NEWS RELEASE

December 9, 2019

Significant cost savings identified in HQCA study of two Alberta primary care clinics

(Calgary, Alberta) The Health Quality Council of Alberta (HQCA) today released a new report with evidence of the value, cost, and quality of care delivered by two primary care clinics in Alberta. Both clinics operate under an alternate funding model. Alternate funding models are designed so that healthcare providers are paid a prospective amount to cover services provided to patients within a specific period of time, versus a fee-for-service model more typical in Alberta primary care clinics.

For the past 20 years, Crowfoot Village Family Practice (CVFP) and The Taber Clinic (TC) have operated successfully under this structure. The HQCA decided to take a closer look at what makes them successful and answer a simple question: Does this model provide better value for Albertans?

The HQCA found that the alternate funding model used by CVFP and TC enabled the design and delivery of a team-based practice model that provides comprehensive, cost-effective care that provides downstream cost-savings to the health system. In 2016-17, the practice models delivered by CVFP and TC realized health system cost savings of $4.3 million and $7.2 million respectively. This trend of health system cost savings has been consistent since 2007-08 with 10-year accumulated savings of $57.3 million and $62.2 million respectively.

HQCA recommendation

No new funding agreements should be implemented without first developing a provincial alternate funding model framework that describes the key elements required to support the development and implementation of alternate funding agreements. The framework must be in alignment with, and support the vision for, primary and community care, and be inclusive of the role of Primary Care Networks.

“Achieving these savings on a larger scale is not as simple as replicating the current funding agreements or the local conditions in which CVFP and TC operate,” says Andrew Neuner, chief executive officer of HQCA. “A vital first step is to first develop a transparent, but adaptable, funding model framework.”

"This work confirms what worldwide literature has shown: invest in primary care and reap the benefits of improved care and reduced costs - especially downstream in hospital-based care,” says Dr. Rick Ward, medical director, Crowfoot Village Family Practice. “Crowfoot Village Family Practice - supported by Calgary Foothills Primary Care Network – has led innovation in Patient

Medical Home construction in urban Alberta. This report confirms that the outcome of this work is improved access, quality care, provider satisfaction, and reduced cost to the system."

"As primary health care providers, we see tremendous benefit to practicing in an alternate funding model, for our patients, ourselves and the health system in Taber," says Dr. Andrea Hargrove, partner, The Taber Clinic. "We are pleased that the HQCA report confirms what we have experienced over the past 19 years. The report shows the robust evidence for continuing this model of care. Our patients benefit from fewer hospital admissions and fewer, more comprehensive, timely clinic visits, from a full functioning multi- disciplinary team. We are hopeful that our model of care can be successfully translated to other communities across the province."

"Our findings corroborate the evidence published from other health systems, that investing in strong, team-based primary care results in better patient outcomes and lower overall health system costs," says Dr. Trevor Theman, Board Chair, HQCA. "We are confident that our recommendation and considerations will move Alberta in the right direction if we are truly committed to transforming primary care delivery."

The full report is available on the HQCA website:

A case study evaluation: Crowfoot Village Family Practice and the Taber Clinic, October 2019.

-30-

For more information and to book an interview:

Lisa Brake, Director, Communications & Engagement
Office: 403.297.4091 Cell: 403.875.0359
Lisa.Brake@hqca.ca

Supporting information attached:

- Making sense of the terminology
- Clinic comparison graphic
- Recommendations and considerations

Making sense of the terminology:

Fee-for-service model: A common payment model in healthcare where a physician is paid specifically for the number and type of services rendered. Specific fee codes determine how much a physician will be paid for a given interaction with a patient.

Alternate funding model: A physician payment model that is an alternative to fee-for-service. Often it is designed so that healthcare providers (usually as a clinic) are paid a prospective amount to cover all services within a specific period of time, most often as a 'per patient per time period' fee. It aims to promote collaborative team-based comprehensive care that encourages health promotion, wellness, continuity of care, and system sustainability.

Practice model: A practice model consists of a set of principles, values, and informal and formal structures (e.g., policies and regulations) that inform how providers operationalize the delivery of patient care in a primary care clinic. It also includes administrative functions and remuneration structures. Administrative functions refer to leadership roles and responsibilities, human resource management, and other duties that are integral to the day-to-day functioning of a primary care clinic. Remuneration structures refer to models of physician payment, the payment of other staff in the clinic, and other financial and legal components that govern the distribution of funds.

Patient's Medical Home (PMH): For the College of Family Physicians of Canada, the patient's medical home (PMH) is a vision that emphasizes the role of the family practice and family physicians in providing high-quality, compassionate, and timely care (CFPC, 2019). The PMH is a family practice defined by its patients as the place they feel most comfortable presenting and discussing their personal and family health and medical concerns.

Taber Clinic:
ANNUAL PER PATIENT COSTS & SAVINGS
2016-17

ANNUAL COSTS	TABER	ALBERTA RURAL	DIFFERENCE
PRIMARY CARE	$378	$366	$12 higher
OTHER PROVIDERS (e.g. specialists)	$326	$406	$80 lower
EMERGENCY DEPARTMENT VISITS	$162	$274	$112 lower
INPATIENT STAYS	$467	$736	$269 lower

ANNUAL SAVINGS:

Per patient: **$449**

For all patients at the Taber Clinic: **$7.2M**

10-YEAR SAVINGS:

For all patients at the Taber Clinic (2007-08 to 2016-17): **$62.2M**

Crowfoot Village Family Practice (CVFP)
ANNUAL PER PATIENT COSTS & SAVINGS
2016-17

ANNUAL COSTS	CVFP	ALBERTA METRO	DIFFERENCE
PRIMARY CARE	$343	$293	$50 higher
OTHER PROVIDERS (e.g. specialists)	$521	$510	$11 higher
EMERGENCY DEPARTMENT VISITS	$86	$110	$24 lower
INPATIENT STAYS	$298	$517	$219 lower

ANNUAL SAVINGS:

Per patient: **$182**

For all patients at the Crowfoot Family Village Practice: **$4.3M**

10-YEAR SAVINGS:

For all patients at the Crowfoot Family Village Practice (2007-08 to 2016-17): **$57.3M**

Recommendation

No new funding agreements should be implemented without first developing a provincial alternate funding model framework that describes the key elements required to support the development and implementation of alternate funding agreements. The framework must be in alignment with, and support the vision for, primary and community care, and inclusive of the role of Primary Care Networks.

To support the recommendation to develop an alternate funding model framework a number of considerations are proposed at the provincial, community, and practice level. These considerations represent the interdependent features that will be important for the development of an alternate funding model framework moving forward. Our goal is to ensure this framework supports the future design, implementation, and management of a sustainable, predictable funding model for the province in achieving the goals of the Primary Health Care Strategy.

Considerations for action

PROVINCIAL-LEVEL CONSIDERATIONS

- Define primary care performance metrics that focus on value-based outcomes and communicate reporting expectations to participating primary care clinics.
- Enhance the reliability of health system cost data, particularly for inpatient service utilization.
- Engage stakeholders to identify the key elements of an alternative payment model that can best incentivize a larger-scale implementation of the PMH model.

COMMUNITY-LEVEL CONSIDERATIONS

- Review negation parameters to accommodate the health service needs of rostered patients.
- Define and develop services that support the health needs of the population served, are adaptable for changing local contexts, and enable scalability and management of the funding agreements.
- Define the PCNs' role in provision of clinical supports and/or healthcare services that complement those offered by practices operating under an alternate funding agreement.

PRACTICE-LEVEL CONSIDERATIONS

- Define metrics to be reported by practices that focus on the shift to a PMH and the provision of team-based care.
- Engaging patients, including completion of a rostering conversation with all newly rostered patients, geographic or contracted, should be embedded in all alternate funding agreements.
- Practices transitioning to an alternate funding agreement should receive PCN change management support toward building a practice model in alignment with PMH principles.