best ways to encourage team-based collaboration.

To date, the PHA and the Family Practice Networks (FPNs), through their joint Collaborative Services Committees (CSCs), have held reasonably detailed discussions about how FCTs within specific regions can collaborate. The FPNs have done an excellent job bringing physician perspectives to the table.

The Potential benefits of FCTs:

The NLMA believes that the benefits for patients will be an incentive for family practices to join FCTs and build genuine partnerships within these teams. Participation in an FCT should enable the patient medical home to become realized in our province. An FCT should provide timely, comprehensive and coordinated care.

When participating in an FCT, a physician should be able to get what they need for patients quickly and conveniently from the array of services provided within the team. Optimal patient care should be available with the support of teams, allied health care providers, and PHA services for vulnerable and complex patients.

FCT Governance and Affiliation Agreements:

The NLMA has focused most of its energy on the establishment of an “affiliation agreement” template that can be used by family practices throughout the province when they decide to join an FCT. The affiliation of family practices with the rest of the FCT will finally enable the hundreds of thousands of patients that are attached to these practices to enjoy the benefits of team-based care.

As the affiliation process begins, physicians will have the opportunity to be involved in governance and have meaningful influence in how the team partnerships operate. While the affiliation agreement template is not yet finished, below are the goals being pursued by the NLMA. Note that these are mainly governance and framework issues. The teams themselves, with physician participation, will decide how to improve services for patients on the ground.

1. **Voluntary Entry and Exit** – practices cannot be compelled to affiliate with an FCT, and once affiliated they may exit the arrangement as well.

2. **Governance** – to ensure a meaningful role for community-based practices in the governance committee of each FCT, where consensus decisions are made about priorities, projects and processes for serving the needs of all patients.

3. **Management and Administrative support for the Team** – to recognize the role of the PHA in providing this support for the functioning of the team [note this does not include management or administrative support for family practices, which will continue to operate as separate enterprises.

4. **Budget** – while the budget for each team will ultimately be a decision of the PHA, the family practices through the governance committee will have input on budget submissions.

5. **Expenses** – ensure that any affiliated family practice that decides to participate in a team project or process, and which incurs related expenses, will be reimbursed for these expenses, including where appropriate for professional time.

6. **Projects and Initiatives** – the types of joint projects and initiatives within teams is for the governance committee to decide, but could include such topics as referrals of patients to allied health providers, rotation of allied health providers to family practice sites, new services that target special populations or services, data sharing to better understand the needs of the whole region and the individual practices, quality improvement and change management initiatives across the whole team, etc.

7. **FPN Role** – recognize the role of the FPNs, in collaboration with the PHA through the CSC, in the development of projects and initiatives that will support family physician integration into these teams within a region.

8. **Practice Representatives** – to ensure that communication between the team and each practice flows through designated practice representatives, and that all health professionals and employees of practices will be included in the general communications regarding team priorities and projects.

9. **Rostering** – to ensure that all patients in affiliated practices must be rostered (which is already a requirement for blended capitation practices but will be new for FFS practices). It is important for the affiliation process to work, so that each patient of a family physician will be entitled to the broader services within an FCT, and this is signaled through rostering. The governance committees will examine the most efficient means for practices to roster their patients.

10. **Autonomy and Partnership** – while family practices will be encouraged to collaborate in joint projects and services within FCTs, to improve access and quality, the FCTs will not control the family practices. Community-based physicians will continue to have autonomy over their number of patients, hours of practice, types of services provided, how they use virtual care, and whether they employ or contract directly with other health care providers, etc. Over time, the partnerships that develop within teams may bring about changes in the way physicians practice, but it will be done through partnership and consensus.

Future Opportunity:

While we are at the very beginning of this change in primary care, FCTs offer a major opportunity. With genuine partnership between the PHA and family physicians, an enormous amount can be accomplished. Of course, the FCTs are not the solution to the access problems in our system unless we recruit more family doctors. This must remain an overriding preoccupation. Team-based care is primarily a quality initiative, and can support improved access, but it will not succeed without parallel success in recruitment and retention.

As always, we would appreciate feedback on the ideas in this letter. Please write to me at president@nlma.nl.ca

Sincerely,

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