
Primary Care Network
CHINOOK
Primary Care: Improving Access in Alberta

# Alberta Primary Care Initiative Vision

- The Alberta Primary Care Initiative is an agreement between AHW, AMA and RHAs to:
  - Improve access to, and effectiveness of, primary care services
  - Through a collaborative, comprehensive approach
  - Entrusting local solutions to local problems

# Quality Care

*The ability for a patient to receive the care he or she wants/needs when he or she wants/needs it.*

Don Berwick

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| " The Old Paradigm" | "The New Paradigm" |
| --- | --- |
| ▪Single physician<br>▪One visit at a time (responsible for that visit only)<br>▪Focus is acute and episodic<br>▪No measurement<br>- Guidelines<br>- Outcomes<br>- Value (accountability)<br>▪High return visit rates<br>▪Low continuity of care<br>▪Follow up sporadic | ▪Physician and Team<br>▪Responsible for a patient panel (population)<br>▪Focus on:<br>- continuity<br>- optimizing visits<br>▪Same day access<br>▪Screening and surveillance<br>▪Chronic disease management<br>▪Measures of process and outcomes<br>▪Integration with specialty programs/medical specialists (service agreements)<br>▪Information system to support |

# What Do Patients Want?

- Patients want:
  - To choose their provider
  - To access their provider when they choose
  - A quality healthcare experience

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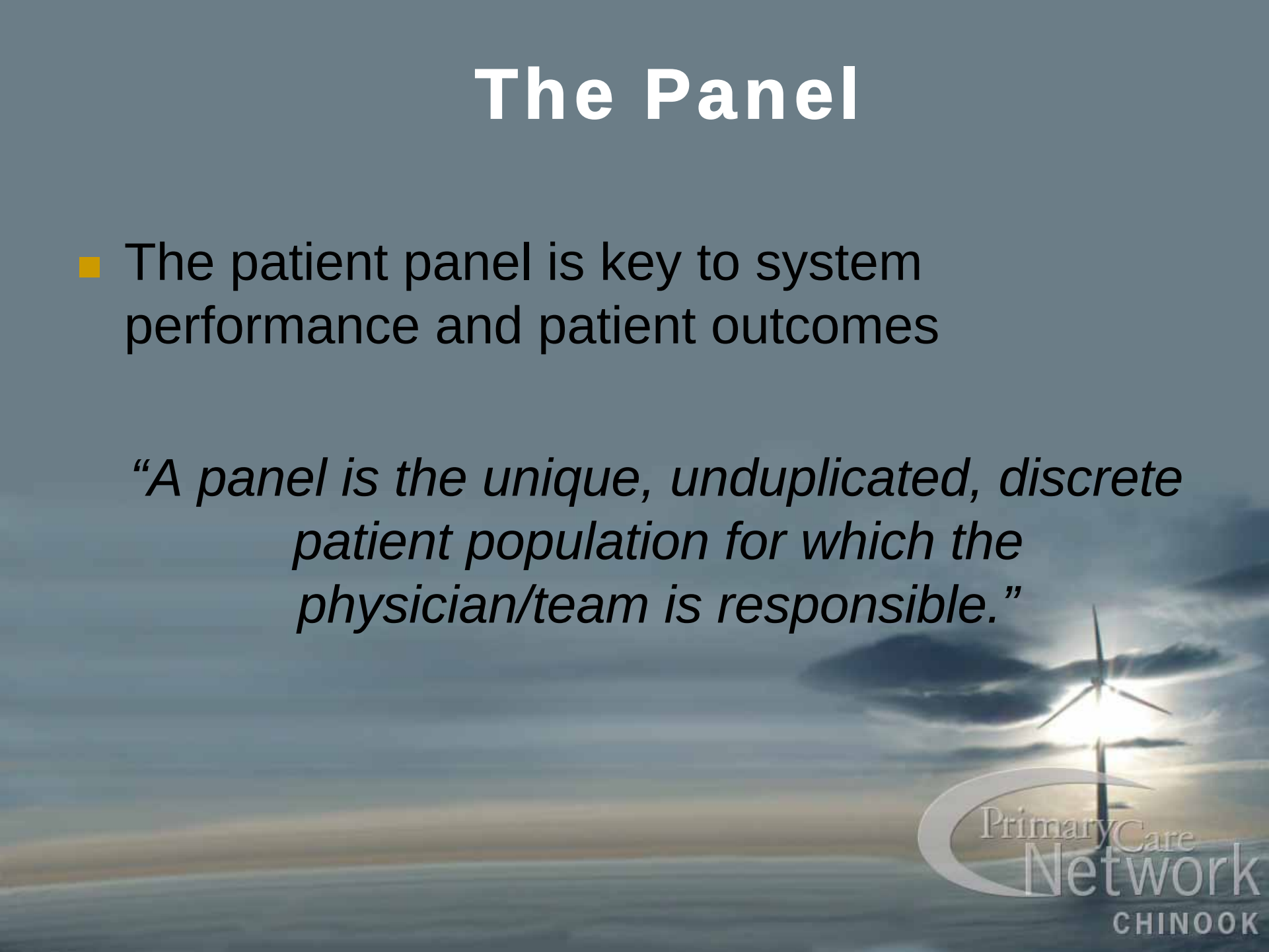
# The Panel

- The patient panel is key to system performance and patient outcomes

*"A panel is the unique, unduplicated, discrete patient population for which the physician/team is responsible."*



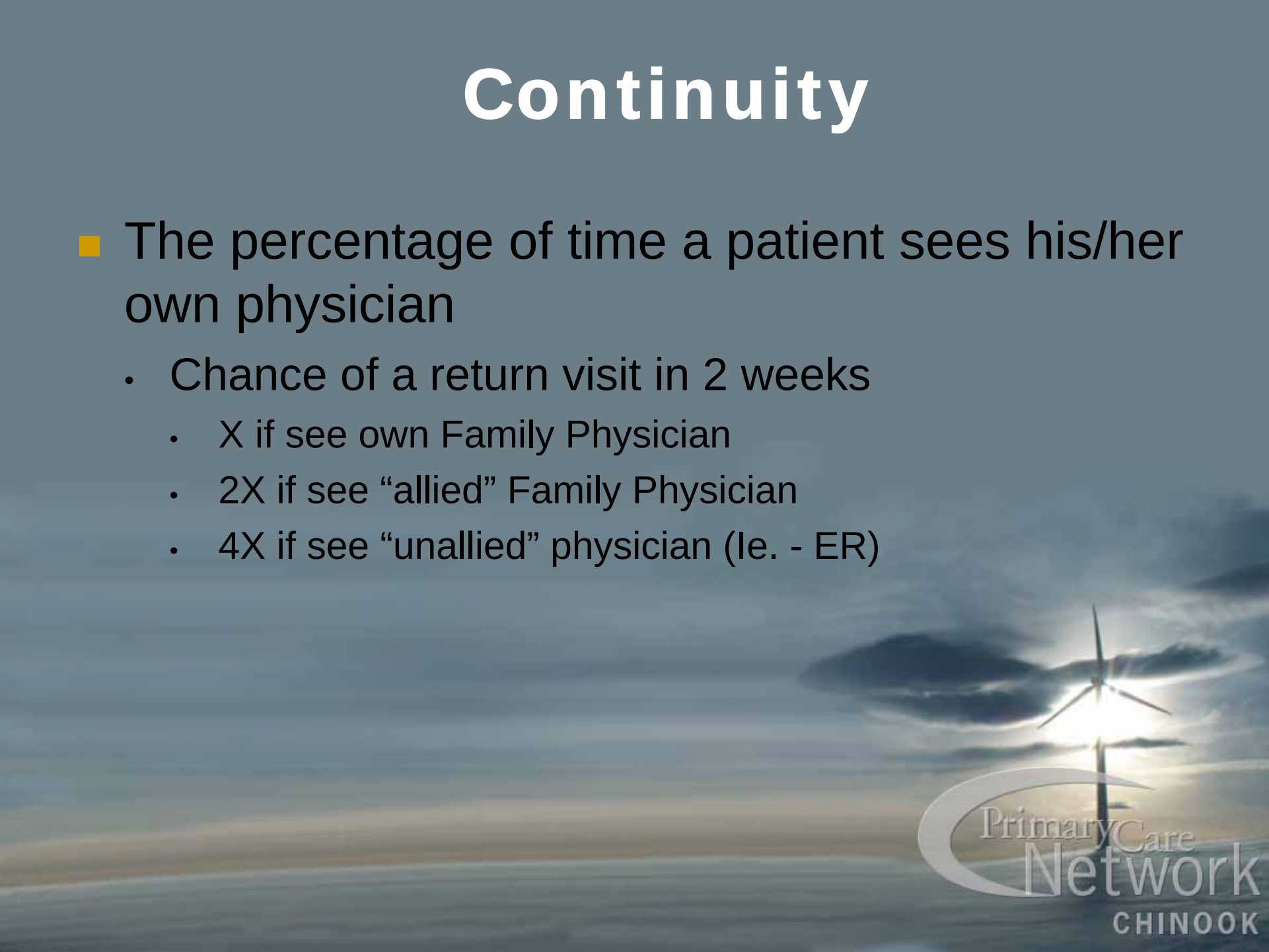
# Panel

- Unit of measure – the yardstick
- Defines work (demand) by physician/team
- Divided by patient characteristics (diabetes, depression, elderly, etc.)
- Adjusted for determinants such as age, sex
- Defines the population for which each provider is responsible and accountable
- Sum of all panels encompasses the entire population (everyone is cared for)

| Physician (FTE) | Panel (Adjusted Panel) | # of Visits by my patients to me | Return Visit Rate (Provider) | # of Visits by my patients to anyone in the clinic | Return Visit Rate (To Clinic) | Continuity Rate |
|---|---|---|---|---|---|---|
| A (1.6) | 1622 (1934) | 4244 | 2.6 | 4401 | 2.7 | 96.4% |
| B (1.0) | 1703 (1799) | 5957 | 3.5 | 6519 | 3.8 | 91.4% |
| C (2.0) | 2453 (2796) | 13773 | 5.6 | 14884 | 6.1 | 92.5% |
| D (1.2) | 1904 (2063) | 9143 | 4.8 | 10603 | 5.6 | 86.2% |
| E (1.2) | 1956 (2104) | 9733 | 5.0 | 11783 | 6.0 | 82.6% |
| F (1.7) | 2885 (3238) | 18314 | 6.3 | 22171 | 7.7 | 82.6% |
| G (0.1) | 267 (234) | 853 | 3.2 | 1055 | 4.0 | 80.9% |

# Continuity

- The percentage of time a patient sees his/her own physician
  - Chance of a return visit in 2 weeks
    - X if see own Family Physician
    - 2X if see “allied” Family Physician
    - 4X if see “unallied” physician (Ie. - ER)



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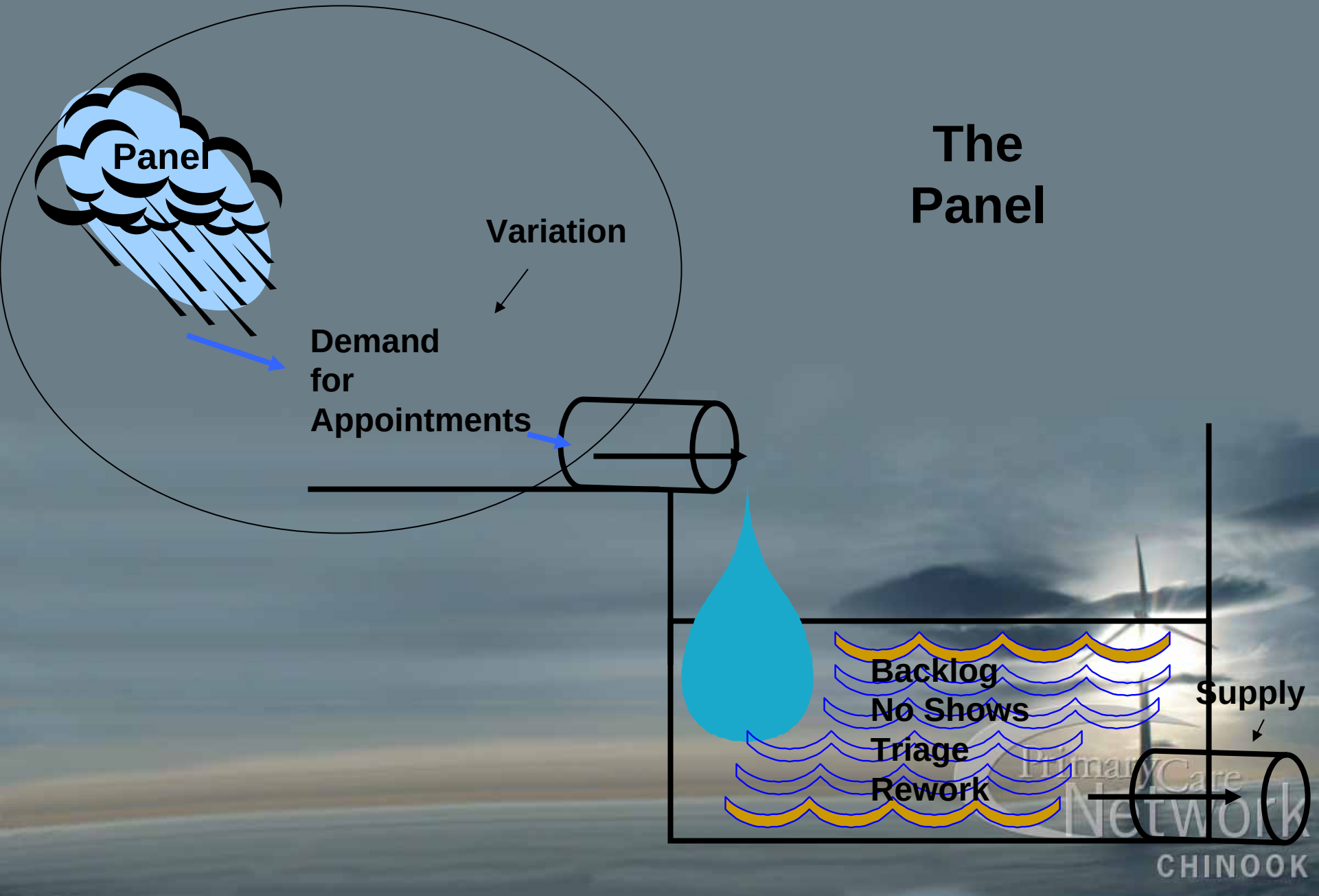
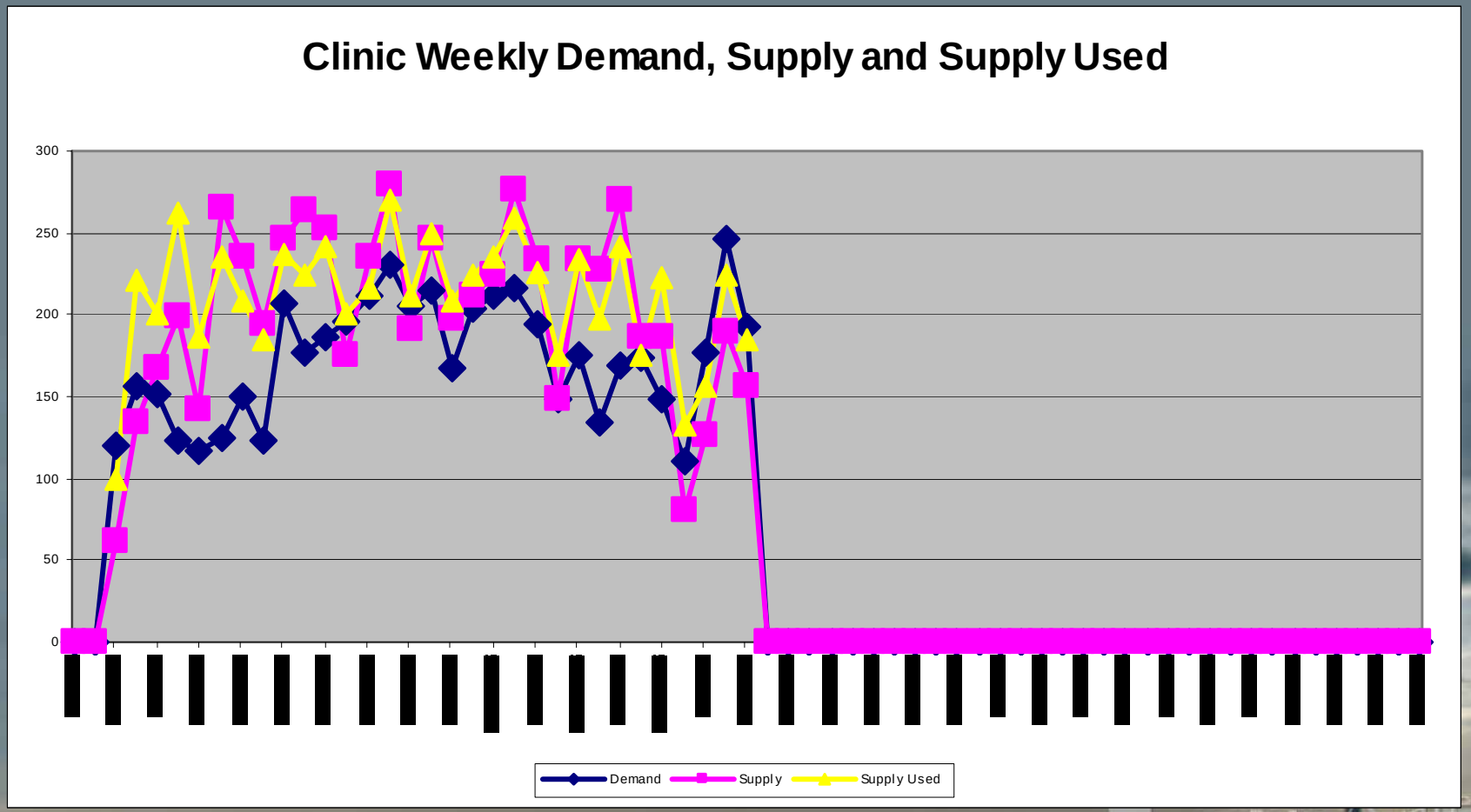
# Access: Why Focus on Delay?

- Delays cost money
- Delays adversely effect clinical outcomes
- We can only go as fast as the slowest step
- Perception that delay = lack of resource
- Delays lead to patient dissatisfaction
- Delays lead to staff dissatisfaction
- Delays lead to provider dissatisfaction

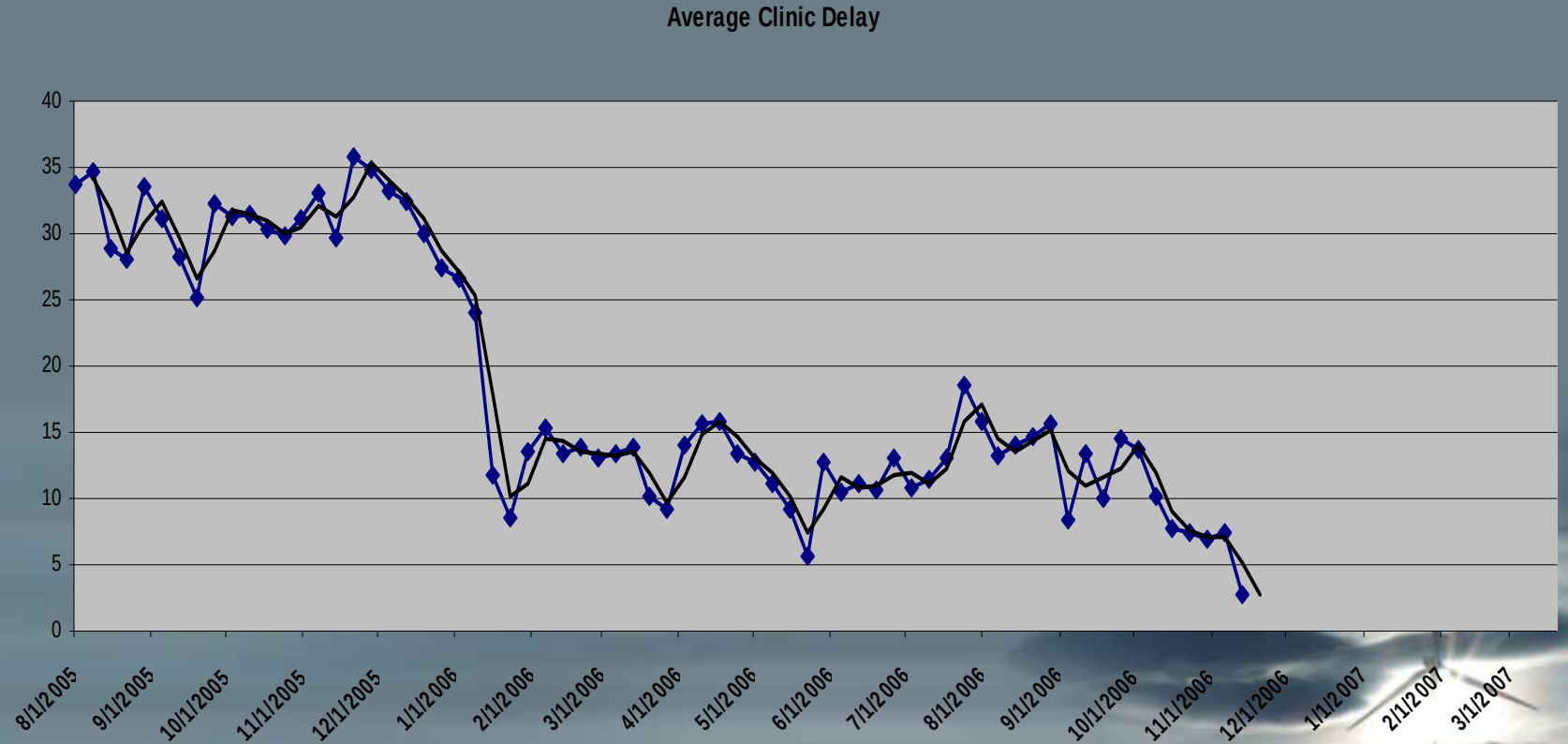
# The "Universe" From Which Demand Comes Is……



# Clinic Weekly Demand and Supply



# Time to 3rd Next Appointment

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# Results

- Patient satisfaction improved
- Staff satisfaction improved
- Provider satisfaction improved
- Delays reduced
- Continuity improved
- Quality improved
- Unnecessary visits reduced
- Increased capacity

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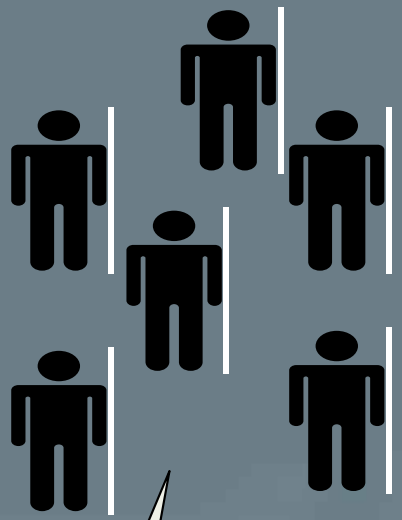
# Panel Size 2000



360 Patients are Over 65

66 have Diabetes

200 not seen

113 have Asthma

60 Patients had more than 10 Office Visits Last Year

248 have Arthritis

130 are Clinically Depressed

228 have Hypertension

160 have Heart Disease

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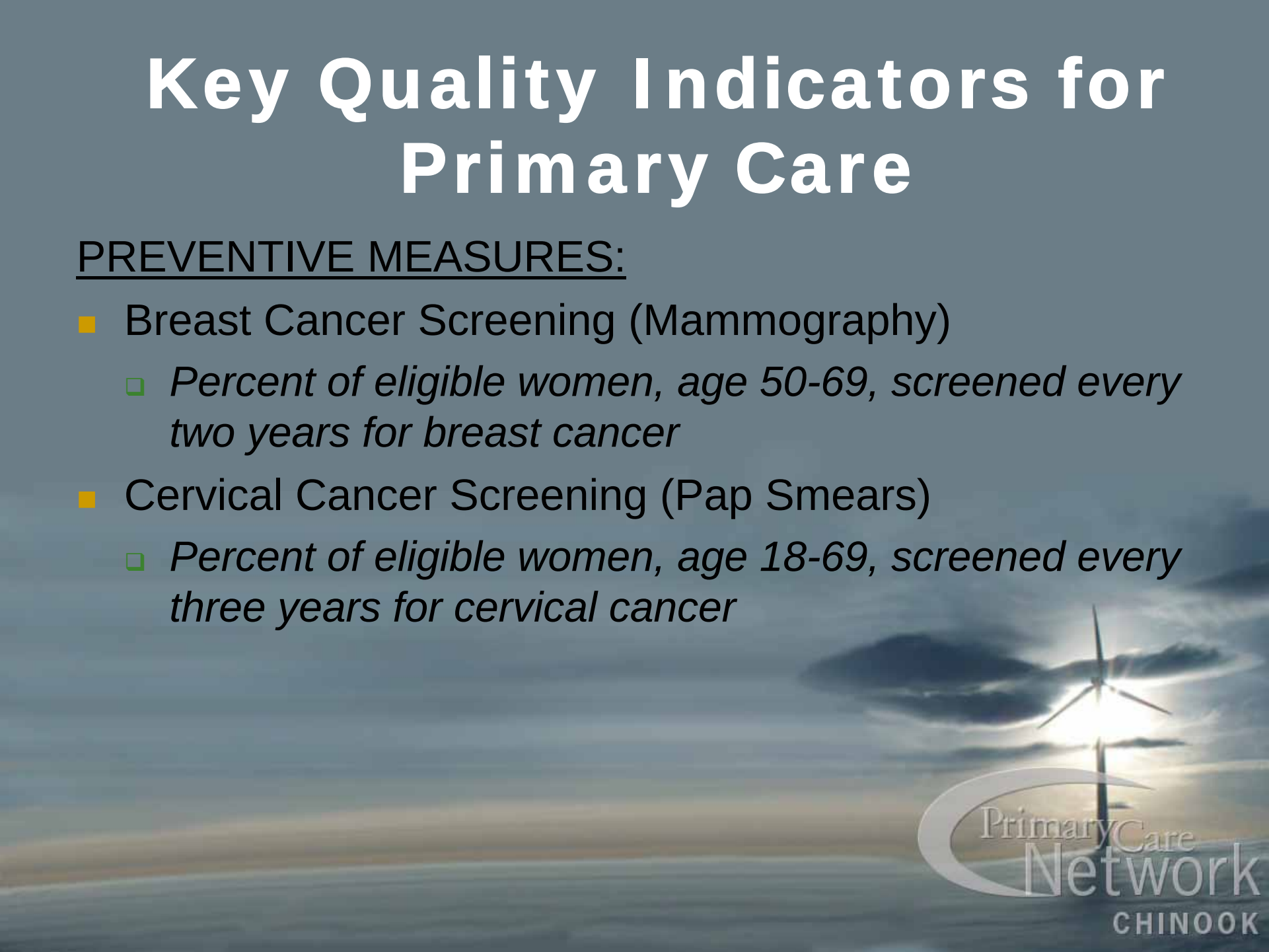
# Key Quality Indicators for Primary Care

PREVENTIVE MEASURES:

- Breast Cancer Screening (Mammography)
  - *Percent of eligible women, age 50-69, screened every two years for breast cancer*
- Cervical Cancer Screening (Pap Smears)
  - *Percent of eligible women, age 18-69, screened every three years for cervical cancer*



## PREVENTIVE MEASURES:

- Colorectal Cancer Screening
  - *Percent of eligible patients, age 50-80, who are up to date with screening for colorectal cancer (depending on personal risk, type of screening used and recommended frequencies)*
- Blood Pressure Screening and Control
  - *Percent of eligible patients who had a blood pressure reading done at the most recent clinic visit, or in the last 6 months (if BP reading was less than or equal to 140/90)*
  - *Percent of eligible patients whose most recent blood pressure (within the last 6 months) was less than or equal to 140/90*

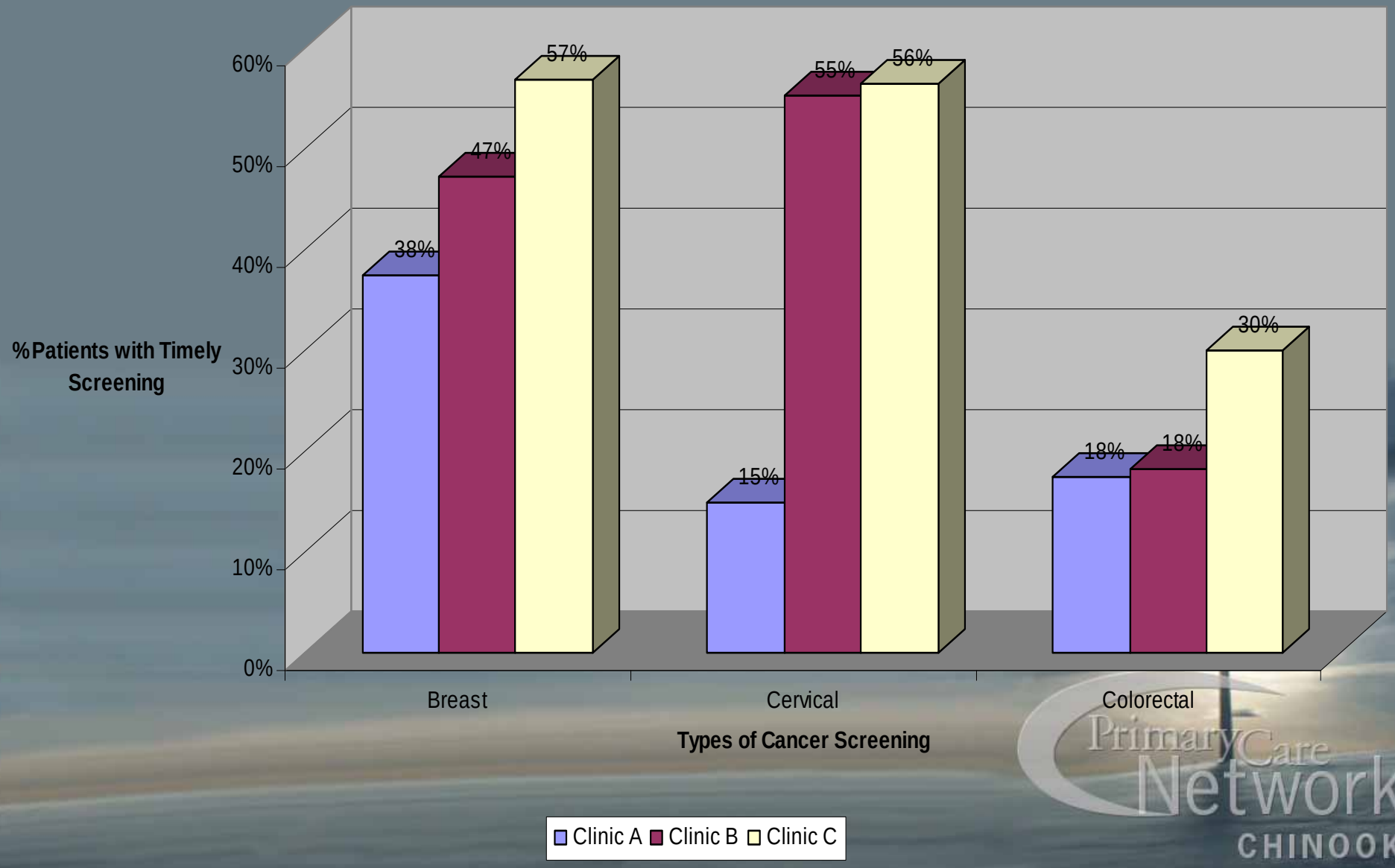
## CHRONIC DISEASE SCREENING & MANAGEMENT MEASURES:

- Diabetes HgbA1c Testing
  - *Percent of diabetic adult patients having at least one HgbA1c test done in the past 6 months*
  - *Percent of diabetic adult patients whose most recent HgbA1c reading (within last 6 months) was less than or equal to 7.0*

- IMMUNIZATION MEASURES:
- Influenza Vaccination
  - *Percent of patients, age 65 and older, who received influenza vaccination within the previous 12 months*
- Pneumococcal Vaccination
  - *Percent of patients, age 65 and older, who have received pneumonia vaccination*

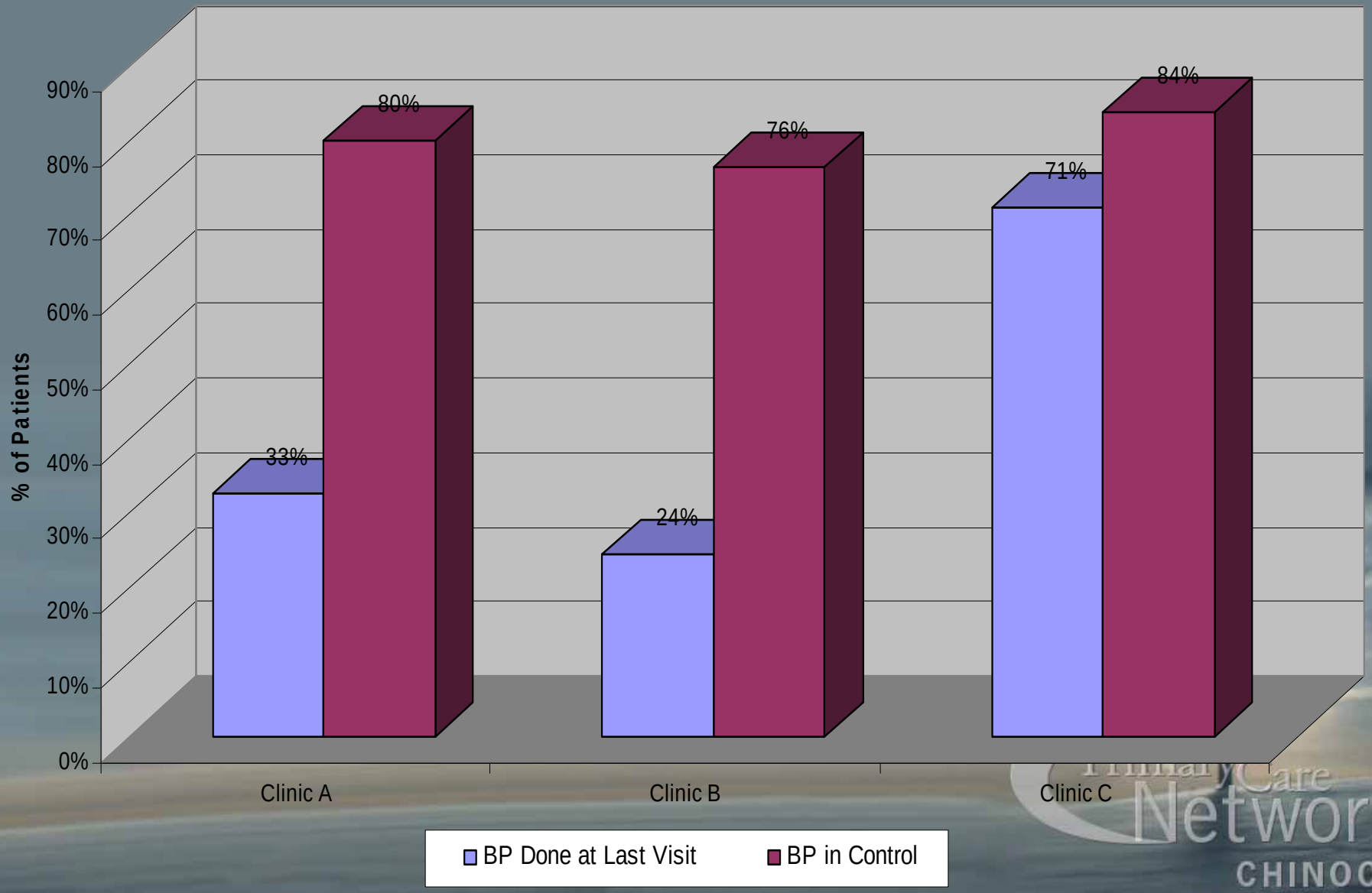
## Cancer Screening Rates

Random samples of 10 eligible patient charts per provider were pulled and reviewed for each of the below measures to determine if timely cancer screening was performed for each patient



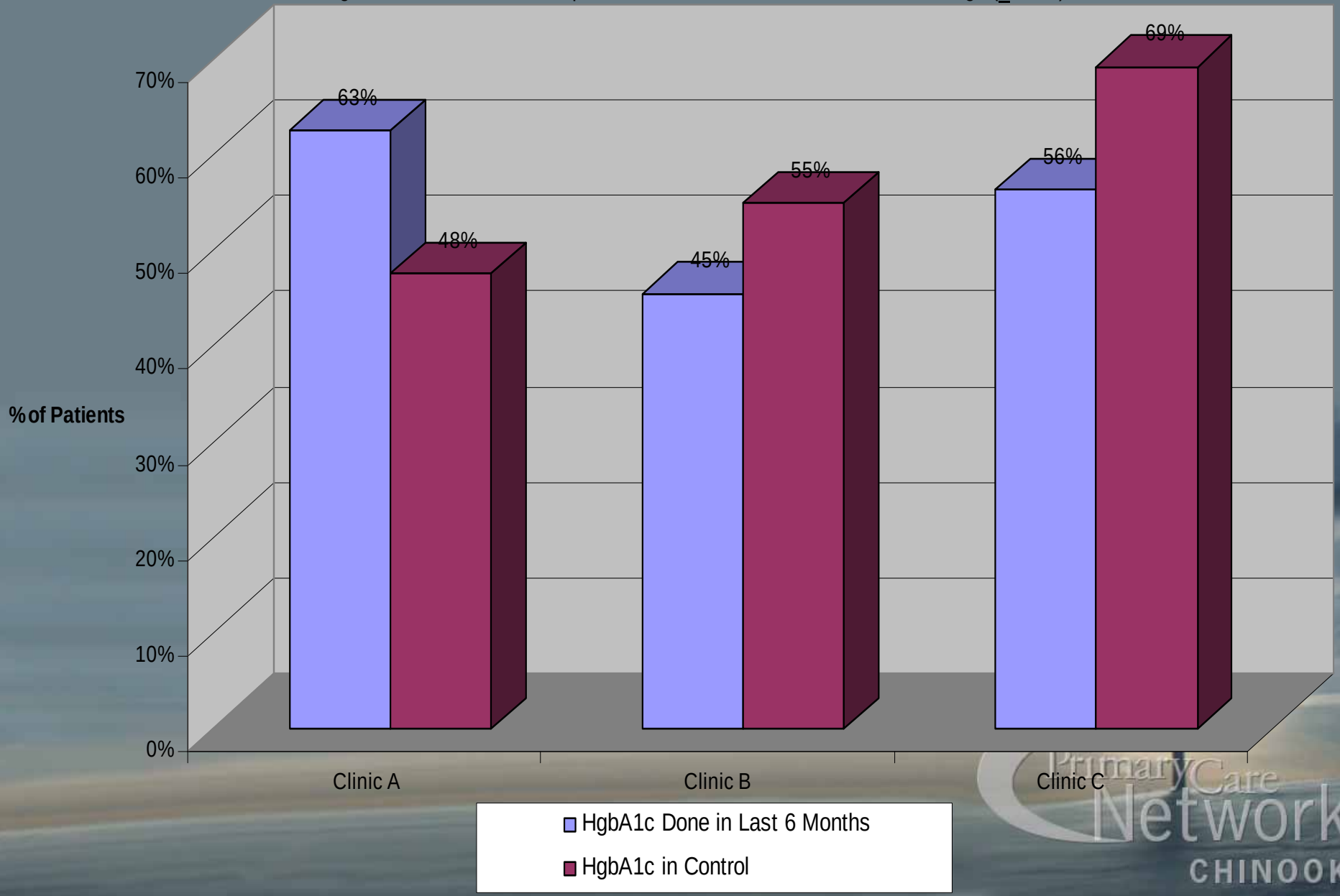
# Blood Pressure Monitoring and Outcomes

Random samples of 10 eligible patient charts per provider were pulled and reviewed to determine if BP was measured at each patient's most recent visit and if the most recent BP for each patient was normal (≤ 140/90)



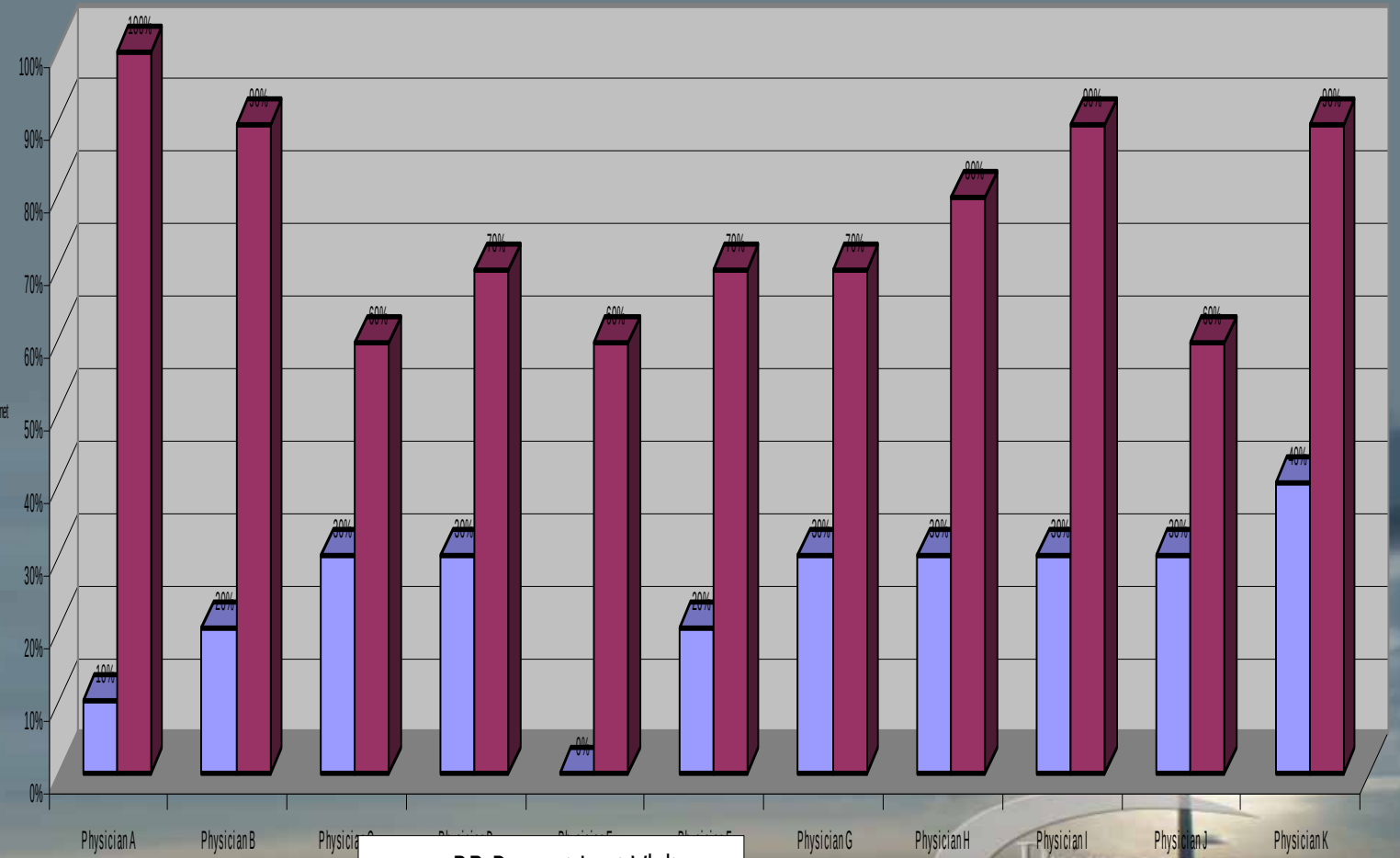
# Diabetic HgbA1c Testing and Control

Random samples of 10 eligible diabetic patient charts per provider were pulled and reviewed to determine if each patient had a HgbA1c test done within the previous 6 months and if it was in normal range (≤ 7.0%)



# Blood Pressure Monitoring and Outcomes

Random samples of 10* eligible patient charts per provider were pulled and reviewed to determine if BP was measured at each patient's most recent visit and if the most recent BP for each patient was normal (<140/90)



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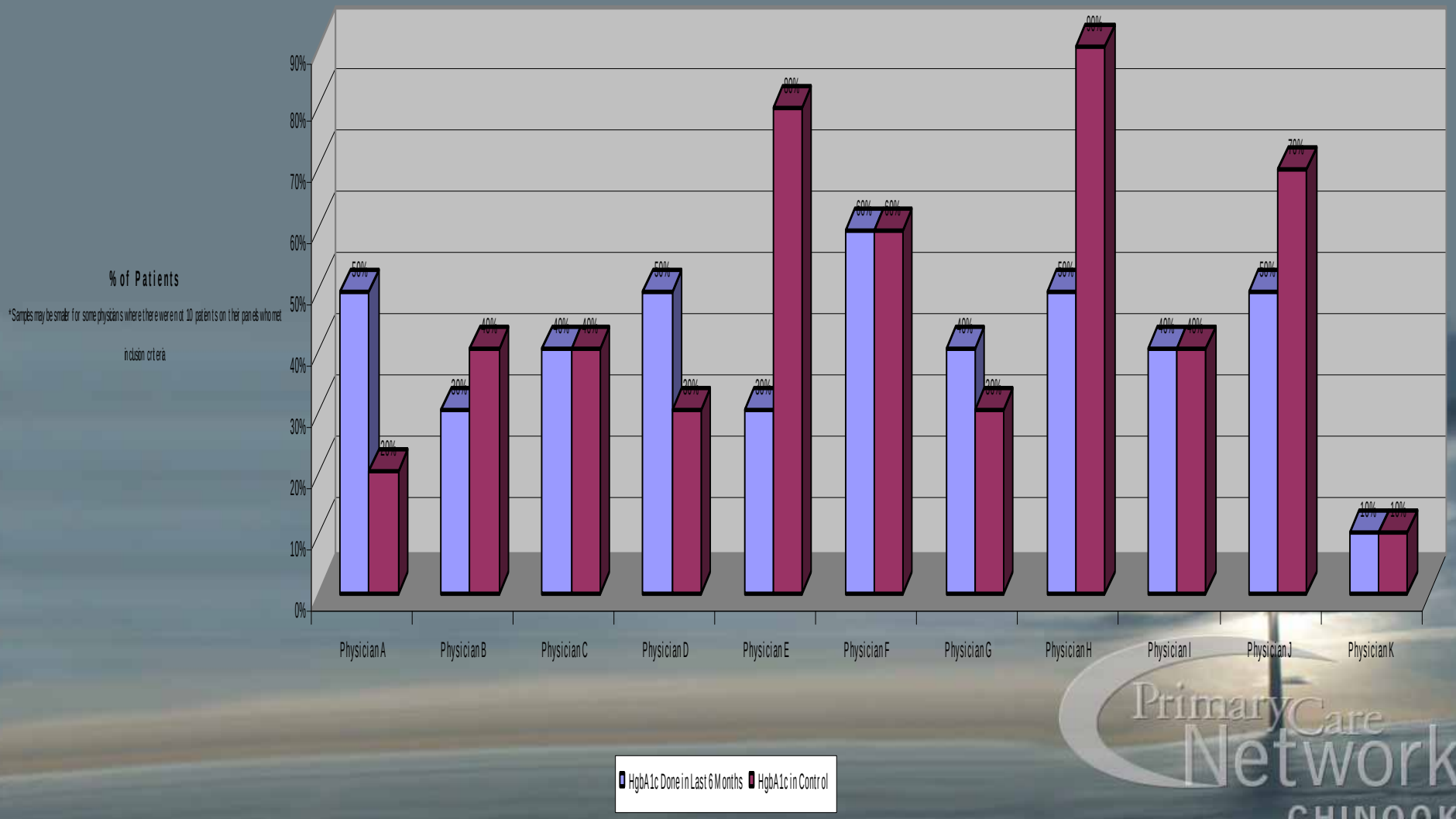


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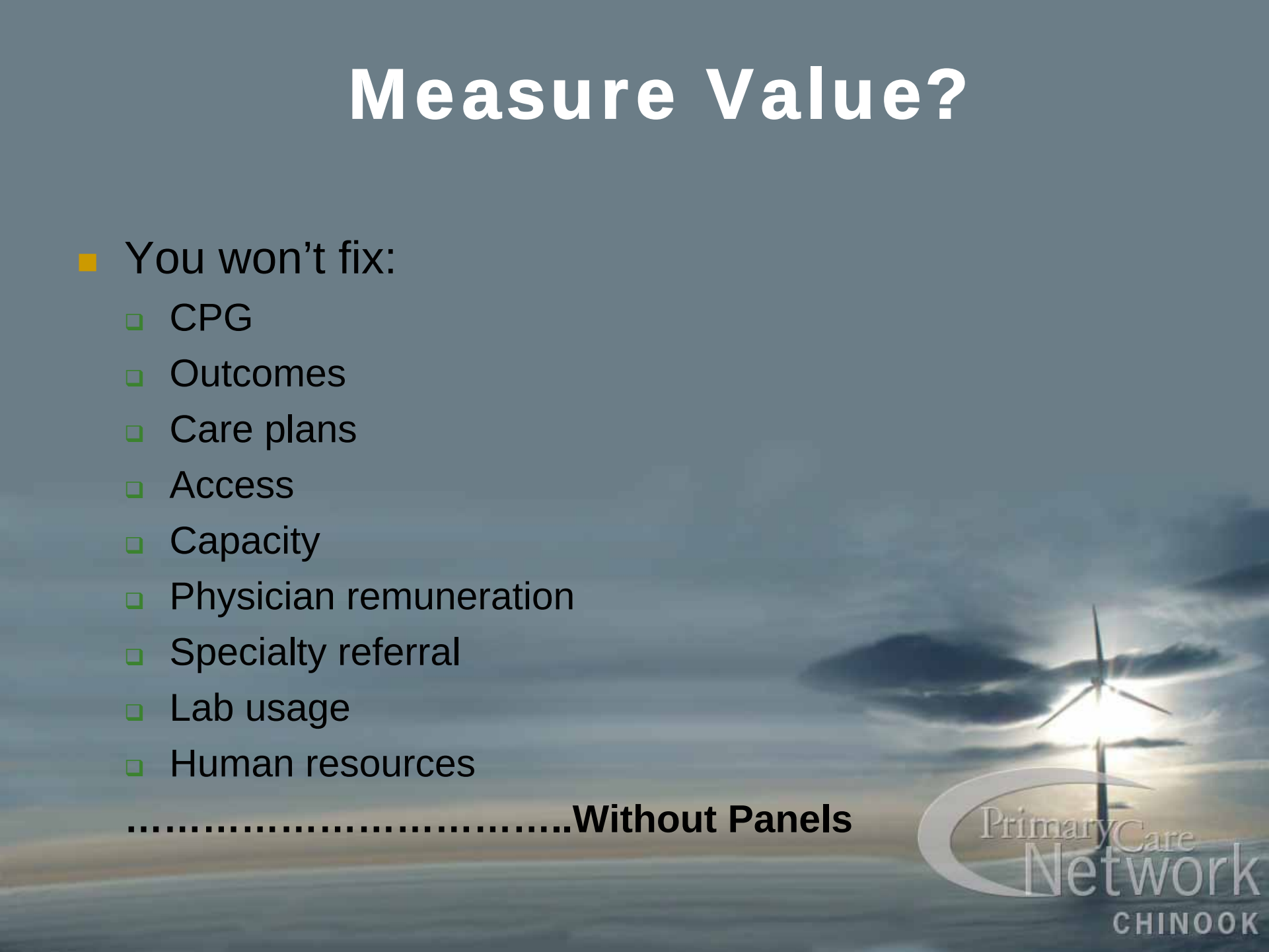
# Supporting the Panel

- The “core” family practice team is the group that support physicians in their day to day generalist work of serving their panel of patients
- RHA services, including community care nurses, public health nurses, rehab, social work and mental health, community and hospital based pharmacies, and specialists support the primary care teams to be successful.

# Measure Value?

- You won't fix:
  - CPG
  - Outcomes
  - Care plans
  - Access
  - Capacity
  - Physician remuneration
  - Specialty referral
  - Lab usage
  - Human resources

**…….Without Panels**



# For More Information

Please visit our website at:

www.chinookprimarycarenetwork.ab.ca

Or contact the Chinook Primary Care Network office at (403) 388-6510