Alberta College of Family Physicians

Modernizing Alberta's Primary Health Care System

Ensuring every Albertan has a family physician

Written Submission Executive Summary | December 2022

Recommendation:

Ensure every Albertan has access to a family physician and a primary health care team by implementing the Patient's Medical Home.

Supporting Recommendation 1: Fund the expansion of family practice teams at the point of care.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? There is a need for basic team-based primary care for a community to provide wellness and preventative care, regular screening, chronic disease management, and mental health. Family physicians spend too much time on administrative work, duplicative forms, inefficient electronic medical records (EMRs) and referral systems and not enough time on patient care. Access to equitable care for often vulnerable, unattached patients is not factored into current primary care funding. Current Primary Care Network (PCN) funding do not consistently and adequately, across the province, provide funding for team members in a PMH (i.e., family practice) Alberta's family physician population, family medicine residents, and medical students do not see comprehensive family practice as a viable or sustainable career option.	• Employ immediate strategies to ensure there is access to a family physician for every Albertan by creating an environment where family physicians, residents, and medical students see comprehensive family practice as welcoming, well supported, viable, and sustainable • Eliminate disincentives for implementing optimal team-based care. Such disincentives include physician fee for service as the dominant remuneration for care provided, daily caps, medico-legal liability issues, limited understanding of scopes • Develop directory of scopes of practice of interdisciplinary team members, with examples and contacts to people willing to share their experiences embedding team members in practice • Add team members (patient-facing and administrative) to clinics where possible by providing ear-marked funds to pay primary care health professionals and administrative teams competitive rates either though clinics or PCNs • Engage and incentivise existing family practice clinic staff to work at the top of their scope to catch up on screening, manage stable chronic diseases, and address care deficit • Provide immediate expanded program funding for intradisciplinary continuing professional education that exists to improve complex clinical patient-oriented outcomes in community practice including mentorship, training, ECHO and case-based learning, complex mental health, and chronic disease management	• Work with Alberta Medical Association's (AMA's) Section of Family Medicine and Section of Rural Medicine using "model office" calculations to ensure that evidence-based funding models are in place to ensure viable and sustainable access to team-based care for a population (i.e., ratio of three to five providers per physician) • Provide new population-based funding to PCNs and primary care and community-based clinics to set up innovative ways to provide primary care in the community including support for unattached patients • Establish and fund a competitive staff compensation grid for each type of health team member (e.g., dietitians, social workers, nurses, pharmacists, etc.) • Provide support for education and quality improvement (QI) for community practices like the support provided in the acute care system • Provide support for community practices to have community navigators/link workers who do social prescribing as part of the intradisciplinary team	• Using newly established health authority(ies) (see Supporting Recommendation 2), flow sustainable and dedicated funding to support family medicine as the foundation for a healthy Alberta • Develop "The Alberta Primary Care Services Act" with a multistakeholder consultation process. By having its own legislation, the funding of the primary care workforce will be permanent • Fund and support changes in training and education that establish best practices for high functioning team-based care from college and university training, medical school, and through residency • Support and leverage advancing the use of technology within the PMH and externally for lab, diagnostics, and specialty consultants to increase capacity and efficiencies for both patients and teams. Some examples: medical scribes, virtual assistants, smart forms, and secure text, email, and document transfer • Provide program funding through professional colleges and universities for interdisciplinary team effectiveness and team-based learning dedicated to care in the PMH and medical neighbourhood (i.e., faculty development, mentorship, observership, shadowing, workshops, and training sessions) • Establish and maintain a workforce planning bureau with the respective professional colleges/associations to monitor and predict health professional supply and demand

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Supporting Recommendation 2: Create community-based health authorities with engaged leadership, patient-based funding, and accountability for the delivery of longitudinal preventative care, chronic disease management, and seamless transitions of care to all Albertans.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? Primary care in Alberta does not currently work as a system or within the whole health and social system. Alberta Health Services (AHS) is primarily an institution and acute care administrative body; it does not understand the key issues of primary care. Public health, home care, and other outpatient services would operate more efficiently and enable local needs to be better served under a provincial primary care governance model. AHS top-level decisions have significant impact in communities and primary care; it is difficult to deliver community-based health services within the current fragmented and unintegrated system. Complex patient care pathways are fragmented and referrals and consultation with specialty are difficult, time consuming, delayed, inefficient, and ineffective.	• Create a full-time compensation package for a Zone PCN leadership dyad (AHS Zone and PCN Lead) that are tasked with zone-level service planning and a core budget to begin early actions for population needs and improved access • Mandate AHS to work with PCN leadership to plan early actions and collective solutions to reallocate existing AHS and PCN resources to address local gaps in patient access to community health and social services • Invest in collective and intersectoral zonal and regional solutions through collaboration with AHS Zones, PCNs, and other service partners in an integrated system (e.g., schools, friendship centres, community centres, social programs, housing, link workers, patient navigators) • Build on the successes of Specialist Link and Connect MD, and the focus on the Alberta Surgical Initiative to increase access to specialist consultation and rapid referrals to community and hospital-based specialists as screening and chronic disease management processes in primary care are ramped up	• Design a regional governance model to support funding and accountability for the delivery of all community-based care in a geographic area that accounts for proven care corridors used by its population (i.e., current zones may not be ideal – divide North into Northwest and Northeast Alberta, and South into Southwest and Southeast) • Ensure all transformational suggestions require incentives for building longitudinal patient/family physician/clinician relationships and continuity of care (i.e., incentivise attachment and longitudinal patient-team relationship while working to serve unattached patients with funding allocated to ensure equitable access to primary care) • Ensure adequate funding through a contract to achieve its annual business plan where its goals and deliverables have been approved. Budget management for the authority will have the flexibility within its funding envelope to make allocation decisions across the organization to achieve its priorities and goals within the global budget	• Ensure that "The Alberta Primary Care Services Act" secures funding and infrastructure support for primary care and establishes the community-based health system as the foundation of the health system • Establish and implement transformations in training and education for primary care team members to better support increased clinical complexity, leadership, and business management skills within the team-based care model • Policy is required to establish a shared accountability and purposeful design for diagnostic and lab service outside of hospital settings for direct and timely access by primary care providers and avoid using emergency departments for access • Establish a contractual and/or performance agreement between the community-based health authority and the hospital-based health authority to assure timely flow of patients from community to hospital services and then back from hospital services to primary services

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Supporting Recommendation 3: Supply multiple and timely sources of system and practice-level information to assist in clinical care, quality improvement (QI), and business decision making.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? Physicians, clinics, PCNs, and Zone leadership are asked to make decisions about QI and clinical practice without access to system-level data or teams who can analyse it. Clinical data assists in making practice-level QI and supports research for complex clinical challenges. During clinical and public health crisis, needed clinical and public health crisis surveillance data has been difficult to access by those providing care. Privacy impact assessment (PIA) delays or costs are a huge barrier to uptake of Central Patient Attachment Registry (CII/CPAR). Information management/ information technology (IM/IT) change management has been slowly progressing through the pandemic and facilitation workforce disruptions occurred over the last several years. There is no way currently for primary care to assess current supply and skillset of physicians, nurses, nurse practitioners, pharmacists, social workers, physician assistants, medical office assistants and others who could support the teams in their practice or surrounding health neighbourhood.	• Continue to support the efforts of CII/ CPAR and build a network of EMRs to move toward one fulsome patient record that all providers and points of care can access • Reduce delays at the level of the Office of the Information and Privacy Commissioner of Alberta (OIPC) to review and approve the PIAs to support uptake of CII/CPAR • Provide current billing data and analytics to the Inter-Zone Implementation Coordination Committee (I-ZICC), Zone PCN leadership and primary care partners; the billing data and analysis will clarify some of the current workforce population and trends in full-time/part-time, scope, focused practice, however we will also need to collect real-world data on existing team members in primary care clinics including nurses, social workers, pharmacists, nurse practitioners, and medical office assistants (MOAs) to further define the primary care community-based workforce	• Continue improvement and refinement of Connect Care-downloaded information to community EMRs to reduce the redundancy and sheer volume of information not relevant to clinical care and follow up in the community • Create a mechanism for EMR clients to deal with vendors to achieve collective impact and more timely customer-responsive changes and enhancements to their products • Provide funding for a dedicated primary care data analytics team to support the planning, measurement, performance management, and service resource assessment • Decisions made regarding resourcing are supported by recommendations developed by strategic leadership and data analytics teams • Provide funding to local clinics and PCNs for data analyst support providing timely data, from clinic EMRs to guide QI and clinical programming and improvement initiatives	• Embed analytics teams in new health authorities and have a provincial team that supports data analysis for creating recommendations and highlighting points of interest for deeper dives and spread and scale • Create data analytics that will enable linking upstream practices in primary care with short-term and long-term downstream outcomes. Both clinical outcomes and costs should be available to support informed planning, system re-design, and QI to achieve the health outcomes expected of a world class primary care system • Continue to support the change management and training in primary and community care with incentives including funding and practice facilitation to implement new practices, workflow, and technologies • Renew the Health Information Act to support new ways of using data for QI, clinical improvements, and for business decision making