ACHIEVING IMPLEMENTATION OF PATIENT'S MEDICAL HOME

The case and strategy for further investment in the Health Transformation Workforce (Improvement Facilitators) to support clinic level changes.

THE ALBERTA APPROACH TO TRANSFORM PRIMARY CARE

Alberta health system leaders have committed to improving the health outcomes for Albertans by prioritizing the transformation of our primary health care system.

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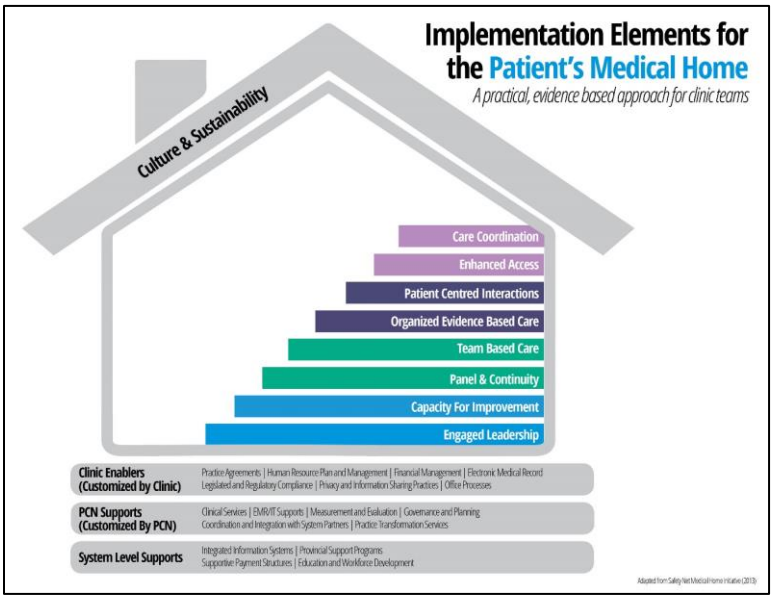


The transformation strategy includes a significant investment in Primary Care Networks (PCNs) and adopting the Patient's Medical Home (PMH) model as the approach to achieve the necessary improvements in primary care practices across Alberta

PCNs play an essential role in leading primary care transformation. This occurs by balancing two key functions:

1. Supplementing the delivery and coordination of clinical services for primary care patients by offering interdisciplinary team-based care programs and services

2. Acting as the platform to implement and scale change by engaging and supporting primary care physicians and teams to make PMH changes in their clinics

SUCCESSFUL DEMONSTRATIONS OF PMH IMPLEMENTATION

Successful demonstrations of implementing PMH elements have occurred and indicate *implementation to scale* is possible in Alberta. PCNs have demonstrated their ability to improve patient care delivery, improve health outcomes[1] and support clinics implement PMH changes to scale.

SCALING UP IMPLEMENTATION OF PMH IN ALBERTA

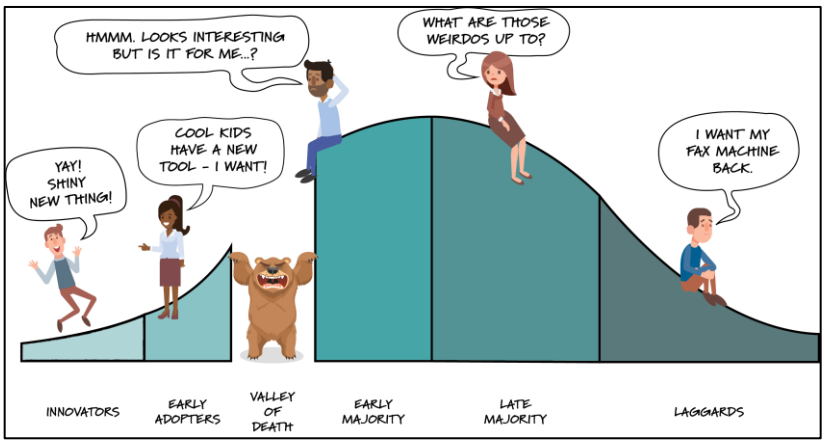
Despite significant progress, it is going to take a greater investment in Improvement Facilitators for Alberta primary care clinics to Implement PMH changes to scale.

Alberta is not alone in addressing this challenge. A 2015 national report, commonly known as "the Naylor Report", identified scaling up from demonstration projects to systemic practice as one of the central problems that Canadian health care faces today.[2]

Led by Dr. Lee Green, The Alberta Scaling Up Report - A Principled Approach for Primary Care Transformation In Alberta (2018)[3] reinforces that "early majority" practices require different supports than "innovator" and "early adopter" practices.

> *"No Health System Has Ever Succeeded In Bending The Cost Curve While Maintaining Or Improving Quality Without Transforming Primary Care, And That Requires A Strong Health Transformation Workforce."*
>
> - Dr. Lee Green MD MPH, Alberta Innovates Translational Health Chair

To reach the "tipping point" for PMH changes, there are two key considerations in identifying the supports required:



1. The majority of practices will require a more individualized "hands-on" approach

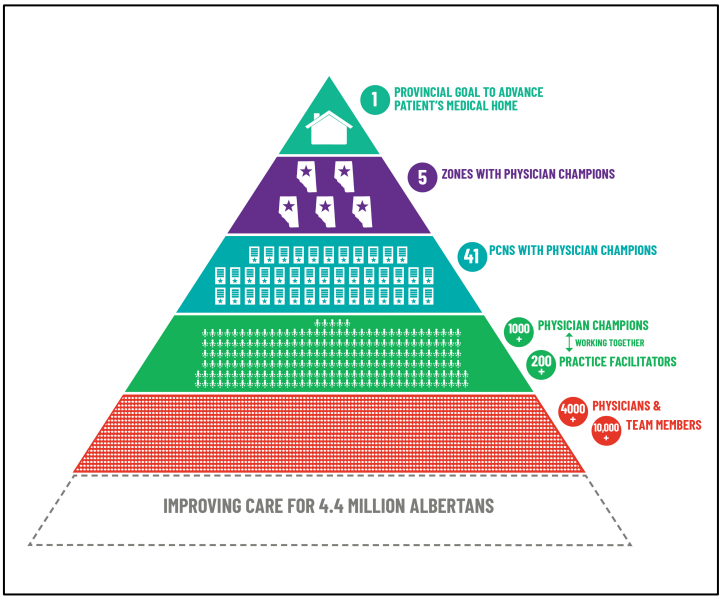
2. The complexity of changes increase with higher levels of PMH implementation

A GREATER INVESTMENT IN IMPROVEMENT FACILITATORS IS REQUIRED

Alberta and other jurisdictions have acknowledged that an investment in Improvement Facilitators (IFs) is a crucial resource that provides a principle-based individualized approach to support practice change.

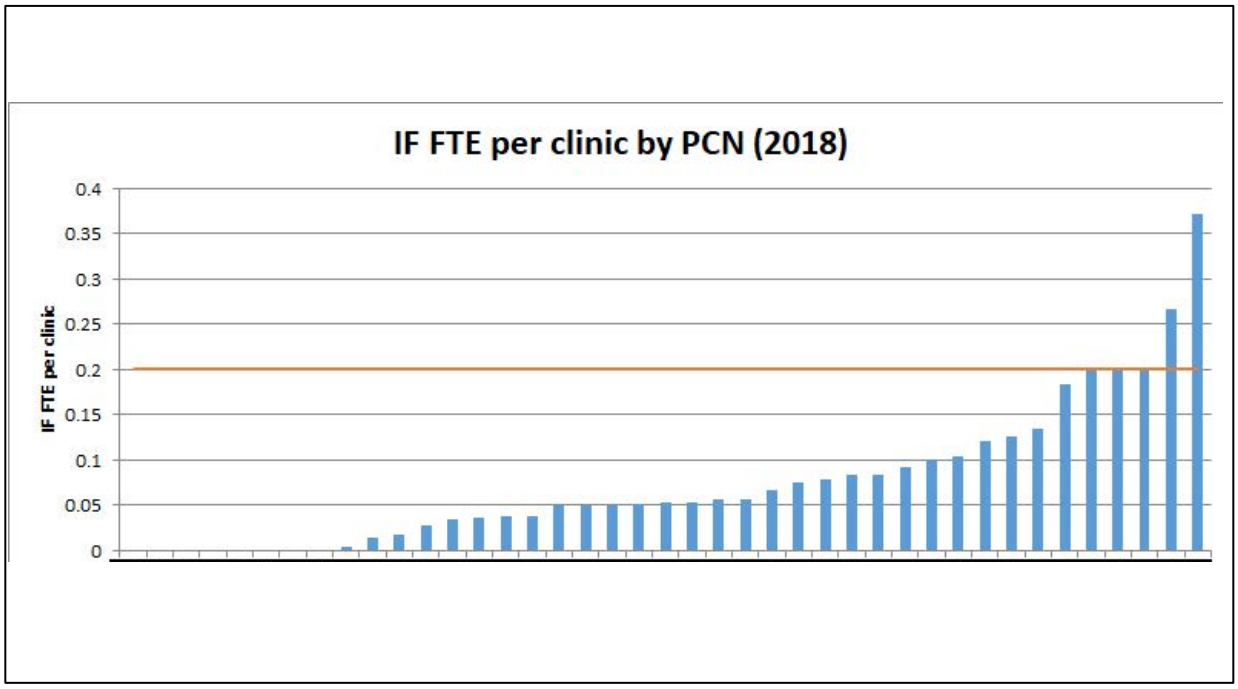
What does an IF "do"?

- Build and cultivate relationships
- Build muscle for change in the practice team
- Engage practice teams in quality improvement
- Fit change to "them" by understanding their contexts
- Show "them" how (information is not enough).
- Bring "them" tools & supports in small steps (what they need, when they need it, how they need it)



Adding additional Improvement Facilitators will drive the ability to scale change to over 1000 primary care clinics, 10,000 team members and impact care of over 4.2 million Albertans.

Some PCNs have already invested in the IF role. The overall investment in IF's has grown from 10 (2013) to 106 (2017); however a decrease to 84 in 2018 occurred for several reasons. These include, PCN surplus funding policy change, re-deployment of IFs to support schedule B measures, and natural attrition.



Even with this investment, the majority of PCNs lack the workforce required to support their member clinics with implementation of the PMH model. The significant gap between current levels of IF

resourcing and target levels of investment places implementation of key strategic priorities at risk, such as CII/ CPAR and the slowing of PMH implementation. As such, a significant and sustained investment in IFs will be required to support the number and complexity of new primary care behaviours in PMH implementation.

The number of IFs required depends on many factors, such as clinic size, complexity of change, geography, and experience with quality improvement. However, international and local data suggests a ratio of **1 IF for every 5 to 8 clinics**[4].

EXPECTED OUTCOME OF CURRENT INVESTMENT

Improvement facilitators have a **40% return on investment (ROI)**[5] when deployed to support practices with clinical improvements. This return on investment is scalable and maximized when the Improvement Facilitators are deployed to support the early and late majority physician clinics with improvement activities. Currently, some improvement facilitators are being utilized for activities not directly related to supporting clinic level improvement. This suggests the ROI will be less than 40%.

Additionally, the current level of investment in improvement facilitators requires trade-offs that result in delayed achievement of milestones and adoption of PMH implementation. PCNs have consistently reported more physician interest in adopting PMH changes than they have capacity to support. The delay in meeting physician interest with required improvement support jeopardizes progress in strategic initiatives like CII/CPAR, which requires a critical mass of physician participation. The current level of IF investment needs to increase in the next 12 months or initiatives like CII/CPAR are at risk of slower than anticipated implementation, delayed value to physicians and waning physician interest.

To achieve the target ratio of 0.2 FTE per clinic (1 IF for every five to eight clinics), Alberta PCNs would need to invest in approximately 213 IF's. Although this new investment is a priority, an opportunity to optimize the current investment in improvement facilitators to re- focus their capacity on supporting clinic level improvements is also required. The increased investment along with optimizing the workforce would help achieve the expected 40% ROI.

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