Patients First® is a registered trademark of the Alberta Medical Association.
Primary Care Networks – Past, Present and Future

February 27, 2014

Presenter: Lucy Grenke, CMA
Alberta Medical Association,
Practice Management Program
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
• **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 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