Strengthening Primary Health Care in Alberta through Family Care Clinics: *From concept to reality*

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October 9, 2012
# Table of Contents

Executive Summary ........................................................................................................... ii  
Setting the Context ........................................................................................................... 1  
The Assignment ............................................................................................................... 3  
Primary Healthcare Reform in Alberta: The complex policy context ........................... 4  
Current State: Making a good system better ................................................................. 7  
Preferred Future State: A home in the health care system for every Albertan .............. 12  
Family Care Clinics: Concept in brief ........................................................................... 13  
Implementation Considerations: Change is a process, not an event ......................... 16  
Summing Up: Creating the “winning conditions” for primary care reform .................. 19  
References ..................................................................................................................... 20  

## Appendices

- Appendix A: Comparison of Provinces and Territories on Features of a High Performing Primary Care System ................................................................................. 22  
- Appendix B: National Health Service Indicators .......................................................... 24  
Executive Summary

The Assignment:

This work has been undertaken on behalf of the Minister of Health of Alberta and in collaboration with the Ministry of Health. The assignment is to help provide a conceptual framework for the deployment of Family Care Clinics (FCCs) in the broader context of an overarching policy objective of enhancing access to primary care services for all Albertans.¹

“My promise, and that of my government, is that ...all Albertans will have a home in the health care system where people know you and your health needs, can help you manage your health, and can help you get more specialized care if it’s needed.”

Premier Redford

The Process:

The work involved looking first and foremost at what is working well in terms of the current state and at the challenges of moving towards a preferred, shared future state...in this case toward developing an integrated, 3-5 year primary care strategy for Alberta.

A three step approach was taken extending over a two month period:

- The first step was to undertake a high-level synthesis of the readily available literature, both peer-reviewed publications and the “grey literature”. (See Part two: “Primer on Primary Care”.)

- The second step was to conduct a series of semi-structured key informant interviews (n=27) from across a broad spectrum of professions and perspectives. This included interviews with academics well versed in primary care from inside and outside Alberta.

- The third and final step was to conduct a series of site visits, including: largest Primary Care Network (PCN) in the province; one of the longest serving integrated family physician-led clinics; and to both the Edmonton and Calgary FCC pilot sites.

We want to thank all those who gave so much of their time, so willingly, to helping us with this important work.

¹ Any discussion paper that addresses “primary care” or “primary health care” faces definitional issues. The terms are often used interchangeably. Generally, the term “primary care” is seen as more limited. For purposes of this issue brief on Family Care Clinics, we are following the consensus in the recent literature that the term is to include the broader range of “determinants of health”, including social services.
**Key Findings:** In terms of high-level takeaways, it is clear from our work that there is a consensus emerging around the following first principles:

- The community strongly supports the Premier’s overall policy goal of “every Albertan having a home in the health care system”, the details of which are assessed in this issue brief.

- Primary care reforms for Alberta are seen as foundational to overall healthcare system performance. Alberta, Ontario and Quebec, “…appear to have made the greatest progress toward primary care transformation in Canada”.  

- Primary Care Networks (PCNs) are considered a basic building block for the primary care system of the future for Alberta. The majority of PCNs are functioning well in terms of providing accessible, good quality, team-based healthcare. They are seen as innovative and as having played a major role in getting Alberta ahead of the primary care curve across Canada.

- One size does not fit all. The Family Care Clinics (FCCs) concept has the potential to support or create the “next generation” of primary care models in Alberta (and across Canada) provided the FCC concept is embedded in the broader context of a longer-term, integrated primary care strategy.

- Quality improvement needs to be an integral part of “the fabric of primary health care practice”, consistent with the *Triple Aim* objectives of: better health, care, and value. This requires the development, tracking and reporting of meaningful metrics.

- There is a consensus on the need to focus on results. The “next generation” of primary health care clinics would, for example, provide (or provide for): extended hours of service; enhanced linkages and partnerships with other community services; fully interoperable electronic patient records; formal attachment of patients; enhanced illness prevention and health promotion; a broader team mix of health and social service providers working to full scope of practice; and ongoing feedback on a “dashboard” of key quality indicators as part of a continuous quality improvement process.

- While there is considerable change fatigue throughout the system as various players in senior leadership positions come and go with regularity, there is nevertheless an appetite for working together to develop an integrated primary care strategy to “take primary health care to the next level”.

**Diagnostic:** A consensus seems to be emerging that the **Current State** of primary care in Alberta can be characterized as follows:

- Alberta’s biggest asset is the ongoing commitment of a well trained and caring provider community willing to work together and embrace the “next generation” of primary care models.

- There are currently 40 Primary Care Networks or PCNs across the province, with over 2500 family physicians (FPs) participating and 600 full time equivalent other health professionals working in interdisciplinary practice settings.

- PCNs have lead to a marked increase in provider morale, reduced emergency visits/hospitalizations and a steady, if uneven, move toward a “more collaborative and caring culture” among health care providers.

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Some PCNs are performing at a higher level than others. According to one recent study, the majority (5/8) are “surging ahead”\(^4\), having adopted good governance and management practices that could and should be emulated (e.g. Taber Clinic: Chinook, profiled nationally in the July 26, 2012 Premiers’ Report). Others are either treading water (2/8) or “mired in antagonism” (1/8), the root causes of which need to be better understood and then addressed.

Form (of payment) should follow function. While no single payment method “holds the key to transforming primary health care”\(^5\), fee-for-service is generally not seen as supporting integrated, interdisciplinary primary care.\(^6\) On the other hand there are concerns that capitation-based funding, based on an age/sex adjusted payment per rostered patient, can lead to under-servicing.

Core funding for PCNs is currently based on fee-for-service billings. Supplementary capitation funding is provided to PCNs (currently $62/deemed enrollee), but the terms and conditions are vague and subject to wide interpretation. There is a lack of clarity around expectations for how the per capita supplements are to be allocated and the attendant service requirements and reporting accountabilities.

Part of Alberta’s success relative to other jurisdictions in terms of achieving expanded access to primary care is due to its Access, Improvement, Measures (AIM) collaboratives. Most PCNs and over one-third of Alberta’s FPs have participated in AIM learning sessions.

Alberta is one of the early Canadian adopters of electronic health records (with the consolidation of IM/IT systems under Alberta Health Services). However the Electronic Medical Record (EMR) system, with its multiple vendors and systems, is in need of improvement and urgent attention.

In terms of patient attachment, while up to 85% of Albertans are deemed to be registered with one PCN or another, unlike some other jurisdictions (e.g. Ontario and Quebec), Alberta does not require formal patient registration. This is important because the research suggests that attachment to a clinic or a clinician not only improves continuity of care over time but “is consistently inversely related to the total cost of care for...higher-care-needs patients”\(^6\).

The development of Strategic Clinical Networks (SCNs) by Alberta Health Services is strongly supported in terms of improved efficiency and effectiveness through the “Leaning” the referral and discharge process. There are, however, important questions and concerns around how horizontal integration of “stepped up” PCNs and FCCs will be coordinated with the vertical integration of referral services under (or in support of) SCNs.

Alberta Health would have adopted a one patient, one record electronic patient record system that is interoperable/compatible with the Electronic Health Record system operated by AHS, perhaps under a shared services model similar to that being put in place in Saskatchewan. (Note: This need not mean moving to a single vendor of provider as this would mean loss of redundancy in the case of a system failure.)

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Based on this work, there is also an emerging consensus on the preferred **Future State** for Alberta’s primary care system (by 2016) and it can be described as follows:

- The government has articulated a *clear, compelling vision statement* for the future, based on the *Triple Aim objectives of: better health, better care, better value.*\(^7\) The cornerstone of this preferred state is a comprehensive, multi-year integrated strategic plan for achieving the objective of “every Albertan having a home in the health system”.

- The Family Care Clinics initiative is embedded in the primary health care strategy and quality improvement is included in Primary Health Care “charters” (one such draft charter has already been developed). PHC charters would set out broad terms and conditions of engagement, clarifying roles and responsibilities within and across the clinical and the patient communities (e.g. clear set of deliverables, core services, reporting responsibilities). They also allow for the flexibility necessary to innovate and to customize service offerings to meet local needs.

- In addition to the Ministerial PHC Advisory Committee (a necessary stakeholder forum), the preferred future would see the establishment of a smaller *Minister’s Primary Health Care Strategy Group* comprised of thought leaders in primary health care to assist in completing the task of finalizing an integrated primary health care strategy for Alberta (within 12 months) and to provide advice on its implementation.

- Both the *Advisory Committee* and the *Strategy Group* would be supported by a dedicated *Primary Health Care Secretariat*. Alberta Health would lead the establishment of the Secretariat. It would have overall responsibility, on behalf of the Minister, for working with the PHC *Strategy Group* in developing and then implementing the primary care multi-year work plan. *Authorities and accountabilities would need to be aligned* with the Secretariat for making operational decisions in connection with determining FCC designation or registration requirements, approving annual work plans and budgets, and monitoring/reporting back to PCNs, FCCs and the Alberta public on progress.

- Health needs vary widely across Alberta. There is a strong consensus around the need to strengthen the *patient voice* in primary care and the regional or zone presence in planning for primary care. Alberta Health and AHS could collaborate with the health professions and existing PCNs to possibly establish “Zone Integrated Plans” or “ZIPs” for primary care possible through zone-based *Primary Care Partnerships*. PCPs would feature broad based representation of stakeholder groups, including the *patient voice*, with a mandate to assist the *Strategy Group* in providing strategic planning advice locally and serving as a community sounding board. The regional partnerships of the future could also support the PHC Secretariat in terms of community outreach and networking.

- The *future state* would also see PCN-clinics and FCCs designated and/or “accredited”, with at least three pathways to being designated (see Figure 1):
  
  - **Stream A**: Fully functioning PCNs and/or PCN clinics being invited to improve their governance practices and service offerings in return for FCC designation and additional funding (i.e. “PCN-plus”);
  - **Stream B**: Alberta Health identifying areas of high, unmet primary care needs with AHS administration/delivery of services through FCCs; and/or

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**Family Care Clinics: From concept to reality**
Stream C: Innovative community-initiated applications for FCC designation that cut across traditional geographic and/or cultural boundaries (e.g. aboriginal health needs).

All primary care clinics would be not-for-profits in the first round and subject to ongoing evaluation against agreed-upon benchmarks or metrics of success consistent with Triple Aim.

Not-for-profit FCCs (as opposed to those FCCs that are AHS-delivered) would be funded through a blended approach based primarily on modified capitation (age/sex adjusted) for prospective payments for core services and additional annual or multi-year grants to meet higher patient or community health needs (e.g. higher prevalence of co-morbidities or mental health and additions in the catchment area).

One-time only transitional or developmental grants would be available to transition to a one patient, one record system; assist community-based groups in developing FCC proposals and/or business plans; provide leadership development training and to support the development of good governance practices (for not-for-profit FCCs); and to support broad-based board representation from other health professions and from the patient’s voice.

Continuous quality improvement would be supported by an integrated PCN/FCC data sharing agreement and evaluation strategy (with funding to leverage up the recently developed PCN data sharing agreement).

Finally, in terms of Next Steps there is an immediate need for:

(1) A compelling vision for the primary health care system of the future and how FCCs fit and how they will be deployed. The vision would stress a number of winning conditions, including the need to focus on results; build on successes (e.g. well managed PCN Clinics); as well as allowing new models to emerge (e.g. nurse-practitioner-led clinics like NP-led Family Health Teams in Ontario). It would stress multiple pathways for advancing the PHC agenda.

(2) An overall change management strategy is required: one that engages all of the key stakeholders in an ongoing, meaningful dialogue about the future of primary care in Alberta. It is important to stress that change management is a process, not an event. This shared, collaborative change process begins with the meeting of the Ministerial Primary Care Advisory Committee (September 24th).

(3) An overall primary health care communications strategy, aimed at both the general public and the internal “publics”, providing further details on the PHC strategy, including FCC deployment.

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“*If you want to go fast, go alone. If you want to go far, go together.*”

_African Proverb_

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8 Dickson, G. et al. (2012) _Evidence-Informed Change Management in Canadian Healthcare Organizations._ Ottawa: Canadian Health Services Research Foundation.
Figure 1: FCC Deployment Framework

**FCC Deployment Framework**

- B. Community-Initiated/ NPO-Delivered
- A. PCN-Initiated/ NPO-Delivered
- C. AH-Initiated/ AHS-Delivered

**Three Streams Approach**

- Core Funding
- Core Team
- Core Services
- Common Governance
- Common Reporting/Indicators/Standards
- Common EMS/EHR Platform

- Local innovation/adaptation
- Capitation-based funding: to promote partnerships in PHC
- Scale economies: shared services
Advancing PHC through Family Care Clinics:  
From concept to reality

Setting the Context

For over a decade now, there has been an increasing focus on the importance of primary health care, including increased support for a wide range of innovations and pilot projects in this arena.¹

For many involved with primary health care (PHC) over the years, it is clear that Canada has now entered a period of potentially transformative change. “Canada’s lackluster primary care performance, together with continuing fiscal turbulence, call for a thoughtful and determined approach to system transformation.”²

A number of provinces have recently embarked on ambitious PHC reform agendas (e.g. Ontario, Saskatchewan and New Brunswick). The recent report of the Premiers’ Health Care Innovation Working Group³ also focused attention on the need to move from “innovation by accident to innovation by design”, with a specific focus on exemplary innovation in terms of interdisciplinary, community based primary health care delivery models.

The impetus for this increased focus on primary health care reforms results, in part, from a convergence of a number of key economic and demographic factors. Canada now spends 11.7% of national income on health, a historic high which places us in the top five internationally. At the same time Canada’s overall performance is lagging behind other industrialized countries both in terms of overall system performance (efficiency) and health outcomes (effectiveness). In terms of efficiency and effectiveness, we now rank in the middle of the pack in terms of OECD countries and at the back of the pack in terms of G-8 (with the United States picking up last place).⁴

The case for stepping up primary health care reforms across Canada was also made in a recent report of the Health Council of Canada (HCC, 2010). It stressed the need to engage in meaningful primary care reform after “myriad small-scale pilot and demonstration projects”.⁵ The HCC points to the fact that many provinces have not met the goal set by First Ministers Health Accord (2004) of 50% of Canadians having 24/7 access to multidisciplinary primary care teams by 2011.

“Canada is not where it should be, and needs to be, in its ability to provide good quality primary health care. Other countries are doing better...for example, Canada continues to have an extraordinarily high rate of visits to emergency departments. This is partly historical/cultural (i.e. just the way it is) and also organizational.”

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¹ Coming out of the September 2000 First Ministers Health Accord, the Government of Canada established an $800 million Primary Care Transition Fund which helped fund, among other important initiatives, Alberta’s Primary Health Networks. The September 2003 First Ministers Health Accord underscored the importance of advancing the PHC agenda by setting a target of 50% of Canadians having access to multidisciplinary primary care teams by 2011.
² Aggarwal and Hutchison (2012).
³ Council of the Federation (2012).
In the specific context of primary health care, these same international comparisons show Canada slipping behind other high income countries in terms of important access and quality indicators. Canada ranked second lowest, ahead again of only the US, in terms of indicators of primary care performance. These indicators include: access to after-hours care, wait times, chronic disease management, mental health, quality improvement, electronic medical records and rates of emergency.

“Among 11 high-income countries, Canada has the fifth lowest percentage of adults (77%) who report having a regular doctor (compared to 94% in Netherlands, the highest performing country) and the third lowest percentage of sicker adults (88%) who have a regular doctor (Netherlands, 99%).”

Countries with a strong primary care sector achieve superior health outcomes at lower cost: “....getting (primary health care) right is the key to attaining long-term sustainability for the larger health care system”.

Turning more specifically to Alberta, while the economic and demographic imperatives may not be as strong as in some other provinces, there are nevertheless some strong policy imperatives to advance the PHC agenda. For example, according to a recent Health Council of Canada report, Alberta ranks fifth in health care performance in Canada, with the second highest per capita expenditure of all of the provinces. Alberta, where just 79% of its residents have a regular medical doctor, was one of two provinces given the poorest rating for the indicator “access to a family doctor”. This is well behind the 90% in Nova Scotia and New Brunswick. In terms of demographic imperatives for change, some 80% of Albertans over the age of 45 years report having at least one chronic condition.

The recent health report of the Premiers entitled From Innovation to Action also adds a sense of urgency to share innovations in primary health care reforms. The final report was released on July 26, 2012, stating:

“...team-based models of care: have been shown to lead to better health outcomes for people with chronic disease; have been shown to lead to better care through increased access to healthcare and improved patient experience; and have been shown to lead to better value through better use of clinical resources.”

Importantly, the HCIWG report shines a light on select exemplars of team-based models of care and local innovative practices. Approximately 40 contenders were nominated, but only seven were featured in the final report based on 13 best practice criteria (see Appendix C). In moving from “innovation by accident” to innovation by design”, Premiers underscore the opportunity to leverage up theses innovative practices across the country if Canada is to reverse the slide internationally. One of these innovative practices featured in the final report included the Chinook Primary Care Network – Taber Clinic, Alberta.

“Alberta’s Taber Clinic has introduced a team based primary health model. They credit their success in chronic disease prevention and management on a number of factors, but two in particular have the potential to be replicated. The first is Alberta’s Access, Improvement, Measures (AIM) Program. AIM is a quality improvement initiative that uses a set of principles and a proven process that reduces wait times for appointments and improves how patient care is managed, which in turn leads to improved quality

6 Aggarwall and Hutchison (2012), p. 16.
7 Ibid.
8 Ibid.
outcomes. The second is using Alberta’s Validated Patient Lists. With these lists, the Taber Clinic could create registries to monitor chronic disease among their patients and do a better job of planning the mix of health professionals they needed. The lists also helped them increase screening and health promotion initiatives.”

There have been a series of consultations around future directions in primary health care going back to January 2010.

“Primary health care is the cornerstone of a broader health care system. It is the first point of contact with the health care system and should assume the role of a trusted partner. Emphasis must shift from a system that is predominantly illness-focused to one that focuses on all the factors that contribute to health through health promotion, disease prevention, chronic disease management, and population health across the lifespan.”

In sum, there is a growing recognition that without better, more integrated and comprehensive primary care programs, Canada and Alberta will not succeed in realizing our full potential as high performing health care systems. According to one interviewee, lack of integration of primary health care is the “Achilles’ Heel” of our system. Experts believe that what is required to realize the full potential of primary healthcare reform is “…strong government and professional leadership working in concert”.13

The Assignment

Earlier this year, the Government of Alberta made an election commitment to “provide every Albertan with a home in the health care system” through the creation of up to 140 Family Care Clinics (FCCs) by 2016.

The Minister of Health has been mandated to deliver on this commitment. Minister Horne commissioned the authors on August 1, 2012 to conduct a high-level synthesis of the available literature on primary healthcare reforms and of a series of key informant interviews to help define the concept of Family Care Clinics and to identify key implementation issues and options.

Due to the diversity of views and the complexity of primary care, the number of key informants interviewed was doubled and series of site visits were arranged to get a hands-on view of how PCN Clinics are working and to see how the new Family Care Clinics are organized and operated.

The report has three major sections. The first takes stock of the current state of primary (health) care reform in Alberta and across the country. The second describes a possible preferred future state that reflects the emerging consensus amongst key players and that would build on both the Premier’s Promise and the Minister’s vision of Alberta becoming a “beacon” for primary care across Canada. The third section sets out some of the key issues and possible ways to address them in the context of a proposed approach to managing the change process that would take primary health care in Alberta from the current to the preferred future state.

11 Ibid. p. 16.
13 Hutchison et.al. (2011).
This Issue Brief draws on readily available research evidence from across Canada and from some international sources (see Part two: Synthesis of the Literature) and the key findings from the site visits and the key informant interviews. This report provides a summary of key findings and a proposed conceptual model for the future.

The primary purpose of the Issue Brief was to assist the Minister and the Ministry in a stakeholder dialogue session held September 24th (Ministers Advisory Committee on Primary Health Care). This final draft incorporates some key insights received from that session. This Issue Brief does not benefit from the community consultations or engagement undertaken by MLAs over the course of the summer break of the Legislature. It is anticipated that synopsis of important additional information will also be factored into the development of next steps and will provide another important perspective on the change management challenges associated with the deployment of FCCs across Alberta.

Primary Healthcare Reform in Alberta: The complex policy context

The “driving force” behind this policy agenda is Premier Redford’s commitment to improve the overall functioning of the health system by providing all Albertans with “a home in the health care system” where they can expect to receive ready access to a full range of integrated health and social services.

“My promise, and that of my government, is that ...all Albertans will have a home in the health care system where people know you and your health needs, can help you manage your health, and can help you get more specialized care if it’s needed.”

Premier Redford

In general, there is considerable confusion around the concept of FCCs and the specific roles and functions they will play in the reformed primary care system, especially as they relate to current PCNs and various initiatives that the AHS has underway (e.g. Strategic Clinical Networks). This issue brief raises some of these important topics.

First and foremost there is a consensus around the overall objectives of primary health care reform in Alberta, including the role FCCs will play. The consensus revolves around the need to increase the health of Albertans, improve the effectiveness of the healthcare system and provide increased value for money for the taxpayer’s dollar. The Triple Aim objectives of better health, better care and better value resonate strongly with those interviewed and are consistent with both the literature on primary health care reform and the frame of reference for the recent Premiers’ report: From Innovation to Action.

More specifically, the objectives of PHC reform, as set out by Premier, include:

“...coordination/integration of care across the continuum; expansion of team-based approaches to clinical care; improved quality/appropriateness of care; enhanced focus on prevention and the management of chronic and complex illnesses; greater emphasis

Note: There have been frequent consultations and meetings with both the Minister’s office and senior officials of the Ministry to ensure that this report reflects the rapidly moving primary healthcare policy agenda.
on patient engagement/self-management and self-care; and the implementation and use of electronic medical records and information management systems.”

These parameters essentially provide a checklist for Alberta’s plans to take the primary healthcare system to the next level.

Understanding the Alberta Policy Context: As in many jurisdictions across the country, the policy context in Alberta for primary care reform is ever-changing, with a range of important political, economic, social/cultural and technological factors in play.

What follows is a brief “PEST” analysis of the top ten factors affecting or driving the PHC agenda in Alberta and across Canada.

Political considerations:

(1) Managing expectations is always a challenge when it comes to any major healthcare reform. So it is with moving forward with deployment of FCCs. As important as primary health care reform is to overall system, reforming it is not a “cure-all” and the pace of change may not satisfy all primary health are related needs quickly enough for all.

(2) Managing relations with key stakeholders is key. Relations between the government and some of the key provider groups are not where they once were and or where they need to be. Building and maintaining mutual trust and respect is an ongoing part of the change process. Physician engagement, not at the expense of consulting with other professionals, is critical to success: “In those jurisdictions where primary healthcare transformation has been the most far-reaching, major initiatives have been negotiated with the provincial medical association”.

(3) Managing or aligning authorities and accountabilities in the system, for example between Alberta Health and Alberta Health Services, and between the Alberta Medical Association and the Primary Care Networks. Also, with the abrupt dissolution of the regional authorities in 2008 the patient voice in the system has essentially been lost. Community Health Councils were eliminated and (far fewer) Community Advisory Committees have met only on a few occasions and have no explicit or well understood role to play.

Economic Considerations:

(4) According to CIHI’s most recent estimates, overall health spending in Alberta for FY 2011 was $24.9 billion, or some $6,570 per capita (second highest only to Newfoundland at $6,884). However, at 26.3%, Alberta’s public health care expenditures, as a percent of total public sector spending, is one of the lowest in the country.

(5) Physician payments account for 14% of Alberta’s total public sector health spending. Alberta also has among the lowest percentage across Canada in terms of proportion of total clinical earnings accounted for by alternative clinical payments...just 12% relative to an average across Canada of 21% (2008-2009). Alberta Health expects to spend more than $170 million on the PCN program in 2012-13 and has provided over $700 million in additional funding since the inception of the program in 2005).

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(6) While Alberta continues to fare well relative to other provinces in terms of growth in Gross Domestic Product per capita, overall revenue growth is tied to the price of oil and gas/oil and to fluctuations in exchange rates due to external factors.

**Social Considerations:**

(7) In 2011 the population of Alberta was 3.6 million, an increase of 10.8% in five years. While Alberta still has a relatively young population, 11.1% of the population is aged 65 and over compared to a national average of 14.8%...it too has a large and growing seniors population...with all that this implies in terms of need for enhanced prevention and management of chronic diseases. “Approximately 80% of Albertans over 45 have at least one chronic condition”.

(8) Like the other western provinces and territories, Alberta has a significant Aboriginal community (over 188,000 in the 2006 census)...with fertility rates still well above the rest of Alberta and a much higher incidence of child and infant mortality (15 deaths/100 live births) and high prevalence of, for example, early onset or Type I diabetes.

**Technological Considerations:**

(9) Alberta is one of the few jurisdictions in Canada that has a fully integrated electronic health records system (under AHS). It also has the highest percentage of community-based physicians using electronic medical records (at 68%)

(10) Challenge is that not all Albertans have an EMR and not all EMR systems are compatible/interoperable.

Notwithstanding these challenges, both the literature and key informants suggest that many/most Albertans are already well served and they have high levels of satisfaction with the system once they access it. As one expert from outside Alberta observed: “if only the rest of Canada had Alberta’s challenges, we’d be doing much better”. Or, as a senior leader from Alberta stated: “we have all or most of the key parts, all we need to do is connect the dots and we would be in a lot better place than many people realize”.

All of this to say, that PHC reform in Alberta should be framed as “making a good system better”.

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18 Canada Health Infoway (personal communication).
Current State: Making a good system better

The literature review and the key informant interviews both point to the fact that Alberta has a good primary care platform from which to build a better, more integrated PHC system. It has many of the key attributes of a good system including: generous supply of well trained family physicians, 85% of whom are now associated with a still growing number of Primary Care Networks; a high degree of digitized information in both the institutional and community settings; relatively good infrastructure, both publicly provided and now privately built via PCNs; and strong leadership in key positions throughout the system.

According to one recent study of primary health care reforms, Alberta, along with British Columbia, Ontario and Quebec, “...appear to have made the greatest progress toward primary care transformation in Canada”. However, no one province has all the attributes or elements required to achieve the full value of a strong primary care system. For some interviewees, they see “connecting the dots” of different parts of the current PHC system as the key policy challenge for Alberta to become “the best of the best”.

Retrospective on Primary Health Networks: Primary Care Networks or PCNs were first introduced in Alberta in 2005, taking advantage of the federal government’s $800 million Primary Health Care Transition Fund.

What is a PCN?

“Primary Care Networks or PCNs are a made-in-Alberta approach to improving access to and better coordinating care for patients across the province. A PCN...is a network of doctors and other health providers such as nurses, dietitians and pharmacists working together to provide primary health care to patients. Each Network has the flexibility to develop programs and to provide services in a way that works locally to meet the specific needs of patients.”

The introduction of PCNs is generally regarded in the literature and in the community as a “game changer” for Alberta. They are seen, for example, as one of the principle reasons for Alberta being one of only three provinces to deliver on the First Ministers 2004 Accord promise of 50% or more access to team-based primary care services.

In terms of a basic statement of intent, PCNs receive targeted payments over and above fee-for-service billings (initially $50/capita increase to $62/capita early in 2012) to:

“... support enhanced staffing (including administration), premises and equipment, chronic disease management, expanded office hours, and 24/7 access to appropriate primary care”.

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19 Aggarwall and Hutchison (2012).
20 See Primary Care Initiative website (www.albertapci.ca).
21 Ibid.
Form (of payment) should follow function. While no single payment method “holds the key to transforming primary health care”\textsuperscript{22}, fee-for-service is generally not seen as supporting integrated, interdisciplinary primary care.\textsuperscript{23} On the other hand there are concerns that capitation-based funding, based on an age/sex adjusted payment per rostered patient, can lead to under-servicing.

There are currently 40 PCNs across the province, with over 2,500 family physicians (FPs) participating and 600 full-time equivalent other health professionals working in interdisciplinary practice settings.

Based on a review of various recent studies and reports as well as the semi-structured interviews, it would appear that the supplement does not necessarily produce the intended benefits.

Indeed, results across PCNs have been mixed. For example, according to Reay et al. (2012), a majority of PCNs studied (5/8) are performing at a high level or “surging ahead” in terms of delivering on the original intents and purposes as set out in the tripartite agreement. Other PCNs are either “cautious planners” (2/8), holding their own in term of meeting access targets or, the remainder (1/8), “mired in antagonism”, having failed to deliver on the basic statement of intent.\textsuperscript{24} The fact that some PCNs have lived up to the spirit of the agreement while others are not has created some tension within and across PCNs. This source of tension in the current system needs to be addressed on a priority basis.

In terms of attachment, while up to 85\% of Albertans are “deemed” through the so-called “four-cut system” to be registered with one PCN or another, unlike Quebec, B.C. and Ontario, Alberta does not require formal patient registration. “Attachment to practice is consistently inversely related to the total cost of care for...higher-care-needs patients”\textsuperscript{25}. Attachment or rostering is seen as key because it enhances overall accountability of providers to patients, and vice versa.

In terms of value for money, the recent Alberta Auditor General’s Report... “found weaknesses in the design and implementation of the accountability systems for the PCN program”.\textsuperscript{26} He went on to observe that “the PCN program does not have defined service delivery expectations, performance measures and targets for individual program objectives”.\textsuperscript{27}

Based on the key informant interviews, the AG’s report is widely regarded as being fair and balanced. There is a clear, strong consensus that the current reporting protocols do not do the job. In the opinion of a number of interviewees, the current reporting requirements are purely transactional, with the monthly reports disappearing into a “black hole”.

The Alberta primary care community appears prepared to work with government and AHS to provide meaningful reporting out on the key metrics of success. But they also need benchmarks and want to create positive feedback loops as part of an increased overall priority on continuous quality improvement. (See Appendix B for an example of five key result areas that have helped focus the National Health Service in the United Kingdom to focus its primary care reform agenda.)


\textsuperscript{24} Reay et al. (2012), p. 5.

\textsuperscript{25} Hollander et al. (2009).


\textsuperscript{27} Ibid, p. 35.
Recognizing the need to set benchmarks and compare performance PCNs have proceeded under the auspices of the Primary Care Alliance (PCA) with developing their own data sharing agreement. It took over a year to build the trust necessary to garner broad-based agreement on what would be collected in common and what would be shared with what level of anonymity. This data sharing agreement is just about to get started and is clearly something to build on for the future as part of an overall PHC strategy for the province.

**Family Care Clinics (Pilots):** Early in 2012, the Government announced the creation of three pilot Family Care Clinics to address clear and compelling needs in each of the three communities: Slave Lake; East Edmonton; and East Calgary. Each were identified, according to a robust community needs assessment tool, as areas of compelling need.

Based on two site visits, we were very impressed with both the energy and enthusiasm the leaders were bringing to the task. All were experienced in primary care and more importantly had led major change initiatives before. The two FCCs in Calgary and Edmonton are quite different in terms of physical facilities, staff complement, patient pools they serve, etc. The East Edmonton FCC, for example, had been in the planning/building phase for close to 10 years as was repurposed. The East Calgary FCC was also repurposed, but was less than 10 months in development. We did not have an opportunity to do a site visit of the Slave Lake FCC, but it too had a very short runway in terms of need to get it up and running because of the devastating fire in that community.

Given that the three pilot FCCs have only been in operation for a few months, it is impossible to fully assess how well they are doing. That said, there are some early positive signs of progress that include:

- a significant drop in ED visits and hospitalizations (e.g. 20% in Slave Lake);
- a reduction in wait times, with same day access (as measured by third-next available appointment) in 2 of the 3 FCCs;
- an increase in the number of rostered or attached patients (e.g. increased by 1950 in East Edmonton and by 1600 in East Calgary); and
- Improved integration of local services (East Calgary).

Based on the interviews, there are also some key takeaways in terms of what to do (and what not to do) that may help in terms of the deployment of what is billed as the first “wave” of FCCs. These include:

- beware of unintended consequences in terms of souring professional relationships and in terms of the potential to bid up locum hourly fees (e.g. from $145 to $200 for off-hours in Calgary);
- be open and transparent in terms of the process for selecting FCC sites;
- ensure that that the composite community needs index being developed by/for Alberta Health is applied in an open and transparent way;
- engage the community of patients at every step in the process; and work to ensure positive working relationships or affiliation with the local PCNs to avoid the perception/reality of competing for patients; and
- be flexible in terms of approach and timetable, establishing benchmarks from the beginning and evaluating and adjusting as you go along (e.g. adjusting hours of service).

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28 Presentation by Dr. Richard Lewanczuk at September 24, 2012 Advisory Committee meeting.
On another front, we also confirmed that there is a great potential for economies of scale on back office functions (e.g. bulk buying of interpreters and supporting integrated IM/IT systems).

**Other Jurisdictions:** Other jurisdictions have experiences that might assist in creating, not just managing the change process. In terms of key indicators of access and quality of care, the literature points to relative successes in British Columbia, Ontario and Quebec. Both New Brunswick and Saskatchewan have recently announced major primary health care initiatives that warrant scrutiny.

The jurisdictions that appears to be most applicable to the Alberta process are Ontario, because of its experimentation over time with different primary care models (i.e. application of the “Plan, Do, Study, Act” ...or PDSA approach) and British Columbia because of the degree to which authorities and accountabilities have been truly decentralized to the regional authorities (or, in Alberta’s case, the regional authority).

Like PCNs, Family Health Teams were implemented in 2005. Unlike PCNs, which are physician-led in all cases, FHTs can be either family physician led, community led or be of mixed governance.

FHTs were created with the goals to improve primary care access, improve quality and continuing of care, and increase cost-effectiveness. FHTs roster/enroll patients directly to a specific family physician. Physician funding in FHTs is primarily blended capitation (but it some cases it is directly to the FHT through blended salary) through Family Health Organization (FHOs) or Family Health Networks (FHNs). FHOs and FHNs are very similar and physicians must be in one of these models to be affiliated with a FHT.

According to one recent study, there are 170 FHTs serving nearly 2 million Ontarians. Typically each FHT has one FHO/FHN within it. Blended capitation provides a base payment (age and sex adjusted) per patient plus incentives/bonuses for immunizations, PAP smears, etc. Depending on multiple factors, FHTs can be large or small, and they deliver primary care through an interdisciplinary team of allied health professionals that usually work with family physicians. The team’s composition depends on the needs of the population but are normally composed of a RN/RPN, pharmacist, dietician, and mental health counsellor (physiotherapy is not included and the odd FHT will have an occupational therapist). Physician assistants are being introduced into the team structure.

Physicians in FHTs are supposed to provide same day access (although this is not always the case) and after hours coverage (including use of the Telephone Health Advisory Service). The Ontario Telemedicine Network (OTN) provides two-way videoconferencing and has been very useful for connecting FHTs to other specialists’ services that may not exist within a community, provider education, and team meetings.

**Overall Assessment of Current State:** Primary care reforms for Alberta are foundational to overall healthcare system performance. The key strengths of the current Alberta PHC system include:

- Alberta is among the most active provinces (along with BC and Nova Scotia) in implementing formal patient self management and patient education programs;
- Alberta is moving to integrated electronic health records (with the consolidation of IM/IT systems under Alberta Health Services);

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29 Aggarwall and Hutchison (2012).
Alberta has introduced quality improvement programs (including Access Improvement Measures or AIM collaboratives);

Alberta has a committed, well trained primary care provider community willing to try enhanced models of care delivery that provide more patient and family centred care.

Alberta is already relatively well-endowed in terms of FP's per capita (in 2010, Alberta had 109 FP's per 100,000 population higher than the Canadian average of 103) and more family physicians and nurse practitioners are being trained; and

Alberta has introduced progressive legislative changes that permit a broader range of health professionals, pharmacists, nurses and others to work to expanded scopes of practice (e.g. permitting NPs to do differential diagnoses).

Some of the key areas of concern include:

- Inability or unwillingness to recognize that no single funding or payment method “holds the key to transforming primary health care”. Alberta ranks well behind all other jurisdictions in Canada in terms of moving to more blended or alternative payment plans for physicians (accounting for just 17% of total physicians’ earnings according to most recent CIHI data).

- There is no single “right” model for the funding, organization and delivery of primary health care. Different models have different strengths and weaknesses and may perform better or worse in different contexts.

- There is a need to clarify or update the original terms and conditions of engagement of PCNs with the objective of improving overall governance/accountability and “taking PCNs to the next level” in terms of deepening and broadening access to the broader range of health and social services: i.e. spawning the “next generation” of primary care models across Canada.

- While it is estimated by some that up to 70% of physicians use some form of electronic records, Alberta lags well behind other jurisdictions in terms of moving toward interoperable/portable EMRs. This system is described by some as “a mess” and in need of urgent attention.

- There are concerns around how horizontal integration of “stepped up” PCNs and FCCs will be coordinated with the rapidly emerging vertical integration of referral services under Strategic Clinical Network. Effective primary care reform is seen as “foundational” to the success of the SCNs and needs to be fully integrated at the zone-level through “Zone Integrated Plans” or “ZIPs”.

- In contrast to other jurisdictions such as Ontario, PCNs are exclusively physician-led. This is seen as a serious limitation by Alberta Health and by the other health professions.

On balance, Alberta currently has a strong primary health care platform and a number of other attributes upon which to make a good system better, provided it can deal with the areas concern that have been identified.

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34 Hutchison et al. (2011).
Preferred Future State: A home in the health care system for every Albertan

The emerging consensus on the preferred **Future State** for Alberta’s primary care system can be described as follows:

Overall, there is a **strong consensus** that Alberta can and must do better in terms of delivering high quality, accessible primary care services. FFCs can play a critical, but complementary role in taking the primary care system to “another level” in terms of improving access to a broader, more integrated range of health and social services. That said, they need to be “embedded” in the broader context of a province-wide primary (health) care strategy.

A preferred future state would see the Government having articulated a clear, compelling vision statement, based on **Triple Aim objectives of**: better health, better care, and better value. Primary care reform is a means to a series of ends, including very importantly reducing the rising pressures on the acute care system by reducing unnecessary hospitalizations and emergency department visits.

The deployment of Family Care Clinics will have been undertaken in a step-by-step, evidence/needs based transparent process as part of a comprehensive, multi-year plan for achieving the objective of “every Albertan having a home in the health system”.

Specifically, in the preferred future state, the FCC initiative would be part of a multiyear, integrated primary care strategy with zone-level, PHC “charters” setting out clear authorities and accountabilities in order to enhance access to core services (see below) and implement continuous overall quality improvement. This emphasis on overall quality is key.

“Quality is to be defined and depends on whether one assesses only the performance of practitioners or also the contributions of patients and of the health care system; on how broadly health and responsibility for health are defined; on whether the maximally effective or optimally effective care is sought; and on whether individual or social preferences define the optimum. We also need detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care.”

A culture of collaborative care would be well established, reflecting the increased priority placed on leadership development and good governance. There were many references to the need to open up or improve the overall governance of PNCs as Alberta moves to a FCC primary care platform.

In this context, governance refers to:

“... the frameworks that outline the responsibilities, structures, processes, and organizational traditions that a body uses to ensure an organization achieves its goals. Roles, responsibilities, and processes for decision-making, stakeholder engagement, and accountability that are useful for establishing organizational values, purpose, and strategic direction are key components of governance. Primary health care frameworks need to consider governance in three strategic areas: corporate governance, clinical governance, and community engagement”.

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In terms of oversight, the Minister would meet quarterly with his Primary Care Advisory Committee. This “constituency forum” would need, however, to be complemented by Primary Health Care Strategy Group comprised of independent experts in and/or champions for primary health care. It would meet at least once annually and more frequently at the call of the chair (the Minister).

Both the Advisory Committee and the Strategy Group would be supported by a dedicated Primary Care Secretariat, which would be led by a dedicated Assistant Deputy Minister from Alberta Health. It would have delegated authority from the Minister of Health on policy matters and be responsible for plan implementation and for operational decisions in connection with, for example: determining FCC designation; negotiating and administering FCC agreements with PCNs in relation to “stepped up” PCN clinics or community groups ready to form qualifying FCCs; and making all management decisions.

Zone-based “Primary Care Partnerships” would be established with broad based representation of stakeholder groups (including lay representatives), with a mandate to assist the Minister’s Strategy Group (e.g. strategic planning; sounding board) and support the PHC Secretariat or “Trust” (e.g. community outreach/networking).

**Family Care Clinics: Concept in brief**

One of the specific deliverables of this project is to assess the findings of the synthesis of the literature and the key informant interviews and to clarify how Family Care Clinics would function and how they would relate to current fully functioning or “surging ahead” Primary Care Networks or PCN-clinics.

For purposes of this Issue Brief, we defined FCCs as follows:

> Family Care Clinics are: local, team-based primary health care delivery programs that provide individual and family-based primary healthcare services aligned with the needs of their community. They are intended to complement existing primary care programs such as many of the current Primary Health Networks and the emerging Strategic Clinical Networks.

There is an emerging consensus that FCCs should build on rather than replace PCNs that are working well to provide access to a broad range of health benefits to Albertans through interdisciplinary teams, but now need to look at “taking the concept to the next level”. What does the “next level” look like? For many, designated FCCs will provide a broader range of core health and social services, will co-locate where possible, will be funded in a manner consistent with promoting partnership in primary care (i.e. modified capitation methods), operate using an interoperable, portable information technology platform, and will be encouraged and incentivized to adapt or modify ancillary service offerings to meet local community needs/priorities. FCCs will be evaluated constantly in the spirit of the PDSA approach. They will report periodically and adhere to a philosophy of continuous quality improvement.

Family Care Clinics would share the following key attributes or characteristics:

- A governance model in keeping with best practices (including providing for “patients’ voice”);
- Capitation-based funding as core funding model (with performance enhancements through local ARPs);
Formal patient attachment (with negation);
Multidisciplinary teams that meet or beat minimum critical mass standards;
Provision of a broad set of core services in a co-located or proximate common space;
Integration/coordination both vertically (with SCNs) and horizontally (i.e. service agreements or understandings with current PCNs);
Access initiatives to specifically address unattached patients, 24/7, TTNA (Time to third next available appointment or advanced access)...and geographic issues/underserviced areas (e.g. “stepped up” telemedicine program à la Ontario and/or FCC mobile or FCC “lite”).

The Primary Health Care system of the future would include enhanced data sharing both across FCCs for continuous improvement and with the public, with an expanded role for Health Quality Council. The coordination of PHC services would ensure seamless, safe transitions from one level of care to the other. In the Alberta context this means “connecting the dots” between primary healthcare reform, FCC formation and the ongoing work to implement Strategic Clinical Networks (SCNs). Without an effective primary healthcare strategy, “SCNs will fail and failure is not an option...every SCN should help every Albertan have an identified primary care ‘home’ in the community – where prevention strategies are implemented and where uncomplicated episodic care and chronic care is managed”. 38 The preferred future state would provide for continuity of care that aligns primary healthcare services between PCNs, FCCs and AHS; that provides for continuity of care.39

Based on an emerging consensus across the country, model FCCs should provide (or provide for) the following core PHC services:
- basic ambulatory care;
- complex care;
- health promotion for individuals and families;
- mental health and addictions;
- screening and disease prevention (including chronic diseases);
- geriatric care; and
- child and maternal health care.

A key challenge in terms of setting out required core services is to ensure that the “bar” is not set so high as to preclude or dissuade groups seeking the FCC designation or so low as to not meet the overall FCC policy goals and objectives. Another key consideration is to allow for, indeed promote aligning resources in keeping with local health needs (e.g. some communities requiring stepped up geriatric or palliative care programs while other, younger communities may require stronger child and maternal health programs).

Quality of care involves meeting the needs of the patients (and their families) in a safe, effective and timely way for each and every core service being provided by the FCC. This requires upfront and ongoing training and ongoing support for quality improvement. Underpinning this is the work of the Health Quality Council of Alberta (HQCA) and the roles of the professional regulatory bodies. This ties in

with the need for tracking of key indicators over time and to address the concern registered by many interviewees that the current reports provide little or no feedback to PCNs to help them improve.

In the preferred future, Alberta would have adopted a “one patient, one record” EMR system that is interoperable/compatible with EHR system operated by AHS, with one time financial grants available to help those PCN clinics to help them migrate their IM/IT systems to the common EMR platform.

Continuous quality improvement would be supported by an integrated PCN/ FCC data sharing agreement and evaluation strategy. This information and evaluation strategy would be administered by the Health Quality Council of Alberta and would provide ongoing evaluation and feedback.

In terms of remunerating providers, provider compensation policy would be aligned with overall health system goals, with a reduced reliance on fee-for-service and the attendant challenges of reducing what one physician called the “hot potato patients”...those complicated cases that the fee schedule cannot deal with fairly. There would be a commensurate increased reliance on (modified) capitation systems and blended compensation systems as they promote primary care partnerships and more of focus on the needs of patients and their families.

Finally, in keeping with the overall Triple Aim framework, the future state of Alberta’s integrated PHC system is intended to provide better value as well as better health and better healthcare. This involves improved efficiency and effectiveness:

- **Efficiency** involves striking the right balance in terms of allocating available the new resources for FCCs ($75 million in the current fiscal year and growing over time) in a way that will generate the highest returns in terms of health outputs. This would, for example, involve entering into service agreements to ensure appropriate levels of care are provided. Creating a “home” for every Albertan in the health care system should not only reduce demands on the secondary and tertiary care but it should also minimize the patient’s direct and indirect (opportunity) costs of time spent in seeking/receiving treatment.

- **Effectiveness** in terms of health indicators would involve tracking the performance of PCNs and FCCs overtime according to a standard sets or a dashboard of common indicators. It is acknowledged that improvements in overall health status, but sentinel indicators (e.g. wait times or smoking rates) can be affected in the short run and should be monitored and evaluated.

- **Equity** involves taking steps to level the access and health outcomes health playing field between rural and urban parts of the province and between the majority of Albertans and those Albertans who may not have a home of any kind, never mind a home in the health care system. There is a strong consensus among interviewees that FCCs should first help those most in need...rural/remote Albertans and semi-urban/urban concentrations of the homeless population, mentally ill, and members of the aboriginal community. Again, the narrowing of health inequalities across socio-economic groups or across regions will take any number of years but needs to be monitored and evaluated.
Implementation Considerations: Change is a process, not an event\textsuperscript{40}.

\begin{quote}
\textit{Everybody likes progress, it’s the changes they don’t like.}
Will Rogers
\end{quote}

Different models of change abound, with various tools, techniques and instruments that assist in creating change.\textsuperscript{41} What is clear from recent research\textsuperscript{42} is that the approach taken to system or organizational-level change is neither fixed nor linear. It is increasingly being recognized that health leaders are expected to create change, not just to managing it. And, as indicated previously, that change is a process, not an event. Based on the interviews, the biggest impediments to change are system inertia, uncertainty and a worry from the community that FCCs are just another fad to be replaced in short order by the next flavour of the month.

Culture is very important. Creating a caring, collaborative PHC team culture will take time. The work by Reay et al. underscores the fact that successful primary health care innovation is often accomplished behind the scenes.\textsuperscript{43} More generally, the literature supports this and the fact that “the magic of the informal often trumps the logic of the formal”\textsuperscript{44}.

A review of the recent experience of PCNs observes that actual practices “show that in settings where work routines are deeply embedded in highly institutionalized contexts such as health care, change agents at the frontline achieve desired outcomes not through open arguments but instead through under-the-radar activities that gradually legitimize new practices without scrutiny by elite and powerful stakeholders”…concluding that “…gaining agreement of all key stakeholders is not always the most effective way to legitimize new practices”\textsuperscript{45}.

Specifically, in the Alberta context the change process would need to: overcome the considerable obstacles to engaging physicians and other clinicians in the change process; re-engage the public in an early, ongoing and meaningful dialogue about PHC reform, including what’s “in it for them” in terms of patients engagement; deal with the issues around horizontal and vertical integration of specialty care services and primary health care; and be clear about the authorities and accountabilities for PHC reform.

There is a need to see change as a step by step change creating local opportunities for adaptation and innovation, one of the true innovations that accompanied the advent of PCNs in 2005.

Finally, there is a need to overcome the combined forces of change fatigue and cynicism.

Many described wide-spread “change fatigue”. One interviewee observed that there have been two Ministers, two Deputy Ministers and two Presidents of the AMA in the past two years alone”. Hence, the need for a clear, longer-term, overarching, PHC strategic plan and then a commitment to “ride that horse for a while”.

\textsuperscript{40} Dickson et al. (2012).
\textsuperscript{41} Ibid.
\textsuperscript{42} Ibid.
\textsuperscript{43} Reay et al. (2012)
\textsuperscript{45} Reay et al. (2012).
Moving from the current state to a preferred future state involves adopting a model of change that is open, transparent and accountable. In this context, it is worth repeating that change management needs to be seen as a process, not an event: Not, as one interviewee put it “just another political box to be checked off”.

**Three Stream Conceptual Model for FCC Deployment:** Moving from the current to the preferred future state of PHC would see Family Care Clinics being afforded special designation with additional strategic funding. There would be three, non mutually exclusive and indeed reinforcing pathways or streams to receiving FCC designation/funding (see Figure 1 below):

*Stream A:* Fully functioning PCNs or PCN clinics are invited to extend their offerings in return for FCC designation and additional funding. A clear set of eligibility criteria would be established such as extended service offerings (hours, breadth of services); previous participation in AIM Collaboratives; minimum panel sizes, etc. These criteria would be developed as part of the overall strategic plan and in consultation with the primary care stakeholders via the Ministerial Advisory Committee;

*Stream B:* Alberta Health identifies areas of high, unmet primary care needs according to the composite measure of community health needs that has been developed and then, after consultations with the communities involved and based on the recommendations coming out of the PHC Secretariat, Alberta Health Services is directed to form/operate FCCs; and

*Stream C:* Compelling, innovative community-initiated applications for FCC designation would be entertained or solicited. This could certainly include proposals for non-physician led FCCs or proposals coming from the aboriginal community that reflect different customs or cultures.

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![Figure 1: FCC Deployment Framework](image-url)
All FCC designations would be subject to ongoing evaluation against agreed-upon benchmark metrics and be subject to regular Accreditation Canada assessments (on a three year cycle).

FCCs would be funded primarily on a modified capitation basis and would agree to provide a set of core services and to promote partnership in primary care. Additional annual or multi-year grants are available to meet higher needs (e.g. higher prevalence of co-morbidities or mental health and additions in the catchment area). Developmental grants would be available to: assist community-based groups in developing FCC proposal (and business plans); provide leadership development training and to support the development of good governance practices (for not-for-profit FCCs); to support broad-based board representation from other health professions and from the “patient’s voice”.

The model of change suggested here will require that the urgency of the policy change be re-affirmed repeatedly and clearly. It would be undertaken through an open, ongoing, transparent, inclusive and collaborative process that involves working through and with existing PCNs and through/with the broader clinical community.

The change process needs to emphasize that this is a ongoing process of making a good system better. Short term wins are possible because of a number of existing PHC system strengths including:

- a strong base of physical infrastructure support for primary healthcare delivery systems...in many cases as a result of private investments in buildings and equipment...because original tripartite agreement did not provide for capital funding;
- well-trained cadre of committed healthcare professionals...unlike many other jurisdictions, family physicians comprise about 50% of the physician workforce...with about 3/4 reporting being in a group or inter-professional practice; and
- a commitment to streamline referral processes through the continued rolling out of Strategic Clinical Networks or SCNs.

Strategic Clinical Networks (SCNs) are the mechanism through which Alberta Health Services plans to empower and support physicians and clinical leaders in AHS and in the community to develop and implement evidence-based, clinician-led, team-delivered health improvement strategies across Alberta.

This issue brief and key informant interviews both suggest the following additional challenges around making a good system better through the introduction of the FCC model.

- Balancing the forces of inertia, complacency and cynicism on the one hand and the demonstrating the urgency for and commitment to change on the other.
- Overcoming the lack of consultations to date around FCCs and the anxiety throughout the community.
- Addressing the ambiguity around the relationship between FCCs and PCNs and their respective funding and governance.

Summing Up: Creating the “winning conditions” for primary care reform

This evidence brief and key informant interviews suggest there is an opportunity to leverage the current strengths of Alberta’s primary care system to deliver on the promise of providing every Albertan with a home in the healthcare system by 2016. This work also underscores the need to move forward with the primary health care reform agenda. “Access to health care is the most important issue in determining Albertans’ satisfaction with the health care system, but only 48% of Albertans currently report access to healthcare services as easy”\(^47\).

There is no need to “blow up” the current system or “reinvent the wheel”. There are important lessons to be learned from the positive experience with most Primary Health Care Networks, which in the opinion of most is a solid building block for the future. There are also important lessons to be learned from other jurisdictions, especially those of Ontario and British Columbia around the ongoing process of change.

All of these lessons, however, point to the fact that no one system of primary care can meet all the needs of every Albertan. Different approaches will need to be tried and evaluated through a concerted Plan Do Study Act (PDSA) process. This will not be easy, as primary health care involves complex adaptive systems requiring complex adaptive leadership approaches.

While the details need to be worked out and there are many unknowns and uncertainties, as Hutchison et al. (2011) point out:

“A culture of change in primary health care is gathering force… the general shape of transformed primary health care is becoming clear. The renewed system will offer interprofessional team-based care, multi-component funding and payment arrangements, enrollment of patients, ongoing performance measurement and quality improvement processes”\(^48\).

Alberta has the opportunity to seize the moment and show the way for other provinces. It can be the “beacon” for primary health care reform agenda for all of Canada.

\(^47\) Government of Alberta (2012a)  
\(^48\) Hutchison et al. (2011) p. 282.
References


### Appendix A: Comparison of Provinces and Territories on Features of a High Performing Primary Care System

<table>
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<th>Feature</th>
<th>British Columbia</th>
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<tr>
<td>% of GPs/FPs that report using only EMR or a combination of EMR and paper charts</td>
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<td>Ongoing performance measurement</td>
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<td>Training and support for quality improvement</td>
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<td>Feature</td>
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<td>Saskatchewan</td>
<td>Manitoba</td>
<td>Ontario</td>
<td>Quebec</td>
<td>New Brunswick</td>
<td>PEI</td>
<td>Nova Scotia</td>
<td>Newfoundland &amp; Labrador</td>
<td>Yukon</td>
<td>Nunavut</td>
<td>North West Territories</td>
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<tr>
<td>Leadership development</td>
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<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>ND</td>
<td>o</td>
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<td>Coordination, integration and partnerships</td>
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<td>o</td>
<td>o</td>
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<td>x</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>x</td>
<td>x</td>
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<tr>
<td>with other health and social services</td>
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<td>Systematic evaluation of innovation</td>
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<td>x</td>
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<td>o</td>
<td></td>
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<td>ND</td>
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<td>Research capacity and productivity</td>
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<td>ND</td>
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</table>

Data presented in this table are from Hutchison et al (2011) and Strumpf et al (2012), College of Family Physicians of Canada (2010), Marchildon and Chatwood (2012), key informants and our review of published and grey literature. Data for EMR implementation was provided by key informants.

Note: X indicates widespread or system-level implementation; O indicates limited implementation (e.g., local initiatives, pilot/demonstration projects or implementation as part of a research project); an empty cell indicates no implementation; ND indicates no data are available.


- Addresses a Gap
- Triple Aim
- Patient-Centred
- Equitable Access to Health Care
- Health Promotion/Illness Prevention
- Simple to Operationalize
- Replicable across Canada
- Rural/Remote
- Multi-Stakeholder Engagement
- Commitment to a Common Purpose
- Optimizes Skills/Scopes of Practice
- Optimizes Technology
- Financial Sustainability