# Alberta Doctors' Digest

## Incentivizing comprehensive, longitudinal care

On Thursday, December 19, AMA President Dr. Shelley Duggan joined Premier Danielle Smith and Alberta's Minister of Health, Adriana LaGrange, for a press conference to announce details of the Physician Comprehensive Care Model (PCCM) for primary care. Co-developed by AMA physician leaders and Alberta Health, the new model blends elements of both existing Fee-For-Service (FFS) and clinical Alternative Relationship Plans (cARPs) to create a hybrid approach to physician compensation. The PCCM will go live on April 1, 2025.

During the press conference, Premier Smith stated that, "this new model will help build healthier communities and dramatically improve our ability to recruit and to retain primary care physicians." She also noted that, "recruitment and retention of family physicians is a nationwide challenge and here in Alberta, we think a big part of the solution is fair compensation and incentives … with this announcement, I think the risk of losing family physicians to more attractive jurisdictions is done. This new model will make Alberta an enticing and competitive place for doctors to come and to settle, and to set up shop and to stay for good."

Minister LaGrange added that, "we believe the new compensation model will relieve pressure in other areas of the health system and that it will encourage comprehensive care in all phases of a patient's life … we expect the model will be a game-changer in attracting family physicians from other provinces and countries."

The model was more than a year in the making. It was first promised in the fall of 2023 when the AMA signed a memorandum of understanding (MOU) with the Minister of Health, just days after the release of the *Modernizing Alberta's Primary Health Care System* (MAPS) final report. The MOU committed both parties to work together on the "design and implementation of a longitudinal family practice (LFP) physician compensation model that reflects family physicians' and rural generalists' extensive training, experience and leadership in primary health care." The AMA first presented government with a LFP proposal in late 2023. Government announced that it had agreed to the framework for the model on April 17, 2024, and that it expected the details to be ready in the fall. The AMA was relentless in its advocacy to see those details finalized and worked closely with government to get the PCCM across the finish line.

"Family physicians have been anxiously awaiting this announcement," explains Dr. Sarah Bates, the president of the AMA's Section of Family Medicine and a family physician practicing in Calgary. "We anticipate this model will allow many primary care physicians to continue to deliver comprehensive, life-long care to their patients, while keeping their community clinics viable."

The PCCM is intended to stabilize and strengthen community physician practices by providing an alternative to the existing fee-for-service model for family physicians and

rural generalists who practice comprehensive, longitudinal patient care. The new, optional model compensates physicians in a way that recognizes the increased demands placed on physician's practices by complex patients, while also addressing critically important work beyond direct patient care. This includes tasks such as charting, consultation letters, reviewing labs and other practice management pieces that are required to run a family practice.

To do this, the model blends various elements, including encounter-based payments, time-based payments (which will compensate for both direct and indirect care), and panel-based payments. The Physician Comprehensive Care Model for Primary Care Essentials guide provides an overview of the various elements and how it works.

From the start, it was understood that the PCCM is entirely optional and that physicians will need to determine if it fits their practice style, community needs and patient care goals. Some rural physicians, who do much of their work in local hospitals and health centres, may see fewer benefits but could consider the PCCM for the community portion of their practices. The AMA has developed a range of tools to help physicians decide what's right for them, including an online calculator that compares the PCCM to other compensation options. A virtual information session was held on January 8 to explore some of the details of the PCCM, including a demonstration of the calculator, and a recording of the session is available on the AMA website.

Enrolment for the PCCM began in mid-January and requires family physicians to express their interest in moving to the new model to the AMA. Once eligibility has been confirmed, physicians will be provided with an application/attestation form. To be eligible, physicians must have a clinic-based practice, commit to longitudinal care and provide 400 hours of direct and indirect care over 40 or more weeks per year. Physicians must also meet the minimum patient panel size requirement of 500 patients, a number chosen by the Minister of Health, and utilize the Community Information Integration Central Patient Attachment Registry (CII/CPAR), a provincial system that captures the confirmed relationship between a primary provider and their panelled patients. As paneling with CPAR is a pre-requisite to joining the PCCM, physicians who aren't yet on CII/CPAR should start the enrolment process as soon as possible. You can learn more about CII/CPAR on the AMA website.

Picture 1During the announcement, Dr. Shelley Duggan explained that the new model: "will significantly, meaningfully and positively impact our health care system for years to come … today in Alberta, lack of access to family and rural generalist physician care is a common denominator for many of the problems that we see." Dr. Duggan notes that the "announcement recognizes and invests in physician-led primary care, making it possible for these physicians to do what only they can do … it is our hope that the model will help to restore Alberta as a destination of choice for physician residents and medical students."

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**Sidebar**

The December 19 announcement also included new rates for Family Medicine Alternative Relationship Plans (FMARP) for physicians who provide inpatient care in hospitals and rural generalists. The improved rates better recognize family physicians who are currently providing comprehensive care and hospitalist services under clinical ARPs and will also apply to the clinical component of the Academic Medicine and Health Services Program (AMHSP). These new rates were developed using a derived day

approach (DDA) to bring family medicine clinical ARP and AMHSP earnings in line with family physician fee-for-service colleagues. You can learn more about this approach on the AMA website.