Primary Health Care in Alberta

Our Changing Society
Alberta is changing and so are our health issues. We’re living longer. Our population is more diverse and we come from all parts of the globe, bringing our unique health characteristics with us. We live more sedentary lives and while our standard of living is high, close to ten percent of us still live below the poverty line.

All this and more affects our health and impacts our health and social systems. Our health issues are complex and rooted in our lifestyles. More and more care is at the community level; about 80% of Albertans over 45 have at least one chronic condition that is largely self-managed with support from local health providers and services in the community. One in five of us will experience a mental illness in our lifetime, and the rest of us will be affected by mental illness experienced by a friend, family member or colleague. In fact, the business of health care has largely become the business of managing chronic disease, such as type two diabetes, cardiovascular disease and cancer.

The upshot is that this generation of Canadian children are expected to have a lower life expectancy than the generation before them. This is a sad commentary about Canada – despite a health system we are justifiably proud of, we have failed to achieve the improved health outcomes that we expect ourselves to be able to achieve.

We need to do more, try more, learn more and achieve more if we’re going to reverse this trend and improve our health outcomes. The foundation for these better health outcomes lies within primary health care.

Defining Primary Health Care
When we talk about primary health care, we are talking about an approach that acknowledges all the services that play a part in health status. Primary health care goes beyond caring for people when they’re sick. It builds in prevention and screening. It recognizes that sometimes the prescription people need is a link between their children’s needs in the school system with the services their health care providers can offer. It means bringing together the health services needed by the elderly with supports like community day programs to help prevent the isolation that can lead to illness; sometimes people need friends, not medication, to lead healthier and happier lives.

Primary care emphasizes medical care and treating people. Primary health care is about all the services that contribute to health. In Alberta, we want primary health care to include links and alliances with schools, housing, parenting programs and other social support programs. We want primary health care to focus attention on screening and prevention. We want primary health care to include wellness and fitness initiatives. That’s because our success in health care is largely determined by what people do in other areas of their lives, including their lifestyles, housing, or treatment for addictions and mental health. Integrating these services and approaches into our thinking and the practice of primary health care are key to our future success. We also need primary health care to be better integrated with the acute care and specialist services that people need, so that all aspects of our health system are integrated and people are supported in their care journeys.
Primary health care also includes health promotion; illness, injury and disease prevention; and, diagnosis, treatment and management of chronic disease. In Alberta, primary health care will give Albertans a home in the health care system. A home in the health care system could be a PCN, FCC or physician’s office. It is a place where you regularly go to receive basic care, and where the providers know you and your health needs. Just as importantly, primary health care will create linkages with the other building blocks of a healthier society: continuing care, home care, early childhood development, mental health, social services, education, public health and acute care.

**The Goal for Primary Health Care in Alberta**

Our goal is to create a primary health care system that provides seamless support and quality health services for individuals and families and reaches beyond the health system into the community to work with all the resources necessary to create a healthier Alberta. This will require using all the resources we have within primary health care, making better connections with other health services and social supports, and better supporting Albertans in leading healthier and happier lives.

We want to move from a system where people have difficulty accessing essential primary health care to a system where people can access a member of their primary health care team the same day when required, and not have to visit the emergency department. We want a system where people know that their needs are being coordinated by their health care team and that their health history is available to all the providers they access without having to repeat tests and tell their story over and over.

**The Way Forward**

The way forward for primary health care includes work on many aspects of the health care system, including the ways that primary health care is organized, clear standards for primary health care, new ways of evaluating initiatives so we can keep on doing better, and coming up with improvements to the ways that our health workforce is educated and compensated. It includes establishing Family Care Clinics (FCCs) as another way to increase our ability to reach Albertans and give everyone a home in the health system. In these early stages, this means an emphasis on areas which are un-served or underserved, but not to the point of excluding others, including Primary Care Networks (PCNs), that may want to explore the FCC model for their populations.

The way forward also includes continuing and enhancing the role played by PCNs. PCNs will remain an important part of our primary health care system. We know some will find that their operations closely mirror those of FCCs and may decide to evolve into an FCC structure. Others may become enhanced PCNs that meet the new standards and guidelines that FCCs will have to meet, but differ in terms of governance or other characteristics.

We also want to take the leading and innovative work being done in various PCNs and spread these good practices to other areas, including work being done to identify groups of patients with similar needs and providing them with targeted interventions. Throughout the health system, this means building linkages to services that support early childhood development, mental health and other issues such as homelessness; and reaching underserved populations.

We also have the opportunity within primary health care to ensure better integration with specialist services, so people don’t have to wait as long to see someone. Other initiatives that are currently underway will focus on providing people with more assistance in coordinating their family’s care. Work is going to be done to further develop strategic clinical networks, which are province-wide teams bringing together the experiences
and expertise of health care professionals, researchers, government, communities and patients and their families to improve our health care system.

All of these initiatives will be supported with new ways of measuring and evaluating the progress being made to improve the health of Albertans.

Throughout this process, we will be working to ensure that work in primary health care is coordinated with related Government of Alberta initiatives, including:

- The Social Policy Framework;
- Creating Connections: Alberta’s Mental Health and Addiction Strategy;
- The Alberta Cancer Plan;
- The Maternal-Infant Health Strategy
- Early Childhood Development Initiatives; and
- The Alberta Tobacco Reduction Strategy.

A Closer Look at Family Care Clinics

FCCs are one part of improvements that will help transform Alberta’s primary health care system. FCCs are local team-based primary health care delivery organizations that provide individual and family-focused primary health care services aligned with the needs of their community. Team-based care means that the providers in a FCC will work closely together and will build on each other’s skills to meet the needs of the populations they serve.

FCCs share characteristics with many PCNs. However, FCCs will be different from PCNs in how they are created and how they are governed. PCNs are physician-organized and physician-led business structures. FCCs will be planned by communities working with health and other service providers. While each will involve physicians and/or nurse practitioners affiliated with a physician, along with other service providers, FCCs will be run by not-for-profit organizations whose boards will include community representation, or by Alberta Health Services.

FCCs will also differ in the breadth of services that they are able to provide - services which not all PCNs have incorporated within their operations. FCCs have a mandate to go beyond the typical services of diagnosis of health conditions, treatment, and referrals to specialists and for lab tests and X-rays. FCCs will have a renewed and resourced emphasis on wellness, self-management, patient education, addiction and mental health treatment, chronic disease prevention and management, and injury prevention.

FCCs will serve Albertans, including those under-served, those without a family physician and those with high needs. FCCs will be part of their community and will establish linkages and partnerships with food banks, housing services, community recreation centres, community development agencies, social workers with offices nearby or in a clinic, and could have nursing/medical/social work students assist in clinics.

Physicians, nurse practitioners, pharmacists, physiotherapists and other health professionals will all have a place in the FCC. Albertans will be attached to this team of providers and supports in an ongoing relationship and will be able to work with the FCC to decide who it is they need to see for a particular concern, accessing them directly where it makes sense.
Our Journey

Improving primary health care in Alberta and becoming a healthier society isn’t about one thing. It’s going to take work on ways of delivering primary health care, improvements to the way we educate and draw on the resources of health providers, and finding better ways of measuring and evaluating what is being done. Advancing primary health care isn’t a linear, step by step process - changes are going to be occurring all over the primary health care system, but at the end of the day, it’s all about improving access and care for Albertans.
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GUIDE AND REFERENCE MANUAL FOR FAMILY CARE CLINICS
SECTION 1:
INTRODUCTION
1.0 INTRODUCTION

1.1 Background

Providing an accessible primary health care system and giving Albertans the tools and guidance they need to take charge of their health has increasingly been recognized as a high priority for Albertans. One of the priority focus areas for the Government of Alberta is that all Albertans should be attached to a primary health care team, allowing them faster access to a defined set of services that meet their needs. The development of Family Care Clinics (FCCs) will provide another important primary health care service delivery vehicle to address these priorities. FCCs are designed to encourage Albertans to take increased ownership for their health, enhance access to related community supports, and to improve the health outcomes for both individuals and communities.

Over the past decade, Primary Care Networks (PCNs) have emerged as the predominant model of primary care delivery in Alberta, bringing together teams of health professionals to meet the needs of citizens. FCCs build on the strengths of PCNs – they are both complementary and supportive. They are local team-based primary health care delivery organizations that provide individual and family-focused primary health care services aligned with the needs of their community.

FCCs are a key part of the Government of Alberta’s goal for every Albertan to have a home in the health system. In an FCC, individuals will receive their primary health care from a team, which may include physicians, nurse practitioners, registered nurses and licensed practical nurses, dietitians, pharmacists, mental health providers, social workers and others as appropriate. It will be possible to book an appointment directly with the most appropriate FCC Service Provider. The FCC team will also play an important role in client navigation and case management, ensuring clients are looked after when needing to see a specialist, enter a hospital, or require home care or residential continuing care.

FCCs focus on delivering excellence in primary health care. Complementary to and supportive of PCNs, FCCs are transformative in a number of ways:

- **Access is improved:** With FCCs, the door to the health system is open wider and stays open longer. All FCCs will – at a minimum – provide a standard set of services reducing the need for clients to go to several locations and through multiple systems. FCCs will provide direct access to the most appropriate provider, with extended hours and same day access.

- **Health care services are integrated and coordinated:** All FCCs will have collaborative interdisciplinary teams and will work in an environment that is focused on the client. FCCs will provide comprehensive quality primary health care services either directly or in partnership with other service providers and will help clients navigate the system to ensure they get the services they need at the right time from the right service provider at the right location.
• **The community is engaged:** The FCC will make efforts to link with other service providers already present in the community. The FCC’s vision includes enabling access to other health care services, as well as community social services and supports that influence health and well-being.

• **Wellness is promoted:** The emphasis on wellness is an integral part of FCC culture. Increasing focus on wellness is critical to preventing illness and injuries before they negatively impact the health of Albertans.

• **Citizens manage their own health:** Better health outcomes start with individual awareness of healthy living habits, disease and injury prevention, and citizens doing their part to promote well-being. FCCs seek to broaden and deepen efforts to reach more individuals and families to develop self-management strategies and care plans to promote healthy living and improve health.

• **Better information, better decisions:** FCCs will take advantage of technology to collect, store and access medical information in a standardized, timely and accurate way. Better information and public awareness will lead to better decision making and improved health outcomes.

• **Monitor quality and achieve positive outcomes:** FCCs will utilize performance data, evidence-informed guidelines and standardized accountability mechanisms to report on results and inform improvement.

### 1.2 Family Care Clinic Service Delivery Framework

The proposed FCC Service Delivery Framework is depicted in the graphic on the following page. The Framework positions individuals and families as the central focus of the primary health care system and the FCC.

A collaborative, interdisciplinary FCC team works in partnership with clients, other health care service providers and community social support agencies to deliver comprehensive primary health care services. These comprehensive primary health care services are represented by the blue arrows on the framework diagram.

The ongoing screening, diagnosis, treatment, follow up, self-management, education, prevention and promotion cycle that supports effective primary health care delivery is represented by the green arrows in the diagram.

FCCs must operate as part of a coordinated and integrated service delivery system with strong linkages to the full range of health services provided by Alberta Health Services (AHS), PCNs and other health services organizations. These are represented on the far right of the graphic.

FCCs also require strong linkages with other government ministries and community social service agencies that provide services that significantly impact the determinants of health. These are referenced on the left of the graphic. The FCC Collaborative Team plays a major role in assisting clients to access the services they need, from the most appropriate service provider, at the right location and time.
1.3 Overview of the Guide and Reference Manual for Family Care Clinics

This Guide and Reference Manual has been developed to assist organizations, individuals, and communities who are interested in developing an FCC. This is an ambitious and transformational initiative and this Guide and Reference Manual is intended to assist all applicants in their preparation of an FCC application, as well as the establishment and operation of their clinic.

Every attempt has been made to include all the information you will need, or direct you to an easily available source. Below are some important things you need to know about the way this Guide and Reference Manual is organized.

- **Section 1** provides a brief introduction and information on the organization of the Guide and Reference Manual.

- **Section 2** provides a description of the FCC program, the goals and objectives of the program, the services to be provided and the operating requirements.
• **Section 3** provides a process roadmap; it is your best overall guide to the work you need to do and when it should be completed. This section includes an overview of key tasks to be completed, related deliverables and timelines.

• **Section 4** provides direction and guidance relating to FCC governance and accountability structures. It includes: definitions of governance and accountability; identifies the legal structures for first wave FCCs; outlines key governance roles, responsibilities and accountabilities relating to FCCs; and outlines potential options for interested PCNs to transition to FCC status.

• **Section 5** details the developmental supports and funding available to facilitate the development of your FCC, including what activities are eligible for funding support and the processes required to access these supports.

• **Section 6** provides an overview of the required sections for the Business Plan.

• **Section 7** provides the detailed financial templates that must be completed as part of the Business Planning process.

• **Section 8** has been developed to assist applicants in understanding the basic Information Management Technology (IMT) and Data Management (DM) components and guidelines for FCCs.

• **Section 9** provides direction and guidance relating to FCC health workforce. It identifies the requirements for FCC health workforce that need to be taken into consideration by FCC applicants when developing their health workforce plans.

• **Section 10** provides information on privacy and security, including requirements relating to custodianship of data and the completion of Privacy Impact Assessments.

Your initial efforts will be focused on completing the required FCC application form which is included in this Application Kit.

If your application is selected as part of the Wave 1 FCC rollout, you will then need to move through the remaining stages of the design process overviewed in the Alberta FCC Development Process Roadmap detailed in Section 3 of this Application Kit.
SECTION 2:
FAMILY CARE CLINIC
PROGRAM DESCRIPTION
2.0 FAMILY CARE CLINIC PROGRAM DESCRIPTION

2.1 FCC Program Goal and Objectives

The primary goal of the FCC program is that “Albertans have access to primary health care when they need it, where they need it, from the most appropriate service provider(s).” Each FCC will be expected to focus on the achievement of the following specific objectives:

1. Provide individual and family-focused comprehensive quality primary health care services across the lifespan based on population health needs.
2. Manage timely access to primary health care, including same day access.
3. Increase emphasis on health promotion, disease and injury prevention, screening, self-management, and care of chronic disease and complex needs.
4. Use a collaborative interdisciplinary team approach to service planning and delivery.
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.
6. Maintain accessible and efficient information systems.
7. Monitor quality and achieve positive outcomes, guided by evidence-informed practice.

2.2 FCC Team Functions

The vision for FCCs includes the expectation that Albertans can anticipate that similar functions will be fulfilled by all FCC teams. This means FCCs must – at a minimum – provide a standard set of functions. These required functions are:

- Differential diagnosis and treatment;
- Care planning and access to supports;
- Specialist referral, case management, and navigation;
- Health promotion and prevention;
- Linkages to other health services (e.g. acute care, continuing care, rehabilitation, etc.), community and social programming, and agencies; and
• Education and self-management support.

2.3 FCC Services – Comprehensive Primary Health Care Services

To fulfill the required FCC functions listed above; all FCCs will provide comprehensive primary health care services to their community either directly through on-site staff, or indirectly through linkages to other health providers already present in the community. This comprehensive approach to primary health care will improve access, service co-ordination, continuity of care, and appropriate use of resources.

Comprehensive primary health care services are defined as “a wide range of health programs and services that are linked together efficiently and effectively to meet the primary health care needs of the population across the lifespan.” Emphasis is placed on providing a smooth, seamless transition through the health system, with consistent and appropriate care providers.

The following services must be provided by each FCC, either directly or indirectly. Direct provision means the service is provided on-site by the FCC; indirect means active linkages will be provided to other providers or services available in the community or accessible via technology:

• Basic ambulatory care and follow-up;
• Chronic disease prevention and management;
• Addiction and mental health services;
• Care of clients with complex needs;
• Minor emergency care;
• Follow-up primary care;
• Rehabilitative care services;
• Family planning and pregnancy counseling services;
• Maternal and child health services;
• Palliative and end of life care;
• Geriatric care;
• Health promotion and disease and injury prevention services;
• Population health improvement; and
• Individual and family engagement.

A more detailed description of each of these services is provided in Table 1 following.
### Table 1: Comprehensive Primary Health Care Services

<table>
<thead>
<tr>
<th>Basic ambulatory care and follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessment, diagnosis, management and follow-up of simple episodic health concerns.</td>
</tr>
<tr>
<td>• Routine, periodic health assessments.</td>
</tr>
<tr>
<td>• Opportunistic prevention and health promotion services.</td>
</tr>
<tr>
<td>• Minor surgery – treatment and follow-up.</td>
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<table>
<thead>
<tr>
<th>Chronic disease prevention and management</th>
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</thead>
<tbody>
<tr>
<td>• Proactive screening.</td>
</tr>
<tr>
<td>• Ambulatory care and follow-up for clients with chronic conditions.</td>
</tr>
<tr>
<td>• Chronic disease management services – the FCC is an integral part of a collaborative, community-based service delivery framework that includes health promotion, prevention, early detection and primary treatment.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Addiction and mental health services</th>
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</thead>
<tbody>
<tr>
<td>• Early identification and treatment of addiction and mental health problems, including mental health screening and diagnostic interviews.</td>
</tr>
<tr>
<td>• Mental health and addictions counseling and services for individuals and families.</td>
</tr>
<tr>
<td>• Assistance to individuals and their families “navigate” the system.</td>
</tr>
<tr>
<td>• Crisis support services.</td>
</tr>
<tr>
<td>• Education to encourage individuals and families to make healthy lifestyle choices that will contribute to maintaining good mental health.</td>
</tr>
<tr>
<td>• Counseling services for families of catastrophically or terminally ill clients.</td>
</tr>
<tr>
<td>• Counseling services for family members of clients with chronic diseases or conditions.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Care of clients with complex needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessment, diagnosis, management and follow-up for clients with complex health concerns.</td>
</tr>
<tr>
<td>• Opportunistic prevention and health promotion service.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Minor emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minor emergency care including conditions relating to age, distress or potential for deterioration, or complications that would benefit from intervention or reassurance within one to two hours; e.g., headaches or chronic back pain.</td>
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<table>
<thead>
<tr>
<th>Follow-up primary care</th>
</tr>
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<tbody>
<tr>
<td>• Support and/or provision of primary care to clients in hospitals and continuing care facilities where appropriate.</td>
</tr>
<tr>
<td>• Discharge planning and out-patient follow-up services; e.g., linkages to home care, rehabilitation.</td>
</tr>
<tr>
<td><strong>Rehabilitative care services</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>• Provision of, or linkage to, community rehabilitative services such as physical therapy, occupational therapy, speech language pathology, audiology and respiratory therapy.</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Family planning and pregnancy counseling services</strong></th>
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</thead>
<tbody>
<tr>
<td>• Counseling for birth control and family planning.</td>
</tr>
<tr>
<td>• Education, screening and treatment of sexually transmitted diseases.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Maternal and child health services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Antenatal care to term services.</td>
</tr>
<tr>
<td>• Postpartum maternal and newborn care.</td>
</tr>
<tr>
<td>• Well-child care services.</td>
</tr>
<tr>
<td>• Screening, parent education and counseling regarding infant/child health and development.</td>
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<table>
<thead>
<tr>
<th><strong>Palliative and end of life care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Basic ambulatory care supports and follow-up.</td>
</tr>
<tr>
<td>• Access to necessary medical supplies, medications and supportive practical equipment based on assessed needs.</td>
</tr>
<tr>
<td>• Pain and symptom assessment and management.</td>
</tr>
<tr>
<td>• Home visits and access to supports for caregivers.</td>
</tr>
<tr>
<td>• Linkages and timely co-ordination with other service providers.</td>
</tr>
<tr>
<td>• Access to palliative care specialist consultation.</td>
</tr>
<tr>
<td>• Advanced care directives and planning options for non-cancer and cancer patients identified as palliative.</td>
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<table>
<thead>
<tr>
<th><strong>Geriatric care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Basic ambulatory care and follow-up tailored to geriatric clients’ needs.</td>
</tr>
<tr>
<td>• Counseling and supports focused on the unique needs of geriatric clients and their families.</td>
</tr>
<tr>
<td>• Services to support “aging in place”.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Health promotion and disease and injury prevention services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Screening of clients at risk to prevent disease or to allow for early detection, early intervention and counseling to reduce risk.</td>
</tr>
<tr>
<td>• Access to immunization services and programs.</td>
</tr>
<tr>
<td>• Periodic health assessments.</td>
</tr>
<tr>
<td>• Organized population health screening and health promotion targeted at the FCC population.</td>
</tr>
<tr>
<td>• Development and implementation of health promotion and injury prevention programs.</td>
</tr>
</tbody>
</table>
Population health improvement

- Delivery of programs and services that address the needs of FCC client populations or sub-populations within it, and the factors that contribute and determine health status.
- Establishment of linkages and partnerships with community-based services to provide social supports for clients.

Individual and family engagement

- Capacity building for client self-management.
- Design and implementation of programs and approaches to effectively engage individuals and families in planning for and taking accountability for their health.

2.4 FCC Team Mix

Delivery of the required functions and comprehensive primary health care services will rely on an appropriate mix of service providers with appropriate expertise. A physician and/or nurse practitioner linked to a physician, are an essential part of the FCC team because they can provide differential diagnosis (i.e., a process of elimination used to determine an individual’s medical diagnosis). Beyond the physician and/or nurse practitioner, the selection of team members will vary depending on workforce availability and community needs.

Minimum team requirements have been defined and must include the following:

- **Either a physician or a nurse practitioner linked to a physician.** While the nurse practitioner must have access to a physician, the physician does not have to be available on-site.
- **A minimum of two additional service providers.** The choice of providers will be made by each FCC based on community needs. Case management and navigation functions and linkages to social and community supports must be addressed by these additional staff.
- **A designated Business Manager supported by a receptionist and administrative personnel.** As Wave 1 FCCs are being developed, a workforce guide will be developed to assist the initial FCCs in recruitment and job design. As well, training will be available to facilitate the development of collaborative team-based care.

2.5 Hours of Operation

FCCs will be required to operate from 7 a.m. to 9 p.m., seven days a week unless community needs demonstrate other hours of operation are required. In addition, FCCs will provide same day access for both scheduled and non-scheduled appointments.
2.6 Minimum Catchment Area Population

Efficient deployment of FCCs depends on ensuring a community is large enough to sustain an FCC and to warrant both the required minimum hours of service and the comprehensive range of services that FCCs will provide. For the Wave 1 rollout, it has been determined that the minimum community size or service area population is 2,500.

For more remote areas of the province, FCCs may use a centralized model with smaller site delivery for communities smaller than 2,500, provided the central FCC is connected to a broader service area. Delivery in these smaller communities could be done using telehealth or mobile teams of providers connected to a central FCC.

2.7 Operating Policy Guidelines

Operating policy requirements have been identified to support each of the seven FCC program objectives. The expectation is that FCCs would meet the following requirements within the first year of operation. Those with asterisks* may require a longer term implementation timeline.

Table 2: FCC Policy Operating Requirements

<table>
<thead>
<tr>
<th>Objective # 1: Provide individual and family focused comprehensive quality primary health care services across the lifespan, based on population health needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide comprehensive primary health care services either directly or in partnership with other service providers.</td>
</tr>
<tr>
<td>• Utilize population health needs assessments and information about the clients served by the FCC to inform service planning and delivery.</td>
</tr>
<tr>
<td>• Engage community representatives in FCC service planning and implementation.</td>
</tr>
<tr>
<td>• Implement processes to include feedback from individuals and families as part of the FCC evaluation process.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective # 2: Manage timely access to primary health care, including same day access.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide same day access for both scheduled and non-scheduled appointments.</td>
</tr>
<tr>
<td>• Operate from 7 a.m. to 9 p.m. seven days a week at a minimum unless community needs and circumstances dictate other hours of operation are required.</td>
</tr>
<tr>
<td>• Implement a process for tracking unattached individuals that become attached to the FCC.</td>
</tr>
<tr>
<td>• Provide access and attachment for currently unattached individuals.</td>
</tr>
<tr>
<td>• Provide after-hours on-call services.*</td>
</tr>
<tr>
<td>• Utilize appropriate technologies to enhance access; e.g., HealthLink.</td>
</tr>
<tr>
<td>• Implement a process to track the impact of the FCC on local Emergency Departments.</td>
</tr>
<tr>
<td>• Facilitate the provision of direct access to most appropriate provider.</td>
</tr>
</tbody>
</table>
Communicate to the public timely accurate information regarding the availability of services and hours of operation.

**Objective # 3: Increase emphasis on health promotion, disease and injury prevention, screening, self-management, and care of chronic disease and complex needs.**

- Identify and develop service priorities across the continuum of care and the lifespan based on population health needs of the community.
- Early detection of existing diseases to optimize quality of life and functioning.
- Support and enable self-management.
- Address the health care needs of those with chronic and complex conditions.

**Objective # 4: Use a collaborative interdisciplinary team approach to service planning and delivery.**

- Provide an appropriate mix and number of providers to meet service population needs. The team may consist of, but is not limited to: family physicians, nurse practitioners, registered nurses, licensed practical nurses, social workers, psychologists, paramedics, pharmacists, dietitians, addiction and mental health workers, case managers, community partners and others as appropriate. The team is not limited to regulated providers.
- Provide for the teaching and mentoring of health care providers; e.g., practicum placements, preceptorship, etc.*
- Provide interdisciplinary education and training of all staff on teamwork across disciplines.
- Align organizational policies, structures and supports to implement the Provincial Collaborative Practice and Education Framework for Change.*
- Obtain feedback from staff on satisfaction, safety and quality of services. Quality is defined as per the Health Quality Council of Alberta.

**Objective # 5: Improve co-ordination, continuity and integration of primary health care services, including effective linkages with other relevant ministries and community service providers and agencies.**

- Register individuals using formal enrolment process**, including unattached individuals, to the FCC, for the provision of primary health care services.
- Ensure effective case co-ordination and navigation for individuals and families.
- Establish linkages and partnerships, taking the social determinants of health into consideration. Linkages and partnerships can consist of, but are not limited to: municipal government social services and supports, other government ministries, food banks, housing services, community recreation centres, schools, parent link centres, and other social and community agencies; and other primary care health services such as emergency services – ED and EMS, medical specialists, hospitals, urgent care centers, community health centers, primary care networks, public health services, home care, continuing care, mental health, etc.
- Co-locate FCC services with community social services agencies where possible and practical.*
Establish inter-agency networking structures to support client navigation and continuity of services across sectors.

Facilitate access to appropriate and timely diagnostic tests.

**Objective # 6: Maintain accessible and efficient information systems.**

- 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 AHS).
- Utilize the standard provincial suite of IMT systems and services that is provided to all clinics.
- Comply with mandatory reporting requirements for FCCs, including performance reporting, service event/workload reporting, business plan reporting, financial reporting and reciprocal billing.
- Actively support, use and contribute to provincial eHealth services, including Alberta Netcare, Provincial Registries, Pharmaceutical Information Network (PIN), Laboratory and Diagnostic Imaging results reporting and other emerging technologies.
- Comply with all other FCC Program Standards and Guidelines for IMT.
- Complete and maintain updated Privacy Impact Assessments as applicable.

**Objective # 7: Monitor quality and achieve positive outcomes, guided by evidence-informed practice.**

- Utilize evidence-based guidelines and available best practice information to inform clinic operations.
- Identify and manage risk, including safety of individuals and staff.
- Develop and implement a quality improvement plan which identifies and prioritizes quality improvement initiatives based on such criteria as high risk, high volume, current level of care and cost.*
- Collect data on established performance indicators and utilize these to inform the development of quality improvement priorities and plans.
- Develop and implement an evaluation plan which measures ongoing improvements to primary care health services.*
- Publicly share measurable performance indicator results.*
- Work toward achieving Accreditation Standards.
- Obtain accreditation status.*

**Note:** Those with asterisks* may require a longer term implementation timeline

**Policy and procedures on attachment are under development.**

### 2.8 Primary Health Care Standards

Alberta’s primary health care initiative is about raising the bar and using our resources to improve access and achieve better health outcomes. Our focus will be on outcomes and standards. FCCs will be required to utilize evidence based clinical standards and implement a quality improvement plan to manage performance. FCCs will be required to adhere to standards and pursue accredited status.
Accreditation is one of the most effective ways for health services organizations to regularly and consistently examine and improve the quality of their services. Health care organizations that participate in accreditation programs are evaluating their performance against national standards of excellence. These standards examine all aspects of service provision, from client safety and ethics, to staff training and partnering with the community. Accreditation standards, such as Canada’s Primary Care standards, are to be utilized to guide service planning, delivery and evaluation efforts.

In addition, FCCs will be expected to appoint a clinical advisor to ensure the provision of responsible, high quality clinical care within the FCC. This role will provide clinical oversight of all clinical activities and is discussed in more detail in Section 9.3.5.
SECTION 3: FAMILY CARE CLINIC DEVELOPMENT PROCESS ROADMAP
3.0 FAMILY CARE CLINIC DEVELOPMENT PROCESS—ROADMAP

3.1 Introduction

The Alberta FCC Development Roadmap provides an overview of the key process steps for the development and implementation of FCCs. The “Roadmap” is supported by more detailed information in other sections of this Guide and Reference Manual regarding program objectives, required services, governance, service/business planning and other operating requirements. Figure 1 provides an overview of the five stages in the process. More detailed descriptions of each stage are included, along with specific references to the sections of this Guide and Reference Manual that provide more details regarding FCC program guidelines.

The Roadmap also applies to existing PCNs wishing to transition to FCC status. It is anticipated that PCNs with high levels of readiness and interest in transitioning to FCC status may be able to establish their FCC more quickly.

Alberta Health has established an FCC Implementation Team that will be available to provide information, advice and support at all stages outlined in the “Roadmap”. During the application stage, the FCC Implementation Team will be primarily focused on clarifying the application process and providing information. During the subsequent stages the FCC Implementation Team will provide on-the-ground support to assist successful applicants with the formation, planning and pre-operational stages. Section 5 of the Guide and Reference Manual provides more details relating to the nature and timing of supports to be provided by Alberta Health.

3.2 Stage 1: Pre-Application Stage

Prior to launching the application process, stakeholder input and feedback is being sought on the Draft Application Kit and the FCC development and implementation process. As well as seeking input from primary health care providers, the engagement process includes a strong focus on getting input from PCNs relating to issues, options and ideas for PCNs wishing to form an FCC or transition to FCC status. Input from these consultations will be used to further update the Application Kit and other supporting materials required to support the application process.
Alberta Family Care Clinic Development Roadmap

**Pre Application Stage**
- 2 months
- Provider Feedback On Application Kit
- Engagement On PCN Transition Options & Issues
- Application Kit finalized

**Application Stage**
- 3 months
- Establish Community Working Group
- Submit Letter Of Interest
- Complete & Submit Application Form
- Successful Applicants Proceed to Formation Stage

**Formation Stage**
- 2 months
- Execute Development Grant Agreement
- Establish Legal, Board & Accountability Structures
- Recruit Business Manager
- Develop Governance Policies & Bylaws
- Advance Work on Facility
- Commence PIA

**Planning Stage**
- 3 months
- Develop the FCC Business Plan
- Develop the FCC Budget & Complete Financial Templates
- Prepare for Staff Recruitment
- Continue Facility Planning
- Submit Business & Budget to AH
- Proceed to Next Stage on Approval of Budget

**Pre-operational Stage**
- 3 months
- Execute Operating Grant Agreement
- Execute Lease Agreement
- Complete Staff Recruitment & Training
- Acquire Business Infrastructure – IT, Equipment, etc.
- Submit PIA

**Operational Stage**
- Ongoing
- Develop Programs & Services
- Develop Staff & Collaborative Team
- Develop Care Protocols & Map Services Across Sectors
- Enroll patients & Provide Services
- Monitor Results & Continuously Improve Performance

**Ongoing Evaluation and Process Improvements**

Note: PCNs with high levels of readiness and interest may be able to transition to FCC status more quickly.

**Deliverables**
- Provider input received
- Application Kit finalized
- Letters of Interest received
- Readiness assessment
- Application Submitted
- First wave FCCs identified
- Legal entity established
- Board or Advisory Committee established
- Bus. Man. hired
- Development Grant Agreement in place
- Bylaws and governance policies developed
- Bus. Plan completed
- Budget and financial templates completed
- Bus. Plan reviewed and approved
- Staffing completed
- Facility leases executed
- IT and business systems operational
- Operational Grant Agreement Executed
- Programs delivered
- Collaborative team development
- Ongoing monitoring, evaluation & reporting
- Annual Updates to Business Plan and Budget
3.3 Stage 2: Application

The next step is to confirm the level of interest in establishing an FCC. At this stage you should complete the following tasks:

- **Establish a Community Working Group (CWG):** Applicants interested in establishing an FCC are encouraged to establish a Community Working Group that engages key stakeholders and potential service delivery partners to provide leadership to the FCC application and development process.

- **Submit Letter of Interest:** Groups interested in forming an FCC should complete and submit a Letter of Interest to Alberta Health. This will signal interest from a potential applicant for the FCC Implementation team to provide more information.

- **Complete FCC Application:** Interested applicants will submit an application. Some initial support will be provided by the FCC Implementation Team to prospective applicants to ensure they understand the application requirements and FCC program policy and operating guidelines. Support will also include providing linkages to available community needs and available community readiness assessment data.

- **Submit FCC Applications:** Completed FCC Applications will be submitted to Alberta Health for review and evaluation utilizing the criteria detailed in Attachment #1 of this Guide and Reference Manual.

First Wave Applications will be reviewed by the Selection Committee and the list of recommended applicants will be submitted to the Minister of Health for review and approval. Successful applicants will be notified by Alberta Health.

3.4 Stage 3: Formation

At this stage, your group will have been invited by the Ministry to proceed with the development of your FCC, and you will be required to determine your legal, governance and accountability structures. Specific tasks in this stage include:

- **Execute Development Grant Agreement:** Your group will execute a development grant agreement with Alberta Health which details the funding and other supports available to develop your FCC.

- **Establish FCC Legal Entity:** For the first wave implementation the following legal structures are acceptable options.
  - **Non-profit FCC Corporation:** A non-profit corporation (NPC) may be established to operate an FCC, provided the corporation adheres to Alberta Health FCC program policies and operating guidelines. The NPC would be governed by a Board of Directors with health provider, consumer and community representation.
Alberta Health Services: AHS may apply to operate an FCC, provided it adheres to Alberta Health FCC program policies and operating guidelines. For AHS-operated FCCs, an Advisory Committee, including provider, consumer and community representation, would be required.

- **Establish Articles of Association:** Each FCC non-profit corporation must establish its' Articles of Association consistent with the guidelines detailed in Section 4.4 of this Reference Manual.

- **Establish FCC Bylaws:** Each FCC non-profit corporation must establish its bylaws, addressing:
  - FCC program purposes, objectives and operating requirements;
  - Board of Directors composition, membership, appointment processes, terms, etc.;
  - Powers, duties and accountabilities of the Board of Directors;
  - Powers, duties and accountabilities of the Business Manager;
  - Business plan and budget approval requirements;
  - Financial reporting, audit and accounting requirements; and
  - FCC performance monitoring and reporting requirements.

- **Establish the Board of Directors or Advisory Committee:** Appoint the Board of Directors or Advisory Committee, consistent with the approved FCC Bylaws.

- **Recruit FCC Business Manager:** Subject to Alberta Health approval of developmental funding, the FCC should move quickly to recruit a Business Manager to execute key activities required to get the FCC up and running.

- **Advance Work on Facility Requirements:** Continue work of facility requirements and identification of potential housing options for the FCC.

- **Develop NPC Governance Policies:** Initiate work on the development of governance policies required to ensure the Board's governance responsibilities and accountabilities are being fulfilled.

- **Commence PIA:** Work on the Privacy Impact Assessment will need to be initiated early in the process to ensure it is in place in time for start-up.

**Note:** Section 4 of this Reference Manual dealing with governance and accountability provides more details relating to:

- Definitions of governance and accountability;
- Governance and accountability requirements;
- Information on potential FCC legal, governance structures; and
- Options for transitioning PCN physician clinics and/or PCNs to FCC status.
3.5 Stage 4: Planning

By this stage you will have established your legal entity for the FCC and developed some of your foundational governance policies. During stage four you will be focused on the following key tasks:

- **Develop the FCC Business Plan:** Review relevant documents and background information and organize and conduct a series of planning sessions with the Community Working Group (CWG) to develop the key elements of the Business Plan. A senior business consultant, under contract with Alberta Health (part of the FCC Implementation Team) will coordinate the planning process and facilitate CWG meetings. The business consultant will be supported by other technical resources from Alberta Health and AHS as required. Key steps in the process should include:
  - **FCC Program Overview:** Review the Alberta Health FCC Program Goals, Objectives and Operating Policy Requirements detailed in Section 1 of this Applicants’ Guide and Reference Manual.
  - **Community Assessment:** Review and finalize community assessment data – primary care services utilization levels, community needs assessments, readiness to implement an FCC and other considerations.
  - **Business Plan Development:** Consistent with FCC-established provincial policy requirements and guidelines, develop the draft FCC Business Plan, including the required sections and standardized templates. Required sections will include, but not be limited to:
    - Executive Summary;
    - FCC Name and Community/Service Area Profile;
    - FCC Mission and Operating Principles;
    - Governance and Leadership Structure;
    - FCC Service Priorities, Key Results and Performance Measures;
    - Service Delivery Framework and Strategies;
    - Staffing Plan;
    - Facilities and Equipment Infrastructure;
    - FCC Performance Monitoring and Results Reporting (Note: minimum requirements will be provided by Alberta Health in the Business Planning templates);
    - Local Communications and Marketing Plan; and
    - FCC Financial Plan and Budget Templates.

- **Develop Budget and Complete Financial Templates:** Develop budget utilizing guidelines in Section 7 of this Guide and Reference Manual and the standardized financial templates included in Attachment #2 of this Guide and Reference Manual.

- **Initiate Staff Recruitment:** Work should be done on establishing the collaborative team composition and initial work on recruitment should begin.
• **Facility Development:** Continued work on facility development, if required, should occur during this stage. See Attachment #5 of this Guide and Reference Manual for Facility Guidelines.

• **Business Plan Review and Approval:** The draft Business Plans and Financial templates will be submitted to Alberta Health for review and approval. The senior business consultants will provide support as required to the process.

### 3.6 Stage 5: Pre-operational

By this stage your organization will have developed your FCC Business Plan in consultation with local primary health care providers and other key community stakeholders; and your budget will have been developed. These will have been submitted to Alberta Health for review and potential approval. The next steps in the process are as follows:

• **Execute Operating Grant Agreement:** Based on the approved Business Plan and Budget, Alberta Health will develop an Operating Grant Agreement that will serve as a vehicle to fund the FCC. The agreement will clearly define the service relationship including, but not limited to: primary health care services to be provided by the FCC; funding to be provided by Alberta Health; services to be provided to support FCC operations; FCC operating requirements; and monitoring and results reporting requirements.

• **Develop FCC Operational Infrastructure:** The FCC Business Manager will work with the FCC Implementation Team, the Board or Advisory Committee and other key stakeholders to develop the administrative, human resource, facility, equipment and business infrastructure required for the FCC. Key areas for development will include:
  
  o Acquire physical space/facility to house FCC operations;
  o Establish required business systems;
  o Complete recruitment of required human resources;
  o Establish required human resource management policies, procedures and systems;
  o Provide initial training and development for the Collaborative Team;
  o Ensure access to effective Information Technology and Information Management, including alignment/integration with FCC Shared Services Delivery; and
  o Ensure effective communications and marketing.

• **Submit Privacy Impact Assessment (PIA):** Submit PIA to The Office of Information and Privacy Commission and Alberta Health.
3.7 Stage 6: Operational

By this stage the FCC will have recruited its health care providers and have the bulk of the infrastructure in place to support FCC operations. Key tasks to be completed on an ongoing basis in the operational phase include:

- **Program/Service Development**: Developing, implementing and continuously improving programs for targeted populations based on defined primary health care needs.

- **Service Plan Implementation**: Implementing the approved Business Plan priorities and strategic initiatives and providing regular progress reports as required.

- **Funding Agreement Alignment**: Ensuring service delivery, governance and operating systems are aligned with the requirements of the funding agreement.

- **Service Coordination**: Planning and coordinating client care and service delivery across service delivery partners.

- **Management Systems**: Ensuring basic organizational leadership and management functions are effectively and efficiently handled consistent with established FCC Program and operational requirements and the FCC program shared services model which is under development.
SECTION 4:
GOVERNANCE AND ACCOUNTABILITY
4.0 GOVERNANCE AND ACCOUNTABILITY

4.1 Introduction

This section of the Guide and Reference Manual provides direction and guidance relating to FCC governance and accountability structures. It includes: definitions of governance and accountability; identifies the potential legal structures for first and subsequent waves of FCCs; outlines key governance roles, responsibilities and accountabilities relating to FCCs; and outlines potential options for interested PCNs to transition to FCC status or for other stakeholders to participate in FCCs.

There are basic mandatory requirements for each FCC; but there is also flexibility in how FCCs can be organized. This will allow for adaptation to the specific requirements of the community, the service providers, or other factors that will impact the success of the individual FCC. Communities or organizations interested in becoming an FCC must describe in their business/service plan proposal the ways in which they will meet these requirements.

The Ministry of Health is responsible for the overall strategic direction for primary health care in Alberta which includes the formation and operation of FCCs. All FCCs will be approved by the Minister of Health and will be required to operate in accordance with established Alberta Health FCC program policies, standards and regulations. Additionally, FCC entities will enter into grant agreements (Grant Agreement) with the Department and will be required to meet grant expectations around reporting, financial accountability, service level requirements, business outcomes as well as other requirements expected of FCCs as part of the FCC Program. An important part of the governance role is to ensure this is happening.

4.2 Definitions

Governance: Governance in any organization describes the processes by which decisions are made and implemented, and who has the authority and accountability to make those decisions. Governance in publicly funded organizations describes how they conduct their affairs and manage resources entrusted to them in the best interest of the citizens.

Accountability: Accountability is an obligation to answer for the execution of one’s assigned responsibilities. The basic ingredients of successful accountability relationships are as follows:

- Set measurable goals, and responsibilities;
- Plan what needs to be done to achieve goals;
- Do the work and monitor progress;
- Report on results; and
- Evaluate results and provide feedback.
4.3 Eligible Legal Structures: Wave 1

FCCs may be operated by several different types of organizations. Only two legal entities, non-profit corporations (NPC) and Alberta Heath Services (AHS), are being considered for Wave 1. These two recommended legal entities are the most straightforward models to implement within current reporting and funding systems; and they allow a broad range of health providers and organizations, including Primary Care Networks, independent physician clinics, and other service providers to establish FCCs within a reasonable timeframe.

4.3.1 Wave 1 FCC Implementation

The following organizational options are eligible for Wave 1 FCCs

- **Non-profit Corporation:** A non-profit corporation may be established to operate an FCC, provided the corporation adheres to Alberta Health FCC program policies and operating requirements and subsequent requirements to be stipulated in their Grant Agreement with the Department. Whether the NPC is formed by providers interested in participating in an FCC or by communities who wish to ensure FCC services for their area, NPC governance would have to align with the collaborative team model that is fundamental to the FCC initiative. In both instances a mixed blend of provider and community representation would be essential on the board.

- **Alberta Health Services-operated:** AHS may operate an FCC, provided AHS adheres to the same Alberta Health FCC program policies and operating requirements set out for NPCs. Along those lines, an AHS-operated FCC would be required to have an Advisory Committee comprising similar representation and responsibilities as set out for NPCs.

**Note:** Since AHS already has a governance board in place that is accountable for the overall leadership of the organization and its programs and services, an FCC Advisory Committee will be used for FCCs that are operated by Alberta Health Services. This will provide a sub-level of direct accountability for each AHS-run FCC under the umbrella of AHS.

4.4 Non-profit Corporation Requirements

For NPC-operated FCCs certain corporate requirements must be met in order to ensure consistency among FCCs, promote governance and alignment with fundamental policy and operational guidelines and to meet the Government’s accountability mandate to Albertans. Particulars around minimal standards for Board Composition, accountability and corporate Articles of Association would be stipulated in guidelines released by the Department on FCC rollout. The following outlines some of the overarching principles that would be expected of FCC NPCs.

4.4.1 NPC Governance Board Accountabilities

FCCs operated by NPCs will be governed by a Board of Directors that will have overall accountability for FCC. The Board will have accountability for:

- **Business Plan:** Reviewing and recommending to Alberta Health the FCC annual business/service plan;
- **Grant Agreement**: Ensuring the Corporation adheres to the Grant Agreement requirements;

- **By-law Development**: Developing and approving bylaws for the FCC and monitoring the effectiveness of their implementation;

- **Appointment of the Business Manager**: Hiring, supporting and evaluating the performance of the Business Manager;

- **Fiscal Stewardship**: Providing strong fiscal stewardship for the organization, including the approval of the budget, monitoring expenditures and ensuring financial reporting requirements are met;

- **Performance Monitoring, Evaluation and Results Reporting**: Monitoring and evaluating the results achieved by the organization against required performance metrics and measures;

- **Strategic Relationships and Networks**: Maintaining strategic relationships, networks and effective communications with relevant community and provincial stakeholders;

- **Risk Mitigation**: Ensuring appropriate risk identification and mitigation policies and practices are in place; and

- **Board Evaluation and Development**: Evaluating performance of the Board; and seeking opportunities to continuously improve Board effectiveness.

### 4.4.2 NPC Board Composition

In order to ensure FCCs reflect the collaborative model intended for the Program, FCCs must have a Board of Directors that reflects a minimum complement of community and provider representatives. As such, it is expected that the number of Directors would be no less than five members. At minimum, a Board of Directors would comprise:

- A minimum of two different types of health care providers, which shall constitute 2/5 of the Board;

- A client representative(s), which shall constitute 1/5 of the Board;

- External community leader(s)/representatives which shall constitute 2/5 of the Board. These representatives are non-FCC staff.

FCCs could also add other members with desired expertise to their Board as may be required (e.g. legal, governance, finance, etc.).

In the event an FCC wishes to augment its Board beyond the five director minimum, no representative group should exceed its stated proportion. For example, the health care provider complement would retain its 2/5<sup>th</sup> proportion. The maximum recommended size of an FCC Board is ten members.

In order to ensure representative decision making, the Board Chair would be selected from the complement of Directors. However, to avoid potential conflict of interest issues between governance and operations, the Board Chair would not be a health care service provider and conflict of interest provisions would be built into the bylaws.
The composition of the Board along with procedures relating to their appointment must be included in the bylaws of the NPC.

### 4.4.3 Selection and Removal of Directors

Directors are appointed or elected by the members of the FCC. A Director must be a member of the FCC and the overall composition of the Board must match the minimal requirements set out in Section 4.4.3. Beyond the minimal compositional requirements set out by Alberta Health, FCCs are provided flexibility in determining what corporate provisions best match their FCC.

A Director may be appointed or elected and may have set terms as decided by the FCC. The FCC must also decide whether it would want to set a maximum number of years of service for Directors or whether such a maximum would remove essential expertise from the Board.

Apart from the expiry of a Director’s term and an inability to be reappointed, there are other options available for the removal or withdrawal of a Director. For example:

- A Director ceases to hold office when:
  1. The Director delivers a notice of resignation to the Company;
  2. The Director ceases to be qualified as a Director based on minimal Board composition requirements;
  3. The Director dies; or
  4. The Members by resolution vote to remove the Director.

FCC Articles of Association or FCC Bylaws should also stipulate the explicit powers of Directors, any remuneration for Directors, interim appointment of Directors and, as previously noted, what conflict of interest provisions a Director must adhere to.

### 4.4.4 NPC Operational Accountability

FCC service providers would report to a Business Manager responsible for the day-to-day operations of the FCC. The Business Manager would be accountable to the Board Chair directly and not to the Board as a whole so as to avoid any apparent conflict with FCC service providers holding positions as Directors. The Business Manager will not have accountability for decisions related to clinical practice.

### 4.4.5 Documentation

In addition to the board requirements set out above, each FCC NPC would be required to incorporate, at minimum, the following into their bylaws:
4.4.5.1 Articles of Association

- FCC program purposes, objectives and operating requirements.
- Powers, duties and accountabilities of the Board of Directors.
- Powers, duties and accountabilities of the Business Manager.
- Board and Business Manager accountabilities to Alberta Health and the Minister.
- Business plan and budget approval requirements.
- Financial reporting, audit and accounting requirements.
- FCC performance monitoring and reporting requirements.
- The compositional structure of the Board as set out in Section 4.4.2.

4.4.5.2 Memorandum of Association

As a complement to the Articles of Association, the objects of the FCC should be reflected in a NPC’s Memorandum of Association.

In terms of branding, in order to ensure alignment with the Program, FCCs would be asked to adopt a name that reflects the Alberta FCC brand. This can alternatively by the legal name of the FCC NPC or the trade name of the FCC NPC. The Department branding concept for FCCs will be provided in due course.

4.4.5.3 Bylaws

Each NPC FCC must also submit a copy of their bylaws to the Minister. The bylaws should include the following considerations:

- Board of Directors membership, appointment processes, terms, Board remuneration, etc.;
- Board of Directors meetings, notice of meetings and quorum;
- Accountability and reporting responsibility of the Business Manager and clinician lead;
- Conflict of interest provisions; and
- Relationship and reporting responsibilities of management, particularly those relating to the business manager and FCC service providers.

Further details (e.g. conflict of interest, board recruitment, Director evaluation, etc.) and requirements for both the Articles of Association and FCC Bylaws will be developed and shared with FCCs to promote consistency and alignment with the Initiative.

4.5 AHS-operated FCCs

Regardless of corporate origin, FCCs whether an independent NPC or an AHS operated FCC must align to the requirements and standards set out by government. As noted in section 4.3.1 AHS FCCS must adhere to
the Alberta Health FCC program policies and operating requirements. Additionally AHS-FCCS will be bound to accountability and governance provisions as set out in an FCC Grant similar to that for NPC FCCs.

Each FCC is expected to have its own Advisory Committee which matches the composition stated for NPC Boards. Additionally, the terms of reference for the Advisory Committee are expected to contain similar minimal requirements as stipulated for an NPC's Articles of Association or FCC Bylaws. Although the Advisory Committees for AHS operated FCCs would not represent the governing authority for the FCC, the AHS Board is expected to consider these Advisory Committees and representative advisors for the FCCs they represent.

All FCCs must register and have the status of a Community Ambulatory Care Centre (CACC) in accordance with Alberta Health policy.

4.5.1 Advisory Committee Requirements

The Terms of Reference for each “Advisory Committee” shall align with the requirements set out in Article 4.4.3 and the requirements of Article 4.4.4 as applicable.

The “Advisory Committee” must also have the same composition of an NPC FCC Board as listed in 4.4.2.

4.6 PCN – FCC Relationship

PCNs, FCCs and independent physician clinics are complementary and mutually supportive models in an integrated Primary Health Care Service Delivery System. This is diagrammatically represented in Figure 1 following which is a description of the current state. Primary Health Care in Alberta is currently being delivered through a range of service delivery vehicles including: 40 PCNs operating across the province; three pilot FCCs operated by Alberta Health Services; and numerous independent family physician clinics and medicentres.

Figure 1: PCN – FCC Transition Options

Option 1. Current PHC Delivery Entities

Current State Description

PHC in Alberta is currently delivered by:

- PCNs and their associated physician clinics
- 3 pilot FCCs operated by AHS
- Numerous independent physician offices/clinics that are not a part of a PCN or an FCC
- AHS also provides a wide range of primary health care services across the province
4.7 Transition Options for PCNs and Creation of New FCCs

PCNs interested in establishing an FCC or transitioning their PCN to FCC status will be required to operate in accordance with established Alberta Health FCC program policies and guidelines and receive required Alberta Health approvals. In addition, policies and guidelines will be established to rationalize funding for FCCs and PCNs.

A number of options to facilitate the formation of FCCs by PCNs or the transition of PCNs to FCC status have been identified including:

- An individual physician clinic(s) within a PCN could transition to an FCC (Figure 2);
- An existing PCN could establish a non-profit subsidiary for the purpose of operating an FCC (Figure 3); and
- An existing PCN could establish a non-profit organization and transition the entire PCN to an FCC Collaborative (Figure 4). An FCC Collaborative would be required to operate in accordance with FCC program policies and regulations; but would group several FCCs under a common governance and operational structure.

These options are represented diagrammatically in Figures 2, 3, and 4. Other viable options may emerge through consultation and ongoing discussion with the PCNs.

4.7.1 Individual PCN Clinic Transitions to FCC Status (Figure 2)

In this option an individual clinic within a PCN would transition to an FCC delivery model. To accomplish this transition the migrating clinic would create a new NPC for its FCC role. The new FCC NPC would enter into an FCC Grant Agreement with the Ministry and the FCC NPC would have to meet the established governance and accountability requirements. The new FCC NPC would then operate under FCC rules and standards for the provision of PHC services to its target population. The remaining two clinics in the PCN would continue to operate under PCN rules and standards.

![Figure 2: PCN – FCC Transition Options](image-url)
4.7.2 PCN Establishes a Subsidiary NPO to Operate an FCC (Figure 3)

In this option the PCN Parent Company has decided to expand its delivery of PHC services to include both a PCN service delivery model and a FCC service delivery model. To accomplish this, the PCN Parent Co., would create a new FCC NPC which would be a subsidiary of the Parent Co., but be governed in line with the requirements for FCC NPCs. The new FCC NPC would enter into an FCC Grant Agreement with the Ministry and the FCC NPC would have to meet the established governance and accountability requirements for FCCs. The new FCC NPC would then operate under FCC rules and standards for the provision of PHC services to its target population.

**Figure 3: PCN – FCC Transition Options**

**Option 3. A PCN establishes a Subsidiary NPO to operate an FCC**

- A PCN establishes a subsidiary NPC and applies to establish and operate one or more FCCs, in accordance with established AH FCC program policies and regulations and Alberta Health required approvals.
- PCN continues to operate in accordance with PCN program policies and regulations.
- Other PHC service delivery entities identified in Option 1 continue to operate.
- AHS also provides a wide range of primary health care services across the province.

4.7.3 PCN Transitions to FCC Collaborative (Figure 4)

In this option the entire PCN has transitioned from a PCN delivery model to a FCC delivery model. PCN clinics are replaced with FCC clinics and PCN rules and standards are replaced with FCC rules and standards. To accomplish this transition the PCN Parent Co., could either amend its corporate governance structure including corporate bylaws to align with the requirements for FCCs; or the Parent Co. could create a new FCC NPC to operate the new FCC Collaborative in accord with FCC governance and accountability requirements. In either scenario, the existing PCN governance model would have to meet corporate governance requirements for FCCs to ensure consistency with the model and to preserve the foundational objectives of FCCs.
4.8 Accountability

Accountability structures have been built into the FCC Grant Funding Agreement; and FCCs are required to report to Alberta Health through the following mechanisms:

**Business and Financial Plans:** FCC Non-Profit Corporation (NPC) will be required to prepare a three-year rolling business and financial plan, including an annual budget. Business and financial plans are to be updated annually. These plans must be approved by the NPC Board.

The Business and Financial Plan Templates are provided in Attachment # 2 of this Guide and Reference Manual. Details about FCC business plan development and approval processes can be found in section 6 (Business Plan Development).

**Quarterly Financial Reporting:** FCC NPC will be required to prepare quarterly financial statements in accordance with Canadian generally accepted accounting principles.

Further details of financial reporting can be found in section 7 (Financial Plan and Budget).

**Performance Measurement Reporting:** FCC NPC will be required to report on FCC objectives through measurement of clearly defined indicators.

Initial performance measures have been developed for the three pilot sites in consultation with AHS. Descriptions of these draft performance measures and their method of collection are provided in Attachment #4 of this Guide and Reference Manual. In addition an evaluation framework with accompanying performance measures is under development and will involve broad consultation with experts and stakeholders.

**Service Event Reporting:** FCC NPC will be required to provide monthly reports of service events using service event reporting. These claims submitted through service event reporting are for administrative purposes only and will serve as a record of services provided.
**Annual Reporting**: FCC NPC will be required to submit an annual report. An FCC Annual Report Template will be provided.

**Other Reports**: FCC NPC may be required to submit ad hoc reports at the request of Alberta Health.
SECTION 5:
FAMILY CARE CLINIC
DEVELOPMENT FUNDING AND SUPPORT
5.0 FAMILY CARE CLINIC DEVELOPMENT FUNDING AND SUPPORT

5.1 FCC Letter of Interest and Application Completion

5.1.1 Introduction

Applicants may initially submit a Letter of Interest to Alberta Health.

The next step is to complete an Application and the Development Grant Funding Budget Template included in this Application Kit and submit it to Alberta Health. The FCC Implementation Team will provide some support for the completion of the Application (including the Development Grant Funding Budget Template). No funding will be provided for the completion or submission of the Application.

5.2 FCC Development Resources

5.2.1 Introduction

All Applicants, whose Applications are approved, will have access to resources to guide them through FCC development. The term support refers to assistance that is provided by the FCC Implementation Team. The term funding refers to grant funding to be provided through a grant agreement from Alberta Health. Not all applicants will require the same level of development grant funding. All unspent development grant funding must be returned to Alberta Health. Once development activities are completed, you will be required to complete a Statement of Operations showing monies received from Alberta Health and expenditures. The Statement of Operations template is located in Attachment # 3 of this Guide and Reference Manual.

5.2.2 Items Eligible for Development Support or Funding

Items eligible for development support or funding are those that are:

- One-time in nature;
- Time-limited; and
- Directly related to the start-up of the FCC.

Specific items eligible for development support by the FCC Implementation Team would include, but are not limited to:

- Completion of the initial FCC three-year rolling Business Plan, including service plan and budget; and
- Standardized bylaws guidelines, policies, and financial and service reporting templates.
Specific items eligible for development funding would include:

- Requirements to support formal establishment of corporate/governance structure and development of bylaws;
- Recruiting a Business Manager and other administrative support personnel; and
- Logistical expenses (e.g., travel) required to support development of the FCC.

Specific items eligible for both development support and funding by Alberta Health include:

- Development/implementation of appropriate financial and service reporting processes;
- Development/implementation of policies and other related materials to support start-up of the FCCs and ongoing operations; and

5.2.3 Items Ineligible for Development Support or Funding

The following items are ineligible for development support or funding (this list is not exhaustive):

- Costs to complete the Letter of Interest or the Application;
- Items that are not directly related to FCC development;
- Installation of information management platform;
- Information technology or information management costs;
- Training and development (including conferences);
- Costs to host social events;
- Costs for purchasing, leasing or renovating physical infrastructure to support FCC operations;
- Major capital, major equipment, or minor equipment expenditures;
- Compensation, travel, public relations efforts and related expenses unrelated to FCC development;
- Fees or honoraria to members of the FCC governing body or its committees;
- Travel, accommodation and meal expenses unrelated to FCC development;
- Subscriptions to newspapers or periodicals;
- Professional expenses including, but not limited to, fees and memberships in professional associations; and
- Gifts and charitable donations.
In cases where a Primary Care Network, in whole or in part, is transitioning to a FCC, any costs that are normally eligible for Development Funding but have been funded by Alberta Health previously, are deemed to be ineligible.

### 5.3 Accessing Development Support or Funding

All Applicants, who have received approval for their Application, will move to the next step of establishing a formal corporate and governance structure. A contact from Alberta Health will be assigned. Once the formal governance structure has been established, the Alberta Health contact must be notified and the contact will start the process to provide the development grant funding.

### 5.4 Timing of Supports and Funding By Stage

**Timing of Supports and Funding By Stage**

<table>
<thead>
<tr>
<th>Pre-Application Stage</th>
<th>Application Stage</th>
<th>Formative Stage</th>
<th>Planning Stage</th>
<th>Pre-operational Stage</th>
<th>Operational Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timing of AH Supports</strong></td>
<td></td>
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</tr>
<tr>
<td>AH – Continued work to refine Application Kit</td>
<td>FCC Implementation Team support (information &amp; contacts only)</td>
<td>FCC Implementation Team support</td>
<td>FCC Implementation Team support</td>
<td>FCC Implementation Team support</td>
<td>FCC Implementation Team support</td>
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<tr>
<td>Workforce guides</td>
<td>IMT/DM/PIA</td>
<td>Architectural and real estate support</td>
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<td>Change mgt. Sup.</td>
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<td></td>
<td>HR consulting</td>
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<td>Board Training</td>
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<tr>
<td><strong>Timing of Funding Flows</strong></td>
<td></td>
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</tr>
<tr>
<td>No funding</td>
<td>No funding</td>
<td>Developmental Grant – Legal, accounting, hire business manager, Meeting expenses, etc.</td>
<td>Operating Grant as per approved Business Plan</td>
<td>Ongoing operational funding as per annual Business Plan</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 6: BUSINESS PLAN DEVELOPMENT
6.0 BUSINESS PLAN DEVELOPMENT

6.1 Business Plan Requirements

All FCCs are required to complete a rolling three-year Business plan and update it annually. The Business Plan should provide a multi-year overview of the FCC’s service priorities and initiatives, based on community needs, and the resources required to address identified community primary health care service demands. The Plans should also identify key performance indicators that are to be used to monitor performance relative to established service priorities.

Business Plans should be developed using a consistent format and template. However, it is anticipated that there will be variations in Plans based on the unique needs of the population being targeted and factors such as availability of health human resources and availability and linkage to other health and social services.

Business Plans will be reviewed by Alberta Health and approved as a condition of receiving annual operational funding.

6.2 FCC Business Plan Development and Approval Processes

The following key process steps are recommended to develop the initial FCC Business Plan.

- **Step 1: Establish Planning Team:** Establish a Community Working Group/Planning Team that engages key stakeholders and potential service delivery partners to assist with the Business planning process.

- **Step 2: Planning Team Meetings:** Organize and facilitate a series of planning sessions with the CWG to develop the key elements of the Business Plan. A senior business consultant, under contract with Alberta Health and a member of the FCC Implementation Team will coordinate the planning process and facilitate CWG meetings. They will be supported by other technical resources from Alberta Health, and AHS as required. Key steps in the process should include:
  - **Review the FCC Goal and Objective:** Review the Alberta Health FCC program foundational goal, objectives and operating policy requirements detailed in Section 1 and 2 of this Applicants’ Guide and Reference Manual, to set the background and context for the planning work.
  - **Current Situation Review:** Review and finalize community assessment data – primary care services utilization levels, community needs assessments, readiness to implement an FCC and other considerations.
  - **Business Plan Development:** Consistent with FCC established provincial policy requirements and guidelines, develop the draft FCC Business Plan, including the required sections and standardized templates. Required sections will include:
    1. Executive Summary;
2. Introduction, including FCC Name and Community/Service Area;
3. Operating Principles;
4. Governance and Leadership Structures;
5. Community Profile: a description of the community/catchment area being served including: a demographic profile, summary of community needs assessment data, identification of any specific population health issues and challenges that need to be addressed; and other unique community characteristics impacting primary health care service delivery;
6. FCC Service Priorities and Key Results aligned with community needs assessment data;
7. Proposed Service Delivery Strategies including:
   - Services to be directly delivered by the FCC;
   - Service relationship between FCC, PCN and individual physician clinics;
   - Services delivered in partnership with other agencies; and
   - Linkages to other health care and community social supports including process maps for selected key services.
8. Staffing Plan, including collaborative team composition, team practice model, provider compensation model, and provisions for staff education and development.
9. Facilities and Equipment Infrastructure;
10. Information Technology and Data Management Systems, including shared services that will be provided centrally by Alberta Health;
11. Privacy Impact Assessment status;
12. Performance Monitoring, Standards and Evaluation Requirements and Processes;
13. Local Communications and Marketing Plan, consistent with key provincial messages established for the FCC implementation initiative; and
14. Financial Plan and Budget Templates:
   - Draft Business Plan: Document the results in the form of a Draft Business Plan using the standardized template provided and submit to Alberta Health for review and approval.

6.3 FCC Business Plan Template

Standardized Business Plan templates will be provided to assist with the development of the Business Plan.
6.4 FCC Infrastructure

Alberta Health will not be building or purchasing infrastructure as part of the FCC – Wave 1 initiative. Costs associated with both facility lease arrangements and leasehold improvements required to accommodate FCC program service delivery will be supported in accordance with market rates and conditions.

The Facility Guidelines provided in Attachment # 5 of this Guide and Reference Manual will assist applicants in determining their potential infrastructure requirements. Infrastructure requirements will be defined by the programs and services provided in each FCC. Please note that additional infrastructure reference information is currently under development. This additional information will be available for applicants to consult during preparation of a detailed Business Plan which will include a facilities component.

Following approval of the application, Alberta Health will provide the following support:

- Access to consultant resources who will provide expert advice and assistance to approved applicants regarding their development of FCC infrastructure, including:
  - programming
  - leasing information and advice
  - facility development (design and construction) advice,
  - providing due diligence review of applicants’ proposed facility infrastructure development

6.5 FCC Annual Report Template [under development]
SECTION 7:  
FINANCIAL PLANNING AND REPORTING
7.0 FINANCIAL PLANNING AND REPORTING

This section provides guidelines and directions with regards to Financial Plan requirements, capital expenditure guidelines, financial eligible and ineligible expense categories and financial reporting requirements. Section 7.6 (Financial Implications of Transitioning PCNs to FCCs) is in the development stage.

For Wave 1 FCCs, operational funding will be provided through a grant agreement based upon an approved business and financial plan. Over the longer term it is anticipated that Alberta Health will be moving to a client-based funding model.

7.1 General Requirements

All FCCs are required to develop a rolling three-year Financial Plan and submit it to Alberta Health for approval. The Financial Plan will support the service priorities and activities described in the FCC Business Plan. The Business Plan and Financial Plan will be updated by the FCC and approved by Alberta Health on an annual basis.

The FCC must provide financial statements and commit that the FCC will:

- Prepare Financial Plans using an accrual basis of accounting;
- Adhere to accountability requirements established by Alberta Health (this includes but is not limited to financial and results reporting requirements);
- Include only expenditures for goods and services that are being directly purchased by the legal entity of the FCC; or are provided on an in-kind basis; and
- Use a fiscal year ending March 31.

7.2 Specific Requirements

Fiscal Year: The fiscal year for the FCC must end on March 31, regardless of initiation dates. FCCs that do not initiate on April 1 will have a partial fiscal year for their first year of operations and this will be reflected in the financial and performance reporting submissions.

Start-up Financial Plan: Business and Financial Plans will be developed for the period starting from the projected initiation date for the FCC (“go live” date) and ending on the March 31 no less than 36 months later. After Alberta Health has reviewed and approved the FCC’s Business Plan and confirmed that the proposed programming is within current policy guidelines, the Financial Plan can be finalized.

Submission Format: Each FCC must submit an Excel workbook detailing their Financial Plan calculations and supporting assumptions. To support data standardization, the standard set of revenue and expense categories must be used. Costs for resource requirements must be assigned to the appropriate category.
(details are under development) as identified in the Financial Plan and Reporting templates included in this Application Kit.

**Revenue Sources:** Each FCC must clearly identify all anticipated revenue sources. This should include Alberta Health grant funding to support operations, and any other government contributions, donations, other fees and other government revenues. Alberta Health must approve all revenue sources.

**Donations:** Municipalities, charitable organizations and individuals may wish to contribute to the FCC. Contributions could be in the form of in-kind services, funding, physical infrastructure or medical equipment. Any donation to an FCC that will result in additional expenses for the FCC must align with the Business Plan and have prior approval by Alberta Health.

**Balanced Financial Plan Requirement:** Alberta Health will not approve deficit Financial Plans.

**Payment Schedule:** Funding will be paid quarterly. For subsequent years, payments will be reduced by the amount, if any, of surplus funds from the prior year.

**Information Management and Technology (IMT):** FCCs must use the standard IMT solution that is being developed. To support the standard IMT solution, a Shared Services capability is being developed by Alberta Health for the FCC initiative. A standard IMT solution will be implemented in each FCC clinic. There will be minimal IMT operating or capital expenditures budgeted or incurred directly by the FCCs.

**Financial Management and Oversight:** An annual Compliance Report must be submitted to Alberta Health with the audited financial statements. This report will explain how financial information will be managed, and demonstrate that financial transactions are recorded correctly. A description of the process for approving disbursements, creating financial policy, authorizing expenditures, approving payments, and recording disbursements is also part of the Report. A template for the Compliance Report is under development.

### 7.3 Capital Expenditures Guidelines

Funding for construction of new facilities for FCC operations will not be considered in Wave 1. Smaller capital requirements, such as renovations to accommodate service provision, health provider co-location, and to otherwise support FCC functioning would be eligible for grant funding; these would include:

- Leasing space from public and private companies, including required leasehold improvements.
- Utilizing existing surplus facility space within the community from other government ministries and agencies.
- Renovating or upgrading existing health or community facilities to allow the FCC to meet its service mandate and promote collaborative team practice.

**Note:** If the leased space is owned by the providers, the FCC must provide details of how the fair market value was established.
FCC decisions regarding whether a purchase is a capital or operating expenditure must align with the accrual basis of accounting. Some criteria include:

- If the use of a purchase can be reasonably applied to the current fiscal year, it should be an operating expense.
- If a single purchase has a useful life exceeding one fiscal year, but is not of significant dollar value, it should be an operating expense.
- If the sum total of several small purchases of the same type of product or service exceeds a large dollar value, there is a case for capitalizing the expenditure.
- Any individual item that would cost in excess of $5,000 is considered to be a capital expense.

Requests for capital expenditures are to be submitted separately from requests for operating funds utilizing the template (under development).

### 7.4 Financial Plan Revenue and Expense Categories

Standardized templates for financial planning must be utilized by FCC applicants. These templates will include detailed information regarding cost categorization for both revenue and expense and these are under development.

Financial Plans will be evaluated as part of the business plan and must support the programs and services the FCC intends to provide. The FCC must provide a comprehensive list of assumptions used in developing the Financial Plan.

#### Eligible and ineligible Operating and Capital items

<table>
<thead>
<tr>
<th>Type of Expenditure</th>
<th>Description</th>
<th>Eligible/Ineligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td>Purchase and implementation of systems for developing and maintaining electronic medical records.</td>
<td>Ineligible</td>
</tr>
<tr>
<td></td>
<td>Acquisition of desktop hardware, software and services for FCC administration purposes including personal computers, printers, scanners, LAN, PDA, etc.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Medical (or clinical) equipment</td>
<td>Minor equipment for diagnostic and treatment services that supplements existing equipment in support of the delivery of FCC services such as blood cuff monitors, glucose monitors, examination tables. The cost of the individual items should not exceed $5,000.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Type of Expenditure</td>
<td>Description</td>
<td>Eligible/Ineligible</td>
</tr>
<tr>
<td>---------------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Office equipment and furnishings</td>
<td>Furniture and office equipment for patients, and administrative staff.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Upgrades to physical infrastructure</td>
<td>Expansion/renovation of existing facilities which are in accordance with AH guidelines and have been approved by AH.</td>
<td>Eligible</td>
</tr>
<tr>
<td></td>
<td>Expansion/renovation of existing facilities which are not in accordance with AH guidelines.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Major physical infrastructure</td>
<td>New facility construction.</td>
<td>Ineligible</td>
</tr>
<tr>
<td></td>
<td>Major expansion/upgrades to existing facilities.</td>
<td>Ineligible</td>
</tr>
<tr>
<td></td>
<td>Mortgage financing of major physical infrastructure.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Medical laboratory and diagnostic imaging equipment and services</td>
<td>Major equipment used in the provision of medical laboratory and diagnostic imaging services.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Exterior furnishing</td>
<td>Acquisition or the development of exterior furnishings such as decks, benches, lawn chairs.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Purchase or development of non-essential capital assets</td>
<td>Purchase of non-essential capital assets such as gardens, works of art, and decorations.</td>
<td>Ineligible</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Compensation</td>
<td>Details to follow.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Business Travel and accommodation</td>
<td>Travel and accommodation costs while travelling on FCC business such as attending meetings and training courses in accordance with standard government of Alberta rates.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Travel and accommodation</td>
<td>Travel and accommodation costs for <strong>contracted services providers</strong> while attending conferences. Travel from residence to FCC place of business.</td>
<td>Ineligible</td>
</tr>
<tr>
<td></td>
<td>Out of country travel and accommodation for any purpose.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Rent and lease costs</td>
<td>Rent and lease of FCC facilities approved by AH for providing FCC services.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Salaries and benefits</td>
<td>Salaries and benefits providers included in the approved business plan.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Type of Expenditure</td>
<td>Description</td>
<td>Eligible/ Ineligible</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
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</tr>
<tr>
<td>Staff training and continuing professional education</td>
<td>Training costs associated with learning or improving collaborative team-based care by contracted and employed care providers. In province continuing professional education conferences for employees, which are provided for in the contract of employment, to an annual maximum of $1,000. Out of province conferences, within Canada when suitable conferences are not available in Alberta to a maximum of $5,000 per year.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Continuing professional education</td>
<td>Conference fees and travel and accommodation cost related to conferences attended by contracted service providers.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Grants and donations</td>
<td>Making of grants and donations to anyone, including individuals, non-profit corporations, and municipal governments.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Finance charges</td>
<td>Payment of interest on loans and bank overdrafts.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Phone equipment</td>
<td>Telephone equipment for land lines and monthly charges.</td>
<td>Eligible</td>
</tr>
<tr>
<td></td>
<td>Provision of cellular, other smart phones, I phones, I pads and similar equipment to contracted service providers.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Insurance</td>
<td>Property and casualty insurance for the FCC facilities.</td>
<td>Eligible</td>
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<tr>
<td>Professional indemnity insurance</td>
<td>Professional indemnity for service providers with an employment contract with the FCC.</td>
<td>Eligible</td>
</tr>
<tr>
<td></td>
<td>Professional indemnity for contracted service providers.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Recruitment</td>
<td>Recruitment Costs directly associated with recruitment activities for FCC (not for signing bonuses and other incentives).</td>
<td>Eligible</td>
</tr>
<tr>
<td>Social events</td>
<td>Hosting of social events for holiday season and staff awards and recognition, include the purchase of gifts for wishing seasonal greeting and staff recognition gifts and plaques.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Working session and hosting</td>
<td>Reasonable costs of food and non-alcoholic drinks and refreshments such as tea, coffee, juice and soft drinks for staff working sessions and hosting of guests who are not FCC employees or NPC Board members.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Purchases of any type alcoholic drinks for any occasion.</td>
<td>Ineligible</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Overall evaluation of the FCC and other related activities, including the evaluation of the programs and services.</td>
<td>Eligible</td>
</tr>
<tr>
<td>Type of Expenditure</td>
<td>Description</td>
<td>Eligible/Ineligible</td>
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<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Contingency reserves and budgeting</td>
<td>Contingency budget for unforeseen eventualities and reserves for potential termination of the FCC.</td>
<td>Ineligible</td>
</tr>
</tbody>
</table>

### 7.5 Financial Reporting Requirements

FCC accountability includes the requirement to provide financial reporting quarterly to Alberta Health in a standard format that compares actual expenses to budgeted expenses and supports approved service priorities. The purpose of financial reporting is to provide information on how grants funds are being utilized to meet objectives, strategies and service responsibilities, as outlined in the approved business plan.

(a) FCCs will provide financial reporting quarterly. The reporting period is aligned with the quarterly FCC payment cycle

(b) All financial reporting will follow a standard format approved by Alberta Health and will include completed financial reports as outlined in Attachment #2 of this Guide and Reference Manual including variance explanations for differences that are greater than 5 per cent from budget (both surpluses and deficits). The annual financial statements must be audited.

### 7.6 Financial Implications of Transitioning PCNs to FCCs

This section is under development.

### 7.7 Financial Templates

Standardized templates for financial planning and reporting are located in Attachment #2 of this Guide and Reference Manual. The templates identify the key elements that must be included and outlines related content expectations.
SECTION 8:
INFORMATION MANAGEMENT
TECHNOLOGY AND DATA MANAGEMENT
8.0 INFORMATION MANAGEMENT TECHNOLOGY AND DATA MANAGEMENT (IMT/DM)

8.1 Introduction

This guide has been developed to assist applicants in understanding the basic Information Management Technology (IMT) and Data Management (DM) components and guidelines for FCCs.

8.2 Background

FCCs will require an IMT environment that supports effective and efficient care. This includes appropriate computer hardware, software and services to match the vision for the FCC program. Key IMT and DM objectives include support for collaborative interdisciplin ary teams; organization of information around the client (one client, one record); comprehensive care provision; an emphasis on prevention, promotion and screening; care co-ordination for people needing treatment from multiple providers; and greater involvement of individuals, families and communities in the wellness process, including support for client self-management.

As a new Program, FCCs also provide an opportunity to address limitations with the current primary care IMT environment. These opportunities include improving the capability of primary health care providers to share data with other health and social service organizations for continuity of care; improving accountability, transparency and linkage to the government and to the public through outcome-focused data collection and reporting; and improving the comparability, efficiency and quality of the primary health care system through practice consistency and IMT service standardization.

8.3 Principles Driving the FCC IMT/DM Approach

- **FCCs are information-driven organizations.** Data captured electronically is used to inform decision-making on all facets of service. This includes appropriate information to drive evidence-informed care, Clinical Practice Guidelines (CPGs), care pathways, client paneling for prevention, screening, and chronic disease management. It also includes collecting the necessary facts to drive performance management, quality improvement, program evaluation, and evidence-informed planning.

- **FCCs promote and enable the sharing and integration of data.** This applies internally within an FCC, to other FCCs and externally to data shared with other organizations. Internal data sharing supports team-based care, performance management and quality improvement. External data sharing with other FCCs supports integrated client care, FCC comparability and the concept of “one client, one record.” Data sharing and integration with other organizations supports care co-ordination, integrated planning and transparency and accountability to the government and to the public.
• **FCC IMT solutions and services are standards-based, wherever practical.** This includes clinical standards, standards for system functionality and training; for installation, solution maintenance and support; and for data collection, reporting and quality assurance.

• **FCCs exemplify clinical IMT best-practices.** As new entities, the bar for clinical IMT will be set higher than existing primary care clinics. This includes the expectation that FCCs will be ‘paperless’ organizations from the start. All clinics will implement a comprehensive IMT solution before the doors open for client care. This will ensure paper-based processes do not become entrenched in day-to-day workflow.

• **FCCs will standardize on a single IMT solution.** A single software product will be deployed for each business need (Clinical Information System, administration, finance, human resources, payroll, analytics, etc.) on standardized hardware and networking components. The same IMT solution will be used by all FCCs.

• **FCCs implement lean IMT services.** This means the IMT solution is focused on providing value with less cost. This includes elimination of wasteful practices such as duplication, underutilized functionality, product defects and system and service delays. It also means attention is paid to key requirements and outcomes, rather than trying to be everything to everyone.

• **FCC leverage existing provincial IMT assets.** The FCCs will build on services and systems that are already in place rather than develop parallel solutions. This means, for example, leveraging Alberta’s Electronic Health Record (EHR) infrastructure for information exchange, the Alberta Health Care Data Repository (AHDR) for data warehousing and analytic services and Alberta’s MyHealth.Alberta.ca Consumer Health Portal and Personal Health Record (PHR).

• **FCCs integrate with key AHS information systems.** To support a client’s transition from service to service, FCCs will integrate with AHS information systems to the extent possible.

### 8.4 FCC IMT/DM Approach

#### 8.4.1 Shared Services

Critical to the success of realizing the vision of ‘one client, one record’ is a consistent approach to IMT across FCCs. To achieve this goal and minimize cost, a standard IMT solution has been developed for the Program. FCC applicants/clinics are required to use the standard IMT solution instead of one of their own choosing.

To support the standard IMT solution, a Shared Services capability is being developed for the FCC initiative. Shared Services scope is intended to support many FCC core functions such as privacy and security, human resources, finance and payroll. It consolidates all software, hardware and support requirements into a set of services provisioned by a single provider. The Shared Services Provider is responsible for implementing the standard IMT solution in each FCC clinic and providing ongoing support. Service Level Agreements ensure the Shared Services Provider is effective and remains accountable to the FCCs.
8.4.2 Shared Service IMT Solution Components

The standard IMT solution provided by FCC Shared Services is designed to address the core clinical, collaboration and administration requirements of the clinic. It includes the following components:

- **Software:**
  - Clinical information systems (registration, scheduling, electronic client charting, decision support);
  - Office automation systems (word processing, spreadsheet, dictation, scanning);
  - Administrative systems (accounting, billing, HR);
  - Reporting and analysis systems (data mart, business intelligence); and
  - Communications systems (secure email, conferencing software, efaxing).

- **Hardware:**
  - Computer equipment (desktop workstations, printers, scanners);
  - Mobile equipment (laptops, tablets);
  - Bring your own Device (user-supplied smart phones, tablets, laptops);
  - Network equipment (routers, switches, firewalls);
  - Communication equipment (phones, faxing, teleconferencing, videoconferencing); and
  - Office cabling (network cabling, phone cabling, equipment racks).

- **Services:**
  - IMT Solution Readiness Services (PIA, workflow analysis, data migration);
  - Installation Services (planning, building wiring, installation, configuration, training);
  - Hardware Support Services (equipment troubleshooting, maintenance, replacement);
  - Software Support Services (software administration, troubleshooting, monitoring, user management, upgrading and patching, clinical system management/improvement);
  - Change Management Services (clinical workflow assessment);
8.4.3 Relationship Between EMR, CIS and EHR

EMR, EHR and CIS are terms used interchangeably, many times incorrectly, to describe the information systems that create and manage electronic patient information.

An Electronic Medical Record (EMR) is a computerized record of health-related information on an individual that is created and managed by care providers in a single clinic. An example would be the EMRs used in community physician offices.

A Clinical Information System (CIS) is a computerized record of health-related information on an individual that is created and managed by licensed clinicians and staff across multiple clinics who are jointly involved in the individual’s health and care. An example would be the CIS used in hospital settings.

The Electronic Health Record (EHR) is the aggregate record of computerized health information on an individual that is created and gathered cumulatively across many health care organizations. Patient information from multiple systems such as EMRs, CISs, lab and diagnostic imaging are consolidated into the aggregate record. An example would be Alberta Netcare, which is used by clinicians across the province.

FCCs will be supported by a Clinical Information System to capture and manage patient data. At the heart of the CIS will be an EMR that has been configured to support interdisciplinary team members across multiple FCCs and integrate with provincial IMT assets such as Alberta Netcare. It will also eventually link with other health services in the community.

8.5 Wave 1 Clinics

Alberta Health is currently collaborating with key health system stakeholders to define requirements for the IMT solution and select a shared services provider. This process will not be completed in time to implement the Wave 1 of FCCs. As such, some of the more advanced capabilities will need to be phased in over time; e.g.; data marts and business intelligence tools; secure email; support for user supplied devices; etc.

An IT expert from the FCC Implementation Team will be assigned to the FCC to help determine the IMT and data management requirements for the clinic. The results of the assessment will be included as part of the Business Plan. The FCC may have additional requirements that are above and beyond the IMT solution. These requirements will need to be documented by the FCC. Areas to be considered include:

- Linkages to community services and programs;
- Support of specific health needs; and
- Support of Service Delivery Framework, including telehealth, partnerships:
Linkages to Alberta Health Services;
Linkages to Specialists;
Linkages to Pharmacists; and
Linkages to Health Link Alberta.

The assigned IMT expert from the FCC Implementation Team will work with the clinic to document and prioritize these requirements. These requirements will then be reviewed to determine if they are appropriate for inclusion in the IMT solution.

The combined IMT requirements will be considered together during the evaluation of the Business Plan.

8.6 Data Management

As information-driven organizations, FCCs are required to collect, manage and share a wide variety of data on care delivery and operations. This includes but is not limited to:

- Clinical and utilization data;
- Financial data;
- Quality of service data;
- Administrative data; and
- Performance/outcomes information.

It is important that this is done consistently, accurately and in accordance with legal requirements. As such, Shared Services support will be provided to the clinics for reporting, data standards and data stewardship. A training program on the importance of data quality and adherence to client registration and data collection standards will also be made available to FCC staff. Professional practice charting and documentation standards are also being developed and will need to be adhered to.

8.7 IMT Standards and Guidelines

FCCs are expected to follow IMT/DM Standards and Guidelines. Key concepts include:

- FCCs are information-driven organizations;
- FCCs will enable the appropriate sharing and comparability of data;
- FCCs will be standards-based whenever practical;
- IMT solutions will leverage existing provincial IMT assets such as Alberta Netcare;
- All FCCs will implement the IMT solution;
• For Wave 1 clinics, the standard IMT solution will be implemented across all clinics with more advanced capabilities to be phased in over time;

• All FCCs will be paperless to the extent the IMT solution will enable;

• Electronic client charting is mandatory;

• EMR data input will follow published charting etiquette guidelines;

• EMR data migration will support core data being migrated; and

• EMR training and continued improvement sessions are mandatory.

8.8 IMT Engagement Process

8.8.1 Business Plan

For approved FCC applications, support will be provided to complete the IMT/DM portion of the Business Plan. The IMT/DM plan will build on the IMT solution by identifying the applicants’ requirements. Requirements will be reviewed to determine if they are appropriate for inclusion in the IMT solution. An IMT/DM expert from the FCC Implementation Team will clarify the IMT solution components, standards and guidelines and will document and prioritize requirements.

8.8.2 FCC Build Phase

Once the business plan has been approved, an IMT Project Manager will be assigned by the Shared Services Provider to lead the activities required to plan and implement the IMT solution. The Project Manager will work closely with IMT vendors and the FCC team to ensure a smooth transition to the IMT solution.

8.8.3 FCC Ongoing Operations

Once the FCC is operating, the Shared Services Provider will be responsible for the ongoing support of the IMT solution. This includes helpdesk services, ongoing training and support for data reporting and analysis.

8.8.4 Funding

Funding for the IMT solution, as per the approved business plan, will be provided by Alberta Health. Funding will support the defined hardware, software and services components.

Funding for non-core requirements identified above and beyond the IMT solution will have to be identified by the FCC and included in the Business Plan.

_Funding for the IMT solution does not need to be included in the Business Plan. For non-core requirements, cost estimates are required in the Business Plan._
SECTION 9:
WORKFORCE DEVELOPMENT
9.0 WORKFORCE DEVELOPMENT

9.1 Introduction

This section of the Guide and Reference Manual provides direction and guidance relating to FCC health workforce planning. It identifies the requirements for FCC health workforce that need to be taken into consideration by FCC applicants when developing their health workforce plans. The health workforce plan should provide an overview of staffing required to provide the identified primary health care services needed by the community.

All FCCs are required to complete a health workforce plan and update it annually as part of the business planning process. FCC health workforce plans will be reviewed by Alberta Health and approved as a condition of funding.

A member of Alberta Health’s FCC Implementation Team will provide assistance to successful applicants to develop the FCC health workforce plan as part of the business planning process.

9.2 Collaborative Practice

The success and value add of FCCs rests heavily on a supportive and collaborative culture between FCC service providers, non-clinical staff, clients, and their families and caregivers. Therefore, FCCs are required to implement a collaborative practice model as described below.

Following the work of the Collaborative Practice and Education Steering Committee (CPESC), Alberta has adopted the terminology “collaborative practice” rather than “multi-disciplinary”, “inter-professional” or “interdisciplinary” in recognition that the client, their family/caregivers and non-regulated staff are also members of the team. According to CPESC¹, “as part of a health system that uses collaborative practice where and when it makes a positive impact on the provision of care, health care service providers will develop competencies for collaborative practice and will demonstrate the principles of collaboration through their actions:

- Health care service providers will give person-centred care by focusing on the needs of individuals and will work collaboratively with them to achieve the best possible outcomes. This collaboration will include the individual’s network of family, caregivers and support.
- Decisions will be made jointly by health care service providers, individuals, their families and caregivers.
- Health care service providers will form a partnership with individuals, their families and caregivers based on trust, open communication and the sharing of information.
- Health care service providers will interact with each other, individuals, their families and caregivers in ways that preserve dignity and build respect. Health care service providers will honour the individual’s choices and recognize each individual’s unique circumstances.

¹BACKGROUND INFORMATION FOR THE COLLABORATIVE PRACTICE AND EDUCATION WORKPLAN FOR CHANGE UPDATED: OCTOBER 2012
Health care service providers will share accountability in a just and equitable work culture.

Health care service providers will know their own role and scope of practice, will understand and respect the scopes of practice of all other health care service providers and will value all contributions to individual care.”

Figure 6: CPESC Model for Collaborative Practice

Each FCC will be expected to meet the following requirements for collaborative practice:

- FCC Business Plans must demonstrate how regular communication and care planning (to share information about clients’ and families’ needs across the team) will be achieved, especially when the team is not co-located.

- FCCs must develop goals, objectives and a team approach to service delivery to enhance team formation and functioning.

Note: A guide on collaborative practice in addition to change management support will be provided at the formation stage. Training on collaborative practice and distributive decision making will be provided at the pre-operational stage.

9.3 Health Workforce Plan Development

Keeping in mind that the FCC team provides primary health care services in a collaborative setting, the following human resource areas must be addressed by FCC applicants:

- Recruitment and Retention;
- Compensation and Benefits;
- Staff Training and Education;
- Occupational Health and Safety;
• Organizational Design; and
• Performance Management.

**Note:** Details of each human resource area are provided below.

### 9.3.1 Recruitment and Retention

When staffing, consideration needs to be given to the finite number of workforce resources available and the challenges some areas, such as rural and remote, have in attracting and retaining FCC service providers.

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.

The Staff Education and Training section speaks to training for collaborative practice. Many of the skills needed for effective teaming are soft skills that are challenging to educate. The recruitment and selection of team members must therefore test for team fit and collaboration skills.

Each FCC will utilize the following guidelines for recruitment and retention of its workforce:

- Build inter-professional competencies (Canadian Inter-professional Health Collaborative Competency Framework) into the selection interviews for staffing so FCCs are able to recruit people who have the skills to collaborate effectively.
- FCCs are to 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 providers.
- FCCs are to submit a workforce plan as part of their proposal that demonstrates innovative job design.

**Note:** An FCC Implementation Team will provide assistance and information on job design and inter-professional competencies to successful FCC applicants. A guide on professional competencies will be available at the formation stage on the FCC website.

### 9.3.2 Compensation and Benefits

In order to attract and retain a workforce, the FCC service provider compensation and benefits must be competitive with market rates so FCCs are able to attract and retain a health workforce. The funding for remuneration of FCC service providers would be included in the overall funding of FCCs. The FCCs are responsible for compensation of its health workforce. For AHS operated FCCs, employee compensation is subject to relevant collective agreements.

In Alberta, the majority of healthcare providers are paid on an hourly basis; consequently, health workforce (employees such as nurses and some independent contractors such as psychologists) are familiar and accustomed to being remunerated by the hour. The pay-by-the-hour method is a well-developed
remuneration model that is straightforward, easily understood, manageable and simple to implement, administer and modify. An hourly rate model can be easily adapted as the FCC program evolves. It also enables predictable and accurate budgeting, and allows FCC service providers to focus on overall client care provided collaboratively as part of the team. FCC service providers, including contractors and inclusive of physicians, will be paid on a model that encourages team based care.

Based on community needs assessments, FCCs may need to engage providers for small amounts of their time. Rather than establish all providers linked to an FCC, contracting should be a tool available to FCCs. Other providers may find employment agreements the preferred arrangement. FCCs can use both contract and employment arrangements.

Each FCC will be an employer and will recruit its own team of healthcare practitioners. Some of the FCCs will be small entities so it would not be feasible for each of these FCCs to run and administer pension/benefit plans for its employees. FCCs can buy into group pension/benefit plans; however, such group pension/benefit plans will have limited options due to the potential small size/pocket of each FCC’s staff. Alternatively, at this time, FCCs can pay out pension/benefits as part of its regular FCC service provider compensation. A preliminary analysis of compensation of healthcare providers in Alberta shows that the pension/benefits amounts to an average of 20% of regular compensation.

Each FCC will be required to submit estimated costs associated and related to collaborative team compensation and benefits. A guide on benchmark positions, including compensation ranges, will be provided at the formation stage. FCC physician compensation is under discussion.

### 9.3.3 Staff Training and Education

As identified in the *FCC Operating Policy Requirements*, located in section 2.7, all FCCs are required to use a collaborative interdisciplinary team approach to service planning and delivery. In designing a collaborative team environment for FCCs, it is important that FCC service providers have a common understanding of the factors that lead to effective team work. The CPESC adopted the *Inter-professional Competency Framework* released by the Canadian Inter-professional Health Collaborative (CIHC) as the set of competencies that will be used in Alberta. CPESC recommends that the competency domains in the framework are the standard to which all current and future collaborative practice and education initiatives (including educational curricula) in Alberta will be aligned.

Most health disciplines use a competency profile to describe the skills, knowledge and behaviours required for practice. Although many profiles acknowledge the importance of collaborative practice, not all incorporate collaborative practice competencies explicitly within them. The CIHC intended that the *Inter-professional Competency Framework* serves as a set of competencies to guide collaborative practice and education across all health disciplines and across Canada. These competencies have now generally been accepted across Canada. The following sets of six domains are quoted from the Competency Framework:

1. **Role Clarification**: Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve client/family and community goals.
2. **Individual/Client/Family and Community-Centred Care**: Learners/practitioners seek out, integrate and value, as a partner, the input and the engagement of the client/family/community in designing and implementing care/services.

3. **Team Functioning**: Learners/practitioners understand the principles of team work dynamics and group/team processes to enable effective inter-professional collaboration.

4. **Collaborative Leadership**: Learners/practitioners understand and can apply leadership principles that support a collaborative practice model.

5. **Inter-professional Communication**: Learners/practitioners from different professions communicate with each other in a collaborative, responsive and responsible manner.

6. **Inter-professional Conflict Resolution**: Learners/practitioners actively engage self and others, including the individual/client/family, in positively and constructively addressing disagreements as they arise.

Collaboration skills are developed over time and require education, support and resources. Research\(^2\) has indicated that one of main barriers to strong collaborative care is a lack of understanding of members’ roles among the team. Without understanding the competencies and the role of other professions, it is difficult to build trust and develop collaborative processes.

**Note**: Education on collaborative team-based care, roles and scopes of practice will be offered externally at the formation stage and beyond via contracted services through Alberta Health. It is not expected that each FCC will develop training in these areas.

FCCs will also be expected to provide for the teaching and mentoring of health care providers (e.g. practicum placements, preceptorships, etc.). Most health care provider education programs require students to complete a series of clinical experiences (referred to as clinical placements or practicums) in order to graduate or to meet the licensing requirements for practice. Education programs have expanded and the need for clinical placement sites, especially those clearly demonstrating collaborative practice, has grown as well. Some programs must send their students to other provinces for clinical experience in order to meet requirements for graduation. Thus, the provision of clinical placement sites and supervision of students, residents and interns is critical to meet the province’s need for future practitioners.

**Note**: As per the [*FCC Operating Policy Requirements*](#) located in section 2.7, a longer term implementation timeline may be required for the provision of teaching and mentoring of health care providers discussed above.

### 9.3.4 Occupational Health and Safety (OH&S)

Alberta Human Resources has created guidelines for community clinics and physician offices regarding OH&S standards entitled [*Handbook for Occupational Hazards and Controls for Community Clinics and Doctors’ Offices*](#).

FCCs will be considered a community clinic for purposes of OH&S.

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\(^2\)Besneret al. Creating Enticing Environments for Teaching & Learning, 2011  
9.3.5 Organizational Design

There will be two streams of work within an FCC: the business stream and the clinical stream. A business manager role has previously been identified as part of the core team mix. In general, the business manager is responsible for the clinic’s efficient and effective day-to-day operations within the FCC. The business manager is also responsible for providing leadership in the overall planning, co-ordination, implementation and evaluation of all programs and services provided to the population. In addition, the business manager is accountable for the successful and fiscally responsible operation of the clinic.

While the business manager is responsible for the efficient management of the FCC, he or she is not required to have clinical expertise. A centralized clinical advisory team will support the clinic in subsequent waves as part of the shared services model.

The role of the centralized clinical advisory team would be to:

- Provide direction regarding clinical practice guidelines, service provision and service delivery based on evidence-informed decision-making; and
- Co-ordinate and support FCC quality management, risk management and the primary care accreditation process.

9.3.6 Performance Management

Performance indicators that measure overall elements of workforce (and not just collaboration) are required as well and will be standardized across all FCCs.

Note: Performance indicators are in development and will be included in the accountability framework and grant agreement. An FCC Implementation Team will provide assistance and information on performance measures to successful FCC applicants.

9.3.7 Key Position Descriptions (Under Development)

Note: Functional benchmark job descriptions for key FCC positions will be provided to assist FCCs in job design. Occupational profiles will also be provided that outline scopes and roles of specific occupations.
SECTION 10:
PRIVACY AND SECURITY
10.0 PRIVACY AND SECURITY

10.1 Background and Definitions

The Health Information Act (HIA) addresses the collection, use, disclosure and protection of health information in the health sector. Alignment with the privacy and security requirements established in the HIA is critical to the establishment of the FCCs. The HIA is the primary piece of legislation governing privacy in the health sector; however, other privacy legislation may be applicable to the establishment and operation of FCCs such as the Personal Information Protection Act.

There is a boundary or “controlled arena” around custodians who are subject to the HIA. Subject to certain provisions in the HIA, individually identifying health information can move from one custodian to another within the controlled arena for authorized purposes. Outside the arena, the movement of individually identifying health information is more restricted.

10.1.1 Custodian

Under the HIA, a custodian is an organization or individual in the health system that receives and uses health information in their custody or under their control. Custodian is defined under section 1(1)(f) to include organizations such as AHS and provincial health boards; health service providers designated in the regulations as a custodian or who are within a class of health service providers that is designated in the regulations; and the Minister and Department. The definition does not include other provincial government departments and agencies or local public bodies such as schools, post-secondary institutions and municipalities.

10.1.2 Affiliate

An affiliate as defined by the HIA includes: an individual employed by a custodian; a person who performs a service for the custodian as an appointee, volunteer or student or under a contract or agency relationship with the custodian; a health services provider who is exercising the right to admit and treat patients at a hospital as defined in the Hospitals Act; an information manager, and a person who is designated under the regulations to be an affiliate.

10.1.3 Privacy Impact Assessment

Under the HIA, custodians must submit Privacy Impact Assessments (PIAs) to the Office of the Information and Privacy Commissioner before implementing practices or information systems that will collect, use, or disclose individually identifying health information. This includes changes to existing practices or information systems.

PIAs need to be developed to support the FCCs collection, use, and disclosure of individually identifying health information and enable Alberta Netcare access. Alberta Health has undertaken the development of an umbrella PIA as a requirement of establishing the FCCs. However, each FCC will need to develop their own more detailed PIA. As part of the umbrella PIA, Alberta Health will review the information collected.
generally at FCCs which is to be provided to Alberta Health for reporting purposes; part of this review will determine if the collection and use of individually identifying information meets the principles in the HIA in terms of accessing the least amount of information necessary, at the highest level of anonymity, based on the need to know.

10.1.4 Alberta Netcare

Custodians wishing to gain access to Alberta Netcare, and become authorized custodians, must complete a Provincial Organizational Readiness Assessment (pORA), PIA, as well as sign an Information Manager Agreement with Alberta Health. Authorized custodians are able to sponsor their affiliates for access to Alberta Netcare.

10.1.5 Office of the Information and Privacy Commissioner

The Office of the Information and Privacy Commissioner (OIPC) is the legislated oversight body for health information privacy in Alberta. The OIPC has a role in monitoring compliance by custodians with the HIA and may conduct investigations accordingly. The acceptance of a PIA by the OIPC is required before IMT solutions, which collect, use or disclose personal health information can proceed.

10.1.6 Threat and Risk Assessment

The Security Threat and Risk Assessment for an FCC would involve the use of security assessment tools already in place (e.g. Provincial Organizational Readiness Assessment (pORA)) to assess risk, vulnerabilities, and potential mitigation strategies. Existing tools and processes can be leveraged in a modified form to accommodate the establishment and operation of FCCs.

10.2 Privacy and Security Requirements for Wave 1

This Guide and Reference Manual is intended to provide FCC applicants with some basic information on the initial privacy and security requirements for the formation of an FCC. Additional privacy and security guidelines for FCCs will be developed to provide detailed operating requirements and guidance for FCCs.

There are two critical FCC privacy and security requirements for Wave 1 FCCs:

- Development of FCC policies and procedures related to privacy and security; and
- Development of an FCC PIA and submission to the OIPC.

10.2.1 AHS FCCs

In cases where the FCC is AHS-owned and operated, AHS acts as the custodian and the staff of the FCC is its affiliates. AHS FCCs will need to contact the AHS Privacy Office to complete their PIA and policy work when establishing an FCC.
10.2.2 Non-profit FCCs

The forthcoming privacy and security guidelines will detail how the custodian and affiliate relationships will be structured inside a non-profit FCC to support compliance with the HIA. These guidelines will provide FCCs with alignment between the requirements under the HIA and the governance structure of a non-profit FCC.

10.3 Policies and Procedures

Under the Health Information Act section 63(1), each custodian must establish or adopt policies and procedures that will facilitate the implementation of this Act and the regulations. These policies will be required to demonstrate compliance with the HIA and are required for the completion of a PIA. Developing policies and procedures tailored to the specific circumstances and the mix of providers in the FCC is required.

An example of policies and procedures can be found in the Alberta Medical Association’s Health Information Act Guide to Policies and Procedures for Physician Offices.

10.4 Privacy Impact Assessment

A PIA must be submitted to the OIPC prior to an FCC beginning operations. A specific FCC PIA will be required to cover the information systems used by an FCC, the governance structure, and should also reference the policies developed by the FCC.

An OIPC PIA template pre-populated with content from the Alberta Health FCC Umbrella PIA will be made available; the umbrella PIA covers the information sharing between Alberta Health and FCCs. The umbrella PIA will need to be consulted, as well as referenced, in the establishment of an FCC-specific PIA.

10.5 Access to Alberta Netcare

Netcare will be a key tool for FCCs. In order to obtain access an FCC must:

- Complete and submit a PIA to the OIPC;
- Sign an Information Manager Agreement with Alberta Health; and
- Complete and submit a pORA to Alberta Health for acceptance.

Proponents must submit their PIA and pORA before the clinic is operational as the PIA may reveal administrative and operational privacy issues, and the pORA process may reveal certain information technology security issues that need to be addressed before access to Netcare can be granted. These may take some time to resolve so proponents should plan to submit these documents at least three months prior to needing access to Netcare.
10.6 MyHealth.Alberta.ca Personal Health Portal

The MyHealth.Alberta.ca Personal Health Portal may be leveraged by Wave 1 FCCs to enable clients to manage their health information and support engagement with providers. FCCs utilizing this technology will need to develop privacy policies to support their interactions with clients through this technology.

10.7 Health Information Act Training

Training on the HIA is mandatory for all FCC staff and is required prior to an FCC gaining access to Alberta Netcare. Training is critical to ensure custodians and affiliates are in compliance with the HIA. Alberta Health has a training program on the HIA which provides information on the responsibilities of custodians and affiliates under the Act. The training also explains the rules for collecting, using, disclosing and protecting health information. Alberta Health’s HIA training will be made available to FCC applicants.

10.8 FCC Implementation Team

The Alberta Health FCC Implementation Team can provide support towards establishing custodial structures for non-profit FCCs, advice and guidance on the development of an FCC’s PIA, and will liaise with the Alberta Netcare deployment team to support access to Alberta Netcare.

AHS owned and operated FCCs can contact the AHS Privacy Office

Phone: 1-877-476-9874.

privacy@albertahealthservices.ca

Reference Material:

2. Office of the Information and Privacy Commissioner PIA Requirements Document
3. Alberta Health FCC umbrella PIA
4. OIPC Privacy Impact Assessment Template with blanked FCC PIA components included
5. Provincial Organizational Readiness Assessment template
ATTACHMENT 1

CRITERIA FOR FCC APPLICATION APPROVAL

Wave 1 Family Care Clinic applications will be evaluated on, but not limited to, the following criteria:

1. **Alignment with FCC program goal and objectives:** Evidence that application is in line with FCC program goal and objectives.

2. **Mandatory requirements:** Meets mandatory requirements relating to
   - Comprehensive Primary Health Care Services
   - Governance Structure
   - Legal Structure
   - Collaborative Interdisciplinary Team Mix
   - Hours of Operation
   - Minimum community/service area population
   - Information Management Technology

3. **Community Needs:** Demonstrated awareness of primary health care needs within the community as well as knowledge of primary health care services, supports and potential partners.

4. **Service Strategy Alignment:** Demonstrated alignment of proposed strategies with identified service gaps (i.e. evidence that the proposed service focus responds to unmet primary health care needs).

5. **Collaborative Team:** Collaborative team composition is appropriately matched to the FCC program philosophy and the proposed service area size and needs.

6. **Community Linkages/Partnerships:** Evidence of established or potential linkages/partnerships with other health care and community services agencies (e.g. parent link centre) to provide coordinated service delivery, including linkages with AHS and PCNs, where applicable, to support service integration.

7. **Operational Readiness:** Time required for the FCC fully operational; e.g., access to facilities, human resource commitments, and other administrative infrastructure.

8. **Client Attachment:** Evidence of effective mechanism to encourage client attachment to the FCC provider team.
9. **Critical Success Factors/Barriers**: Assessment of how thoroughly applicants have identified the factors that will be critical to their proposed FCC success; barriers to implementation and the associated mitigation strategies.
X FAMILY CARE CLINIC

Annual 3 Year Financial Plan

For the 3 year period April 1, 20XX to March 31, 20XX

Signature Section

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<th>Title:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCC Business Manager</td>
<td></td>
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<tr>
<td>FCC Board Chair</td>
<td></td>
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</tr>
<tr>
<td>AHS Chief Financial Officer (CFO)</td>
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</tbody>
</table>

For Non Profit FCCs, the Annual Budget should be signed by the FCC Business Manager and the FCC Board Chair. For Alberta Health Services (AHS) FCCs, the Annual Budget should be signed by the FCC Business Manager and the AHS CFO.
## X FAMILY CARE CLINIC

**Budget for Operating Revenues and Expenses**

**For the Year Ended March 31**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
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<tr>
<td>Contributions from Alberta Health</td>
<td>$</td>
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<tr>
<td>Contributions from municipal governments</td>
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<tr>
<td>Contributions from Alberta Health Services</td>
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<tr>
<td>Interest and Investment income</td>
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<td>$</td>
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<tr>
<td>Donations</td>
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<tr>
<td>Other Income (Specify)</td>
<td>$</td>
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</tr>
<tr>
<td><strong>Total Revenue</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Purchase of capital assets</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Computer hardware</td>
<td>$</td>
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<tr>
<td>Computer software</td>
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<tr>
<td>Leasehold improvements</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Total Purchase of capital assets</strong></td>
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<tr>
<td><strong>Expenses</strong></td>
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<tr>
<td>Basic Ambulatory care and follow-up</td>
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<tr>
<td>Chronic disease prevention and management</td>
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<tr>
<td>Addiction and mental health services</td>
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<tr>
<td>Care of patients with complex needs</td>
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<tr>
<td>Minor emergency care</td>
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<tr>
<td>Follow-up primary care</td>
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<tr>
<td>Rehabilitative care services</td>
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<tr>
<td>Family planning and pregnancy counseling services</td>
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<tr>
<td>Palliative and end of life care</td>
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<tr>
<td>Geriatric care</td>
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<tr>
<td>Health promotion and disease and injury prevention services</td>
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<tr>
<td>Population health improvement</td>
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<tr>
<td>Individual and family engagement</td>
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<td>Evaluation</td>
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<tr>
<td>Communication</td>
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<tr>
<td>Staff training and continuing professional education</td>
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<tr>
<td>Administration**</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Information technology</td>
<td>$</td>
<td>$</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td></td>
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<tr>
<td><strong>Excess (Deficiency) of Revenue Over Expenses</strong></td>
<td>$</td>
<td>- $</td>
<td>- $</td>
<td>- $</td>
</tr>
</tbody>
</table>

* Do not include deferred capital contributions.

** Includes facility operating costs, general office expenses, program medical supplies and equipment, and other expenses. Do not include amortization. Provide breakdown below.
### X FAMILY CARE CLINIC

**Schedule 1 - Expenses by Object Budget**
For the Year Ended March 31, 20XX

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries and Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician compensation</td>
<td>$ #VALUE!</td>
<td>$ #VALUE!</td>
<td>$ #VALUE!</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Licensed Practical Nurses</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health/Addiction Counselors</td>
<td></td>
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<tr>
<td>Dieticians</td>
<td></td>
<td></td>
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<tr>
<td>Physical Therapists</td>
<td></td>
<td></td>
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<tr>
<td>Occupational Therapists</td>
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<tr>
<td>Pharmacists</td>
<td></td>
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<tr>
<td>Social Workers</td>
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<td></td>
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<tr>
<td>Other Clinical Staff</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Business Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others administrative staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Salaries and Benefits subtotal</strong></td>
<td>-</td>
<td>$ #VALUE!</td>
<td>$ #VALUE!</td>
</tr>
</tbody>
</table>

**Purchase of Capital Assets**

- Computer hardware $ 
- Computer software $ 
- Leasehold Improvements $ 
- Other $ 
- **Total Purchase of Capital Assets** $ 

**Facility Operating Costs**

- General office expenses, supplies and services $ 
- Program/medical supplies and equipment** $ 
- Information technology $ 
- Communication $ 
- Other expenses*** $ 
- **Total Expenses** $ 

---

*Amounts must match totals on Statement of Operations
**Include equipment that costs less than the $5,000 capitalization threshold
***Do not include amortization. Specify significant amounts below.
Please provide a list of all the capital purchases planned for the next 3 years.
X FAMILY CARE CLINIC
MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING
March 31, 2013

The Accompanying Financial Statements are the responsibility of management. The Financial Statements were prepared in accordance with Canadian Generally Accepted Accounting Principles using the deferral method of accounting. Accounting policies are consistent with those used to prepare annual audited statements. There were no changes to accounting policies during the last twelve months.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising of written policies, standards and procedures, a formal authorization structure and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained and assets are adequately safeguarded.

In signing below, we certify that the following statements are true.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCC Business Manager</td>
<td></td>
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<tr>
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</tbody>
</table>

For Non Profit FCCs, Statement of Management Responsibility should be signed by the FCC Business Manager and the FCC Board Chair. For Alberta Health Services (AHS) FCCs, Statement of Management Responsibility should be signed by the FCC Business Manager and the AHS CFO.
X FAMILY CARE CLINIC
Statement of Operations
For the Year Ended March 31, 2013

<table>
<thead>
<tr>
<th>(Col A)</th>
<th>(Col B)</th>
<th>(Col C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>Budget</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>Contributions from Alberta Health</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Deferred capital contributions</td>
<td></td>
<td></td>
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<tr>
<td>Contributions from Alberta Health Services</td>
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<td></td>
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<tr>
<td>Contributions from municipal governments</td>
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<tr>
<td>Donations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest and Investment Income</td>
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<td></td>
</tr>
<tr>
<td>Other Income (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Budget</td>
<td>Actual</td>
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<tr>
<td></td>
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<tr>
<td>Basic Ambulatory care and follow-up</td>
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<tr>
<td>Chronic disease prevention and management</td>
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<tr>
<td>Addiction and mental health services</td>
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<tr>
<td>Care of patients with complex needs</td>
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<td>Minor emergency care</td>
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<td>Follow-up primary care</td>
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<td>Rehabilitative care services</td>
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<td>Geriatric care</td>
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<tr>
<td>Population health improvement</td>
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<td>Individual and family engagement</td>
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<tr>
<td>Communication</td>
<td></td>
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<tr>
<td>Staff training and continuing professional education</td>
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<tr>
<td>Administration*</td>
<td></td>
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<tr>
<td>Information technology/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excess / (Deficiency) of Revenue Over Expenses</td>
<td>$</td>
<td>-</td>
</tr>
</tbody>
</table>

* Includes facility operating costs, general office expenses, program/medical supplies and equipment, amortization and other expenses. Provide breakdown below.
### X FAMILY CARE CLINIC

**Statement of Financial Position**

As at March 31, 2013

<table>
<thead>
<tr>
<th></th>
<th>Actual 2013</th>
<th>Actual 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets:</strong></td>
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<tr>
<td>Current Assets:</td>
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<tr>
<td>Cash</td>
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<tr>
<td>Short-term Investments (Note 4)</td>
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<tr>
<td>Accounts Receivable</td>
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<td>Prepaid expenses</td>
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<td><strong>Total Current Assets</strong></td>
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<td>$ -</td>
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<td>Capital Assets (Note 5)</td>
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<tr>
<td><strong>Total Assets</strong></td>
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<td>$ -</td>
</tr>
<tr>
<td><strong>Liabilities and Net Assets:</strong></td>
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<td>$ -</td>
</tr>
<tr>
<td>Current Liabilities:</td>
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<td></td>
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<tr>
<td>Accounts payable and accrued liabilities</td>
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<tr>
<td>Deferred revenue (Note 8)</td>
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<tr>
<td><strong>Total Liabilities</strong></td>
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<tr>
<td><strong>Net Assets</strong></td>
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<tr>
<td>Invested in property and equipment</td>
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<tr>
<td>Invested in Leasehold improvements</td>
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<tr>
<td>Unrestricted</td>
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<tr>
<td><strong>Total Net Assets</strong></td>
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<td>$ -</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Assets</strong></td>
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<td>$ -</td>
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</tbody>
</table>
## X FAMILY CARE CLINIC

**Statement of Cash Flows**

**For the Year Ended March 31, 2013**

<table>
<thead>
<tr>
<th>Activity</th>
<th>2013</th>
<th>2012</th>
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<tbody>
<tr>
<td><strong>Operating Activities</strong></td>
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<tr>
<td>Excess of revenue over expenses</td>
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<tr>
<td>Items not affecting cash</td>
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<td>Amortization of equipment</td>
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<tr>
<td>Amortization of leasehold improvements</td>
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<tr>
<td><strong>Changes in non-cash working capital</strong></td>
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<td>Accounts receivable</td>
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<td>Prepaid expenses</td>
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<td></td>
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<tr>
<td>Accounts payable and accrued liabilities</td>
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</tr>
<tr>
<td>Deferred contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash flow from (used by) operating activities</td>
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<td></td>
</tr>
<tr>
<td><strong>Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions from Alberta Health for purchase of equipment</td>
<td></td>
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</tr>
<tr>
<td><strong>Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of equipment</td>
<td></td>
<td></td>
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<tr>
<td>Sale of equipment</td>
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<tr>
<td>Purchase of short-term investments</td>
<td></td>
<td></td>
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<tr>
<td><strong>Increase (decrease) in cash</strong></td>
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<tr>
<td>Cash, beginning of year</td>
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<td></td>
</tr>
<tr>
<td>Cash, end of year</td>
<td>$</td>
<td>$</td>
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<tr>
<td><strong>Cash flow supplementary information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notes to the Financial Statements

Note 1: Authority, Purpose and Operations

The [insert name here] Family Care Clinic (the "FCC") was established on [insert go live date here]. The FCC is governed by [insert name here] Not for Profit Corporation and provides comprehensive primary care services to residents within the FCC's geographical area in accordance with the terms of the approved Business Plan and approved amendments.

Note 2: Significant Accounting Policies and Reporting Practices

Basis of Presentation

The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles for Not-For-Profit Organizations.

These financial statements use the deferral method of accounting for contributions, key elements of which are:
- Unrestricted contributions are recognized as revenue in the year received or receivable
- Restricted non-capital contributions are deferred and recognized as revenue in the year in which the related expenses are incurred.
- Restricted capital contributions are deferred and recognized as revenue in the year the related amortization expense of the capital asset is recorded.
- All other revenue is recognized as unrestricted or restricted

Note 3: Budget

The budget was approved by the Board on ........

The above Notes are required at a minimum. Any additional Notes that are pertinent to the current fiscal period should also be included. Some examples are as follows:

Note 4: Financial Instruments

The carrying value of cash, accounts receivable and accounts payable and accrued liabilities approximates its fair value due to the immediate or short-term maturity of these instruments. Short-term investments are classified as held-for-trading financial assets and are measured at their fair value. Any changes in fair value measurements are reflected in the Statement of Operations in the period in which they occur.

Note 5: Property and Equipment

Computer equipment, software, leasehold improvements and other capital assets are stated at cost less accumulated amortization. Property and equipment are amortized over their estimated useful lives at the following rates and methods:

- Computer hardware: 25% straight line method
- Computer software: 20% straight line method
- Leasehold improvements: 6 years straight line method
- Other: 10% straight line method
## X FAMILY CARE CLINIC
### Schedule 1 - Expenses by Object
#### For the Year Ended March 31, 2013

<table>
<thead>
<tr>
<th></th>
<th>2019 Budget</th>
<th>2019 Actual</th>
<th>2012 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and benefits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
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<tr>
<td>Licensed Practical Nurses</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health/Addiction Counselors</td>
<td></td>
<td></td>
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<tr>
<td>Dentists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapists</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Occupational Therapists</td>
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<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other clinical staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other administrative staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and benefits subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility operating costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General office expenses, supplies and services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program medical supplies and equipment*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization of equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization of leasehold improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other expenses**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Include equipment that costs less than the $2,500 capitalization threshold
**Other: Specify significant amounts below

Please provide a list of all the capital purchases planned for the next 3 years.
### X FAMILY CARE CLINIC

#### Funding Reconciliation

For the Year Ended March 31, 2013

<table>
<thead>
<tr>
<th></th>
<th>2012 Budget</th>
<th>2012 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus as per Statement of Operations</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Add: Amortization of equipment</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Add: Amortization of Leasehold improvements</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Less: Purchase of equipment</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Less: Leasehold improvements</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Less: Amortization of deferred capital contributions from Alberta Health</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Surplus for budget purposes

<table>
<thead>
<tr>
<th></th>
<th>2012 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus for budget purposes</td>
<td>$</td>
</tr>
</tbody>
</table>
ATTACHMENT 3

STATEMENT OF OPERATIONS TEMPLATE

X FAMILY CARE CLINIC

Funded Development Support Activities

Management's Responsibility For Financial Reporting

3/31/20XX

In signing below, we certify that the following statements are true.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCC Business Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCC Board Chair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHS Chief Financial Officer (CFO)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Not-For Profit FCCs, the Development Support Budget should be signed by the FCC Business Manager and the FCC Board Chair.

For Alberta Health Services (AHS) FCCs, the Development Support Budget should be signed by the FCC Business Manager and the AHS CFO.
## X FAMILY CARE CLINIC

**Funded Development Support Activities**

**Statement of Operations**

**For the Year Ended March 31, 20XX**

<table>
<thead>
<tr>
<th>2013</th>
<th>Budget</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development grant funding contributions from Alberta Health</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other development support income</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Development Support Revenue</strong></td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal requirements to support formal establishment of corporate/governance structure and development of bylaws</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Recruitment of Business Manager and administrative support personnel and pre-operational salaries and benefits</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Development/implementation of appropriate financial and service reporting processes</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Development of operational and human resource policies</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Development and implementation of program manuals and other related materials as required</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Logistical support expenses (e.g., travel) required to support development and start-up of the FGC</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Development Support Expenses</strong></td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td><strong>Excess (Deficiency) of Revenue over Expenses</strong></td>
<td>$</td>
<td>-</td>
</tr>
</tbody>
</table>
ATTACHMENT 4

FCC PILOT PERFORMANCE MEASURES

These FCC Performance Measures have been approved for use in the three pilot FCCs. An Evaluation Framework with accompanying performance measures is under development and will involve broad consultation with experts and stakeholders.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Requirement</th>
<th>Measure / Indicator</th>
<th>Definition / Description</th>
<th>Reference</th>
</tr>
</thead>
</table>
| Manage timely access to primary health care, including same day access    | Provides same day access for both scheduled and non-scheduled appointments                      | Time to Third Next Available appointment by provider type                             | This indicator measures the number of calendar days to the third next available appointment (TNA) by provider type.  
Third next available appointment for a specific appointment type, count the number of calendar days from a selected data collection day to the day when the third next appointment of the same type is available. | AIM Access Measure and CIHI Pan-Canadian Access Indicator #32 Rationale: In the 10-Year Plan to Strengthen Health Care, the First Ministers recommended that 50% of the Canadian population have access to 24/7 PHC services by multidisciplinary teams by the year 2011. Excessive wait times can be a barrier to access to healthcare and are frequently monitored to indicate system performance and service supply constraints. Measurement of the third available appointment assesses wait time by taking into account same day                                   |
<table>
<thead>
<tr>
<th>Operate from 7am to 9pm, 7 days/week at a minimum, unless community needs demonstrate other hours of operation are required</th>
<th>Average number of extended hours (beyond 9:00 am to 5:00 pm, Monday to Friday), provided by FCC per Month during reporting period</th>
<th>This indicator measures the frequency of after hours coverage. Numerator: The Sum of the extended Hours in reporting period / Denominator: Number of Months in Reporting period</th>
<th>CIHIP an-Canadian Indicator #31 Rationale: In the 10-Year Plan to Strengthen Health Care, the First Ministers recommended that 50% of the Canadian population have access to 24/7 PHC services by multidisciplinary teams by the year 2011. A higher average number of extended hours per organization can be interpreted as a positive result.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track impact on local Emergency Departments, inpatient services and other health services</td>
<td>Percent of FCC individuals responding to the following question: What would you have done if the FCC was not able to help you today?</td>
<td>This indicator is intended to assess from the FCC individuals perspective, the impact of FCCs on emergency department usage. Numerator: Number of FCC individuals</td>
<td>Rationale: It may not be possible to determine if FCCs are impacting ED utilization in Calgary and Edmonton with administrative data. This indicator will provide a proxy measure for avoidance of non-urgent visits to the</td>
</tr>
<tr>
<td>Provide individual and family focused, comprehensive, quality, primary healthcare services across the lifespan, based on population health needs</td>
<td>FCCs will be individual / family focused</td>
<td>Percent of FCC individuals who respond yes to the care plan questions:</td>
<td>This indicator is intended to assess from the FCC individual’s perspective, how involved they are in their care planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Since you first came to the clinic, has anyone at the clinic... see questions 1a–f on Return Visit On-Site Survey (Appendix B)</td>
<td>Numerator: Number of FCC individuals responding “yes”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percent of FCC individuals who indicate that they are “satisfied / happy” or “very satisfied / happy” to the following questions:</td>
<td>Denominator: total number of survey respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How happy are you with… “…how much your family is involved in your care and the level of social supports in your care?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“…with the care you get from the Family Care Clinic?”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See question 2 &amp; 3 on the Return Visit On-Site Survey (Appendix B)</td>
<td></td>
</tr>
<tr>
<td>□ Gone to emergency</td>
<td>□ Done nothing</td>
<td>□ Treated myself</td>
<td>□ Got family or friend advice</td>
</tr>
</tbody>
</table>
| Denominator: total number of survey respondents (see question 5 Appendix B) | Emergency department.
**Visit Survey (Appendix B)**

<table>
<thead>
<tr>
<th>Percent of FCC individuals who “Strongly agree” or “somewhat agree” to the following question:</th>
<th>This indicator is intended to assess from the FCC individual’s perspective, their overall experience with care</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you think about your health care, how much do you agree or disagree with this statement:</td>
<td>Numerator: Number of FCC individuals responding “Strongly agree” or “Somewhat agree”</td>
</tr>
<tr>
<td>”I receive exactly what I want and need, exactly when and how I want and need it.”</td>
<td>Denominator: total number of survey respondents</td>
</tr>
</tbody>
</table>

see question 4 on the return visit survey (appendix B)

---

**Increase emphasis on health promotion, disease and injury prevention, screening, self-management, care of chronic disease and complex needs.**

<table>
<thead>
<tr>
<th>Primary care is connected to prevention and health promotion across the life cycle</th>
<th>Percent of FCC individuals, 12 years and over, who were screened by their PHC provider for the following common health risks over the past 12 months: tobacco use, unhealthy eating habits, problem drug use, physical inactivity, overweight status, unsafe sexual practises, and unmanaged stress and/or depression</th>
<th>This indicator measures the frequency of screening activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: Total number patients who have been screened by each sub category of health risks during reporting period</td>
<td>Denominator: Total number of patients 12 years and older during reporting period</td>
</tr>
</tbody>
</table>

CIHI #13
The Canadian Task Force on Preventive Health Care (CTFPHC) recommended a number of areas in which PHC providers should provide screening and advice on common health risks. These recommendations were based on strong evidence indicating that PHC can have a positive effect on long-term behavioural changes. A high rate for this indicator can be interpreted as a
<table>
<thead>
<tr>
<th>Provide clinical treatment to those with chronic / complex conditions.</th>
<th>For patients diagnosed with chronic condition / disease(s): The percent of FCC individuals maintaining or improving quality of life.</th>
<th>This indicator measures Quality of Life for those with chronic conditions Numerator: Number of FCC individuals maintaining or improving quality of life Denominator: total number of survey respondents</th>
<th>Quality metric SF12v2 or EuroQoL–5D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize a collaborative interdisciplinary team approach working to full scope of practice within defined role</td>
<td>Interdisciplinary team members work to full scope of practice as defined by their clinical roles and respective professional associations</td>
<td>The percent of FCC teams maintaining or improving measures of key elements of healthcare team effectiveness (HTE; e.g., collaboration, continuity of care, professional development, team functioning, work satisfaction)</td>
<td>This indicator is intended to assess from the FCC providers perspective, team effectiveness E.g., Healthcare Team Effectiveness Measures associated with HTE and AIM program activity</td>
</tr>
<tr>
<td>Improve coordination, continuity and integration of primary health care services including effective linkages with other relevant ministries and community service providers and agencies</td>
<td>Formally enrol patients, including unattached patients, to the FCC, for the provision of, and access to, primary healthcare services</td>
<td>Total number of current formally enrolled individuals to the FCC</td>
<td>This indicator measures how many FCC individuals have been formally enrolled. Total number of formally enrolled patients that have a formal enrolment agreement with FCC in a defined pilot period</td>
</tr>
</tbody>
</table>
ATTACHMENT 5

FACILITY GUIDELINES

The facility planning guide below is provided to help successful applicants establish their facility and space requirements. It provides an overview of the range of potential spaces that may be included in an FCC. **It is not intended to suggest that all FCCs must have all of facility elements described in the guide.** Depending upon the size of the proposed FCC, existing infrastructure and the unique needs and circumstances of the community space requirements will vary.

SUGGESTED ROOM SCHEDULE

The Suggested Room Schedule outlines the various components that may be found in an FCC. It specifies room types, room dimensions, and identifies some special considerations for these rooms. As FCC facility requirements will be dependent on the services provided, **not all of the rooms identified in the list are necessarily required.** The Suggested Room Schedule is organized into functional groups of space and with the Accommodation Reference Material helps provide the applicant with a visual sense of how the space may be organized.

**Staff Space**

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># Of Rooms Needed</th>
<th>Total Area Needed</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Office</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enclosed</td>
</tr>
<tr>
<td>Shared Office</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enclosed, for 2 people</td>
</tr>
<tr>
<td>Administrator</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enclosed, seating for up to 2 visitors/clients.</td>
</tr>
<tr>
<td>Touch Down/Technical/Open Area Workstation</td>
<td>4.6 – 5.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Administrative Support Space

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># of Rooms Needed</th>
<th>Total Area Needed</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception</td>
<td>5.5 m²/ workstation + counter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reception counter to have barrier free accessible portion</td>
</tr>
<tr>
<td>Waiting Room</td>
<td>1.5 m²/pers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adjacent and visible to waiting room</td>
</tr>
<tr>
<td>Child Play area</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical/Social Staff Consult – Interview Office</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Additional seating to meet with clients. May have double entry/exit.</td>
</tr>
<tr>
<td>Meeting Room (Small)</td>
<td>2 m²/pers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Groups up to 15 Flexible use/multi-purpose</td>
</tr>
<tr>
<td>Meeting Room (Medium - Large)</td>
<td>2 m²/pers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Groups of 15 to 25 Flexible use/multi-purpose</td>
</tr>
<tr>
<td>Medical Records file area/room</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Secure storage (18.6 m² supports approx. 3000)</td>
</tr>
</tbody>
</table>
### Application Kit Wave 1: Guide and Reference Manual

#### Room Description

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># of Rooms Needed</th>
<th>Total Area Needed</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storage - archive</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Secure storage, non-active records</td>
</tr>
<tr>
<td>Storage – equipment, oxygen</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies (office)</td>
<td>10 - 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer Server Room/cabinet</td>
<td>3.0 - 7.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Requirement to be reviewed, security needs</td>
</tr>
<tr>
<td>Staff Lunch Room</td>
<td>12 or 1.5 m²/person (over 8 people)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Counter with sink and space for refrigerator</td>
</tr>
<tr>
<td>Staff locker room</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Subtotals

#### Clinical / Social Spaces

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># of Rooms Needed</th>
<th>Total Area Needed</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Exam Room</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sink, Examination Table</td>
</tr>
<tr>
<td>Large/Barrier-free Exam Room</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sink, Examination Table, scooter/stretcher</td>
</tr>
<tr>
<td>Room Description</td>
<td>Suggested Room Net Area (m²)</td>
<td># of Rooms Needed</td>
<td>Total Area Needed</td>
<td>Existing Space Available</td>
<td>Total Net Area Needed</td>
<td>Guidance Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Minor Treatment/Procedure Room</td>
<td>15.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>access</td>
</tr>
<tr>
<td>Multi-purpose Counseling</td>
<td>12 – seats up to 6 people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sink</td>
</tr>
<tr>
<td>Specialist Requirement ECG/EEG/Evoked Potential/EMG Testing Room</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Construction requirements will be determined by specialist needs. (For multi-purpose use, there may be need to store extra equipment and supplies in the room)</td>
</tr>
<tr>
<td>Specialist Requirement ECG/EEG/Evoked Potential/EMG Prep Room</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sink, Examination Table</td>
</tr>
<tr>
<td>Radiography Room</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Special construction requirements. Control Room included (7.5 m²)</td>
</tr>
<tr>
<td>Ultrasound Room</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography Room</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Special construction requirements</td>
</tr>
</tbody>
</table>
### Room Description

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># of Rooms Needed</th>
<th>Total Area Needed</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab / Med room</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Includes sink, space for small refrigerator and secure cabinets (e.g. samples drawn &amp; stored)</td>
</tr>
<tr>
<td>Patient Gowning Area</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May be done in exam or testing rooms</td>
</tr>
<tr>
<td>Telehealth Consultation Room</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A/V requirements and acoustical privacy</td>
</tr>
<tr>
<td>Rehabilitation - Physiotherapist</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May be multi-purpose/multi-user</td>
</tr>
<tr>
<td>Pharmacy area</td>
<td>As required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Secure, counter and sink</td>
</tr>
</tbody>
</table>

### Service Space

<table>
<thead>
<tr>
<th>Room Description</th>
<th>Suggested Room Net Area (m²)</th>
<th># of Rooms Needed</th>
<th>Total Area Required</th>
<th>Existing Space Available</th>
<th>Total Net Area Needed</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washroom (public male/female)</td>
<td>4.6 – 6.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Barrier Free/bariatric/scooter accessible Note: If there is no access to general building washrooms, then code</td>
</tr>
</tbody>
</table>
requirements will determine capacity and size

| Washroom (staff) | 4.6 | Wheelchair Accessible |
| Washroom (clinical) | 4.6 | Wheelchair Accessible. Sample storage area |
| Housekeeping Room | 4.6 | Floor sink, supply storage |
| Clean Utility | 9.3 | |
| Soiled Utility | 9.3 | Sink |
| Loading Dock/Area | As needed | Access to loading area may be needed |

**Subtotals**

### Grossing Factors

<table>
<thead>
<tr>
<th>Net Area</th>
<th>Suggested Net Area Grossing Factor</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>In commercial office building or retail space (High efficiency 80%, limited amount of non-habitable space)</td>
<td>1.25</td>
<td>Focus is on leasing space in a larger building.</td>
</tr>
<tr>
<td>Commercial space (Moderate efficiency 75%)</td>
<td>1.33</td>
<td>Focus is on leased space.</td>
</tr>
</tbody>
</table>

**Note:** If a stand-alone facility is leased (includes all component and building grossing) then the grossing factor is about 1.60; however, new building construction is not being considered for funding.
# Space Requirement Calculation

<table>
<thead>
<tr>
<th>Space Summary</th>
<th>Total Area Required</th>
<th>Existing Space Available</th>
<th>Net Area Needed (New Space)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Space Subtotals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Support Space Subtotals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinical/Social Space Subtotals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Service Space Subtotals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td></td>
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</tbody>
</table>

x Grossing Factor

**Total Gross New Area Requirement (m²)**

**Note:** For determination of tenant improvement cost estimates, consider that the overall amount of space to be developed may include portions of existing space as well as new space dependent on the location, layout, and relationship of these spaces.

**ACCOMMODATION REFERENCE MATERIAL:**

The Accommodation Reference Material describes the different spaces in the FCC in greater detail and indicates functional relationships between the rooms and areas within the FCC. The information expands on the special design considerations for the rooms and their associated construction requirements. The Accommodation Reference Material also includes definitions of the terms used to describe floor area calculations.

**Room and Function Summary**

**General Information:** All rooms and program delivery space used by staff will require network connectivity (structured wiring or wireless). There is also need to consider the amount and type of electrical supply as equipment demands in the space may be very high dependent on the nature of the services offered.

**Office – Private:** The private office is used by staff requiring an enclosed space due to the need for privacy and confidentiality (written or verbal) or to conduct small meetings with colleagues.

**Office – Shared:** Offices may be provided for staff but shared on a scheduled basis. The shared offices would be enclosed and outfitted to accommodate two separate workstations.
Touch Down/Technical/Open Area Workstation: Some staff whose primary responsibilities will involve working in program specific space, such as counseling offices or exam rooms, could be accommodated at open or screened work stations.

Reception: The reception area provided for a receptionist will accommodate a workstation for the receptionist to perform clerical functions and a counter (also barrier-free accessible) to greet patients/clients and provide information and directions. It should be located to allow for good visual observation of the entry and waiting area.

Waiting Room: The waiting room will accommodate patients, clients and visitors who are waiting to see staff. The room should be located to permit staff to monitor those waiting but designed to preserve staff privacy and confidentiality. It will contain appropriate seating (including bariatric chairs as required) and may also provide directional information as well as displays and resource material.

Child Play Area: The child play area will be a distinct area adjacent to and visible from the main waiting area for parental supervision and control. Visibility from the reception area is also an asset. The area will accommodate appropriately sized furniture and storage for toys.

Clinical/Social Staff Consult-Interview Office: A consult-interview office would be located adjacent to the waiting area and staff workspace. It serves as common use space for staff that may not have an enclosed office or access to an exam room to meet with clients/patients. This office typically has two entrance/exit doors and may be used for initial contact with clients/patients, particularly when there may be safety concerns. There are acoustic requirements and may be security requirements as well (e.g. duress alarm).

Meeting Rooms: The meeting rooms will contain furniture that can be adjusted into various configurations to meet a variety of needs (e.g. meeting, classroom, video-conference, etc).

Medical Records File Area/Room: A medical records file area/room accommodates active patient charts and other files requiring some security. The area/room may be adjacent to the reception or administrative area to facilitate access to files with a lockable door or secure shelving systems. This space should be relatively small given the movement towards electronic charting and records management.

Storage Rooms: Various storage rooms or areas may be required to accommodate archived records (these should be secured in cabinet or lockable room) or equipment, medical (oxygen) and non-medical supplies, and program materials.

Supplies: An office supply room or area will support the functions of the office administration (e.g. storage of paper stock, office supplies, office files, photocopier, fax machine and mail service). The room will contain shelving, storage cabinets, and a work table as well as appropriate electrical supply. The size of this room will be dependent on the functions associated with the office and is not dependent upon the size of the patient population.

Computer Server Room/Closet/Cabinet: A room may be provided for server equipment; however, a secure cabinet that is easily accessible may also suffice. Consultation with IT specialists will confirm the need.

Staff Lunch Room: The staff lunch room will contain a counter with sink and cupboards and room for a refrigerator. There will be a table and chairs and possibly soft seating to accommodate staff.
**Staff Locker Room:** Staff locker rooms may be required in offices with a large number of staff and functions that require staff to change clothing on site. The room will vary in size according to the number of staff to be accommodated and will contain or be adjacent to the staff washroom.

**Exam Rooms:** Exam rooms will support physical examinations and treatment of patients. The rooms will contain a work station, exam table, sink, cupboards, stool and chairs as well as equipment related to the procedures undertaken. Exam rooms will be close to the waiting area with access to this area monitored by the reception. Acoustic requirements should be considered along with other special requirements, such as barrier-free accessibility or the need to accommodate larger numbers of people (e.g. family members, translators, others for support).

**Minor Treatment Room:** The minor treatment room can be used on an as-needed or scheduled basis for minor surgical procedures, sterile dressing applications, pre-exam measurements (blood pressure, height and weight), patient/client form filling, etc.

**Multi-purpose Counseling Room:** A multi-purpose counseling room will be used by various health professionals (psychologists, social workers, mental health therapists, dietitians, etc.) for group counseling, self-help groups, family counseling, etc. It could contain appropriate soft seating (chairs, sofas) and coffee/end tables, and table lamps and will be located near the entrance/waiting area.

**ECG/EEG/Evoked Potential/EMG Testing Room:** This room may be required should a specialist be affiliated with the FCC. The room may serve as a dedicated or multi-purpose assessment and testing room. There will be special construction requirements dependent on the testing to be accommodated. The room needs to be large enough to allow access to the patient as well as accommodate various equipment that is in use or stored. It will contain a work station, exam table, sink, cupboards, chairs and a linen hamper.

**ECG/EEG/Evoked Potential/EMG Prep Room:** As noted above, this room will only be required should a specialist be affiliated with the FCC. This room will support the functions of the Testing Room and will contain a patient change area, examination table for any preparation (e.g. placement of electrodes, etc.), sink and cupboards.

**Radiography Room:** This room will be used to provide diagnostic radiography and has special construction requirements to accommodate the equipment (e.g. increased power supply, floor and ceiling load, radiation shielding). The room will contain a separate Radiography Control Area (work counter, chair, system controls), workstation, sink, mobile equipment, radiographic system (includes patient table), storage cabinets, linen hamper and stool.

**Ultrasound Room:** This room will be used to provide diagnostic ultrasound and will contain an ultrasound machine, workstation, examination table, chairs, sink, linen hamper and storage cabinets. There will be need to accommodate family members if required.

**Mammography Room:** This room is used for diagnosis and assessment. There will be special construction requirements for this space (e.g. potential radiation shielding, etc.). The room needs to be large enough to accommodate equipment and will contain a work station, sink, storage cabinet, chair and a utility cart. Some equipment units are capable of biopsy, and if this function is required then there will be need to increase the room area by 15-20%.
Lab/Med Room: The lab/med room will be used in clinics where blood and urine specimens are collected and held for pick-up by personnel from medical testing companies. The room will contain a sink, countertop, shelving, and a small refrigerator. The medication room and lab may be combined with care taken to ensure infection prevention & control measures. If combined, it will contain storage for medications and drug samples in lockable cupboards.

Patient Gowning Area: If a patient gowning area is required, small private cubicles will be provided for patients to change and wait to be escorted to a testing/procedure room (e.g. radiography, ultrasound, mammography rooms, etc.).

Telehealth Consultation Room: A Telehealth consultation room will contain appropriate video-conferencing and AV equipment and construction will consider acoustic requirements and the potential need for privacy and confidentiality.

Rehabilitation – Physiotherapist Room: A rehabilitation room will have a larger floor area to support program delivery through accommodation of special furniture/equipment. Its location will be easily accessible from the waiting area.

Pharmacy Area: If a pharmacy area is required, it will contain a counter and sink with lockable cupboards.

Washrooms: Public washrooms may be available within the general building that the FCC is located in. If there are no building public washrooms, the occupant load of the FCC will determine the size of the washrooms required based on building code requirements. Staff and clinical washrooms will be barrier-free and contain a toilet and sink.

Housekeeping Room: A room may be provided for the storage of cleaning equipment of in-house or contract cleaning services. The room will include a hand sink, floor sink, shelving for paper products, and room for storage of bins/carts and cleaning equipment (e.g. mops, vacuum cleaners, etc.).

Clean Utility Room: A clean utility room will be used to store clean supplies (e.g. gowns, boxes of gloves, etc.) and may contain a counter top and both base and upper cupboards.

Soiled Utility Room: A soiled utility room will be used for the temporary storage of garbage, recycling, disposal of expired medications, sharps, etc. It may contain bins, a sink, countertop or shelving.

Calculation of Floor Areas – Net and Gross

Net Floor Area:

The net floor area of each room is the product of the interior room dimensions (length x width). The total net floor area is the sum of the room list.

Gross Floor Area:

The gross floor area includes other rooms, spaces and elements in a facility which may not be included in the room list but need to be included in the space (e.g. interior corridors, partitions, columns, mechanical and electrical service spaces, interior stairs, entrance vestibule, etc.). The total gross floor area is calculated by multiplying the total net floor area by a grossing factor that will provide an amount of space to cover the rooms, space and elements in a facility not included in the room list.
Family Care Clinics are a key part of the Government of Alberta’s goal for every Albertan to have a home in the healthcare system. The Family Care Clinic model was established to ensure that Albertans have access to primary health care when they need it, where they need it, and from the most appropriate service providers. The Family Care Clinic model is an innovative and comprehensive approach to primary health care for you and your family.

**STEP 1 – Guide and Reference Manual for Family Care Clinics**

**STEP 2 – Family Care Clinic Letter of Interest Form**
Complete and submit your Letter of Interest Form to Alberta Health at XXX@gov.ab.ca by <date>.

**STEP 3 – Family Care Clinic Application Form and Development Grant Funding Budget Template**
Complete and submit your *Family Care Clinic Application Form and Development Grant Funding Budget Template* to Alberta Health at XXXX@gov.ab.ca by <date>.

**Please ensure you submit all attachments, as requested in the application form, as well as your completed Development Grant Funding Budget Template when submitting your completed application.**

- Alberta Health will review all applications in <date>.
- Successful applicants will be notified prior to <date>. 
FAMILY CARE CLINIC LETTER OF INTEREST FORM

Submission Date: _________________________

Attention: Executive Director – Family Care Clinic Program
Primary Health Care Branch
Alberta Health

We are interested in a FCC in the community of ______________________ (name of community). We ______ (are or are not) currently a part of the ______________________ (name of PCN if applicable) Primary Care Network. Following is a brief overview of our vision for our proposed Family Care Clinic:

Name of Primary Contact _________________________

Email: _________________________ Phone: _________________________

Return and submit completed form to XXX@gov.ab.ca by <date>.

A representative from Alberta Health will contact you to arrange a time to discuss the next step.
FAMILY CARE CLINIC
APPLICATION FORM WAVE 1

IMPORTANT:

Prior to completing this application, you should have submitted your Letter of Interest Form to Alberta Health and read the Guide and Reference Manual for Family Care Clinics included in this Application Kit.

INSTRUCTIONS:

Answer each of the questions accurately, completely, and concisely. Applications will be evaluated according to the information provided.

The application review will focus on the areas listed in Attachment 1: Criteria for FCC Application Approval.

Closing Date

Your complete Family Care Clinic Wave 1 Application Form, along with supporting documentation as requested in the application, must be received by Alberta Health on or before <date>. It is also expected that at this time you will submit your completed Development Grant Funding Budget template to Alberta Health.

Applications must be submitted to Alberta Health at XXXXXXX@gov.ab.ca.

Contact

If you have questions about this application or experience technical difficulty with the form, please e-mail XXXXX or call XXXXXX at XXXXX for assistance.

Disclaimer

It is the applicant’s responsibility to ensure all information provided is up-to-date and correct to the best knowledge of the applicant, and the application reaches Alberta Health on, or prior to, the application closing deadline. Alberta Health is not responsible for applications that are delayed or misdirected. You should receive a follow up e-mail from Alberta Health confirming receipt of your application. If you do not receive confirmation, please e-mail Alberta Health at XXXXXXX@gov.ab.ca to follow up.

By submitting applications, applicants acknowledge that this is not a competitive procurement/tender and that determination of the successful candidates shall be made at Alberta Health’s sole and absolute discretion. In reviewing applications, Alberta Health reserves the right to discuss and disclose the contents of such applications within the broader public sector and the applicants, by submitting applications, expressly consent to such disclosure.
Successful applicants are not automatically approved for funding elements identified in this application form. Approvals for funding elements are sought through the Business Plan and Budget submission process.

Upon approval of an application, substantial efforts and support will be provided to the successful applicants throughout the next stages (formation, planning, pre-operational, and operational).
Family Care Clinic Application Form Wave 1

SECTION 1: ABOUT YOU

Note: Alberta Health may release this information without prior consent.

1. **Status**: Check which of the following best describes you and provide additional information as requested (Note: ensure you complete applicable sub questions):

   - [ ] Currently not an Entity/Clinic (You are an entirely new entity, not currently a clinic/network of clinics and want to establish a Family Care Clinic).
   - [ ] Independent Physician Clinic transitioning to a Family Care Clinic.
   - [ ] Single Clinic within a Primary Care Network transitioning to a Family Care Clinic
     - Indicate current Primary Care Network name: __________
     - Indicate current clinic name: _________ ______
   - [ ] Entire Primary Care Network/Multiple Clinics within a Primary Care Network transitioning to a Family Care Clinic Collaborative
     - Indicate current Primary Care Network name: _____________
     - Indicate all individual clinic names (use the clinics current name) for which you will be submitting application forms for. **You are required to submit 1 application for each clinic transitioning to a Family Care Clinic Collaborative.**

     | Clinic name:          |
     |----------------------|
     | Clinic address:       |

   - [ ] Other (i.e. Community Health Centre) transitioning to a Family Care Clinic.
     - Describe: ________________________.

2. **Business Contact Information**

<table>
<thead>
<tr>
<th>Name of Primary Contact (Title, First Name, Last Name):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address of Primary Contact:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Alternate phone number:</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
<tr>
<td>Email Address:</td>
</tr>
</tbody>
</table>
SECTION 2: ABOUT YOUR PROPOSED FAMILY CARE CLINIC

3. Family Care Clinic(s) Location Information:

Name of Proposed Family Care Clinic (Note: All Family Care Clinics will be required to meet Visual Identity Guidelines – in development).

Address of Proposed Family Care Clinic:

4. Community Profile:

A) Community Profile Awareness

☐ Check to confirm that you have read the community profile that corresponds to your local area located XXXXX.

B) Community Size/Service Area Population: A minimum community size/service area population of 2,500 is required in order to register as Family Care Clinic. Indicate the estimated community/service area population size that your Family Care Clinic expects to serve once fully operational and corresponding geographic boundaries that define your community/service area in the space provided below:

| Estimated community/service area population size: __________ |
| Describe the geographic boundaries of your community/service area population: |

C) Attached Clients: Indicate the estimated number of clients within your community/service area population that you expect will be attached to your Family Care Clinic once fully operational. In addition, please outline how you intend to encourage client attachment to your Family Care Clinic team (i.e. what mechanisms do you propose?):

| |
| |
D) **Additional Details:** If there are other relevant community/service area characteristics provide details:


5. **Existing Primary Health Care Services:** List the existing primary health care services in your proposed community/service area. Examples include, but are not limited to: Community Health Centres, Walk-in Clinics, Urgent Care Centres, Family Practice Clinics, Mental Health and Addiction Services, Community Support Services/Alberta Supports, Public Health Units, Hospitals, etc.

<table>
<thead>
<tr>
<th>Primary Health Care Service/Organization</th>
<th>Organization Name</th>
<th>Distance from Proposed Family Care Clinic (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

6. **Service Gaps:** Based on the community profile completed by Alberta Health and Alberta Health Services (Link) referred to in Question 4(a), describe any gaps in primary health care services in your community (i.e. primary health care services that are not available) and/or any difficulties regarding client access to primary health care services in your community. Also describe how your Family Care Clinic intends to address these gaps.

<table>
<thead>
<tr>
<th>Gaps in Primary Health Care Services</th>
<th>How Family Care Clinic Will Address Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. **Mandatory Family Care Clinic Comprehensive Primary Health Care Services:** Indicate how your Family Care Clinic intends to deliver the mandatory services listed (Onsite/Linked)

*Note:* you will have the opportunity to provide details about Family Care Clinic Partners/Linkages later on in this application.

<table>
<thead>
<tr>
<th>Mandatory Services to be Provided</th>
<th>How will the service be provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Onsite</td>
</tr>
<tr>
<td>Basic ambulatory care and follow-up</td>
<td>☐</td>
</tr>
<tr>
<td>Chronic disease prevention and management</td>
<td>☐</td>
</tr>
<tr>
<td>Addiction and mental health services</td>
<td>☐</td>
</tr>
<tr>
<td>Care of clients with complex needs</td>
<td>☐</td>
</tr>
<tr>
<td>Minor emergency care</td>
<td>☐</td>
</tr>
<tr>
<td>Follow-up primary care</td>
<td>☐</td>
</tr>
<tr>
<td>Rehabilitative care services</td>
<td>☐</td>
</tr>
<tr>
<td>Family planning and pregnancy counseling services</td>
<td>☐</td>
</tr>
<tr>
<td>Maternal and child health services</td>
<td>☐</td>
</tr>
<tr>
<td>Palliative and end of life care</td>
<td>☐</td>
</tr>
<tr>
<td>Geriatric care</td>
<td>☐</td>
</tr>
<tr>
<td>Health promotion and disease and injury prevention services</td>
<td>☐</td>
</tr>
<tr>
<td>Population health improvement</td>
<td>☐</td>
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<tr>
<td>Individual and family engagement</td>
<td>☐</td>
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</table>

8. **Team Composition:**

   A) **Minimum Team Mix:**

   ☐ Check box to confirm your commitment to meeting the minimum team mix requirements for Family Care Clinics. *(Note: The Family Care Clinic Guide and Reference Manual states minimal team mix requirements)*

   B) **Proposed on-site Family Care Clinic Team Members:** Indicate your proposed Family Care Clinic team members that will be co-located within your Family Care Clinic facility and provide details as requested.

*Note:* This question is intended to provide Alberta Health with an idea of the Family Care Clinic provider team you intend to have support your Family Care Clinic, it is not a requirement that you have these resources secured at this point, nor will approval of this application automatically imply approval of your
proposed human resources. Successful applicants will have access to resources if required help guide them through the establishment of their Family Care Clinic provider team and approvals for funding elements inclusive of human resources, will be sought through the Business Plan and Budget Submission Process.

* Working Definition of FTE: 1950-2200 hours/year (based on provider type)

<table>
<thead>
<tr>
<th>Position Title/Professional Designation (If Applicable)</th>
<th>FTE* (hours/year)</th>
<th>Proposed Function(s)</th>
</tr>
</thead>
</table>
| C) Proposed Linked Family Care Clinic Team Members (not located on-site): Indicate your proposed Family Care Clinic team members that will be linked to your Family Care Clinic facility and provide details as requested. Note: This question is intended to provide Alberta Health with an idea of the Family Care Clinic provider team you intend to have support your Family Care Clinic, it is not a requirement that you have these resources secured at this point, nor will approval of this application automatically imply approval of your proposed human resources. Successful applicants will have access to resources if required help guide them through the establishment of their Family Care Clinic provider team and approvals for funding elements inclusive of human resources, will be sought through the Business Plan and Budget Submission Process.

<table>
<thead>
<tr>
<th>Position Title/Professional Designation (If Applicable)</th>
<th>FTE* (hours/year)</th>
<th>Proposed function(s), reason for not collocating, and how this team member will contribute to team based care:</th>
<th>Offsite Location</th>
</tr>
</thead>
</table>

9. **Hours of Operation:** Does your Family Care Clinic commit to operating from 7:00 am to 9:00 pm, seven days/week? (Note: ensure you complete applicable sub questions)

- Yes
- No
  - Specify the alternate hours you propose, and provide rationale/substantiation for your proposed hours of operation, based on the needs of the community you will be serving.

<table>
<thead>
<tr>
<th>Alternate hours you propose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale/Substantiation for alternate hours:</td>
</tr>
</tbody>
</table>
10. **Information Management and Technology (IMT)**

☐ Check to confirm your commitment to utilize the standard provincial suite of IMT systems and services that is provided to all clinics by FCC Shared Services.

11. **Legal Structure**: Check the legal structure you intend to operate under and if you deem appropriate, provide associated details in the box below:

- ☐ Non-profit Corporation governed by a Board of Directors with provider, consumer, and community representation.
- ☐ Alberta Health Services operated Family Care Clinic with Advisory Committee, including provider, consumer and community representation.

Additional information (optional):

12. **Governance Structure**: Describe the proposed composition of your Board of Directors/Decision Making Board (**Note**: there are Board composition requirements located in the *Family Care Clinic Guide and Reference Manual*).

13. **Operational Policy Requirements**:

☐ Check to indicate that you have read, understand, and are committed to the Family Care Clinic Operational Policy Requirements detailed in the *Family Care Clinic Guide and Reference Manual*.

**SECTION 3: ABOUT YOUR READINESS TO OPERATE**

14. **Family Care Clinic Partners/Linkages**: Indicate partnerships/linkages your Family Care Clinic intends to make with individuals, groups, or organizations (e.g. parent link centres) to support the delivery of primary health care. Also indicate if you have any associated letters of commitment identifying the planned partnership/linkage, please indicate this, and submit these letters with your application. Include linkages to AHS and PCNs.
15. **Collaboration and Integration:** Describe how you plan to collaborate and integrate your Family Care Clinic with both Alberta Health Services and Primary Care Networks below:


16. **Funding Partners:** Identify any funding partners (e.g. municipality, community agency, business, etc.) that may contribute towards:

- One-time or on-going infrastructure and capital for your Family Care Clinic, and/or
- On-going operating costs (including in-kind support) for your Family Care Clinic.

Please attach a signed letter of commitment from each identified partner, including a description of the nature of the proposed support(s), the specific term(s) and amount(s) of the planned contribution(s).

<table>
<thead>
<tr>
<th>Funding Partner</th>
<th>One-time/on-going infrastructure and capital (Yes/No)</th>
<th>On-going operating costs (including in-kind support) (Yes/No)</th>
<th>Letter of Commitment attached (Yes/No)</th>
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</table>

17. **Family Care Clinic Team Member Commitment:** Has your group received commitment from any individuals to fulfill the human resources required to meet your proposed team composition identified in Question 8? *(Note: ensure you complete applicable sub questions)*

- [ ] Yes
  - Indicate individuals that have provided a letter of commitment and their corresponding position within your Family Care Clinic. Also ensure that you submit letters with your application.

- [ ] No
18. **Family Care Clinic Location**: Has your group identified a potential location for your Family Care Clinic? **Note**: ensure you complete applicable sub questions

- **Yes**
  - Provide location details:
    - Address: 
    - Square Feet: 
    - Will facility renovations be required to become fully operational? (Yes/No). If yes, describe renovations required:

- **No**
  - Provide brief description and time line of your plans to identify a permanent site:

19. **Estimated Time Required to Become Operational**:

   **A) Roadmap Timeline Awareness**:
   - Please check to confirm that you have read the *Alberta Family Care Clinic Development Roadmap* and associated Timelines located in the *Family Care Clinic Guide and Reference Manual*.

   **B) Ability to Meet Roadmap Timeline**: Please indicate whether you are able to meet the timelines as outlined in the *Alberta Family Care Clinic Development Roadmap*. **(Note: ensure you complete applicable sub questions)**
   - **Yes**
   - **No**
     - Provide details of your circumstance and provide details of your proposed alternate timeline.

20. **Critical Success Factors**: In the space provided below, identify critical success factors to ensuring your readiness to operate (e.g. training, leadership, etc.)
21. **Barriers to Success:** Identify any barriers that limit your readiness to operate and your associated mitigation strategy (i.e. outstanding contractual obligations, facility access, health workforce recruitment etc.).

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Mitigation Strategy</th>
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<tr>
<td></td>
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## SECTION 4: APPLICATION STRENGTHS

22. **Application Strengths:** What do you perceive as the strengths of your application? Provide any details related to these strengths that you feel may be pertinent in our assessment of your application (i.e. unique/innovative characteristics). **One** page max. length.

### Checklist for Family Care Clinic Wave 1 Application

- Ensure that all documents as requested in the application (i.e. relevant commitment letters), are scanned and ready to be attached when sending email with your completed application forms to Alberta Health at XXXXX@gov.ab.ca.
- Complete your Development Grant Funding Budget Template.
- Ensure that your Family Care Clinic Wave 1 Application Form, associated attachments (as requested in the application), and the Development Grant Funding Budget Template are submitted on or before <date>.
FAMILY CARE CLINIC DEVELOPMENT GRANT FUNDING BUDGET TEMPLATE

X FAMILY CARE CLINIC
Development Grant Funding Budget
For the Period Ended March 31, 20XX

In signing below, we certify that the following statements are true.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCC Business Manager</td>
<td></td>
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<tr>
<td>FCC Board Chair</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>AHS Chief Financial Officer (CFO)</td>
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</table>

For Not-For Profit FCCs, the Development Funding Budget should be signed by the FCC Business Manager and the FCC Board Chair.
For Alberta Health Services (AHS) FCCs, the Development Funding Budget should be signed by the FCC Business Manager and the AHS CFO.
X FAMILY CARE CLINIC
Development Grant Funding Budget
For the Period Ended March 31, 20XX

Legal requirements to support formal establishment of corporate/governance structure and development of bylaws

Recruitment of Business Manager and administrative support personnel and pre-operational salaries and benefits

Development/implementation of appropriate financial and service reporting processes

Development of operational and human resource policies

Development and implementation of program manuals and other related materials as required

Logistical support expenses (e.g., travel) required to support development and start-up of the FCC

Total Development Budget

$ -