

What is Primary Care?

- Refers to the services you receive for your basic, everyday health needs
- Your first point of contact within the health care system and is provided to you by your family doctor and other health professionals

What is Primary Care?

- Includes the initial care, treatment and follow-up of various conditions as well as referrals to the rest of the health system as appropriate
- Encompasses the promotion of wellness, and prevention and management of chronic diseases and injuries

What are Primary Care Networks?

- Made-in-Alberta approach to ensure that you receive the right care, from the right health professional, at the right time
- Led by family doctors, these Networks are improving access to, and better coordinating care for Albertans
- A team of health professionals led by family doctors delivers and co-ordinates health services, resulting in better collaboration, more timely referrals and more comprehensive care

What are Primary Care Networks?

- A Network can be one clinic with many family doctors and other health professionals or many family doctors and other health professionals in several clinics in a geographic area
- Each PCN provides basic primary care but also sets priorities designed to meet local health needs
- PCNs are established within a framework set by Alberta Health (AH), Alberta Medical Association (AMA) and Alberta Health Services (AHS)

History

- In 2003, AH, the AMA and AHS established the Primary Care Initiative to improve access to family physicians and other frontline health care providers in Alberta
- The purpose was to develop PCNs and support them in meeting the objectives of the program
- Today, there are over 40 PCNs operating throughout Alberta with more in development. Approximately 2.5 million patients are seen each year.
- Over 80% of eligible family doctors in Alberta are working in PCNs

Provincial Objectives

Increase emphasis on Improve coordination health promotion, and integration with Facilitate the greater Increase proportion of Provide coordinated injury prevention, other health services use of multi-PCN residents with 24/7 access to care of medically including secondary, disciplinary teams to ready access to appropriate primary complex patients and tertiary and LTC provide primary care care services care of patients with through speciality comprehensive care chronic disease care linkages

What is the Camrose PCN

- Established in 2005, the network consists of 3 family practice clinics in Camrose and surrounding area
- 27 participating family physicians serving almost 24,000 Albertans with the support of 19 healthcare providers and administration

Camrose PCN Executive Director Talks About the PCN

Vision

Supporting family doctors in delivering coordinated, quality rural primary care with the support of other health professionals and enhancing the doctors' capacity and quality of life

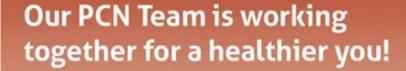
Initiatives



Programming

THE CAMROSE PRIMARY CARE NETWORK

YOU



PCN Physicians



- Smith Clinic/ City Centre Walk-In Clinic 780.672.2423
- Gemini Health Medical Clinic 780.672.9850
- St. Mary's Hospital 780.679.6100
- Bashaw
 Health Center
 780.372.3740

PCN Programs

To access the PCN programs call 780.608.4927, email info@camrosepcn.com or visit www.camrosepcn.com

- Atrial Fibrillation Program
- Dietitian
- Geriatric Assessment Program
- Grief and Bereavement Support
- · Maternal Newborn Clinic
- Mental Health Liaison Program
- · New Moms' Network

- · On Your Weigh
- Cancer Support Program
- · Palliative Care
- Pharmacist
- Risk Reduction Program
- · Social Worker
- · Tube of Life
- · Virtual Trek

Talk to your family doctor about how YOU can access PCN programs or visit WWW.CAMROSEPCN.COM



Camrose PCN #1108, Suite 4, Edgeworth Centre (Main Floor) 4512 - 53 Street, Camrose, AB (780) 608-4927 or info@camrosepcn.com

Programming



Be evidence-based and patient-centred – using multiple strategies and interventions



Empower patients to increase control over and improve their health



Promote collaboration among physicians, healthcare providers, organizations, patients, families and community groups

The Patient Journey (Maternal Newborn Clinic)

Referral to PCN Maternal Newborn Clinic

via

- PCN physician
- Unattached self referral

Patient contacted by clinic & initial appointment booked with RN and physician

RN to review patient chart

Initial appointment with RN and physician

- Introduction to perinatal program
- •Confirm Estimated Delivery Date, physical assessment
- Education teaching guidelines
- •Develop care plan
- •Diagnostic investigations and bloodwork per provincial guidelines and as indicated
- •Referral(s) to specialist(s), other health and community provider(s) as required
- •RN communication with public health if required

Routine prenatal visits per Provincial Guidelines and as indicated

Ongoing

- Assessment and Support
- •Education per CPC teaching guidelines
- •Update care plan as required
- $\bullet \mbox{Diagnostic}$ investigations and bloodwork per provincial guidelines and as indicated
- •Referral(s) to specialist(s), other health and community provider(s) as required
- •Confirm unattached patient has a primary care physician prior to delivery
- •RN communication with Public Health if required

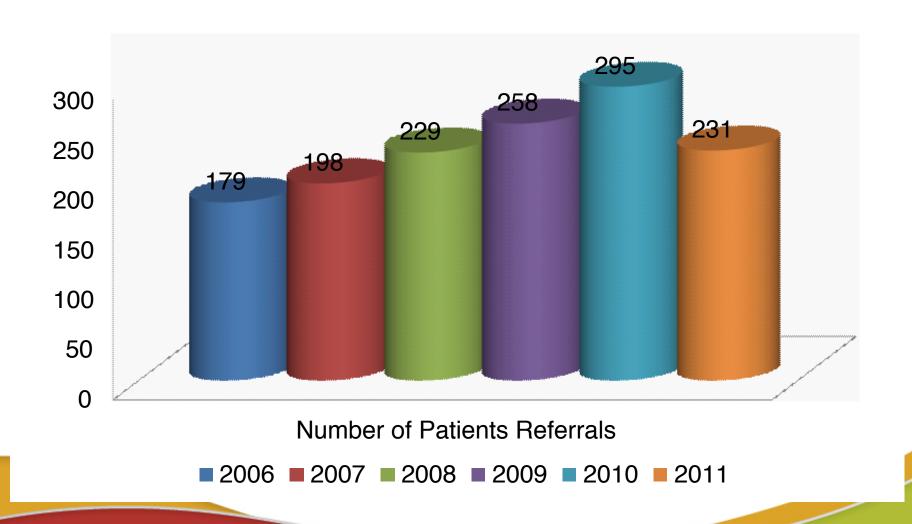
Delivery of Baby

- •Copy of PNOB to primary care physician and perinatal clinic
- Initial postpartum perinatal clinic appointment booked

Identification of high risk pregnancy

Obstetric specialist(s) consult / referral

Camrose PCN Maternal Newborn Clinic Prenatal Clinic



The Patient Journey (Risk Reduction Program)

PCN Physician Referral to **Risk Reduction Program** Referral appropriate for RRP Referral **not** appropriate for RRP or case **RRP Team Member** management not required (RN, Pharmacist, or Dietitian) Initial Assessment appointment Conducts initial patient triage by telephone booked with RN Pt offered alternative programming Initial Assessment by RN and **Devise Action Plan with Pt** options Pt Discharge Letter sent to Physician File Closed Notes Pt assigned to a Case Manager • If at any point in this care map a patient is (RN/Pharmacist/Dietitian) deemed to require emergent care, **Note:** Pt may request physician or nurse Pt attends classes &/or participates in transport will be arranged by EMS and the to reopen file at any time if they desire exercise program per Action Plan physician will be made aware to actively commit to Ongoing involvement and communication Internal Referrals as needed (PCN participating with Primary Care Physician will occur Dietitian, Pharmacist, Mental Health throughout this care map Liaison) External Referrals as needed to other Pt requires no Further Assistance to Health &/or Community Providers Manage Health Goals **Ongoing Follow-Up** 3/6/9/12 Month Reassessment by RN •as required to stabilize patient and/or Assess progress & achievement of achieve outcomes by case manager Pt requires Further Assistance to patient's Health Goals per their Action and/or multidisciplinary team Manage Health Goals Plan •update Action Plan with patient as required

Cost Saving Numbers

Risk Reduction Program Example

PCN Patient Visit - estimated 60 minutes per visit x average wage \$45.55/hour (with Dieitian, Pharmacist and/or RN)

VS

Family Physician Visit - estimated 15 minutes per visit x billing code \$35.91/visit (with family physician only)

2010-11 PCN Patient Visits = 1082 PCN Healthcare Provider = \$45.44/hour = \$49,166 per year PCN Family Physician = \$143/hour (\$35.91 x 4) = \$153,726 per year

Benefits of PCN

- Cost savings of \$105,560 per year
- •More time spent with the patient/enhanced care plan resulting in an opportunity for identifying other risk factors and / or better management of chronic disease
- •Enhanced communication between physician, healthcare providers and patient resulting in more appropriate and timely referrals
- Physician and Healthcare providers working to full scope of practice

What Do the Patients Think?

"It's been one year from "You have diabetes" to "You look great". What this doesn't say is that I feel better and am in better health because of the support from my family, friends, doctor and the Edgeworth PCN.

While your doctor provides clinical information about diabetes and starts a treatment plan it is the PCN that gives you the opportunity to know the what's and how's of the "better health" you look for after this kind of diagnosis. From the nurse that helps you cut through the information overload to the dietitian that simplifies the Canada Food Guide to the pharmacist that explains drugs and options you are well cared for. Beyond the information they share the greatest benefit of dealing with the PCN staff is the personal support and caring they give.

Treatment of diabetes is all about reducing the risk of complications in the future but the byproduct of following the advice of the PCN staff is feeling better today. So instead of the maybes of risk reduction you can enjoy the realities of being more active, happier and feeling great.

While the PCN staff all tell you that it is "you" who decides to change your lifestyle, their caring, time for you approach makes it impossible to not follow their advice. If you choose to be healthy – choose to use the resources of the PCN."

Morris Henderson – PCN Risk Reduction Patient

"I have greatly benefited from going to the PCN and getting a lot of advice and help from my dietician and pharmacist.

Both the dietitian and pharmacist have been wonderful to deal with and understand my situation.

I personally appreciate the fact that my Dr. is informed about what is done at the PCN, as I believe having everyone in on my care can only be of a benefit to me. What one person doesn't think of, maybe another will.

With the PCN, the Dr. is in on what is happening and he does not need to spend time getting the information from the patient, as he already has it straight from PCN. This increases efficiency in both offices.

Anne Stang Camrose PCN Patient

"I started with the PCN in January 2012 when their weight wise classes began. I have found the support from the instructors, the people who attend the classes, and the monthly visits to the On Your Weigh Lead Nurse to be a huge benefit to my success on my journey of healthiness and weight loss. This has opened so many more doors for me because I feel so much better and have become more knowledgeable about the foods I eat. The PCN has been a great addition for the people of Camrose and area like myself for programs they offer to help people reach whatever goals they are trying to achieve."

Mona Phillips Camrose PCN Patient

What Do the Physicians Think?

"The Camrose PCN works as a great mediator between physicians and the community. The PCN aims to fill in the gaps in primary care that a family doctor does not have the time or resources to do. Patients receive extensive counseling and management through the multi-disciplinary approach adopted by the PCN and ultimately improve patient care.

Recently, a diabetic patient of mine was admitted and needed to start insulin. He did well in hospital and was referred to the PCN on discharge. As a family physician, it is a great relief to know that he has accessible education and support and his chances of managing his disease effectively, are greatly improved."

Dr. Lindsay Bick PCN Family Physician

"The Virtual Trek is a great health prevention campaign for our community. I am really impressed with the numbers of patients that have enjoyed the experience and the difference campaigns such as this can impact the health and wellness of individuals and their families.

There is significant value in the PCN having the capacity to engage in community development projects such as the Virtual Trek. Motivating people to get active is imperative in one's journey of health."

Dr. Diana Peters PCN Family Physician



What Do Health Providers Think?

"St. Mary's Hospital Stroke Prevention Clinic and Heart Function Clinic serve patient populations that require long term care and encouragement within the clinic and community. For patients to successfully change to a healthier lifestyle, we realize within our clinic that the more actively involved the healthcare system is with our patients, the more likely they are to continue on with their programs.

Once a patient is seen within these clinics, we follow them on a regular basis but always try to see where the best fit for them is within the community for further support. An example of this is the PCN, where our Heart Failure patient who is diabetic can be followed on a long term basis by the team at the PCN to encourage and teach the patient about their disease while at the same time working with their family physician to manage their diabetes. We are appreciative the partnership we have between the different programs in the community that are available

to assist us with our patients health. "

Cheryl King RN Stroke Prevention Clinic St. Mary's Covenant Health

"No one is exempt from the heartache of a loss, so let us keep learning together so we can continue to help each other in our grief. The attendees are so grateful to the physicians for sponsoring the workshop, lunch, refreshments etc.... but I think it is more than that....I think the attendees feel validated in their grief when their physicians provide this opportunity for them to be supported.

Our goal in common is "wellness" for the clients that the PCN serves....I believe that "dealing with our grief" helps keep us healthy..."not dealing with our grief" can lead to illness."

Colette Howery - Registered Nurse with a Certificate in Grief Support



What Do Our Partners Think?

"The partnership with the Camrose PCN has had a great deal of value added to the interface with community addiction and mental health.

The Mental Health liaison program interfaces with the PCN and St. Mary's emergency department and this interface has had added value with working with the physicians at St. Mary's and the PCN.

The Seniors/Geriatric program has also had added value to folks in this program. The partnership has been beneficial to all clients within community addiction and mental health. *The seamless access to services is what is valued by clients and their families.* Commitment from both AHS-Community Addiction and Mental Health and the PCN has been very positive which demonstrates the work that can be done in a collaborative team approach."

Brenda Nelson Community Addiction and Mental Health Alberta Health Services "The Augustana Fitness Centre has had the pleasure of collaborating with the Camrose Primary Care Network on many programs and initiatives over the past few years and we could not be happier to have such a cooperative, innovative and supportive partner in the health system. By working together through initiatives such as the Virtual Trek and Health and Fitness Educational and Support Sessions, we have been able to build capacity for the Camrose Community to live healthy and active lifestyles.

The holistic, grassroots approach that the Camrose PCN takes in providing health resources and services is admirable and we have witnessed first-hand how this approach allows health needs to be met in a more efficient, personal, and caring manner.

The staff at the Camrose PCN are great to work with and always treat their partners and clients with a smiling face and a friendly, respectful demeanor. We are very fortunate to have the PCN as community partners and neighbors in the Edgeworth Centre."

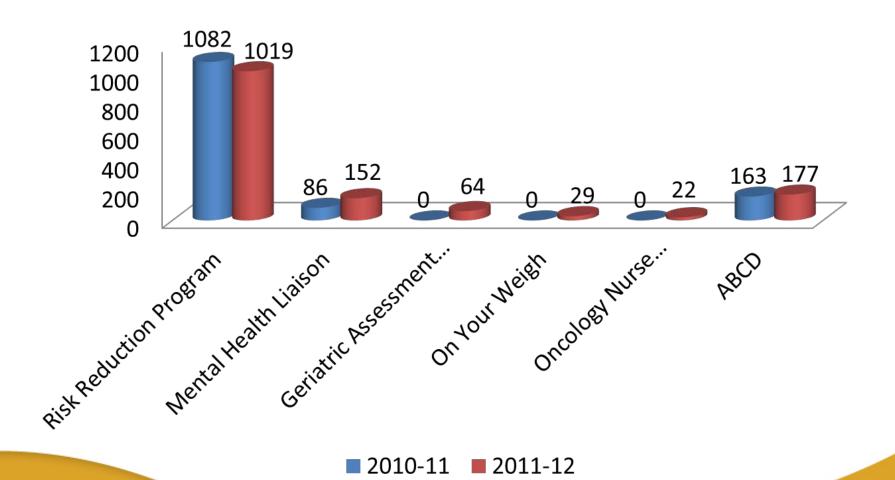
Jalene Johnson & Deanna Roper University of Alberta Augustana Fitness Center



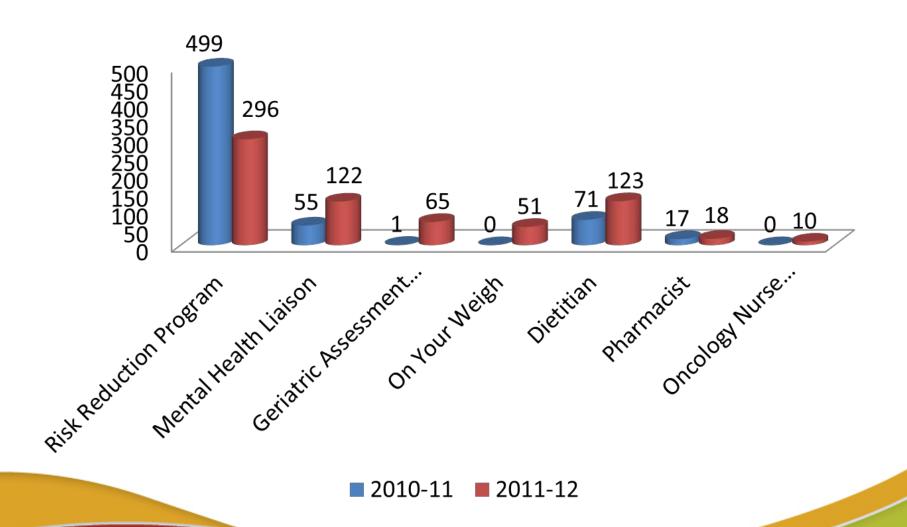
Why I Chose the PCN



Camrose PCN Total Number of Visits

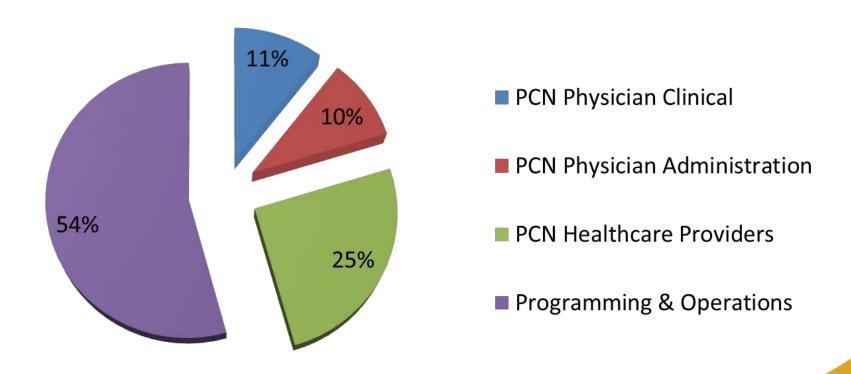


Camrose PCN Total Number of Referrals



Where Does the Money Go?

Camrose PCN Expenditures



Contact Us

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