NL Health Services

[INSERT DATE]

Re: Offer to Join Family Care Team as an Affiliated Practice

Dear Dr. [INSERT PHYSICAN NAME],

Thank you for your expressed interest in participating in the Family Care Team/FCT model. NL Health Services offers your clinic the opportunity to join the [INSERT GEOGRAPHIC NAME] Family Care Team as an Affiliated Practice/AP on the terms outlined in this letter.

Affiliated Practices offer a valuable contribution to the new FCT model, which is intended to improve access and continuity of primary health care for individuals and families in their community through use of an inter-disciplinary team-based approach providing streamlined access to multiple health care professionals that focus on meeting the health and social needs of individuals and families in Newfoundland and Labrador.

Affiliated Practices participate in Family Care Teams in accordance with 1) the Department of Health and Community Services policy *Family Care Teams: A Health Policy Framework for Newfoundland and Labrador* (the Framework) and 2) the enclosed "Affiliating with Family Care Teams NL: Governance and Policies Guide for Affiliating Community Practices" developed collaboratively among the Department, NL Health Services and the Newfoundland and Labrador Medical Association.

The Affiliated Practice is responsible for the delivery and administration of primary care services to its patients in collaboration with other team members. As an FCT member, the Affiliated Practice will participate in the FCT in accordance with the Framework and Guide and commits to:

- Maintain membership in the Family Practice Network within their Zone, where an FPN exists;
- Work with NL Health Services, within a Family Care Team, toward the shared goals of increasing access to quality primary care, and a team-based approach to the provision of primary care;
- Affiliated Practice family physicians will register with and use Patient Connect NL as one source of new patients for their roster;
- If the Affiliated Practice does not currently use the Provincial EMR, the Affiliated Practice agrees to implement use of the Provincial EMR within twelve months of the date of signing this Agreement; and,
- Participate in the formal provincial evaluation of Family Care Teams.

The Family Care Team will operate in accordance with the FCT Framework and Guide, and commits to:

- Implement a Family Care Team Leadership Committee, which has a shared leadership and governance model that includes representatives from Affiliated Practices;
- Provide patients of the AP with access to an enhanced team of health professionals. The Family Care Team Leadership Committee will develop care pathways and processes with APs that are clinically effective and efficient;
- Support APs with quality and practice improvement support provided by NL Health Services; and,

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- Provide remuneration for designated planning and administrative time consistent with Family Practice Renewal Program honoraria policy.

If you are interested to join the above-referenced Family Care Team, please have each family physician member of the clinic print and sign their name as indicated in Annex A and send to [INSERT NLHS EMAIL] to confirm and complete registration as an Affiliated Practice. In the event of any family physicians leaving the Affiliated Practice or new family physicians joining the Affiliate Practice please use the forms at Annexes B and C respectively.

Yours Truly,

(INSERT FCT MANAGER NAME)

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ANNEX A

Date:
Clinic Name:

By signing, each physician, on their own behalf and on behalf of _____[CLINIC NAME] acknowledges they have read, understood and agree to fulfill their individual and collective responsibilities as members of an Affiliated Practice participating in a Family Care Team in accordance with the above Letter of Offer.

_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature
_____	_____
Physician Name	Signature

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ANNEX B

NOTICE OF DEPARTURE FROM AFFILIATED PRACTICE

I write to advise that as of _____ [DATE] I am no longer a member of _____ [CLINIC NAME] which is an Affiliate Practice member of _____ Family Care Team.

_____
Signature

_____
Physician Name

_____
Date

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ANNEX C

AFFILIATED PRACTICE NEW MEMBER ACKNOWLEDGMENT

By my signature, I acknowledge that I have read, understand and agree to fulfill my responsibilities as a member of the Affiliated Practice under the attached Letter of Offer signed by the _____ (Clinic Name).

_____
Signature

_____
Physician Name

_____
Date