

PRIMARY CARE NETWORKS: The Alberta Experience

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Faculty/Presenter Disclosure

- Dr. Phillip van der Merwe
- Relationships with commercial interests:
 - Grants/Research Support – none
 - Speakers Bureau/Honoraria – none
 - Consulting Fees – none
 - Other - none

Faculty/Presenter Disclosure

- Managing Potential Bias
 - Plenty to manage
 - Loyal only to principles and not institutions or authority
 - One of these principles being the dedication to a universal, publically funded health care system
 - No financial barriers to access
 - All waits are bad
 - Institutions and authority are only valuable if they support, grow, protect and spread principles.
 - Status Quo is kurare to progress

My Story



- Came to Canada in 1992 (Calgary in 1995)



- Isolated, no collegiality, poor support, no access
- A sense of having to be everything to everyone



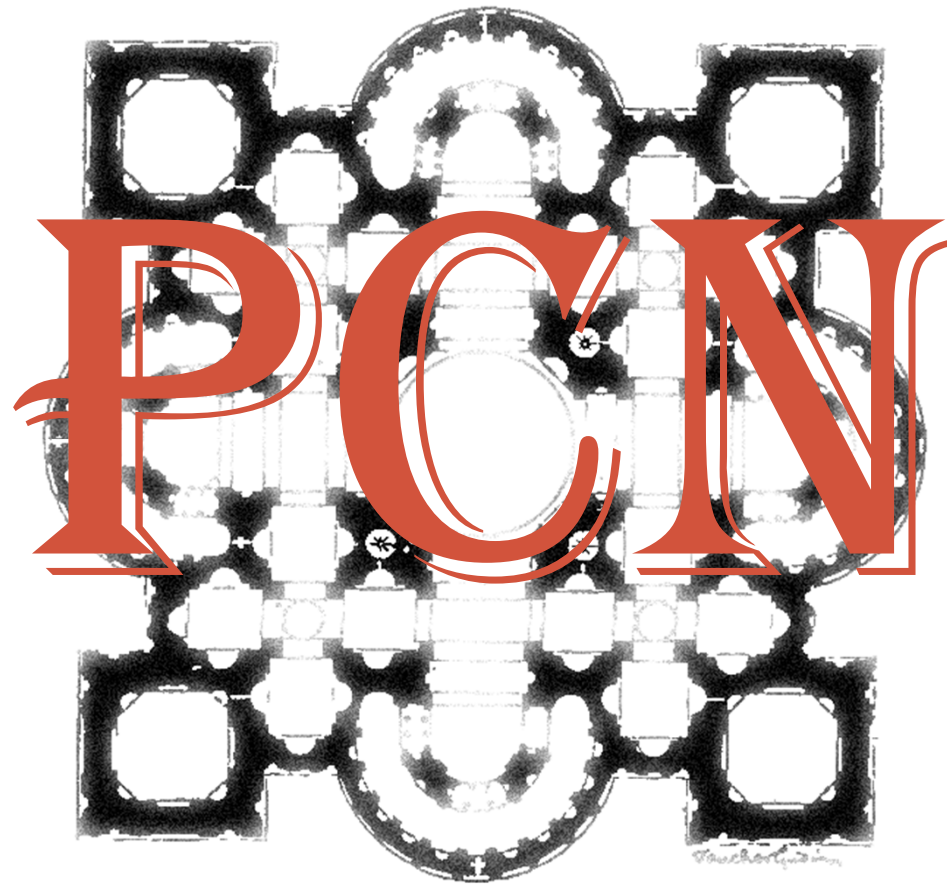
Time for Transformation



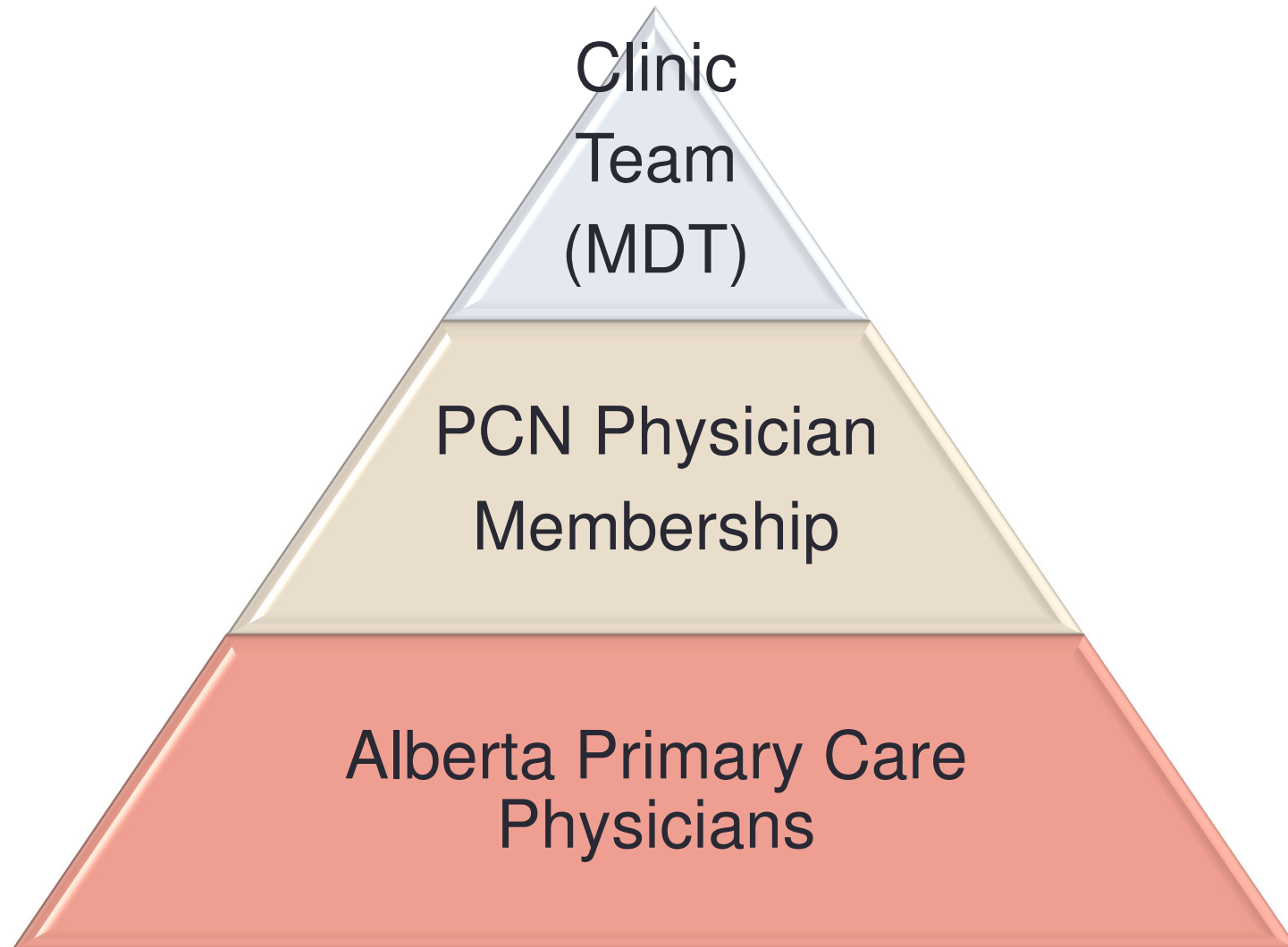
- Approached to help start up our PCN 11 years ago
- Literally salvation from the purgatory of GP gloom

Primary Care Networks

A Renaissance in General Practice

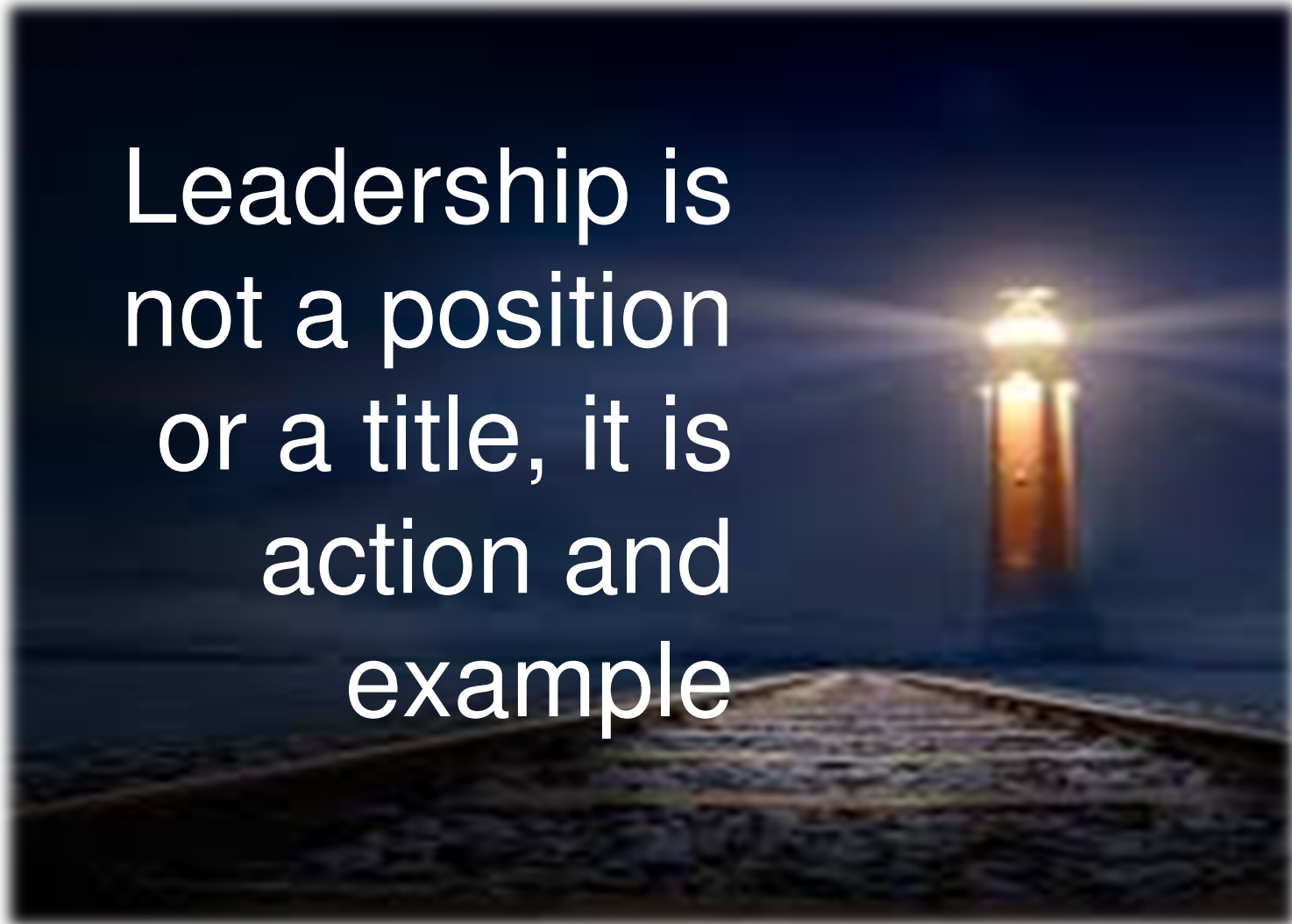


PCNs, Teamwork and Connection



Key Success Factor: Leadership

Leadership is
not a position
or a title, it is
action and
example



From Autonomy to Accountability:

The culture shift to becoming a new kind of doctor



Autonomous Professionalism:

Classical features

- Altruism
- Quest for excellence
- Management of poorly functioning physicians
- Rationing of public-health care resources

Autonomy is a constructed reality (not a divinely ordained right)

- Culturally granted by the public/patients
- Structurally/ legally granted by the state
- Based on trust, respect and deference as
SUBSTITUTES for ACCOUNTABILITY

Professional Accountability:

- Core attribute of professionalism
- Autonomy is a substitute/ delegated form of accountability
- This was necessary in a world where, prior to the 70's, systemic assessment of clinical work wasn't possible

Question



Panel Math:

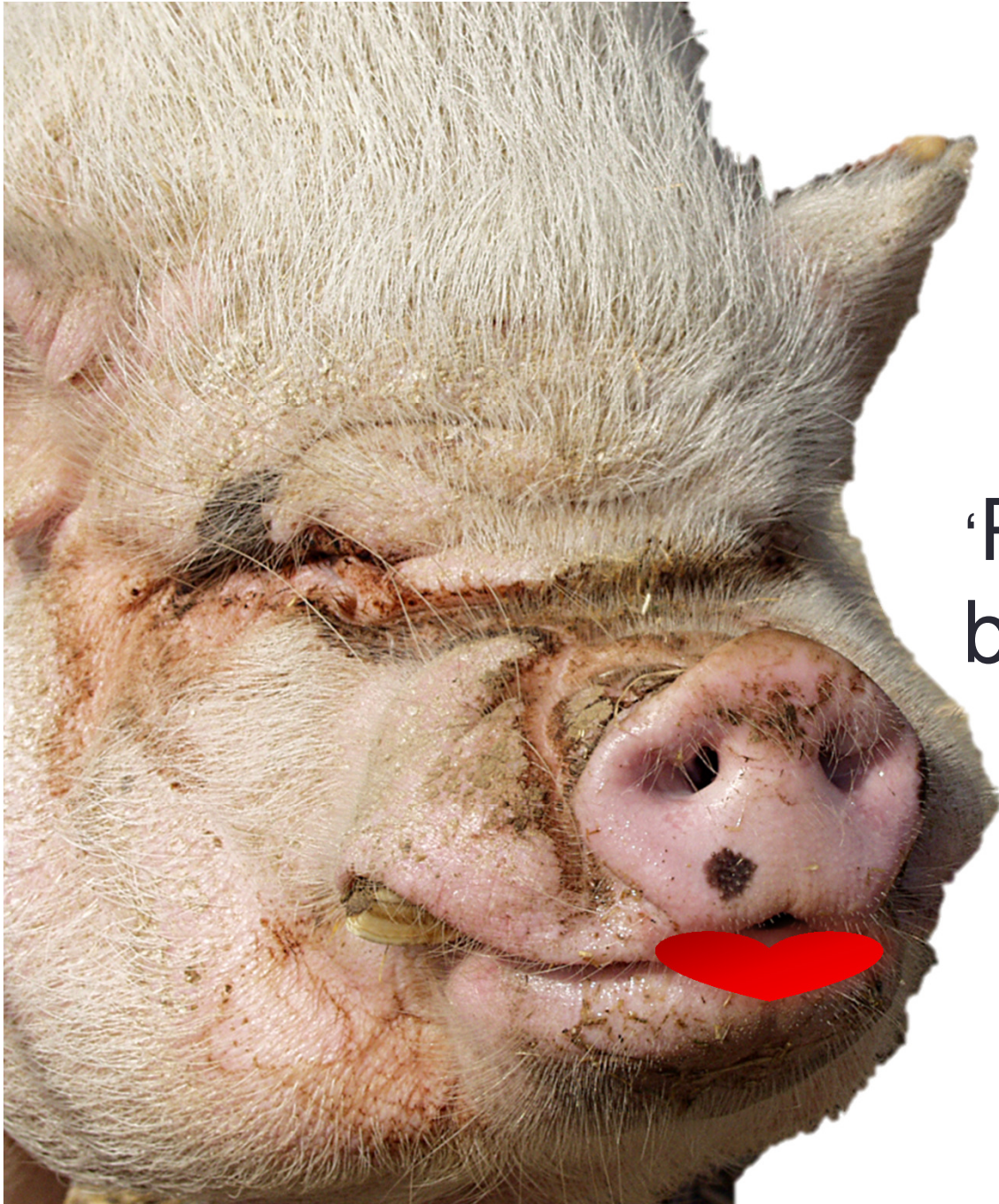
Fractions (not fracking) for proactive care



Adults with Hypertension



Full Patient Panel



‘Panel’ alone can
be a tough sell...



Why Screening?

- ✓ Family physicians do a good job of screening patients – when patients book screening appointments!
- ✓ About 1/3 of patients with family physicians do not present for screening*

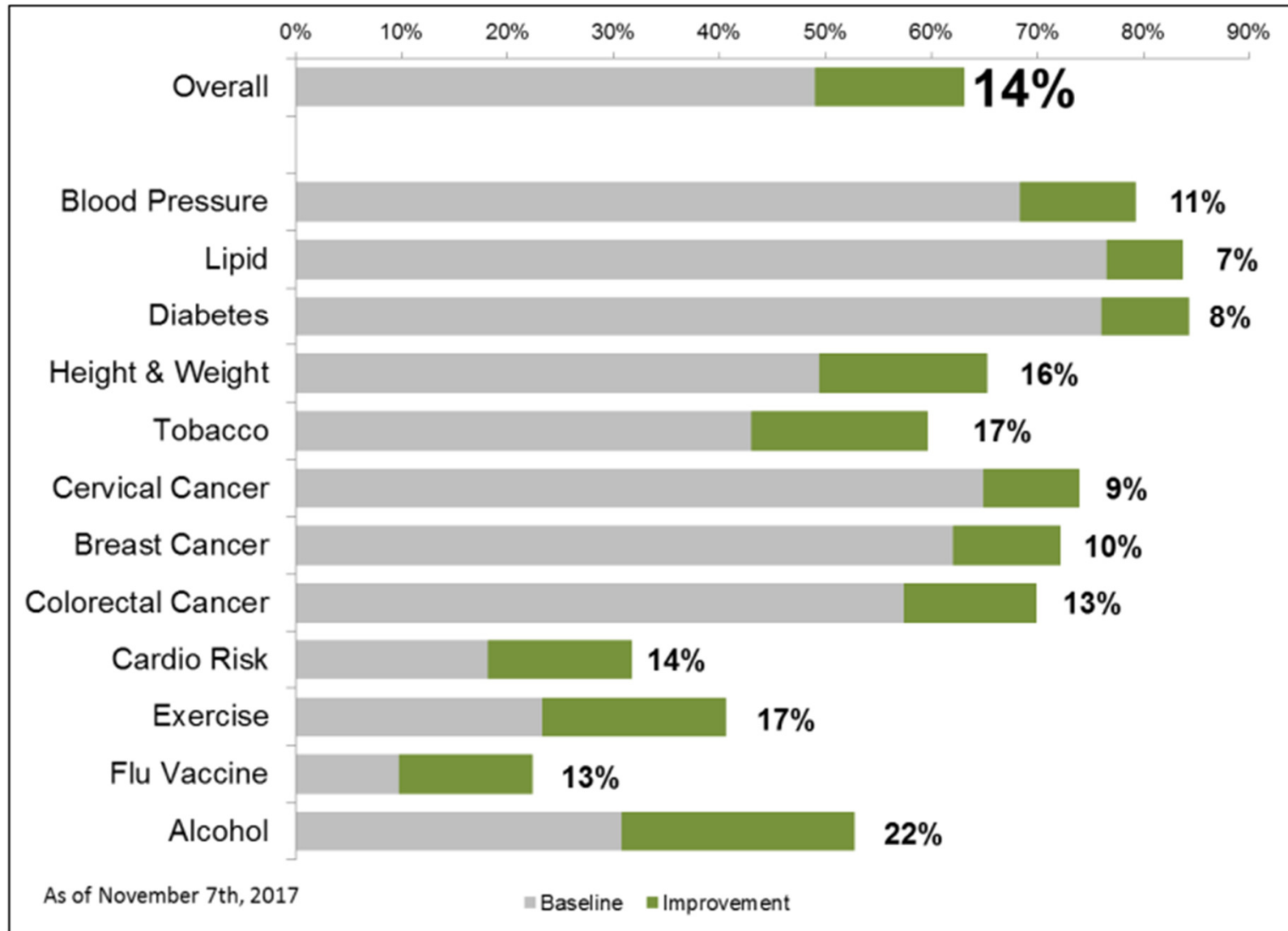
* *Toward Optimized Practice data*

A new approach to screening

- Optimize the EMR and team
 - **Opportunistic** – offer screening at any visit
 - **Outreach** – contact patients who don't come in

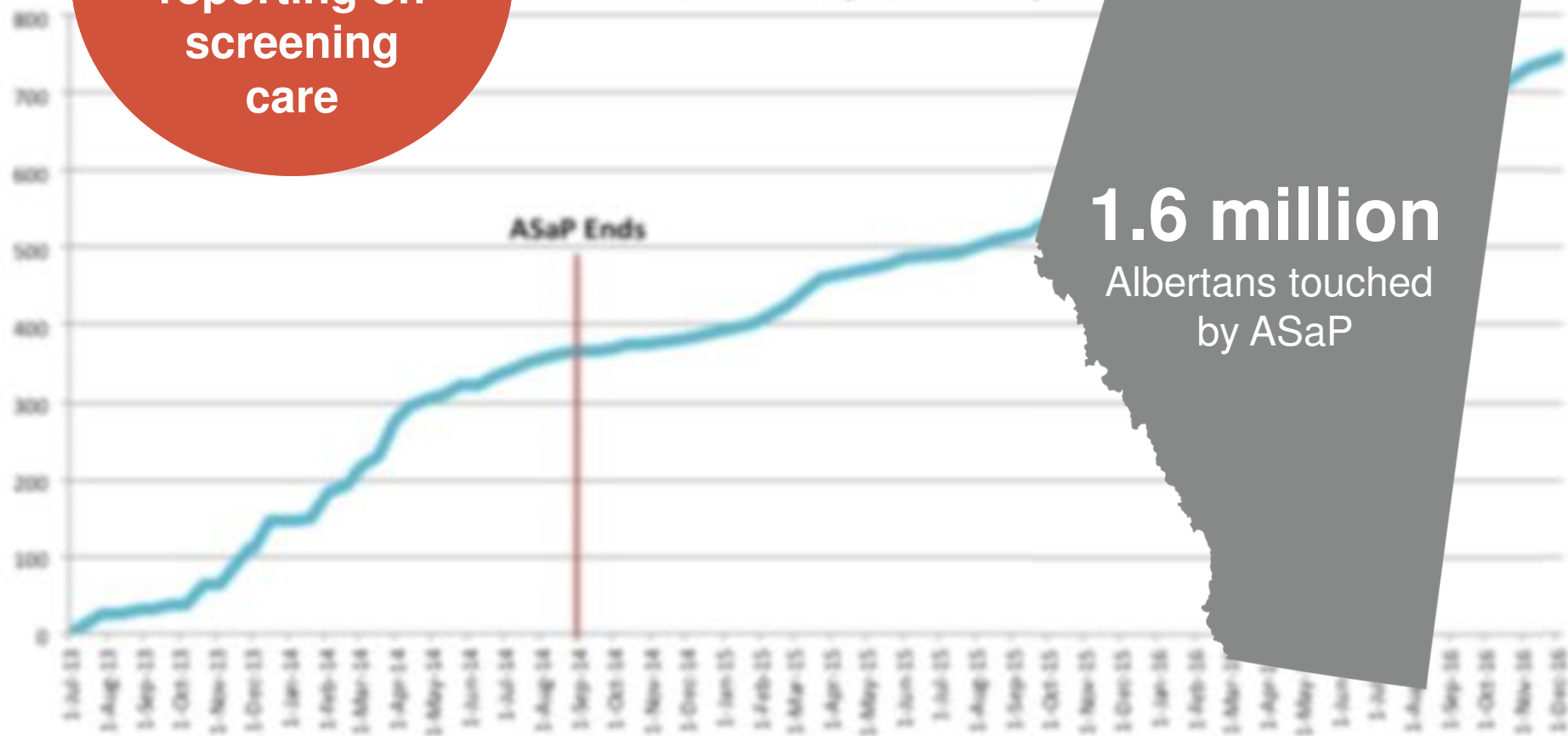
Panel processes critical for success

ASaP Impact on Screening Rates



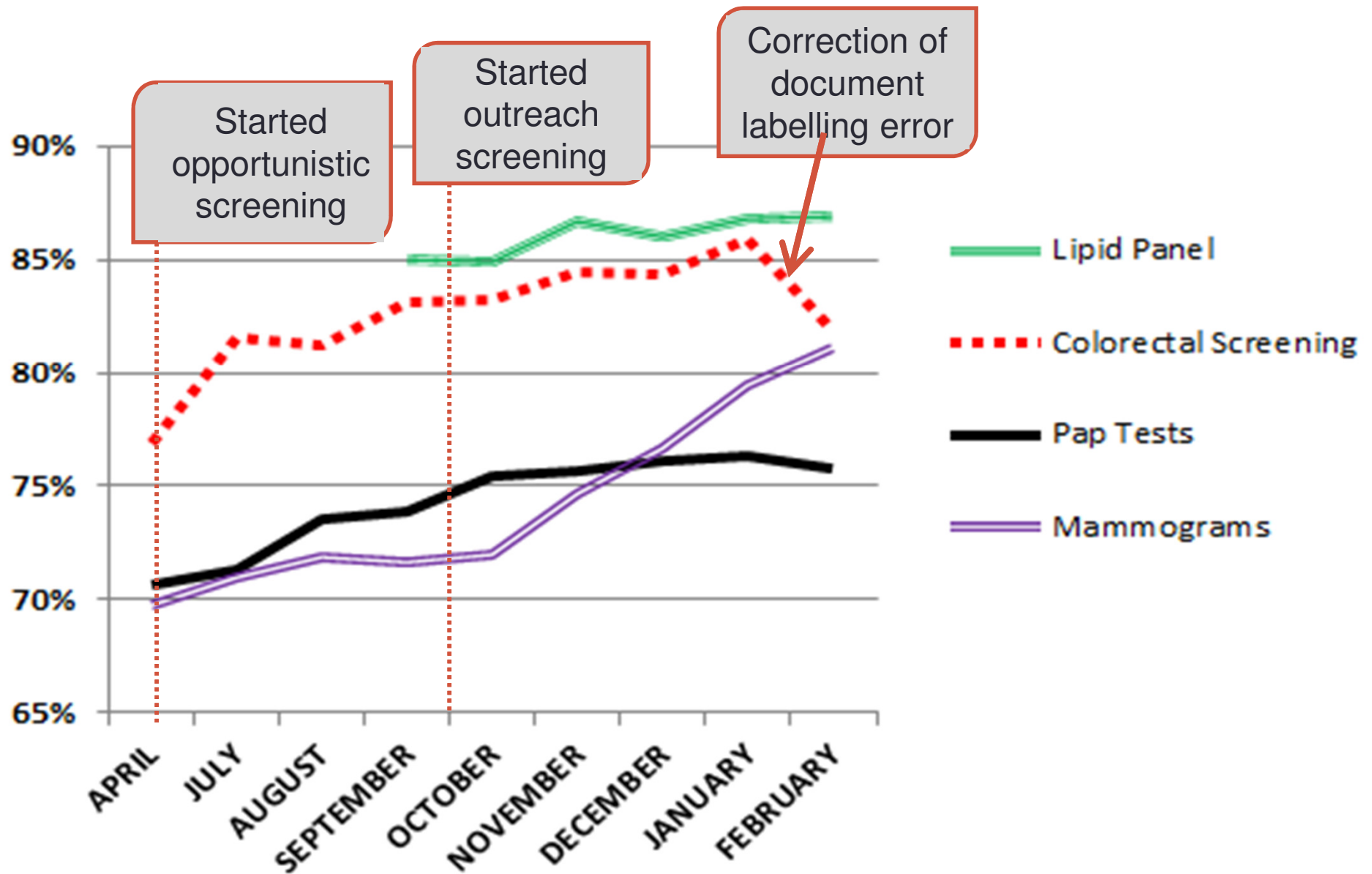
49% of practices are reporting on screening care

ASaP Enrolment (2013-2016)

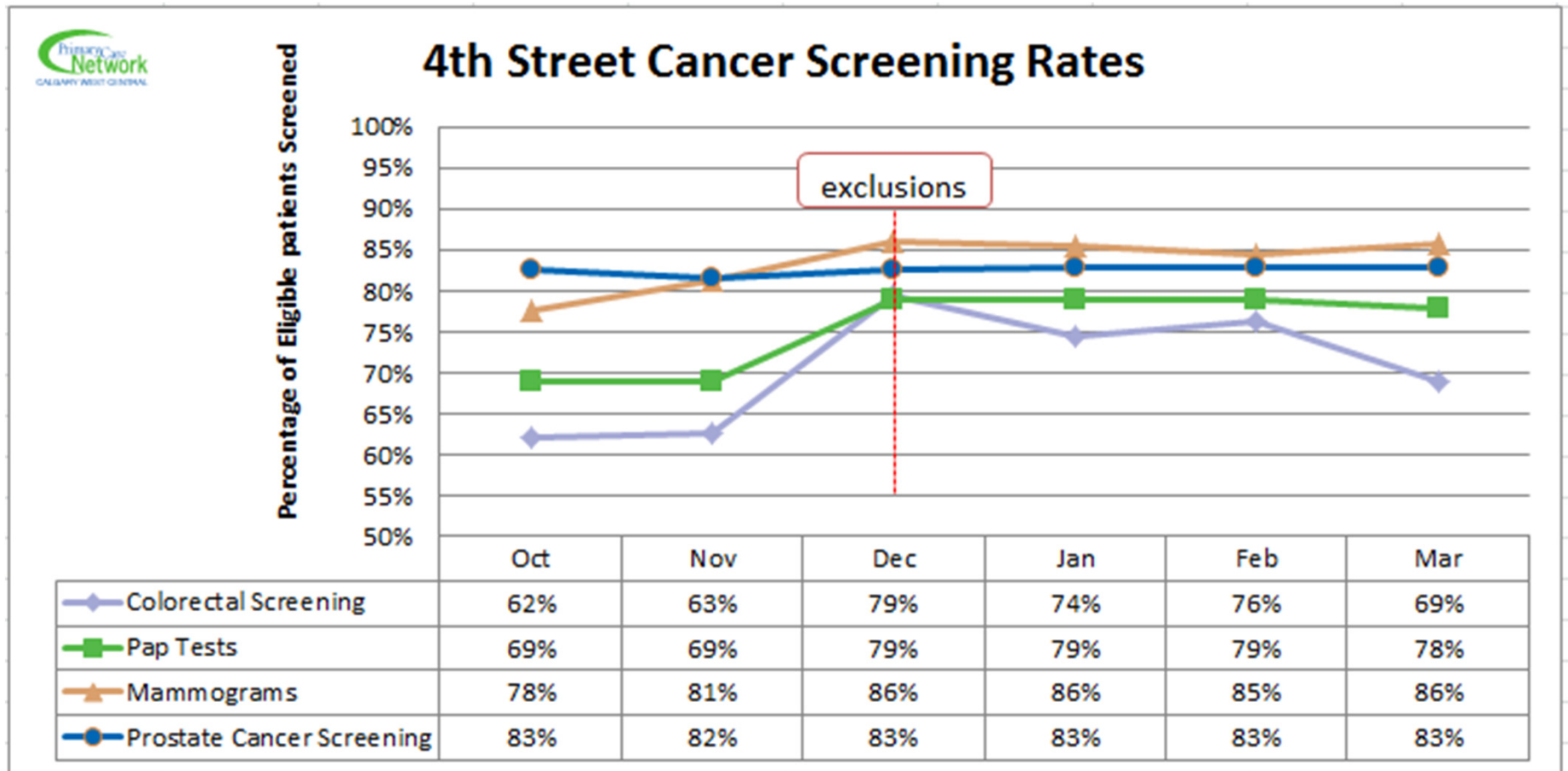


1.6 million
Albertans touched
by ASaP

My Clinic's Screening Data

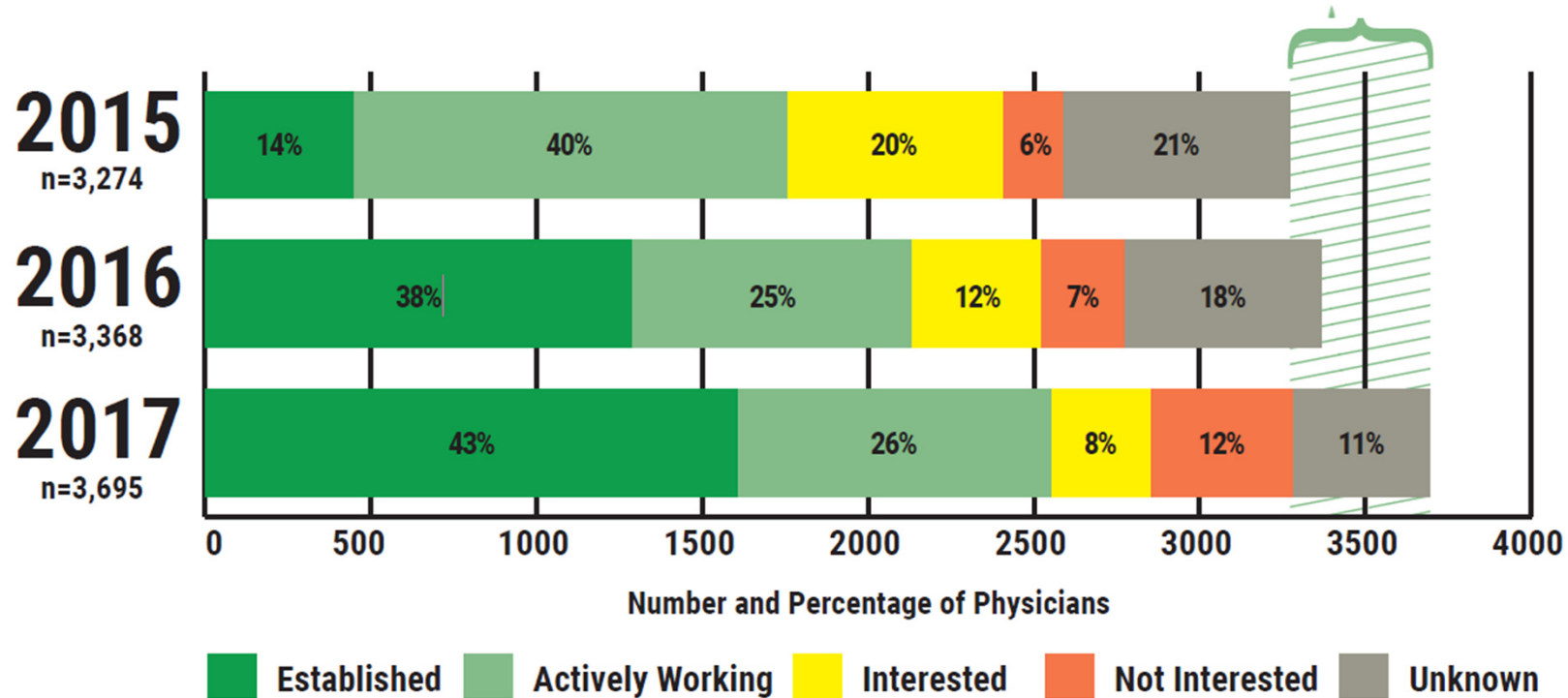


My Clinic's Screening Data



Panel Progress

The number of PCN physicians in Alberta has grown by nearly 13% between 2015 to 2017



69%
PHYSICIANS WITH ESTABLISHED PANELS OR
ACTIVELY WORKING ON PANEL PROCESSES

Panel

My panel number: **1113**



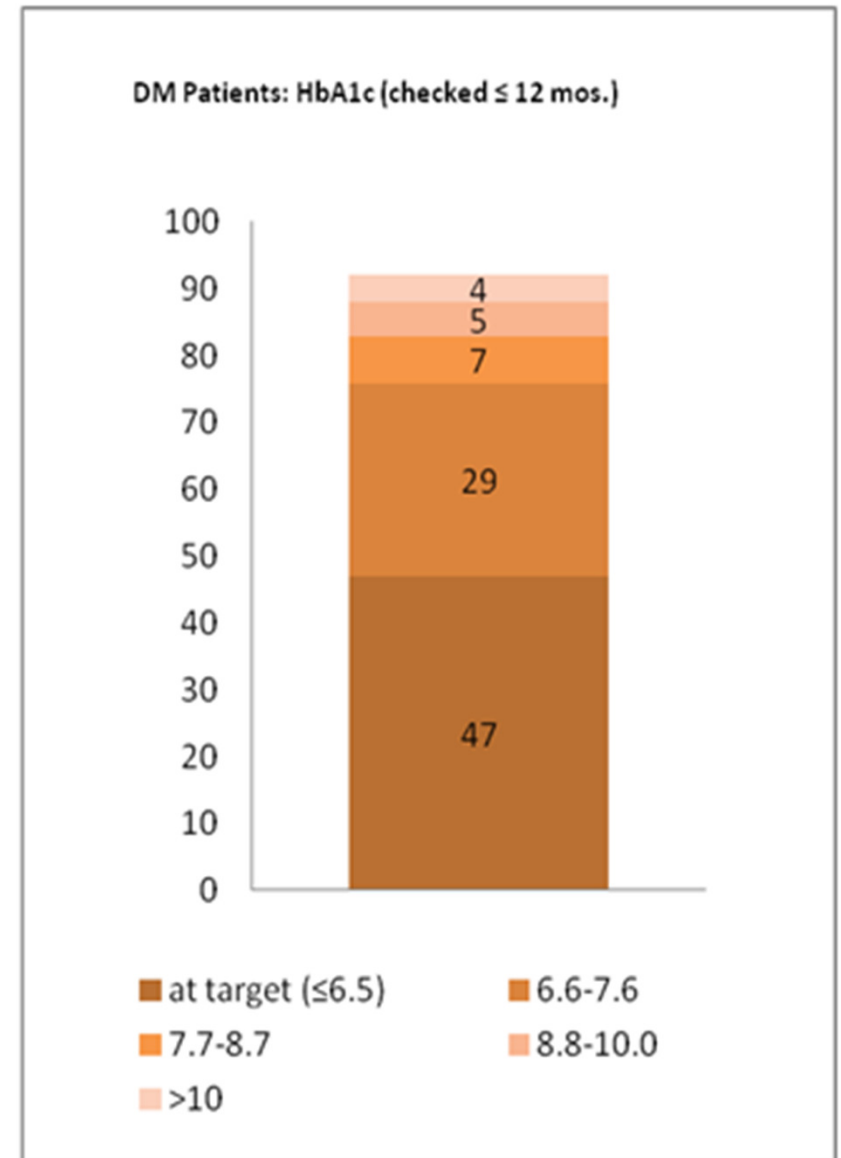
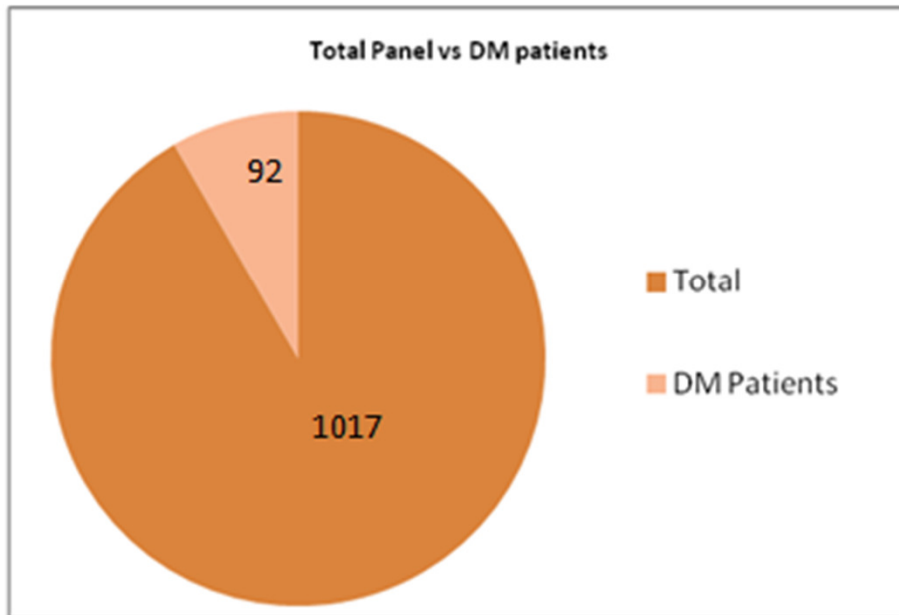
Strategic Team Composition



Key Success Factor: MEASUREMENT



DM Patients: HbA1C (checked ≤ 12 mos.)





**Calgary West Central PCN:
2013 Flood
100 000 displaced
5 billion**

Challenge:

No standard measurement of expected outcomes



Panel Reports

- Practice characteristics
- Panel characteristics
- Preventative care and imaging
- Chronic conditions and frequent diagnoses
- Pharmaceuticals
- Utilization



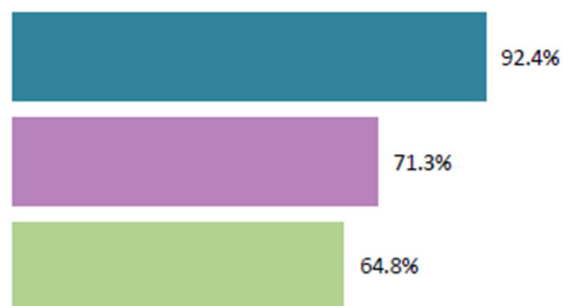
Breast cancer screening ▲

Percentage of female patients age 50 to 74 with at least one breast cancer screening test as of March 31, 2017.

▲ Your result is in the top 16 per cent of all physicians in your Zone.

■ Your Panel ■ PCN Panel ■ Zone Panel

Percentage of patients



Number of patients on your panel

Eligible	Screened	Not screened
132	122	10

About the measure

This metric is based on data from the Alberta Breast Cancer Screening program (ABCSP) which looks at whether patients had at least one mammogram completed within a 30-month period. For this metric, the HQCA has aligned with the Alberta Health Services Cancer Screening Program (AHSCSP) screening timeframes. This is because AHSCSP is responsible for sending notifications to patients on when they are due for screening. Each patient is counted only once.

This metric excludes female patients younger than age 50, older than age 74, and women with a history of invasive breast cancer who had a screening mammogram.

Interpretation

Consider the number of patients not screened.

If you are surprised by the number of patients on your panel not screened, an EMR search might help you to identify patients who should be called in for screening.

Compare your screening rate to your peers.

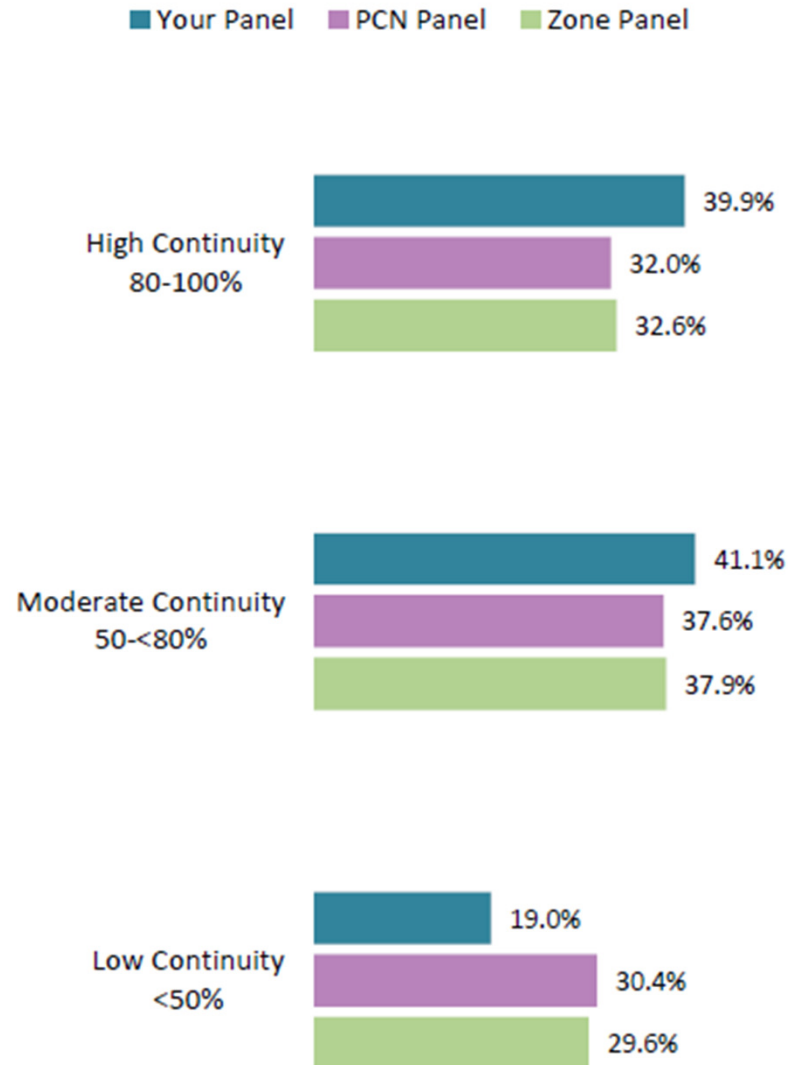
If your screening rate is considerably different from your peers, what practice or patient factors might be influencing rates? Consider what you can do to improve screening rates for your patients.

Possible actions

Consider an initiative to improve screening rates.

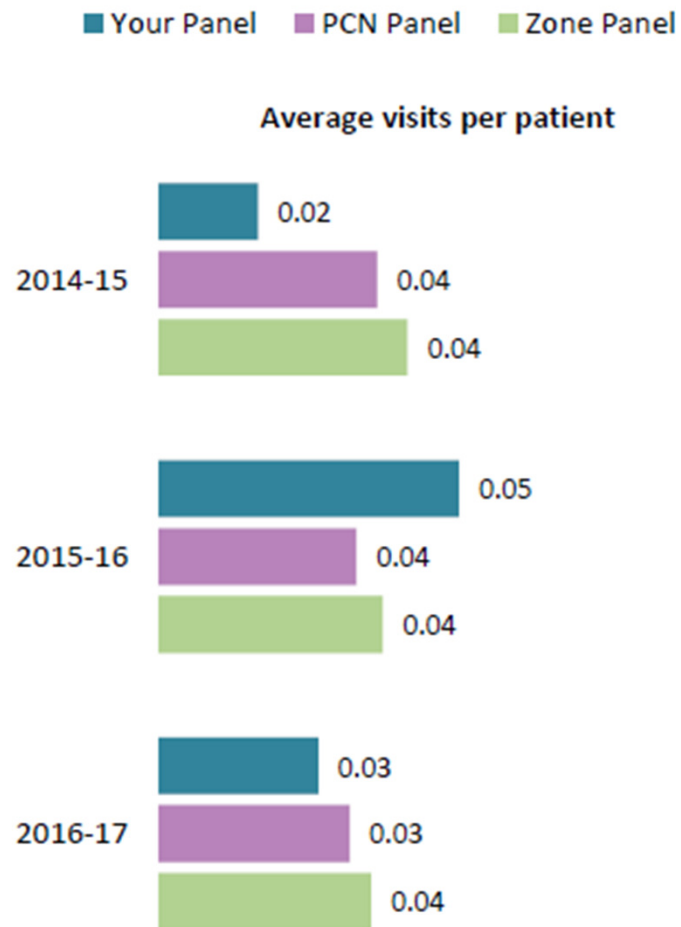
Consider a quality improvement initiative to improve screening. Resources are available at [Toward Optimized Practice](#).

HQCA Data - Continuity



HQCA Data - ED Visits for GPSC*

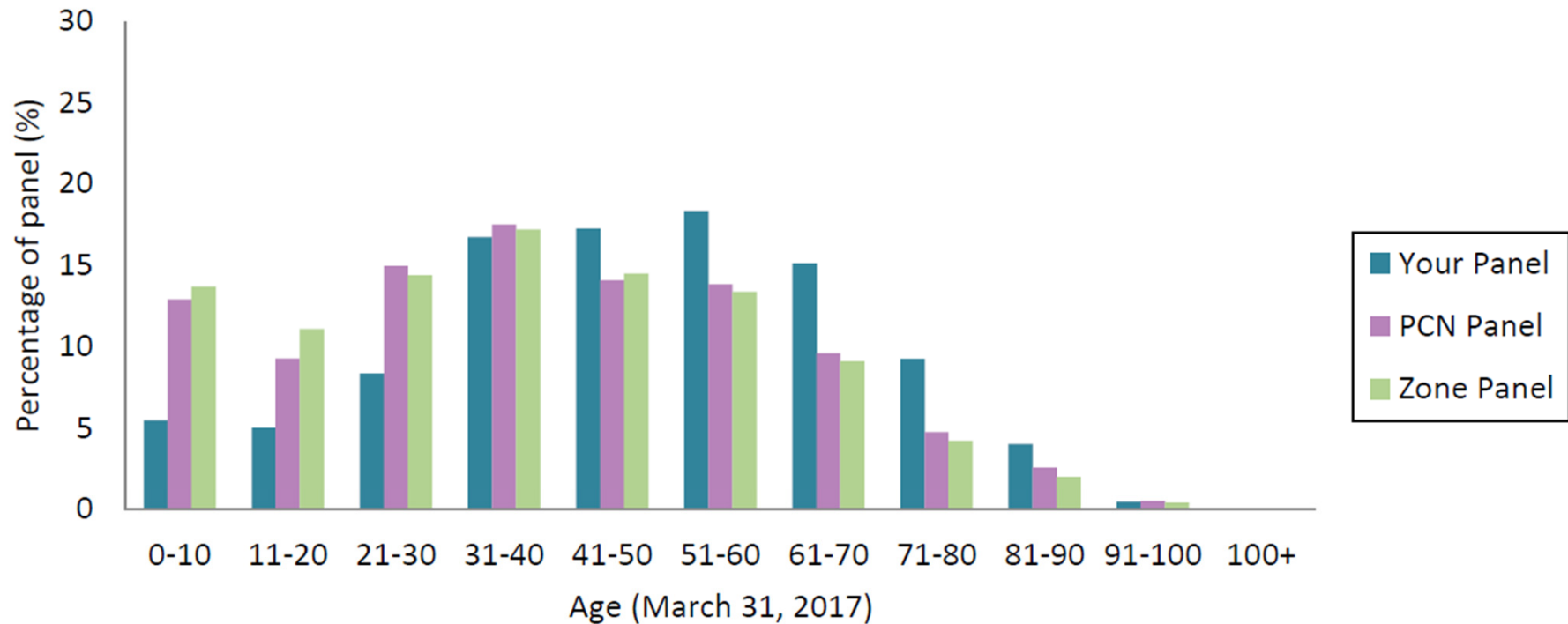
(*general practitioner sensitive conditions)



HQCA Data – Age Distribution

Age distribution

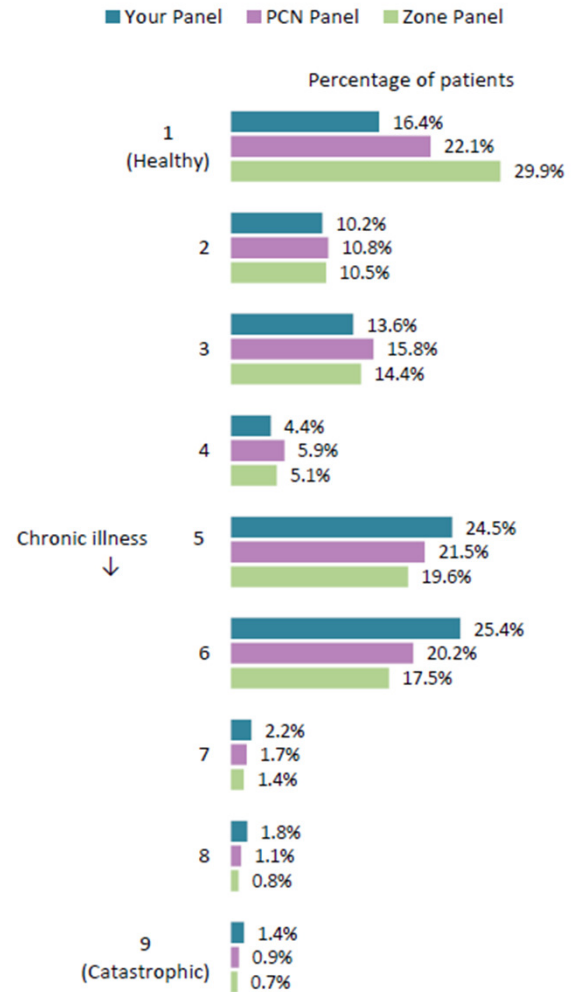
Distribution of your panel into different age categories, as of March 31, 2017.



Average age (years)	Your panel	PCN panel	Zone panel
	48.3	39.2	37.9

HQCA Data – Burden of Illness

CRG Level
1. Healthy, no major conditions
2. Significant acute
3. Single minor chronic
4. Multiple minor chronic
5. Single dominant or moderate chronic
6. Pairs- multiple dominant/moderate chronic
7. Triples- multiple dominant chronic
8. Malignancies
9. Catastrophic



	Your panel	PCN panel	Zone panel
Average CRG score	4.1	3.7	3.4
Patients with CRG ≥ 5	55.4%	45.4%	40.1%



Hope continued to rise...

Faith, Charity & Hope, Canmore, AB

Evidence

RESEARCH ■ HEALTH SERVICES

The effect of provider affiliation with a primary care network on emergency department visits and hospital admissions

Finlay A. McAlister MD MSc, Jeffrey A. Bakal PhD, Lee Green MD MPH, Brad Bahler MD, Richard Lewanczuk MD PhD


■ Cite as: *CMAJ* 2018 March 12;190:E276-84. doi: 10.1503/cmaj.170385



Making an impact

69 fewer emergency department visits, and

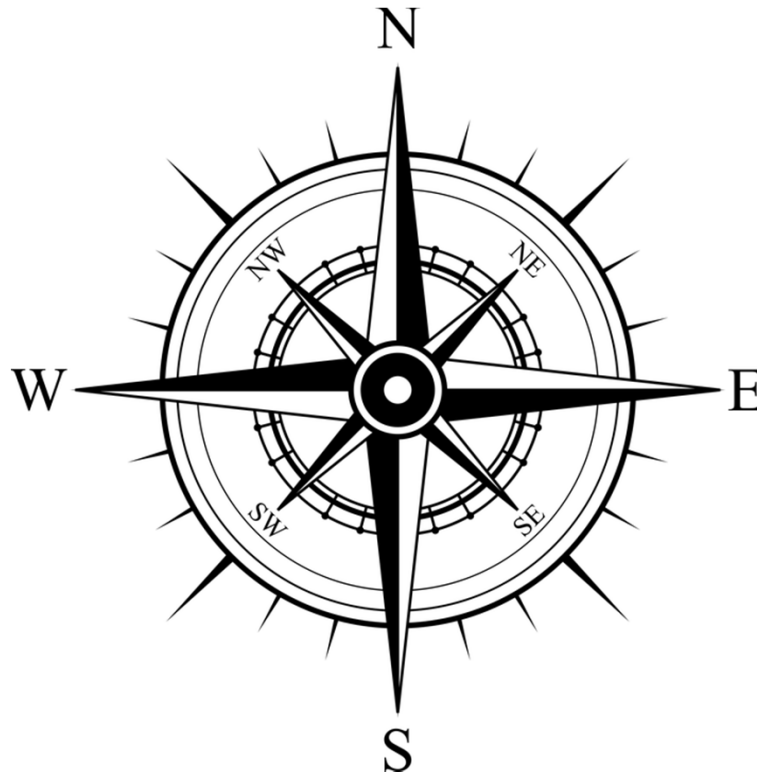
86 fewer hospital days per 1000 patient-years



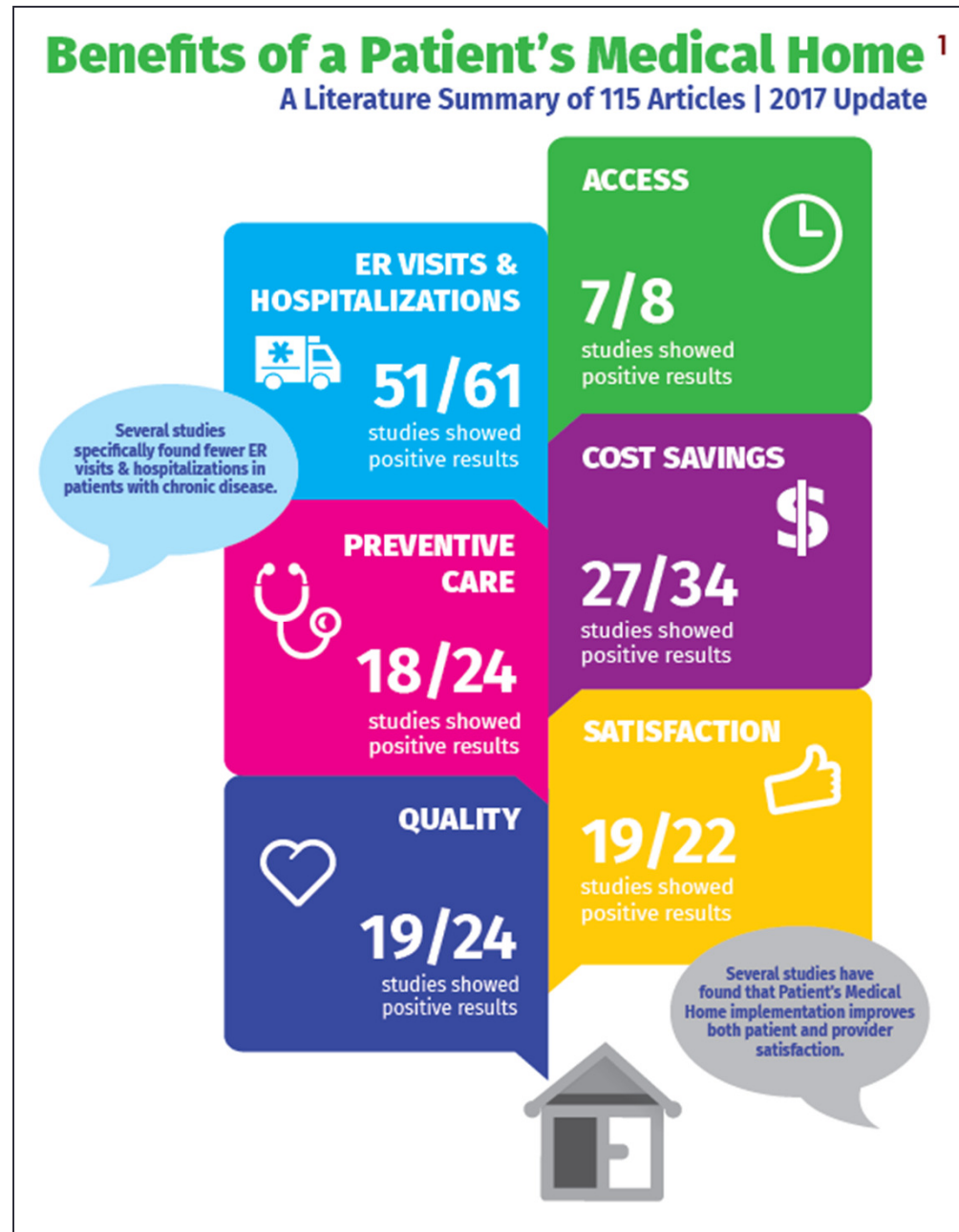
**Wood Buffalo PCN:
2016/17 Fort McMurray Fires
88 000 persons displaced
\$10 billion**

Key Success Factor: PMH

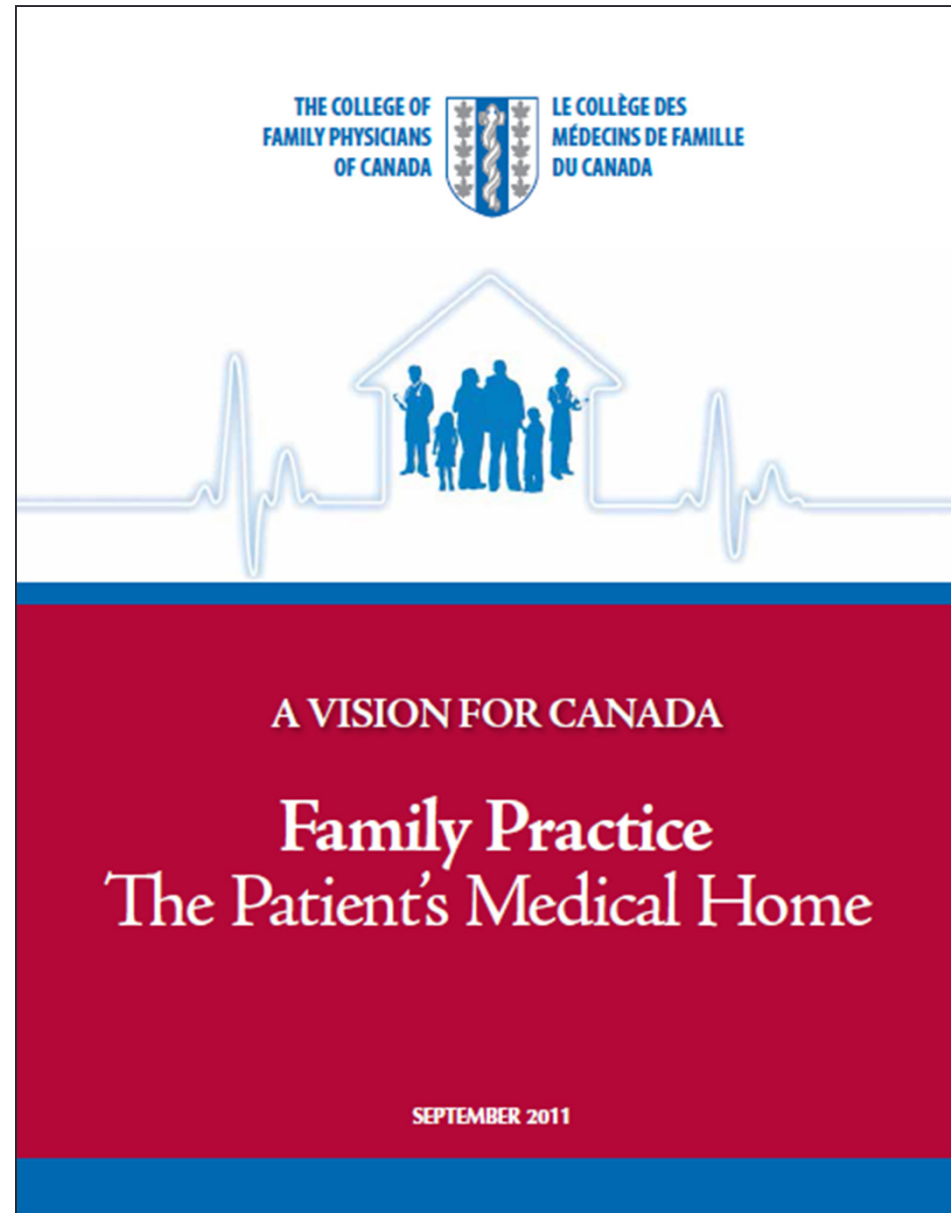
Patient's Medical Home



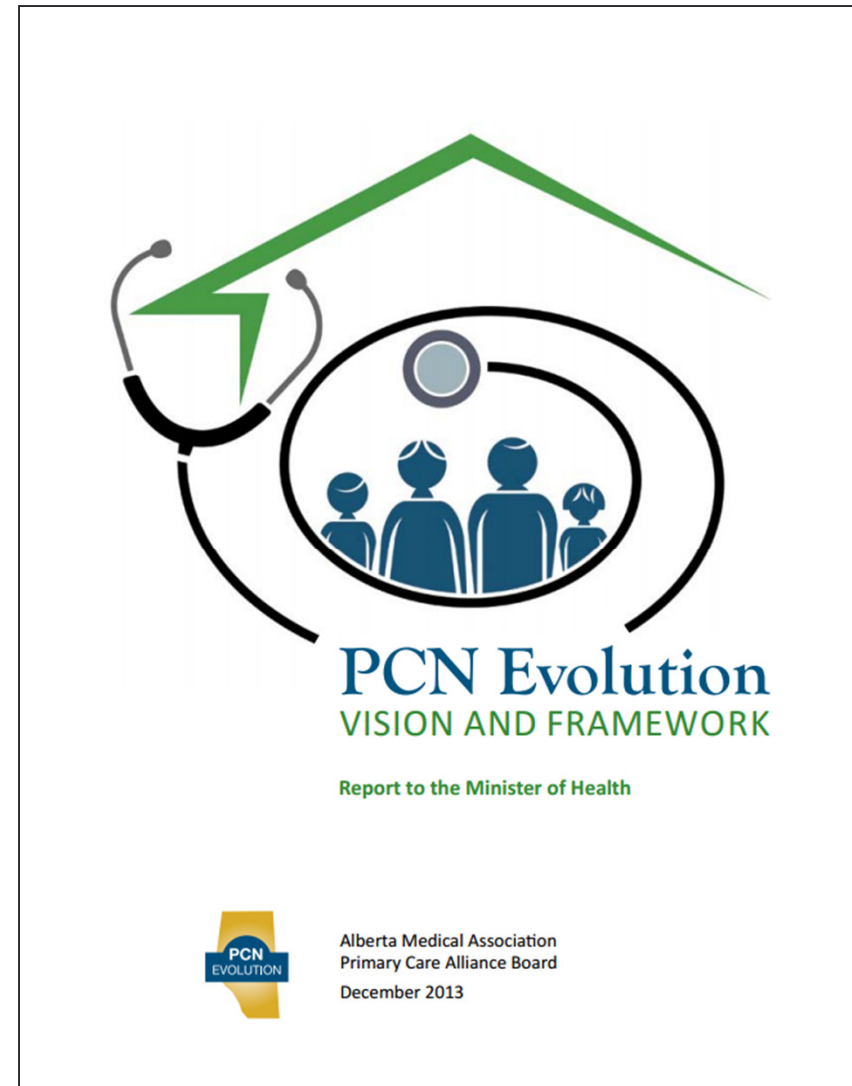
PMH: Global

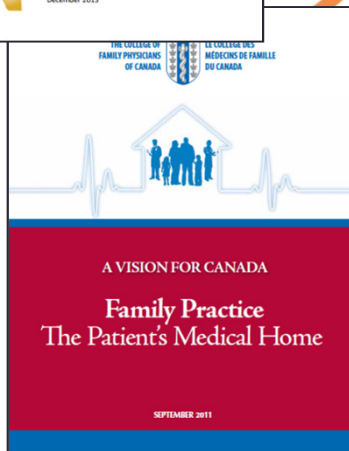
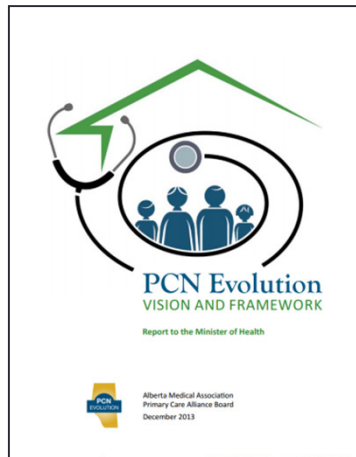


PMH: Canada

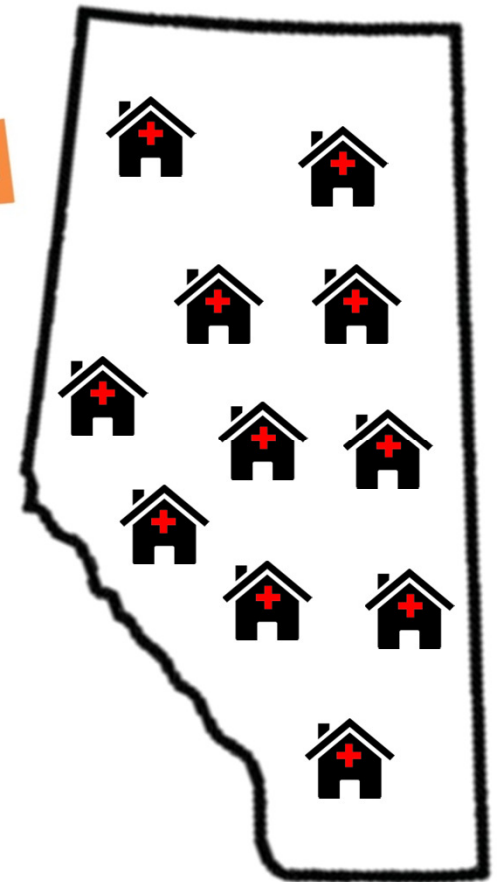


PMH Alberta: PCN Evolution (Really a cultural revolution)



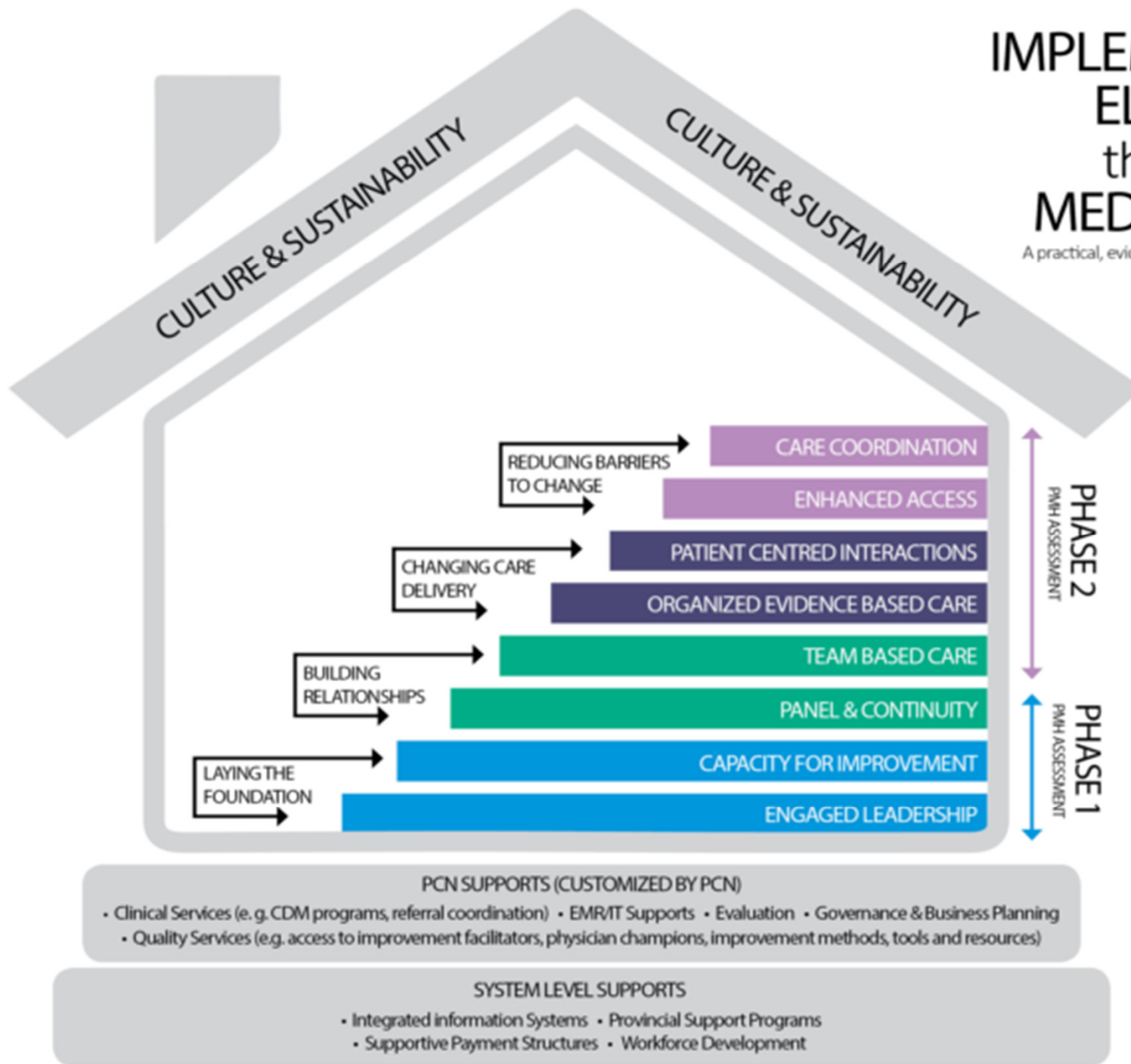


10 Goals

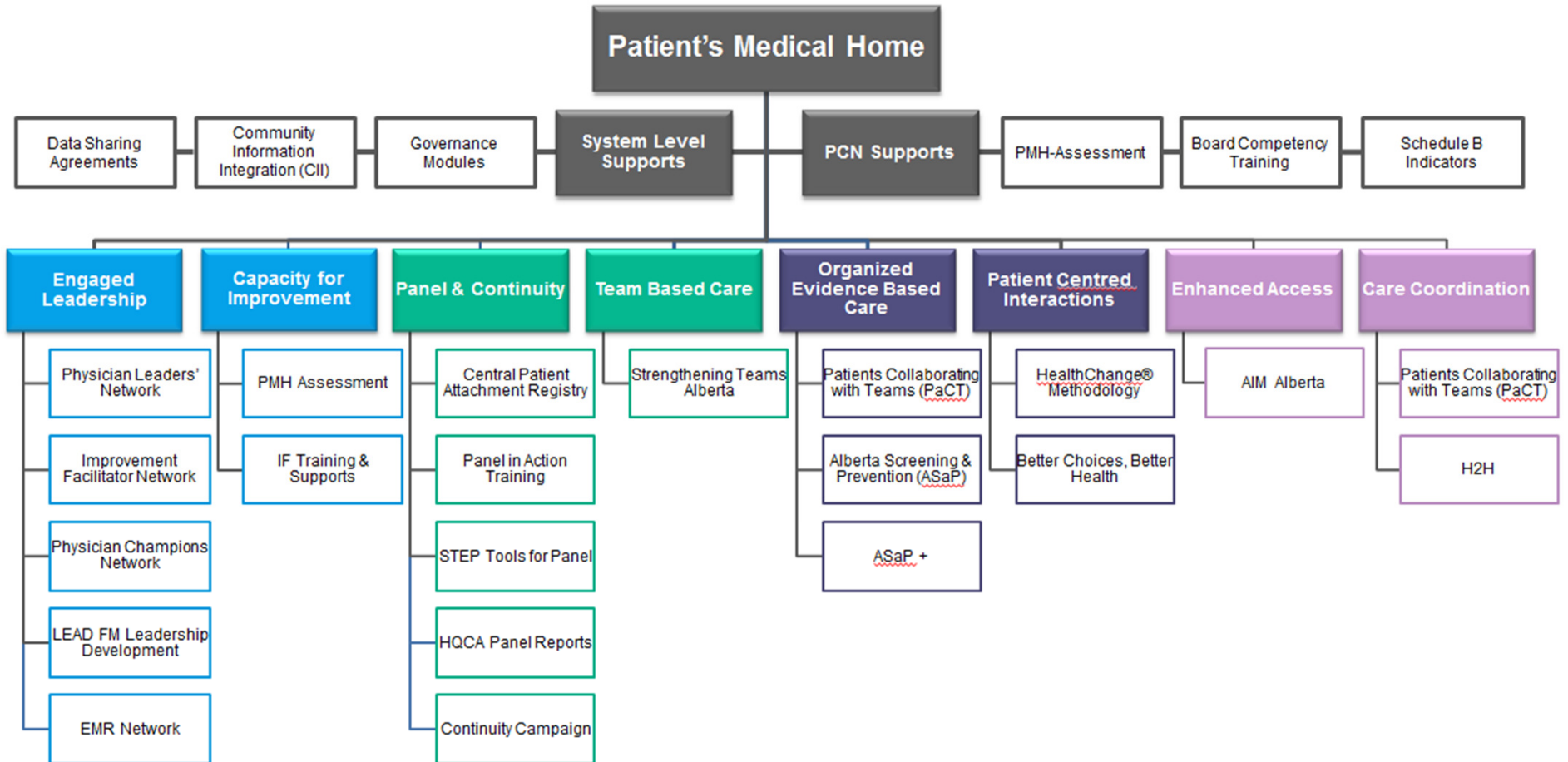


IMPLEMENTATION ELEMENTS for the PATIENT'S MEDICAL HOME

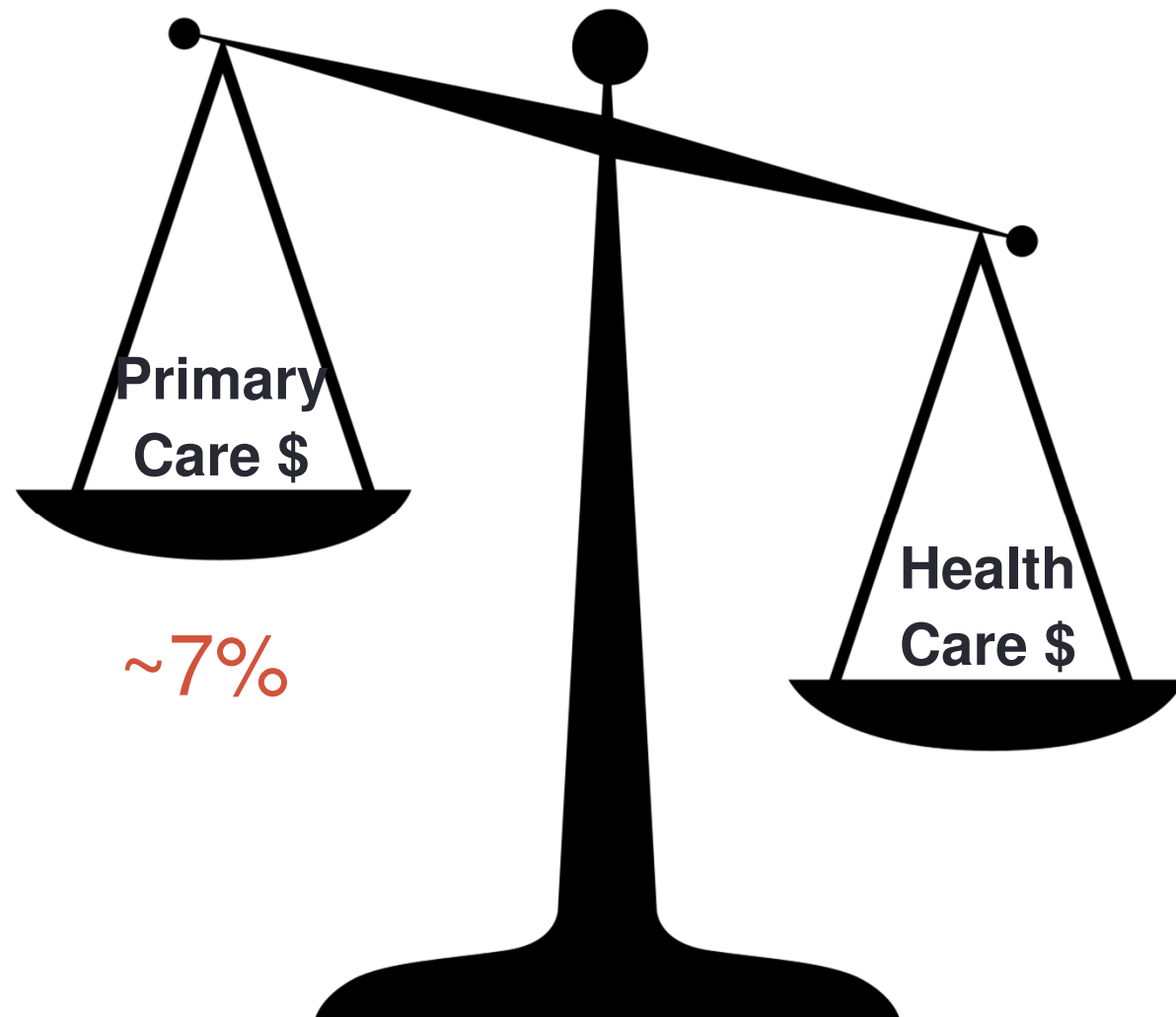
A practical, evidence based approach for clinic teams



We've only just begun...



The last commandment: Fiscal cliff be damned



Primary Care: Driving system change



To cross-border unity and collaboration!

