DISCUSSION PAPER

Patients First®

AMA VISION FOR PRIMARY AND CHRONIC CARE

October 2010

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Vision: Patients First®

Alberta's physicians are committed to a future where:

- Alberta's health care system is defined by quality: patient-centric; safe; timely; effective
- Albertans are supported in attaining optimal health with access to:
    - Healthy lifestyle choices
    - Healthy environments
    - Healthy communities
    - Health care services, with access based primarily on need not ability to pay
- The patient-physician relationship, founded on compassion, trust and respect, remains a cornerstone of the health system:
    - Patient choice of a physician
    - Physicians as the agents of patients, acting always in the patient's best interests
    - Clinical and professional autonomy is honored
- Resources:
    - For the health care system are allocated on the best evidence as to the overall contribution of these investments to a healthy economy and to the health objectives of patients and populations.
    - Within the health care system are allocated on the best evidence as to what is most effective and efficient in meeting health care needs.
- Patients and providers are partners with funders and managers in the management of the health care system with roles and responsibilities that are clearly specified with appropriate accountabilities.

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Mission: Leadership and Support

The Alberta Medical Association
stands as an advocate for its physician members
providing leadership and support
for their role in the provision of quality health care

INTRODUCTION

This document

- Creates a vision and strategy to shape and guide Alberta Medical Association (AMA) decisions and directions with regard to primary and chronic care delivery
- Presents our position to be shared with our partners in the process of developing a provincial strategy for primary and chronic care
- Is consistent with the AMA's mission and priorities (key result areas) as most recently expressed in its overall Strategic Plan and 2008 and 2009 Business Plan
- Considers:
    - The AMA's vision of Patients First®
    - Alberta Health Services' (AHS') *A Discussion Paper on Primary Care Models*
    - College of Family Physicians of Canada's (CFPC's) discussion paper *Patient-Centred Primary Care in Canada: Bring It On Home*

Patients First® and primary and chronic care

In order to realize our vision of Patients First®, we first require a sound, comprehensive, well planned and adequately resourced primary and chronic care system. Only then can primary care be organized and structured to optimize its delivery to best advantage for all Albertans.

With this document, the AMA proposes an initial approach to defining such a system. Within a workable model we provide goals, strategies and indicators of success to lay out, monitor and measure our progress to the system we hope to build, together.

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SEEKING A NEW APPROACH

Many organizations and individuals are working to improve and reform primary care in Alberta. The aforementioned AHS discussion paper on primary care models, for example, seeks to build upon the success of primary care networks (PCNs), essentially proposing an "enhanced PCN" as the hub for Alberta's primary and chronic care system.

The concept of Patients First® seeks to provide improved patient wellness and optimal Value for Patients™ by establishing the family physician as the leader of a team of health care professionals. In the AMA's view, PCNs are essential on a go-forward basis, but represent only one strategy to move us toward the system we seek in which the patient is at the hub.

This document, while aligning with many of the components of the proposed AHS model, goes beyond it by suggesting many other strategies to achieve our vision of Patients First®. The AMA believes that all parties involved need to broaden our thinking to achieve a vision in which:

- Every Albertan has a responsible primary care physician supported by an inter-professional team
- The system looks after the health needs of populations as well as the health of individuals
- The scope of primary care services increases to better accommodate a focus on prevention and health promotion as well as a more organized and systematic approach to chronic disease management
- Care is truly coordinated between the primary care team and the larger health care system
- There are stronger connections, enhanced support and improved access to specialist care for primary care physicians

Achieving such a vision will require thoughtful consideration and discussion. The AMA recommends that the concept of the **patient-centred medical care home** is a strong starting point. The CFPC presented such a model in their 2009 paper *Patient-Centred Primary Care in Canada: Bring It On Home:.*

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THE PATIENT-CENTRED MEDICAL CARE HOME

A medical home is a patient's personal source for multifaceted primary health care. It is based on a relationship between the patient and physician, formed to improve the patient's health across a continuum of referrals and services.

The CFPC defines a medical home as a medical office or clinic with the following "pillars" where each patient would have:

- Her or his own family doctor
- Access to other health professionals in a team led by the patient's own family doctor
- Timely appointments for all visits with the family doctor and with other primary care team members
- Arrangement and coordination of all other medical services, including referrals to consulting specialists
- An electronic medical record (EMR)

The above model, sourced from the CFPC paper, provides a pan-Canadian perspective. In Alberta, the AMA suggests the medical home would also include:

- Appropriate funding and resources
- Necessary system supports for ongoing evaluation and quality management
- A comprehensive information and knowledge management strategy
- Practice management support for increased scope, complexity, etc. of primary and chronic care systems
- Relationship management/governance support for and among physicians, clinics and the broader health care system, e.g., AHS

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In addition to the CFPC medical home model, the AMA's strategy for primary and chronic care should also consider the principles suggested and adopted by the American Academy of Family Physicians (AAFP), the American College of Pediatricians, the American College of Physicians and the American Osteopathic Association. While the principles are similar to the CFCP's model, those relating to care coordination and integration are highlighted more strongly.

AAFP'S PRINCIPLES OF THE PATIENT-CENTRED HOME

Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation: The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life (acute care. chronic care. preventative services and end-of-life care).

Care is coordinated and/or integrated across the complex health care system and the patient's community: Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care, when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centred outcomes that are defined by a care-planning process. Evidence-based medicine and clinical decision making support tools guide decision making. Physicians accept accountability for continuous quality improvement through voluntary engagement of performance measurement and improvement. Patients actively participate in decision making and feedback is sought. Information technology is used appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.

Systems enhance access to care: Systems such as open scheduling, expanded hours and new options for communication between physicians, patients and practice staff improve access.

Payment appropriately recognizes the added value provided to patients: Payment is based upon a structure that reflects value provided, supports adoption and use of health information, supports enhanced communication, recognizes case mix differences and allows physicians to share any savings.

ENVIRONMENTAL SCAN

Progress and challenges

Under the trilateral master agreement between Alberta Health and Wellness, the AMA and AHS, this province has been a leader in reforming the primary care environment. As we look back over this first phase, it's useful to ask: What has been accomplished and what challenges do we still face?

- Over the past several years, physicians have worked with various stakeholders to strengthen primary and chronic care delivery, for the most part through the development of the Primary Care Initiative (PCI) that led to the emergence of primary care networks (PCNs). Today over 30 PCNs are operating, involving more than 60% of Alberta's family physicians and with more in development.

- While considerable progress has been made, 36% of Albertans still do not have access to a PCN (as of June 2010) and 19% of Albertans still do not have a primary care physician (Health Quality Council of Alberta, 2009).

- Physician supply – almost universally across specialty type and geographic location – continues to lag behind actual requirements in Alberta and some areas of shortage are even more pronounced. The shortages ebb and flow over time, depending on a variety of factors:
    - Changing physician demographics
    - Changing population demographics
    - Demand for quality care
    - Health system changes: evolving health provider roles; technology changes and other delivery innovation

- Access to specialist services continues as a significant source of frustration for both patients and primary care physicians. AHS has developed clinical networks (CNs) which may serve to strengthen the relationships between primary care physicians and specialists, but these have just emerged onto the scene. Time will tell if CNs truly improve the linkages necessary to improve access.

- Increasing numbers of Albertans suffer from chronic disease. A recent survey found 79% of the adult population have one chronic disease and 57% have two or more (AHS, 2010). The incidence of chronic disease is also expected to get worse over time as the baby-boomer generation ages, creating more demand for services related to chronic disease. AHS estimates suggest the yearly cost for patients with multiple chronic diseases averages $10,000 per year – which exceeds $4,700 per year for patients undergoing cancer care and $600 per year for acute illness.

- Health care funding is uncertain and can change depending on economic forces impacting the province and Provincial Government. Hospitalization and secondary care account for much of the growth in expenditures. There will be intensified pressure to seek value for the dollars we spend in health care – and to achieve maximum health outcomes from the resulting services.

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- There is a lack of a formal collaborative planning and implementation between AMA and AHS when other sectors of the system are involved. The result has been some overlap and duplication (e.g., of some services offered by PCNs) or missed opportunities for improved, more seamless service.

- Initiatives such as the Performance and Diligence Indicators (PDI) program have laid the groundwork for PCN-based quality evaluation, but the system lacks a comprehensive framework or necessary investment for such important measurement to occur in a sustainable fashion.

- Physicians are trained to perform their time-honored professional role in overseeing the patient's primary care needs. The advent of PCNs, however, has shown that an evolved world of primary care will require physicians to apply skills and assume roles for which their traditional medical training has not necessarily prepared them, including new:

    - Leadership roles requiring training in organizational development and team effectiveness
    - Relationships requiring knowledge of governance and associated legal obligations

- On a more positive note, the recent addition to the fee schedule of an item for physician-patient collaboration on developing a complex care plan has shown to be a positive example of funding that supports comprehensive care of complex patients maximizing resources inside inter-professional teams and the community.

- Rural PCNs, which are typically much smaller in size, have been challenged to provide the full range of PCN services under the current funding model. With smaller overall patient populations than in urban areas, there is an even smaller base of patients with chronic conditions. However, the resource challenges of being prepared to serve a smaller group of chronic care patients are not necessarily less intense than in high-volume PCNs. For example, it is difficult for the rural physician to run effective programs because of recruiting challenges such as trying to recruit 0.25 FTE or a nurse or dietician positions. Many rural primary care physicians are seeking more flexible approaches in how they are funded and how they may use resources.

- To address the issues and complexities facing many smaller PCNs, pressure has intensified to look at new models for delivery that consider the optimal size needed for the various governance, infrastructure and clinical functions required. Many primary care physicians are concerned that the concept of local solutions for local problems may get diminished or lost as new models are explored.

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THE PILLARS OF THE MEDICAL HOME MODEL

An analysis follows of the five pillars of the medical home. For each we provide a gap analysis between the concept and current environment. We then lay out goals for the health system that might accompany each pillar along with strategies to reach the goals. Finally, we propose an initial set of indicators that could begin measuring progress against our goals. We welcome discussion to further develop these proposals.

Pillar 1: A personal family doctor for every patient

The role of the family physician is essential to each patient-centred medical home. This concept suggests every Albertan should have an identified primary care physician. This relationship goes further than that which currently exists within a PCN. Within this pillar, the affiliation between doctor and patient is formalized, and both parties assume roles and responsibilities with respect to their relationship.

Gap Analysis

- 19% of Albertans still do not have a primary care physician (Health Quality Council of Alberta, 2009).
- Currently, only 64% of Albertans have access to a PCN. (Alberta Health and Wellness)
- In many areas, Albertans have trouble finding a clinic close to their home that is willing or able to accept new patients.
- Relationships between patients and individual physicians are currently informal.
- Physicians would expect and require support for undertaking enrollment or attachment of patients and the associated administrative burden.

While the creation of the complex care plan has succeeded in creating a traceable link between physicians and regular patients for whom these plans have been developed, the administration/rules on the code have allowed some gaps to develop.

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Pillar 1: A personal family doctor for every patient

GOALS	STRATEGIES	INDICATORS OF SUCCESS
A personal family doctor for every patient.	Continue work on Validated Patient Lists (short term). Examine the concept of formal attachment/enrollment (long term). Develop incentives for patients to increase attachment to physicians through value-added services (e.g., access to phone consults for formally attached patients). Define patient responsibilities within the "medical home" and undertake public education. Embed responsibilities within the "Patient's Charter" that outlines patient responsibilities when using the health care system.	Number of patients who are formally attached to a family physician. Percentage of care that patients received from the doctor they are attached to. Physician-population ratios. Physician-patient panel size. Third-next-available appointment or related wait time data.[1] Decrease in emergency room utilization by patients for non-urgent medical issues.
Improve supply (attraction and retention) of physicians (by section and region) relative to targets. .	Promote family medicine with medical schools and provide incentives to: • Attract new graduates to family practice • Locate in areas undersupplied • Keep physicians within rural locations and support spouses/families of physicians Increase access and funding to process improvements (e.g., Practice Management Program [PMP] services, LEAN[2]). Investigate reasons why regions are undersupplied and develop marketing strategies aimed to address undersupplied areas as well as educational material to address perceptions, etc.	Number of medical students who choose residency in family medicine. Number of family medicine residents who move to community practice. Prevalence of marketing material and evaluation of effectiveness.

[1] "Third-next-available" refers to the time between when a patient calls to the third-next-available opening. This measure is used in Access. Improvement. Measures. (AIM) as an indicator of access.

[2] LEAN refers to the practice of maximizing customer value while minimizing waste. Simply, LEAN means creating more value for customers with fewer resources. A LEAN organization understands customer value and focuses its key processes to continuously increase it. The ultimate goal is to provide perfect value to the customer through a perfect value creation process that has zero waste.

Pillar 2: Access to a patient-centred team

Each practice that becomes a medical home should provide patients with access to a team of health care providers, working together within trusted relationships. Typically, a medical home provides "cradle-to-grave" care, coordinates all care and facilitates a partnership between individual patients, their physician/care team and, where appropriate, the patient's family.

Gap Analysis

- Currently, only 64% of Albertans have access to a PCN. There are a number of regions in the province that are totally without PCNs.
- There is some service duplication between PCNs and AHS resulting from insufficient coordination of activities between AHS and primary care physicians. AHS' focus has typically been acute care.
- Current incentives do not align to adequately support team-based practice (e.g., "whites-of-the-eye" rule in the Schedule of Medical Benefits [SOMB], inadequate recognition for group visits, etc.).
- Existing PCN funding model is insufficient to allow for expanded services and enhanced use of allied health care providers ($50 per patient since 2003 inception, based on a four-cut funding methodology). In fact, PCNs have been asked to do more with less if one considers the impact of general cost-of-living increases and salary increases for clinical staff since the 2003 rate was set.
- Current PCI policy prohibits any major investment in capital expenditures to house a whole team of health professionals. Many physician offices do not have adequate space for a team, or even part of a team, of multiple allied health care professionals.
- Existing PCNs have indicated the need for more assistance and/or funding to assist with:
  - EMR support for PCNs
  - General training of clinical staff
  - Physician leadership support
  - Team development and change management support
  - Ensuring PCNs can offer similar benefits for staff to those within AHS

Pillar 2: Access to a patient-centred team

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Expand coverage of primary care networks so that every Albertan has access to a PCN.	Continue to fund/support and explore alternative funding sources for the PCI program office and the PMP which support PCN development. Examine opportunities to streamline existing processes in developing a PCN (Primary Care Initiative Committee [PCIC] documentation requirements, etc.) that may deter physicians from developing or joining an existing PCN.	Number of PCNs established. Percentage of Albertans who are part of a PCN. Percentage of physicians in PCNs. Scope of services provided by PCNs. New, more streamlined processes for physicians and satisfaction with those processes.
Provide cradle-to-grave care that integrates all care, including that required outside of the "medical home."	Build on the existing PCN model and identify opportunities to broaden the scope that would include elements outlined in the "enhanced PCN" model presented by AHS. (This means embedding core services such as home care, public health, mental health and chronic disease management programming within a PCN.) Examine and evaluate incentives for the entire patient-team to achieve performance targets (e.g., clinical targets as proposed within PDI).	Percentage of alternate providers used in medical home (by percent of budget, etc.). Access to physicians (wait times).
Ensure "local solutions to local problems" remains a central principle.	Examine options and strategies to support the continuation of local solutions for local problems.	

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Improve and expand use of allied health care providers working together with physicians. (The physician would serve as the central hub or quarterback for all activities.)	Examine new funding options to support expanded services (reallocation of dollars to PCNs). Identify type and mix (e.g., physician assistants, nurse practitioners, etc.) required to support a medical home and associated training requirements. Examine funding requirements associated with overall support (physician leadership support, change management/training, etc.) and the basic infrastructure needed to support expanded health care teams, e.g., physical space in physician offices. Explore models to support unique challenges for rural primary care physicians (e.g., flexible systems for sharing resources across geographic boundaries/PCN boundaries or creation of an umbrella administrative support program for multiple PCNs. Examine need for development of clinical care pathways, guidelines or care plans to ensure team-based care is optimal. Re-examine four-cut funding methodology and address current funding rate of $50/patient. Address the delegated authority and the whites-of-the-eye rule in the SOMB to support the enhanced use of alternate providers. Allow physicians to bill for services provided to patients by their allied health provider partners within their medical home (similar to legal/dental model). Examine opportunities to expand use of, and associated payment billing codes for, the technology (e.g., webcams, etc.) within physician offices.	Increased percentage of alternate providers used in medical home (by percent of budget, etc.). Appropriate physician-to-allied-health-professional ratios (1:3 is suggested in literature). Access to physicians and/or their teams (wait times). Increase in physician panel size. Increased funding or flexibility to support infrastructure requirements. Increased funding to support physician leadership training, change management etc. Increased flexibility in rules to address identified challenges in rural Alberta. Establishment of health-team outcome indicators. Identification of health care gaps and strategies developed to address them. Establishment of outcome indicators for developing care plans, clinical pathways, etc. Change secured in negotiations for whites-of-the-eye rule and usage by physicians tracked. Availability of new billing codes to reflect expanded use of technology within physician offices.

Pillar 3: Timely access to patient-centred care

In a study conducted by Wong, et al. (2008), timely access to services was rated by patients as one of the most important elements of primary care. To improve access, we need more physicians, better organized, supported and more effective team-based care, enhanced and sustained EMR capability and innovative scheduling systems to assist physicians with the challenges they face within their practices.

Gap Analysis

- 19% of Albertans still do not have a primary care physician (Health Quality Council of Alberta, 2009).
- Physician supply lags behind actual physician-resource requirements. This shortage is almost universal across types of physicians and location of practice.
- Technology to assist physicians with respect to access is slow to emerge and many physicians continue to practise without an EMR. EMRs assist with easier information exchange:
  - To enhance the referral-consultation process
  - Between clinics or various health care settings, e.g., long-term care, hospitals, PCNs, etc.

  (Information from the Physician Office System Program [POSP] suggests that currently only 50% of physicians have an EMR but this should increase within the next year.)
- Many physicians need guidance and support to begin the often overwhelming task of looking at efficiency and access improvements within their family practice.
- Physicians have ever-increasing competing demands on their work time related to:
  - Delivery of clinical services—both insured and uninsured
  - Teaching
  - Research
  - Administration
- More than ever before, physicians are looking to work part time or for “turn-key” operations where they do not need to worry about administrative/management issues.
- Patients who cannot get timely access to their family physician often default to the local emergency department, which creates an even greater burden on this overwhelmed acute care resource.

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Pillar 3: Timely access to patient-centred care

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Improve the timeliness of access to primary care physicians.	Examine options around delegated authority and the whites-of the-eye rule in the SOMB to support the enhanced use of alternate providers to provide more access options for patients. Seek agreement towards implementing innovative delivery approaches aimed to improve accessibility for patients by substituting email, webcam or telephone encounters for face-to-face visits; reimbursement for group visits where appropriate, etc. Enable and develop incentives for physicians to increase their panel size and open practices to new patients.	Number of patients who are formally attached to a family physician. Physician-population ratios. Physician-patient panel size. Third-next-available appointment or related wait time data. Increased use of innovative delivery methods for consultations.
Improve supply of physicians (by section and region) relative to targets.	Explore incentives for physicians to locate in undersupplied areas. Examine feasibility and develop innovative programs such as teaching by primary care physicians, community support for recruiting of family physicians, paid travel or increased overhead coverage, etc.	Fewer physician vacancies in rural locations or underserviced areas within large urban centres. Number of physicians by type and specialty against benchmark targets. Increase in number of innovative incentive programs.

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Improve efficiency of physicians' offices.	Increase access to and funding for process improvements (e.g., AMA's PMP). Increase support for more services within the office environment (e.g., support for infection prevention and occupational health standard requirements. Explore other ways in which care can be provided that may be more efficient (e.g., email or telephone consults, group visits, etc.). Improve physician training/education in the areas of governance, leadership, change management, etc., (i.e.. via PMP services).	Increase in panel size of physicians. Increased level of programs and services for physicians.

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Pillar 4: Coordination of care including access to consulting specialists

Effective primary care should be comprehensive, ensure continuity and coordination of care between clinicians and all levels of care required. Within the medical home, the concept of continuity is critical not only to enhancing quality, but also to reducing errors. Ensuring that patients have access to a suite of primary care services provided and/or coordinated by their personal physician and team of health care providers is a key objective.

A medical home must be linked with other health care services in the community and province, including hospitals and other care service areas like home care, rehabilitation care, etc.

Gap Analysis

- Wait times for access to specialists continues to be problematic despite various efforts to improve. The prolonged wait period between referral and consultation and then to surgery/treatment make surgical outcomes less ideal than if referrals were more timely.
- Physician supply for specialists is below physician resource planning requirements. This shortage is almost universal across types of specialists and is worse in certain locations within the province.
- Specialists complain that many referrals are inappropriate, inadequately documented or improperly investigated prior to their referral.
- Many primary care physicians are overwhelmed with activities associated with securing a specialist referral and level of communication they receive back from specialists on acceptance of referrals.
- Difficult access to some high demand specialty areas (e.g., orthopedics) is exacerbated by competition from third-party payers (e.g., Workers' Compensation Board, armed forces) that provide incentives to preferred access.
- Specialist-linkages funding has been underutilized and has not resulted in the level of activities initially conceived. There has been a lack of integrated approaches as individual groups tackled the issues separately (until more recently).

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Pillar 4: Coordination of care including access to consulting specialists

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Enhance family physician-specialist linkages. Reduce work and time involved in making referrals.	AMA collaborates with AHS clinical networks (CNs) and explores opportunities for improved dialogue/involvement (short term). Seek ways to reduce work and time associated in making referrals to specialists by exploring (long term): • Reimbursement for telephone or email consults between general practitioners and specialists (to seek advice or support where a formal consult may not be required or for ongoing follow-up). • Unique models to improve access to specialists such as block booking time of specialists, specialty clinics (e.g., triage and assess consultation requests pre-referral). • Concept of a "clearing house" or centralized centre that can assist family physicians in determining where the most immediate and appropriate specialist opening may exist. • Funding to seek opportunities for enhancing pre-screening of referrals to specialists to ensure best use of specialists (similar to the Bone and Joint Project). • Technological supports to streamline information flow between general practitioners and specialists. • Funding to support the expanded use of telemedicine.	Third-next-available appointment for specialists. Establish baselines and reduced wait time targets for period between: • Family physician and specialist • Specialist consult and treatment/surgery More standardized, simpler and uniform process for consultation/referral. Physician satisfaction on access to specialist services. Active involvement of family physicians within AHS clinical networks. Increased operating room time provided by AHS.
Improve supply of specialist physicians (by section and region) relative to targets	Development of a specialist recruitment and training strategy with associated funding.	Supply of key specialists (e.g., orthopedics) against benchmarks.
Improve efficiency of specialists.	Increase access and funding to process improvements (e.g., AMA's PMP services).	Number of specialists undertaking "access improvement activities."

Pillar 5: Electronic information and communication (EMR)

The patient-centred approach emphasizes the need for electronic health records/EMRs to assist in the management of patient care as well as to facilitate electronic communications between physicians and other health care providers to facilitate the coordination of care in a “cradle-to-grave” medical home model.

Gap Analysis

- Currently 50% of physicians in Alberta do not have an EMR within their office (Source: POSP). While EMRs have greatly assisted with information sharing, currently it is often ad hoc, slow or irrelevant.
- The capacity of qualified service providers in Alberta has limited the rapid adoption of EMRs by physicians.
- Many physicians have resisted adopting an EMR for many reasons including: uncertainty around continuation of POSP after the master agreement expires March 31, 2011; lack of awareness of the benefits to make them desire the change and undertake the work involved in implementing an EMR (new work flows, changed roles, general change management issues); the time commitment required and physician out-of-pocket costs.
- Communication and information-sharing barriers exist due primarily to a lack of infrastructure and exchange protocols required to safely and securely exchange information between systems and/or facilities.
- Funding for EMRs relies on 30% contribution by physicians and some physicians find this prohibitive.
- The current Qualified Service Provider (QSP) EMRs are not able to support aggregate data collection and detailed reporting required for population-level chronic disease management, assessment and planning.

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Pillar 5: Electronic information and communication (EMR)

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Improve the uptake of EMRs by primary care physicians.	Continue financial support of POSP initiative. Re-examine existing POSP rules/policy such that they are consistent with a medical home with multiple health care providers (allow them to be covered under POSP funding). This would entail examining the adequacy of the current license ratio of one physician to three clinical or administrative staff. Additional funding to support EMR development within an enhanced PCN model or a medical home. Ensure a strong and effective plan is implemented, continuing to communicate the various resources and benefits available to physicians participating in the program under Vendor Conformance and Usability Requirements (VCUR) 2008. Ensure the Master Service Level Agreement between government and the QSPs remains valid for the next five years. AMA to continue to advocate on primary care physicians' behalf for an EMR strategy that will enable effective and continuous patient management.	Number of clinics/physicians with an EMR. Integration of all important data sets into EMRs. Number of clinics/PCNs using EMR data sets for program planning and delivery to improve health outcomes. No turnover in EMR vendors. Consistent funding over long term. Physician satisfaction on QSPs and POSP initiative overall.

SOME OTHER FUNDAMENTALS

Appropriate funding and resources

In the patient-centred approach, remuneration models create the incentives for the delivery of primary care to more diverse patient populations and enable the change embodied in the medical home model. Funding needs to be sufficient, predictable, sustainable and stable. There is strong evidence that investment in developing the right mix of incentives and providing the required resources will ultimately result in savings to the health care system.

In a study by Reid, et al (2010) on a medical home approach in Seattle, Washington, the medical home model approach was noted to improve the quality of health care and control costs (see Appendix A for detailed information). Their research study found that patients in a medical home experienced 29% fewer emergency visits, 6% fewer hospitalizations, and an estimated total savings of $10.30 per patient per month. They estimated a return on investment (ROI) of 1.5:1. That is, for every dollar spent to implement the medical home, they gained $1.50 in savings.

In another study by Landon, et al. (2010), the biggest barriers to the successful implementation of the patient-centred medical home were developing the right payment model, as well as the need for up-front funding to assist in the assembly of the infrastructure and personnel required to implement the model correctly.

A third study evaluating seven of the largest medical homes within the USA noted four critical factors were essential for success. These are: dedicated care managers; expanded access; performance management tools; and effective incentive payments (Fields, Leshen and Patel, 2010).

Gap Analysis

- Currently funding is inadequate/insufficient to meet or address the broader mandate of an enhanced PCN within the medical home concept.
- The processes and bureaucracy associated with developing PCNs and alternate relationship plans (ARPs) have been very onerous for physicians and some have opted out as a result. There has also been, in general, inadequate access to alternate payment models.
- Many physicians suggest the existing PCN four-cut funding is outdated and does not determine panel size fairly.
- The current PCN reimbursement rate of $50 has not been addressed in several years despite continued increases in health care provider salaries, leasing and other business costs, etc.
- Sustainability issues exist and include non-financial resources (providers, plant, equipment, supplies) to reach the service delivery objectives of a medical home. Over many years, a shortage of human resources and out-dated or inadequate infrastructure have been consistent and formidable barriers to sustaining meaningful health care reform.

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Appropriate funding and resources

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Remuneration supports the efficiency and cost-effectiveness of physician time and skills.	Explore a variety of innovative and varying remuneration systems that support the desired service delivery model (without increasing bureaucracy) and that are aligned to the goals of comprehensive primary care: • Gross income versus net income alternatives (i.e., addressing overhead issues). • Physicians as employees versus independent contractors • The role of incentives to foster desired outcomes/behaviors • The possibilities within benefit programs. • Turn-key operation	Evolving average cost.
Remuneration is fair and appropriate to support the concept of an enhanced PCN or medical home.	Reallocate funds to support the population health, home care activities, etc., within the enhanced PCN model. Develop a strategy that recognizes regional differences in business cost (consistent with the business costs study commissioned by the AMA). Support and fund physicians for email communications, expanded phone consultations, group visits and other innovative delivery options outlined to achieve efficiencies and improve timely access to care. Align the rules within the SOMB to facilitate the type of care desired (e.g., removal of the whites-of-the-eye rule to enhance the use of alternate providers and allow physicians to bill for them). Explore financial support for technology to achieve desired standards in coordinating care across diverse, multidisciplinary teams and sectors. Examine funding requirements for infrastructure to support expanded health care teams, e.g., physical space in physician offices.	Increase in percentage of funding to primary care (not to the detriment of tertiary and other non-primary care). Increased funding or flexibility to support infrastructure requirements. Flexible policy rules to address identified challenges in rural Alberta.

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Overall funding is stable/predictable to allow for long-range planning that can extend over several years.	Explore models to support unique challenges of rural primary care physicians, e.g., flexible systems for sharing resources across geographic areas/PCN boundaries. Ensure funding is stable and sustainable through trilateral negotiations and secure specific commitments to this end.	New agreement with a long-term financial commitment. Financial incentives from multiple budgets are aligned and used to support desired programs.

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Quality improvement and evaluation

An important support to the medical home concept is the ability to monitor performance in meeting the health needs of Albertans. Tracking performance is an essential element of evaluating the success and overall value of the model. To ensure a solid foundation, indicators of success – key performance indicators (KPIs) – need to be considered in all areas.

Gap Analysis

- Alberta has a strong information technology strategy, but it falls short of being a comprehensive, overall information strategy that should include core information requirements and identify gaps in our current information base. Data-analysis capacity needs to be strengthened – and sustainably resourced.
- Experience with the PDI Initiative has shown the difficulty in achieving a consensus around how KPIs shall be defined, used, measured, etc.
- Few physicians have the technology or infrastructure in place to track evaluation/outcome data easily.
- Current PCN funding does not adequately support the workload and costs associated with well-defined and sophisticated evaluation processes.
- The mandate of the PMP is currently limited to family physicians within (or pursuing) a PCN. All physicians require quality improvement initiatives – not only those in PCNs. Enhancing support to assist physicians with efficiency or improving access as well as building evaluation processes/systems will contribute to overall improved primary care delivery and access to specialist services.
- Despite evidence that defined chronic disease patient registries and attachment to a family physician improve health outcomes, there is sparse activity in these areas.

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Quality improvement and evaluation

GOALS	STRATEGIES	INDICATORS OF SUCCESS
Foster and promote a focus on quality improvement and evaluation.	Develop a provincial framework with corresponding funding and support for quality improvement and evaluation (beyond current efforts). Seek a broader mandate (and associated funding required) for PMP to facilitate support for: • Assisting physicians with relationship management, change management, organizational development, governance, etc. between physicians, physicians and clinics, and physicians and other parts of the health care system, e.g., AHS. • Quality improvement activities (e.g., improving access, office efficiency). • Helping physicians to develop and implement evaluation strategies/processes. Continue funding and support for the PDI initiative. Identify and develop benchmark quality improvement activities for PCNs and strategies to address issues. Provide support and funding to promote evaluation activities throughout all the dimensions within the medical home concept. Develop continuing medical education options to offer more quality-improvement offerings.	PMP scope expanded to cover all physicians, general practitioners and specialists. Evidence of relationship management/governance structures. Increased uptake by physicians of access/efficiency improvement activities. Increased uptake by physicians of evaluation processes/systems. Number of PDI initiative indicators adopted or percent involvement of physicians in PDI or similar programs.

GOALS	STRATEGIES	INDICATORS OF SUCCESS
	Build evaluation and measurement systems into each medical home to chart ongoing progress.	
With our trilateral partners, develop a sustainable, well-resourced information strategy that identifies core information requirements and gaps in our current information base.	Develop an independent, trusted source of information and analysis, integrated with trilateral agreement. Build on existing expertise, including the HQCA and others, e.g., Institute for Health Economics (IHE). Establish expectations for program information required to support decision making. Review delivery-based plans/programs on an ongoing basis against expected outcomes and objectives.	Master Agreement contains terms to resource and sustain a more robust and comprehensive information strategy. Increased funding to organizations such as HQCA, IHE, etc. Successful development of a strategy with key deliverables outlined and targets identified.

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STRATEGIC ACTIVITIES

The AMA's strategic plan for physician compensation encompasses objectives and goals over a multi-year period. The following strategic activities have been identified to move forward toward these objectives and goals which will impact and be impacted by the primary and chronic care strategy (PCCS).

1. Embed PCCS throughout the work of the clinical networks.
2. Identify topics for Negotiations 2011 discussions.
3. Develop a discussion paper on formal enrolment.
4. Identify supports to facilitate the introduction of physician assistants into primary care.
5. Identify supports to encourage family physician-led, inter-professional teams composed of allied health professionals.
6. Develop options to further enhance general practitioner-specialist interfaces.
7. Develop options to address process improvement opportunities
8. Collect information and review.
9. Identify strategic linkages of PCCS to the Alberta health system.

Details on the purpose of these activities, plans for the next 12 months, links to strategic objectives, etc., will be developed going forward. This work will empower the advancement of a medical home model for Alberta and we look forward to involving all parties in these discussions.

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APPENDIX A

Highlights of evidence supporting the medical home concept

Considerable research and evidence suggests having more Albertans attached to primary care physicians and improved access to primary care services through a team-delivered approach, will result in better population health outcomes, increased physician and patient satisfaction and a reduction in overall health expenditures. Some of the more recent studies worth noting include the following:

- Ferrer, et al., outlined the mechanisms that make primary care successful and noted: "Primary care improves health care system functioning through such services as managing and triaging undifferentiated symptoms, matching patient needs to health care resources, and enhancing the system's ability to adapt to new circumstances" (Ferrer et al. 2005: 691).
- Barbara Starfield, in her book *Primary Care: Balancing Health Needs, Services and Technology* discussed primary care in regard to morbidity, quality, population health, health systems and international health. She and her colleagues have noted that primary care is an international phenomenon and that the countries with poor primary care services, on average, have poorer health outcomes (Starfield 2000).
- Having a regular source of care was found to be the most important factor associated with receiving preventive care services, even after considering the effect of demographic characteristics, financial status, and need for ongoing care (Starfield, Shi and Macinko, 2005).
- Atun et al. confirmed that "improved population health outcomes and equity, more appropriate utilization of services, greater user satisfaction and lower costs in health systems were associated where a strong primary care orientation exists" (Atun, 2004).
- The greater the continuity or longitudinality of the care relationship between care providers and patients, the greater the level of satisfaction and ability to reduce costs (Starfield, Shi and Macinko, 2005).
- A recent study in British Columbia reported that "attachment to practice is consistently inversely related to the total cost of care for both diabetes and Congestive Heart Failure (CHF) for higher-care-needs patients." The study indicated that a 1% increase in attachment to practice is associated with an average decrease in the total cost of care of $80–$323. This decrease was noted to be primarily due to a decrease in hospital costs and, to a more modest degree, medical costs (general practitioners, specialists and diagnostic services) (Hollander, et al., 2009).
- Raddish, Horn and Sharkey (1999) examined the association between provider continuity and costs. While they only included hospital visits, instead of hospital costs, the authors concluded that continuity of care "was associated with a reduction in resource utilization and costs" (Raddish et al., 1999). Similarly, Sans-Corrales and colleagues (2006) conducted a systematic review of the relationship between family medicine attributes and satisfaction, health and costs. They found that continuity of care was related to lower costs (Sans-Corrales, et al., 2006).

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- Guthrie and colleagues stressed the importance of continuity of care and noted that patients are more satisfied when they regularly see the same doctor (Guthrie et al, 2008).
- Rosenthal found that urban and rural communities where there was an adequate supply of primary care practitioners experienced lower infant mortality, higher birth rates, and immunization rates at or above national standards” (Rosenthal T.C. 2008).
- Schoen and colleagues surveyed adults in seven countries, and reported having a medical home was associated with less difficulty accessing care after hours, improved flow of information across providers, a positive opinion about health care, fewer duplicate tests, and lower rates of medical errors (Schoen C., et al. 2007).
- Reid et al. (2010) reported on a medical home approach pioneered by Group Health Cooperative, a nonprofit, consumer-governed, integrated health insurance and care delivery system based in Seattle, Washington. Their research study found the medical home concept to not only improve the quality of health care but also control costs. In their one year evaluation, they found that patients in the medical home experienced: an increase by ten minutes in the average length of a clinic patient-physician visit, 29% fewer emergency visits, 6% fewer hospitalizations, and an estimated total savings of $10.30 per patient per month. They estimated a return on investment of 1.5:1. That is, for every dollar spent to implement the medical home, they gained $1.50 in savings.
- In another study by Landon, et al (2010), the biggest barriers to the successful implementation of the patient-centred medical home were developing the right payment model, as well as the need for up-front funding to assist in the assembly of the infrastructure and personnel required to implement the model correctly.
- A study by Fields, Leshen and Patel (2010) of the seven largest medical home pilots within the US showed evidence that four factors are essential to the success of a medical home approach. These included: dedicated non-physician care managers; expanded access to services; performance management tools; and effective and appropriate incentive payments.

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APPENDIX B

Goal statements from General Practice Representation Working Group

The General Practice Representation Working Group brings together the executives of the Sections of General Practice and Rural Medicine along with the physician leads group of the PCNs. A number of specific goals have been established in terms of what the AMA wants to achieve for its members.

These include:

- Care should be patient-centred and built on sustained, caring, compassionate and trusting patient-physician relationships.
- Services must be high quality and emphasize continuous improvement, clinical competence, evidence-based practice and satisfaction for patients and providers.
- Incentives will be aligned to support team-based practice while improving clinical outcomes.
- Stable funding will be provided to support the development of stable models and teams.
- The focus will be on health maintenance, disease prevention, early interventions and identifying those at risk of disease.
- The system provides information, advice and infrastructure to enable self-care.
- Every Albertan should have access to, and be encouraged to select, a family physician who is able to provide continuity of care.
- Information management and decision-support strategies will be aligned with the PCCS.
- Reliable information systems are necessary to support high quality, cost-effective primary care.
- Education and training supports are aligned to support the PCCS.
- Care coordination resides with the primary care physician as the leader of the primary care team.
- Primary care should be provided through a collaborative medical and non-medical team approach that is coordinated and facilitated by the primary care physician.
- Public health, home care and other aspects of primary care must work together collaboratively.

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- Could expand the following objectives based on content in AHS paper, Australia literature, CFPC report on medical home, etc.:
  - Access
  - Accountability
  - Continuity
  - Coordination
  - Integration
  - Effectiveness
  - Quality
- Financial incentives from multiple budgets are aligned and used to support desired programs. This includes funding required to support multidisciplinary care.
- The performance and outcomes from the PCCS are measured and monitored.
- The development of new programs and enhancements is informed by the best-available evidence.
- The PCCS fosters strong relationships between family physicians and other providers.
- The PCCS will lead to a system that is able to facilitate the achievement of provincial priorities.
- The PCCS will be cognizant of administrative burdens and costs as well as ease of implementation.

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