



PCN Evolution

VISION AND FRAMEWORK

Report to the Minister of Health



Alberta Medical Association
Primary Care Alliance Board
December 2013

The contributions of Alberta Health, Alberta Health Services, the Alberta Medical Association, Alberta College of Family Physicians and physician leaders are integral to this report and are gratefully acknowledged.

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VISION AND FRAMEWORK

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I. Introduction

The AMA's Primary Care Alliance (PCA) Board, with contributions from the Primary Care Network (PCN) 2.0 Steering Committee, has prepared the vision and framework for PCN Evolution in this report to the Alberta minister of health, as mandated in the Primary Medical Care/Primary Care Networks Consultation Agreement.

PCN 2.0 will implement strategies – some over the next few months and some over years – to do the following:

- Informally and formally connect Albertans with family physicians and PCN health homes.
- Improve access and integrate delivery of primary health and social needs-based care.
- Enhance health professional teams by working toward an inter-professional team model.
- Establish seamless transitions for patients between primary care and specialists and specialty care.
- Establish effective governance at all levels and increase organizational effectiveness.
- Develop clear performance goals and measurement indicators for PCN accountability.
- Review physician compensation models and funding to enable effective team-based care.
- Implement information management and information technology (IM/IT) enablers for efficient information sharing.

Members of the PCA include representatives from the AMA's sections of General Practice and Rural Medicine and PCN physician leads from each of the five zones. Members of the steering committee include: the PCN Physician Leads Executive (five physicians), Section of General Practice (SGP) and Section of Rural Medicine (SRM) presidents, Alberta College of Family Physicians (ACFP) president, and Alberta Health (AH) and Alberta Health Services (AHS) representatives.

The terms PCN 2.0 and PCN Evolution will be used interchangeably in this report.

II. Background

1.0 The Birth of PCNs – The Early Story

Alberta's PCNs arose from the 2003 to 2011 trilateral Master Agreement between the Alberta Medical Association (AMA), AH and AHS. Schedule G of the agreement outlined the trilateral Primary Care Initiative and described the formation of local primary care initiatives in which a group of family physicians (in a not-for-profit corporation [NPC]) formed a legal agreement with the regional health authority (now AHS) to provide a set of primary care services targeted to the local needs of a defined population of patients.

Local primary care initiatives were later rebranded as PCNs. The first PCN "went live" in May 2005.

The PCN objectives set out in the agreement are to:

- Increase the proportion of Albertans with ready access to primary care.
- Provide coordinated 24/7 management of access to appropriate primary care services.
- Increase emphasis on health promotion, disease and injury prevention, care of the medically complex patient and patients with chronic diseases.
- Improve coordination and integration with other health care services including secondary, tertiary and long-term care through specialty care linkages to primary care.
- Facilitate use of multi-disciplinary teams to provide comprehensive primary care.

The PCN services set out in the agreement are:

- a. Services directly related to the provision of primary care services to the patient population:
 - Basic ambulatory care and follow-up

- Care of complex problems and follow-up
 - Screening/chronic disease prevention
 - Care of chronically ill patients
 - Family planning and pregnancy counseling
 - Obstetrical care
 - Well-child care
 - Palliative care
 - Geriatric care
 - Minor surgery
 - Minor emergency care
 - Primary in-patient care including hospitals and long-term care institutions
 - Rehabilitative care
 - Psychological counseling
 - Information management
 - Population health
- b. Services related to linkages within or between primary health care and other areas:
- 24-hour, 7-day-per-week management of access to appropriate primary care services
 - Access to laboratory and diagnostic imaging
 - Coordination of:
 - Home care
 - Emergency room services
 - Long-term care
 - Secondary care
 - Public health
- c. Acceptance into the patient population and provision of the service responsibilities to an equitable and agreed upon allocation of unattached patients.

1.1 Current Status of PCNs and the PCN Program

As of September 2013, there are 41 PCNs operating in Alberta. Approximately 3,000 family physicians currently practice in PCNs serving the primary care needs of over 75% of Albertans (as paneled in PCNs in April 2013). PCNs have grown and matured over the past eight years, with early PCNs now well established. According to the May 2011 Malatest and Associates summary report on *Primary Care Initiative Evaluation*, the 29 PCNs evaluated had made major strides in meeting the objectives originally laid out for them. The 2011 findings are mentioned in sections of this report, where relevant.

PCNs are meeting objectives outlined for them in a variety of ways, as local needs dictate. These PCNs have earned their place as an important and integral part of the primary care delivery landscape in Alberta. The key successes of the current model are:

- PCNs have provided a platform for building a primary health care (PHC) system in Alberta. Prior to the introduction of PCNs, there was no mechanism for AH, AHS and the AMA to engage in joint planning and coordination of PHC services.

- PCNs have delivered significant improvements in PHC. A series of evaluations conducted over the past several years have demonstrated improvements in access to, and delivery of, comprehensive PHC for Albertans (e.g., *Primary Care Initiative Evaluation Summary Report*, 2011, by the Health Quality Council of Alberta [HQCA], 2013.).
- PCNs have provided improvements in access to a broader range of services and movement to a more proactive approach to health care. Ultimately, this has been a popular model with physicians and has introduced foundational concepts such as panel management, inter-professional team-based care, group governance and resource pooling.

1.2 PCN Evolution – The Next Step in PCN Growth and Development

In 2010, the AMA released its *Vision for Primary and Chronic Care* in which it referred to PCN Evolution and recommended the College of Family Physicians of Canada (CFPC) concept of the patient-centred medical care home as a strong starting point. The following year, the CFPC published *A Vision for Canada: Family Practice - The Patient's Medical Home*, which presents the pillars of the medical home model and the goals to establish these pillars in a team-based environment.

In 2011, the expiry of the Primary Care Initiative Agreement provided the opportunity to evolve and enhance the PCN model. That year the AMA formed the Primary Care Alliance (PCA) to represent the broad interests of primary care physicians. The PCA executive consists of a PCN Physician Leads Executive Chair, the president of the SGP, the president of the SRM, an academic representative and the president of the ACFP (guest).

In January 2013, the minister of health met with representatives from the AMA's PCA to discuss ways to enhance and evolve PCNs. The AMA's *Vision for Primary and Chronic Care* provided the key elements of the PCA's approach, based on the medical home model.

A new AMA/AH Agreement was signed in May 2013, with a special agreement for primary care. The Primary Medical Care/ Primary Care Networks Consultation Agreement commits the parties to develop a framework for PCN Evolution, including consideration of how this evolution will link with the broader provincial primary health care strategy. The AMA's PCA, with contributions from the PCN 2.0 Steering Committee, is the body charged with developing the vision and framework document.

III. The Medical Home Model

Underpinning the PCN Evolution is the concept of a patient-centred health home model (or more simply, "health home"), that is designed around patients rather than diseases or programs, health care professionals or separate funding streams. The patient's values, beliefs and wishes guide treatment plans developed by the physician and health care team. The patient is at the centre of a team-based approach to providing ongoing, timely, appropriate and comprehensive care.

The AMA, CFPC, ACFP and AH all support the health home concept for primary care. This model is also increasingly cited in the literature as the ideal mechanism for improving both patient health outcomes and the delivery of primary care in general, and is viewed with growing favor within the primary care physician community.

One of the fundamental goals of PCN Evolution is the realization of the family practice medical/health home model developed by the CFPC. This model is supported by both the AMA in its *Vision for Primary and Chronic Care* and by the provincial government's concept for Family Care Clinics (FCCs) ("FCCs are a key part of the Government of Alberta's goal for every Albertan to have a home in the health care system.", Page 5, *Primary Health Care Transformation Family Care Clinic Reference Manual*, June 4, 2013).

The CFPC defines the medical home as follows:

"The patient's medical home is a family practice defined by its patients as the place they feel most comfortable – most at home – to present and discuss their personal and family health and medical concerns. It is the central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need. It is where patients and their families, and their personal caregivers are listened to and respected as active participants in both the decision making

and the provision of their ongoing care. It is the home base for the continuous interaction between patients and their personal family physicians, who are the most responsible providers of their medical care. It is where a team or network of caregivers, including nurses, physician assistants and other health professionals – located in the same physical site or linked virtually from different practice sites throughout the local or extended community – work together with the patient’s family physician to provide and coordinate a comprehensive range of medical and health care services required by each person. It is where patient-doctor, patient-nurse, and other therapeutic relationships are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population and the community being served.”

The CFPC has 10 pillars with goals that are the basis for the medical home (see Appendix A for additional information on the goals):

- **Patient-Centred**
Goal 1: A Patient’s Medical Home will be patient-centred.
- **Personal Family Physician**
Goal 2: A Patient’s Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.
- **Team-based Care**
Goal 3: A Patient’s Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient’s personal family physician working together with peer physicians, nurses and others.
- **Timely Access**
Goal 4: A Patient’s Medical Home will ensure i) timely access to appointments in the practice, and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.
- **Comprehensive Care**
Goal 5: A Patient’s Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.
- **Continuity**
Goal 6: A Patient’s Medical Home will provide continuity of care, relationships, and information for its patients.
- **Electronic Medical Records and Health Information**
Goal 7: A Patient’s Medical Home will maintain electronic medical records (EMRs) for its patients.
- **Education, Training and Research**
Goal 8: Patients’ Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.
- **System Supports**
Goal 9: A Patient’s Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).
- **Evaluation**
Goal 10: Patients’ Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice, and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

PCN Evolution will be built on these pillars as family physician offices make progress toward the PCN health home model.

IV. Vision for PCN Evolution

The AMA's vision for primary care in Alberta is based on the medical/health home model where every Albertan has a personal family physician who works with a team of health care professionals to provide a broad scope of primary care services for patients.

PCNs play a key role in the provision of primary care to Albertans within the framework of *Alberta's Primary Health Care Strategy*. The AMA and PCN 2.0 Steering Committee goal for primary care is that every Albertan will have the opportunity to be part of a patient-centred health home supported by an effective, community-based PCN. Our goal is to educate all Albertans about PCNS, and the benefits of being part of a PCN health home.

Physician clinics are evolving toward the CFPC model for the medical home; and the family physician clinic, supported by the PCN, is becoming a patient's health home. It is the hub for providing and coordinating primary care.

The key components of the vision for primary care are:

1. Physician/Health Care Team patient relationship

- The physician leads the inter-professional health care team that provides comprehensive, collaborative, evidence-based patient care to achieve accepted and measurable standards for access and quality.
- Patients formally designate their PCN primary care physician as their primary care provider of choice. This formally established relationship (i.e., attachment) helps patients view their family physician and the PCN as the place where they are best served for all of their primary care needs.

2. Primary care services

- Primary care services may not all be provided under the same roof, but, as necessary, through links to health professionals within the PCN, AHS and community-based partners. In some communities, PCNs and FCCs may link to share resources and services. Integration is enhanced by referrals to medical specialists, specialty care, secondary care and tertiary care for seamless transitions between these services.
- PCNs integrate care more closely with community and social services to ensure that basic social service needs are met for vulnerable populations and that population health needs are met.

3. Access

- Patients are able to access primary care services the day they request them in fully enhanced PCNs.
- Building on current successes, PCNs establish programs to match patients without family physicians to family physicians who are taking new patients. Province-wide initiatives support Albertans with processes to find family physicians taking new patients in their communities.

4. Governance and accountability

- Governance structures reflect the need for local oversight within a framework for collaboration and accountability in evolved PCNs. Public representatives are added to the governance framework, and health professionals have representation on some committees.
- Accountability measures are built into the governance model. Standards and measures are in place to evaluate the effectiveness of PCNs, and patients have opportunities to rate their satisfaction with the PCN and the health care team.

5. Supports and enablers

- IM/IT is an essential enabler for team-based care within the PCN and links with other levels and types of care outside the PCN.
- All PCNs are fully automated with EMRs, which allow effective sharing of information by the health care team and allow the future flow of information from other health care partners, such as AHS. The use of EMRs maximizes benefits to patients and the physician practice.
- Funding is sufficient to support innovation, and physician compensation models are in place to support team-based care. Capitation and blended funding models are options that physicians can choose to adopt.
- Policy supports team-based care by allowing PCN funding to be used for capital expenditures to build spaces for health care teams. Reserve funds and PCN surpluses are used by PCNs to implement PCN 2.0 activities.

V. Framework

The goals and strategies for the framework are summarized in Appendix B.

1.0 Connecting Patients to the PCN Health Home

1.1 Notifying Patients about their PCNs

The benefits of attachment to a health home are well documented, but patient awareness of their connection to PCN health homes in Alberta is very limited. The 2012 *Report of the Auditor General of Alberta* reinforced earlier observations that many Albertans are unaware their physicians are in a PCN, or of the services the PCN provides for them.

One of the identified early opportunities for PCN Evolution is to develop strategies to increase public awareness of PCNs and the services they provide. Participants at the October 18-19, 2013, PCN Physician Leads Forum shared ideas to achieve this goal.

1.1.1 Raising awareness about PCNs

- Provide information about the purpose of PCNs.
- Inform patients about the PCN they are part of, by virtue of their physician practicing in the PCN.
- Provide information to patients about:
 - The services provided by their PCN.
 - The hours of operation and locations of service delivery, including after-hours care.
- Explain the benefits of being linked to a family physician, the inter-professional health care team and the PCN health home.
- Use the opportunity to explain the benefits of formalizing the relationship with their family physician and the health home. This discussion could be the first step in formally linking the patient to the family physician.

1.1.2 Notification tactics

1.1.2.1 Provincial level

Explore the option and components of a targeted provincial media campaign to promote PCNs and to encourage patients to ask their family physicians about their PCN health homes. This could be concurrent with other awareness and notification tactics being implemented in PCNs. Significant funding will be needed to develop a successful awareness tactic that could be integrated into an awareness campaign about *Alberta's Primary Health Care Strategy*.

Develop generic materials (brochures, posters, handouts) to describe PCNs, services PCNs provide, etc. These materials could be developed, coordinated and distributed at the provincial level to individual PCNs, and then distributed to individual physician clinics and other PCN care delivery sites to help inform patients about PCNs.

Develop a generic document with criteria for standard content that PCNs could format and customize locally to confirm a patient's association with the PCN, available services, locations of service delivery and after-hours care. The PCN Physician Leads Forum strongly endorsed this locally-based approach using a customizable document.

1.1.2.2 Local PCN level

- **PCNs could customize the generic document with local information** about the PCN health home and specific services. Local assistance could be provided to PCNs, as required.
- **The local PCN letter could be distributed to every patient visiting a PCN physician clinic or PCN delivery site over the course of the next several months/years.** It is estimated that the majority of a PCN's patients would receive the letter over 12 to 18 months.

- **PCNs could be encouraged to expand their own local promotion activities** related to heightening awareness of PCN services and benefits of connection to a health home through website development, development of local communication plans (e.g., use of local media), and local health and wellness promotion events.

1.2 Finding Family Physicians for Albertans

Data indicates that approximately three million Albertans are paneled to PCNs, while others have family physicians that do not practice in a PCN. There are many Albertans, however, who do not currently have a family physician for various reasons. As part of PCN Evolution, efforts will be made to find PCN family physicians and health homes for these Albertans. They generally fall into three broad categories:

- A. Patients who would like to be part of a physician's practice/PCN but cannot find a local physician accepting new patients.
- B. Patients who are often young, healthy and mobile. They do not want, or perceive that they do not need an ongoing link with a physician practice/PCN, and use walk-in clinics and emergency departments, if required.
- C. The difficult-to-reach patient (e.g., marginalized, transient, homeless, Aboriginal, new Canadians, or those requiring care for mental health, addictions or complex care).

Each of these groups provides a different set of challenges for linking them to a family physician and a health home. While some methods may work to some degree, no one strategy will work well for all three groups. Indeed, a number of different strategies for each group may need to be implemented over time to link the majority of these currently unattached patients to a PCN physician and the health home.

1.2.1 Group A: Albertans actively looking for a family physician/health home

Patients in Group A may be the easiest to assist in finding a PCN family physician and health home, and focusing efforts on this group initially may be most effective. Assuming a physician has the panel space, various existing strategies could be used to connect these patients to an accepting physician in a PCN. A number of large, urban PCNs have indicated they always have some capacity to take on new patients and provide them a family physician and a health home.

Physicians in some northern/rural/remote and small PCNs, however, have indicated just the opposite. They do not have capacity to link patients in a more consistent way to PCN physicians due to physician shortages which have created large panel sizes.

Physicians in these PCNs have reported that they cannot use the same approaches to find family physicians as those used in large, urban PCNs. It is possible that no attachment strategy will be successful given the current lack of capacity in these under-served areas to take on new patients, or to provide the comprehensive array of services considered part of the ideal PCN health home. Proper supports could facilitate a variety of innovative access strategies and technology-based processes that could help increase the number of patients cared for by a physician and the inter-professional health team (which will likely be small in rural, remote and northern areas).

1.2.1.1 Websites to link patients with family physicians

Some urban PCNs have websites to help Albertans find physicians in their areas. For example, both Edmonton area and Calgary area PCNs currently use shared web-based approaches to help patients find a family physician. Both approaches have a number of benefits and some disadvantages. The Edmonton-wide PCN approach immediately informs prospective patients of the physicians in their area accepting new patients, but it relies on the patient to follow up and make the appointment directly with the physician. Currently, there is no mechanism to track how many patients have successfully found a family physician using this approach.

The Calgary-wide PCN approach asks the prospective patient to register online and someone from a PCN contacts them when a physician accepting new patients becomes available, which may take several months. The drawback is the delay in connecting a patient desiring a physician with an available physician. The benefit is that successful connections are tracked, because the PCN contacts the patient and facilitates the connection to an available physician. Both models can be readily expanded to encompass the needs of other PCNs, and fully replicated in other geographic areas.

A single product and process for connecting patients with an available primary care physician has been recommended as it would better support promotion of the site and facilitate ease of public use. Leveraging the functionality of both systems into one could result in offering the best of both approaches: to immediately find which physicians are taking new patients and to track how many patients have been linked with a family physician. This new hybrid approach will be explored further with the PCNs.

1.2.1.2 Additional PCN strategies

PCNs have also explored other ways for Albertans to find family physicians who are accepting new patients. These strategies link patients to family physicians at the point of care (e.g., children receiving care, women receiving prenatal care, and patients visiting the emergency department, attending PCN after-hours clinics, and those being discharged from hospitals).

1.2.1.3 Possible strategies

- Expand strategies to enhance access by enhancing capacity in physician offices through:
 - Quality improvement strategies such as AIM (Access Improvement Measures) for more effective appointment scheduling.
 - Innovative use of technological approaches (e.g., email) for some patient encounters that might increase physician capacity to add new patients and still provide quality/timely/continuity of care to an expanded panel.
- Explore the option of a provincial web-based initiative to link patients with PCN family physicians taking new patients in their areas.
- Northern/rural/remote and small PCNs may need to take different approaches for attaching patients to a health home than those used by large/urban PCNs.
- As part of the 'Early Opportunities' work plan, PCN strategies to link patients to available family physicians are being gathered for a tool box of strategies for all PCNs and clinics to use, if they choose.

1.2.2 Group B: Albertans not actively looking for a family physician or a health home

Group B patients, who may be young, healthy, and mobile, do not see a need or the benefit of seeing the same physician regularly, or being a member of a health home as they rarely seek care. Traditional strategies will not likely be effective with these patients because they do not perceive a need to be linked to a physician or PCN even in areas where family physicians can be easily found.

1.2.2.1 Possible strategies

- A province-wide communications strategy using traditional and social media to publicize the benefits of being part of a health home.
- Promotional material regarding the health home and its benefits placed at common points of care (e.g., after-hours clinics and emergency departments).
- Increased attempts to link these patients to a family physician/PCN at the time of medical need (e.g., walk-in clinic, PCN after-hours clinic, emergency department, etc.). An offer to assist the patient through the process of finding a family physician could be beneficial.

1.2.3 Group C: The difficult-to-reach patient

Group C patients are likely the most challenging group to link to an appropriate health home, but are also likely to show the greatest health improvement once linked. Linking this group of patients is more challenging because it is not a uniform group, and is comprised of many separate and distinct sub-groups. Each provides its own unique set of challenges, likely requiring equally unique strategies to connect its patients with a family physician and health home.

1.2.3.1 Possible strategies

- PCN outreach clinics in inner city areas (possibly with an alternative funding model) to provide more comprehensive and consistent care, and to build trusting relationships with patients in order to link them with a family physician.
- Establishing relationships with Group C patients through health care professionals (e.g., nurses providing care) may provide an effective entry point to the health home and a family physician.
- One-on-one navigation support to assist in finding family physicians could be instrumental for this group.
- Leverage and identify existing AHS relationships and programs to support Group C patients in connecting with PCN clinics.

1.2.4 Additional strategies for finding family physicians for Albertans

- A provincially developed toolbox of strategies for PCNs to tailor for their use.
- More research to better identify the number of people still without family physicians.

1.3 Formally Linking Patients to a PCN Health Home (Attachment)

Formally linking patients to a PCN family physician (referred to as attachment) and the inter-professional health care team is a foundational principle of the PCN health home model. The literature consistently indicates that improved patient care and better health outcomes are achieved when patients are formally linked or connected to a physician backed by a health care team. The PCN health home will ensure that every patient has a personal family physician who will be the most responsible provider of his or her medical care. Implementation of the PCN health home model is best enabled by formalizing the existing linkages between current patients and their primary care physicians.

The designation of the most responsible health professional is important for coordination of patient care, clinical accountability and patient advocacy. Linking patients to physicians can occur formally or informally, but recognizing the ongoing relationship between the patient and the family physician is central to the PCN health home model of primary care delivery.

The goals and benefits of the health home (i.e., timely access, comprehensive care, continuity of care, health outcomes, and improved service integration with other parts of the health system) can be best achieved when both parties formally recognize the physician-patient relationship. A formal relationship, where trust develops between patients and a team of health professionals, also helps to ensure services such as screening and prevention, chronic disease management and care for complex health issues are provided continuously over time to patients. On a broader scale, there is good evidence showing lowered health system costs, improved quality of care and improved data for health system planning.

1.3.1 Formalizing the relationships between family physicians and their current patients

Formally recognizing the relationship between a specific patient and a specific physician may be done through a simple, written agreement. In the agreement, the physician commits to best efforts to provide comprehensive care to the patient, and the patient commits to seek the majority of his/her primary care from the PCN family physician and members of the supporting primary care team or practice group. Although not legally binding, formally linking patients with family physicians represents a commitment by both parties that encourages greater continuity of care. A physician's panel is composed of all of the individual patients to whom the physician provides care.

The AMA, the CFPC and AH have all released reports in the last several years outlining the benefits of a more formalized relationship for both patients and physicians. The AMA recently released its *Discussion Paper: A Model for Formal Attachment in Alberta* (March 2013) supporting the adoption of a formal model. The paper also clarifies the AMA's perspective on what is and is not included in the model. The model formalizes and builds on the existing relationship between a patient and his/her family physician.

As discussed, linking specific patients to specific physicians can occur anywhere along the continuum from informal (current scenario) to formal (desired future state) relationships. A formal attachment is usually defined by the existence of a simple, signed document or written commitment between patient and physician.

Attachment is a common term used to refer to the process of linking patients to family physicians. It may have some negative connotations for both patients and physicians. Different jurisdictions use other synonyms such as: enrolled, registered, rostered and/or paneled. “Attachment” or “attached” is occasionally used in this framework; however, we have chosen to not settle exclusively on this term, choosing instead to refer to formalizing the patient/physician relationship or formally linking physicians and patients.

1.3.2 AMA vision for attachment

The following sections: Key principles, Key characteristics, Benefits, Proposed model, and What it will take to implement attachment, are taken from the AMA’s *Discussion Paper: A Model for Formal Attachment in Alberta*, March 2013.

Key principles guiding the development of the formal attachment model are:

1. **Patients First®:** Patient care, rights and choice must remain paramount.
2. **Value for Patients®:** The model must provide added value to individual patients and the overall primary care system.
3. **Payment independence:** Formal patient linking is separate and distinct from physician funding and is not tied to any specific physician compensation model.
4. **Clinical independence:** Physicians continue to manage their practices as independent entities and patient care decisions are made by physicians and their patients.
5. **Physician representation:** Implementation of a formal patient attachment model is preceded by careful planning and extensive physician consultation.
6. **Financial feasibility:** Physicians will not be negatively impacted.
7. **Clear terms and conditions:** The obligations and rights of physicians, patients and others are clearly defined and communicated.
8. **Simplicity:** Forms and processes are simple and efficient to increase participation and avoid unnecessary administration.

Key characteristics of an Alberta model include:

- Participation is voluntary for patients and physicians.
- Each patient is attached to a specific primary physician; comprehensive care delivery may be supported by a consistent primary care team or a practice group.
- There is mutual agreement by the patient and the physician to the attachment.
- The patient or physician is able to terminate the commitment at any time.
- A written commitment form is signed by the patient and physician.
- Participation is independent of, and compatible with, a variety of physician payment models.
- A physician continues to control his/her own panel size.
- Patients, both attached and unattached, are not restricted in seeking care from other health professionals.
- Attachment data are tracked in a central registry with limited patient demographic information (e.g., name, birthdate, AHI, gender, primary physician practice ID, practice group/location, date of attachment).
- No clinical information is stored in the central registry and appropriate privacy and access controls are in place.
- Central registry allows for real time data entry through a secure web/electronic interface. Clinics without EMRs can access the information. All that is needed is a computer and Internet access. In time, electronic records management vendors would be expected to provide an interface between the EMR and the central registry.

Benefits of formal relationships between patients and physicians

1. *Improved health outcomes*

The patient-physician relationship is central to the role of the family physician and fundamental to improved health outcomes. In fact the more physicians a patient sees, the greater the likelihood of adverse effects.

Formal patient attachment establishes and strengthens a longitudinal patient-physician relationship that leads to improved patient health outcomes. Benefits of formalizing the patient-physician relationship include:

- Physicians are in a better position to understand their patient needs.
- Problems are better recognized.
- Care becomes patient-focused rather than disease or visit-focused.
- Better preventive care is provided.
- Patients feel more able to care for themselves.
- Patients are more likely to follow through on advice from a known physician and team.
- Fewer hospitalizations are needed.

2. *Increased continuity of care*

Formal patient attachment improves continuity of care which has been associated with higher quality follow-up and fewer adverse clinical outcomes. Evidence also suggests that continuity and comprehensiveness of care when anchored in the primacy of the patient-physician relationship has a number of benefits, including:

- More efficient, higher quality health care delivery.
- Lower health care costs.
- Higher patient and physician satisfaction.

Formal patient attachment also allows for improved information exchange with other components of the health system for more coordinated patient care. For example, with access to attachment information, hospitals can help ensure timely and appropriate information updates and/or post-discharge follow-up for medical events (e.g., hospitalization, ER visit) with the family physician.

3. *Panel management and quality improvement*

Physicians who can clearly identify their patient panels can provide consistent preventative and proactive care, utilize chronic disease registries and make effective use of targeted education strategies. Effective population health initiatives require information on attached and unattached patients in order to provide screening, immunization and other preventative health care to the broader population.

In addition, formal patient attachment will enable quality improvement initiatives both within a practice as well as at a regional and provincial level. An identified patient panel is required for meaningful process and outcome measurement and evaluation. Access and continuity measures, among others, require an understanding of the denominator of the patient panel. This is the foundation for the development of clinical indicators that practices can use to assess their own clinical improvements.

Physicians have reported that having a stable list of patients made it easier for them to manage their patient panel. They felt it resulted in increased familiarity with patients' health issues, improved accuracy of medication lists, problem lists and improved consistency in screening, prevention and health promotion activities. Physicians also found it simpler to administer and plan their practice activities knowing the true demographics of their practices.

4. Lower health system costs

There is evidence that attachment to a primary care physician results in lower costs to the health system overall. Having a regular primary care physician and team results in:

- Improved diagnoses, which lead to more timely and appropriate use of diagnostic testing and referrals and reduce redundancy and duplication of services.
- Improved preventative care and reduced hospitalization.
- Less recourse to medication as a first-line treatment.
- Reduced ER visits and hospitalizations.

Approximately 40% of new health problems in primary care practices are undifferentiated and are best managed by “watchful waiting” involving minimal investigation or referral. “Watchful waiting” as a care strategy works best where there is a strong trust relationship between patient and physician.

In a recent study from British Columbia, Hollander et al. showed that for patients with complex health problems, a high level of patient attachment was inversely correlated to health system cost; this effect was more significant than patient age.

5. Improved data for health system planning

Formal patient attachment will assist decision makers with health policy and planning at a local, zonal and provincial level.

The central registry provides reliable data on the number of unattached patients and can enable strategies to connect these patients to physicians accepting patients. This will also assist with targeted recruitment and program planning, resource allocation, population health initiatives and evaluation.

Formal patient attachment also provides the ability to identify and gather consolidated patient data through a primary physician, which support epidemiologic research in primary care.

Knowledge of true patient numbers will allow better calculation of certain indicators and measures for broad, as well as clinic-specific, datasets.

Proposed model of formal patient attachment

The proposed model recognizes the diversity of practices throughout Alberta and the various needs and expectations of government, physicians and patients. It is understood that the model needs to:

- Be applicable to a variety of practices regardless of size or degree of allied professional team support.
- Recognize physicians cannot be available 24/7 and have provisions for cross coverage and team care.
- Recognize not all physicians will choose to participate.
- Recognize that there are patients who will choose not to be attached.
- Be, at a minimum, cost neutral for physicians.
- Reflect that physicians will continue to provide care to both attached and unattached patients.
- Accept that in areas of physician under-supply, it may not be possible to attach every patient.
- Formalize existing patient-physician trust relationships.

What it will take to implement formal attachment

The AMA document also describes the key elements that it will take to implement formal attachment in Alberta, including:

- Physician engagement
- Public awareness
- Development of a central registry
- Funding for administrative costs
- Standardized forms and communications materials
- Change management resources

The AMA attachment paper also lays out a proposed step-by-step process for formal attachment.

1.3.3 Physician concerns about formal attachment

While many physicians would not deny the benefits of more formal relationships with their patients, many have raised concerns about the consequences of formal attachment.

Physician concerns include:

- Formal enrollment is often linked to payment systems with negotiation. The AMA position is that physician funding and formal linkages are separate and distinct issues, and a model for formal linkages could be implemented with a variety of different funding models, including the status quo (fee for service [FFS]).
- Formal linkages could bring the imposition of required performance measures, but one does not lead to the other. However, a validated patient panel could enable the measurement of key indicators of patient health that would allow physicians to better plan for the effective use of clinic resources.
- The potential liability associated with being formally linked with patients not seen very often, whether due to patients' lack of attendance at the clinic, or the inability to see them on a timely basis in rural and remote locations where physicians already have unmanageable panel sizes and may have difficulty providing timely, comprehensive care.

1.3.3.1 Working group to develop strategies

Information is currently being gathered from PCNs on experiences formalizing patient relationships with a primary care physician. In addition, AH has established a working group to provide advice on the elements and implementation requirements for a provincial strategy on formal attachment. Some issues for resolution could include:

- **Terminology** for formal attachment and if there is a need to identify and use different terms to describe the relationship, as both physicians and patients have expressed some discomfort regarding the term "attachment" of a patient to a physician.
 - A preferred approach may be to refer to "patients designating their preferred family physicians" (a process done **by them**), rather than referring to a physician attaching a patient (which is a process that is done **to them**).
 - The BC program "A GP for Me" appears to be patient-friendly; because it discusses patient and physician roles, and uses the tagline "Your doctor is your partner in health."
- **Parameters** for what is and is not inherent in attachment (e.g., performance measures).
- **Communications** to introduce the concept to physicians and patients alike:
 - Acceptable terminology should be developed and used in all patient communications.
 - A province-wide awareness initiative would be useful.
 - Materials (e.g., posters, flyers, brochures) could be developed provincially and rolled out locally to PCN physician offices to standardize message delivery explaining attachment.

- **Funding strategies** to support formalizing physician/patient relationships.
- The **differences in capacity** between urban PCNs and rural/remote/small PCNs to implement a formalized strategy. Different approaches for formal linkages may need to be considered by the working group for various PCNs.

2.0 Improving Delivery of Primary Care Services in PCNs

2.1 Same-Day/Next-Day Access to the Health Home

One of the foundational pillars of the medical home model for family practice is the provision of “timely access to appointments in the practice...” as noted in the CFPC medical home model. PCN health homes will reflect this goal by:

- Ensuring patients have 24/7 access to medical advice and the provision of, or direction to, needed care.
- Implementing advanced access strategies to ensure patients have timely access to their personal family physician or other appropriate members of the health home team.
- Ensuring patients have access to another physician, nurse or other qualified health team member when the patient’s personal family physician is unavailable.
- Ensuring the health home panel size is appropriate to ensure timely access to appointments and safe, high-quality care for each patient and the practice population being served.

2.1.1 Background

A well-functioning primary care system has demonstrated improved quality of care received by patients and reduced health care system costs (Starfield, 2005). The CFPC’s *A Vision for Canada: Family Practice - The Patient’s Medical Home* notes that “timely access to appointments is essential in the delivery of patient-centred care” and that “improved access to care can reduce redundancy and duplication of services, improve health outcomes, achieve better patient and provider satisfaction and lead to a reduction in emergency visits.” Same-day scheduling or advanced scheduling has emerged as a strategy to improve access to same-day appointments.

Murray and Tantau (2000) described advanced access as eliminating the distinction between urgent and routine, and requiring that practices “do all of today’s work today.” It is about “offering patients appointments on the day they call, regardless of the reason for the visit.” Broad adoption of advanced scheduling techniques, introduction of new access strategies and leveraging current successful PCN and clinic strategies to expand primary care service capacity are all key elements of an optimized delivery system providing same-day/next-day access.

Key objectives of the primary care initiative were to increase the proportion of residents with ready access to primary care and to provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services.

Early evaluation of the impact of PCNs on these targeted areas is reported in the *Primary Care Initiative Evaluation* (2011). Malatest noted that access could be conceptualized in three ways: access or attachment to a primary care physician; access to the services of a family physician once a patient is attached, including after-hours care; and access to referred services. It was reported that PCNs had generally taken steps to address access issues at all levels:

- All PCNs reported use of PCN-based inter-professional teams and other health care providers.
- 90% of PCNs were reported to have programs in place to identify and accept unattached patients.
- 48% of PCNs provided walk-in clinics/services or same-day appointments availability for attached patients.
- 75% of PCN physicians reported capacity to provide same-day urgent care (compared to 57% for non-PCN physicians).
- 79% of PCNs reported PCN-linked after-hours care was available.
- 66% of PCNs provided enhanced referral and navigation services within PCNs and to other regional/community programming and specialists.

- PCNs reported use of a variety of means of expanding access, including:
 - Partnerships with Health Link.
 - PCN after-hours clinics.
 - Partnerships with AHS urgent care/emergency facilities.
 - Physician on-call support and extended clinic hours.

2.1.2 Current state

The Malatest evaluation report was based on reported activity in 29 PCNs for the period 2008-09. There are now 41 PCNs in operation and most have continued their efforts in meeting the core objectives of the Primary Care Initiative, including enhancing access to care.

The seven Calgary area PCNs, in partnership with AHS, have developed a Calgary Zone Primary Care Action Plan, which establishes shared goals and the structures and processes required to direct collaborative initiatives. One of the first initiatives to be undertaken is to improve patient access to timely and appropriate primary care. Calgary Zone PCNs are looking to leverage existing programs, facilities and practices to enhance access to care across the zone. They have committed to developing common definitions, measurement tools, performance indicators and targets for access in primary care. This more formalized collaboration of PCNs within a zonal structure may represent a best practice to be considered and possibly emulated in other geographic areas of the province.

Other individual PCNs are undertaking similar efforts to leverage successful current practices of clinics within their PCN, and adopting successful practices from other PCNs. PCNs in other AHS zones are also exploring various opportunities to collaborate in addressing service access and quality improvement issues.

Strategies that many individual clinics and PCNs have already implemented include:

- Operating PCN sponsored after-hours clinics.
- Supporting physician availability through primary care on-call models.
- Utilizing intake and referral resources such as Health Link and appropriate referral to AHS emergency departments.
- Providing extended hours of service in physician and PCN clinics.
- Promoting public awareness of services and hours of service through local websites and media.
- Promoting advanced scheduling models to ensure availability of same-day appointments.
- Utilizing the inter-professional team to expand overall capacity of the primary care team.

2.1.3 Enhancing access to PCN health homes

2.1.3.1 Leveraging current strategies

PCN Evolution will use the successful strategies currently implemented in clinics and PCNs throughout the province leveraged to create a “tool kit” of access improvement strategies that can be expanded in scale to include other PCNs and clinics, or replicated in other PCNs and clinics. Through the use of learning collaboratives, coordinated facilitation and implementation support, PCNs will be supported in the further development of access enhancement tools for use by other PCNs. PCNs and individual clinics will also be supported, to the extent possible and as required, in the implementation of new access enhancement strategies. Additional access enhancements in some jurisdictions may be limited by human resource limits, financial capacity or patient demand.

As part of the early opportunities component of the PCN Evolution project, AMA resources are gathering information from PCNs about the strategies they are currently using to enhance access to primary care services. A project plan will guide required work to develop these strategies for shared access by other PCNs or replication and implementation in other PCNs.

2.1.3.2 Developing education and training tools to enhance access

Effective access improvement programs exist in Alberta, and numerous PCNs and individual physician clinics are benefiting from implementing program strategies. Some physician practices have not participated in these programs due to limits in the number of sessions offered in a year, or to the time commitment required for training, and the lack of resources to cover for staff time to do so. A need has been identified to develop targeted education and training tools to support clinics in the implementation and ongoing management of various access enhancement strategies. Going forward, PCN Evolution will investigate the development of these tactics.

2.1.3.3 Using electronic communications to deliver health services

The use of electronic means of communication continues to expand and evolve. Physicians are interested in exploring means to support patient demands to use electronic communications to meet their health care needs in an expeditious manner. The CFPC noted that timely access to care and information can be achieved through use of email, telephone and web-based communications. Apparently, a broader use of electronic communications to deliver health care services (e-access) requires further development of appropriate supports and processes (e.g., assurance of privacy, appropriate use guidelines, liability protection, remuneration strategies).

PCN Evolution will work with several physician clinics to explore and develop standard requirements, tools and processes for the appropriate use of electronic communications to improve access to same-day/next-day services. As part of the Early Opportunities project, a blueprint for e-access is being developed to support interested clinics in trialing some of the tools and processes to support e-communications between physicians and patients. The blueprint will address such issues as scope of information exchanged, privacy protection, appropriate risk assessments and mitigation, patient consent requirements, technology requirements, staff training and an evaluation framework.

2.1.3.4 Measurement and supports

Third-next-available (TNA) appointments

An important element of access improvement is measuring the current delay and backlog in the appointment schedule, and reduction in delay over time to ensure sustainability of access improvements. Many PCNs and physician clinics have adopted an internationally recognized standard measurement of access known as TNA appointment. TNA is the most basic measure of access where clinic scheduling staff is asked to count the number of days to the TNA appointment for all providers within a practice, one-time per week, and record this information for examination over time. The TNA delay measure provides feedback on the amount of time a patient has to wait to see a member of the health professional team and measures the success of backlog reduction.

Alberta's AIM Initiative, AMA's Toward Optimized Practice (TOP) Program, individual clinic resources and the use of PCN funds all support physician clinics and PCNs in implementing TNA measurement, as part of an overall quality improvement initiative for primary care practices. Physician clinics and PCNs continue to commit to adopting access measures such as TNA. Calgary Zone PCNs have committed as a group to support the adoption of common definitions and processes for measuring TNA across the zone, and will develop a common benchmark for time to third-next-available appointment. PCN Evolution can leverage Calgary Zone PCNs' collaboration and strategy to further adopt common access measurement throughout the province.

Successful implementation and sustainable use of TNA occurs when the practice is adopted within an overall quality improvement strategy such as that supported by Alberta AIM or TOP. It is clear that accelerated, widespread adoption of TNA measurement across all PCNs and clinics is beyond the current capacity of the AIM and TOP programs. As part of PCN Evolution, strategies are being explored to expedite adoption of TNA as an access measurement on a province-wide basis and resource requirements are being developed.

Measuring continuity

While time to TNA is a recognized measure of wait time, it is a point-in-time measure. A more longitudinal and perhaps more telling measure of access may be measurement of continuity of care. This measure is based on patient behaviour in reaction to their ease of access to their primary care provider team. It is dependent upon availability of clinic panel information and patient utilization information as reflected in billing records. The underlying premise of this measure is that when patients feel their needs are being appropriately met through their health home, their utilization will reflect a commitment to their health home. PCN Evolution will include exploring the appropriateness, feasibility and implementation requirements for measuring continuity of care.

2.1.4 Summary of strategies and requirements

- Leverage current successful Alberta clinic and PCN practices to provide a tool box of resources for other PCNs and clinics to adopt:
 - PCN partnerships, AMA resources and others could provide implementation assistance.
 - Some strategies may require further development to accommodate broader participation and adoption.
- Develop a collaboration framework that supports PCNs working together at a zonal level to develop and implement common approaches to specific access issues.
- Provide training and support to clinics in the adoption of advanced scheduling techniques.
- Work with stakeholders to develop appropriate training materials and capacity to support a province-wide adoption of TNA appointments as a local measure of access.
- Develop targeted education and training programs to enhance access.
- Work with community stakeholders and AHS in developing continuity of care as a longitudinal measurement of access.
- Evaluate the use of e-access strategies to determine requirements for further adoption as appropriate.

2.2 Enhanced Teams

As set out in the original Primary Care Initiative Agreement, a PCN is formed when a group of family physicians joins with AHS to provide comprehensive primary care services to a defined population of patients in a geographical area. A key objective outlined for PCNs in the 2003 to 2011 agreement is to “facilitate use of multi-disciplinary teams to provide comprehensive primary care.”

The term multi-disciplinary team is generally understood to mean various health professionals working parallel to each other, but not necessarily collaborating in the care of a patient. For health care teams to be most effective, an inter-professional model is most successful. In inter-professional teams, each health professional works to his/her full scope of practice, collaborates in the planning and comprehensive care of the patient, and communicates effectively with the team.

Each PCN is unique in the composition of its health professional team, based on a number of factors such as local patient population needs and PCN priority initiatives, availability of various health professionals in the community, space considerations to house the team, competing resources required to meet business plan objectives, and the budget of the PCN to hire appropriate individuals.

While physicians continue as clinical leaders and coordinators of the continuum of patient care within the health home, collaboration with the PCN team in the health home is a key to comprehensive patient care. One of the strategies in PCN Evolution is to enhance teams and to further develop a collaborative, inter-professional work culture centred on the patient.

There are various characteristics that define enhanced teams, including:

- Health professionals work at their full scopes of practice.
- Collaborative working relationships among providers.

- Effective flow of communication, including electronic access to patient medical records.
- Evidence-based shared-care pathways and integrated care protocols.
- Multiple points of access to the team.
- Number and breadth of allied health professionals appropriate to address PCN needs.
- Co-location of teams.
- Level and nature of integration (e.g., operating as a soccer team or a relay team).
- Team-based care training and team development.
- Primary care specific skills training.
- Active quality improvement.

2.2.1 Current status

Some of the characteristics listed above have been addressed by PCNs as they mature while other aspects have been more challenging.

1. Areas where PCNs are generally doing well with enhancing team-based care:

- Team members generally work at their full scopes of practice.
- More effective flow of communication across the health team.
- Evidence-based shared care pathways and integrated care protocols in place.
- Multiple points of access are available.

To maximize health professionals working to their full scopes of practice, roles and responsibilities must be carefully defined to mitigate medical-legal issues and patient safety risks. Physicians have historically been fully responsible for patients in their care, but with the team approach, careful definition is required for “who is responsible for what.”

Physicians support the concept of multiple points of access to PCN health professionals to improve timely access to care and with fully functioning health teams, patients should not need to access all care through the family physician. Change is required to fully optimize this reality, as the current FFS physician compensation models provide incentives contrary to enhanced team-based care.

2. Areas where PCNs have met barriers to enhancing teams:

- Number and breadth of allied health professionals is limited.
- Physical space limitations to co-locate teams.

Many mature PCNs have plateaued in terms of their ability to integrate more allied health professionals either in centralized PCN clinics or through a distributed model co-locating health professional teams in family practice clinics due to barriers.

Key barriers, under existing funding and policy guidelines, are limited financial resources in PCN budgets to hire more staff and policy limitations on capital investment to house team members. Physicians support a model where health professionals are co-located within physician clinics as the hub of the health home, and where patient needs dictate, additional team members practice in a central location to serve the entire PCN.

Current policy does not allow PCNs to expand the space needed for effective team-based care within physician clinics.

Strategies to address these issues

Policy changes must support capital investment to create spaces for teams. As well, indexed funding would allow PCNs to budget more efficiently as they would not need to hold reserves for anticipated increases in labor costs over an undetermined timeframe.

3. Areas where strategies will further optimize teams:

- Specific skills training for primary care in community settings.
- Inter-professional team-based-care training and team development.
- Active quality improvement initiatives.
- Level and nature of integration (e.g., operate as a soccer team or a relay team).

To continue to enhance team approaches to care, there are fundamental aspects that can be leveraged to optimize existing and future inter-professional teams.

Optimizing teams

- Primary-care-specific training for allied health professionals both pre- and post-certification. This requires engagement of professional educational bodies to align training programs to meet the demand for primary care skills in community settings. Many highly skilled nurses, pharmacists, and other health care professionals are not easily transplantable from the acute care health system to primary care clinics, which require a broader knowledge base and skill set.
- The second area to optimize teams is formal training about the practical application of team-based care. Creating a high-functioning team requires more than co-locating professionals. Each health profession has its own culture and values that members of the team bring with them.

Family practice clinics and PCNs have learned that reframing and “out-of-the-box” thinking is required to enable a group of professionals to truly work as a team for patients with complex and unique requirements. This includes:

- Development of interactive team care protocols.
- Change management and open communication to build high-functioning teams.
- Clarity about boundaries of roles/responsibilities.
- Clarifying medical-legal aspects of team care and multiple points of access.
- Education on the respective scopes of practice of various health professionals.

Interprofessional education (IPE)

In its 2010 *Framework for Action on Interprofessional Education & Collaborative Practice*, the World Health Organization defines IPE as follows: “Interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.”

There are a number of universities and programs in Canada that focus on inter-professional education and best practices. Locally, the University of Alberta’s Health Sciences Education and Research Commons (HSERC) Interprofessional Learning Pathway has mandatory courses and learning experiences for health sciences students. These courses help students build competencies that prepare them to work as part of a health care team after graduation.

HSERC has developed an Interprofessional Learning Pathway Competency Framework. The HSERC website states “The framework rests on four core inter-professional competencies that have been identified as critical to inter-professional practice: communication, collaboration, role clarification and reflection. The theme of patient-centred care is woven throughout

the four competencies. Elements of these competencies are taught in a single-discipline context and can be applied to an inter-professional setting. Each inter-professional competency is performed at three levels along a continuum of experience: exposure, immersion and integration.”

IPE for practicing professionals

HSERC is currently also providing IPE for practicing health professionals. HSERC Director, Dr. Sharla King, confirms that providing this type of education for health care professionals providing team-based care in PCNs could be arranged upon request.

- A third area to optimize teams is evaluation of the effectiveness and efficiency of centralized versus distributed versus hybrid care models. A variety of team models are currently used in PCNs; however, data is required to inform decisions on the best model for the future of PCNs. Evaluation data would be a key component to allow PCNs to increase focus on continuous quality improvement (CQI) of their teams.

PCN 2.0 strategies to enhance teams:

- Ensure physician compensation policy and models are available to support team-based care.
- Change policy to allow capital investment to create spaces for teams.
- Index funding to allow PCNs to keep up with unionized rates for staff.
- Encourage educational bodies to provide focused primary care education to students in health-related faculties.
- Encourage universities to develop IPE/workshops for practicing health care professionals.
- Identify opportunities for PCN health care teams to participate in existing IPE, through Alberta universities and/or other programs.
- Evaluate the effectiveness of various models of care: centralized versus co-located versus hybrid, and use data to inform choices.

2.3 Integrating Services

2.3.1 Integration with other Alberta Health and Human Services outside the PCN

2.3.1.1 Horizontal integration with primary care services and social services

Horizontal integration involves coordination and linking to primary care services provided by community-based health professionals, primary care related programs of health organizations and inter-sectorial services (social and community services) outside the PCN.

Current status

As with all PCN 2.0 strategies, some mature and/or larger PCNs may already have enhanced horizontal integration of primary care services in their geographical areas. On the other hand, rural and/or small PCNs may have more easily established links to other primary care services in their areas, due to the knowledge of services available in the community and integration with these services.

Given that AHS is the joint venture partner in PCNs, most PCNs have established horizontal integration with AHS programs. According to the *Primary Care Initiative Evaluation Summary Report*, “100% of PCNs had developed relationships with home care, 90% with community mental health, 90% with public health, and 84% with hospitals/emergency departments. The degree of success varies by geography and by program.”

While some strides have been made, there are still significant opportunities to avoid service duplication, fill service gaps and improve existing services that are not serving patients in an optimal fashion. Information technology (IT) barriers such as lack of inter-operability and privacy concerns have hampered some integration efforts and support is needed to overcome these barriers.

Continued progress in this area will require commitment of all stakeholders to patient-focused approaches, development of a culture of collaboration and communication, and a PCN governance structure that enables further movement toward integration on a local and provincial level.

PCNs recognize their part in applying their best efforts on a local level to improve integration for their patients' needs. Quarterbacked by their family physician and supported by the primary care team in the PCN health home, this means ensuring the patient gets to the right professional at the right time with the right information.

1. In most cases, PCNs currently integrate effectively – either within their own communities, or if necessary through links to more centralized services, with:

- **AHS and other community-based primary care services**
 - Rehabilitative services: physiotherapy, occupational therapy.
 - Pharmacists (if not already connected to the PCN).
 - Laboratory and radiology services.
 - Public health services.
 - Mental health.
 - Home care.
 - Psychology services.
 - Palliative and long-term care.
 - Other primary care services as required.

2. To optimize patient health outcomes, many PCNs could improve integration with:

- **Services that deal with the social determinants of health.**
 - Social services and community programs for vulnerable populations, to address:
 - ◆ Homelessness, poverty.
 - ◆ Initiatives such as Assured Income for the Severely Handicapped (AISH), Fetal Alcohol Syndrome initiatives, etc.
 - ◆ Addictions.
 - ◆ Special needs such as sexual health, pregnancy counselling.

2.3.1.1.1 Alberta Supports – Integrating PCNs with social-based services

AH has engaged with Alberta Supports to link social-based services with PCNs. Alberta Supports provides information about how to access social-based services for high-needs and vulnerable populations.

AH will communicate with PCNs about how physicians and patients can access Alberta Supports services through the use of a website or telephone.

The government is implementing four pilot projects around Alberta that will connect PCNs with the services provided by social services via a single point of access. The goal is to recognize and coordinate care of Albertans for whom social determinants of health are affecting health outcomes. The findings from these pilot projects will be instructive going forward for linkages to social and community services and programs in Alberta cities and towns.

Recommendation and strategies

- Encourage further linking with community and social services and AHS services to address the needs of vulnerable populations.
- Access Alberta Supports to assist patients with social-based needs.
- Build on learnings from the current pilot projects in four Alberta communities where community and social programs and services are being co-located.
- Build on learnings from current projects within AHS that are successfully integrating vulnerable populations.
- Share current PCN experiences in implementing population health strategies.
- Include feedback from public and AHS representatives in planning strategies to provide care to marginalized populations to avoid duplication of services.
- Initiate community engagement processes as a standard activity within a PCN's business planning cycle.

2.3.1.1.2 Improved population and public health integration

Background

Alberta's Primary Health Care Strategy emphasizes that PHC is the appropriate level to deliver and coordinate the range of health, community and social services. Further, it challenges that too many Albertans do not have a home in the health system, a place where they are known and trust that they will receive timely and coordinated care for their physical, mental and social needs.

The CFPC identified the importance of the medical home to provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs:

Goal 5: A Patient's Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

5.5 Patients' Medical Homes should address the health needs of both the individuals and populations they serve, incorporating the effects that social determinants such as poverty, job loss, culture, gender and homelessness have on health.

"While family practices and PMHs focus primarily on the care of individuals and their families, it is important for physicians and other team members to understand and address the health challenges facing their practice populations within each community as a whole."

"Each PMH should understand how social determinants of health, such as poverty, job loss, culture or gender related challenges, and homelessness are impacting both its patients and the populations residing and working in the practice's communities."

Barriers to integration

The Minister's Expert Advisory Group (EAG) on *Social and Community Integration* report identifies seven barriers to integration, as well as improvement pillars to deal with these barriers.

PCN governing boards, physicians and inter-professional teams have overcome many of the same barriers as they worked together to establish the PCN organization, programs and processes. It required significant personal, professional and cultural change to manage and deliver care differently.

The Improvement Pillars have been classified as:

Improvement Pillar	Potential Improvement Efforts
1. Structural	<ul style="list-style-type: none"> Governance and structures should be community based, appropriate and have local emphasis.
2. Practice	<ul style="list-style-type: none"> Community-based, community integration. Shift to an interdisciplinary team-based practice with community partnerships. Focus on harm reduction across primary care.
3. Disincentives/ Incentives	<ul style="list-style-type: none"> Develop systems that reward good practice and make a commitment to accountability.
4. Attitudinal	<ul style="list-style-type: none"> Non-judgmental practices to address the role of bias in a marginalized population.
5. Policies	<ul style="list-style-type: none"> Put an appropriate focus on populations or groups that consume a disproportionately large amount of resources to address underlying social determinants of poor health and resource consumption. Provincial level should better rationalize and better align ethical frameworks, codes of practice and confidentiality and privacy rules. Outcomes should be linked to “wellness of life.”
6. Philosophical	<ul style="list-style-type: none"> Empowerment of individuals and the democratic nature of the FCCs.
7. People Based	<ul style="list-style-type: none"> Focus on the Six Rights: Right Patient, Right Provider, Right Place, Right Time, Right Cost and Right Organization. Links to community should be both innovative and flexible.

PCN services for local populations

Many PCNs have established linkages with AHS public health programs and/or other community and social services. These PCNs are serving an area encompassing some aspect of a vulnerable population and have organized PCN services around the whole patient, including the integration of social or community services.

PCNs may also provide opportunities to leverage population and public health integration due to their focus on, and understanding of, their local populations. As PCNs evolve their governance structure to include community representation at the appropriate levels of engagement (Improvement Pillar 1: Structural), it should follow that an increased emphasis will be placed on understanding and meeting the greater PHC needs of the population.

As *Alberta’s Primary Health Care Strategy* is rolled out and the goals toward improved social and community integration are understood, PCNs may well be best placed in the primary care system to incorporate many of the potential strategies.

2.3.2 Integration of Primary Care with Specialty/Specialist Services

Vertical integration refers to the coordination and integration of care with physician specialists, specialty care, secondary care and tertiary care.

The *Primary Care Initiative Evaluation Summary Report* indicated that integration with specialist physicians “occurs in 84% of PCNs; however, the scope has been relatively limited.”

Originally funded through the Specialist Linkages grant funding, most PCN initiatives to link with specialists have focused on developing relationships with individual specialists who provide consultative services through the PCN. This has, at times, resulted in an unintended consequence of PCNs competing to gain access to scarce resources. Others have focused on centralizing and/or streamlining the specialist referral process for family physician practices.

With respect to vertical integration between primary care and levels of specialty and tertiary care, one of the mechanisms with the potential to significantly impact the patient experience is the AHS Strategic Clinical Networks and Operational Clinical Networks (SCNs and OCNs).

SCNs/OCNs are still in early stages of development and PCNs can play a vital part in making these initiatives successful. Input from primary care professionals, throughout the development of patient care pathways, is important to ensure they are developed from the ground up (the patient's view of the system) and that they recognize the entry point to the health system for patients is primary care.

From a PCN perspective, a fundamental requirement to achieve success is clarity of SCN/OCN governance and accountability. An overarching, cohesive approach to common elements (e.g., referral processes) among all SCNs is essential to prevent duplicative efforts and pathway siloes. It is also critical to engage primary care in this approach. For practical functionality, the process must recognize the one-to-many relationship of PCNs to SCNs. As an example, it would not be effective for each SCN to develop its own e-referral portal and expect that primary care will adopt the multiple entry points. It would be much more feasible and practical to develop a single portal for primary care to access multiple pathways.

PCNs, then, have the joint responsibility to engage, perhaps through formation of a key informant group, to ensure there is a coordinated approach in terms of primary care participation in SCNs/OCNs. When these components are in place, PCNs can be an excellent vehicle to operationalize pathways integrating them into programs and services delivered within the PCN and through participating physician practices.

While some effective work is being done in linking primary care with specialists, much more is needed to provide seamless patient transfers from primary to specialty care and back again. A practical approach is needed on how to integrate these transfers more effectively to enhance patient outcomes and safety.

Hospital discharge planning is a critical area that needs to be improved with seamless avenues of communication between specialists/acute care centres and family physicians. This needs to be acted upon locally, but could take a zonal approach in terms of policies and procedures.

2.3.2.1 Strategies

- Every SCN and OCN should include PCN primary care physician(s) representatives to provide advice on building patient care pathways and on common referral processes that recognize primary care as the entry point to the health care system.
- PCNs will collaborate to ensure a coordinated approach to primary care participation in SCNs/OCNs.
- PCN 2.0 commits to exploring and implementing improved communications and processes for uniform referrals to specialists, and for discharge planning from acute care centres/specialists to family physicians.

3.0 Accountability

3.1 Governance and Organizational Effectiveness

Governance refers to the system by which organizations are directed and controlled. A governance structure specifies the distribution of rights and responsibilities among different participants, at different levels in the organization, and specifies the rules and procedures for making decisions in the affairs of the organization. Governance provides the structure through which organizations set and pursue their objectives, while reflecting the context of the social, regulatory and political environment. Governance is a mechanism for monitoring the actions, policies and decisions of organizations and aligns interests among the stakeholders.

Following an audit of the PCN program in 2012, the Office of the Auditor General (OAG) made several recommendations to AH and AHS for accountability and performance management that will strengthen the governance framework.

The PHC system is undergoing a review at the provincial level and will result in a provincial governance framework that outlines the accountabilities and responsibilities for primary care services in Alberta. Within this framework, accountabilities and responsibilities will devolve to the levels and players engaged within PCN 2.0, requiring an effective, transparent and engaged governance structure.

3.1.1 Key elements of a PCN governance model

1. Strong vision and leadership.
2. Innovation and delivery at the local levels regarding the cooperative efforts and sharing of resources between Authorities (AHS) and Physicians (Master Agreement Schedule G Article 3[h]).
3. Collective responsibility and planning to meet the primary care needs of patients at all levels.
4. A multi-tiered structure with accountabilities and responsibilities defined for each level, including local, zonal and provincial.
5. Clear expectations and targets for PCN program objectives from AH (OAG Report 2012).
6. Goals and service delivery expectations are defined and have defined performance measures and targets (OAG Report 2012).
7. Systems are established to evaluate and report on the performance of the PCN program (OAG Report 2012).
8. Meaningful public input and community participation in primary care delivery decision making.
9. Active, engaged and responsible decision makers at all levels within the governance structure.

3.1.2 PCN Evolution governance structure

The PCN Evolution governance structure is in accordance with the 2011-2018 AMA Agreement and with the structures within AH.

Formed by joint ventures between primary care physicians and AHS, PCNs are responsible for meeting the objectives and service responsibilities laid out in the 2003-2011 Master Agreement (Schedule G). PCNs are accountable to AH for meeting these objectives and responsibilities.

Alberta's Primary Health Care Strategy will set out the vision for PHC in Alberta and establish desired outcomes and measures to assess progress. The strategy will also clarify performance expectations and the accountability relationships in the delivery of primary care.

Governance and management of PCNs has been established through the partnership and legal construct between the local organization of physicians (e.g., NPCs) and AHS. Although the PCN has had demonstrated success in integrating service delivery with inter-professional teams, chronic disease management programs and other local initiatives, it has been generally recognized that there is more work to be done in implementing a patient-centred health home model.

The patient-centred health home model includes community participation and feedback as an integral component of its ongoing planning and evaluation of services. It's key to gaining knowledge from the community about the broad health issues, resource availabilities and limitations, as well as a different perspective on the services provided.

Therefore, the PCN Evolution governance structure will include public engagement and representation at the PCN board to enhance the level of transparency and improve its understanding of community needs and how best to deliver services to meet them. There will also be opportunities to measure patients' experience and satisfaction with the PCN health home.

Roles

Organization	Accountable to	Responsibilities
Minister of Health AH	Legislative Assembly/ Albertans	<ul style="list-style-type: none"> Establish health care policy. Provide direction: primary care objectives. Establish infrastructure for evaluation and reporting. Establish accountability framework for evaluation and reporting.
PCN Committee	MoH	Provides advice: <ul style="list-style-type: none"> Program management Policy Issues
AHS	MoH	<ul style="list-style-type: none"> Promote and protect the health of the population. Assess the health needs of Albertans. Provide health services responsive to the needs of individuals and communities. Ensure reasonable access to quality health services. Determine priorities in the provision of health services. Participate as a joint venture partner in each of the PCNs. Approve the PCN business plan and budget.
PCN Boards	AH	<ul style="list-style-type: none"> Ensure the appropriate governance and legal constructs for the PCN are in place. Establish the PCN strategy. Approve the PCN business plan. Approve the PCN budget. Establish infrastructure for evaluation and reporting. Establish accountability framework for evaluation. Ensure appropriate policies and processes for the operations of the PCN are in place. Establish and oversee the accountability framework for the PCN Board and individual members. Hire into and evaluate the senior staff role.
AMA	AMA Members	<ul style="list-style-type: none"> Provide advice and oversight for appropriate representation at the PCN Committee.
AHS	MoH	<ul style="list-style-type: none"> Provide advice and oversight for appropriate representation at the PCN Committee.

3.1.3 PCN Program Management Office (PCN PMO)

Operationally, various aspects of the PCN Program will be supported through the PCN PMO established by way of a grant agreement in the 2011-2018 AMA Agreement. The AMA and AH are working together to determine the appropriate role of the PCN PMO.

3.1.4 PCN operational effectiveness structure

Although the PCN's "local solutions for local needs" approach has been successful in the planning and delivery of local services, there has been criticism that it is not effective nor efficient in establishing standardized or common practices and processes required of provincial or zonal primary care systems. It has been difficult to evaluate overall PCN performance with little or no common measurement base and, as a consequence, difficult to establish accountability and responsibility.

Governance and operational effectiveness may be improved through the design and implementation of coordinated organizational structures and processes. There has been some success demonstrated by PCNs that have consolidated resources and efforts in planning and executing initiatives that are common to the group, in a city or geographical area.

These initiatives identify common practices or processes required of PCNs and coordinate efforts to find a common solution. As an example, the Calgary Zone Primary Care Action Plan has established an informal, collaborative effort between the seven PCNs and AHS, Calgary Zone, to "support current collaborative work to build a sustainable primary care system and to increase the pace of primary care development."

The structure and processes are limited to specific goals agreed upon by a coordinating council. It has also been agreed that there is no intent to infringe upon or alter the authority or responsibility of individual PCNs operating within this structure.

As PCN Evolution is rolled out with clear and measurable objectives from AH, there will be many opportunities for the PCNs to collaborate and consolidate planning efforts to advance the implementation of provincial strategies. The collaboration will be driven by a reasonable and rational approach: how best to deliver locally, while using resources organized through a provincial, zonal or needs-based approach. Support and coordination for the management of the initiatives will be planned and resourced through an agreement by and amongst the participating PCNs.

Evaluation of governance effectiveness

Anecdotal information also indicates that the current governance structure and processes may not be effective and, more specifically, there are not standard and consistent mechanisms to measure or correct performance at the governance committees. In the current provincial PCN governance structure, there is not a clear delineation of accountability, authority and responsibility and ultimately, consequences for performance.

As the PCN Evolution aligns with *Alberta's Primary Health Care Strategy* and the accountability of the evaluation framework, there will be an opportunity to include the evaluation of the effectiveness of the PCN's governing structures and processes.

3.1.5 Strategies for governance and organizational effectiveness

- Establish collaborative initiatives with key stakeholders within a geographical area to identify common practices or processes required of PCNs and coordinate efforts to find common solutions.
- Add public representatives to PCN governance boards.
- AHS as a joint partner in every PCN in the province and through this partnership commits resources to support effective governance and integrate decision making.
- PCN governance (NPC physician group and AHS) remains at the local level.
- *Alberta's Primary Health Care Strategy* will build in clear accountability structures.
- Evaluation framework will include a review of governance effectiveness.

3.2 PCN Evaluation

3.2.1 Background

The introduction and implementation of the enhanced accountability processes of the governance structure, and the system redesign to improve performance of PCNs, requires a structured approach to clearly define the performance goals, establish measurement indicators, and monitor and report on the progress of PCN Evolution. A comprehensive evaluation framework is also required to align the provincial, zonal and local initiatives currently underway or planned.

Alberta's OAG 2012 report on the audit of the PCN program highlighted the need for increased accountability and enhanced performance management. The recommendations for AH and AHS have been mentioned in the section in this document on ***Governance and Organizational Effectiveness***.

They are:

- Establish clear expectations and targets for PCN performance objectives.
- Develop systems to evaluate and report performance of the PCN program.
- Improve its systems to provide information and support to help the PCNs and AHS achieve PCN program objectives.
- Improve its (AH) systems for PCNs by obtaining assurances that PCNs are complying with the financial and operating policies of the PCN program.

The OAG recommended that AHS, within the context of its provincial primary health care responsibilities:

- Define goals and service delivery expectations for its involvement in PCNs.
- Define performance measures and targets.
- Evaluate and report on its performance as a PCN joint venture participant.

In 2011, one of the Malatest Report findings identified that an important element of system level design should be evaluating the effectiveness and outcomes of PCN programs; however, there were limitations for PCNs in self-evaluating the effectiveness of their programs and services. The limitations were identified as a result of lack of clear direction, information gaps in systems and processes and the possibility that too few PCN expenditures were allocated to evaluation activities within PCNs.

For the purposes of preparing this report, TOP conducted an informal survey of PCNs to assist in understanding what PCNs are measuring and the tools they use. The initial findings are:

- All PCNs are measuring/evaluating some program activity (chronic care measures, quality of life, screening and prevention, etc.).
- There is significant variability in what is being measured from PCN to PCN.
- Three PCNs collect and support collection of TNA appointments for all PCN physicians/providers with common toolsets and methods; five PCNs collect TNA for PCN programs but not for physicians.
- There is no common approach to panel/continuity processes and measures.
- Many PCNs are doing some form of patient satisfaction surveys.
- PCNs are requesting tools and processes to enable program evaluation. The current methods used by PCNs appear to be resource intensive.
- The level and sophistication of measurement depends on the PCN budget resources available.
- The support of the Measurement Coordination Initiative is viewed positively.
- There is not a general acceptance from all PCNs to "share" information outside of the PCN.

3.2.2 PCN Evaluation

An evaluation framework outlines a comprehensive approach to establish and measure meaningful outcome indicators and should provide standardized, useful tools for conducting and reporting on performance. With measures and tools in place, PCNs will advance their efforts to produce the province-wide benefits envisioned by the provincial health care stakeholders who created the vision for PCNs.

PCN physicians and health professionals often relate anecdotes about the positive impact their PCNs are having for patients. By establishing a system to formally track progress, verbal affirmations will be supported through quantitative and qualitative evidence.

PCN Evaluation falls under the PHC Evaluation Framework and AH Logic Model

PCN Evaluation will align with the PHC Evaluation Framework and Logic Model for Alberta’s Primary Health Care System (AH Logic Model). The AH Logic Model establishes three tiers:

- Enablers: specifies elements that must be in place to enable change.
- Service delivery: itemizes activities at the delivery site level.
- Outcomes: represents the results at the three levels (health system, PHC system and delivery site).

PCN Evaluation will address the delivery site and system level outcomes listed in the AH Logic Model.

Delivery site outcomes include:

<ul style="list-style-type: none">• Timely access to PHC• Attached patients• Early detection of risk and disease	<ul style="list-style-type: none">• Interdisciplinary collaborative care• Patient self-management• Enhanced patient and provider experience
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The system level outcomes include:

<ul style="list-style-type: none">• Greater attachment• Improved PHC access• Improved quality• Improved health status	<ul style="list-style-type: none">• Improved self-management• Increased provider engagement and satisfaction
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Evaluation includes PCN Business Plan

Another aspect of the evaluation framework will be the PCNs’ business planning processes and outcomes. Through business cycle reporting of business plans, mid-year reviews, and annual report and budget reviews, PCN performance is evaluated against the business plan’s stated goals in meeting the objectives and service responsibilities. See **Background** section of this document for the key objectives and service responsibilities.

3.2.3 Evaluation findings support continuing improvements

PCN evaluation work, occurring at different levels, will also support:

1. System-wide lessons learned on the effectiveness of the PCN model of primary care pertaining to delivery, strategies and processes.
2. Lessons learned that can be generalized, adapted and implemented by other primary care delivery models.

3. AHS ability to review and refine their primary care processes as they pertain to service delivery and population health planning.
4. PCNs effectiveness in delivering programs that meet local needs.

By creating accountability processes and measures to track against these outcomes, the PCNs will standardize information requirements and collect information using the same definitions, data standards and compliance systems. Information will be efficiently aggregated to produce the right information for the right level of reporting requirements.

This information will be used locally, zonally and provincially to develop systems and processes for continuous improvement programs.

3.2.4 Development of PCN Evaluation

AH will use its provincial working group to lead the development of the metrics within PCN Evaluation. The working group includes representatives of PCN boards, physicians, health professional teams and affiliated professional organizations.

In anticipation of the work required to complete a provincial PCN Evaluation, the following considerations were compiled this year by a multi-stakeholder PCN working group on the topic of core measurement reporting.

Principles to guide measurement in PHC:

- Measurement must examine key attributes of PHC.
- Measures will align, where possible, with provincial and national initiatives to enhance standardization and support aggregate reporting.
- Measurement will focus on both performance and quality improvement efforts from the PCN and systems level.
- Financial and administrative burdens will be minimized, where possible, by considering workflow and clinical information systems implications when planning measurement activities.

Essential elements of the evaluation process include:

- Measures should allow PCNs to know their clients and patients. Measurement and evaluation activities will be oriented to the care provider by providing timely, accurate and meaningful information back to the delivery site. This flow of information is essential to enable patient-centred care.
- The behavioral change required “out in the field” will take a long time: valuing the information, seeing the benefit of collecting the data, becoming secure with sharing data about one’s practices and patients; learning to be comfortable with not being perfect, and embracing the value of change will lead to success. None of this is as simple as clicking a response box and later producing a computer-generated report.
- Data sharing is a key element. When sharing is more valuable than keeping, the willingness to collaborate, problem-solve and integrate will improve the system.
- This work should start with a short mandatory list of commonly agreed to indicators and build in a staged process of sharing to enable CQI along the way (e.g., start by sharing just within a clinic over the course of one year; advancing to sharing within a PCN [year 2]; and then zonal reports [year 3]), which will allow provincial reports.

Measurement work would operate under the following principles:

- Imbed co-operation and respect into the process.
- Encourage growth and improvement (non-judgemental).
- Use evidence to promote success.
- Evolve over time as the provincial vision for PHC evolves.

System enablers required include:

- IM/IT systems to facilitate minimal burden for data collection and reporting.
- Required updates to IM/IT system to ensure timely and efficient reporting and data sharing, and to maintain consistent data standards.
- Adequate and competent resources (i.e., human and financial).
- Provincial partners that can support PCNs through the provision of required data and reports.

Strategies for evaluation

- Align with the work currently underway as part of the *Evaluation Framework for Alberta's Primary Health Care System* (2013).
- Ensure that IM/IT systems facilitate a coordinated, integrated approach to evaluation and measurement.
- PCN experience and expertise will be considered in developing the provincial PCN Evaluation framework.
- Information collected, analyzed and reported will be used to initiate and develop systems and processes for CQI programs.

4.0 Enablers

4.1 Funding and Compensation

Funding is a tool that can help to achieve desired outcomes as PCN Evolution is developed and rolled out. Given the complexity of PCN Evolution with multiple strategies to develop trilaterally, details to agree on, and processes to implement over a period of time, it is not possible to detail the specific areas and amounts of funding required to support PCN Evolution strategies at this time.

There are some areas, however, where funding is needed to support the PCN 2.0 approach to primary care service delivery and, where applicable, these are mentioned in sections of this report and are collated in general terms below.

4.1.1 Current PCN funding

The current per capita funding for PCNs, outlined in the 2011-2018 Primary Medical Care/Primary Care Networks Consultation Agreement, is a fee of \$62 per PCN patient that meets the four-cut funding criteria. This methodology is defined on the Primary Care Initiative website as follows:

The Four Cut Funding Methodology is a way of assigning patients to one primary care provider in Alberta. All patients who have visited a family physician (or pediatrician or nurse practitioner) are assigned to a patient list. These patients are called enrollees, and they are only counted once, even if they have seen multiple physicians.

Enrollees are identified using a four-step method that identifies all patients who have received any service from a family physician over the past 36 months, and informally assigns the patient to a physician. All of the patients assigned to all of the physicians in the PCN make up the PCN enrollee list.

PCNs vary in size based on the number of physicians practicing in them; therefore, the number of patients served by the PCN differs as well. This means that larger urban PCNs, with over 100 physicians (for example) and thousands of patients, are much better able to develop a variety of programs and services to meet varied patient needs and to hire health professionals than are small rural PCNs with three physicians and a smaller patient population.

As many costs of operating PCNs are fixed costs, PCNs have varying amounts of per-capita funding to meet the costs associated with meeting clinical programming requirements.

Usage of PCN funds

PCN per capita funding (and surplus) can be used to fund a variety of ongoing and one-time costs associated with the running and maintenance of the PCN, its staffing and ongoing delivery of priority initiatives and programs. Costs such as wages and benefits for staff, capital costs (leasing, renovating and maintaining office and clinical space), education/training (such as AIM) and related travel of physicians and staff, office and medical supplies, medical and IT/EMR equipment, office furniture, costs associated with conducting PCN evaluation/quality improvement and information management, improvement, promotion and communication costs, and administration and support services can all be paid out of PCN per capita (and surplus) funds, as long as they can be shown to be relevant to and directly support the work of the PCN and the delivery of its priority initiatives and programs.

4.1.2 Principles for funding to support PCN Evolution

- PCN 2.0 funding should be sufficient to accomplish enhanced primary care and to fulfill all expectations placed on PCNs and member physician clinics, if they choose to participate in PCN 2.0.
- PCN funding should align with incentives conducive to inter-professional team-based care.
- Optional physician compensation models should be available for PCN physicians to support the team approach to care delivery.
- Local solutions for local population needs should continue to be supported.
- Funding should follow the patient.
- Per-capita funding should vary by need (risk adjusted - age/gender/comorbidities) as well as rural/remote.
- The need for prevention services for a healthy public should be recognized.
- Principles are needed to guide the use of PCN funds to pay physicians for PCN duties.
- To the extent possible, funding policy should support the use and further development of co-located health care teams.

4.1.3 Current barriers to PCN Evolution

Physician compensation models

Most family physicians in PCNs are compensated for the services they provide through a FFS model. This model incentivizes episodic care and requires the physician to see the patient in order for services to be compensated. The FFS model does not incentivize or align well with comprehensive team-based care.

Other physician compensation models support the PCN health care team approach to providing primary care services. Examples include the capitation model, which is defined on the Alternate Relationship Plan Program Management Office website as follows: "Compensation is based on an annual amount per rostered patient (adjusted for sex and age) for a defined set of insured medical services. Rosters may be composed of enrolled patients or all patients within a defined geographic area. This model provides a population-based form of compensation that encourages innovative, quality health care. It is usually associated with family physicians/general practitioners in primary health care."

Two clinics in PCNs currently use a capitation funding model.

Capitation is not the only appropriate physician compensation model to support team care. Various compensation models are being explored as options to consider for PCN physicians.

4.1.4 Strategies to support PCN Evolution

Physician compensation enhancements

- **A group will be formed to look at options for family physician compensation models** that support efficient team-based care.

- **Develop and define fees for medical services** that FFS physicians provide to patients through electronic communication (e-access) to improve access:
 - Secure messages
 - Telephone
 - Personal computer (PC)-based video-conferencing

Additional funding-related strategies to support PCN Evolution

- Policy changes to allow the use of closing costs reserve funds to expand or build spaces to enable co-location of health care teams.
- Smaller PCNs that have lower patient populations and, therefore, lower total budgets may benefit from grants or another funding mechanism to build enhanced teams and implement other PCN 2.0 strategies.
- Develop strategies and appropriate funding support to optimize such IM/IT initiatives such as:
 - Data management.
 - Integration with community providers.
 - EMRs for the team to input patient data.
 - Training physicians and health professionals to meet chart etiquette and data standards.
 - Funds for EMR vendors to conform to provincial standards to meet information sharing and analytic requirements.
 - Data migration — the patient record can be moved/consolidated into sources of care.

Future discussions about funding

As PCN Evolution is implemented over the next few years, financial needs for specific activities will become clearer. They can then be discussed and defined in more detail as to how support should be provided within the processes and structures of AH and the AMA.

4.2 IM/IT

4.2.1 IM/IT Summary Report

4.2.1.1 IM/IT today

Vast amounts of electronic data is being captured and put to work throughout primary care physician offices and PCNs across Alberta. From assisting with scheduling, to gathering simple patient demographics, to tracking more complex data such as A1C blood glucose levels in diabetes patients, information is accumulated through many different EMR solutions when patients visit physicians and inter-professional health care teams.

Physicians and patients understand and support the collection, analysis and sharing of electronic information among health team professionals to enhance PHC delivery and continuity of care. In fact, patients are often surprised to learn that their health information does not always follow them from one provider to another, including hospitals.

More than 80% of Alberta's primary care physicians use EMRs in their practices today. While information may be added to EMRs at the point of care, data cannot typically be shared outside of a PCN or physician office electronically since the health exchange infrastructure across the province is not sufficiently deployed to support primary care. A few PCNs share information but only after large investments have occurred with significant resources from AHS and other experts.

Automating, sharing and analyzing health information are valuable components of an efficient and effective health care future in Alberta. The next phase must focus on the ever-changing IM/IT needs which require governance, data standards, policies, procedures and enhancements to the provincial Health Information Exchange (pHIE) infrastructure.

Business and clinical needs are the driving forces behind IM/IT solutions. However, a successful made-in-Alberta overall IM/IT program can only be achieved through the support of leadership and governance — with AH, AHS and the AMA working together.

4.2.1.2 Change is underway

It is understood and acknowledged that the provincial EMR strategy will drive the IM/IT directions and implementation to support any future provincial initiatives, including that of PCN Evolution. It is expected that the IM/IT policies and implementation activities required for PCN Evolution will be overseen by the provincial Electronic Health Record Committee, which in turn is governed by the Health Information Executive Committee.

PCN Evolution, collaboration with AH and AHS to establish a provincial EMR strategy, and alignment with *Alberta's Primary Health Care Strategy* will work to address the IM/IT changes necessary to pave the way toward well organized, accountable and effective PHC.

Many of the strategies identified for consideration with PCN Evolution have significant technological connections. For instance, patient access will benefit from e-referrals and online consultations. Population health data, for research and analysis, can only be realistically gathered and “mined” through automated data gathering. The integration of external health care services (such as home care, mental health and pharmacy) into a health home is made smoother if all utilize common or compatible IM/IT infrastructure. Other examples are highlighted throughout the report.

The AMA sees improving IM/IT as a key area of focus in PCN Evolution. A recent report from health technology experts Bill Pascal and Denis Protti shows that health care lags behind other industries such as finance, retail and airline transportation in terms of data exchange and analysis. The *Review of Maximizing Value from Health Information Technology* shows that Alberta has done very well when compared to the rest of Canada in collecting health care data electronically and there are many initiatives in place to close the gap.

Following a review of Health IT in Canada, New Zealand, Australia, the United States, Europe and the United Kingdom, the AMA identified three goals:

- 1. Accumulation/automation:** Data collection in a digital format occurs throughout the province in a number of ways. These include: physicians populating EMRs; Alberta Netcare, the provincial Electronic Health Record (EHR), handling lab results and diagnostic imaging; the Pharmacy Information Network with medication and allergy information; and in some cases hospital discharge summaries, consultation and operative reports.
- 2. Information exchange/information sharing:** Standardized infrastructure, formatting protocol, policies and consistent measurement are necessary to successfully share patient data electronically among health care professionals for continuity of care. Limited resources and competing priorities have challenged pHE in the past. Source data — which comes from a variety of health care providers such as labs, diagnostic imaging, hospital facilities and community services — must be easily transferred between systems, including the EMRs. The challenge is the plethora of source information systems and the multitude of EMRs throughout the province. The ability for the disparate systems to “talk” to each other is limited from both technical and policy perspectives, but can be overcome with appropriate funding, infrastructure and engagement.
- 3. Analytics:** The ultimate goal of data collection is being able to utilize the data for analysis. The HQCA and a few PCNs have achieved some success in this area through time-consuming manual supplements to collect, compile and report on the data. The Provincial Health Analytics Network will be another valuable resource to PCNs in data analytics. In order to expand this capability throughout primary care, the province will need to review automating these processes.

4.2.1.3 Key requirements

Funding, EMR vendor engagement, information exchange, leadership/governance

The AMA has identified components that need to be addressed for a successful IM/IT strategy:

- **Funding:** Physicians should not be expected to fund entire EMR and EHR costs since the health system in general is also a benefactor of this electronic information. The Physician Office System Program (POSP) previously reimbursed physicians up to a maximum of 70% for their EMR costs, but that program is now being discontinued. The AMA and

AH are investigating other forms of funding and supports for physician use of IM/IT. It is recognized by all parties that incentives, as in other jurisdictions, must be in place to continue building a successful provincial IM/IT system.

- **Vendor engagement:** About 15 EMR vendors currently provide EMR solutions throughout the province, including the successful candidates for the last POSP program: Med Access, TELUS Practice Health Solutions and Wolf EMRs. The EMR vendors will need to meet the developing provincial information exchange standards to ensure they can support the sharing of information among health care professionals. The EMRs will also need to support the increased IM/IT requirements and business needs within PCN Evolution's opportunity areas. EMR vendors will need incentives to conform.
- **Information exchange or sharing:** Primary care is the biggest user/consumer of health information and needs seamless integration at the point of care for both providers and patients. Health information exchange is complex and multifactorial, involving technical, legal, policy, cultural/social and clinical process elements. In its simplest terms, information integration is the foundational infrastructure to exchange information from one system to another. As we move toward team-based care initiatives and a patient-centred health system, the need for timely, accurate and reliable information exchange grows. There has been large investment into the pHIE system. This system needs to be available to support primary care's necessary two-way flow of information. Providers and their patients benefit from having seamless and timely access to all relevant health data at the point of care. Elimination of unnecessary repeat tests can be achieved as well as providing a complete picture to assist in a thorough diagnosis/treatment plan. The pHIE is a key infrastructure component to meet PCN Evolution principles.

4.2.1.4 Other key enablers

Depending on the opportunity area, other enablers are required to ensure success. They include:

- **Data management:** Given the variety of EMRs in use and the plan for two provincial Clinical Information Systems (CIS) to be offered to primary care, a comprehensive data management system must be implemented to enable moving information from one system to another to support continuity of care, medico-legal obligations and historical health information.
- **Advanced usage:** Many primary care practices and PCNs are not using EMRs to full potential. Using an EMR much like a "paper" chart does not capitalize on the opportunities available for data collation, report creation, implementation of reminders/alerts, ability to make queries between health care teams and integration with the provincial EHR. Advanced usage will need to be supported through change management and resources.
- **Meaningful use:** This is an initiative being looked at by AMA, AHS and AH to support users expanding their EMR usage beyond just electronic capture of patient data to using the data more effectively to benefit both the patient and health system. Alberta has just started looking at the application of meaningful use to remunerate physicians for meeting yet-to-be-specified outcomes. The four areas being reviewed are:
 - Effective use of IT.
 - Direct patient care within a practice setting.
 - Patient care across the continuum.
 - Health system analysis.

All four areas require the ability to conduct quality measurement at the clinical level. This includes developing and using patient panels to anchor outcomes.

- **Community referral/consultation technology, policies, processes and change management:** Substantial time and effort is being spent by providers and staff moving patients from primary to specialist care. The processes are time consuming and often lack the ability to track progress. Closing the loop with the consultation after the referral can also be very challenging. The process is often thwarted by manual processes and a lack of information integration. Trilateral support is required to improve this activity with pHIE serving as an enabler. AHS is working on a limited production rollout, but expansion is needed to include all primary care physicians and specialists.

- **Integrating provincial registries with primary care EMRs:** Client, provider and facility registries must be connected to ensure data is linked correctly. The registries will be the provincial “source of truth” rather than identifying data dispersed through numerous discrete systems. Data analysis in PCN Evolution will also require linkage between the EMR and the provincial disease registries.

4.2.1.5 Suggested IM/IT requirements for PCN Evolution principles

How will IM/IT changes impact PCN Evolution? Many of the strategies identified for consideration within PCN Evolution will be impacted from linking physician-patient relationships to standardization of data collection and information exchange.

A few **key enablers** are necessary to support the business needs within each opportunity area. These include:

- **EMRs** must be used to digitize health information. Primary care physicians and teams must use EMRs and EHRs.
- **pHIE must be in place** with standards developed and implemented, for seamless and timely exchange of digitized health information.
- **Change management** must be established to support clinic adoption of new technology, processes and policies. This includes strong communication to gain provider, staff and patient engagement.

Some specific IM/IT criteria to support PCN Evolution strategies are necessary and highlighted below.

Linkage

- Patient demographics must be standardized to include complete patient name, date of birth, gender and personal health number with a discrete data field in the EMR to capture the patients “linkage” to the provider.
- Patient list validation may be needed.
- Tracking of patient movement (deceased patients, moving out of area) is necessary.

Access

- Alternate forms of secure communication are needed such as encrypted email, e-consults, online booking and telehealth.
- Digital reports must be accessible from multiple contact points within the health system, such as the ER, inpatient discharge, diagnostic imaging and other health services.
- The Personal Health Portal will allow patients to track their health and wellness journey and access appropriate support material and resources.
- Online booking could assist patients in finding appropriate providers, preparing for appointments and receiving reminders.

Standards and measures

- Common data standards, data collection and protocols need to be supported and embedded in EMRs. Appropriate education and training is required for both physicians and inter-professionals to move to standardized data collection.
- Analysis and reporting tools are available within the conformed Alberta EMRs but most clinic personnel need to be trained to use them.

Accountability

- Patient and provider data must be collected in a standard format.
- Data sharing and exchange specifications must be established.
- Multiple data sources such as EMRs, AH and AHS need to be systematized.

Enhanced teams

- Remote access to an EMR is necessary.
- Mobile input devices such as laptops, tablets and smartphones will be required for portable data inputting.
- External health care services such as home care, mental health and pharmacists must be able to integrate.
- Secure messaging is needed between multidisciplinary teams and health care services.
- Ability to easily access and input into the health system will impact the role health care professionals can carry out.
- Health care professionals and patients must be able to perform communications such as secure emails and patient portals.
- Specialist consultants, and the ability to communicate with specialists, must be included in the expanded team.

Horizontal/vertical integration

- Alternative secure communication such as encrypted email, e-referral, e-consult and telehealth, needs to be expanded between health system providers and between health providers and other services as well (e.g., social services, education, etc.).
- Provider and encounter registries are necessary.

Population health

- Electronic patient panels and the ability to analyze data are required.
- Client, provider and facility registries must be established for data mining.
- Automated communication mediums such as email, phone and portals are needed.
- HQCA data will be an excellent starting point to be built upon with EMR integration and automated processes.
- Automated tools for recalls and reminders exist within EMRs and providers need to know how to utilize these effectively.

Public engagement

- The Personal Health Portal will give Albertans an opportunity to manage their health care needs, learn more about health and wellness, and access available health care programs and services.

Funding

- EMRs will provide the ability to track outcomes so that physicians can be remunerated when meeting PCN Evolution requirements.

4.2.1.6 Recommendations for IM/IT opportunity area success

Leadership and governance

Successful PCN Evolution requires leadership support for IM/IT enablers and funding incentives for primary care adoption. Three main stakeholders must be involved: AH, AHS and the AMA. To ensure alignment and leverage with other provincial IM/IT initiatives, this PCN Evolution governance body should report to the Health Information Executive Committee, which currently includes the AH deputy minister and chief executive officers from AHS and the AMA.

Suggested responsibilities include:

- Setting and overseeing policy for PCN Evolution IM/IT.
- Monitoring outcomes and investigating deficiencies occurring with IM/IT.
- Promoting sustainability of PCN Evolution enablers.
- Overseeing implementation and operations of PCN Evolution.

Governance

In order for IM/IT supports to assist the other opportunity areas, a trilateral body should be established to oversee planning, implementation and operations of the enablers. This body must report to a leadership committee so the latter can continue to move PCN Evolution IM/IT priorities forward.

This trilateral body should be designed as a working group with the following purpose:

- Link business and clinical requirements with available IM/IT solutions.
- Identify gaps where IM/IT enablers do not exist to enable PCN Evolution requirements and bring forward findings to decision makers.
- Advise on PCN Evolution IM/IT to various PCN stakeholders.
- Monitor the changing provincial IM/IT environment and make recommendations as necessary.

Reporting to both the PCN Evolution Steering Committee and Provincial EHR Strategy Committee, the trilateral body should include primary care and IM/IT representatives from AH, AHS, AMA and PCNs.

4.3 PCN 2.0 Strategies for IM/IT

- Investigate forms of funding and supports for physicians' use of IM/IT that supports patient care and health system needs.
- Investigate incentives for EMR vendors to support the increased IM/IT requirements and business needs within PCN Evolution's opportunity areas.
- Support the pHIE as a key infrastructure component to meet PCN Evolution needs.
- Implement a comprehensive data management system.
- Support advanced usage of EMRs through change management and resources.
- Integrate provincial registries with primary care EMRs to ensure a provincial "source of truth" for patient and provider data.
- Support linkages between primary and specialty care for community referral/consultation technology, policies, processes and change management.

APPENDIX A

CFPC Goals and Recommendations for the Medical Home Model

Goal 1: A Patient's Medical Home will be patient-centred.

Recommendations

- 1.1: Care and caregivers in a Patient's Medical Home must be person-focused and provide services that are responsive to patients' feelings, preferences and expectations.
- 1.2: Patients, their families, and their personal caregivers should be listened to and respected as active participants in their care decisions and their ongoing care.
- 1.3: Patients should have access to their medical records as agreed upon by each person and his other family physician and team.
- 1.4: Self-managed care should be encouraged and supported as part of the care plans for each patient.
- 1.5: Strategies that encourage user-friendly access to information and care for patients beyond traditional office visits (e.g., email communication) should be incorporated into the Patient's Medical Home.
- 1.6: Patient participation and feedback (e.g., patient advisory councils) should be included as part of the ongoing planning and evaluation of services provided in the Patient's Medical Home.

Goal 2: A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.

Recommendations

- 2.1: By 2015, 95% of the people in each community throughout Canada should have a personal family physician.
- 2.2: By 2020, every person in Canada should have a personal family physician.
- 2.3: By 2022, every person in Canada should have a personal family physician whose practice serves as a Patient's Medical Home.
- 2.4: Each patient in a Patient's Medical Home should be registered to the practice of his or her personal family physician.

Goal 3: A Patient's Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses and others.

Recommendations

- 3.1: A Patient's Medical Home may include one or more family physicians, each with his or her own panel of patients.
- 3.2: Family physicians with special interests or skills, along with other medical specialists, should be part of a Patient's Medical Home team or network, collaborating with the patient's personal family physician to provide timely access to a broad range of primary care and consulting services.

- 3.3: On-site, shared-care models to support timely medical consultations and continuity of care should be encouraged and supported as part of each Patient’s Medical Home.
- 3.4: The composition of the teams or networks of health professionals and providers in Patients’ Medical Homes may vary from one practice and community to another.
- 3.5: The location of each of the members of a Patient’s Medical Home’s team should be flexible, based on community needs and realities; team members may be on-site in the same facility or may function as part of physical or virtual networks located throughout local, nearby or, for many rural and remote practices, distant communities.
- 3.6: The personal family physician and nurse should form the core of most Patient’s Medical Home teams or networks, with the roles of others such as physician assistants, pharmacists, psychologists, social workers, physio- and occupational therapists, and dietitians to be encouraged and supported as needed.
- 3.7: Physicians, nurses, and other members of the Patient’s Medical Home team should each be encouraged and supported to develop and sustain ongoing professional relationships with patients; each caregiver should be presented to each patient as a member of his or her personal medical home team.
- 3.8: Nurses and other health professionals who provide services as part of a Patient’s Medical Home team should do so within their professional scopes of practice and personally acquired competencies. Their roles in providing both episodic and ongoing care should support and complement—but not replace—those of the family physician.
- 3.9: The roles and responsibilities of the team members of each Patient’s Medical Home should be clearly defined. The leadership and support roles assigned to the different team members for the clinical, governance and administrative/management responsibilities required in a Patient’s Medical Home will vary from service to service and practice to practice, and thus should be determined within each setting.
- 3.10: Health system support, including appropriate funding, should be available to support all members of the health professional team in each Patient’s Medical Home.
- 3.11: Each health provider/professional team member must have appropriate liability protection.
- 3.12: Ongoing research to evaluate the effectiveness of teams in family practice/primary care should be carried out in Patients’ Medical Homes.

Goal 4: A Patient’s Medical Home will ensure i) timely access to appointments in the practice, and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.

Recommendations

- 4.1: A Patient’s Medical Home should ensure access for patients to medical advice and the provision of or direction to needed care 24 hours a day, 7 days a week, 365 days a year.
- 4.2: Patient’s Medical Home practices should adopt advanced access or same-day scheduling strategies to ensure timely appointments with the patient’s personal family physician or other appropriate members of the team.
- 4.3: When the patient’s personal family physician is unavailable, appointments should be made with another physician, nurse, or other qualified health professional member of the Patient’s Medical Home team.
- 4.4: Patients should have the opportunity to participate with their family physicians and Patient’s Medical Home teams in planning and evaluating the effectiveness of the practice’s appointment booking system to ensure timely access to and adequate time allotment for appointments.

- 4.5: Panel size for a Patient’s Medical Home and its providers should be appropriate to ensure timely access to appointments and safe, high-quality care for each patient and the practice population being served.
- 4.6: Panel size should take into consideration the needs of the community, the workload of the health care providers, and the safety of the patients.
- 4.7: Defined links should be established between the Patient’s Medical Home and other medical specialists and medical care services in the local or nearest community to ensure timely appointments for patients being referred for investigations, treatments, and other consultations.

Goal 5: A Patient’s Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

Recommendations

- 5.1: In a Patient’s Medical Home, the patient’s personal family physician should work collaboratively with the other team members to provide a comprehensive range of services for people of all ages, including the management of undifferentiated illness and complex medical presentations.
- 5.2: A Patient’s Medical Home should meet the public health needs of the patients and population it serves.
- 5.3: Patients’ Medical Homes should prioritize the delivery of evidence-based care for illness and injury prevention and health promotion, reinforcing these at each patient visit.
- 5.4: The health care system should support Patients’ Medical Homes to ensure their key role in the management and coordination of care for patients with chronic diseases, including mental illness.
- 5.5: Patients’ Medical Homes should address the health needs of both the individuals and populations they serve, incorporating the effects that social determinants such as poverty, job loss, culture, gender, and homelessness have on health.

Goal 6: A Patient’s Medical Home will provide continuity of care, relationships, and information for its patients.

Recommendations

- 6.1: Care for each person in a Patient’s Medical Home should be provided continuously over time.
- 6.2: Patient’s Medical Homes should foster continuity of relationships between patients and each of their caregivers.
- 6.3: Patient’s Medical Home teams should ensure continuity of the care being provided for their patients in different settings, including the family practice office, hospitals, long-term care and other community-based institutions, and the patient’s residence.
- 6.4: A Patient’s Medical Home should advocate on behalf of its patients to help ensure continuity of their care throughout the health care system.
- 6.5: A Patient’s Medical Home should serve as the hub that ensures coordination and continuity of the information related to all the medical care services their patients receive throughout the medical community.

Goal 7: A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.

Recommendations

- 7.1: By 2022, all family physicians in Canada should be using EMRs in their practices.
- 7.2: System supports, including funding to support the transition from paper records, must be in place to enable every Patient's Medical Home to introduce and maintain EMRs.
- 7.3: EMR products for use in Patients' Medical Homes should be identified and approved by a centralized process that includes family physicians and other health professionals. Each practice should be allowed to select its EMR product and service providers from a list of provincially, territorially, or regionally approved vendors.
- 7.4: EMRs approved for family practice/Patients' Medical Homes must include appropriate standards for recording and following patient care in a primary care setting; e-prescribing capacity; incorporated clinical decision support programs; e-referral and consultation tools; advanced-access e-scheduling programs; and systems that support teaching, research, evaluation, and continuous quality improvement in the practice.
- 7.5: EMR and electronic health record systems must be interconnected, user-friendly, and interoperable.
- 7.6: There should be a pan-Canadian electronic health care communication and information infrastructure that ensures secure access to medical records and privacy and confidentiality of communications for all citizens and their medical and health care providers.

Goal 8: Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.

Recommendations

- 8.1: Patients' Medical Homes should be identified and supported by medical and other health profession schools as prime locations for the experiential training of their students and residents.
- 8.2: Patients' Medical Homes should teach and model their core defining elements including patient-centred care, teams/networks, EMRs, timely access to appointments, comprehensive continuing care, management of undifferentiated and complex problems, coordination of care, practice-based research, and continuous quality improvement.
- 8.3: Patients' Medical Homes should provide a training environment for family medicine residents that models and enables residents to achieve the objectives of the Triple C Competency-based Family Medicine Curriculum, the Four Principles of Family Medicine, and the Can MEDS-Family Medicine (Can MEDS-FM) Roles.
- 8.4: Patients' Medical Homes should be identified as optimal sites for training experiences for residents in all medical specialties.
- 8.5: Sufficient system funding and resources must be provided to ensure that teaching faculty and facility requirements will be met by every Patient's Medical Home teaching site.
- 8.6: Patients' Medical Homes should encourage and support their physicians, other health professionals, students, and residents to participate in research carried out in their practice settings.
- 8.7: Patients' Medical Homes should function as ideal sites for community-based research focused on patient health outcomes and the effectiveness of care and services.

- 8.8: Competitions for research grants relevant to primary care and family practice such as the Canadian Institutes of Health Research's Strategy for Patient-Oriented Research should be strongly supported.
- 8.9: Family physicians and other health professionals in Patient's Medical Home practices should be encouraged and supported to compete aggressively for research grants to study the effectiveness of the services they provide.

Goal 9: A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).

Recommendations

- 9.1: Patients' Medical Homes should establish CQI programs that evaluate the quality and cost effectiveness of the services they provide and the satisfaction of their patients and providers.
- 9.2: Indicators should be defined to help guide the CQI activity of Patients' Medical Homes, based on the objectives, goals, and recommendations in this document, and other published quality indicators for family practice.
- 9.3: To ensure relevance for the populations being cared for in primary care/family practice settings, clinical practice guidelines and performance indicators must be applicable to patients with comorbidities and complex medical presentations.
- 9.4: All members of the health professional team, as well as trainees and patients, should participate in the CQI activity carried out in each Patient's Medical Home.
- 9.5: Annual national multi-stakeholder forums should be held to monitor and evaluate the effectiveness of Patient's Medical Home initiatives across Canada.

Goal 10: Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

Recommendations

- 10.1: Governance, administrative, and management roles and responsibilities should be clearly defined and supported in each Patient's Medical Home.
- 10.2: The individuals responsible for assuming and carrying out the governance, administrative, and management roles and responsibilities will vary from one Patient's Medical Home to another and should be determined by the stakeholders involved in each practice.
- 10.3: Leadership development programs should be offered for those assuming the governance, administrative, and management roles in each Patient's Medical Home.
- 10.4: Sufficient system funding must be available to support Patients' Medical Homes, including the clinical, teaching, research, and administrative roles of all members of Patient's Medical Home teams.
- 10.5: Blended payment models should be introduced in every province/territory as a preferred option for remunerating family physicians in practices functioning as Patients' Medical Homes.
- 10.6: Research evaluating the impact and effectiveness of different physician payment models on access to care, patient health outcomes, and patient and provider satisfaction should be ongoing.

- 10.7: Governments, the public, family physicians, and other medical and health professions and their organizations, should support and participate in establishing and sustaining Patients' Medical Homes across Canada.
- 10.8: Future federal/provincial/territorial health care funding agreements must include clear accountability provisions with a requirement that each jurisdiction eligible to receive funds must meet explicitly defined targets, including those related to primary care and comprehensive family practice.
- 10.9: Future federal/provincial/territorial agreements must include commitments to primary care/family practice/Patient's Medical Home priorities including illness and injury prevention, population health, EMRs, home care, and pharmacare.
- 10.10: The current federal/provincial/territorial Health Accord, which expires in 2014, must be extended for at least another decade.

APPENDIX B

PCN Evolution Goals and Strategies Summary

Goal: Albertans are knowledgeable about their PCNs and their health homes.

Strategies to raise awareness

- Provide information about the purpose of PCNs.
- Inform patients about the PCN where their physician practices and their membership in the PCN.
- Provide information to patients about:
 - Services provided by their PCN.
 - Hours of operation and service delivery locations, including after-hours care.
- Explain the benefits of being linked to a family physician, the inter-professional health care team and the PCN health home.
- Use the opportunity to explain the benefits of formalizing the relationship with their family physician and the health home. This discussion could be the first step in formally linking the patient to the family physician.

Goal: Every Albertan has a family physician and a health home.

Strategies/considerations for Group A – Albertans looking for a family physician

- Expand strategies to enhance access by building capacity in physician offices through:
 - Quality improvement strategies such as AIM, ASaP (Alberta Screening and Prevention), the AMA's PMP (Practice Management Program) for more effective appointment scheduling.
 - Innovative use of technological approaches (e.g., email) for some patient encounters to increase physician capacity for adding new patients while providing quality, timely and continuity of care to an expanded panel.
- Explore the option of a provincial web-based initiative to link patients with PCN family physicians accepting new patients in their areas.
- Northern, rural/remote and small PCNs may need to use different strategies than those used by large/urban PCNs for attaching patients to a health home.
- As part of the 'Early Opportunities' work plan, PCN strategies for linking patients to available family physicians are being collected for a strategy toolbox, and will be available to all PCNs and clinics.

Strategies for Group B – Albertans not actively looking for a family physician or a health home

- A province-wide communications strategy using traditional and social media to publicize the benefits of a health home.
- Promotional material regarding the health home and its benefits placed at common points of care such as after-hours clinics and emergency departments.
- Increased attempts to link these patients to a family physician/PCN at the time of medical need at the walk-in clinic, PCN after-hours clinic, emergency department, etc.

Strategies for Group C – Difficult to reach Albertans

- PCN outreach clinics in inner city areas (possibly with an alternative funding model) could provide more comprehensive and consistent care, and build trusting relationships with patients to help link them with a family physician.
- Establishing relationships with Group C patients through health care professionals (e.g., nurses providing care) may provide an effective entry point to the health home and a family physician.

- One-on-one navigation support to assist in finding family physicians.
- Leverage and identify existing AHS relationships and programs to support Group C patients in connecting with PCN clinics.

Additional strategies for finding family physicians for Albertans

- A toolbox of strategies developed provincially and made available to PCNs to tailor for their use.
- More research to better identify the number of people still without family physicians.

Goal: Albertans are formally linked to their family physicians and the PCN health home.

Strategies

- Information is currently being gathered from PCNs on their experience in formalizing patient relationships with a primary care physician. A provincial group will discuss and develop attachment strategies. Discussion topics may include: **Terminology** for formal “attachment” and whether there is a need to identify and use different terminology to describe the relationship. Both physicians and patients have expressed some discomfort regarding the term “attachment” of a patient to a physician.
 - A preferred approach may be to refer to “patients designating their preferred family physicians” (a process done **by them**) rather than referring to a physician attaching a patient (which is a process that is done **to them**).
 - The BC program “A GP for Me” appears to be patient-friendly. It addressed the roles and responsibilities of the patient and the physician, using “Your doctor is your partner in health” as a tagline.
- **Parameters** for what is and is not inherent in attachment (e.g., performance measures).
- **Communications** to introduce the concept to physicians and patients alike.
 - Acceptable terminology for development and use in all patient communications.
 - Usefulness of a province-wide awareness initiative.
 - Provincial development of materials (e.g., posters, flyers, brochures) to standardize message delivery. Local PCNs would not have to develop their own materials and could use the provincially developed ones to assist them in discussions with patients.
- **Funding strategies** to support formalizing physician/patient relationships.
- **Differences in capacity** between urban PCNs and rural/remote/small PCNs to implement a formalized strategy. Different strategies for formal linkages may need to be considered by the Working Group for various PCNs.

Goal: Albertans have appropriate access to their family physicians and/or PCN health homes.

Strategies

- Leverage current successful Alberta clinic and PCN practices to provide a toolbox of resources for other PCNs and clinics to adopt:
 - PCN partnerships, AMA resources and others could provide implementation assistance.
 - Some strategies may require further development to accommodate broader participation and adoption.
- Develop a collaboration framework to support zonal PCN collaboration to develop and implement common approaches to specific access issues.
- Provide training and support to clinics to adopt advanced scheduling techniques.

- Work with stakeholders to develop appropriate training materials and capacity to support province-wide adoption of TNA appointments as a local measure of access.
- Develop targeted education and training programs to enhance access.
- Work with community stakeholders and AHS to develop continuity of care as a longitudinal measurement of access.
- Evaluate the use of e-access strategies to determine requirements for further adoption, as appropriate.

Goal: PCN health professionals work to full scopes of practice to provide collaborative, comprehensive team-based patient care.

Strategies to enhance teams

- Ensure physician compensation policy and models are available to support team-based care.
- Change policy to allow capital investment to create physical space to co-locate teams.
- Index funding that allows PCNs to keep pace with inflationary changes and local market conditions for compensation.
- Encourage educational bodies to provide focused primary care education to students in health-related faculties.
- Encourage universities to develop IPE/workshops for practicing health care professionals.
- Identify opportunities for PCN health care teams to participate in existing IPE delivered through Alberta universities and/or other programs.
- Evaluate the effectiveness of various team models of care and use data to inform choices.

Goal: Social and community services for vulnerable populations are effectively integrated with PCN primary care services.

Strategies

- Encourage further linkages with community and social services to address the needs of vulnerable populations.
- Access Alberta Supports to assist patients with social-based needs.
- Build on learnings from the current pilot projects in the four Alberta communities where community and social programs and services are being co-located.
- Build on learnings from current projects within AHS that are successfully integrating vulnerable populations.
- Share current PCN experiences with implementing population health strategies.
- Include feedback from public and AHS representatives in planning strategies to provide care to marginalized populations to avoid duplication of services.
- Initiate community engagement processes as a standard activity within a PCN's business planning cycle.

Goal: Seamless and efficient transfers exist between primary care physicians and specialists.

Strategies

- Every SCN and OCN should include PCN primary care physician(s) representatives to provide advice on building patient care pathways and on common referral processes that recognize primary care as the entry point to the health care system.
- PCNs will collaborate to ensure a coordinated approach to primary care participation in SCNs/OCNs.

- PCN 2.0 commits to exploring and implementing improved processes with AHS for uniform referrals to specialists and for discharge planning from specialists to family physicians.

Goal: Effective governance structures are in place for accountability at all levels within primary care.

Strategies

- PCNs should establish collaborative initiatives with key stakeholders within a geographical area to identify common practices or processes required of PCNs and coordinate efforts to find common solutions.
- Add public representatives to PCN governance boards.
- PCN governance (NPC physician group and AHS) remains at the local level.
- *Alberta's Primary Health Care Strategy* will build in clear accountability structures.
- Evaluation framework will include a review of governance effectiveness.

Goal: PCN accountability and effectiveness is clearly understood through the evaluation framework.

Strategies

- Align with the work currently underway to develop the AH Logic Model for the Primary Health Care Evaluation Framework 2013.
- Ensure that IM/IT systems will facilitate a coordinated, integrated approach to evaluation and measurement.
- PCN experience and expertise will be considered in developing the provincial evaluation framework.
- Information collected, analyzed and reported will be used to initiate and develop systems and processes for CQI programs.

Goal: Funding and compensation models are sufficient and appropriate to support PCN team-based care.

Strategies

- Physician compensation enhancements
 - A group will be formed to look at options for family physician compensation models that support efficient team-based care.
- Develop and define fees for medical services that FFS physicians provide to patients through electronic communication (e-access) to improve access (i.e., secure messages, telephone, PC-based video-conferencing).

Additional funding-related strategies

- Change policy to allow the use of closing costs reserve funds to expand or build spaces to enable co-location of health care teams.
- Smaller PCNs that have lower patient populations and commensurate lower total budgets may benefit from grants or another funding mechanism to build enhanced teams and implement other PCN 2.0 strategies.

- Develop strategies and appropriate funding support to optimize IM/IT initiatives such as:
 - Data management.
 - Integration with community providers.
 - EMRs for the team to input patient data.
 - Training for physicians and health professionals to meet chart etiquette and data standards.
 - Funds for EMR vendors to conform to provincial standards to meet information sharing and analytic requirements.
 - Data migration – to move/consolidate patient records into sources of care.

Goal: IM/IT solutions support effective and appropriate information sharing across Alberta’s health system.

Strategies

- Investigate forms of funding and supports for physicians to use IM/IT to support patient care and health system needs.
- Investigate incentives for EMR vendors to support the increased IM/IT requirements and business needs within PCN Evolution opportunity areas.
- Support the pHIE as a key infrastructure component to meet PCN Evolution needs.
- Implement a comprehensive data management system.
- Support advanced usage of EMRs through change management and resources.
- Integrate provincial registries with primary care EMRs to ensure a provincial “source of truth” for patient and provider data.
- Support linkages between primary and specialty care for community referral/consultation technology, policies, processes and change management.

APPENDIX C

ACRONYMS

ACFP	Alberta College of Family Physicians
AH	Alberta Health
AHI	Alberta Health Insurance
AHS	Alberta Health Services
AIM	Access Improvement Measures
AMA	Alberta Medical Association
BC	British Columbia
CFPC	College of Family Physicians of Canada
CIS	Clinical Information Systems
CQI	Continuous Quality Improvement
EAG	Minister’s Expert Advisory Group
EHR	Electronic Health Record
EMR	Electronic Medical Record
ER	Emergency Room
FCC	Family Care Clinic
FFS	Fee for Service
GP	General Practitioner
HIEC	Health Information Executive Committee
HQCA	Health Quality Council of Alberta
HSERC	Health Sciences Education and Research Commons
ID	Identification
IM/IT	Information management/information technology
IPE	Inter-professional Education
IT	Information Technology
MRP	Most Responsible Provider
NPC	Not-for-Profit Corporation
OAG	Office of the Auditor General
OCN	Operational Clinical Network
PC	Personal Computer
PCA	Primary Care Alliance
PCN	Primary Care Network
PCN PMO	PCN Program Management Office
PHC	Primary Health Care
pHIE	provincial Health Information Exchange
PMH	Patient Medical Home
POSP	Physician Office System Program
SCN	Strategic Clinical Network
SGP	Section of General Practice
SRM	Section of Rural Medicine
TNA	Third-next-available (appointment)
TOP	Toward Optimized Practice

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