ALBERTA MEDICAL ASSOCIATION

Patients First®

Primary Care Networks – *Past, Present and Future*

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PCNs: the Past

What is a PCN?

- Primary Care Network (PCN)
- Joint venture to improve primary care services in a geographic area through collaboration of
  - a group of primary care physicians (via not-for-profit company)
  - and local Alberta Health Services (AHS)
- Governance – physicians and AHS jointly accountable to Minister of Health
  - operated by the physician not-for-profit company

Origin of PCNs

- 2003 Trilateral Master Agreement
  - AHS, AMA and Alberta Health
  - Per capita funding from Alberta Health
- Recognition of need for primary care reform
- Development of relationships/collaboration between local service delivery providers

Five Provincial Objectives

1. Increase the proportion of residents with ready ***access to primary care***

2. Provide ***coordinated 24/7 management*** of access to primary care services

3. Increase the emphasis on:
   - ***health promotion, disease and injury prevention***;
   - care of the ***medically complex patient***; and,
   - care of the patient with ***chronic disease***.

4. Improve ***coordination and integration*** with other health care services including secondary, tertiary and long-term care through specialty linkages to primary care

5. Facilitate the greater use of ***multi-disciplinary teams*** to provide comprehensive primary care

Guiding Principles

- Local solutions to meet local needs
- Developed by front-line care physicians and other providers who understood local health environment and gaps in patient care
- Optimize limited human resources
- Focus on the achievable and greatest impact

PCNs: the Present

Where are we now?

- 42 PCNs in different stages of organizational maturity/delivery
  - Measurable outcomes, breadth of services, integration of professional teams, quality improvement
  - 0 to 10 years
  - >80% family physicians
- Physicians working with other allied health professionals in primary care
  - Over 600 FTE employed plus many more AHS staff integrated in PCN programs

Where are we now?

- Formalized working relationships between primary care physicians and various AHS groups
- Evidence that the model results in better patient care (HQCA, Malatest)
- Infrastructure for further collaboration

What have we learned?

- High-functioning teams don’t just “happen”
- Well-functioning teams increase physician/ provider satisfaction
- Primary care skills are a specialization
- Organic, “bottom-up” development has made it challenging to translate to value in the public domain
- Lack the robust data to support further refinement and decision-making
- Change takes time

Why change?

- Individual PCNs are already evolving
- Greater need for
  - measurement and evaluation
  - demonstrated accountability for public funds
  - integration of other community stakeholders
  - sharing of best practices
  - increase in patient/community engagement
- Evolve from primary care to primary health care
  - social aspects of health
  - community service integration

PCNs: the Future

What is PCN Evolution?

- A coordinated way to support PCNs province wide in evolving to the next level of maturity
- Framework to provide direct for all PCNs; align policies and enablers
- Build on successes of current PCNs
- Collaboration of Alberta Health, AMA, AHS, PCN Executive Directors, Alberta College of Family Physicians
- Links to AH Primary Health Care Strategy and the AMA Primary Care Strategy

The Vision

- Every Albertan has a health home
  - Family physician supported by a robust inter-professional primary care team
  - A place where they are known and receive continuity of care
  - Coordination hub for health services and links to specialty care
- Care is proactive and collaborative
  - Emphasis on early prevention and health promotion
  - Patient is empowered to be a partner with the physician and team in attaining their optimum health
  - Decision-making and coordinated care is supported by electronic medical records accessible to relevant professionals

The Vision

- Care is accessible and evidence-based
  - Timely access to the right care delivered by the right person at the right time
  - 24/7 appropriate access
  - Evidence-based clinical decision-making and quality measurement/improvement
- Patient-centred care
  - Care is organized around the patient; not siloed by provider groups or delivery mechanisms or funding streams
  - Integration with community services and social supports
  - Robust data is available for local service delivery planning

The Vision

- Service delivery is sustainable and accountable
  - Demonstrated value for money
  - Complementary services; no service duplication or fragmentation
  - Standardized data infrastructure is in place
  - Accountability measures are available province-wide for comparability and evaluation
- Engaged patients, providers and communities
  - Community engagement in improving health of their populations
  - Coordination of efforts and partnerships

PCN Evolution Components

- **Promotion of Patient Health Home model**
  - Patient relationship is fundamental with physician and primary care team
  - Formal identification of patient panels
  - Connecting unattached patients
  - Continuity of care
  - Health home as hub
    - Coordination of links to PCN, AHS and community-based services
    - Greater integration with specialty care, secondary and tertiary for seamless transition
    - Integration with community and social services

PCN Evolution Components

- **Enhanced primary care professional teams**
  - Physician-led inter-professional team
  - From relay team to soccer team
  - Creating physician capacity – full scopes of practice
  - Primary care specific training
- **Population health emphasis**
  - Move from pure primary care to primary health care
  - Social determinants of health
  - Social and community service integration
  - Healthy lifestyles and communities

PCN Evolution Components

- **Evaluation framework**
  - consistent data standards and measures
- **Greater accountability to public**
  - Patient and community engagement
- **System supports and enablers**
  - Policy
  - Support infrastructure
  - Electronic medical records
  - Team-based care – physician payment models

Implications - Community Leaders

Implications for community physician attraction and retention:

- Younger physicians trained in team-based care
- Expect to work in a supportive team environment
- Provider engagement and satisfaction
- Support for end of career physicians
- Community engagement/support
- Population-based health initiatives

Questions/Dialogue