



Proposal for Family Care Clinic Pilot Projects –  
An AMA Approach

Date: October 12, 2012

**TABLE OF CONTENTS**

I. INTRODUCTION .....	3
A. Background and Purpose.....	3
B. Selection of Pilot Projects.....	4
1. Process for proposal submission.....	4
2. AMA support.....	4
3. Rationale for selection criteria .....	4
II. SELECTION CRITERIA.....	5
A. Key Success Factors for Pilot Projects .....	5
B. Quality of Proposed Model .....	6
III. APPENDIX A – Evolution of Family Practice.....	9
IV. APPENDIX B - Primary Care Delivery – Conceptual Model .....	10
V. APPENDIX C – Proposal Scoring Worksheet.....	11

---

## I. INTRODUCTION

### A. Background and Purpose

One of the three priority areas identified by the AMA's Primary Care Alliance Board (PCA) is the development and implementation of pilot Family Care Clinic (FCC) proposals by interested physician groups. As part of the AMA *Primary Care Action and Project Plan*, this document proposes a process and selection criteria for AMA sponsored family care clinic pilot projects.

It is AMA's strong belief that improving primary health care, improving appropriate access and health outcomes can most cost-effectively be achieved by enhancing existing family practices to become robust medical homes. The AMA seeks to back up this belief through proactively providing evidence of successful pilot projects to the public and government.

This document relies heavily on the AMA Board document *A Vision for Family Care Clinics* available on the AMA website. The premise of this document is that what government has recently labeled as a "family care clinic" is in essence an enhanced family practice or "medical home"<sup>1</sup> (see diagram in Appendix A) exhibiting the following key attributes:

1. **Patient Attachment** – patients are identifiable and attached to a physician providing care in the context of a trust relationship with a high degree of support from a physician-led interdisciplinary primary care team.
2. **Patient-Centered Care** – a "one stop" clinic offering comprehensive services where patients receive the majority of their primary care.
3. **Continuity of Care** – the patient receives "cradle-to-grave" care from a consistent primary care team with all relevant patient data.
4. **Multiple Points of Access** – a collaborative care model allows patients to access care directly from the primary care team member that is most appropriate to their situation.
5. **Service Integration** – appropriate patient information flow is coordinated by a single responsible team regardless of where the patient is receiving care.
6. **Service Enhancement** – the clinic will not duplicate, but rather enhance, what is already in place in existing family practices, AHS programs and services, or specialized primary care initiatives of local primary care networks.

Another key premise of the vision document is that a family care clinic is not limited to a homogenous or prescriptive model of ownership or service delivery. Finally, FCCs as defined in the vision document are not in competition with primary care networks (PCNs) but instead integrate with them. The analogy is that the PCN becomes the primary care "medical neighborhood" in which the "medical home" resides. Services that cannot feasibly be delivered within a medical home may be provided through PCN programming, Alberta Health Services (AHS) programs or other providers. (See diagram in Appendix B)

Throughout this document the terms family care clinic (FCC) and medical home are synonymous.

---

<sup>1</sup> Medical home as defined in "AMA Vision for Primary and Chronic Care", Alberta Medical Association, October 2010 and "Patient-Centred Primary Care in Canada: Bring it on Home", The College of Family Physicians of Canada, October 2009

## ***B. Selection of Pilot Projects***

### **1. Process for proposal submission**

**It is important to be aware this is an internal AMA process only. At this time there is no guarantee that any proposed pilot projects will be approved or funded by Alberta Health. Application criteria, timeframes or specific funding details have not been released by Alberta Health at the time this document was developed.**

The process is open to any interested physician group (including PCNs) providing primary care that wishes to adopt a family care clinic type service model and apply for funding from Alberta Health to accomplish their vision. Given the government's urgency on family care clinics the proposed timeframe to present to Alberta Health is expected to be before the end of 2012. With this very short timeframe, it is likely that interested groups will have already engaged in preliminary visioning and planning. The proposed process is:

- (1) Interested physician groups should submit a brief letter to indicate their desire to develop a proposal (i) by email to [primarycarealliance@albertadoctors.org](mailto:primarycarealliance@albertadoctors.org) , or (ii) by fax 780.482.5445 "Attention: Nella Papaanni." The expression of interest letter should include some basic information about who is involved in the proposal, a cursory overview of your vision and a contact person for future correspondence.
- (2) Interested groups will be contacted and desired AMA assistance to develop the proposal will be identified and a resource assigned to work with the group.
- (3) A guideline and template for proposals will be provided to interested physician groups. This will allow for side-by-side comparison of proposals by a PCA Selection Committee. The template will be flexible, concise and in point form.
- (4) Written proposals must be submitted by a TBD date. Proposals will be reviewed by the PCA Selection Committee and evaluated against the selection criteria. A face-to-face or video-conference meeting with physician group representatives will be held to clarify questions and provide feedback.
- (5) Up to six proposals will be selected to proceed with more detailed proposal development.
- (6) Final proposals will be reviewed a final time by the PCA Selection Committee and presented to Alberta Health according to a timeline provided by Alberta Health.

### **2. AMA support**

AMA is committed to providing support to groups in developing and implementing pilot projects. Assistance will be available from the AMA as required, which could include project manager, proposal writer, planning facilitation, financial budgeting, or general review.

### **3. Rationale for selection criteria**

There are two selection criteria gates. The first category looks at the likelihood of success based on best practices research on the factors that make pilot projects successful. These are identified as key success factors. The second category of the evaluation is the quality of the proposal itself.

Given the highly political environment and the public visibility of these pilot projects, it is in everyone's best interest to ensure these projects are able to demonstrate success. Thus, the proposal must satisfy the key success factors.

Proposals that do not score well on the criteria are not ideal candidates for the initial AMA sponsored pilot projects. This is not necessarily a reflection on the quality of the proposal, but an assessment of whether the proposal would allow for relatively rapid and successful implementation as a pilot project. The AMA will continue to work with the physicians to refine the proposals so they may be submitted at a later date.

All things being equal, the selection committee will also consider the diversity of the pilot projects with the objective of demonstrating that multiple models can meet the objectives of the medical home.

## II. SELECTION CRITERIA

### *A. Key Success Factors for Pilot Projects*

A minimum score in this category is mandatory as these factors address the most common reasons projects fail in implementation. The minimum score is defined in the accompanying Scoring Worksheet in Appendix C.

#### **a. Project sponsorship**

- The project has a strong leader to act as sponsor with established decision-making authority and credibility among his/her peers.
- The project sponsor recognizes the importance of this role and his/her role in being the primary source of communication.
- The project sponsor is able and willing to dedicate the necessary time to the project.

#### **b. People readiness**

- The physician leadership can demonstrate shared values, a common vision and support for the leadership of the project sponsor.
- There is evidence of an initial level of awareness and support for change among impacted individuals (physicians, existing allied health professionals, support staff/management).
- There is a plan for staged communication and change management, including team development and training.
- The physician group has a keen awareness of the significance of pilot success (e.g., public/government scrutiny, public relations elements, commitment to knowledge sharing, etc.) and the need for a formalized evaluation.
- The physician group is supportive of engaging in public relations strategies, supported by AMA, to share their successes with various stakeholder groups (e.g., MLA visits, various media connections, etc.).

#### **c. Organizational readiness (e.g., ability to implement in a relatively short timeframe)**

- The physician group currently operates with defined existing management structures (e.g., have a formal group decision-making process, demonstrated successes with change).
- The physician group already has some existing formalized processes (e.g., existing team-based care model, documented team protocols).

- A portion of the relevant key elements of the proposed medical home are already in place (e.g., adequate physical infrastructure, established partnerships, trained clinical and administrative management resources).

**d. Scale of change**

- The selection committee will consider the magnitude of the change in terms of number of people impacted and the gap between current and future state (e.g., is it a significant change from how the group operates currently).
- The selection committee will assess whether the resource plan for physicians, allied health professionals and support staff seems realistic and achievable.

**e. Proposed timeframe**

- The selection committee will consider whether the proposal is realistic and implementable in less than one year.
- The selection committee will consider whether implementation is considered in incremental steps vs. “big-bang” implementation and how that relates to probability of a successful implementation.

**f. Economic feasibility**

- The proposal has identified and quantified funding sources for initial implementation as well as ongoing operations.
- The proposal identifies the preferred physician payment model (e.g. hourly rate, per capita, fixed annual amount, a blended model with some fee-for-service components, etc.) and quantifies the physician payment expected.
- The proposal has identified and quantified realistic and reasonable implementation costs.
- The proposal has identified and quantified realistic and sustainable ongoing operations costs including new and existing allied health professionals and support staff.
- The proposal clearly defines the ownership model and the governance structure.

## ***B. Quality of Proposed Model***

It is not intended that every proposal must consider every bullet point listed nor is the listing below exhaustive. The intent of the criteria in this document is to provide examples of the types of things to look for in assessing each of the key elements of the proposal. It is also not necessary that every element consist of new plans; where the clinic already meets the criteria, the proposal merely needs to demonstrate that it already exists.

**a. Alignment with Key Family Care Clinic Principles**

**i) Patient Attachment**

- How will the proposed model encourage greater patient attachment to a physician (e.g., more timely access, formal enrolment, confirmed patient lists, etc.)?
- How will attachment be defined and demonstrated?
- How will the clinic manage unattached patients?

**ii) Patient-Centered Medical Home**

- In what ways is the proposal patient-centered?
- What provisions are made for offering comprehensive care either in the medical home or with partnerships?

- 
- The proposal identifies the roles of existing and new allied health professionals.
  - How will the model incorporate greater focus on screening, prevention and health promotion?
  - Does the model contemplate strategies to address specific patient sub-populations (e.g., those with frequent ED use, frail and elderly, new immigrant or other underserved populations, uncontrolled chronic disease patients, pre-diabetes patients, target intensive users of the health system, etc.)?
  - What steps are being taken to ensure a positive patient experience?
- iii) Continuity of Care
- In what ways are there provisions for longitudinal care of the patient cradle-to-grave (e.g., physicians with specialized skills, partnerships through the PCN or otherwise for pre- and post-natal, geriatric, palliative, etc.)?
  - How will consistency of care be achieved (, identified patient panels, use of other health provider/physician teams, case conferencing, single EMR record, etc.)?
  - What is the plan for information management and sharing? How will patient privacy and data be protected?
- iv) Service Integration
- The proposal describes what service integration exists (or will exist) with the local primary care network.
  - The proposal describes how it will achieve coordination of patient care with other health service providers (e.g., AHS – primary care and specialty programs, specialists, community programs and services, etc.).
- v) Service Enhancement
- The proposal lists the spectrum of services to be offered through the medical home and those which are new or different.
- vi) Multiple Points of Access
- The proposal describes how patients will access services and the most appropriate care provider.
- b. Outcome Measurement and Evaluation**
- Has the proposal defined specific objectives and outcomes?
  - How well does the proposal specifically address key government issues: access to a family physician, after-hours access, wait times for primary care, and ED usage?
  - In what ways has the proposal enhanced (or demonstrated existing) provisions for appropriate access (e.g., appointment triage, after-hours provisions, same-day emergent appointments, paneling, use of phone calls, email, prescription renewals, etc.)?
  - How will the clinic measure and report metrics to demonstrate the effectiveness of the model in addressing the key government issues (e.g., tracking of newly attached patients, wait times, etc.)?
  - Does the proposal contemplate how data will be collected for evaluation of outcomes, who will be responsible and with what frequency?
- c. Accountability Plans**
- What reporting and assurance does the proposal make available to the funder and how frequent is that reporting?
  - How does the proposal provide for course correction and remedies if objectives are not achieved?
-

- The proposal demonstrates an understanding that conformance to minimum standards (as yet undefined) may be a requirement.

**d. Quality of Strategic Planning**

- Does the proposal outline a plan for community engagement?
- Is the spectrum of active community stakeholders defined for a) the planning stage and b) ongoing operations?
- Are the expected levels of engagement for each stakeholder defined for both a) the planning stage and b) ongoing operations (e.g., informational only, occasional feedback, advisory participation, governance participation, etc.)?
- Does the proposal have a plan for patient engagement, both in their taking ownership of their own health and for service delivery and quality improvements?
- Does the proposal plan for communications within the organization, with patients, other stakeholders, etc.?

**e. Value for Money**

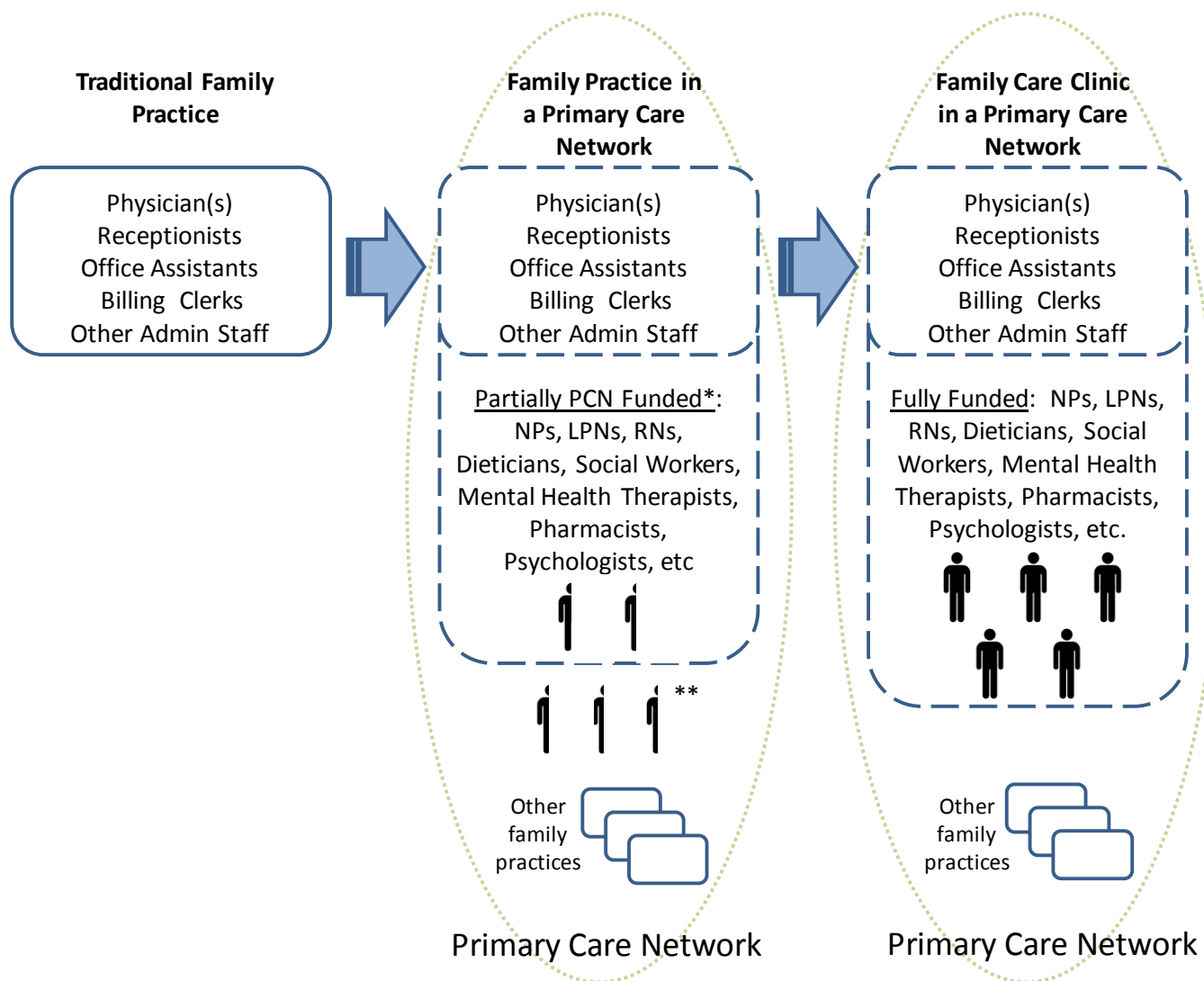
- Does the proposal demonstrate a quantitative return on investment from a health system perspective?
- Does the proposal demonstrate operational cost effectiveness relative to outcomes?
- Does the proposal have a plan for ongoing measurement and reporting of value for money metrics?

**f. Innovation**

- What new or innovative ideas are presented in the proposal that, if successful, could be propagated to other primary care settings?



### III. APPENDIX A – Evolution of Family Practice

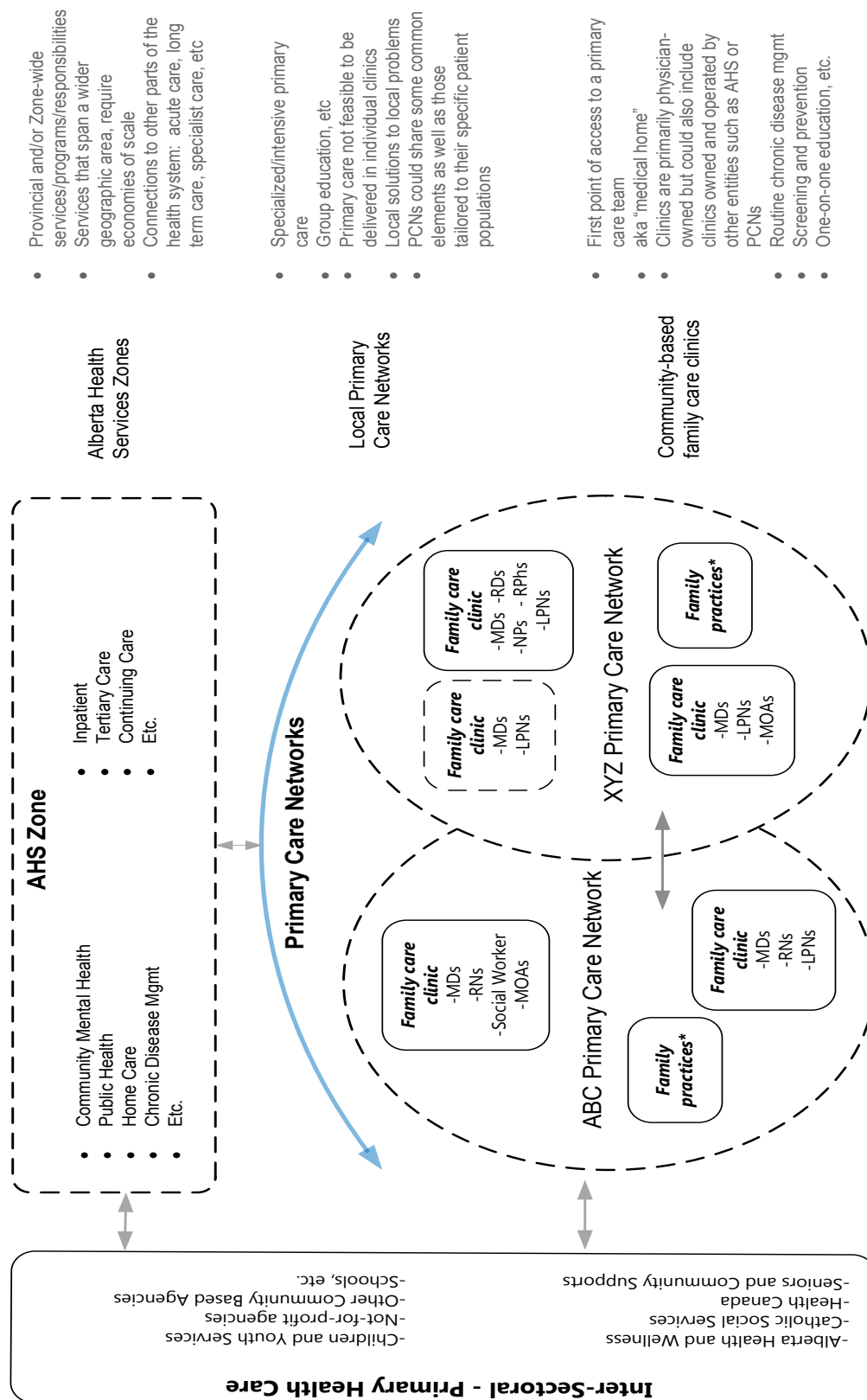


\* Current PCN funding limits the number and breadth of Allied Health Professionals patients can access.

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

## IV. APPENDIX B - Primary Care Delivery - Conceptual Model

### Primary Care Delivery – Conceptual Model



\* Traditional family practices would continue to be participants in Primary Care Networks

## V. APPENDIX C – Proposal Scoring Worksheet

Rating System- 3 strongly agree, 2 agree, 1 somewhat disagree, 0 disagree or unable to assess

### Section A - Mandatory for Go/No-Go – Key Success Factors

Success Factor	Indicators : consider the following when assigning rating to the proposal	RATING	WEIGHTING	SCORE (Rating X Weighting)
<b>Sponsorship</b>	<ul style="list-style-type: none"> <li>Proposal has a strong leader.</li> <li>Sponsor has decision-making authority and support of peers.</li> <li>Sponsor has sufficient time to devote to project.</li> </ul>		20	
<b>Organizational Readiness</b>	<ul style="list-style-type: none"> <li>Existing organization has established formal decision-making mechanisms.</li> <li>Formalized processes exist (e.g., team-based care model, documentation of team protocols).</li> <li>Demonstrated success implementing change.</li> </ul>		20	
<b>People Readiness</b>	<ul style="list-style-type: none"> <li>Physician group has clearly articulated shared values and commitment to the proposal.</li> <li>Demonstrated understanding of the significance to pilot success.</li> <li>There is a level of awareness and support for change among physician peers.</li> <li>Physician peers have committed availability to provide input/feedback during proposal development.</li> </ul>		15	
<b>Scale of Change</b>	Change proposed is relatively minor change to status quo (rating 3) or a major shift from status quo (rating 0)?		5	
	Rate on a spectrum of: Solo practice (rating 0), 6 – 8 physicians (rating 3) or large practice with 20+ physicians (rating 0).		5	
<b>Staff Resource Plan</b>	<ul style="list-style-type: none"> <li>Resource plan is detailed, well thought out and success does not rely heavily on new recruitment.</li> </ul>		15	
<b>Timeframe</b>	<ul style="list-style-type: none"> <li>Timeframe is realistic given other key success factors.</li> <li>Rate on a spectrum of: Timeframe &lt;2 months (0), between 6 and 9 months (3), greater than 1 year (0).</li> </ul>		10	
<b>Economic Feasibility</b>	<ul style="list-style-type: none"> <li>Detailed and realistic funding requirements sources and cost estimates.</li> </ul>		10	
<b>TOTAL KEY SUCCESS FACTORS SCORE</b>				

*\*If any proposal scores a 0 on any of the six key success factors, carefully consider before moving ahead to section B*

**Proposals must score at least 240 on Section A to continue on to Section B of the selection criteria.**

### Section B – QUALITY OF PROPOSAL

Component	Indicators: consider the following when assigning rating to the proposal	RATING	WEIGHTING	SCORE (Rating X Weighting)
<b>Patient Attachment</b>	<ul style="list-style-type: none"> <li>Encourages greater patient attachment to a physician (e.g., more timely access, patient contracts, confirmed patient lists, etc.). This is defined and demonstrated.</li> <li>Process to manage unattached patients.</li> </ul>		5	
<b>Patient-Centered Medical Home</b>	<ul style="list-style-type: none"> <li>Patient-centered and steps will be taken to ensure a positive patient experience.</li> <li>Provisions are made for offering comprehensive care.</li> <li>Roles of existing and new allied health providers are identified.</li> <li>There is a greater focus on screening, prevention and health promotion.</li> <li>There are strategies to address specific patient sub-populations (e.g., those with frequent ED use, frail and elderly, new immigrant or other underserved populations, uncontrolled chronic disease patients, pre-diabetes patients, etc.).</li> </ul>		5	
<b>Continuity of Care</b>	<ul style="list-style-type: none"> <li>Provisions for longitudinal care of the patient cradle-to-grave exist.</li> <li>Plan/process to ensure consistency of care (e.g., identified patient panels, use of nurse/physician teamlets, case conferencing, single EMR record, etc.) exist.</li> <li>A plan is available for information management and sharing.</li> <li>Patient privacy and data will be protected.</li> </ul>		5	
<b>Service Integration</b>	<ul style="list-style-type: none"> <li>Service integration exists (or will exist) within the local PCN.</li> <li>There is coordination of patient care with other health service providers.</li> </ul>		5	
<b>Service Enhancement</b>	<ul style="list-style-type: none"> <li>A spectrum of services is offered, of which some are new or different.</li> </ul>		5	
<b>Access</b>	<ul style="list-style-type: none"> <li>Patients will access services through the most appropriate care provider.</li> <li>There is enhanced, or there is already, appropriate access.</li> </ul>		5	

<b>Outcome Measurement and Evaluation</b>	<ul style="list-style-type: none"> <li>Defined specific objectives and outcomes.</li> <li>Government issues are addressed (e.g., access, wait times, after-hours and ED usage) and metrics are able to be measured and reported to demonstrate effectiveness.</li> <li>Data will be collected for evaluation of outcomes by a responsible person at a regular frequency.</li> </ul>		20	
<b>Accountability</b>	<ul style="list-style-type: none"> <li>Reporting and assurance is made available to the funder.</li> <li>Demonstrates an understanding that conformance to minimum standards (as yet undefined) may be a requirement.</li> <li>Has a course correction and remedies available if objectives are not achieved.</li> </ul>		15	
<b>Strategic Planning</b>	<ul style="list-style-type: none"> <li>Outlines a plan for community engagement during the planning stage and ongoing operations.</li> <li>Defines expected levels of engagement for each stakeholder at the a) the planning stage and b) ongoing operations.</li> <li>Has a patient engagement plan (taking ownership of their own health and for service delivery and quality improvements).</li> <li>Has a communication plan (within the organization, with patients, other stakeholders).</li> </ul>		15	
<b>Value for Money</b>	<ul style="list-style-type: none"> <li>Demonstrates cost effectiveness relative to outcomes.</li> <li>Has a plan for ongoing measurement and reporting of value for money metrics.</li> </ul>		15	
<b>Innovation</b>	<ul style="list-style-type: none"> <li>Has unique elements with large potential for positive impact to the community/primary care.</li> <li>Proposal has elements distinguishing it from other pilot projects (to encourage diversity of models).</li> </ul>		5	
<b>TOTAL QUALITY OF PROPOSAL SCORE</b>				

Key Success Factors score	
Quality of Proposal score	
<b>OVERALL SCORE</b>	