Evolving Primary Care Networks in Alberta

A Companion Document to the PCN Evolution Vision and Framework (December 2013) of the Primary Care Alliance

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Contents

Preamble

The initiatives outlined in this document represent potential actions that will feed into the implementation planning phase of the Primary Care Network (PCN) Evolution Project. These ideas will be shared with the family medicine community in the province as well as with senior leaders in the health system. It is recognized that during the implementation phase that the actions listed below may be removed, modified, enhanced or other actions added to ensure feasibility and alignment with other work related to primary health care reform.

Introduction

Primary health care has been identified as a top priority for the Government of Alberta, Alberta Health (AH), the Alberta College of Family Physicians (ACFP), Alberta Health Services (AHS) and the Alberta Medical Association (AMA). Primary health care reform is central to the social policy framework approved by Cabinet in the Spring.

To support the reform agenda, a number of important projects have been launched including the development of a Primary Health Care Strategy, development of a Primary Health Care Evaluation Framework and the design and deployment of the Family Care Clinic model. In addition to these initiatives, the minister of health requested the Primary Care Alliance (PCA), a committee of the AMA, to consider ways in which an enhanced PCN model could become a platform for primary health care reform in the province.

An initial report was delivered to the minister in June that laid out the key principles associated with PCN reform and a demonstration of alignment with the other initiatives described above. That report was the culmination of contributions from the AMA, AH, the ACFP and representatives from AHS who worked together to address the Minister's request for an over-arching framework for the future of primary health care. The report provided a "blueprint" of areas to explore to enhance PCNs.

After a review of this initial report with the Minister, a subsequent report and more specific action plan were requested for the end of this calendar year. The PCA, with meaningful input from its partners have developed an extensive report that addresses these requests.

This companion report seeks to focus attention on a subset of specific initiatives, notably those that:

- Align with the recently developed Primary Health Care Strategy.
- Can be implemented through program changes or on a voluntary basis over the next two fiscal years.
- May be implemented with little or no incremental operational funding for PCNs through the use of surplus and closing cost reserve funds.
- Do not require significant compensation or funding reform as a pre-requisite for success.
- Foster pan-PCN cooperation to jointly fund and implement.
- Leverage infrastructure that exists in the province, notably with AHS.
- Avoid overwhelming PCNs and their participating physicians by phasing initiatives.

Summary of Objectives and Proposed Initiatives

The initiatives described in this document aim to achieve a number of over-arching objectives. These objectives are listed below and are distilled from several sources including the *PCN Evolution Vision and Framework* document as well as additional discussions with physician leaders, engagement of the Section of General Practice and input from AH and AHS. On the following pages, a set of initiatives that contribute to achieving these objectives is described. These initiatives are deliberately high-level to ensure this document remains brief, but considerable additional work to plan and implement these initiatives will be required prior to implementation.

Objective I: Encourage meaningful linkages between patients and providers and establish health home teams

Initiative A: Establish Patient Panels – Year 1

It is recognized that a broader initiative related to attachment is being launched by AH and will include representatives from many stakeholders and will look at the issue of attachment beyond PCNs. PCN representatives will participate in this process. Despite this provincial initiative, there can be important and immediate benefit to establishing accurate panels within existing PCNs. Past efforts by PCNs have discovered significant overlap among physician clinics within a PCN, undermining continuity of care, quality of care and accountability to patients for follow-up.

The actions described below will be useful to the provincial attachment initiative under all realistic rollout scenarios. There is no intent to undermine or delay this provincial initiative. In order to facilitate the establishment of accurate panels for each health home, we propose the following be launched in Year 1:

- Review current PCN rosters and clarify which family physician is the most responsible provider for that patient. Similar initiatives have been undertaken by a number of PCNs. This initiative is not an invention but, rather, part of a spread strategy.
- This initiative allows for a clearer accountability between provider and patient, which has been shown to improve patient care, continuity of care and practice efficiency, along with other benefits.
- These rosters can provide a useful starting point for the broader attachment initiative and panels established through this initiative would eventually be incorporated into the provincial systems and processes once they are ready for deployment.

Initiative B: Manage Panels (provided over Year 1 and Year 2)

- Develop in-house expertise on establishing and managing panels (e.g. POET role) or leverage Advanced Access Programs, TOP or resources from larger PCNs if in-house expertise is not realistic for a particular PCN.
- Establish patient-centred disease registries for all panels within each PCN for Diabetes, COPD, CHF, Asthma and other key conditions or other tools to more proactively manage care for patients living with chronic conditions.
- Develop and deploy training and practice supports for health home teams on panel management to allow the incorporation of new clinical and operational practices to provide better care to the panel of patients.
- Report on key measures for patient panels (screening and immunization metrics [ASaP], third next available, continuity, patient experience). *Note:* These measures should align with the provincial core indicators currently in development.

Initiative C: Develop Provincial Panel Management IT System

- Investigate options to develop provincial or regional databases to store patient panel data and to collate this information with data from other sources to improve PCN ability to improve care. AHS would need to play a central role in the planning and implementation of such a system.
- This system would need to fold into provincial IM/IT plans as well as support the provincial attachment strategy which will incorporate practices within and outside the PCNs.

Initiative D: Identify Health Home Teams – Year 2

PCN Evolution embraces the concept of the health home, developed based on the patient-centred medical home concept. The provincial Primary Health Care Strategy states as an objective that all Albertans will have a health home that provides:

- Access to comprehensive primary health care services;
- Attachment to a specific health care provider within a team or to a team of providers;
- Care delivered through inter-disciplinary teams;
- Care coordinated with other parts of the health system, such as specialists and home care; and
- Effective connections with social services and supports, when needed.

Although current compensation and funding models present obstacles to the full realization of the health home, immediate progress can be made to encourage the development of health home teams. An important early step will be the identification of provider teams that will form the basis of the Health Home. AHS will assist PCNs and their participating physician clinics in establishing health home teams by providing data and other supports.

- Work with PCNs and individual physician clinics to identify teams of providers that will form the basis for health homes. These will represent care settings that may be a single physician's office or a consortium of physician offices.
- Health home team definitions will be used for the purposes of service planning, practice optimization, data analysis, and accountability on key measures.

Objective II: Expand access for all Albertans

Too many Albertans lack access to a family physician and too many of those who have a family physician do not have timely access to those services. The following initiatives seek to improve this situation on both of these critical fronts.

Initiative E: Expand access for unattached patients through online resources to link patients and family medicine practices – Year 1

Consortia of PCNs have had significant success with the deployment of websites to match patients looking for a family physician with practices that are accepting new patients. Based on the platforms developed in Calgary and Edmonton, it is proposed to develop a provincial website to assist in this matching process. It is anticipated that this web platform would include all PCNs in the province. The provincial solution may benefit from leveraging existing AHS platforms. More work will be required to establish technical and business requirements and assign ownership for funding, developing and rolling out this platform.

Initiative F: Improve timely access to primary care for individuals with a family physician – Year 2

For patients with a family physician, there is a commitment to improve timely access to the family medicine and other primary health care services provided through the PCN. Many physician offices have participated in advanced access programs, but the spread of these practices has been slow and, at its current pace, it would take many years to achieve spread through current approaches. Therefore, it is proposed that a spread strategy be developed for enhanced access principles that will include:

- Develop PCN "in house" expertise with mini-modules on access improvement. This will provide a point of leverage to accelerate the adoption of advanced access.
- Commitment to expose X% of physician clinics to the modules within year 1 and Y% by end of year 2. Clinics that have already experienced AIM would count toward these targets.

In addition to the spread strategy, it will be important that data related to access is collected at the health home level (see Initiative D) and reported up through PCNs to AH and AHS. Based on discussions with the key parties involved in this work to date, it is proposed that third-next-available appointment and continuity be used as key measures for access. In

addition, patient reported measures related to access can be incorporated in the patient experience initiative described below. This reporting will enable the identification of successful practices and further encourage spread. It will also represent the beginning of the implementation of the provincial evaluation framework for primary health care. In order to achieve this, the completion of a number of key steps will be required, including:

- Complete required privacy impact assessments and establish appropriate data-sharing agreements to enable reporting on key metrics for health home patient panels. Privacy and legal services can be jointly funded across participating PCNs and supported by AHS to accelerate this process.
- Implement data collection and reporting protocols for key measures. This will include disseminating measure definitions aligned with MCI initiative and the provincial evaluation framework, assisting PCNs and practices in understanding how to collect accurate data, assisting practices to adopt the clinical and operational practices associated with improving performance on these measures and establishing templates and processes to facilitate reporting.
    - Third-next-available appointment: X% of health home teams collecting and reporting in year 2 and Y% by the end of year 3.
    - Continuity: X% of health home teams or PCNs collecting and reporting in year 2 and Y% by the end of year 3.[1]

Objective III: Improve patient experience

Participants in the PCN Evolution project acknowledge the importance of patient-centred service design and also acknowledge the importance of patient engagement and satisfaction measurement to achieving a high-performing primary health care system.

Initiative G: Develop tools and protocols to collect and report data related to patient experience – Years 1 and 2

It is proposed that a PCN tool and protocol for measuring, reporting and improving patient experience in the context of a health home be developed in year 1 and deployed in year 2. These tools and processes should leverage learnings from the world class and well-respected PAR process developed and currently administered by the College of Physicians & Surgeons of Alberta.

Objective IV: Expand community involvement in PCN governance

Patients and community members deserve a voice in decisions related to PCN services and the PCN Evolution participants recognize this.

Initiative H: Establish community boards and committees – Years 1 and 2

It is proposed that within the next fiscal year, all PCN boards create a community representative seat and that PCN boards establish Community Advisory Committees during the following fiscal year. Some additional details will need to be worked out to ensure the most appropriate approach for each of the two legal models. It will also be necessary to establish training programs for community members so they are equipped to contribute appropriately to the board and committee work. This training may be beneficial for all Board members and the participants and approach to the training programs should be explored more fully and balanced with the cost to implement. It will be important that roles and responsibilities with existing AHS health advisory councils are clarified prior to rolling-out CACs.

[1] These data are currently provided by HQCA to a number of the PCNs in the province. Further work will be required to assess feasibility of expanding this process for all PCNs.

Objective V: Improve performance through the development of quality improvement plans for all health home teams

Quality Improvement (QI) science has changed the face of health care across the world and is a cornerstone of the success of some of the world's most advanced models of care including Kaiser Permanente, the Cleveland Clinic, Geisinger and Virginia Mason. The IHI and other organizations have developed interventions, bundles and wholesale strategies for embedding QI practices into the modus operandi of health systems across North America, including in Alberta. Quality improvement plans focused on core metrics have been used in many systems and jurisdictions and help to provide a level of consistency to practice improvement efforts. Alberta's PCNs and primary care physicians have significant experience in QI through TOP 10 and ASaP, which have been considered very successful initiatives. These plans involve establishing baseline measures, reviewing those measures with the practice team, prioritizing areas for improvement and developing changes to clinical or operational processes to improve them. Finally, it involves reviewing measures to see the impact of the improvement initiatives in an ongoing learning and fine-tuning process. Practices implementing these QI initiatives have experienced enhanced patient care and more efficient and invigorated practice environments.

Initiative I: Embed quality improvement plans into normal PCN business and operational processes

It is proposed that QI be embedded in the normal operational structures and processes of PCNs with a narrow focus on a small set of measures. Specific actions would include:

- **Year 1 – Develop QI training and support programs** to encourage the spread of QI capacity across the primary care sector, including a straightforward and manageable quality improvement plan template.
- **Year 2 – Implement QI planning by all health home teams and PCNs.** The plans will involve establishing baselines on key measures, identification of priority areas for improvement based on results, a target for improvement on all key measures and an implementation plan for initiatives related to improving performance.
- **Year 2 – Celebrate successes in QI** from across the PCNs at semi-annual PCN Forum and other venues.

Note: Implementation of comprehensive QI plans would likely require enhanced support, not currently funded by PCNs. This may be accomplished through joint support program development and the refocusing and alignment of resources in AIM, PMP, TOP and other resources available in AH and AHS.

Objective VI: Improve horizontal and vertical integration with local partners

Service integration is an important goal of Alberta's health system and a key expectation of Albertans. The following initiatives address both horizontal and vertical integration planning with key partners.

Initiative J: Conduct joint planning and coordination sessions with delivery partners across the continuum of care and community supports

It is proposed that periodic joint planning and coordination sessions be executed with AHS to develop integrated services plans to deliver improvements in and across different care settings (e.g., improved discharge planning, supports for long-term care and home care, improving access to specialist services, etc.). Similar planning sessions will be conducted with Alberta Supports, a program of the Ministry of Human Services that will foster a streamlined access to community supports for eligible Albertans. This joint planning will present an opportunity to develop coordinated and robust partnerships between PCNs, physician practices and the community and social supports many vulnerable patients need to improve their overall well-being.

Objective VII: Modernize primary care offices through improved spatial design and co-location of teams

The PCN Evolution participants agree that many physician offices lack the modern spatial design to foster interdisciplinary, team-based care. It is also recognized that physician offices are often owned by the physicians practicing in these spaces or are under various lease arrangements and that transitioning space would be a voluntary initiative.

Initiative K: Develop a strategy to enhance and modernize clinical spaces to make them appropriate for interdisciplinary, team-based care

It is proposed that a strategy be developed, including policies, guidelines and a budget, to encourage the development of more modern primary health care settings, including integrated EMR stations, space for telemedicine equipment and space for allied health professionals, visiting specialists and nurses.

Conclusion and Alignment with Other Provincial Initiatives

This document has already acknowledged the important work of other related initiatives including the Evaluation Framework, deployment of FCCs and the publication of a broad Primary Health Care Strategy for Alberta. Other important initiatives include a provincial IM/IT or EMR strategy for the province, an "Attachment Strategy" as well as a need for a provincial funding and compensation reform initiative for primary care. This document does not focus on these as they are initiatives underway with involvement of key stakeholders in various committees and project teams. There is a commitment from PCN Evolution participants to ensure there is ongoing communication and alignment of these programs as they prepare for roll-out. Over the next several months, detailed and integrated implementation plans will be developed for the full suite of initiatives.

From the best currently available information, the intent of the initiatives in this document will provide a foundation for near-term progress toward achieving the objectives of the many provincial primary care projects. With the appropriate attention, resources and support, these initiatives may form the basis for physician and stakeholder engagement and change management as we evolve to a more advanced and modern system for primary health care service delivery in Alberta.