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Modernizing Alberta's Primary Health Care System (MAPS)

Strategic Advisory Panel Final Report

March 31, 2023

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Message from the Co-Chairs

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Primary health care has long been recognized as the bedrock of the broader healthcare system, and fostering its efficacy and promoting the necessary change requires strategic investment. The good news is that Alberta has made important advances in this capacity over the last 20 years - we have been at the leading edge of electronic medical record adoption; we have adopted and are implementing the Patient's Medical Homes vision faster than other Canadian jurisdictions; and we have Primary Care Networks. At the same time, we have significant gaps that are negatively affecting our entire health system and Albertans, including:

- We have not kept pace with changing expectations from Albertans related to how they interact with the system;
- We are predominantly organized as independent provider owned clinics who receive little in way of infrastructure and resource supports relative to the acute care sector;
- We lack supply and funding for providers to achieve interdisciplinary team-based care;
- There is limited integration with communities and the social services sector; and
- We have failed to protect the health and well-being of our own primary health care workforce.

These gaps have created care deficits within our system including lower screening rates, suboptimal chronic disease prevention and management, conditions presenting at advanced stages, and a reliance on hospital and emergency care for issues that would be far better managed in the community. This is a particular concern in rural and remote parts of the province, for Indigenous peoples, and for other underserved populations with needs that are more challenging to address.

The foundation, as currently constructed, is not strong enough to withstand the pressures our system faces. The pressure will continue to escalate as our population

ages, grows and becomes more diverse. Our health workforce is under immense strain with high rates of burnout. There is a legitimate crisis and the time to act is now.

Rebuilding the foundation starts with mutual trust and respect amongst all stakeholders in primary health care. The citizens of Alberta must be central, and the providers in our system need hope for a better future now more than ever. Hope will only come with sustained efforts to **build trust, strengthen collaboration, achieve reconciliation, and increase transparency.**

The Modernizing Alberta's Primary Health Care System (MAPS) initiative is our opportunity to rebuild the foundation in a trusting and respectful environment through partnership and collaboration. It is the start of a long journey, with an ongoing need for robust consultation at all stages of implementation. The strategic shifts and recommendations in this report offer a roadmap for how Alberta's primary health care system should evolve over the next five to ten years. It will not be easy, and it must be done.

It is not a question of whether we should invest; investments will be made. The choice is between investing in communities and the providers in those communities to rebuild and modernize our foundation, or continuing to spend increasing amounts to meet the care needs of Albertans through hospitals and emergency departments. Our citizens have been clear; they want care in their communities, delivered by trusted providers, in a way that meets their needs.

The MAPS Strategic Advisory Panel worked in parallel to, but independently from the MAPS Indigenous Primary Health Care Advisory Panel. The advice contained within this report should be considered together with their independent advice. We strongly believe that synergies should be sought, equity advanced and that **actions to eliminate discrimination and racism in our health care system should be immediate.** We thank the Indigenous health experts and community leaders, who contributed to setting a bold direction for Indigenous health and wellness.

Finally, we wish to express our deepest gratitude for the contributions and dedication of everyone who has helped bring this work to fruition, including our fellow members of the Strategic Advisory Panel, the members of the International Expert Panel and the project team. Their myriad contributions to this report underscore a fundamental truth: a stable health care system cannot exist without a strong foundation of primary health care. With this in mind, we are pleased to submit this report outlining the MAPS Strategic Advisory Panel's vision and recommendations for the future of primary health care in Alberta. We are honoured to have had the opportunity to serve as the co-Chairs of this Strategic Advisory Panel and look to the future with hope that together we will achieve the primary health care system that Albertans expect of us.

Sincerely,

Dr. Brad Bahler
Physician
Sylvan Family Health

Dr. Janet Reynolds
Physician
Crowfoot Village Family Practice

Strategic Advisory Panel

The Strategic Advisory Panel is composed of members with expertise in primary health care, health systems transformation and Alberta's primary health care system. The Strategic Advisory Panel Members are:

Dr. Brad Bahler, co-chair	**Dr. Janet Reynolds, co-chair**
Dr. Linda Slocombe	**Dr. Rithesh Ram**
Alison Ross	**Robert (Bob) Schultz**
Yvonne Chiu	**Dr. June Bergman**
Dr. Joseph Ojedokun	**Dr. Cathy Scrimshaw**
Dr. Shahnaz Sadiq	**Dr. Jon Hilner**
Joy Peacock	**Dr. Robert Warren**
Cheryl Andres	**Karen McDonald**
Judy Birdsell	**Dale Cooney**
Dr. Jordan LaRue	**Tim Murphy**
Stacey Strilchuk	**Christine Hughes**

Additional information on the mandate of the Strategic Advisory Panel or individual panel members can be found at: https://www.alberta.ca/strategic-advisory-panel.aspx

International Expert Panel

The International Expert Panel is composed of members with expertise in primary health care, health systems transformation and primary health care systems globally. The International Expert Panel Members are:

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Additional information on the mandate of the International Expert Panel or individual panel members can be found at: https://www.alberta.ca/international-expert-panel.aspx

What Matters to People in Alberta

What Matters to People in Alberta

As early as 1978, the World Health Organization along with the United Nations declared primary health care as a basic human right for all people everywhere. Today, some people in Alberta still do not have access to primary health care in equitable and appropriate ways. Many communities and demographics remain underserved and face troubling disparities when accessing care and services. This is especially true for Indigenous peoples and communities seeking culturally safe and holistic primary health care, and also for people living in rural and remote parts of the province who have limited choice and must travel or wait for even basic primary health care that is usually readily available in urban centers.

Albertans expect their primary health care system to be there for them and their loved ones throughout their life journey—at the right time, in the right place, by the right provider with the right information. More than that, they want their perspectives on their health, the health care system, and how decisions and investments are made by the government to be valued and respected by those who provide care and those who oversee it.

Since the COVID-19 pandemic, the public has been engaged at a level never before seen about how health services are funded and organized, how the health system is performing, and how their primary health care teams and an overburdened workforce will be able to meet their needs. Albertans are calling for bold transformation to modernize Alberta's primary health care system that is focused on empowering citizens (who are sometimes patients) and their communities, taking a multi-sectoral approach that is rooted in the social determinants of health, and is governed in a way that is accountable to the public.

To better understand what matters to people in Alberta, the Modernizing Alberta's Primary Health Care System (MAPS) initiative sought the perspectives of the public

through targeted engagement. One way was by inviting Imagine Citizens Network (ICN)[1] to engage with people who live in Alberta to capture what matters most to them about primary health care and to share what was learned with the MAPS initiative. ICN talked to Albertans from across the province to identify guiding principles that reflect peoples' values regarding the redesign and delivery of primary health care programs, services and care. The principles these citizens identified are as follows:

- **The foundation–equitable and inclusive access:** A primary health care system that serves ALL Albertans equitably and inclusively, ensuring timely access by addressing barriers such as (but not limited to) geographical, cultural, physical, social-economic, and sensory.
- **A whole person approach that incorporates a broad definition of health:** A primary health care system that focuses on the whole person, provides individualized care, and where health is broadly defined to include physical, mental, spiritual, and emotional aspects.
- **Mental health as a critical component:** A primary health care system where mental health services and care are a critical component and fully integrated in the primary health care system.
- **Team-based care:** A primary health care system that uses an interprofessional, team-based approach to care. This approach employs a broad team working together, ensuring the right people provide the right care, and physicians are not necessarily the primary point of contact. The team also includes the patient and their caregivers.
- **Based on relationships:** A primary health care system with organizational structures and processes purposefully developed to actively support relationships between patients and health care providers. These relationships are characterized by mutual

[1]Imagine Citizens Network is an Alberta-based, independent, citizen-led organization established in 2015 whose vision is "a health system intentionally designed in partnership between citizens and other shareholders to achieve the best possible experiences and outcomes for all Albertans".

trust, respect, compassion and understanding. Relationships are built on:

  - Choice – in who to develop the relationship with and the role one plays.
  - The conviction that people know what matters most in the context of their lives and need to be supported to establish their strategies for health and well-being.

- **Effective communication supporting care and navigation:** A primary health care system in which all Albertans can easily access the information they need about their health, their care, and to navigate the system. They can comfortably share information about their health with their providers.
- **Confidence in safety:** A primary health care system where people are safe (physically, culturally, psychologically), and there is a trauma-informed approach to care.
- **A proactive approach:** A proactive primary health care system focuses on prevention, well-being and all aspects of the social determinants of health.
- **Integrated care:** A primary health care system in which health care services are better integrated with other care (e.g., primary care with acute care), and community services that impact health and well-being.
- **Effective system communication:** A primary health care system that eliminates silos with effective communication and information-sharing across the system and between systems.
- **Community-based:** A primary health care system that recognizes communities as key sources of the important physical, social, and spiritual assets that enable health. Communities should be the primary level at which care is organized, including a [patient's medical home] as the anchor, and the level at which health outcomes are reported.
- **Including peoples' voices:** A primary health care system in which lived experience is recognized as critical knowledge to draw upon as we redesign our primary health care services and system. Therefore:

- Structural change must be designed with full and inclusive citizen involvement.
- Governance systems must reflect the citizen-patient voice.

So what does this mean for the MAPS initiative? The MAPS Strategic Advisory Panel embraced these citizen-oriented principles in their entirety. The united perspective of this diverse group of leaders is that in order to modernize Alberta's primary health care system, the entire health system needs a reset to refocus on the people living in Alberta who are the ultimate shareholders and beneficiaries of health care in Alberta.

At the heart of this movement is creating meaningful partnerships between people that are based on mutual trust and respect. Albertans' value their relationships with their primary health care providers–family physicians and other professionals–yet they know that these care providers do not always work effectively as a team and often work in isolation without access to an interprofessional team. While existing policies, regulations and education programs related to how these professionals train and work have been set up to protect public safety, they have also created professional silos, enabled arbitrary power differentials, and limited a person's ability to make informed choices and decisions about their own health.

Primary health care professionals across the province–who themselves are citizens, patients and family caregivers–also see these challenges and are striving to overcome them. The reality is that these dedicated professionals and leaders, working tirelessly to keep up to the needs of patients and communities, can't do this on their own. Bold, shared leadership and political will is needed to bridge the divide from the primary health care we currently have to a future primary health care **SYSTEM** where the person is at the heart of their health journey. Where the primary health care system is designed together with and for Alberta's diverse people and communities.

People in Alberta deserve no less.

Executive Summary

Executive Summary

Albertans expect their primary health care system to be there for them and their loved ones throughout their life journey—at the right time, in the right place, by the right provider with the right information.

The MAPS vision is simple: When primary health care works, people and families are connected with trusted health workers and support systems through consistent and equitable access to comprehensive services. This includes integrated care with connections to non-health sectors, community support, housing and a huge number of other services and networks of care that have been developed to address the broader social determinants of health throughout their lives.

Alberta's Minister of Health set a strategic mandate for the Modernizing Alberta's Primary Health Care System (MAPS) initiative: recommend to the government an 'action plan' or 'roadmap' for how Alberta can work to achieve increased equity of access to quality primary health care services for all Albertans, no matter who they are, or where in the province they live. The Minister convened the MAPS Strategic Advisory Panel to develop the recommendations and a roadmap for modernizing Alberta's primary health care system.

The process of extensive engagement that followed involved two expert panels composed of over 40 individuals from across the spectrum of primary health care models, patients and citizens, Colleges, Associations and professions (medical doctors, nurse practitioners, registered nurses, pharmacists and a range of allied healthcare providers). The panels met over 12 times to discuss and debate a wide range of innovations, approaches and solutions, drawn from successful transformational best practices here in Alberta and from across the globe.

Their deliberations and the engagement process was enhanced through numerous working groups, public consultations, consideration of over 25 written submissions from

key stakeholders (including the Alberta College of Family Physicians, Alberta Medical Association, the Provincial Primary Care Network Committee, Imagine Citizens Network, Alberta College of Pharmacy, and the Universities of Alberta and Calgary) and a two day forum that brought together 115 participants representing stakeholders from across the province and beyond. Together, they heard presentations from health care leaders and primary health care experts, and participated in focused sessions on the topics of rural and remote communities, underserved populations, team-based primary health care and Indigenous health and wellness.

Many ideas were put forward and considered by the panels. A common theme throughout all of the engagement and panel meetings was the importance of having a comprehensive plan that provides a roadmap for the next 5-10 years. This report, therefore, represents an unprecedented level of consensus, especially for an initiative of this magnitude, inclusivity, breadth and importance in transforming primary health care – marking a substantial achievement in charting the path forward for making primary health care better for all Albertans, and meeting the challenge mandate set out by the Minister.

The 11 overarching recommendations, which are detailed in this report, have been put forward to the Minister of Health by the MAPS Strategic Advisory Panel to strengthen primary health care in the province and to achieve a primary health care-oriented health system that delivers the following outcomes:

Access	Integration	Quality	Albertans as Partners	Culturally Safe and Appropriate Care
All Albertans, including First Nations, Métis, and Inuit peoples, have access to timely, appropriate primary health care services from a regular provider or a team.	Every Albertan has a patient's medical home that provides primary care services and integrates with other providers seamlessly with other health, social and community services to provide primary health care.	Albertans receive high quality services from an accountable, innovative and sustainable primary health care system that is constantly improving at all levels in response to changing needs.	Albertans and their social support networks are meaningful partners in achieving their health and wellness goals.	All people, including First Nations, Métis and Inuit persons, have access to high quality, culturally safe care that is free of racism, and designed and delivered in a manner that respects their unique health care needs.

Health care services are currently oriented and organized around the acute care system and facilities rather than citizens, patients and caregivers and primary health care. Equitable access to those services, particularly in rural, remote, and Indigenous communities is a challenge. Primary health care in Alberta is fragmented, with siloes across the province and within communities. Like other jurisdictions, Alberta's health care system, including primary health care, is facing unprecedented pressures. There is an increasing need to:

- Purposefully organize Alberta's health system around, and prioritize investments in, primary health care; and
- Improve integration between primary care, other parts of the health system and community-based social services, and
- Create an environment that supports, values and enables primary care providers in doing what they do best - providing quality primary care to the people of Alberta.

Alberta has a strong foundation in primary health care delivery. This foundation includes highly trained and dedicated health care providers across the province working in

primary health care. In 2017, Alberta became the first Canadian jurisdiction to introduce a provincial governance structure for Primary Care Networks (PCNs) to facilitate integration and alignment of primary health care services across PCNs, Alberta Health Services (AHS), and community agencies. Today, there are 40 PCNs[2] in the province that provide non-physician team-based services and population health services, and that facilitate quality improvement initiatives as well as evaluation, monitoring and reporting. PCNs play a vital role in coordinating health services including specialized programs and longitudinal care to help patients access the care they need and in collaborating in broader health system initiatives. PCNs support approximately 3,800 family physicians who practice in an estimated 1,000 clinics.

Despite this strong foundation in primary health care, the province faces a number of challenges that must be addressed if primary health care in Alberta is to meet the needs and expectations of the diverse people and communities it serves across the province, notably:

- **Access to care:** Only four out of ten Albertans reported being able to get a same day/next day appointment with their primary health care provider (a number that has been steadily declining over the past five years).[3] There has been a steady decline in interest in family medicine by students in Alberta. The March 2023 Canadian Resident Matching Service (CaRMS) report showed that there were 42 unmatched family medicine residency positions in Alberta (increased from just seven unmatched in Alberta in 2017) compared to only two unmatched in BC and none in Saskatchewan. These challenges can only be addressed by having a healthy, engaged, thriving workforce that feels valued and is supported in the work they do.
- **Lack of team-based primary care:** People are often not able to access interdisciplinary care through their patient's medical home because most providers do not work in interprofessional teams. The ratio of non-physician clinical resources funded through Alberta's PCNs is estimated at 0.4 FTE per PCN family physician.[4]

[2] As of the publication date. Effective April 1, 2023, an amalgamation of two PCNs (Saddle Hills and Peace Region) will change this number to a total of 39 PCNs.

Additional team resources may be funded by physicians through their FFS earnings, but the number and type of team resources is unknown. It is widely accepted that the non-physician resources are insufficient to the need.

- **Lack of continuity of care:** Continuity of care, a continuous relationship with a primary care provider, is a significant challenge for many Albertans despite the evidence that continuity of care is critical to a more effective overall health care system. Several studies in Alberta and around the world have demonstrated that improvements to continuity of care are associated with lower costs, lower utilization of the acute care system, and improved population outcomes.
- **Fragmentation of governance, responsibility and accountability:** Governance and integration in primary health care is not structured to support a true primary health care system and has resulted in fragmentation with no single organization or authority that can represent the needs of the primary health care sector or enable alignment of the many stakeholders. No one organization is accountable for primary health care.
- **Misalignment between responsibility, authority, and capacity:** PCNs are responsible for providing adequate support to primary care clinics, but have limited capacity to do so because of a funding model that disadvantages rural communities, does not consider distinct local needs and characteristics; and does not account for unattached patients.

The vision for primary health care in Alberta is clear.

If Alberta is to truly address the known challenges, emerging issues, and most importantly, build on the strengths of the current system, a renewed vision for primary health care in Alberta is needed.

Every person in Alberta should have access to primary health care and a diverse interprofessional team of care providers in their patient's medical home. Primary care should be integrated with other health and well-being services including community, social, education, and acute care providers to address all the factors that influence a person's health. People should have access to the healthcare they need, from the right provider, at the right time with the right information to make informed health decisions together. People and communities should have a say in the care they receive.

Providers should be supported and funded to do what they do best - provide quality primary health care. The future primary health care system should create a stable, supportive environment that appropriately values the wellness of primary health care providers and the critical role they fill in our healthcare system. The primary care system relies on a healthy, engaged and supported workforce that has the resources needed to deliver quality primary care whether in urban/suburban, rural, remote or Indigenous communities.

By significantly investing in integrated primary health care, people in Alberta will live healthier lives. There should be less burden on hospitals, emergency departments and ambulance services. Public health outcomes should improve and overall health system costs should decrease for individuals with chronic disease or comorbidities. Alberta can build a leading, sustainable primary health care system for generations to come.

To achieve this vision, a number of strategic shifts are needed in how primary health care is viewed and decisions are made. These changes in paradigm will be the foundation for building a modernized and integrated primary health care system. The future primary health care system in Alberta will see us move from the current state to a desired future state by realizing the following strategic shifts:

FROM…	TO…
Citizens and communities are not meaningfully involved; health and social care are not integrated	Design primary health care with and around the needs of people and communities, inclusive of health and social care
Interprofessional teams are not the usual mode of primary health care delivery; many primary health care providers are not enabled to work to their full scope of practice or supported by an effective health workforce strategy; workforce planning is disjointed	Create a primary health care system that is built with engaged and highly collaborative teams in a patient's medical home, that is integrated with other care services including community and social care. The workforce should be built with a focus on provider wellness where teams are provided support, capacity and resources needed to thrive
Too often, services and programs are designed at a provincial level and fail to reflect the unique needs of Alberta's rural and remote communities	Recognize that rural and remote primary health care is different from urban centers and that planning and decision-making should happen locally in the communities
Efforts related to quality and safety improvement and innovation are fragmented, with multiple organizations playing limited roles	Enable a learning system where quality and safety improvement is the *modus operandi* for providers, leaders and community members who have capabilities, teams and support for implementation, measurement and innovation
Responsibility and authority are disjointed with no clear governance and accountability in primary health care and limited tracking of impacts and outcomes of investments	Establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes

In order to deliver on this, the MAPS Strategic Advisory Panel has developed 11 overarching recommendations against five categories that will meaningfully transform, modernize and sustain a true primary health care system in Alberta.

These recommendations have been developed to build and modernize a primary health care system and not to provide solutions to individual challenges. Each of these recommendations is linked and enables and strengthens each other. As such, these recommendations should be implemented together and in support of each other. The collective implementation of these recommendations is necessary if Alberta is to truly move the needle on improving individual, provider, community and system wide positive outcomes for the primary health care system.

Overarching Recommendations:

Transforming governance by strengthening and aligning accountabilities

1. Reform primary health care governance with clear accountabilities by:
    a. Establishing the resourcing and governance frameworks to support the patient's medical home (PMH) as the main practice model for primary health care in Alberta.
    b. Evolving and expanding the Primary Care Network (PCN) model to become Regional Primary Health Care Networks.
    c. Establishing the Alberta Primary Health Care Organization to provide oversight and leadership to the primary health care system in Alberta.
    d. Integrating decision-making and planning processes for primary health care with AHS and other actors by establishing a Provincial Health Integration Commission.

2. Align primary health care funding with delivery and accountability under the new provincial governance model.

Evolving patient's medical homes within an integrated health neighbourhood

3. Embrace patients and citizens as partners to empower people and communities to participate in and develop a primary health care system oriented around the people in Alberta.
4. Accelerate efforts to ensure every person in Alberta can be connected to a patient's medical home that provides team-based primary care with a diverse team of health care professionals.
5. Systematically connect every patient's medical home to a broader integrated health neighbourhood to enable whole of person care that integrates primary care with other primary health care services including social, community and acute care systems. Primary care alone cannot address all aspects of an individual's health.
6. Reduce the financial risk of clinic ownership and administrative burden through targeted investments in clinic supports, technology and infrastructure.
7. Invest in quality, safety, and innovation capabilities and capacity as a strategic priority with the primary health care system and embed these capabilities throughout the primary health care system.

Enabling the primary health care workforce to improve health outcomes

8. Establish a comprehensive primary health care workforce strategy aimed at building and sustaining a healthy, engaged and diverse workforce who are supported in providing team-based care across the province with targeted actions to:
    a. Retain the current workforce including urgent supports;
    b. Increase the supply of health care providers working in primary care in Alberta;

and

c. Recruit and train additional primary health care providers.

9. Adapt and improve a remuneration model that enables diverse teams of care providers and continuity of care within the patient's medical homes in support of the workforce strategy including expanding alternative models such as blended capitation model or capitation models as viable alternatives to fee for service.

Digitally enabling primary health care to improve health outcomes

10. Accelerate the implementation of actions that make the eHealth environment more functional and robust for primary health care teams including improved integration and data sharing capabilities across EMRs and other systems and continue to invest in "one patient one record" functionality to empower patients to access and use their health information as a partner in their primary health care team.

Significantly investing in primary health care

11. Develop a well defined investment plan to significantly invest in primary health care and measure the impact to achieve better outcomes and value across the health system. The total level of funding required to implement the recommendations must be sufficient to fully address the gaps noted and implement the full set of recommendations.

These recommendations set a bold new direction for primary health care in Alberta. The Government of Alberta can take immediate action in the next 12 to 24 months to both stabilize the primary health care system by providing immediate support and to begin the critical work required to implement these long term actions. The modernization of the primary health care system is not a generation away. The implementation roadmap presented in this report lays out a path to modernization within a five year time frame

with the supports and systems in place to continuously drive improved outcomes for generations to come.

The recommendations will reorient the health care system around people and communities. When implemented, all Albertans can expect access to timely primary health care in a patient's medical home of their choosing, delivered by a diverse team of providers who know them, their goals and have been their partner throughout their health journey. People and providers will have access to the information they need to make informed decisions together. Teams of care providers will be supported, funded and provided the resources to do what they do best—deliver quality primary health care. People will have access to the care and resources they need to address all the factors that impact their health through an integrated health neighbourhood.

This vision is attainable. These recommendations are bold, but realistic. Taken together, the recommendations provided in this report provide the roadmap for modernizing Alberta's primary health care system and setting a new standard for primary health care for generations to come.

Overview of the Modernizing Alberta's Primary Health Care System (MAPS) Initiative

Overview of the Modernizing Alberta's Primary Health Care System (MAPS) Initiative

Introduction

Each day, thousands of Albertans receive primary care services, usually from a family physician, nurse practitioner, nurse or pharmacist. Although these interactions between Albertans and their primary care providers typically occur in one of the many clinics located throughout the province, they may also occur in the patient's home, at long-term care facilities, on university or college campuses, or increasingly, virtually via phone, secure messaging, or by video. In general, these visits involve routine care, care for urgent but minor or common health problems, mental health care, maternity and well-baby care, psychosocial services, liaison with home care, health promotion and disease prevention, nutrition counseling and end-of-life care. It is also a key source of chronic disease prevention and management.

Primary Health Care vs. Primary Care

Primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment.

Primary care Primary care is the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury.

(Health Canada, 2012)

Family physicians are highly trained specialists with a unique and irreplaceable skill set focused on providing longitudinal and relationship based care to people in Alberta (throughout this report the term Family Physician is used but refers to Family Medicine

Specialists). In some cases, patients may receive care from a broader team of clinicians and other professionals seeking to assist them in better managing their health and the life conditions which affect their health. The broader team may include nurses, mental health workers (psychologists, counselors, behavioral health consultants), dieticians, physiotherapists, social workers, care coordinators, and others. For most people, most of the time, their health care needs can be addressed at the level of primary care.[5]

For many years, we focused on primary care that was traditionally delivered by healthcare providers. However, in recent years, policy makers and providers have begun adopting the term primary health care to distinguish between the traditional approach and one that is broader and more reliant on interprofessional teams to deliver care and services that cover a broader range of health, wellness, and social needs.[6] High quality primary health care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[7]

The benefits of a strong primary health care system

A strong primary health care system has physical infrastructure located in the right places in their communities, where people can easily access the health services they need when they need them. Health care providers who are trained, empowered, and incentivized to deliver quality primary health care as a team. Systems and policies that ensure essential medicines, vaccines and diagnostics are available and of high quality. Adequate funding is essential to ensure a system can provide the fundamental services that most people need. These services must work together and be integrated to support the patient enabling continuity of care and one care plan.

When primary health care works, people and families are connected with trusted health workers and supportive systems throughout their lives and have access to comprehensive services including from non-health sectors such as human services and

housing, among others, addressing more than 80 percent of people's common health needs throughout their lives.

"Achieving the highest quality healthcare available depends on moving purposefully toward what is known as integrated care."

(The Office of the Auditor General of Alberta, Better Healthcare for Albertans, May 2017)

Background

Alberta has a strong foundation in primary care delivery. This strong foundation includes highly trained and dedicated health care providers across the province working in primary health care. In 2003, Alberta was the first jurisdiction across Canada to introduce Primary Care Networks (PCNs). Today, there are 40 PCNs[3] in the province that provide non-physician team-based services, population health services and facilitate quality improvement initiatives, as well as evaluation, monitoring and reporting. PCNs support approximately 3,800 family physicians who practice in an estimated 1,000 patient's medical homes. PCNs also play a vital role in coordinating health services including specialized and long term care to help patients access the care they need and in collaborating in broader health system initiatives. In 2017, Alberta became the first Canadian jurisdiction to introduce a provincial governance structure for PCNs to facilitate integration and alignment of primary health care services across PCNs, Alberta Health Services (AHS), and community agencies.

Despite this strong foundation in primary care, the province faces a number of high-level challenges. The structure of health care services, which—like most jurisdictions—remains organized around its acute care system and facilities rather than citizens, patients, caregivers, and primary health care providers; and equitable access to those services, particularly in rural, remote, and Indigenous communities.

[3] As of the publication date. Effective April 1, 2023, an amalgamation of two PCNs (Saddle Hills and Peace Region) will change this number to a total of 39 PCNs.

Primary health care services are fragmented, with different elements siloed from one another across the province. While these challenges are not new (they existed well before the onset of COVID-19), they have been exacerbated by the pandemic. Like other jurisdictions, Alberta's health care system, including primary health care, is facing unprecedented pressures at this time. The impact of the pandemic is still being felt by primary health care providers who continue to face increased workloads and burnout.

The Modernizing Alberta's Primary Health Care System (MAPS) initiative is about improving primary health care in Alberta. It is the outcome of the growing recognition of the need to:

i. Purposefully organize Alberta's health system around, and prioritize investments in, primary health care;

ii. Improve integration between primary care, other parts of the health system and community-based social services; and

iii. Create an environment that supports, values and enables primary care providers in doing what they do best - providing quality primary care to the people of Alberta.

It is against this backdrop that Alberta Health launched the MAPS initiative to identify actionable steps to improve primary health care in Alberta in the short-term and over the next five to ten years.

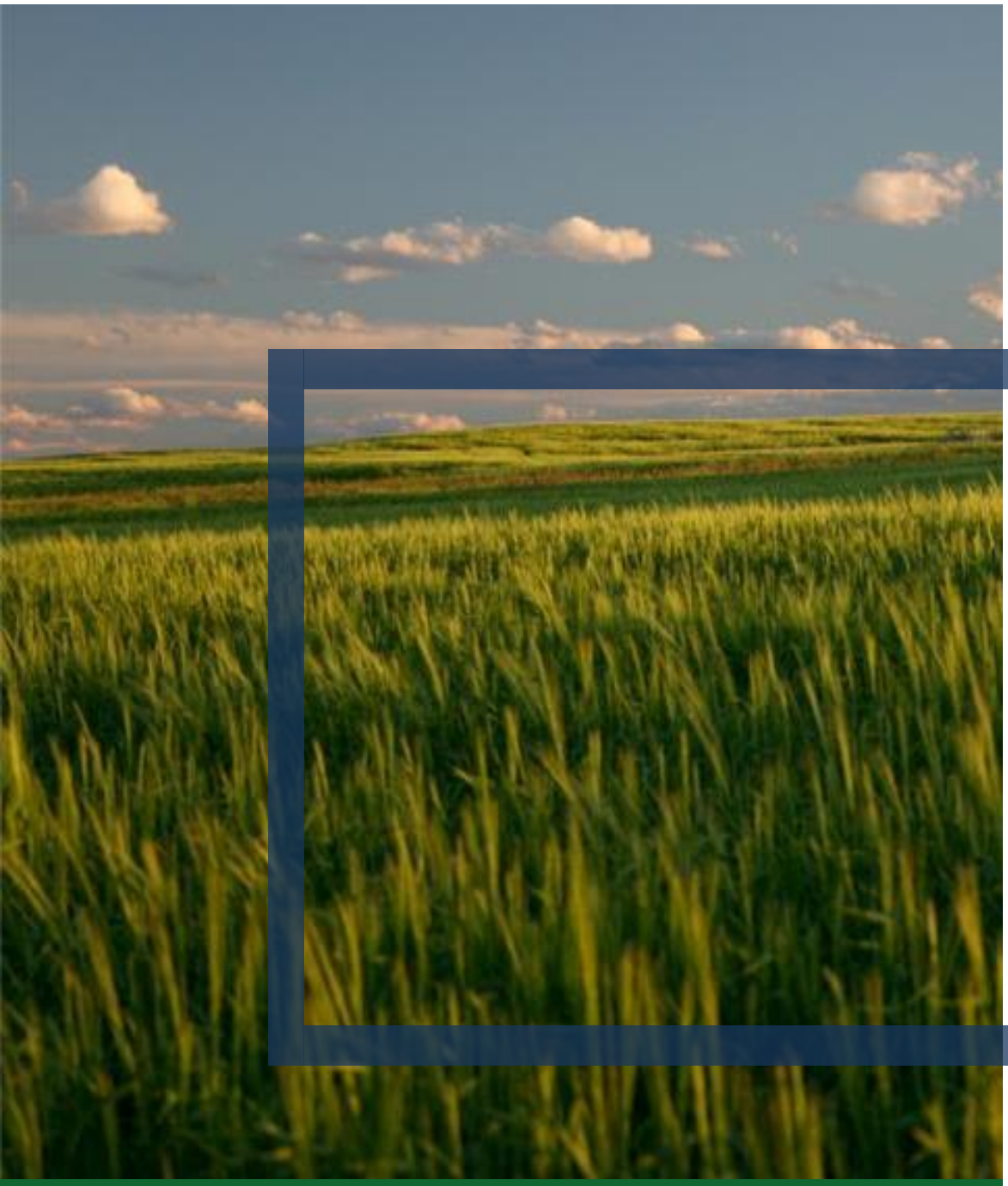
Vision and Desired Outcomes

Alberta's Minister of Health set a strategic mandate for the MAPS initiative: *recommend to government an 'action plan' or 'roadmap' for how Alberta can work to achieve increased equity of access to an equitable quality of primary healthcare services for all Albertans, no matter who they are, or where in the province they live.* This vision and direction acted as a guide for the initiative's Advisory Panels, and it was maintained that all deliberations and recommendation evaluations would be made with its message in mind.

At its core, the underlying vision of the MAPS initiative is to deliver improved outcomes, cost-effective care to all Albertans, and to strengthen how the broader health system supports and is oriented around primary health care providers, patients and caregivers. In this way, the MAPS initiative is an opportunity for Alberta to build on its primary health care assets, including PCNs, primary health care providers, patients, and caregivers, to strengthen the province's underlying health system.

A series of recommendations, which are outlined in this report, have been put forward to the Minister of Health on proposed ways to strengthen primary health care in the province and to achieve a primary health care-oriented health system that delivers the following overarching outcomes:

Access	All Albertans, including First Nations, Métis, and Inuit peoples, have access to timely, appropriate primary health care services from a regular provider or a team. Care options are flexible and reflect individual and population health needs.
Integration	Every Albertan has a patient's medical home that provides primary care services and integrates with other providers seamlessly with other health, social and community services to provide primary health care. Coordination and communication between providers and organizations is promoted and facilitated by service planning and the provincial governance structure.
Quality	Albertans receive high quality services from an accountable, innovative and sustainable primary health care system that is constantly improving at all levels in response to changing needs. Health service delivery is evidence informed, follows best practices, and uses resources efficiently.
Albertans as Partners	Albertans and their social support networks are meaningful partners in achieving their health and wellness goals. Health services are proactive, recognize and address underlying influences on health outcomes, and respect individual needs and preferences.
Culturally Safe and Appropriate Care	All people, including First Nations, Métis and Inuit persons, have access to high quality, culturally safe care that is free of racism, and designed and delivered in a manner that respects their unique health care needs.



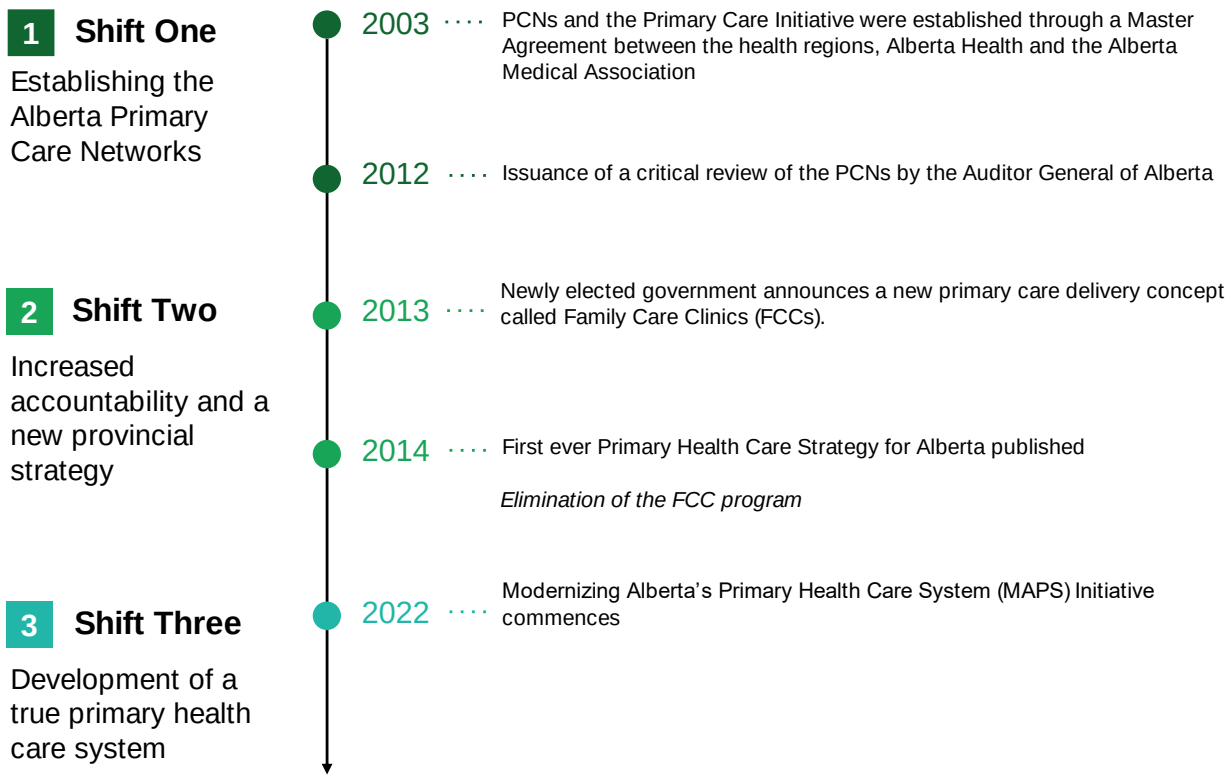
Primary Health Care in Alberta

Primary Health Care Context in Alberta

The primary health care landscape across Canada has experienced incremental change since the late 1990s, with policy innovations and significant investments in system transformation enabling reform across all provinces.[7] Although the specific goals and objectives for primary health care differ across provinces and territories, they all involve common themes as follows:

- Improved access
- Better coordination and integration
- Adoption of team-based approaches
- Improved quality of care
- Emphasis on patient engagement
- Implementation of information management and information technology

Significant efforts have also been made to innovate within primary care to address issues. Examples of these include new models of primary care that facilitate access to interprofessional teams, policies that increase accountability for care provided to rostered patients, and requirements for providers to provide timely access and enhanced access to after-hours care.[9] Health systems across Canada have also developed policies to increase their deployment of nurse practitioners in primary care settings,[10,11] as well as to expand scope of community pharmacists to address common minor ailments.[12] Over the past 20+ years, there have been three significant shifts relating to the primary health care system in Alberta.



Shift One: Establishing the Alberta Primary Care Networks

Between 2003 to 2006 the Federal government provided funding to support the First Ministers' commitment to making team-based care a central component of health care reform. With available funding and political will behind the initiative, senior health system leaders offered their support to a group of physician leaders who, with support from the Alberta Medical Association and the then Regional Health Authorities (predecessor to Alberta Health Services), devised the blueprint for what would become Alberta's Primary Care Networks (PCNs).

In 2003, the PCNs and the Primary Care Initiative were established through a Master Agreement between the health regions, Alberta Health and the Alberta Medical Association. Funding flowed to each PCN based on the number of patients assigned to each participating family physician. This flat fee per patient was paid to the PCN.

The use of these funds were limited by a broad and loose policy framework. This resulted in significant variability in the organization, prioritization and even the use of

the available funds. There was no overarching provincial strategy or policy framework to which the PCNs could guide their local strategies and operations. By 2013, PCNs had underspent their allocations by nearly $100 million. Some had amassed huge reserves while others had budgeted and spent according to their allocations and had only basic reserves to provide working capital.

In 2012, the Auditor General of Alberta issued a critical review of the PCNs for the significant weaknesses in the accountability structures for the PCNs and recommended that improved structures be put in place to create consistent performance management and financial reporting.

Shift Two: Increased accountability and a new provincial strategy

In response to the Auditor General's report, the newly elected government announced a new primary care delivery concept called Family Care Clinics (FCCs). Three pilots of these clinics were announced, one in Edmonton, one in Slave Lake and one in Calgary, with a second wave of up to 80 additional FCCs across the province. These models would have non-fee-for-service compensation models for physicians and included funding, on a grant basis, for an interprofessional team of care providers based on the target population to be served. There would be tight and formal attachment policies for patients and the governance would include physicians, but not be led by physicians. A robust set of performance measures would be collected and reported.

In parallel, and in response to the design and implementation of FCCs, a distinct effort was launched to improve the accountability and performance of PCNs. This effort resulted in the establishment of a process led by physicians to develop policy shifts, initiatives and investments that could be made to align the accountability structures and quality of care provided through PCNs with those of the FCCs (2013-14). The $100M in reserves was a potential funding source for the changes, enabled by a major policy decision by Alberta Health to assume responsibility for all wind-down costs in the event a PCN needed to close or lay-off employees.

At the same time as both of these efforts were underway, the Minister of Health struck a Primary Health Care Strategy Working Group to support the development of a first-ever Primary Health Care

Strategy for the province (2013-14). This strategy, published in 2014, provided a clear vision and policy framework for a more high-functioning primary health care system for the province and envisioned a primary health care system where:

- All Albertans are connected to a well-coordinated and accessible primary health care home and also have access to comprehensive care across the province;
- Focus is placed on wellness, prevention, chronic disease management, and early detection screening;
- Teams of providers deliver care beyond medical services (e.g. mental health, social/community services, etc.), have longer hours of service, and connect patients to health, social, and community programs;
- Integration of health records enable continuity of care; and
- Communities participate in service planning and work together to emphasize sharing information and work towards common goals.

In 2014 the FCC program was eliminated and the $100M in reserve funding was repatriated by the Government. The basis for these decisions was linked to the government's fiscal situation, but the effect on the relationships between family physicians, Alberta Health and Alberta Health Services was significant.

Continuing evolution of primary health care in Alberta

Alberta has continued to evolve. Local and global events have further shaped primary health care in Alberta. Examples of these include, but are not limited to:

- Introduction of a new governance structure for PCNs that aims to improve integration between PCN services, Alberta Health Services, and community-based services;
- The rapid deployment and adoption of virtual care across the province[13], which itself poses challenges related to access and quality of care[14] ; and
- Pilot of a blended capitation model (distinct from the existing arrangements at Crowfoot and Taber Clinics).

While some of these dynamics have helped move the agenda forward, others have created anxiety, mistrust or confusion among primary health care system stakeholders. This reinforces the need for role clarity across primary health care system stakeholders. It is also clear that important challenges remain with respect to equitable access to quality of care for Albertans.

A new shift in primary health care in Alberta

Alberta is at the leading edge of a new significant shift, driven in part through the MAPS initiative, and heavily influenced by workforce pressures and changing needs of the population resulting from the pandemic. There are still significant opportunities to:

- Further improve the alignment of accountability, authority, and responsibility to strengthen governance within the primary health care system;
- Increase adoption of interprofessional team-based care approaches in patient's medical homes (PMH);
- Enhance the information and technology ecosystem with standards for digital solutions for patient health record management, and integrate across the health system; and
- Invest in achieving better health outcomes for Indigenous populations, and those living in remote and rural parts of the province.

The MAPS initiative and the recommendations provided within this document set the direction of a new paradigm shift in primary health care in Alberta. One that refocuses and emphasizes on access to team-based care, integration between primary care and community care, and is built on the foundation of a coordinated and accountable primary health care system.

The primary health care system in Alberta must shift to be more responsive and effective in addressing a lack of cultural safety, disparate outcomes and challenges with access for Indigenous Peoples in Alberta. The future primary health care system must be designed with Indigenous Peoples to provide accessible, relevant and culturally safe primary health care to First Nations, Métis and Inuit peoples across Alberta. To that end, as a part of the MAPS initiative, the Minister has established an Indigenous Primary Health Care Advisory Panel to identify opportunities to improve primary health care for Indigenous peoples. The Indigenous Primary Health Care Advisory Panel will be submitting their own recommendations report, which should be read in complement to this document.

The primary health care environment in Alberta, the relationships between the Government and health care providers, and the ability of key stakeholders to organize around a shared vision has constantly shifted over time. There have been periods of high trust, and shared interest in collaboration and positive action that have led to meaningful developments in primary health care, including the establishment and evolution of the PCNs in Alberta. There have also been periods of diminished trust or disagreements that have prevented the establishment of a shared vision to drive positive change.

The MAPS initiative relies on strengthening trust, a shared vision, a commitment to mutual action between the Government of Alberta, primary health care providers and the ultimate stakeholders in primary health care - the people of Alberta.

Photo courtesy of the Government of Alberta

Primary Health Care in Alberta - The Case for Change

Primary Health Care in Alberta - The Case for Change

The Benefits of Strong Primary Health Care

Health systems with strong primary health care have better population health, higher patient satisfaction, fewer unnecessary hospital admissions, greater health equity, and lower health costs.[15,16] Access and relational continuity of care are two major pillars of strong primary health care. While there are additional characteristics defining a strong primary health care system, including integration and comprehensiveness, the impacts of access and continuity are particularly well-established in the literature.

Access

Access is how a patient interacts with the healthcare system, and is impacted by geographical, temporal, financial, cultural and digital factors.[17] Access to primary health care has been shown to improve population health outcomes. There is strong evidence correlating the strength of the primary health care system with lower mortality rates.[18,19] Other studies have shown that countries with strong primary health care performed better on outcomes for patients with chronic diseases and mental illnesses.[20,21,22] Additionally, access to primary care is associated with preventative activities and health promotion, including counseling for smoking cessation, immunization, and routine cancer screening.[23,24,25]

More accessible primary health care is also expected to reduce overall health system costs, by reducing hospitalization rates and emergency department visits.[26] Primary health care can generally prevent the need for hospitalization for specific conditions known as Ambulatory Care Sensitive Conditions (ACSCs), including diabetes, chronic obstructive pulmonary disease, asthma, hypertension and congestive heart failure. When these conditions are managed in a coordinated way in the community, patients with

these conditions have fewer exacerbations requiring hospitalization. Hospitalizations for these conditions are generally defined as being avoidable.[27]

Relational Continuity

Relational continuity is defined as an ongoing relationship between the patient and primary care provider, leading to the establishment of strong mutual trust and understanding. The impact of relational continuity, specifically, on patient outcomes and system costs is well-documented in the literature. The primary care provider could be considered a single practitioner or a group/health team.[28]

Several studies in Alberta and around the world have demonstrated that improvements to relational continuity of care are associated with lower costs, lower utilization of the acute care system, and improved population outcomes. One study in Alberta found that unplanned hospitalizations and emergency department (ED) visits declined with increasing relational continuity of care with a primary care provider.[29] A second study in Alberta found that relational continuity of care with a primary care provider or clinic was associated with reduced emergency department use within 30 days of discharge, and a shorter length of stay. The relationship between relational continuity and length of stay was strongest for patients with major chronic disease.[30] These findings are further validated by a CIHI study which found that in Alberta, the likelihood of being hospitalized for ACSCs was 29% higher in those with a low physician continuity score, compared to those with a high physician continuity score. Similarly, the likelihood of visiting an ED for Family Practice Sensitive Conditions was 43% higher in those with a low physician continuity score, compared to those with a high physician continuity score.[31]

Additional studies in the U.S. and Canada have quantified the impact of relational continuity on health system costs. A B.C. study found that an increase of 5% in the overall attachment level to a primary care practice for a selected group of high-care-needs patients could have resulted in savings of $142M in 2010/11.[32] In the U.S, studies have reported savings of $52 per patient per year up to $151 per patient per year with

every 0.1 increase in physician continuity score for the general population.[33, 34] Investing in relational continuity between patients and their care team would be expected to have a positive impact on the acute care sector, and reduce downstream system costs.

Key Challenges Facing Primary Health Care in Alberta

Many of the access and continuity measures suggest that there is plenty of room for strengthening primary health care in Alberta.

Albertans face challenges in accessing primary health care in a timely manner:

- An estimated 12 - 16% of Albertans do not have a regular health care provider, representing approximately 600,000 - 750,000 people.[35,36,37]
- Only four out of ten Albertans reported being able to get a same day/next day appointment with their primary health care provider (a number that has been steadily declining over the past five years).[38]
- Only one in three Albertans reported ease in finding after-hours care.[39] Access to after-hours care is particularly important for low income Albertans, who may not be able to take time away from work.

In addition to challenges in accessing primary health care, Albertans do not consistently receive coordination of their care across the care continuum, with only 40% of Albertans

reporting that their provider frequently coordinates their care with social services or other community providers.[40] Care coordination is particularly a barrier for Albertans with specific and/or complex medical needs, including seniors, refugees and migrants, and individuals experiencing homelessness, who often require services across multiple providers.[41,42,43]

Finally, the comprehensive needs of underserved populations are not being met in a systematic and consistent way. It is well established that health and well-being vary based on social and economic factors known as the social determinants of health, which are described as the conditions in which people are born, grow, live, work and age. Canadian estimates have found that approximately 50% of health outcomes can be attributed to these factors.[44] The social determinants of health impact the ability of underserved populations to access comprehensive and appropriate care. Examples in Alberta include:

- Many Albertans living in rural communities must travel extensively to see their health care provider.[45] As 67% of rural Albertans do not have access to reliable high-speed internet at federal target speeds[46], access to virtual care options is limited.
- Seniors are often unable to access the care they need from the right provider, in the right place, and at the right time.[47]
- Refugees and migrants face challenges in accessing and navigating the health care system due to language and cultural barriers, health system literacy challenges, and a lack of culturally appropriate mental health services or trauma-informed care.[48]
- Individuals experiencing homelessness are not regularly connected to long-term solutions when utilizing the health system.[49]

There are wide disparities in health outcomes between communities and population groups in Alberta. Examples of these disparities include:

- The age-standardized prevalence rate of diabetes ranges from 4.4 to 17.2 per 100,000 people across communities.[50]

- Similarly, the age-standardized rate of visits to the emergency department for mental and behavioral disorders ranges from 792.2 to 9,548.0 per 100,000 people.[51]
- Income has a significant impact on health, demonstrated by a four-year difference in life expectancy at birth between the highest and lowest income groups (83.4 vs. 79.3 years), and a substantial difference in death rates for cancer (124 compared to 172 per 100,000 population). Injury mortality and smoking rates follow a similar trend.[52]
- Life expectancy at birth is lower in rural areas, ranging from a three year average of 79.2 years in the North Zone to 83.1 years in Calgary from 2015 - 2017.[53]
- The life expectancy at birth of First Nations people was 63.2 years in 2021, compared with 81.4 in the general population – a difference of 18.2 years.[54]

Historically, primary care has focused on addressing the immediate health concern rather than the underlying social conditions that give rise to poor health. Despite increasing awareness of the impact of the social determinants of health, family physicians have reported feeling powerless in being able to address them and some do not see it as an area in which they can intervene.[55] Barriers that family physicians face in addressing the social determinants of health include time constraints, lack of clinical and administrative supports, knowledge gaps, uncertainty in how to access support, and remuneration that does not recognize social care delivered by health care providers. Health and social services frequently exist in silos, making it challenging for patients to receive the social support they could benefit from. An alternative model of primary health care is required to address the social determinants and improve health outcomes for underserved populations.

Strengthening Alberta's Primary Health Care System

The Patient's Medical Home (PMH) framework provides a helpful blueprint, outlining 10 total components, for the continued evolution of primary health care in Alberta. There are four components of the framework (comprehensive team-based care, connected

care, measurement and quality improvement, and governance) that require significant investment if Alberta is to achieve its vision for primary health care.

The College of Family Physicians of Canada introduced the PMH as an approach to delivering high-quality and comprehensive primary care. The framework of the PMH envisions teams led by family physicians to promote partnerships between providers, patients, and families to improve patient health outcomes through communication, engagement, and team-based care.[56]

The PMH framework was designed with the social determinants of health in mind, and takes into account the unique needs of underserved populations. One of the goals of the PMH is to "assess and address the social determinants of health (e.g., income, education, housing, immigration status) as relevant for the individual, community and policy levels."[57] Early studies of the PMH model in other jurisdictions have shown improvements in access, comprehensiveness, and coordination of care; all of which are required to address the needs of underserved populations.[58,59]

The concept of an Integrated Health Neighbourhood (IHN) expands on the PMH framework, to include a network of providers and services outside of the PMH in the delivery of primary health care services. The PMH acts as a hub for coordinating care within the neighborhood, including referrals to other health professionals, specialists, hospitals and home care, continuing care, and to broader social and community supports, such as community-based mental health and addictions and social services.[60] The IHN remains conceptual in Alberta, as there is no single organization responsible for organizing and aligning the primary care and social sectors that impact citizen health within different regions.

As of 2019, Alberta was a leader in the implementation of the PMH model in Canada, as assessed by the PMH Provincial Report Card.[61] There are several existing examples in Alberta of clinics that operate in alignment with the PMH pillars, including being well-integrated with other health care and social services. According to the PMH website, examples of successful PMH clinics in Alberta include Moose and Squirrel Medical Clinic,

Sylvan Family Health Centre, Westgrove Clinic, Crowfoot Village Family Practice, Taber Clinic and Riverside Medical.[62]

While Alberta is leading the way nationally towards PMH implementation and many providers have realized its benefits, there are some important gaps that remain in realizing the full vision of the PMH and IHN across the province. These include gaps that fall under the following PMH components:

- Comprehensive Team-Based Care
- Health Information Technology
- Measurement, Continuous Quality Improvement and Research
- Governance and Funding

Comprehensive Team-Based Care

Existing models of care limit the ability of patients to access an interprofessional team who know their health journey and goals. In Alberta today, primary care is predominantly delivered through private family physician offices. Most primary health settings in Alberta are built around a physician with limited support staff. This is not due to a lack of interest in interprofessional delivery teams, but rather a lack of resources required to do so.

People are often not able to access interdisciplinary care because most providers do not work in interprofessional teams. While the exact ratio of non-physician care professionals to family physicians in a team-based model of care may vary depending on context, it is clear the current approach results in insufficient non-physician clinical resources to meet the need (at an estimated 0.4 PCN funded FTE per family physician).[63] The ideal ratio of non-physician to physicians could range between 1:1 and 4:1 depending on the size of the physician group, the number of patients connected to those physicians, the health and socioeconomic status of those patients as well as factors in the community where the patients live.

While there have been several targeted workforce strategies in Alberta over many years, they have not been fully effective in addressing models of team-based care where interprofessional teams are trained together, work together and support each other with the necessary skills and resources. This is especially true in rural and remote parts of the province where the supply of health professionals is challenging, and primary health care employers are competing with acute care settings and private businesses. The ultimate result is inequitable distribution of primary health care resources across the province, as evidenced by the variation in the number of health care providers per capita across the province.[64]

A lack of prioritization of primary care provider wellness has impacted turnover and availability of care providers across the province. Challenges in work-life balance have been exacerbated by the pandemic, resulting in increasing numbers of primary care providers experiencing high or severe work-related burnout.[65] Healthcare provider burnout has been associated with lower patient satisfaction, reduced health outcomes and increased costs.[52] Evidence suggests that team-based models of care are associated with reduced burnout and increased provider satisfaction.[66]

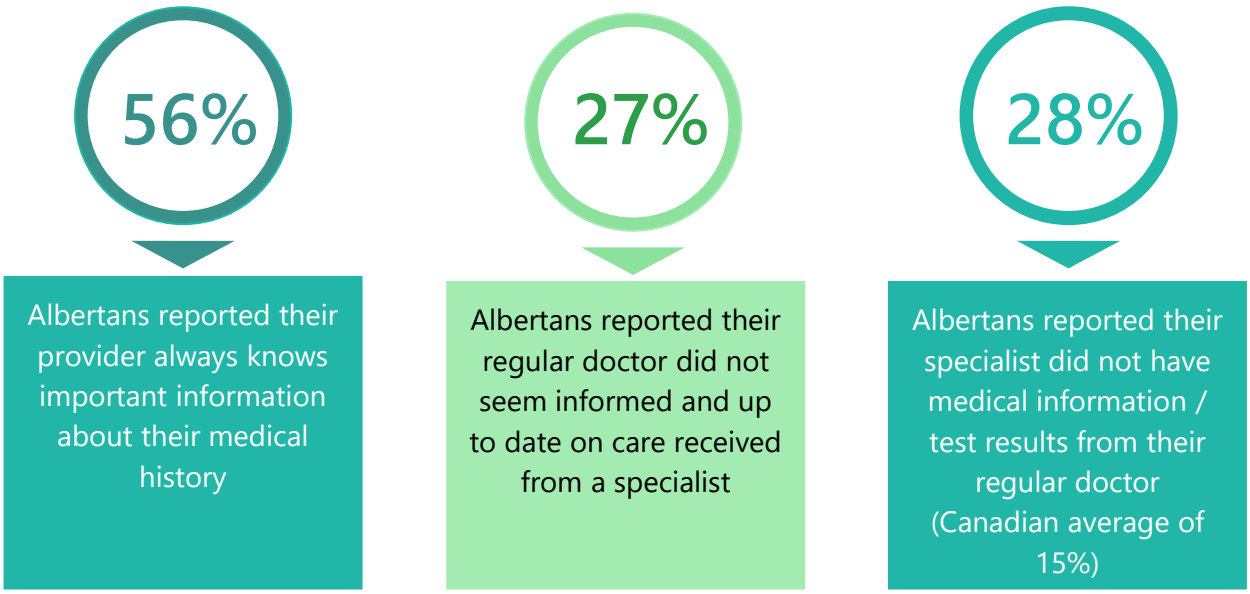
Compounding these issues is the fact that fewer family physicians are choosing to provide comprehensive primary health care to patients in Alberta. The number of family physicians providing comprehensive care per capita has declined by 6.2% since 2019/20 (from 7.0 physicians per 10K population in 2019/20, to 6.5 physicians per 10K population in 2021/22). This trend is more pronounced in the North and South Zones, which have seen a decline of 12.6% and 13.1% in physicians providing comprehensive care respectively.[67] Additionally, there has been a decline in numbers of comprehensive rural generalists, who provide a uniquely comprehensive scope of practice to rural and remote Alberta, and are necessary for sustainability of acute and primary health care services in communities. There are also fewer medical school graduates interested in pursuing family medicine, indicated by the increasing number of unfilled family medicine residency positions in Alberta over the last five years (42 unfilled positions in 2023 compared with seven in 2017 based on the Canadian Resident Matching Service report data released publicly).

Amplifying this effect is a material drop in the number of annual patient contacts for family physicians. Some authors have concluded it is a reduction in the hours worked and an aging patient population.[65] Others have indicated that the reason(s) might also include increased administrative burden, increased complexity of the patient population, changes in professional norms, different choices about work, or different income requirements. Whatever the reason may be, the reduction in annual patient contacts presents a major challenge to expanding access and availability to comprehensive primary health care.[66]

Health Information Technology

Alberta has not fully developed a cohesive eHealth information and technology system that connects the existing infrastructure and builds interoperability between them as a strategic priority. Tools and technology that are implemented do not always meet the needs of patients and providers.

Interoperability between systems is a significant challenge today. The disparate use and lack of coordination between the technology and platforms within primary health care are driving technological fragmentation and impacting the ability for providers to share information. The Community Information Integration / Central Patient Attachment Registry (CII/CPAR) initiative was introduced in Alberta to address the interoperability issues, by facilitating information sharing between primary health care providers and AHS. Uptake of this initiative has been slower than desired, with 35% of community-based physicians participating as of February 2023. As a result of interoperability challenges, the transfer of relevant patient information between care providers and locations is often missing:



- 56% of Albertans reported their provider always knows important information about their medical history;
- 27% of Albertans reported their regular doctor did not seem informed and up to date on care received from a specialist; and
- 28% of Albertans reported their specialist did not have medical information / test results from their regular doctor, compared to a Canadian average of 15%.[68]

Alberta embraced adopting a transformational eHealth Strategy well before other provincial counterparts. MyHealth Records Alberta, for example, is a portal allowing Albertans to access their personal health information, including lab results, immunizations and diagnostic imaging reports. Despite Alberta's leadership in this area, there is still an opportunity to leverage and integrate technology in a more meaningful and empowering way to empower patients to be active participants in their own health management with their own health records. The use of online services for patients in Alberta is significantly below international comparators. For example:

- 7% of Albertans reported the ability to renew prescriptions online, compared to an average of 52% among countries surveyed by the Commonwealth Fund;

- 15% of Albertans reported being able to view test results online, compared to an average of 37% among countries surveyed by the Commonwealth Fund; and
- 7% of Albertans reported being able to view visit summaries online, compared to an average of 26% among countries surveyed by the Commonwealth Fund.[69]

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There is still work needed to invest in the use of technologies to promote integrated information sharing, access to information, patient self-management, and other tools to better meet the needs of the people.

Measurement, Continuous Quality Improvement and Research

Efforts related to quality and safety improvement and innovation are fragmented, with multiple organizations playing limited roles. Although Alberta has several organizations and initiatives geared towards quality and safety improvement and innovation, there are no established provincial standards for primary health care delivery (e.g., basket of services), nor is there a provincial framework (e.g., measurement reporting), agenda, agency or team lead responsibility and adequate resourcing for quality and innovation for primary health care in Alberta today. The current capabilities in the province are not strategically aligned, funded, or delivered—and existing efforts have resulted in an inconsistent and fragmented approach. There is a relative lack of primary health care infrastructure and coordination, compared to the acute care sector to:

- Generate and evaluate data;

- Identify, and expand effective practices or identify and address barriers or inefficient practices;
- Support continuous improvement; and
- Report on results.

Voluntary participation in quality improvement initiatives has led to pockets of excellence but efforts to spread the uptake of quality improvement methods or specific practice improvements, often fail beyond early adopters. This issue is influenced by many factors, including resourcing, but the fact remains that quality improvement has not been systematically prioritized or built into the current governance model in any meaningful way. Implementation of innovations has been inconsistent, and resulted in variation in how care is delivered and the tools being used, and frustration for primary health care providers, private industry partners, government departments and the public. Alberta is rich with innovation yet has not yet realized its full potential and capabilities as a learning health system to embrace and embed innovation.

These factors contribute to the primary health care sector facing challenges in demonstrating the impact of investment in primary health care. This makes it difficult for decision-makers to justify additional investments, especially when compared to other health sectors where more rigorous evidence is readily available to support their cases for investments.

Governance and Funding

Primary care largely remains a cottage industry of approximately 1,000 clinics, mostly owned and operated by physicians who are directly funded by Alberta Health. The first iteration of organizing primary care clinics were called Local Primary Care Initiatives and represented a tentative first step toward incenting collaboration within primary care and with regional health authorities. They enabled family physicians to organize geographically and provided some resources to physician groups to address priorities

and pressures within their clinics and communities. Initially there was minimal provincial influence over how those resources were allocated and very little infrastructure to both ensure resources were utilized appropriately and to demonstrate the impact of such investments. Not surprisingly, there was considerable variation across the province, some of which was appropriate given local circumstances, and some of which could not be as easily justified.

Local Primary Care Initiatives were eventually renamed Primary Care Networks (PCNs), and there has been a gradual progression toward more zonal and provincial standardization, use of resources to address issues that cannot easily be addressed in primary care clinics (e.g., chronic disease management programs), and maturation of the processes related to governance, business planning, reporting, etc. PCNs represent an important step forward in the evolution of the health system that many other jurisdictions are seeking to emulate. Indeed, several PCNs have achieved significant positive outcomes for patients and across the health system (e.g., hospital transition programs for vulnerable patients, clinics for underserved populations) and have improved satisfaction among participating providers. At the same time, evolution of PCNs has contributed to a sense that family physicians have lost the ability to direct resources to priorities at the clinic level, and there has been limited movement to expand the scope of services to address the full scope of primary health care needs that patients have.

While PCNs have been a very positive development in Alberta's health system governance, PCN funding is based on the voluntary participation of family physicians practicing within the PCN's catchment. PCNs are provided with per-capita grant funding of $62 per year for each patient assigned to any of the family physicians associated with that PCN. Member physicians receive varying levels and types of support from their PCN, which can be inadequate for them to meet the needs of their patients and support their needs as providers. In recent years, there has been a trend, especially in some rural areas, of declining family physician participation in PCNs. As a result, the funding for that PCN decreases as the number of patients decreases and family physicians exit. This

instability in PCN funding can have an especially negative impact in smaller PCNs, notably those in rural areas.

The structure and authority of PCNs and their relationship with their member physicians does not enable clear or direct accountability between providers, PCNs, or Alberta Health. PCNs and their member clinics are not provided with the appropriate authority, capacity, or accountability to meet the primary health care needs of the entire population living within their geographical boundaries, meaning many Albertans remain "unattached" and may seek care at hospitals or emergency departments that otherwise could have been met in the community.

Recognizing the historical context of how primary health care governance has evolved in Alberta, the current environment in Alberta faces three core governance challenges: fragmentation, misalignment between responsibility, authority and capacity, and funding.

"We're driving out family physicians with our current government structure and this is leading to further gaps in access"

(Citizen perspective)

Fragmentation

- There is no single organization or authority that can represent the needs of the primary health care sector or enable alignment of the many stakeholders. No one organization is accountable for primary health care.
- There is separate governance for primary care, continuing care, social services, acute care, and other community-based health services. There is a limited ability and no systematic approach for these sectors to engage with one another on issues that impact them all. Similarly, there is limited accountability for outcomes that impact primary health care from each of these sectors, particularly those that address the social determinants of health.

- Participation and representation within the current primary health care governance structures do not reflect the range of key primary health care stakeholders, including, but not limited to, the public (e.g., patients, families, caregivers), providers (e.g., pharmacists, nurses, social workers), community and social services, municipalities, and Indigenous leaders.

Misalignment between responsibility, authority, and capacity

- Primary Care Networks (PCNs) are responsible to provide adequate supports to primary care clinics but have limited capacity to do so due to a funding model that cannot fully fund a PMH, disadvantages small PCN's, does not consider the distinct local needs and characteristics (e.g., population demographics, complexity of health and social needs), and does not account for unattached patients. There are examples of PCNs that successfully leverage financial resources, but levels of support provided to PCN member physicians vary widely.
- PCN member physicians (and their clinics) are often loosely connected to their PCNs, as there is limited bi-directional accountability between member physicians and PCNs. As a result, many PCNs struggle to engage their physician members, and more importantly, physicians often feel their PCN is unable or unwilling to help address pressures at the clinic level.
- Some PCNs struggle to meet clinical and corporate governance expectations in the PCN Policy Manual, partly due to variation in size and legal models across the PCNs.
- The Provincial PCN Committee (PPCNC) and Zone PCN Committees (ZPCNC) do not have authority or funding capacity to effectively direct or enable provincial or zonal PCN priorities, respectively, across PCNs; the accountability of PCNs is to AH.

Investments in primary health care hindered by a limited ability to demonstrate accountability or impact

- Primary care in Alberta is built on the foundation of approximately 1,000 independent small businesses with no requirement to measure, evaluate or demonstrate outcomes.
- While there are examples of excellence in several PCNs, there are not established provincial standards for primary health care delivery (e.g., basket of services) nor is there a provincial performance framework (e.g., measurement, reporting) that links local investments and activities to outcomes at the regional, zonal, and provincial levels.
- There is a relative lack of primary health care infrastructure and coordination, compared to the acute care sector, to generate and evaluate data, identify, and expand effective practices or identify and address barriers or inefficient practices (e.g., low-value care), support continuous improvement, and report on results.
- Voluntary participation in quality improvement initiatives has often meant that pockets of excellence may emerge but efforts to spread the uptake of quality improvement methods or specific practice improvements developed often fail beyond early adopters. This issue is influenced by many factors, including resourcing, but the fact remains that quality improvement has not been systematically prioritized or built into the current governance model meaningfully.

Funding

- The funding of primary health care is siloed across different funding approaches and mechanisms. Disparate funding streams hinder the integration of service planning and delivery.

- The funding of primary health care does not enable the optimal adoption and delivery of team-based care. PCNs are not funded to adequately hire sufficient numbers of interprofessional team members.
- Fee-for-service, the predominant physician payment model in Alberta, does not incentivize physicians to work in a team-based model.
- There is no current funding model to support quality improvement in the PMH today.

Photo courtesy of the Government of Alberta

Strategic Shifts

Strategic Shifts

If Alberta is to truly address the known challenges, emerging issues, and most importantly, build on the strengths of the current system, there needs to be a defined, shared vision for the future primary health care system in Alberta. The aim is to create a resilient and sustainable health system that is people-centric, and primary health care-oriented; one where people can count on their community as a place that keeps themselves and their loved ones healthy and well throughout their life journey.

It will take time, effort, investment and collaboration to achieve the kind of transformation this shared vision will require. To this end, a number of strategic shifts will need to be made in how primary health care is viewed and decisions are made. These changes in paradigm will be the foundation for building a modernized and integrated primary health care system and represent significant paradigm shifts. They will require a re-examination of long-held mental models and perspectives on primary care and how it interacts with the rest of the health care and social services systems in the provision of primary health care. It will also require intentional changes to how primary health care is organized, designed and delivered. The future primary health care system in Alberta will see us move from the current state to a desired future state by realizing the following strategic shifts.

FROM CURRENT STATE…	TO FUTURE STATE…
Citizens and communities are not meaningfully involved; health and social care are not integrated.	Design primary health care with and around the needs of people and communities, inclusive of health and social care.
Interprofessional teams are not the usual mode of primary health care delivery; many primary health care providers are not enabled to work to their full scope of practice or supported by an effective health workforce strategy; workforce planning is disjointed.	Create a primary health care system that is built with healthy, engaged, highly collaborative teams in a patient's medical home integrated with other care services across an integrated health neighborhood. The primary care workforce should be built with a focus on provider wellness, and providing teams with the capacity, support and resources needed to thrive.
Too often, services and programs are designed at a provincial level and fail to reflect the unique needs of Alberta's rural and remote communities.	Recognize that rural and remote primary health care is different from urban centers and that planning and decision-making should happen locally in these communities.
Efforts related to quality and safety improvement and innovation are fragmented, with multiple organizations playing small roles.	Enable a learning system where quality and safety improvement is the modus operandi for providers, leaders and community members who have capabilities, teams and support for implementation, measurement and innovation.
Responsibility and authority are disjointed with no clear governance and accountability in primary health care and limited tracking of impacts and outcomes of investments.	Establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes.

These strategic shifts are described further in the pages that follow, with additional detail regarding each of the strategic shifts in Appendix A.

Design primary health care with and around the needs of people and communities, inclusive of health and social care

"We need a more integrated primary health care/ home care/ community services system. My family doctor said it's easier for him to access the team in long-term care than in the community."

(Citizen perspective)

Citizens and communities are not meaningfully involved; health and social care are not integrated. Primary health care in Alberta currently operates as a cottage industry, with significant fragmentation of services that can make it difficult for providers to organize care and for people to navigate the system and participate meaningfully in their own care as partners with their health care providers. There is also not enough recognition and systematic integration between primary health care, community care and other social services and supports. This has impacted continuity of care as services are not coordinated through a person's life and health journey, or across providers. While citizens want to be able to access services when and how they need them, their voices and experiences are not intentionally sought out as the true shareholders of the system. In order to deliver a comprehensive care approach for people in Alberta, there needs to be a shift to meaningfully…

…design primary health care with and around the needs of people and communities, inclusive of health and social care. All people in Alberta should experience a seamless, coordinated health journey throughout the course of their lives, no matter where they live or how they self-identify. People are at the center of the primary health care system and the system should be designed together with citizens to better meet the needs of communities. People—including patients and family caregivers—must be given the space and a voice to help build a primary health care system that is reflective of and responsive to their needs, and they should also have a say in how to make the primary health care system easier to access and navigate.

Create a primary health care system that is built on highly collaborative teams working together across a Health Neighbourhood with the support and resources they need to thrive

"Primary care networks were supposed to be set up as teams, but over time that has waned."

(Citizen perspective)

Interprofessional teams are not the usual mode of primary health care delivery; many primary health care providers are not enabled to work to their full scope of practice or supported by an effective health workforce strategy. Existing models of care limit the ability of patients to access an interprofessional team who know their health journey and goals. In Alberta today, primary health care is predominantly delivered through private family physician offices. People make an appointment with their family doctor, if they have one, and their family doctor provides treatment or may refer them to another care provider in another clinic or facility. Most primary health care settings in Alberta are built around a physician with limited support staff. People are often not able to access interdisciplinary care through their patient's medical home because most providers do not work in interprofessional teams, and rarely, are co-located in the same clinic.

This is especially true in rural and remote parts of the province where the supply of health professionals, including rural generalists, is challenging, and primary health care employers are competing with acute care settings and private businesses. If team-based primary health care is the future, Alberta needs to…

…create a primary health care system that is built on highly collaborative teams working together across a Health Neighbourhood with the support and resources they need to thrive. The future primary health care model must shift to team-based care as the norm and health care providers need the knowledge and skills for how they can best work together to provide comprehensive care. Team-based care in a supported team environment is essential to improving both patient outcomes and experiences. Funding models must be developed that enable and support patient's medical homes in

implementing and sustaining diverse, yet targeted team-based care that supports people in their health journey without sacrificing quality of life or well-being of the team members. Sufficient investments must be made to integrate and connect the PMH to the Health Neighbourhood—the right funding model must have the right levels of investment to sustain the outcomes the public expects.

Recognize that rural and remote primary health care is different from urban centers, all planning and decision-making should happen locally at the community level to reflect local needs

> "Rural and remote aren't the same as urban and suburban. Rural and remote primary health care aren't the same as each other. It's all different and we need to think differently about it. One size fits all won't work for anyone."
>
> **(Care provider perspective)**

Services and programs are designed at a provincial level and don't reflect the unique needs of Alberta's rural and remote communities. There is no one size fits all approach that can be used to effectively organize primary health care in Alberta. There has not been enough effort to adapt strategies and approaches to meet varying needs across the province. Individuals, communities and regions of the province all vary significantly. Primary health care in Alberta today provides limited flexibility to adapt to unique communities or regions within the province which results in equities in primary health care between different parts of the province and different demographics. Rural residents generally experience poorer overall well-being and health outcomes, have less access to an interprofessional team of healthcare professionals, have less choice of health care providers, and encounter a broad variation in the availability of primary health care and specialty care in their communities. The existing model of primary health care must shift to…

…recognize that rural and remote primary health care is different from urban centers, all planning and decision-making should happen locally at the community level to reflect local needs. The differences in needs across the province are significant. What works in one rural or remote area will not work in another—remote areas of northern Alberta are not the same as rural areas of southern Alberta. The entire system of primary health care in rural and remote areas needs to be designed to bridge gaps and remove barriers facing patients and care providers. People who live in rural and remote areas face challenges in accessing care that other parts of the province do not. They have lifestyles that impact how and when they are able to access care; for example, farmers

are not going to access care in the same way during seeding or harvesting—care needs to be adapted in recognition of these facts of life for rural and remote communities. The workforce in rural and remote areas must reflect the unique care environment including the fact that rural generalists provide enhanced surgical skills (general surgical and obstetrical c-sections), anesthetic care, internal medicine, and other specialties while providing services in primary health care and acute care settings.

The governance of primary health care in rural areas must be sensitive to local needs and embrace partnership and innovation in how they design and organize services to build on strengths and assets in the community. These assets include the primary health care providers who choose to live and work in rural and remote areas of the province.

Enable a learning system where quality and safety improvement is the modus operandi for providers, leaders and community members who have capabilities and teams to support implementation, measurement and innovation

"Value for citizens and patients is the overarching goal for health NOT access, cost containment, convenience or customer service. Value as the goal is what will unite all system participants."

(Citizen perspective)

Efforts related to quality and safety improvement and innovation are fragmented, with multiple organizations playing small roles. Although Alberta has several organizations and initiatives geared towards quality and safety improvement and innovation, there is no provincial framework, agenda, agency or team with a dedicated mandate for quality and innovation for primary health care in Alberta today. The current capabilities in the province are not strategically aligned, funded or delivered—and existing efforts have resulted in an inconsistent and fragmented approach.

While Alberta has invested significant resources, it has been uncoordinated, without a system-wide strategy to drive learning, innovation and improvement within primary health care. These resources tend to compete for provider attention and do not work synergistically. Implementation of disparate innovations, even effective ones, inconsistently across the province over a long period of time has resulted in variation in how care is delivered, and the tools being used, and frustration for primary health care providers, private industry partners, government departments and the public. Alberta is rich with innovation yet has not yet realized its full potential and capabilities as a learning health system to embrace and embed innovation. This reality must shift to…

…enable a learning health system where quality and safety improvement is the modus operandi for providers, leaders and community members who have capabilities and teams to support implementation, measurement and innovation. Quality is a core strategy for high-performing health systems who aim to achieve the

Quintuple Aim—improving population health, improving the care experience, reducing costs, finding joy and value in work, and advancing health equity. A relentless focus on quality can facilitate a learning health system and drive sustainable transformation. It empowers local care teams to address problems that matter to them, while also allowing a system-wide approach for implementation, measurement, and evaluation of change initiatives and innovation.

High-performing health systems build capabilities and expectations for quality improvement and embed those capabilities throughout, from governance and leadership, operational management, and front-line clinical teams. To do this, the primary health care system in Alberta must invest in building effective governance, quality improvement education, infrastructure and resources, and pathways to drive quality as a strategic imperative. It is time to design the primary health care system around quality, safety and innovation and embed quality improvement as a driving force for a resilient learning health system.

Establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes

"Bottom up, community approach instead of top down"

(Citizen perspective)

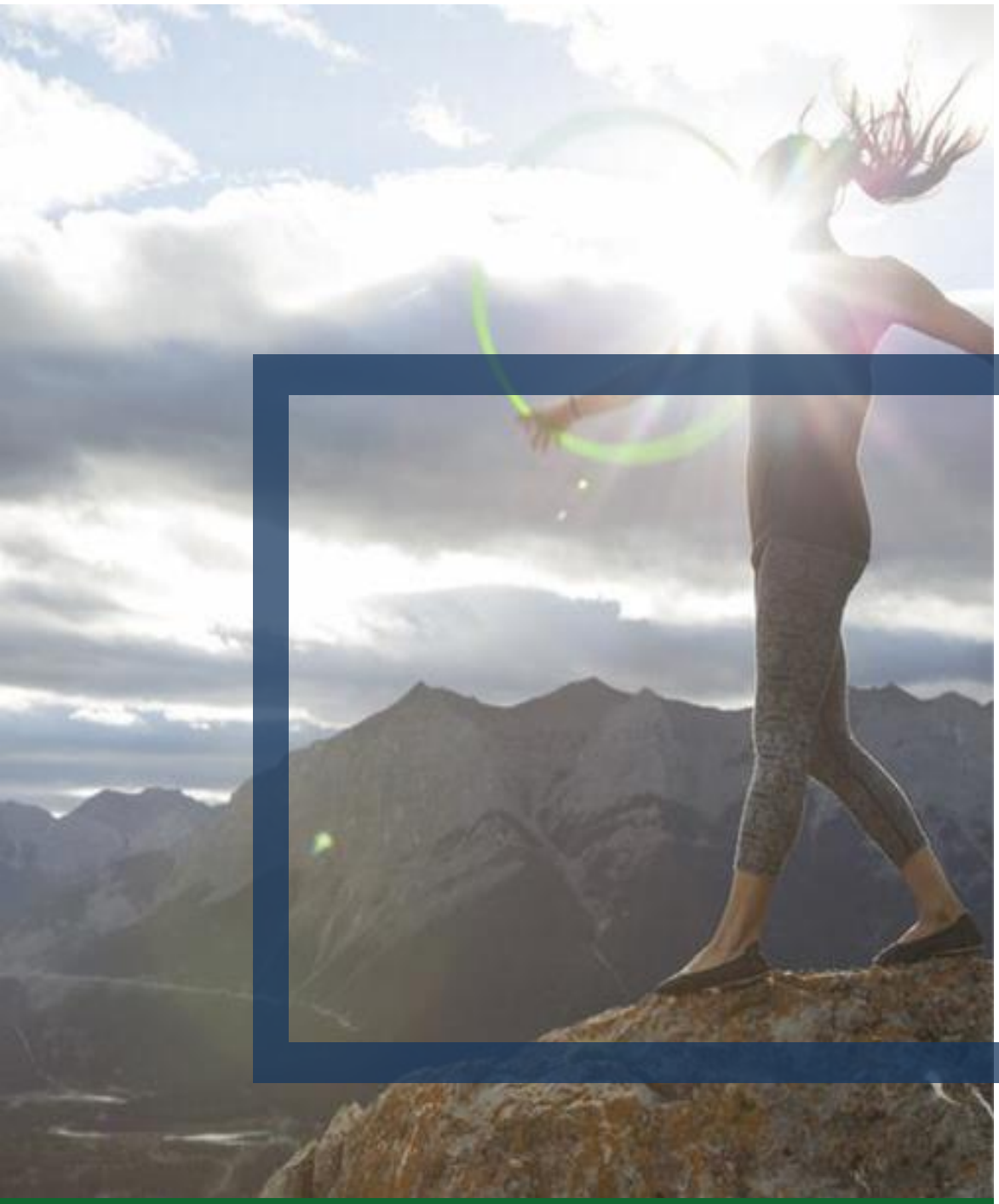
Responsibility and authority are disjointed with no clear governance and accountability in primary health care and limited tracking of impacts and outcomes of investments. Over the years, progress has been made in building governance structures for primary health care in Alberta at the provincial, zonal, regional and clinic levels. The complex governance structure includes Alberta Health, the Provincial Primary Care Network Committee, and several other provincial-level and zonal committees, but they are often disconnected and have limited decision-making authority or access to resources. In this complex structure, many challenges have manifested.

There is no solely accountable body responsible for setting the strategic direction and vision for primary health care. The decisions around resource allocation, workforce strategy, and services are made in silos or across multiple bodies without an aligning central strategy or single point of accountability. Complexity in the governance model makes it difficult to build a cohesive, responsible provincial approach to primary health care. The complexity and misalignment of accountabilities, responsibilities and authority in the current governance model impacts the quality of our primary health care system. Alberta can realign from a top-down hierarchy to…

…establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes. The future primary health care system must be built as just that—a system—with clear accountabilities that are defined within a formalized governance structure and framework with bi-directional accountabilities. The governance model must be simplified and strengthened to ensure

that the primary health care system achieves the intended outcomes for people, communities and the province while always acting in the public interest. Agency must be given to providers and communities in the form of decision-making authority over how services are organized and delivered locally, and influence over how resources are allocated to meet the unique needs of each community across Alberta.

Strategic planning and decisions around resource allocation, workforce strategy and sustainability, and quality and safety improvement and innovation will be more effective with clearly defined accountabilities, leadership authorities and a single unifying direction to follow.



Recommendations for Modernizing Alberta Primary Health Care System

Recommendations for Modernizing Alberta's Primary Health Care System

The vision of the MAPS Strategic Advisory Panel for primary health care in Alberta is to build a true primary health care system. One that connects people to the care they need and that integrates the primary care system to community and social care to support individuals with whole of person care. To that end, the MAPS Strategic Advisory Panel has developed 11 mutually reinforcing and interdependent recommendations across five groupings that, when implemented, will allow Alberta to realize that vision.

These recommendations have been developed to build and modernize a primary health care system and not to provide solutions to individual challenges. Each of these recommendations are linked and enable and strengthen the next. As such, these recommendations should be implemented together and in support of each other. The collective implementation of these recommendations is necessary if Alberta is to truly move the needle on improving individual, provider, community and system-wide positive outcomes for the primary health care system.

The Government of Alberta should consider the need to pass legislation to support or enable the implementation of these recommendations. Passing primary health care-specific legislation would affirm and signal the importance of primary health care in Alberta. Legislation may also be useful or necessary to set the foundational elements of these recommendations and the future primary health care system within the province. The Government of Alberta should consider the appropriateness and necessity of legislation against other tools and authority it has as a part of the process of implementation of these recommendations.

The vision for primary health care in Alberta is clear.

Every person in Alberta should have access to primary care and a diverse interprofessional team of care providers in their medical home. Primary care should be integrated with other health and well-being services, including community, social and acute care providers to address all the factors that influence a person's health. People should have access to the healthcare they need—from the right provider, at the right time with the right information to make informed health decisions together. People and communities should have a say in the care they receive. Providers should be supported and funded to do what they do best: provide quality primary health care in environments where they have the resources and funding they need and where their wellness is prioritized.

Providers should be supported and funded to do what they do best - provide quality primary health care. The future primary health care system should create a stable, supportive environment that appropriately values the wellness of primary health care providers and the critical role they fill in our healthcare system. The primary care system relies on a healthy, engaged and supported workforce that has the resources needed to deliver quality primary care whether in urban/suburban, rural, remote or Indigenous communities.

By significantly investing in integrated primary health care, people in Alberta will have healthier lives. There should be less burden on hospitals, emergency departments and ambulance services. Public health outcomes should improve and overall health system costs should decrease. Alberta can build an integrated, sustainable primary health care system for generations to come.

Sequencing and structure of the recommendations

People and communities should be the focus of the future primary health care system in Alberta. All of the recommendations in this report have been developed to that end—to improve health and health system outcomes for people and communities in Alberta. The recommendations have been developed to build teams that meet the needs of people

and communities and equip them with the resources they need. The recommendations structure and organize teams into a primary health care system that is built with input from people and communities. Each layer of the system must be connected and integrated. Each recommendation builds and supports the next to make it possible for teams to deliver the best care they can within a system that enables and empowers people and providers.

The sequencing of recommendations begins with governance before moving to more patient and community-focused recommendations. This is a deliberate decision by the MAPS Strategic Advisory Panel that was made with consideration of two significant factors:

- In a number of the recommendations, it is necessary to refer to changes in governance to provide context, details or supporting rationale as a part of the detailed recommendations; and
- A strengthened and modernized governance structure is an enabler of the people and community-focused recommendations that follow.

This sequence does not indicate an order of importance or priority. People and communities are at the heart of these recommendations and realizing improved outcomes for the people and communities within the province is paramount.

Overarching Recommendations to Modernize the Primary Health Care System in Alberta

Transforming governance and strengthening and aligning accountabilities

1. Reform primary health care governance by strengthening and clarifying accountabilities
2. Align primary health care funding with delivery and accountability under the new provincial governance model

Evolving patient's medical homes within an integrated health neighbourhood

3. Embrace patients and citizens as partners
4. Accelerate efforts to ensure every person in Alberta can be connected to team-based primary health care using patient medical home principles
5. Systematically connect every patient's medical home to a broader integrated health neighbourhood to enable whole of person care
6. Reduce the financial risk of clinic ownership and administrative burden
7. Invest in quality, safety, and innovation capabilities and capacity as a strategic priority with the primary health care system

Enabling the primary health care workforce to improve health outcomes

8. Establish a comprehensive primary health care workforce strategy aimed at building and sustaining a diverse workforce who are supported in providing team-based care across the province
9. Adapt and improve a remuneration model that enables team based care in support of the workforce strategy

Digitally enabling primary health care to improve health outcomes

10. Accelerate the implementation of actions that make the e-health environment more functional and robust for primary health care teams and patients

Significantly investing in primary health care

11. Significantly invest in and measure the impact of primary health care to achieve better outcomes and value across the health system

Detailed Recommendations

Additional details on the context and specific recommendations is provided in the section that follows. The research, analysis, and rationale that underlie these recommendations have been provided in the Appendix D of this document for reference.

Transforming Governance by Strengthening and Aligning Accountabilities

Transforming Governance, Strengthening and Aligning Accountabilities

RECOMMENDATION 1: Reform primary health care governance by strengthening and clarifying accountabilities

A. **Evolve and expand the PCN model to establish Regional Primary Health Care Networks**

B. **Establish the Alberta Primary Health Care Organization to provide oversight and leadership to the primary health care system in Alberta**

C. **Integrate decision-making and planning processes for primary health care with AHS and other actors by establishing a Provincial Health Integration Commission**

RECOMMENDATION 2: Align primary health care funding with delivery and accountability under the new provincial governance model

WHY IS THIS IMPORTANT FOR ALBERTA?

Over the past 20 years, Alberta's health system has experienced a gradual evolution, transitioning from a highly decentralized model to one characterized by a mixture of structures that have changed how governance functions. Primary health care has experienced a moderate amount of change, with the hospital sector on one end of the spectrum (movement from hospital boards to regional health authorities to AHS), and community specialists on the other end of the spectrum (with no provincial or regional organization).

AHS is a joint venture partner in PCNs and directly operates a small number of primary care clinics. The joint venture model between AHS and PCNs has served as an important vehicle to foster relationships and collaboration; however, there has been no meaningful alignment of funding and decision making between the two organizations. The current governance structure for PCNs includes the Provincial PCN Committee (PPCNC) and Zone PCN Committees (ZPCNCs). These are advisory and voluntary respectively, and do not hold funding or make binding decisions. These issues must be solved in the next iteration of primary health care governance.

Economic and social factors have significant influence on individual and population health outcomes (i.e., social determinants of health) and so the social services sector is a key actor within the realm of primary health care. In Alberta, health and social services are organized, funded, and delivered separately. While there are excellent examples of innovative local collaborations and some meaningful work across Ministries and agencies, these initiatives occur despite the absence of a governance model that would enable coordinated alignment between the health and social services sector.

It is important to acknowledge that health care delivery in rural Alberta is organized differently than it is in larger urban centers. Rural generalists typically work in both community-based clinics and AHS acute care facilities where they provide essential services, including emergency care, labor and delivery, anesthesia, surgery, surgical assists, and act as the most responsible provider (MRP) for in-patients, among others. Communities throughout rural Alberta have expressed a desire to partner around health care delivery and take a strengths-based planning approach to local problem solving. We will specifically explore the contextual implementation considerations of a governance change in rural Alberta within the recommendations.

The Panel has outlined a strong case for change in governance for Alberta's future primary health care system. This is necessary to address the fragmentation of primary health care as well as the misalignment of funding, responsibilities, and authorities. A strong vision for primary health care governance emerged from the panel discussions. If successful in implementation, Alberta can deliver on the strategic shift of establishing primary health care governance that is oriented to give agency to people, communities

and providers, leaders and community members who have capabilities and teams to support implementation measurement and innovation.

Changing Primary Health Care Governance in Alberta

Creating or changing governance structures in a health system as large and complex as Alberta's should not be undertaken lightly. Such changes must be seen as legitimate by key stakeholders and relate meaningfully to the delivery of health care services. Reforms must be undertaken in ways that are mindful and respectful of the energy and capacity of stakeholders, especially the health care providers at the frontline, to adapt and perform in a new environment. Governance changes must also be implemented in a manner that protects patient care from disruptions or other potential negative impacts. Structural and governance changes that ignore these principles risk draining energy and resources from the system, reducing focus on service delivery, and creating uncertainties that may undermine the legitimacy and acceptance of the new governance structure, ultimately decreasing its effectiveness.

Acknowledging that there are challenges in developing, implementing, and operating a new governance framework, the MAPS Strategic Advisory Panel has concluded that genuine and sustainable improvements to the primary health care system would require such a change.

The ultimate goal for Alberta's health care system should be full integration—across health care and with social services—and delivered in a way that provides excellent care for all Albertans. We have recognized for many years, or even decades, that a system which is oriented around communities and enables people to thrive in their homes, is far superior to a system that makes people move to where the services exist in hospitals and other facilities. Albertans recognize that acute and emergency care is necessary, but also realize that the system is out of balance. And we are paying a price for that lack of balance both financially and in terms of the impact on quality of life.

Achieving a primary health care-oriented and highly integrated health system that is primary health care-oriented will be challenging and cannot be realized in a single step. The governance model outlined in this report moves the province closer to a fully integrated system. It falls short of a single organization to organize and deliver all health care. But it does advance the organization of the primary health care system and increase the influence of primary health care overall. It provides mechanisms for collaboration at community, regional, zonal and provincial levels. It creates accountability and demonstrates the impact of higher investment in primary health care. Most importantly, it begins to shift the orientation of the system toward the kind of community-oriented services that evidence shows is more effective, and more importantly, that Albertans want.

Markers of an effective governance model for Alberta's primary health care system should include:

- Patients and caregivers will have a meaningful voice at governance tables and influence over decisions that are made from the local to provincial levels.
- Providers will continue to have autonomy to make decisions that impact clinical care, including which services are delivered within their clinics. They will also have access to additional team members (clinical, administrative, research and quality improvement, and other) in exchange for demonstrating accountability for how those supports have been used to improve access, continuity, and quality of care.
- Provider groups, patients, and community leaders are partners in describing and defining accountabilities that take into consideration local needs as well as contextual assets and limitations.
- Indigenous and municipal leaders will be directly involved in shaping how primary health care services are planned and delivered in their communities.
- Integrated Health Neighbourhoods will be created to bring together the various organizations responsible for the delivery of healthcare, social, and community

services locally. Together, they will address common challenges, pursue common opportunities and leverage their combined resources to the greatest effect. This will enable integration, planning, local problem solving and cross sector collaboration. Regional organizations will be responsible for providing resources and support to this community integrated approach to primary health care.

- Regional service provider organizations (the evolution and extension of current PCNs) will be responsible for meeting the primary health care needs of the entire population within their geographic boundaries. These organizations will be able to influence how resources are allocated to enable PMHs, neighbourhoods and other partners to provide necessary services, in exchange for much more robust demonstration of outcomes than currently exists.
- Support services at the provincial and zonal levels will be organized and accessible to regional service provider organizations. Examples of support services include data, analytics, measurement, and evaluation for quality improvement, purchasing and contracting, EMR vendor management, planning and reporting.
- A provincial structure will enable meaningful integration and strategic allocation of resources between primary care, AHS and other stakeholders who together deliver primary health care for all Albertans.
- Desired outcomes and measures will be clearly identified at provincial, regional and local levels. Transparent public reporting will occur to demonstrate progress toward outcomes, and quality improvement resources will be targeted at areas needing improvement.
- Government will focus its efforts on:
  - Identifying desired outcomes and holding provincial organizations accountable for delivering on results, allowing organizations flexibility in how they deliver services as long as they meet provincial standards;
  - Securing necessary resources for the primary health care sector; and

  - Collaborating across Ministries to ensure a coordinated policy framework and to remove barriers to effective collaboration at other levels of the system.

- Additional investment in primary health care will be contingent upon demonstrating outcomes. Demonstrating outcomes will translate into higher investment in primary health care. Investments will be targeted to those areas which will have the greatest impact. Services that are currently funded in disconnected and sometimes competing ways will be aligned.
- There will be a cascading and connected series of governance structures that make it clear "who is accountable for primary health care". There will be clarity on which decisions are made at local, regional, zonal, and provincial levels. Leadership structures will exist at all levels, and resources will be clearly attached to decision-making authority.

The following recommendations are intended to address the core governance issues facing Alberta's primary health care sector, and to put the province on a path to a model that delivers on the markers noted above. Not all recommendations can be implemented immediately, but over the next five to ten years there should be progressive movement toward a system that can deliver on these characteristics.

DETAILED RECOMMENDATIONS (Recommendation 1: Reform primary health care governance by strengthening and clarifying accountabilities)

The goal of the proposed primary health care governance model is to have key decisions about primary health care made by and as close as possible to patients and providers within the community. The governance structures also aim to facilitate integrated decision-making within communities, to improve communication between providers, system administrators and policy makers and to improve the capacity of all actors in the primary health care ecosystem to better understand and improve performance. The following sections provide an overview of key characteristics of the proposed new governance model for primary health care in Alberta.

Note that the names of these new entities, their legal structures, organizational governance, and responsibilities are notional at this time and would require further analysis and consideration with key stakeholders and advisors before finalizing.

Patient's Medical Home

The Patient's Medical Home describes an approach to delivering high-quality, cost-effective primary care that is patient-centered, comprehensive, team-based, accessible, and built around establishing a longitudinal relationship between a primary care provider and the patient. Recommendations related to the PMH model and encouragement of its broad adoption across Alberta are provided in recommendations 4 and 5. The description in this section relates to the PMH's role in overall PHC governance.

A fundamental characteristic of the proposed PMH model is that the Core Team has the clinical autonomy to design and deliver primary care services in a manner that best meets their patients' needs within their practice environment. The clinical leadership of PMHs will make independent decisions on how to manage and operate the practice, including team composition and individual roles and responsibilities. The proposed model will be flexible and will enable a variety of types of support to the leadership of each PMH based on its organizational maturity and desire to assume various risks and responsibilities. Examples of this flexibility are provided below:

- The leadership of one PMH may wish to run its own recruitment program for Core Team positions while another may wish to rely on the RPHCN to attract and screen applicants for these positions, only interviewing candidates that make it through to late stage interviews.
- The leadership of a large, experienced PMH may choose to act as the employer for RPHCN-funded Core Team members while a newer group may prefer that the RPHCN act as the employer and administer payroll and other core HR-related

activities on their behalf so they can focus on other aspects of transitioning to the new model.

This means that family physicians maintain clinical autonomy while still operating as owners of small businesses. Where desired, family physicians may engage the RPHCN for supports along a continuum, enabling them to focus their own capacity on the areas of highest priority. This autonomy and flexibility will allow each PMH to determine the level of support it desires and/or needs and, therefore, receives based on the unique dispositions, interests, experiences and capacity of its leadership team and the corresponding needs under a variety of circumstances such as in smaller communities.

Over time, it is anticipated that many family physicians may choose to co-locate with other members of their PMH group as this becomes feasible. Family physicians and nurse practitioners can be part of a PMH group practice even if they are not located in the same physical space. Participation in a group practice is marked by the sharing of resources and coordinating operations to ensure reliable access and availability, mutual commitment to excellence in the delivery of care and to the continuous improvement of the quality of care. Part of strengthening the future state of primary health care in Alberta and supporting the voluntary transition towards the proposed group practice model will be finding innovative approaches to network existing solo practices into "virtual groups" so that they are adequately supported, as well as create the infrastructure and conditions for providers to develop into co-located groups over time.

Mandate

PMHs will be committed to and organized around delivering care that is accessible, comprehensive, coordinated and built around longitudinal relational continuity with patients.

Structure

All clinics in Alberta providing primary health care services will have access to resources and supports offered in the new model to enable them to begin or continue their journey toward a fully-realized PMH. While this access will be broadly available, it is important to note that engaging with this support is entirely voluntary; family physicians will not be required to participate. Voluntary participation will involve establishing a bi-lateral agreement with the relevant RPHCN. A PMH can be a single clinic location with multiple family physicians and/or nurse practitioners practicing from that site alongside their core teams. Alternatively, a PMH could incorporate multiple sites, each with one or more family physician/nurse practitioner and their core teams, that are formally linked and collectively supported. The co-location of primary health care services is shown to enhance quality of care and provider experience. However, an inability to establish co-located clinic sites in the short-term will not present a barrier to adopting the new model of care and will allow deployment of supports to all parts of Alberta, including those with a preponderance of single-family physician sites.

Though evidence demonstrates that a minimum group size of 3-5 family physicians and nurse practitioners at the center of care delivery teams is ideal for more effective provision of services and leveraging of team support at scale, there will be flexibility to support smaller practices. This may be especially important in rural and remote communities.

Core Responsibilities

- Maintains clinical autonomy and decision making to enable providers in the PMH to deliver best quality care in alignment with regulatory authorities.
- Delivers core primary care services to the patients connected to the PMH in accordance with the defined needs of that panel, as determined by local providers. The PMH is aligned to clinical best practice and supported by a bidirectional

service/accountability agreement with a Regional Primary Health Care Network (RPHCN).

- Participates in RPHCN initiatives designed to improve care for the population (e.g., quality improvement, uptake of innovation) from an empowered and adequately resourced position.
- Collaborates with other PMHs, Integrated Health Neighbourhood, system partners and RPHCN partners to design and deliver primary health care services at the community level.
- PMH leadership will be able to make its own decisions regarding the level of support it receives from RPHCNs regarding funded team members, balancing its own interests in independence with support available when desired.
- Measures, monitors, evaluates, and provides reporting on relevant key performance indicators.
- Works towards quality team-based delivery of primary health care in alignment with the Quintuple Aim—improving population health, improving the care experience, reducing costs, finding joy and value in work, and advancing health equity.
- Participates in and contributes meaningfully to relevant local efforts by being a member of the Integrated Health Neighbourhood and providing leadership where appropriate and support where needed to resolve priority patient and local coordination challenges.

Note: The core responsibilities noted above are not final nor are they exhaustive. They are meant to be a representative and high-level description of what the PMH will be responsible for. Core responsibilities may vary for different PMHs based on the size and nature of their patient panels, the scope of their clinical service commitments, and their level of involvement in specialized programs and other initiatives. In addition, details of any accountability arrangements and key performance indicators need to be determined through thoughtful collaboration and co-design during the implementation phase.

Accountabilities

- Accountable to the RPHCNs as it relates to resources and other supports from the RPHCN based on bilateral accountability agreements.

Additional responsibilities and accountabilities must and will be accompanied by adequate resources and support. These resources and support should have stability and predictability (e.g., through multi-year commitments) so PMHs can confidently plan, innovate, and deliver primary health care services that maintain and advance quality and safety.

Regional Primary Health Care Networks

Regional Primary Health Care Networks (RPHCNs) build off of nearly 20 years of successes and learning in PCNs. RPHCNs should be viewed as an evolution of PCNs rather than a replacement. RPHCNs will be accountable for the primary health care service delivery for all patients connected to PMHs that are part of the region as well as all those people who are not connected to a PMH residing in the region.

Mandate

RPHCNs will play an instrumental role in the implementation of provincial, regional, and local initiatives focused on quality improvement. There will continue to be a need to collaborate with AHS within its existing zone structures. To that end, RPHCNs will participate in zone-based service planning with AHS, as well as other activities as required by APHCO (further details about APHCO are provided below).

RPHCNs will be instrumental in driving coordination of care and local integration efforts with non-PHC healthcare providers and non-health actors (e.g., housing, social services) in communities within the region. It will engage in this coordination and integration work through its role in the establishment and ongoing functioning of Integrated Health

Neighbourhoods (IHNs). See recommendations 4 & 5 for further information about IHNs.

The RPHCN will be funded and accountable for:

A. All patients connected to PMHs in the region

B. All patients who are not connected to a PMH residing in the region

Total capitated funding (based on A and B above) will be used to augment Core Teams at all the PMHs operating within the region, as well as for PHC services for patients who are not connected to a PMH. This will include RPHCN owned and operated clinics focused on patients who are not connected to a PMH, where necessary. A core goal of the RPHCN is to facilitate patient attachment to a PMH, but it is acknowledged that in some circumstances the RPHCN may need to act to bridge the gap in service that currently exists. This may mean establishing stable infrastructure and team support to create an environment that will attract new providers. Further information about RPHCN funding is available in recommendation 2.

RPHCNs will also be involved in the delivery of clinical care due to their role in the establishment, development, and management of the Broader PMH Team. The Broader PMH Team, an interprofessional team of clinicians, will serve as a shared regional resource to support PMH Core Teams. See Core Responsibilities below or recommendation 4 and 5 for further information about the Broader PMH Team.

RPHCNs may also own and operate clinics for family physicians who want to have a panel of connected patients and operate within the PMH model but who do not want to act as an owner/operator. In these cases, the RPHCN will charge a facility fee/overhead charge at reasonable rates based on market prices. The RPHCN is responsible for striking a balance in supporting existing practices who wish to operate as independent businesses while also looking broadly to address gaps in primary health care provision to further strengthen PMH capacity where needed. The RPHCN may also operate regional clinical programs such as Chronic Disease Management clinics currently run by

some PCNs, but the RPHCN mandate of supporting PMHs as their primary function would be clearly outlined.

As outlined in the description of the PMH, RPHCN's support for PMH Core Teams will range, where appropriate and based on the PMH leadership's preferences, from funding the positions to acting as the employer for staff funded through its budget, assuming responsibility for their payroll, benefits, professional development, and other HR-related requirements. Depending on the needs of the PMHs operating in their region, RPHCNs may also offer support to recruitment initiatives on behalf of any PMH which requests this support.

Key Differences: PCNs and RPHCNs

To better support primary care providers in the delivery of care and to further enable integrated care across the community, RPHCNs will differ from current PCNs in several important ways.

Funded and Accountable for Everyone: PCNs are funded for all patients assigned to family physicians who are members of the PCN. This has resulted in approximately 15% of patients in Alberta being unaffiliated with a PCN. These patients are unable to benefit from the programs and services the PCN offers. Under the new governance, funding and accountability will encompass everyone in Alberta.

Risk-Adjusted Funding: PCNs are funded on a capitated basis at a flat rate per patient regardless of their underlying needs or complexity. To address this, the capitation payments that will fund RPHCNs (and their associated PMHs) will reflect factors that impact the PHC needs of the people being cared for. Further information about risk-adjustment is available in recommendation 2.

Funding and Accountability: PCNs have experienced considerable instability resulting from the current funding model, which has translated into uneven support to PMHs. Conversely, there is limited accountability from PMHs to PCNs for supports received. Through an established bilateral

accountability agreement between individual PMHs and the RPHCN, PMHs will be able to reliably expect specific resources and supports, allowing them to confidently plan and deliver services. Stability of resources and supports provided will also enable PMHs to engage in evaluation, monitoring, innovation, and quality improvement activities that can result in improved performance along all aspects of the Quintuple Aim.

Driving Integration: While PCNs do have local partnerships, there is considerable variation. RPHCNs will be pivotal in driving local integration within the health and community sectors through their role facilitating and supporting service planning and care coordination at the level of IHNs. See recommendations 4 & 5 for more information on the IHN concept.

Structure

Each RPHCN will be a distinct legal entity and will be governed by a Board of Directors (composition to be determined) in accordance with the accountability agreements with the new provincial agency. The number and distribution of RPHCNs across the province has not yet been determined. As this is developed, it will be important to ensure that each RPHCN has a relatively consistent population of patients associated with it and has a manageable geographic footprint.

Core Responsibilities

- Provides regional service planning and coordination for the integrated delivery of primary health care services for all people connected to PMHs within the region as well as to any who are not connected to a PMH, living in the RPHCN's catchment.
- Facilitates vertical and horizontal integration of health care for people living in their catchment by supporting IHNs and by participating in regional and zonal planning initiatives with AHS and other organizations.

- Supports all or parts of a range of infrastructure, resources, and initiatives to enhance PMH capacity to provide primary health care services (e.g., clinical, management and administrative staff, practice infrastructure, clinical leadership, practice facilitators, change management, and quality improvement).
- Provides access to practice facilitators and change management resources to help PMHs leverage evidence, data and evaluation to improve the care experiences and health outcomes for their patients.
- Coordinates and supports the care and attachment of patients who are currently not connected to a PMH.
- Establishes and manages access to a broader PMH team that includes professionals with expertise in more narrowly focused aspects of primary health care, including those focused on mental health, nutrition, chronic disease management, addiction supports, maternal and child health, home care, palliative and end-of-life care, navigators, and urgent care. PMH Core Teams may access these resources through an internal referral network and through organizations participating in the region's IHNs.
- Directly operates PMHs, where warranted, based on regional population health needs and/or providers' desired practice model. Where the RPHCN owns and operates the PMH clinic for family physicians who are not interested in the owner/operator role, those physicians will pay a facility fee or overhead charge at reasonable rates based on market prices.

The responsibilities noted above are not final nor are they exhaustive. Responsibilities may vary based on the needs and network practice model in place in the region. They are meant to be a representative and high-level description of the key activities and outcomes for which an RPHCN will be responsible.

Accountabilities

- Accountable to the provincial agency's zonal operations based on provincial accountability and performance frameworks.
- Accountable to PMHs in their region based on bilateral accountability arrangements (i.e., functions and supports that the RPHCN is responsible for providing to the PMHs).
- Accountable to partners within the IHN (e.g., community organizations) to provide resources and supports for community level integration.
- Accountable for approving and funding service plans developed by IHNs in their region.

Alberta Primary Health Care Organization

At the provincial level, there should be an organization responsible for ensuring the quality and improved access to primary health care for the entire province, encompassing both people connected to a PMH and populations who are not connected to a PMH.

Given the context of primary health governance at the provincial level in Alberta, it is recommended that a new organization, Alberta Primary Health Care Organization (APHCO), be created as the focal point of strategic leadership, planning, funding, and oversight for primary health care for the province. APHCO's core functions will include ensuring that primary health care providers have the resources and supports, through the PMHs and regional and local networks, to meet local needs, recognizing that communities face unique challenges and opportunities across different areas of the province. APHCO will work closely with RPHCNs from across the province, as well as key organizations such as AHS, the Health Quality Council of Alberta (HQCA), universities, Alberta Innovates and others, to identify opportunities to leverage their expertise, resources, and data holdings to the benefit of the primary health care system and those

it serves. APHCO will also be responsible for designing and implementing leadership development programs for emerging primary health care leaders as well as funding key leadership positions throughout the primary health care system. Legislation and/or other mechanisms should be considered to ensure that primary health care is enshrined as a key pillar in Alberta's overall health system and that the appropriate responsibilities, institutions, and supports are in place to achieve and maintain quality primary health care.

Mandate

APHCO will be a new organization funded directly by and accountable to the Minister of Health. APHCO will act as the nucleus of the primary health care sector in Alberta and will be responsible for developing and sustaining performance monitoring and reporting systems, setting a culture of continuous quality improvement with support, and developing and disseminating clinical standards, clinical pathways, and clinical-operational leading practices in conjunction with academic institutions and researchers. APHCO will participate in the development and allocation of budgets as well as oversight of expenditures related to primary health care for the entire province.

APHCO will also be responsible for commissioning a scope of services from AHS and other organizations as needed to ensure equitable access to the full breadth of primary health care services across the province. This commissioning will encompass a variety of services that are currently overseen and delivered by AHS. Services such as home care, community mental health, public and population health, chronic disease management programs, laboratory services and diagnostic imaging could fall within the purview of APHCO, as these services pertain to primary health care. APHCO will be able to commission AHS for these services, to ensure that these services are delivered in alignment with the needs of the local communities. Patients and providers will benefit from this greater alignment and coordination of the primary health care system. Through this commissioning process, APHCO will have the leadership, governance, and funding to direct and oversee the delivery of these services while ensuring continuity of

service as AHS will continue to deliver them at the direction of APHCO. Commissioning these services will ensure that APHCO has the appropriate leadership and oversight of the entire primary health care system, while minimizing the risk of negative impact on patients and providers due to the disruption that would be caused by an immediate and significant transfer of responsibility for operations and delivery of these health care services and programs.

Structure

APHCO will be a distinct legal structure with a Board of Directors which should be both skills-based and inclusive of key stakeholders (e.g., providers, community representatives, etc.). Finally, for clarity, APHCO will replace PPCNC and ZPCNC as a new governance structure with both provincial and zonal-level functions.

Core Responsibilities:

- Provides provincial strategic leadership and direction for primary health care.
- Establishes a provincial primary health care services delivery framework (i.e., setting the principles, standards, and policies to guide and support the design, planning, and delivery of primary health care services).
- Establishes clinical standards, requirements, and directives for the delivery of primary health care services.
- Establishes a system of provincial monitoring and reporting of performance of the primary health care sector, including performance frameworks, such as targets and measures.
- Monitors and evaluates RPHCNs.

- Monitors and evaluates zone level primary health care initiatives and activities (e.g., zone-level quality improvement initiatives, commissioned primary health care services from AHS).
- Reports on the provincial primary health care system performance.
- Engages in joint planning and collaborative partnerships (e.g., AHS, Ministries, Family and Community Support Services), such as through a provincial health integration commission, for health system priorities.
- Participates/leads zonal service planning and care coordination initiatives through the provincial health integration commission.
- Designs and implements primary health care leadership development programs to identify, train, develop and recognize emerging primary health care leaders at all levels of the system.
- Recruits and places leaders with the clinical and primary health care system knowledge, skills and experience into funded leadership positions to help primary health care actors at all levels navigate the transition to the new model.
- Commissions AHS for a scope of primary care services, including home care, community mental health, public and population health, chronic disease management programs, laboratory services and diagnostic imaging.
- Ensures the effective implementation of the requisite processes, human resources and infrastructure to establish and manage bi-directional channels for consistent and proactive dialogue, issue escalation and resolution, and risk management between APHCO and the RPHCNs as well as between APHCO and Alberta Health.
- Identifies legislative, regulatory or policy barriers that affect the primary health care system or which prevent the effective implementation of desired changes and engages with Alberta Health to develop and socialize options that could resolve the concerns.

- Develops and advocates for funding commensurate with the patient and community needs throughout the province as well as to support the leadership, management, quality improvement, research and evaluation, monitoring and reporting and other core responsibilities and accountabilities in a manner that provides stability and predictability for all of the primary health care entities described in the new governance model.
- In recognition that the health care system is a significant contributor to climate change[75] and that climate is increasingly becoming a factor that impacts individual and community health,[76] APHCO should work to develop environmental standards for primary health care. These standards should be co-developed with primary care providers and owners of clinics. APHCO should seek opportunities to reduce emissions and the carbon footprint associated with facilities, energy supply, supply chain, transportation, manufacture, use and disposal of medical supplies.

Accountabilities

- Accountable to the Minister of Health and Alberta Health for the performance and outcomes of primary health care.
- Accountable for financial and other reporting as described in accountability agreements.
- Accountable for specific outcomes and deliverables based on accountability agreements, including public reports on clinical and financial performance, the delivery of special projects and public engagement.

Further information about this recommendation can be found in Appendix E.

Provincial Health Integration Commission

Once established, APHCO will be responsible for providing leadership and oversight of the primary health care system in Alberta. APHCO can provide the visibility and

resources to work with AHS and other system actors in the short-term to manage the transition issues that may arise as the new system is established. In addition, there will be an ongoing need to drive cross-sectoral integration and work on shared priorities and challenges.

A formal mechanism should be established to support these important efforts, such as a Provincial Health Integration Commission (PHIC). A critical early priority would be the development and execution of integrated planning processes between APHCO and AHS. In addition, where a need for shared services is identified, such as currently emerging from provider experiences with components of the Alberta Surgical Initiative, PHIC could serve to facilitate discussions on the oversight mechanisms for those shared services. PHIC could also serve as the space to establish data exchange protocols and processes to leverage AHS' considerable data holdings with those of the primary health care sector which could result in the displacement of an important obstacle to more robust planning, measurement, and reporting.

Mandate

The PHIC will be responsible for several important provincial and zone-level initiatives, including service planning, knowledge translation, developing data sharing platforms, and others.

Structure

The precise legal basis of PHIC (e.g., formal Commission, working group established by AH, joint venture, or provincial Committee established via Ministerial Order) matters less than the participation of the key actors and the clarity of its mandate to drive integration, oversee joint efforts and to resolve implementation issues with the new PHC governance model.

Core Responsibilities

PHIC's responsibilities to support health system integration could include:

- Facilitates integrated service planning between APHCO and AHS.
- Makes decisions on provincial operational oversight and accountability for shared service initiatives.
- Supports IT infrastructure and integration as an input for the integrated health system.
- Facilitates data sharing and integrated planning on data privacy, processes, and policies across the health care system and relevant Ministries.
- Sets clinical pathways and performance frameworks to guide the organization and delivery of integrated health services.
- Facilitates collaboration on shared workforce priorities including establishing a "one stop-shop" streamlined process for privileging and credentialing, harmonized physician recruitment strategies and plans.

Accountabilities

- Accountable to Alberta Health for joint work on provincial priorities and shared initiatives.

Alberta Health

In the recommended primary health care governance model, Alberta Health will adopt a more clearly delineated stewardship role. This requires a focus on developing desired outcomes, developing policy frameworks and policies that enable those outcomes, providing adequate funding for a robust primary health care system, and holding APHCO and PHIC accountable for achieving those outcomes. Alberta Health will

continue to be responsible for ensuring that its agents and other funded entities, now including the proposed APHCO, are equipped to achieve their intended objectives. Alberta Health will also remain responsible for the negotiation of the Alberta Medical Association (AMA) Physician Services Agreement as well as for physician payments governed under that agreement. Alberta Health will be an active and engaged participant in bi-lateral channels aimed at improving communication within the system and for the management of issues and risks. Alberta Health will commit to providing timely resolution to policy, funding and other concerns brought to them through these channels. Finally, Alberta Health is uniquely positioned to work with other Ministries to ensure coordinated policy frameworks and efficient funding models for primary health care. Integration at the service delivery level must be matched by a similar level of integration at the government level, notably in the areas of harmonizing policy and funding.

Assuming these roles also means that Alberta Health will shift away from "implementation functions" including direct oversight of PCN operations and participation in committees or groups that are responsible for implementation activities, unless invited for a specific purpose. Although a separation of policy and operations is necessary to have clarity of roles, it is also critical that APHCO and Alberta Health have a close and collaborative working relationship to ensure that policy direction translates to operations and that the government can remove barriers to effective operations through policy, funding, and other levers.

Core Responsibilities:

- Sets policy and direction to achieve a sustainable and accountable health system to promote and protect the health of Albertans.
- Acts in a stewardship capacity over the health system by developing and implementing a strategic policy framework and combining it with effective

oversight, coalition building, regulation, attention to system-design and accountability.

  - Ensuring the policy and direction given to its agents and other funded entities are being implemented as intended.
  - Assessing if desired outcomes are being achieved through strategic monitoring, evaluation and reporting of financial, health system performance, health outcomes and other measures.
  - Developing and implementing policies and securing funding to:
    - Address patient and community needs throughout the province.
    - Support the leadership, management, quality improvement, research and evaluation, monitoring and reporting and other core responsibilities and accountabilities of all the primary health care entities described in the new model.
    - Provide stability and predictability required for providers and governance entities to develop and execute longer-term plans for transformation.
- Engages in intersectoral, intragovernmental and intergovernmental planning and collaboration to ensure that decision-makers beyond the health sector take health data and policies into account.

DETAILED RECOMMENDATIONS (Recommendation 2: Align primary health care funding with delivery and accountability under the new provincial governance model)

This section describes how funding will flow from the payor (Alberta Health) through the primary health care governance structures to the points of care. The section will also describe how funding will flow to support regional and provincial planning, coordination, quality improvement, research, measurement, and reporting initiatives, all of which will be focused on the commitment to providing high-quality, always improving care and to delivering that care in a way that is focused on value. The descriptions are meant to be illustrative.

"Eliminate funding silos in health care so all are working together to provide most cost-effective care and not competing to obtain more funding for their particular part of the process"

(Citizen perspective)

Patient's Medical Homes

To support the transition to the new model, PMHs will be provided a variety of vital supports and resources as described previously. Key among them will be:

- Human resources to develop each PMH's Core Team.
- Access to clinicians on the broader PMH team.
- Training, toolkits and coaching in quality improvement to facilitate the development of Quality Improvement Plans and population-based clinical service plans, where appropriate.
- Protected time for participation in quality improvement activities.
- Access to provincial IM/IT systems and/or support to offset the costs of the PMH's EMR.

- Support to implement measurement and reporting initiatives as well as the PMH level reports.
- Support to participate in or lead research and evaluation projects.
- Capital budgets to support transitions to new clinical space to accommodate the core team and to facilitate co-location of physicians within a group, where feasible and beneficial.

The precise extent of supports and resources will depend on several key variables, including:

- The number of family physicians and/or nurse practitioners in each PMH;
- The number and nature of patients formally connected to each family physician or nurse practitioner (e.g., funding and level of support will be dependent on a per patient or capitated payment; capitated payments will be adjusted based on age and gender and, once feasible, complexity and socio-economic status);
- The specific burden of disease/illness of the connected population for each PMH (a connected population for the PMH that is over-indexed in diabetes, for example, may seek to develop a Core Team that emphasizes providers specifically focused on individuals living with diabetes); and
- The nature of the community being supported by the PMH (i.e., rural, isolated communities may require additional support to establish viable and sustainable PMHs).

Providers in PMHs will maintain clinical autonomy in how resources are applied and optimized within their practices and for their patients. Bilateral accountability agreements between PMHs and RPHCNs will outline the resources and supports PMHs can reliably expect to access as well as the services and outcomes desired from these investments for the PMH.

Physician payments will continue to be governed by the Alberta Medical Association (AMA) Physician Services Agreement. Administration of physician payments will remain part of Alberta Health's responsibilities.

Regional Primary Health Care Networks

To support the PMHs and other frontline operations in a particular region, each RPHCN will receive an allocation of the provincial primary health care budget from APHCO. The primary purpose of this budget will be to fund the resources and supports required at the frontline through provider-operated PMHs. In addition, RPHCNs will, in some cases, operate their own PMHs for unattached patients and/or on behalf of family physicians who do not wish to participate in clinic operations as traditional small business owners. They may also operate after-hours clinics where it is not feasible for provider-operator PMHs to provide this service.

RPHCNs will also help stand up and sustain (i.e., provide backbone supports) IHNs as well as act as the coordinating body for the implementation of regional and provincial initiatives relevant to the region. The RPHCN will hire and manage researchers, quality improvement facilitators and coaches, privacy experts, and staff with the technical expertise to implement evaluation, measurement and reporting programs. These network-based resources will support the PMHs and IHNs in designing and implementing localized projects including integrated care pathways, quality improvement initiatives, clinical program evaluations and other related activities.

The funding for all this work will be come from a capitated payment mechanism based on:

- The number of people (patients) for which the RPHCN and its constituent PMHs are responsible; this will be calculated based on:
  - Total patients formally connected to the family physicians and nurse practitioners working in PMHs within the region regardless of where those patients reside; and

  - Total individuals who reside in the region who are not formally connected to any PMH (anywhere in Alberta).

- The age, sex, and, once feasible, the complexity and socioeconomic status of the people identified above.
- The nature of the communities within the RPHCN's catchment (i.e., rural, isolated communities may require additional supports to establish viable and sustainable PMHs).

Note: Not all the identified risk-adjustments may be feasible in the first rounds of funding. The risk-adjusted funding formula will be improved over time based on experience.

As noted earlier, this proposed funding model for RPHCNs addresses some of the funding challenges within the current PCN funding model.

- Capitated funding includes both attached and unattached patient populations. The PCN funding methodology was based only on patients' association to PCN member physicians leaving a funding gap for the resources and supports needed to provide care for unattached patients and limited the capacity for communities to support unattached patients in finding a family physician.
- The proposed risk-adjusted per capita funding model also acknowledges that different resources are required to support patients with different health profiles and needs. The current PCN funding is a flat rate, regardless of individual patient characteristics or contexts or underlying community health status.

Based on this high-level design, the risk-adjusted capitation payment and the funding for both attached and unattached patients means that the funding broadly follows the patient for primary health care in this model. Each RPHCN will develop a budget approved by its Board of Directors and APHCO. The budget will be developed in alignment and coordination with the PMHs and IHNs in the region to meet the primary health care needs for the RPHCN's patient population. A substantial majority of the

RPHCN budget will be dedicated to providing access and supports to provider-operated PMHs.

RPHCNs will also be able to fund direct clinical operations, such as RPHCN-operated PMHs and the Broader PMH Team, where appropriate.

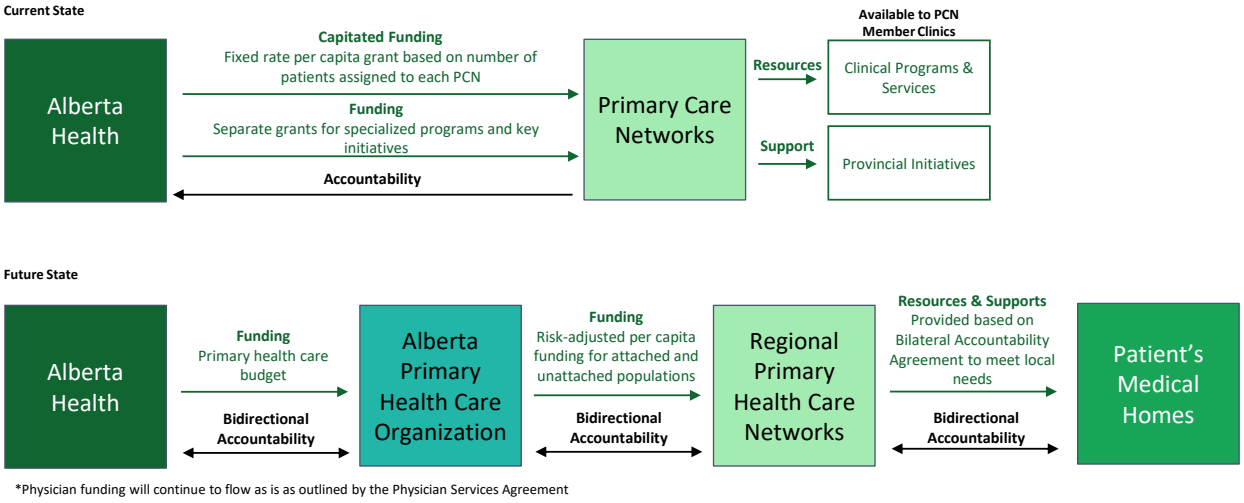
- RPHCN PMHs can be established to provide primary health care service access to unattached patients in the geographic catchment and/or for providers who wish to develop and manage their own patient panels and participate in the PMH model, but who do not wish to operate as private small businesses.
- RPHCNs may also partner with municipalities that are interested in owning and operating clinics in their communities.
- The broader PMH team will consist of specialized clinicians and other support staff who are important to the primary health care of some patients, but most PMHs may lack the scale to hire directly. These may include roles such as dieticians, diabetes educators, addictions counselors, social workers, and health navigators, among others. For more information about the Broader PMH Team, see recommendations 4 and 5.

With their budget, RPHCNs will fund their own operations, including staff to support research and quality improvement initiatives, coordination, and facilitation of IHNs, and management and administrative activities, along with other expected operational costs, such as office space.

Alberta Primary Health Care Organization

The overall budget for primary health care in Alberta will be developed by Alberta Health in coordination with APHCO. A majority of that budget/funding will flow through the proposed governance structures to directly enable team-based care in PMHs. In addition, APHCO will allocate budget to the development of provincial, regional, and

local infrastructure and teams to enable quality improvement, vertical and horizontal integration, and management based on measurement, evaluation, and reporting.



AH will also fund APHCO to enable its own operational capacity as the provincial organization responsible for primary health care for the entire province. APHCO will have some operational flexibility in how it allocates its budget. For the purposes of this high-level illustration of the recommended organizational funding approach, it will be assumed that the per capita funding amount allows for operational flexibility for any structures within the proposed primary health care governance model.

APHCO will allocate funds to:

- Local needs of PMHs and IHNs through the RPHCNs;
- A provincial quality improvement, safety and innovation program directly supporting PMHs and IHNs;
- A renewed EMR support and incentive program;
- Regional, zonal, and provincial initiatives adapted to the needs of local communities;
- Performance monitoring, evaluation, and reporting; and

- Capital investments, notably for clinic space expansion to accommodate the Core Teams and, over time and where feasible, the co-location of the physicians in a group alongside the Core Team.

Within its zonal initiatives and activities, APHCO will also allocate its funding to establish an Innovation Fund with Innovation Hubs throughout the zones to support innovative initiatives within local communities. To support these Innovation Hubs, APHCO will flow dedicated resources at the zonal level and APHCO will flow funding so that RPHCNs themselves can provide dedicated resources and protected time at the clinic level. For more information about these innovation-related concepts, see recommendation 7.

Finally, APHCO will have funding to commission AHS and other organizations for services across the province's zones in alignment with local needs, as informed by RPHCNs who will represent the interests of their local populations, health care providers, and other local stakeholders. The exact form of "commissioning" will require further development, but may include:

- Directly holding funds that would otherwise be allocated to AHS and potentially other organizations, with the responsibility to contract services. Services may include home care, community paramedicine, laboratory and diagnostics, social services, and community addiction and mental health supports.
- Authority to jointly plan with AHS and potentially other organizations how services are delivered, and resources allocated, with the understanding that APHCO will have to approve the plan before resources can be allocated.
- Ability for physicians or nurse practitioners to "prescribe" certain services (e.g., home care) for patients, with a requirement that the organization which delivers those services respond accordingly.

MEASURES OF SUCCESS

- The Alberta Primary Health Care Organization, Regional Primary Health Care Networks and Provincial Health Integration Commission (or Committee) are established
- Improved quality and effectiveness of decision-making and resource allocation across the primary health care system
- Improved coordination of primary health care resources aligned to community needs enabled through dedicated and connected provincial and regional governance bodies
- Adoption of integrated provincial health care planning processes enabled through the Provincial Health Integration Commission
- Team-based care is funded in PMHs through this governance model and funding approach across Alberta
- IHNs are established and are improving local integration and coordination of care across settings and sectors to improve efficiency, quality of care, patient and provider satisfaction and health equity
- The risk-adjusted capitation payment model is established, accounting for demographic, health status and socioeconomic factors as well as rurality/underserviced areas

TARGET MILESTONES

- August 2023: The interim governance structure is stood up and operationalized with supporting oversight bodies
- September 2024: The implementation of the province's modernized primary health care system, including the new APHCO agency, RPHCNs and PHIC, is initiated
- March 2025: The implementation of the province's modernized primary health care

system, including the new APHCO agency, RPHCNs and PHIC, is finalized

- March 2025: Initial funding for immediate priorities, including the design and implementation of APHCO, RPHCNs and PHIC, is allocated

Rural & Remote Considerations

- RPHCNs in rural/underserved areas will receive supplemental supports and funding to accommodate the increased demands placed upon them where there is an insufficient supply of rural generalists and/or where the proportion of people not connected to a PMH is significantly higher.
- IHNs for rural and remote communities will likely have an increased emphasis on planning and coordination between community-based primary health care and acute care facilities since the same rural generalists are often responsible for staffing both settings.
- Rural and underserved area PMHs may have fewer participating rural generalists in the group and may operate as a virtual network with limited or no co-location.
- APHCO governance bodies will include representation from rural and remote communities ensuring the unique perspectives, challenges and context of these communities are considered as decisions are made.
- The funding for rural, remote or underserviced areas will reflect the need for additional resources, where appropriate, to reduce strain on the providers delivering care to these communities.

Evolving Patient's Medical Homes within an Integrated Health Neighbourhood

Evolving Patient's Medical Homes within an Integrated Health Neighbourhood

RECOMMENDATION 3: Embrace patients and citizens as partners

WHY IS THIS IMPORTANT FOR ALBERTA?

Primary health care should be something that happens *with* people—not something that happens *to* them. People should be empowered to participate in, and manage, their own health care journey as a partner with their primary health care teams.

People must be at the center of Alberta's primary health care system.

Modernizing Alberta's primary health care system presents an opportunity for the province to embrace patients and citizens as partners in shaping the primary health care model of the future—one that is designed around their unique needs, and one they can be proud of.

People should have full and timely access to their own health records, culturally safe care, appropriate navigation supports, health literacy education, digital health and self-management tools, and clear communication channels. Citizens[4] and patients must be meaningfully seen and authentically valued as true partners at *every* level—in their own health team within a PMH, their IHN, and the broader primary health care system.

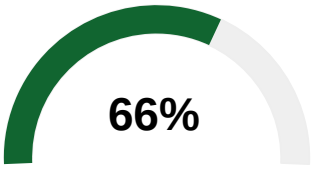
All people interact with the primary health care system at some point in their life. This occurs at the point of care as a relationship with their primary health care team from birth through to end of life. Relationships are based on personal interactions, where

[4] Imagine Citizens Network uses the term "citizen"' to refer to all people living in the province of Alberta. While much of the rhetoric in health care talks of 'patient or person-centred' the term citizen is meant to be more inclusive of all aspects of an individual's life, including but by no means limited to their experience as a patient. Citizens have varied interests in health and health care and sometimes not directly linked to personal experience as a patient.

agency is held equally and based on mutual respect and trust.

Based on the Commonwealth Fund 2020 survey[72] Albertans are not engaged in their care to the extent they want. This limits the development of a trusting relationship with their health care providers.

- 66% of Albertans reported that their regular provider always involves them as much as they want in decisions.
- 68% of Albertans reported that their regular provider always explains things in a way that is easy to understand.
- 55% of Albertans reported that their regular provider always spends enough time.



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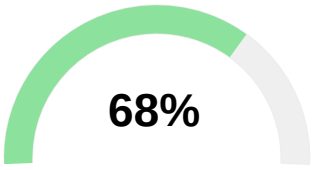

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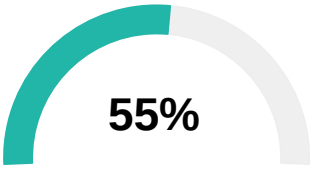


Albertans reported that their regular provider always spends enough time.

People in Alberta should be partners in primary health care throughout the primary health care system including at:

- **At the clinic level:** Patients should be partners in their health care journey with their primary health care teams in their PMH. Patients should be empowered and enabled to self-manage, understand their condition and treatment options, and be actively involved in the development and evaluation of their care plan.
- **At the IHN level:** Primary care must effectively integrate care providers and communities within an IHN, and build partnerships between them. Creating incentives, expectations and opportunities for integration of the PMH and IHN. This should include a robust feedback mechanism that enables input from all people in

the community to ensure that services are culturally appropriate and reflect the unique health and social needs of that community.

- **At the system and policy level:** There are significant challenges facing the province's broader system, including the health literacy of the population and the public's ability to navigate the health system. Having access to information, being able to use it as a tool and knowing how to navigate the province's health care system—independently and/or with support—is critical to accessing quality care in a timely manner.

DETAILED RECOMMENDATIONS (Recommendation 3: Embrace patients and citizens as partners)

Albertans as Partners in their Patient's Medical Home (Patient-Provider Level)

Patient-centric care is what patients and communities think it ought to be. This should be the underlying principle for the patient-provider relationship. If patients (and their family caregivers) are to be considered full and equal partners in their own health care team, Alberta should:

- Establish a standard field in a patient's EMR and include who the person relies on as a trusted family member or support person. This person should be welcomed, as the patient chooses, to be a part of the primary health care team.
- Provide access to health navigation resources in PMHs for those people who need or want additional support in managing their care journey.
- Invest in a comprehensive provincial resource hub to coordinate education, training, technologies and resources for patient self-management of chronic conditions. This includes hiring dedicated health literacy experts to develop and advise on patient and family caregiver materials that can be used locally and adapted to different communities and populations. Additional functionality should be developed in My Health Records to translate information into different languages and formats to

enable effective knowledge sharing with the primary health care team.

- Ensure people have access to their patient records and the right information to enable them to be partner's with their health care team.
- Establish a common patient and provider feedback platform and processes so that timely patient experience information can support ongoing learning and quality improvement across the primary health care team.

Albertans as Partners in their Integrated Health Neighbourhood

At the local level, Albertans can play a role in their IHN and in their communities. Through investments in the MAPS initiative, the province should:

- Involve citizens in decision-making, strategy and priority-setting by giving them seats at leadership tables that exist to foster integration of services across IHNs. Citizens should be supported to access the information and understanding of the context to ensure they can effectively advocate for community needs.
- Expand culturally sensitive case management and navigation supports for:
  - Indigenous peoples across Alberta regardless of if they live in Indigenous communities or outside of them;
  - People with complex needs and high service users; and
  - People who face inequity in primary health care for any number of reasons including socioeconomic status, urban and rural residence, age, education level, sex and gender, ethnicity, displacement, disability, language, immigration status or stigma.
- Build layered public reporting capabilities including the development of community-specific, regional specific and provincial level, publicly-shared dashboards that provides timely and updated information about primary health care. The dashboards should be informed and shaped by people and communities

to include the desired health care outcomes and key indicators that matter most to Albertans.

Albertans as Partners at a System and Policy Level

The primary health care system of the future should be accountable to the people of Alberta. Promoting health literacy, including educating the public on the social, environmental, and lifestyle determinants of health, can improve population health outcomes. To enable Albertans as partners in policy and decision-making at a provincial level, Alberta should:

- Establish community representation within the governance of primary health care at provincial and regional levels. These leadership roles should be supported by adequate resources and accountability for representing the perspectives of patients, communities, and caregivers through formal patient advisory groups.
- Create an independent Citizens' Forum composed of diverse stakeholders whose mandate is to identify, generate and share knowledge with Albertans about the province's collective achievements in supporting healthy communities and healthy Albertans.
- Create a multisectoral (e.g. community health, education, social services, justice, municipal affairs) group to co-develop targeted public awareness and education campaigns to increase Albertans' understanding of the factors that contribute to health.
- Commit to health equity by incorporating appropriate health equity data as a part of measuring health system outcomes, performance and equitable care. This may include the collection and disaggregation of health data along equity dimensions that include but are not limited to sex, gender, income, race or other socio-demographic characteristics, disability, Indigenous status, or stigma. This should include longitudinal outcomes and integrate with data from the social care system where possible.

"Most ethnocultural communities are marginalized due to cultural and socio-economic barriers - we need to pay special attention to these communities. After all they are our population and have a right to access just and equitable health care."

(Citizen perspective)

MEASURES OF SUCCESS

- Improved patient experience including culturally appropriate care, health outcomes, and continuity of positive relationships with the primary health care team
- Implementation and provincial adoption of a comprehensive patient-provider feedback system connected to the broader quality improvement and innovation system
- Progress toward collecting and measuring outcomes from longitudinal data related to health equity and social determinants of health
- Increase in comfort of patients who report being able to share their concerns with their primary care provider or primary health care teams
- Increase in patients who are involved in and actively participate in health care planning and decisions
- Quality of care navigation resulting in improved connection of patients to care across the IHN

TARGET MILESTONES

- June 2025: Community and citizen representation within the governance at the provincial and regional levels is fully realized with citizens holding membership in APHCO and RPHCNs governance bodies
- June 2025: Establishment and public reporting of provincial and community primary health care dashboards is fully implemented including reporting on health equity, public health outcomes, and quality measures

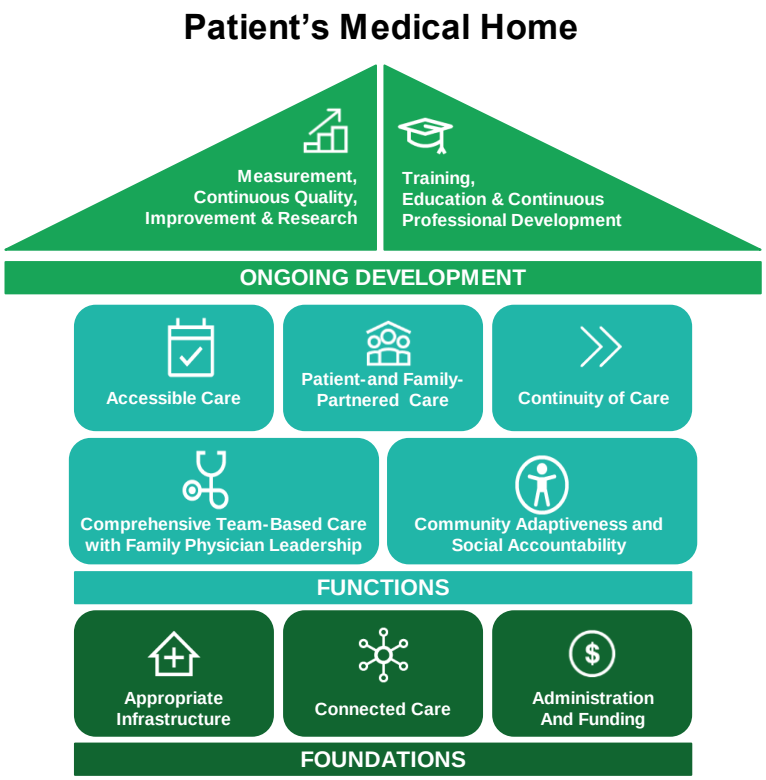
RECOMMENDATION 4: Accelerate efforts to ensure every person in Alberta can be connected to team-based primary health care using patient medical home principles

RECOMMENDATION 5: Systematically connect every patient's medical home to a broader integrated health neighbourhood to enable whole of person care

WHY IS THIS IMPORTANT FOR ALBERTA?

The overarching vision for team-based primary health care in Alberta is that every person in the province can be connected to a PMH, with timely access to interprofessional health providers and services. Each PMH should be connected to an integrated health neighborhood (IHN) that connects primary care to other health care services, community and social care to address all aspects of their health and well-being through whole person care.

All Albertans, regardless of where they live in the province, should have access to primary health care with resources and support required to meet their medical and health goals over their lifetime. The panel envisions that every Albertan should be connected to a PMH that meets the pillars as described by the College of Family Physicians of Canada.[73] This vision is built on the principles of collaboration and teamwork, including the patient's participation in their care alongside interprofessional primary health care teams and supported by the appropriate infrastructure and policies.



Primary health care begins in the community and in order to be effective it must be connected to the community. Just as each community has different needs and assets, IHNs will also vary in form. Primary care can open doors to the broader integrated health neighbourhood, including acute health care, community and social care and other services that impact people's outcomes. In an integrated health neighborhood whole of person care is enabled by connecting people to the care and providers they need as a part of a true primary health care system. This is especially important for people with complex needs that cannot be addressed by primary care teams alone.

Access to primary health care is a challenge for many people in Alberta.

Access to primary health care providers and services is a critical challenge. As of 2020, Alberta had approximately 15% of the population who were not connected to a regular primary care provider. Patients not connected to a PMH experience a broad range of health impacts including an increased burden to manage their own care, increased patient costs, lack of medical follow ups, lack of access to prescriptions and referrals, incorrect, missed or delayed diagnosis and condition specific health impacts.[74]

Team-based care improves health outcomes and reduces demand and costs of the broader health care system.

Team-based care can be effective in addressing common challenges and reducing downstream negative impacts to the health care system and patients. There is a robust body of research that demonstrates team-based care has positive impacts on the health outcomes of individuals. Team-based care has also been shown to positively impact broader downstream system level outcomes including rates of hospitalization, visiting the emergency department or being referred to a specialist.

Alberta has not yet effectively connected primary care to other primary health care services, including community and social care, to enable whole person care for people and communities.

Primary health care begins in the community and to be effective it must be connected to the community. Primary care services must be integrated into a broader health neighbourhood that links clinics with other health care, community and social services (i.e. those offered through the Family and Community Support Services program and other municipal services). Primary care alone cannot address the complex needs and factors that contribute to a person's health and well-being.

DETAILED RECOMMENDATIONS (Recommendation 4: Accelerate efforts to ensure every person in Alberta can be connected to team-based primary health care using patient medical home principles)

All people in Alberta should be connected to a PMH that operates on the principles of accessible, patient-centred care, delivered by a diverse primary health care team throughout a patient's life. Alberta must invest in and accelerate the expansion and development of PMHs within IHNs across Alberta. This expansion should be aligned to community and population needs. This can be achieved by:

- PMHs must be funded appropriately through a comprehensive funding model that supports sustainable population-driven team-based care.
- Patients should be able to access care within their PMH through a variety of channels including in-person care, virtual care, telephone or video-conferencing that are appropriate and aligned with the patient's needs.
- The primary health care system, at the provincial, regional, and local level must invest in mental health supports and services as a critical part of every primary health care team in the community.
- The primary health care system needs to develop and expand the use of culturally safe practices that are embedded into the PMH team's ways of working.
- A common understanding of scopes of practice for each care provider should be developed in the context of a PMH and team-based care to maximize the effectiveness of each team member.

"Rural and remote aren't the same as urban and suburban. Rural and remote primary health care aren't the same as each other. It's all different and we need to think differently about it. One size fits all won't work for anyone."

(Care provider perspective)

The form and structure of PMHs may vary from traditional physician or provider-owned and governed, to community or network-owned and governed, or Indigenous-owned and governed. The functions and characteristics of the PMH should be based on a common definition including:

- *Accessibility of care* (access to care and health advice and information when needed through multiple channels);
- *Team-based care* including a diverse primary health care team supported by an effective funding model that supports diverse care providers;
- *Integration and interoperability* of services and infrastructure including shared medical information within the PMH and to the broader health care system, clear communication mechanisms and coordinated scheduling of appointments;
- Built specifically to *match the community need* in terms of population, demographics, geography, cultural needs, etc.; and
- *Clear expectations and accountabilities* both for teams operating within the model and the network supporting the model.

Within their PMH, patients should have access to a primary care provider of their choice, typically a family physician or nurse practitioner (recognizing that patients may not physically see their "lead provider" at every appointment) as well as a diverse, interprofessional team. The PMH team may include but not be limited to:

- Physicians
- Nurse practitioners
- Registered nurses
- Licensed practical nurses
- Mental health professionals (social workers, psychologists, counselors, etc.)

- Physician assistants
- Medical office assistants
- Office support workers
- Pharmacists
- Other primary health care providers (physiotherapist, dietitian, occupational therapist, chiropractor, community paramedic, dental hygienist, social worker, etc.)

PMHs should also provide health navigation resources for those people who need additional support in accessing the appropriate care for their needs. This should include but not be limited to resources for people who face inequity in primary health care as a result of socioeconomic status, age, education level, sex and gender, ethnicity, displacement, disability, language immigration status or stigma.

Funding models considering both operating expenses and capital infrastructure to support team-based care are essential.

PMHs must be funded appropriately through a comprehensive funding model that supports sustainable population-driven team-based care. They will need to be supported to adapt to the evolving needs and realities of the communities they operate in. There should be community and broader IHN involvement and input into how these services are housed, connected and formed in terms of what works best for their community and the appropriate alignment between expectations and funding.

For example, PMH internal functions, workflows and operations should be funded to enable collaborative team-based primary care services and improve connection and accessibility within the communities they serve. This level of support will also enable care providers to work to their full scope of practice by having support to assist with integration of care.

Funding models also need to account for investment required in physical infrastructure of clinics. By working collaboratively with clinic owners and municipalities, primary health care leadership needs determine the most appropriate ways to ensure capital infrastructure meets the ongoing needs of Albertans.

Enable multiple channels to access primary health care.

Patients should be able to access care within their PMH through a variety of channels including in-person care, virtual care, telephone or video-conferencing that are appropriate and aligned with the patient's needs. Technology to enable home health monitoring and other remote functions should be available for patients. The use of these access channels should supplement in person care and be a part of the care plan developed with the primary health care team.

This is especially critical for many communities who do not have access to some primary health care or specialty services for pragmatic reasons - small populations and areas with very low population density or a lack of care providers in some parts of the province for some services. These challenges are most prevalent and pressing in remote and rural communities. Virtual care can increase the availability and diversity of services and create new channels of access particularly in rural and remote areas where access to some services is not available including:

- Virtual primary health care, specialist and broader IHN services as a complement to in-person models of care;
- Mobile care options including paramedical services and mobile diagnostics;
- Expanding and investing in mobile primary and specialty health care services; and
- Continued evaluation and expansion of the use of home health and home monitoring services.

Different access channels should be integrated as a planned, multi-modal connected network to deliver services, ideally connected to physical infrastructure where possible that support and enable the goal of continuity of care and relational attachment.

These services should be available to other populations who face access challenges to in-person care or as appropriate based on care plans, and should be coordinated with shared information and clear and effective communication infrastructure across the primary health care team.

In addition, integrated appointment and referral processes which incorporate coordinated scheduling of appointments, standardized referral pathways and self-service options should be available to empower patients in managing their own care. Teams should have access to research and capacity to perform quality improvements as a part of their roles, with appropriate dedicated time.

Embed mental health into the primary health care team and PMHs.

The primary health care system, at the provincial, regional, and local level must invest in mental health supports and services as a critical part of every primary health care team in the community. There is a dire need to more effectively provide accessible mental health care and services to people in Alberta. This investment should include integration of services beyond the PMHs and should consider appropriate funding mechanisms to improve access to mental health care.

Mental health is a common driver for individuals seeking primary health care. Physicians, nurse practitioners and other primary health care providers are often the first touchpoint for people seeking treatment for mental health concerns including depression and anxiety. Mental health professionals (i.e., psychologists, counselors or social workers) should be employed within PMH settings or as an extended member of the primary health care team outside of the physical location (clinic setting) supported by integration of services including integration with AHS mental health services and community mental health services. The primary health care system should collaborate

with the Ministry of Mental Health and Addictions to ensure priorities, initiatives and policies are aligned as appropriate.

Develop cultural safety standards, capabilities and practices.

The primary health care system needs to develop and expand the use of culturally safe practices that are embedded into the PMH team's ways of working. These practices and capabilities should be co-developed with participation from diverse people in the province. Culturally safe practices should be included within education and professional development for primary health care providers and teams. These practices should be reviewed and improved as a part of the continuous improvement capabilities embedded in the primary health care system and PMH.

Embed culturally safe care navigation supports.

The primary health care system should develop supports specifically targeted at assisting people with navigating the health care system and care in culturally safe ways. This may include developing roles specifically relating to culturally safe navigation of the primary health care system. Other forms of culturally safe care navigation can include online or telephone resources.

Develop and define a common understanding of scopes of practice and provide training on how to collaboratively work within the PMH and as a part of the IHN.

A common understanding of scopes of practice for each care provider should be developed in the context of a PMH and team-based care to maximize the effectiveness of each team member as a part of the core primary health care team.

The practice of working together as a part of the IHN needs to become a commonly accepted and adopted standard of practice within the PMH. Primary health care team

members should receive training and education targeted at embedding working as a part of the IHN as best practice within the PMH. Professional colleges should work together to set interprofessional standards of practice for primary health care to enable teams to more effectively work together with a common standards framework.

Develop a comprehensive extended hours care strategy.

A provincial extended hours strategy should aim to ensure that no Albertan goes without care or be forced to access care through an emergency department that could be met through other options. A combination of approaches is necessary, including: clinic-based after-hours services, designated after-hours clinics covering a larger geographic footprint (e.g., covering an IHN), and virtual after-hours services. A core guiding principle is continuity back to the PMH, meaning that information about the encounter is shared with the PMH in a timely fashion to enable appropriate follow up. Patients who are not connected to a PMH and access after-hours services should be offered support to become connected to a PMH. It is critically important that 811 Health Link be integrated into a broader after-hours care strategy so that patients are not directed to a “dead end”.

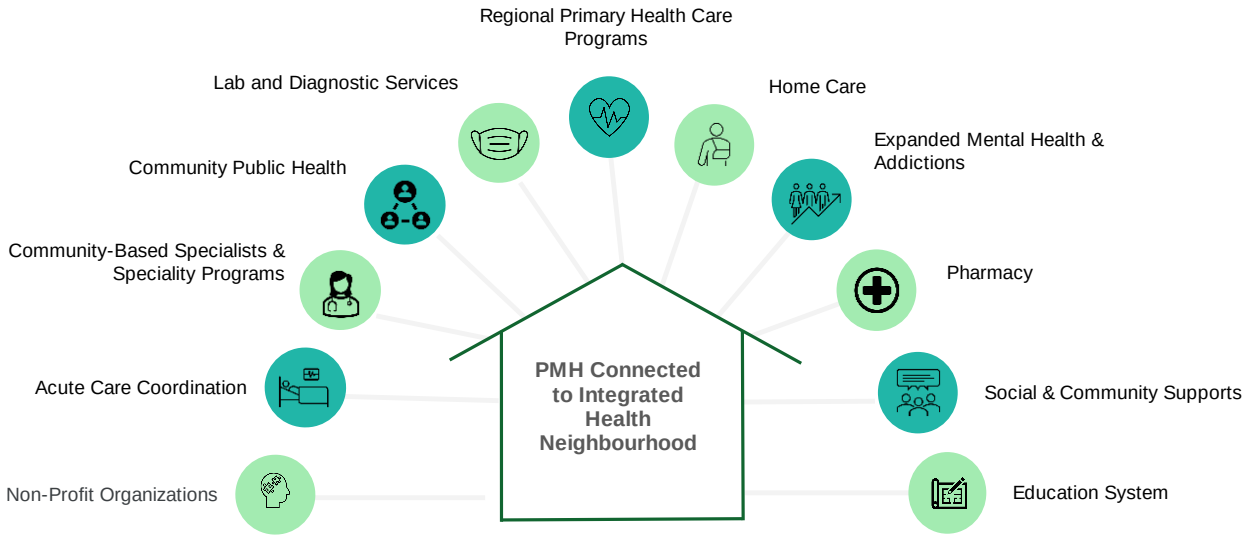
DETAILED RECOMMENDATIONS (Recommendation 5: Systematically connect every patient's medical home to a broader integrated health neighbourhood to enable whole of person care)

Primary health care begins in the community and in order to be effective it must be integrated with and connected to the community. Many people have needs that cannot be addressed by primary care alone; this is especially true for those with complex health needs that are exacerbated by social factors including trauma, poverty, and racism. An integrated health neighborhood can be thought of as an integrated network of diverse care providers in a community that includes community care services, social care and supports, acute care (each IHN should include at least one hospital and could include more than one), chronic disease management, and other health related services. An integrated health neighbourhood model should:

- Be developed to cover the entire province and can be defined by different types of boundaries depending on the communities and regions within the IHN.
- Create more formalized communication and partnerships between primary health care delivery groups such as community pharmacies to improve coordination and reduce errors and duplication.
- Create formalized pathways of care between health and social care sectors.
- Set goals and achieve outcomes relevant to the local community as a connected network with shared accountabilities.
- Communities should be provided incentives to develop and support integrated health neighbourhoods and resources to support integration between care providers.
- IHN's should be developed with input from the community, providers and people with the opportunity to develop an IHN plan and with the ability to access resources to support the development with multi-stakeholder accountabilities.

- Developing a provincial extended hours strategy should aim to ensure that no Albertan goes without care or be forced to access care through an emergency department.
- Enabling direct access to preventative health services and primary health care professionals – such as physiotherapists, chiropractors, psychologists, dieticians, or dental hygienists.
- Care navigator resources should be co-developed and utilized to bridge the gap between primary health care and the broader care system in Alberta.
- Investments should be made to scale and expand Community Health Centres and other programs (e.g., immigrant health clinics) that are highly effective in meeting the needs of targeted populations.

Illustrative Example of an Integrated Health Neighbourhood



This network of integrated care providers and services should be accessible to all people to provide the care and services they need to address the different needs and factors

that impact their health and well-being. PMHs can act as one access point to the health neighborhood and likewise different service providers may assist in connecting people to a PMH. Together the PMH and the IHN should be integrated to provide whole person care.

Patient's medical homes must be supported to systematically integrate with other health care and social services to ensure patients experience seamless transitions between care providers and care settings. The health of individuals relies on a broad range of factors and should be supported by a diverse care team that extends beyond the primary care team in a PMH. PMHs must be meaningfully connected to the IHN including community services and other professionals to support a holistic approach to each person's well-being including but not limited to:

- Community pharmacy
- Dentists
- Community-based physicians not practicing comprehensive family medicine, including specialists
- Home care
- Osteopaths
- Community mental health services
- Traditional healers
- Community paramedics
- Home care and support services
- Public health
- Alberta Health Services (including mental health, chronic disease management and prevention programs, etc.)

- Community social programs and services, including those funded through the Family and Community Support Services program
- Laboratory and diagnostic services
- Navigation supports, including existing provincial services (i.e. 211, Health Link, Netcare) and local services
- Peer supports

Effective governance and integration mechanisms will be essential to expanding the health team to include broader care throughout the community. RPHCNs should support the development of service agreements and protocols to assist with standardizing warm handoffs and expectations to support comprehensive continuity of care for patients. These types of mechanisms can support shared accountability and management across the IHN with common standards of care.

Alberta Health should seek to establish shared leadership and governance mechanisms with other ministries and provincial service providers. This may include formal partnerships or cross-ministry advisory panels to support cross-sectoral integration and collaboration, including:

- Ministry of Health
- Ministry of Seniors, Community and Social Services
- Ministry of Mental Health and Addictions
- Alberta Health Services

Communities and service providers should be active in connecting and building the IHN with support from the RPHCNs and APHCO. The collaboration between communities, the primary health care system, other health care service providers, the broader community, and social care providers should be focused on ensuring that the IHN is able to meet the holistic health needs of the community.

At the local or regional level there should be similar formal and informal channels for cross-service provider collaboration and partnerships. Regional networks should seek to form partnerships and connections with local service providers who are serving similar populations and people within the community. Community health and wellness advisory groups can be formed with leaders at the local and regional level to facilitate coordination and alignment of services and to maintain a community-wide view of health and well-being challenges.

Integrated health neighbourhoods should provide coverage across the province.

IHNs should be developed to cover the entire province and can be defined by different types of boundaries depending on the communities and regions within the IHN. Some key considerations in establishing IHNs should include:

- Population and population demographics within the IHN;

- Municipal or geographic boundaries; and
- Cultural and community driven factors.

Expansion and investment in paramedical, other mobile and virtual programs can improve access and remove barriers to primary health care for patients across the province, and should become a core part of how the broader primary health care system delivers care and integrates with other parts of the broader health and community care systems. IHNs should not deny services to patients from other IHNs across the province but rather work together to ensure that people get the care they need with appropriate communication back to the PMH. There should also be consideration given for how the PMHs and the IHNs connect to acute care. Hospitals, particularly in urban settings do not generally correspond to existing PCN boundaries.

Enable citizens to directly access PHC services not fully funded through the public basket of services.

Providing funding directly to citizens will permit them to access the preventative health services and primary health care professionals they need – such as physiotherapists, chiropractors, psychologists, dieticians, or dental hygienists – without having to wait to be seen by and referred by the most responsible provider within their PMH. Increased provincial health care coverage for individuals can provide access to essential services that are not currently funded through the public basket of services, through collaboration with employers or through the development of publicly or privately-funded personal health spending accounts. Government and private insurers will need to determine what services are eligible.

Co-develop care navigator roles with social services to bridge the gap and provide case management.

Where possible, primary health care services should be designed to be as simple as possible to navigate but it is recognized that additional support for people may be needed in some cases to navigate the primary health care system. Care navigator resources should be developed and utilized to bridge the gap between primary care and the broader community and social care system in Alberta. These resources and roles should be focused on connecting vulnerable populations to the appropriate care resources and providing culturally appropriate case management and follow up services for individuals who require support.

This role is a critical component of facilitating effective integration between the PMH and the IHN to provide comprehensive and holistic care, particularly for those individuals with complex needs. The importance of the care navigator role has also been acknowledged in Alberta's Facility Based Continuing Care Review, to support continuing care clients in navigating across health, community and social services.[20] Care navigators may be best positioned outside of the PMH in community based organizations and networks depending on the expertise required to provide support.

> *"We use the jargon of social determinants. What does that mean? It means there are other sectors in society that have a major influence on my health. My health depends on my income. My health depends on the food I eat, the water I drink, the house I live in, the neighbourhood that I am in. So, it is not only a whole person approach but a whole society approach, especially for primary health care."*
>
> **(Citizen perspective)**

Expand services that support vulnerable and isolated Albertans who face access barriers.

Investments should be made to scale and expand Community Health Centres and other programs (e.g., immigrant health clinics) that are highly effective in meeting the needs of targeted populations. These investments should be targeted at embedding these programs into communities and IHNs and connected to PMHs based on need. Not

every community needs every program but every program should be available to every community that needs it as much as possible.

Expanding the use of community paramedicine services for non-emergent primary health care to members of the community is an effective way to improve access to care for patients who may face barriers. There are existing paramedicine programs delivered in Alberta that could be expanded including:

- Community Response Teams
- City Centre Team Mobile Integrated Healthcare
- Crisis Response and EMS (CREMS)
- Assess Treat and Refer (ATR) Program
- Blood Tribe Department of Health Mobile Medical Unit
- Alex Community Health Centre Mobile Health Clinic

Expansion of these programs could include working with police services who have programs in place as a part of the increasing need to respond to mental health, addictions and social disorder related calls to police. For example, Edmonton Police Services offer the Human-centred Engagement and Liaison Program (HELP) which connects vulnerable populations to broader community support including primary health care, community and social programs using integrated case management and navigation services.

MEASURES OF SUCCESS

- Increased percentage of people in Alberta connected to a PMH with access to a regular primary health care team and provider
- Increased number of PMHs delivering interprofessional team-based care
- Increased quality of referrals between the PMH and other care providers in the IHN through formalized integration channels and established protocols
- Increased funding to improve access to care in the IHN including preventative care such as physiotherapy or dental hygiene
- Development and adoption of cultural safety practices and standards provincially including with PMH and throughout the primary health care system
- Development and implementation of a provincial after hours primary health care strategy

TARGET MILESTONES

- April 2024: Early action toward implementation of team-based care, including early investment opportunities, stimulus funding for team-based care, expanded use of non-FFS compensation models for family physicians and nurse practitioners, expanded integrated supports for vulnerable and underserved Albertans initiated
- April 2024: Immediate deployment of resources and people are targeted to underserved communities to enable the enhanced team-based care model
- September 2028: Province-wide PMH model fully implemented, including provincial coverage of IHNs across the province with all PMH participating in development activities

RECOMMENDATION 6: Reduce financial risk of clinic ownership and administrative burden

WHY IS THIS IMPORTANT FOR ALBERTA?

Administrative burden on physicians and other healthcare professionals is proven to have a negative impact for patients, providers and the broader health care system including decreased time for providing primary care services, increased stress and burnout, decreased efficiency and increased costs. On top of this, many physicians, and especially residents and newer graduates, do not wish to own and operate clinics due to the financial risk and additional management responsibilities associated with ownership.

Primary care providers today spend a significant amount of time on administration related to patient care activities, managing medical records and patient information, managing referrals, and meeting administrative requirements. A report by the Canadian Federation of Independent Business released in January 2023 estimates that physicians are spending 18.5 million hours a year on unnecessary administration. And for many clinic owners, there is an added burden of managing "the business" of primary care, including the cost, labor and risk involved in opening and owning a clinic. Finally, research and consultations with residents and newer family physicians increasingly point to a preference to practice in situations where administrative requirements are minimized, and to not be the owner and operator of clinics.

Investments into interventions and providing standardized infrastructure and support targeted at reducing administrative burden is a key enabler to unlocking significant overall improvements to the primary health care system.

DETAILED RECOMMENDATIONS (Recommendation 6: Reduce financial risk of clinic ownership and administrative burden)

The Government of Alberta should invest in interventions and infrastructure that are targeted at reducing the risk of ownership and administrative burden that physicians currently face. These investments should include the development of a program which offers a choice of varying levels of support and resources that can be opted in to with clear accountabilities. Support options should be provided for all PMHs who wish to opt in regardless of the funding model they utilize with the same clearly defined accountabilities. The included programs and supports should include options for:

- Standardized IM/IT, technology and other infrastructure required by PMHs this may include:
  - EMRs, Business Administration Software (ERP), and technical support (help desk services).
- Clinic management supports including:
  - Administrative support including charting (e.g., real-time dictation, transcription by artificial intelligence (AI), and other automation or technology enabled tools);
  - Accounting, financial and invoicing;
  - Human resources, recruiting and hiring support; and
  - Funding that can be used to reduce administrative burden or hire staff to provide support (e.g., managing clinic inbox, messaging and communication).
- Accelerating efforts to transition to non-fee for service (FFS) compensation models for primary health care providers who are interested by making the process easier while ensuring fair and equitable compensation.

- Transitioning out of situations where physicians own or lease and hold all the risk related to capital infrastructure. This may include, for example, options where interested municipalities own and operate clinics.
- Alberta should provide transitional resources and change management resources to support providers who wish to migrate toward managed or turnkey models or adopt new technology in alignment with standards.
- Additional investment may be required provincially to fund the development of additional primary health care infrastructure and to refresh and modernize clinic infrastructure in collaboration with care providers and communities.

MEASURES OF SUCCESS

- Increased proportion of family physicians practicing comprehensive family medicine
- Dedicated investment made in providing turnkey support provided to clinic owners
- Decreased time spent on clinical administration for primary health care providers
- Decreased reports of administrative or EMR related stress, burnout or leaves of absence or turnover
- Increase access to primary health care capacity (i.e., availability of PMHs) resulting from decreased financial risk or the use of targeted support models
- Improved satisfaction with work life balance and quality of life for primary health care providers and clinic operators
- Community ownership of PMHs or infrastructure across Alberta to increase access to primary health care across the province

TARGET MILESTONES

- Dec 2023: Targeted program launched to provide IM/IT and clinic management supports including transition supports clinic operators
- Mar 2024: Funding is allocated to for investments in reducing financial risk and administrative burden as a part of 2024 healthcare budgeting processes

RECOMMENDATION 7: Invest in quality, safety and innovation capabilities and capacity as a strategic priority within the primary health care system

WHY IS THIS IMPORTANT FOR ALBERTA?

The best health systems in the world invest in quality, safety and innovation as strategic priorities for driving system transformation and change. The best health systems in the world are driven by information to become learning health systems. They establish the infrastructure and commit dedicated resources to enable frontline local teams to address problems that matter to them to improve both experience and care. This is done in balance with a system-wide approach for implementation of initiatives, standardization and system learning.

To do this, health systems and organizations must invest in quality, safety and innovation improvement capabilities including education, training, professional standards, infrastructure and tools required. Teams should have dedicated professional time and capacity that is protected and funded for Quality Improvement (QI). Investments in QI, safety and innovation must be made in a systematic and deliberate way.

The case for a robust health transformation workforce has been well described.[78] This will be a critical component of the required investment. Supporting clinical champions and practice facilitation working at the level of care delivery will be a catalyst for quality, safety and innovation.

Alberta is asset rich when it comes to quality, safety and innovation, yet lacks an organized strategy to scale, spread and embed innovations throughout the primary health care system.

Many organizations and groups currently have an active role in quality, safety and innovation in primary health care Alberta, including:

- Health Quality Council of Alberta
- Alberta Health Services
- Primary Care Networks
- Universities and other post-secondary institutions
- Alberta Medical Association
- Alberta College of Family Physicians
- Alberta Physician Learning Program
- Alberta Innovates
- Health professional and medical regulatory colleges

However, the power and potential of the people and processes invested in quality, safety and innovation across the province has not yet been harnessed. With dedicated investments in infrastructure and training, Alberta should leverage its many assets to build a quality, safety and innovation agenda for the PHC system. What is missing is dedicated investment in infrastructure, research and evaluation; and an organized strategy to improve the capabilities of people in the system (including policy and governance considerations).

DETAILED RECOMMENDATIONS (Recommendation 7: Invest in quality, safety and innovation capabilities and capacity as a strategic priority within the primary health care system)

Alberta needs to formalize and fully resource an integrated quality improvement program, with an aim to enable primary health care teams to conduct quality improvement as a normal part of their job; and demonstrate the impact of quality

improvement activities in terms of better care and better value for resources invested.

This will require formalization of roles and accountabilities of several partners, supported by provincial policies and programs established by decision-makers, health professions regulators, and education institutions. The program should:

- Provide dedicated support to PMHs, including resources for local leadership, data, improvement facilitators, training and education including protected time and coverage for care providers;
- Provide dedicated support to facilitate improvement across IHNs, including community-level data, team-based quality improvement education and training, and connections with other IHNs;
- Provide every RPHCN with the capabilities and capacity to identify gaps and desired improvements relevant to their context and geography, and help clinics and IHNs to conduct improvement activities;
- Include a quality and safety improvement education strategy for care teams, leadership and boards in Alberta that builds from existing assets (e.g., ACFP education and family medicine summit); and
- Enable collaboration with AHS and other provincial partners on common priorities.

Embed quality, safety and innovation in upstream education.

Upstream academic preparation of primary health care professionals is also required. This will require provincial infrastructure, cross-ministerial collaboration, and the commitment and involvement of education institutions, professional associations, and health professional regulatory bodies. Team-based primary health care requires team-based quality and safety education. Pre-professional education and post-graduate training must cover quality, safety and innovation in a team-based context that are aligned to professional standards and licensure requirements.

Accelerate innovation efforts by investing in the creation of innovation hubs and a dedicated primary health care innovation fund.

Alberta has a number of innovation hubs, accelerators and programs in place today. However, these drivers of innovation are not connected to the right infrastructure to scale and spread innovations in primary health care. New thinking is needed for the new way forward. Alberta should invest in a dedicated primary health care innovation strategy and pipeline for identifying, testing, implementing, evaluating, and scaling innovations in primary health care services, processes and models of care.

This could be accelerated with a two-fold approach:

- Setting up a dedicated primary health care innovation fund. The focus of this targeted fund would be to invest in innovations for underserved populations (including Indigenous Albertans), rural/remote communities, cultural groups with unique needs, and individuals with complex medical and social needs.
- Establishing a discrete number (six to eight) of innovation hubs across the province that directly engage with clinics, IHNs, communities, private sector, and "innovation partners" (e.g., Alberta Innovates) to enable strategic spread of proven innovations. These hubs could be aligned with groups of RPHCNs in a geographic zone of the province, with academic institutions that have established innovation hubs, or be community-based entities aligned to community and population needs that span the province. Knowledge sharing and learning would be facilitated through provincial and regional structures to enable grassroots innovation and improvement to flourish and to spread. Innovation hubs can also play a role in addressing the environmental impact of the PHC system and finding opportunities to improve the environmental sustainability of primary health care services.

Invest in building robust data and analytics platforms and infrastructure.

Data and information is essential for measuring and monitoring practice improvements, and the analysis, interpretation and use of data can build public confidence and trust in the performance of the primary health care system. The effective access to and use of information is the foundation of building a learning primary care system. Alberta is data rich yet information poor when it comes to team-based primary health care. Information is held in EMRs locally in private clinics, rarely shared across different providers (including with the social services sector), and Alberta lacks a robust provincial infrastructure to consistently aggregate data for true population-level analyses related to primary health care. AHS has the capacity and capabilities for this type of consolidation and aggregation, yet privacy policy barriers prohibit data and information sharing. There is significant potential and value for Alberta's investment in primary health care data and analytics infrastructure, requiring:

- Development of a provincial primary health care quality and safety scorecard, aligned with the provincial framework. Map existing data and measures to the scorecard, and accelerate data sharing agreements to ensure a comprehensive, integrated provincial approach, with useful information cascading to regional and local levels.
- Establishment of provincial data standards and infrastructure for the integrated primary health care scorecard, including measurement, monitoring, analysis and public reporting of primary health care performance at a provincial, regional, and clinic levels, including the analysis of regional variations.
- Expanded use of the HQCA Primary Care Panel Reports as a critical tool to enable practice-level quality improvements across primary health care teams. Continuously improve and embed the use of these reports in practice standards for family physicians and nurse practitioners (NPs) through regulatory colleges.

- Expanded support provided by HQCA for data quality and data analysis at clinic, local and regional levels so that practice improvement data is shared with health care providers and the public in ways that are useful and easy to understand.
- Establishment of population-level measures and indicators related to health equity and social determinants, including income, employment status and race. This will require coordination and collaboration across government ministries and departments, and health and social service organizations and agencies. An immediate opportunity is to align data and measures with the provincial/municipal Family and Community Support Services[79] program priorities related to social inclusion and equity.

Embed research and evaluation in policy and practice to advance a learning health system.

While there have been pockets of excellence and noteworthy research investments in primary health care in Alberta over several decades, capabilities and capacity for clinical and applied research has been limited primarily to academic medical facilities and teaching universities in Alberta's large urban centres. There is now a real opportunity to embed research and evaluation capabilities directly within teams and in the skeleton of the new primary health care system governance as part of the quality, safety and innovation strategy.

It is equally important that embedded research be a core competency and central to how Alberta Health and other Ministries approach system-level primary health care policy development. As MAPS implementation proceeds, research and evaluation should guide investment decisions, program development, and efforts to demonstrate accountability. It is critical that Alberta Health be actively engaged with Alberta's research community by working collaboratively to build a provincial policy research agenda, commissioning research to help inform policy decisions, and to support overall evaluation of MAPS implementation. This requires focused leadership within Alberta

Health, along with strategic investments that embed research, analytics and evaluation capability within the department that is exclusively focused on primary health care policy issues. It also requires sustained effort to promote development of researchers provincially and to partner with universities and other organizations with specialized expertise in health policy research.

Alberta can look to notable research capacity opportunities in Canada to build a suitable, made-in-province model. For example, the Canadian Institutes of Health Research (CIHR), Health System Impact (HSI) program helps match academic researchers in health services and policy research and related fields with health organizations to develop embedded research projects and programs. Adapting this idea, Ontario is trialing a model within its Family Health Teams in their province. Locally, the Alberta SPOR Support Unit (AbSPORU)[80] Implementation Science Collaborative has embedded researchers and HSI research fellows with practitioners in a number of ongoing quality and safety improvement initiatives within AHS—with additional funding support this could be expanded to include primary health care initiatives outside of AHS.

MEASURES OF SUCCESS

- Rate of spread for priority quality improvement, innovation or safety initiatives at the PMH or regional primary health care network level
- Level of funding provided to the dedicated innovation fund
- Establishment of innovation hubs is complete including rural innovation hubs
- Development of a provincial primary health care quality and safety scorecard, aligned with the provincial framework is complete including access to data enabled by data sharing across the IHN and broader health and social support ecosystem

- Establishment of provincial data standards and infrastructure required to enable the integrated primary health care scorecard, including measurement, monitoring, analysis and public reporting of primary health care performance

TARGET MILESTONES

- Sept 2023: The primary health care quality and safety scorecard is developed including population-level measures and indicators related to health equity and social determinants, including income, employment status and race
- June 2024: The capabilities required to track investments and outcomes are built—this should inform the QI program to enable continuous improvement efforts
- June 2024: A QI program with an innovation pipeline is developed

Rural and Remote Considerations

The experience of interacting with the primary health care system comes with a unique set of challenges, considerations and barriers for people and communities in rural and remote locations. Rural and remote are not the same as urban or suburban and the PMHs and IHNs must be adapted accordingly.

- Access to common patient and provider feedback platforms and processes depend on investments in infrastructure to enable access including basic high speed internet across the province.
- Case management and navigation should be developed to recognize that access to community or social support and other programs in rural and remote communities may be an increased challenge. Smaller rural and remote communities often do not have the resources available to support a full range of

community and social care resources that may be available in other larger communities.

- Building a community-specific, publicly-shared dashboard that provides timely and updated information about primary health care for smaller rural and remote communities will likely require additional support from RPHCNs where communities are smaller and may not have the available infrastructure or expertise required.
- Develop rural and remote specific guidelines for PMH that considers smaller teams in rural and remote settings that appropriately recognizes the multiple roles rural generalists fill in their communities local health care environment.
- Rural primary health care and continuity of care within a PMH and IHN must include consideration for rural specialists who work in rural hospital settings but who are a part of the rural primary health care model in rural and remote locations. There are also expanded duties often required in rural and remote locations such as general surgical and obstetrical surgeries. This may include co-location of services in some rural communities.
- Integration of services within an integrated health neighborhood in rural and remote areas requires integrating and sharing services between rural communities to ensure that all communities have access to the broader health neighborhood care services that are available where rural and remote communities.
- Providing access to care should consider local lifestyles or realities in rural and remote communities. For example, farmers in rural communities may need support and options to access care differently during harvest. Being flexible to local needs and lifestyles where possible is a key consideration for rural and remote communities.
- In rural and remote communities where access to primary health care is a challenge, the ability of patients to access care within their PMH through a variety

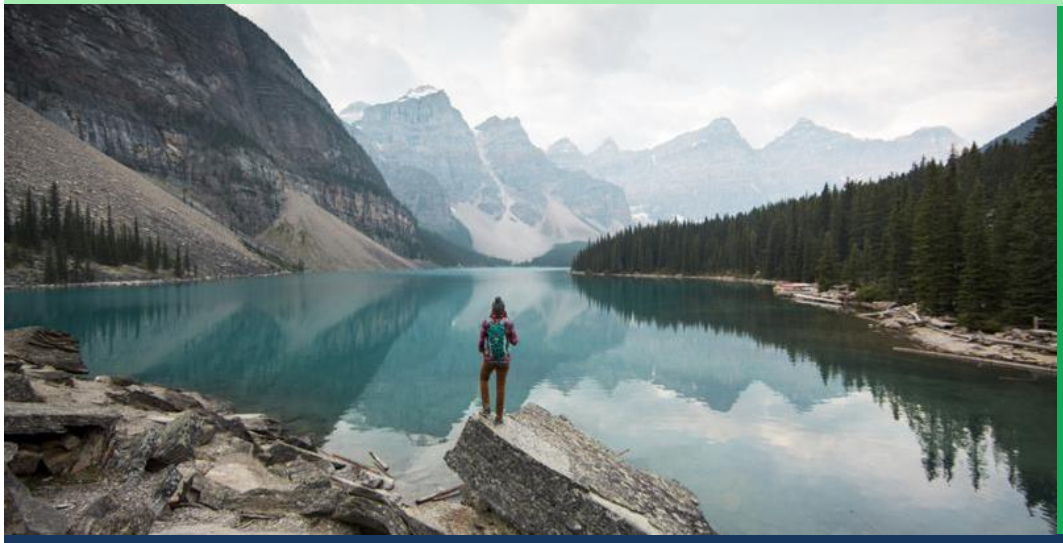
of channels including in-person care, virtual care, telephone or video conferencing, mobile health care teams and diagnostics, home health monitoring and paramedical services is critical where permanent local options may be more limited. Additional investment may be required to support the development of additional primary health care channels in rural and remote locations.

- Community pharmacists may be able to bridge some gaps in care in rural and remote communities where access to rural generalists or nurse practitioners is a challenge if they are funded and enabled to practice to their full scope.
- Geographical distance and the patient's ability to travel in rural and remote communities must be balanced against the availability of other options including virtual care, mobile care providers and mobile diagnostics that may be required to improve access or provide access when no other options are available locally.
- Investment in basic infrastructure is an essential part of accelerating efforts to ensure every person in Alberta can be connected to a PMH. This must include a continued investment in rural high speed internet access which is foundational to enabling access to primary health care services in rural and remote parts of the province.
- Investment in clinic infrastructure and medical infrastructure may also be required in rural and remote communities to ensure teams within the PMH have access to the space, clinical infrastructure and technology they need to provide care.
- The IHNs in rural and remote communities will often have limited access to the broader range of community care and social support that are available in IHNs in urban and suburban settings. Community capacity and size will significantly impact what IHN supports are available locally. The design of the IHN in rural and remote communities may require sharing or coordination of resources within a region.

- Municipalities are important partners in primary health care and should be engaged in developing and shaping the IHNs that are relevant for their community and residents.
- The development of turnkey support models should include rural specific variations of these support models that are developed and tailored with input from rural and remote primary care providers and clinic operators.
- Rural and remote communities should have the option to invest in building medical clinics. Some rural and remote communities in Alberta have explored or begun investing in this infrastructure. There should be consideration given for how to support communities who wish to pursue this option in terms of both the initial investment but also ongoing support and interventions that primary care provider owned clinics may opt in to.
- Provide every RPHCN with the capabilities and capacity to identify gaps and desired improvements relevant to their context and geography, and help clinics and IHNs to conduct improvement activities. This includes providing additional support to rural and remote clinics with limited capacity or smaller teams for quality improvement programs.
- Include a tailored variation of provincial quality and safety improvement education strategy that is focused on rural and remote care teams, leadership and boards in Alberta that builds from existing assets (e.g., Calgary Department of Continuing Medical Education, ACFP education and Family Medicine Summit).
- Embed quality, safety and innovation in rural and remote specific education and training programs.
  - In alignment with the comprehensive workforce strategy, rural primary health care education programs should include rural specific considerations for embedding quality, safety and innovation in rural primary health care contexts.

- Setting up a dedicated primary health care innovation fund should include a specific portion or separate fund dedicated to rural and remote primary health care innovations.
- The establishment of innovation hubs should include rural and remote specific innovation hubs appropriately dispersed throughout the province to support and drive innovation within those regions that reflects the unique opportunities and challenges of rural and remote primary health care.

Enabling the Primary Health Care Workforce to Improve Health Outcomes



Enabling the Primary Health Care Workforce to Improve Health Outcomes

RECOMMENDATION 8: Establish a comprehensive primary health care workforce strategy aimed at building and sustaining a diverse workforce who are supported in providing team-based care across the province

WHY IS THIS IMPORTANT FOR ALBERTA?

The primary care system relies on a healthy, engaged, stable and supported workforce that has the resources needed to deliver quality primary care whether in urban, suburban, rural, remote or Indigenous communities. The wellness of the workforce and the people who provide care is essential to building a sustainable, effective primary health care system. Providers should be supported and empowered to do what they do best - provide quality primary health care. **The future primary health care system should create a stable, supportive environment that appropriately values primary health care providers, the critical role they fill in our health care system and supports their wellness.**

There is no question that Albertans must have equitable and timely access to primary health care. This access includes, but is not limited to, physicians, nurse practitioners, nurses, pharmacists and other health care providers, such as physiotherapists, mental health professionals, and social workers. Research shows that access to interdisciplinary care drives improved patient outcomes and reduces strain on the system.

The future primary health care system should be built around access to collaborative, diverse teams of primary health care providers providing comprehensive care to people in Alberta.

Today, there are challenges impacting Alberta's ability to build and sustain the diverse primary health care workforce needed to deliver community team-based care. The

population of Alberta is changing and the primary health care needs are changing along with it. These changes are being driven by macro level factors such as aging demographics, immigration, continuing migration of Canadians to Alberta, and increasing complexity of primary health care needs across the province. Adequate planning would not only facilitate access to collaborative care environments for patients, but would also enable care providers to develop, deliver, and thrive in a supportive environment. Among the key issues are:

1. ***Supply of diverse care providers:*** Alberta is facing a supply challenge in building and sustaining a stable supply of care providers. This challenge includes family physicians, but extends to the broader members of primary health care teams, including the supply and availability of nurse practitioners, registered and licensed practical nurses, mental health professionals, and other essential primary health care providers. This has been driven by a number of factors including difficulty attracting students to family medicine, challenges with work life balance and burnout, and compensation among others.

   The current overall ratio is less than one interprofessional team member for every two PCN physicians. According to the Alberta Primary Care Network Program Management Office there are more than 3,800 physicians with approximately 1,400 other health care professionals such as nurses, nurse practitioners, dietitians, pharmacists, and mental health professionals. The number of other care providers working on teams is not adequate to support team based care today.

   - While Alberta graduates students from a variety of post-secondary health care programs every year, the retention of these care providers in the province remains a challenge. For example, only 62.7% of family physician graduates (2015-2019) from Albertan institutions registered in Alberta in 2021 (18.3% registered in BC while 14.5% registered in Ontario).[81] This is lagging retention of new family physician graduates in BC (78.1%), Ontario (84.7%), Quebec (74.4%) and Manitoba (72.2%).

- There were 42 unmatched family medicine residency positions in Alberta after the first round of selections. This is compared to two in British Columbia and none in Saskatchewan (CaRMS Report - March 22, 2023).

2. ***Wellness of care providers:*** Primary health care providers are facing significant workforce wellness challenges. Even before the pandemic, care providers struggled with work-life balance and burnout, which can lead to turnover. The lack of support and teams to reduce workload, increased time required on clinical and operational administration, the need to always be available, and the lack of connection to the broader primary care system are among the key issues impacting primary health care providers' wellness. These challenges are amplified in rural and remote communities where perceptions of isolation and a lack of basic infrastructure have had further impacts.

> *"I have learned that often providers want to connect but often are not given time to do so in a safer and more collegial setting. Provider health matters too - especially their spiritual and emotional health."*
>
> **(Citizen perspective)**

3. ***Lack of focus on training and educating a team-based workforce for primary health care in Alberta:*** The current health care workforce has not been trained and educated to provide team-based primary health care across the province.

4. ***Distribution of providers:*** Beyond the supply of care providers, the distribution of care providers is a significant challenge across the province, particularly in rural and remote communities. While select regions of the province have experienced stable or increased numbers of care providers, the supply of care providers in other communities has remained consistently low and has decreased on a per capita basis in recent years. The variation in distribution of care providers in communities across the province has resulted in some communities facing shortages of physicians, nurses, EMT/EMS practitioners, pharmacists, and other community ancillary practitioners while other communities have seen the number of care providers grow.

That imbalance primarily impacts rural, remote and Indigenous communities in Alberta.

Rural and remote health zones in the province have been impacted more significantly than others by the decrease in supply. Edmonton and Calgary health zones have seen an increased median FTE of family physicians from 2012 to 2022 from 0.63 to 0.69 and 0.7 to 0.74 respectively. At the same time, the South zone median FTE of family physicians has decreased from 0.74 to 0.65 and the North zone has fallen from 0.61 to 0.55.

5. ***Compensation:*** Primary health care providers are not valued similarly to other sectors (both in terms of family doctors compared to other specialists and compensation for other staff compared to acute care). The funding and compensation models are not always competitive for care providers, and primary health care providers often compete with acute care settings.

Existing Programs Targeted at Recruitment, Education and Training

Alberta has several post secondary education institutions that are highly regarded around the world. These institutions provide high quality education for a number of primary health care provider roles including licensed practical nurses, registered nurses, nurse practitioners, physicians, mental health professionals, social workers, pharmacists and many other care providers. These programs offer a strong foundation for building and increasing local supply to support team based care.

Alberta has many rural recruitment programs and education plans targeted at primary health care including:

1. Rural Family Medicine Program
2. Rural Education Action Plan (REAP)
3. Rural Preceptorship program
4. Recruitment and Retention Initiative (RRI)
5. Alberta Rural Physician Action Plan (ARPAP)

6. Rural Outreach and Mentorship Initiative (ROMI)
7. AHS International Medical Graduate Program and Alberta Immigrant Nominee Program

These programs have had varying degrees of success but they are not connected or aligned to a broader provincial workforce strategy for primary health care in Alberta.

A thorough presentation of the current challenges relating to the primary health care workforce in Alberta is presented in Appendix D beginning on page 174. This data provides a clear picture of the need for a comprehensive workforce strategy to sustainably build the primary health care workforce of the future.

DETAILED RECOMMENDATIONS (Recommendation 8: Establish a comprehensive primary health care workforce strategy aimed at building and sustaining a diverse workforce who are supported in providing team-based care across the province)

The province must develop a comprehensive primary health care workforce strategy that will serve the primary health care needs of all Albertans—a strategy that goes beyond ratios of physicians per capita to more holistic population-based planning that is scalable and flexible to meet the needs of all communities, rural and urban. It must protect, support and enable the wellness, respect and quality of life of care providers. It must consider core clinical providers, but also newer roles such as community health workers, physician's assistants, research and quality improvement staff, and patient and family caregivers. Consideration should also be given to building around the resources present in communities to address gaps.

The workforce strategy must be developed to enable team-based care delivered by a diverse team of care providers. A comprehensive workforce strategy is the foundation

for building diverse teams supported with appropriate resources, opportunities for training and professional development, competitive compensation models and investments in improving quality of life and wellness of care providers. A comprehensive workforce strategy for primary health care will require inter-ministerial collaboration between Alberta Health, Ministry of Advanced Education and others to align all primary health care system workforce needs, educational, training and recruitment programs in the province.

The Government of Alberta should develop a comprehensive workforce strategy including investing in specific programs and initiatives and actions to:

Improve the working environment and provider wellness to support and retain the current workforce

Immediate action should be taken to create a working environment for primary health care providers across the province that values them and supports their well-being. Immediate support is required to ensure the current workforce is healthy, engaged, respected and supported as a part of stabilizing the existing workforce. This should be a part of the overall plan to retain the existing supply of primary health care providers across the province to support diverse team-based care. These supports and retention initiatives should include:

- Targeted investments for primary health care providers that protect and improve quality of life, reduce burnout and well-being programs meant to support primary health care providers in managing their own health and well-being. This should include investments in training and education to support other members of the primary health care team in managing administrative workload, and protecting providers ability to take time off or to pursue professional development.
- Developing funding and remuneration models that support team-based care including a competitive compensation strategy for non-physician health care

providers that provides parity with acute care, and incentives or supports for cost of living in rural and remote communities.

- Partnering with post secondary institutions, professional associations and others to expand and tailor training and continuing educational opportunities for health care providers, particularly in rural and remote communities, that include specific team-based professional development opportunities, as well as, rural and remote specific development and training programs.
- The RPHCNs should develop clear mechanisms to engage with health care providers on an ongoing basis to understand and proactively address drivers of turnover, burnout, and other factors which impact retention of primary health care providers in Alberta.
- Investments in infrastructure and coverage to support rural and remote primary care providers who may have less access to required clinical resources to reduce some of the challenges in day to day care to reduce turnover in rural and remote locations.
- Investing in proactive counseling and peer support programs for primary health care providers who are suffering from burnout as a service to support primary care provider wellness and reduce burnout.

Increase the supply of diverse primary health care providers and supporting team members to enable province-wide team-based care across the province

Training, education and development of a supply of new primary health care, community and social care, and other supporting roles required to support the primary health care system in Alberta. Specific actions to increase the supply of diverse providers include:

- Invest in building interprofessional and diverse care providers (particularly in rural and remote communities) and incentivize learners to participate in team-based learning and educational programs.

- Empower the RPHCN to recruit primary health care providers to their communities as a part of the workforce strategy.
- Enable and fund nurse practitioners to practice in primary health care with their own patient panels as a part of a primary health care team within a PMH and provide additional resources to increase the supply of nurse practitioners trained locally. The province should develop nurse practitioner specific recruitment programs for primary health care.
- Create at least one center of excellence in training in each zone with formalized university support that is tailored to providing education, training and development opportunities aligned with specific needs in each zone. This should support care providers in the community in professional development through local and distance learning opportunities.
- Increase the overall educational capacity in post-secondary institutions for primary health care related programs including for nurse practitioners, physicians, pharmacists, mental health professionals, registered and licensed practical nurses and other support roles. This can include expanding existing collaborative programs with post-secondary institutions to create additional educational programs that offer hands-on training in rural healthcare community facilities.
- Build on existing education pathways for rural health care professionals, such as online, asynchronous learning can remove barriers to continuous education and, therefore, improve the quality of health services in rural settings.
- Create a physician's assistant program for Alberta leveraging practices from other jurisdictions or the Canadian Armed Forces that is tailored to primary health care in Alberta.
- Provide incentives to encourage and support health care professionals in rural Alberta to mentor students and new health care providers in rural and remote communities. This could build on alumni networks in collaboration with universities.

Recruit and train additional primary health care teams including supporting administrative team members

Recruit and hire to fill gaps in the total number of care providers or to fill needs for specific types of care providers available locally. Recruiting and training efforts should:

- Provide incentives for family members of primary health care providers and candidates to reduce barriers or to support them in working in the same communities.
- Streamline and reduce the time required to recruit internationally qualified health care professionals who fill a specific gap or need in the primary health care workforce in Alberta.
- RPHCNs should develop plans to engage and involve communities in developing tailored plans and supports to create welcoming environments that improve recruitment efforts, result in greater retention, and make transitions smoother when new providers arrive, particularly in rural and remote communities. This can include working with existing and expansion of programs such as Rural Health Professionals Action Plan.
- Evaluate and re-prioritize existing rural recruitment programs to improve their effectiveness while exploring other strategies tailored to team-based care. This should include evaluation and expansion of the many rural recruitment programs that exist to include recruitment efforts for other types of care providers beyond physicians where possible.
- Provide comprehensive health data literacy and educational programs for primary health care providers to empower teams and improve interoperability within the primary health care system as a core part of training, education and professional development.

MEASURES OF SUCCESS

- Increased diverse care providers practicing in primary health care in all regions of the province
- Increased ratio of non-physician to physicians in PMHs over time
- Increased supply of primary care providers trained locally in Alberta with related increases in retention rates and local licensing to practice primary health care
- Increased in nurse practitioners who have patient panels within a PMH or are part of primary health care teams in a family physician led patient medical home
- Rate of graduates from post-secondary institutions electing to practice in primary health care settings, including rural generalists, in rural and remote communities increasing over time
- Increased mentorship or preceptorship opportunities within rural and remote primary health care settings
- Improved parity in supply of primary care providers across the province including family physicians and nurse practitioners
- Increased provider supply in relation to population growth provincially, regionally and locally

TARGET MILESTONES

- April 2024: Implementation of stimulus funding for team-based care and expanded use of non-FFS compensation models for family physicians and nurse practitioners (early action)
- June 2024: Build a robust workforce strategy with defined targets, including a 4:1 team-based care staffing ratio in PMHs across the province
- September 2026: Creation of a physician's assistant program
- September 2028: A robust workforce strategy with defined targets is executed, including a 4:1 team-based care staffing ratio in PMHs across the province

RECOMMENDATION 9: Adapt and improve a remuneration model that enables team-based care in support of the workforce strategy

WHY IS THIS IMPORTANT FOR ALBERTA?

Physician compensation is a complex but vital lever for any health system seeking to shift to a strategy based on quality, a goal Alberta endeavors to achieve. Physicians play a natural leadership role given their unique skill set, training, and trust with the public. Revitalizing primary health care requires widespread support and engagement from family physicians.

Over the past several decades, particularly in primary care, evidence has emerged regarding the fit between the traditional fee-for-service (FFS) model of physician payments and the provision of strong primary care. As a result, across the developed world and in many parts of Canada, significant investments have been made to establish alternative approaches to physician compensation that removes barriers to team collaboration and work sharing.

As advances in health care resulted in patients living longer, often with multiple chronic conditions and a complex mix of pharmaceuticals to help them manage their health, the prevailing mental model of FFS remuneration has been challenged. Patients no longer present with the run-of-the-mill episodic primary health care matters of the past. They are presenting long-term, complex challenges that require significantly more time from the physician than a typical patient and benefit from collaboration with a broader set of health professionals such as physiotherapists, dieticians, pharmacists, social workers, and psychologists. FFS models have not adapted to keep up with the realities of an ever more complex environment.

To effectively manage complex patients with chronic diseases, family physicians needed to shift from a stand-alone clinical service provider to a manager of a population's health supported by new tools, techniques, and approaches. We are now recognizing

the value proposition and economic benefits of primary health care systematically maximizing the screening and chronic condition management of a population.

For physicians who act as small business owners managing a community-based clinic with employees, service providers, office space costs (mortgage or lease, for example) and other expenses, there will always be hesitation to change payment models that may have a destabilizing impact on a well-established practice.

Health systems worldwide have begun to experiment with new ways to compensate physicians allowing them to meet the challenge of the shifting and adapting to the growing care requirements of a population. The most common alternative to FFS in Canada and globally is payment that is based on capitation. Many jurisdictions (e.g. New Zealand, UK, Ontario) transitioned to full or blended capitation models. Some of these jurisdictions (e.g. Ontario) offer more than one type of payment model (e.g. a mostly capitated and a mostly FFS model).

The existing models open to entry in Alberta include traditional FFS and Blended Capitation. There are existing avenues to improve the blended capitation model and FFS within the existing AMA and Alberta Health Physician Services Agreement. Subsequent rounds of negotiations should consider both changes to existing FFS models that would allow more collaboration and integration with team supports, and improvements to the Blended Capitation Model (BCM) which may make it a more desired alternative.

DETAILED RECOMMENDATIONS (Recommendation 9: Adapt and improve a remuneration model that enables team-based care in support of the workforce strategy)

In advance of and within future rounds of negotiations between the AMA and Alberta Health, work with physician leaders to progress various options that allow both early positive experiences with team-based care and full immersion in a team-based care environment:

- Progress existing alternate models such as BCM or capitation to make them attractive and viable enough to appeal more broadly to physicians.
- Specifically incent experimentation and experiences in team-based care by adapting FFS through considerations such as delegation, billing for team activity, collaborative care conferencing, or supervision.
- Develop remuneration models for practice management, administration, team management and quality improvement initiatives in all compensation structures.
- Develop a compensation model that specifically addresses the workload and complexity of rural generalists and physicians who practice in multiple settings (acute care, surgical, obstetrics etc.) in rural and remote communities.
- Develop funding and remuneration models that support community pharmacists to use their full scope and contribute to overall increased capacity of the health system and population health. This should include appropriate funding for services beyond dispensing. Community pharmacies should be funded to support new ways of working that are patient and outcome focused and help fill gaps in the health care system (e.g., community pharmacy as a health hub) with appropriate consideration for integration of services and information sharing.

"I'd like to see the billing model changed to allow providers to spend more time with those who need it, and to be compensated for it"

(Citizen perspective)

Design and provide incentives for the adoption of alternative compensation models designed for team-based primary health care delivery; enable choice among models to ensure suitability and viability within the local context and for the population served while establishing a common set of parameters across models (e.g. team-based approach, accountable for population-based metrics, equivalent pay across activity

types including clinical and non-clinical).

Special consideration should be given to address the urgent compensation needs of existing providers whose practices are in crisis. Although outside the scope of this report, the Strategic Advisory Panel points to the specific need to stabilize these practices through innovative, ad hoc solutions developed in partnership with Alberta Health.

MEASURES OF SUCCESS

- Increase in the use of alternative remuneration models including BCM or capitation
- Improved team access to team based care enabled by remuneration and funding models that support diverse care providers
- Piloting of compensation models that support practice management and quality improvement initiatives

TARGET MILESTONES

- April 2024: Evolution and expanded use of non-FFS compensation models for family physicians and nurse practitioners

Rural and Remote Considerations

- Remuneration should reflect the nature, complexity, effort, and competency required to do a job. The job of a rural generalist is substantially different from the job of a family physician in an urban environment by virtue of the breadth and diversity of services provided and responsibilities undertaken.

- To address this difference, an alternative compensation model should be specifically designed to:
  - Address the workload and complexity of rural generalist's practices should be developed that can support recruitment and retention efforts and provide stability, recognition and respect for complex work undertaken by rural generalists; and
  - Encourage the adoption of team-based care that could distribute the burden and workload and triage patient care, reserving in-person physician appointments for patients with more serious issues.[82]
- Provide additional incentives for rural and remote communities to offset increased costs of living in rural and remote locations or for families of care providers to incentivize relocation to rural and remote communities.
- Allocate spots in Alberta's post-secondary institutions for students from rural and remote communities to enroll in primary health care (and related) programs. These held positions could be conditional on students returning to their communities after graduation. Moreover, this can be further supplemented by conditional incentives, such as loan forgiveness or free tuition.
- Expand capacity in existing and successful programs such as the Rural Integrated Community Clerkship or the University of Calgary Longitudinal Integrated Clerkship that are targeted at providing rural and remote education experience.
- Alberta post secondary institutions should develop educational pathways for attracting learners from high school and undergrad programs into medicine including targeting learners from rural and remote communities (Northern Ontario School of Medicine may provide lessons learned in implementation to accelerate development of similar pathways in Alberta). This should be connected to rural generalist specific post secondary programs or learning opportunities related to providing primary health care in different professions.

- Creation of training sites in rural settings where all members of an interprofessional team can train together and develop the skills and competencies required to provide team-based care in rural and remote settings.
- Creation of a physician's assistant program is a significant consideration for improving the supply and capacity of primary health care teams in rural and remote settings.
- Rural and remote focused training programs should incorporate and be designed in recognition of the need for rural generalists and the broad range of services that care providers in these communities often provide.
- Specific educational and professional development opportunities should be developed that are tailored to rural primary health care providers and teams. This should include considerations for professional development for smaller teams and the increasing requirement for rural generalists in rural and remote locations.
- RPHCNs should engage and involve rural and remote communities in developing tailored plans and supports to create welcoming environments and make transitions smoother when new providers arrive.
- Evaluation and reprioritization of existing programs should include the evaluation and expansion of the many rural recruitment programs that exist. Rural and remote recruitment initiatives should be expanded to include recruitment for other types of care providers beyond physicians where possible.

Digitally-Enabling Primary Health Care to Improve Health Outcomes

Digitally-Enabling Primary Health Care to Improve Health Outcomes

RECOMMENDATION 10: Accelerate the implementation of actions that make the e-health environment more functional and robust for primary health care teams and patients

WHY IS THIS IMPORTANT FOR ALBERTA?

While Alberta embraced adopting a transformational eHealth Strategy well before other provincial counterparts, there is still an opportunity to leverage and integrate technology in a more meaningful way to empower patients as active participants in their own health management. Work must be done to enhance the use of technologies to promote integrated information sharing, access to information, patient self-management, and other tools to better meet the needs of the people.

Alberta must accelerate efforts to achieve a coordinated, integrated and interoperable primary health care eHealth ecosystem in Alberta that meets the needs of care teams and patients.

Alberta is a historical leader in eHealth and information technology.

Of note, Alberta has historically been a leader in the health technology and information space. Alberta ran the Physician Office System Program in the early 2000's to incent and enable adoption of electronic medical records among physicians, which contributed to higher uptake in Alberta compared to other Canadian jurisdictions. Other key accomplishments include significant progress toward a comprehensive information management and technology ecosystem, including Netcare, MyHealth Records, the Pharmacy Integration Network and eDelivery.

Alberta has continued to invest in various programs, initiatives and supports to continue to develop e-health capabilities to support improved outcomes for people and providers as well as further integrate and connect IM/IT infrastructure. Major current initiatives include:

- **Community Information Integration / Central Patient Attachment Registry (CII/CPAR):** Brings patient health information from community clinics into Netcare for sharing between AHS and community healthcare providers. It facilitates sharing of consultation reports back to PMHs and other providers, identifies relationships between patients and their primary care provider and allows primary care providers to identify and coordinate when patients are on multiple panels.
- **Enabling New Models of Care (ENMOC):** A strategic initiative to redesign and replace nine core end-of-life business applications for the Alberta Health Care Insurance Plan and establish a trusted source for all data pertaining to client and provider registration, enrollment, facilities, and payment.
- **Connect Care:** A single clinical information system providing 120K+ clinical users a central access point to patient information for services provided by AHS (system implementation is expected to be complete by fall 2024).
- **eReferral:** Electronic referrals have been available for several years through Netcare, and there are plans to significantly expand e-referral capability, including tracking, through the Alberta Surgical Initiative.
- **ePrescribe:** A national electronic prescribing service championed by Canada Health Infoway and currently being beta-tested in Alberta.

There are several core challenges with e-health, technology and information systems today.

Limited collaboration with EMR vendors

Alberta is an open market for EMR providers but with a high concentration of physicians on three main vendors: TELUS Health Solutions, QHR Technologies, and Microquest. Most clinics have procured and contracted with EMR providers directly and independently, meaning there is limited opportunity for volume discounts and very little leverage to address performance issues. There are functional inconsistencies and variations even when clinics may have procured with the same EMR. Alberta Health has some influence on the entrance of new products into the market, but there is a notable lack of support for individual clinics, ability to quickly resolve performance issues at the provincial level, or mechanism to compel EMR vendors to facilitate sharing of data that is locked into EMRs. In addition, EMR cost increases and additional cost increases associated with integrating EMR systems with the health ecosystem have dramatically impacted existing community providers and limited uptake of new technologies.

Alberta's 2021 Provincial eHealth Strategy recommended establishing a provincial EMR program and working in partnership with the EMR vendor community, AHS, and the AMA to validate and co-design required EMR functionalities for data sharing and integration with key provincial assets. Strengthening of standards, stronger performance management, and collaboration with the EMR vendor community will be critical in advancing the eHealth ecosystem.

Integration between EMRs and other information systems is lacking

Alberta has invested in finding ways to connect and share information between information systems across the province. The Community Information Integration/ Central Patient Attachment Registry Initiative (CII/CPAR) is a strategic initiative designed to enable two-way exchange of information between EMRs and Alberta Netcare enabling more comprehensive data exchange and communication between community-based providers, their patients and the extended care team. Uptake of this initiative has been steady although slower than desired likely due to challenges and a perceived low value propositions for community providers.

Integration and interoperability of systems for information sharing and communication across the continuum of care is lacking, including with community specialists, mental health, and home care providers. There is minimal or no information sharing from primary health care with social service providers. Legislative, policy, infrastructure and process related barriers are among the factors that are contributing to challenges with information sharing and interoperability.

While Alberta continues to strengthen integration between information systems, this has not yet fully translated into better informational continuity for patients, with 28% of Albertans reporting that specialists did not have basic medical info/test results from their regular doctor (vs. 15% Canadian average) and 27% reporting their regular doctor did not seem informed on care received from a specialist (vs. 20% Canadian average). The reality is Connect Care has caused significant challenges for community primary care providers. The combination of CII/CPAR and the complete roll out and optimization of Connect Care should help to address these issues.

Need for better integration of virtual technologies with existing in-person services to ensure continuity of care while also improving access

The COVID-19 pandemic has rapidly shifted the requirements of access to primary care, affecting family physicians and their community-based practices. In addition to virtual services offered through existing clinics, several virtual providers and programs currently operate in Alberta, including 811 Health Link, TELUS Health MyCare, Maple, the Alberta Indigenous Virtual Care Clinic, and the Virtual Opioid Dependency Program.

Satisfaction with virtual care during the first part of the pandemic was high among patients and just marginally below that reported for in-person care. Similarly, a nationwide survey of 1,800 people conducted by the Canadian Medical Assocation[83] in May 2020 showed 91% of those polled were satisfied or very satisfied with the care they had received virtually, and 56% of respondents felt their family doctor was using virtual care or telehealth services effectively.

Another survey from 2021 among Canadian physicians found that almost all will continue to use virtual care after the pandemic, and 64% said they will maintain or increase their current level of use. Finally, research has shown that telehealth can address a number of the access challenges faced in accessing primary care when in person options may not be readily available, particularly in rural and remote areas including decreased travel time, improved access to care, improved communication with providers, and improved ability of patients to manage chronic conditions.[84]

The emergence and expansion of virtual care across Alberta has been effective in meeting some of the access and availability challenges that exist for patients in the province. However, use of virtual care and technology enabled care options has not yet reached maturity as a part of an integrated, accessible primary health care system. In particular, expansion of virtual care has led to some challenges including concerns that virtual care is compromising continuity of care and leading to increased utilization of laboratory and diagnostic services, and emergency department visits.

DETAILED RECOMMENDATIONS (Recommendation 10: Accelerate the implementation of actions that make the e-health environment more functional and robust for primary health care teams and patients)

Well-designed health information technology is essential to making high-quality primary care more accessible, convenient, and efficient for patients, families, and interdisciplinary care teams. Alberta's Provincial eHealth Strategy (2021) outlines many of the directions that are necessary to achieve a robust information ecosystem in the province. In addition to the actions outlined in this strategy, it is necessary to make specific targeted investments and actions that immediately improve the primary health care information management and technology environment in Alberta. Major actions include the following:

Re-establish a provincial program to better support clinics in optimizing the functionality and interoperability of EMRs

- Establishing a vendor partnership model for PMHs and community specialist clinics to establish:
  - Supports for a limited number of EMRs including Connect Care which meet and adhere to a common set of standards for core functionality in EMRs across PMHs in Alberta;
  - Standards for integration and interoperability including real-time integration with NetCare and Connect Care to enable information and data sharing within an integrated primary health care system;
  - The ability to coordinate and collaborate with vendors to develop and implement new functional requirements or capabilities tailored to meet the needs of people and providers in Alberta;
  - Common standards for vendors for entry into the market for EMR vendors including core functional requirements, reporting capabilities and data management; and
  - Providing training and resources for PMHs, patients and families to enable advanced EMR functions, reduce administrative burden, and enable more effective information exchange.
- Offering financial incentives for care providers who use approved EMRs that adhere to functional, data and interoperability requirements and agree to accountability standards including panel management standards and data sharing standards (including CII/CPAR).
- Providing EMRs as a part of core infrastructure for clinics that are operated by a RPHCN with the option to build into Alternative Relationship Plans (ARPs).

- Making updates and amendments to privacy legislation to remove barriers to data sharing for clinical uses and for secondary uses including research, evaluation and quality improvement initiatives.

Accelerate efforts to establish a health information and communication highway in Alberta

- Enable all providers within the primary health care system to communicate, access and share information safely and securely.
- Integrate Connect Care and specialist users to the information highway to enable a universal electronic referral platform and bi-directional communication in Alberta.
- Prioritize resolution of current integration issues between Connect Care and community systems including "mixed context" providers.
- Build a health and wellness data coalition that includes EMR, social and community care data to better enable data driven integrated primary health and community care, prevention, and interventions to support whole of person and community approaches to meeting the health needs of all Albertans. This may require refreshing or amending relevant health information legislation to facilitate the safe sharing and use of information while protecting privacy of individual's personal information.
- Identify and develop partnerships to support innovation in e-health, information sharing and integration with innovation sector organizations and agencies such as Alberta Innovates and the Alberta Machine Intelligence Institute.

"We need health and non-health (social data) data brought together. My health is defined by much more than just the care I receive from time to time."

(Citizen perspective)

Continue to invest in One Patient One Record for people in Alberta

- Enable people in Alberta to access their complete and up to date health records as a functional requirement for “One Patient One Record” capabilities. “One patient one record” is a powerful tool for people in Alberta to use to support and manage their health journey with their health team.
- Continued investment and prioritization of a functional “One Patient One Record” environment enabled by interoperability and information exchange within the primary health care system. This should include engagement with primary health care providers in the continued development to ensure provider and patient needs are met.
- Optimize and fully implement CII/CPAR by increasing the value proposition for providers and patients as a part of building a mature, interoperable health information technology environment.
- Provide a comprehensive health data literacy and educational program for providers and the public to enable full use of the tools and technology available to them to enable One Patient One Record and to empower patients to use their information as a tool to support their primary health care journey.
- Ensure data is protected and private information remains secure allowing patients and providers the ability to access and use information and data to support individual care within primary health care teams and at the regional and provincial level for research, QI initiatives, reporting and as an enabler of innovation.
- Continuously review how technology is used and integrate the use of remote technology such as biometric remote monitoring as a part of care plans and integrated to one patient one record capabilities.

Optimizing and leveraging the virtual care environment to support primary health care in Alberta

Access to primary health care should be enabled through multiple access channels including virtual care. In person care cannot be replaced by virtual care. However, virtual care, when effectively integrated and connected to the PMH, can complement and augment in-person care and enable access to people who may face access barriers particularly in rural and remote parts of the province where other options for care may be limited. There are a number of ways that virtual care can be optimized to support primary health care in Alberta:

- Partnership opportunities with virtual providers to improve access to primary health care services, particularly in rural and remote communities, and better support primary health care providers working without the benefit of a team.
- Partnerships with RPHCNs to expand after-hours care and support clinics who cannot provide after hours care.
- Expansion of Alberta Indigenous Virtual Care Clinics and consideration for similar models of care for remote and rural locations to improve culturally appropriate care.
- Connecting patients who call 811 to their PMH and enabling attachment of patients to a PMH and being able to activate after hours support, such as paramedical support or home care.
- Investment in the expanded use of specialized virtual and technology enabled programs, such as the Virtual Opioid Dependency Program, to virtually connect people to care and remove barriers to access.
- Test, evaluate and strategically scale the use of virtual or technology enabled care programs such as home health monitoring or virtual diagnostics.

Invest in expanding patient navigation, provider search and scheduling

- Invest in, expand and rebrand the Alberta Find a Doctor platform to ensure there are links to navigation supports, facilitate attaching patients to a PMH, include other health and community care providers. There should also be long term consideration given to the potential to expand functionality to include appointment scheduling for primary health care providers including virtual options that can complement in-person care at the PMH.

MEASURES OF SUCCESS

- Improved access to complete, timely and accurate patient information for providers in the PMH and patients or caregivers
- Ability of PMH EMRs to share and receive data with Netcare, including integration with Connect Care
- Legislation is updated to remove barriers to data sharing for clinical use and for secondary uses including research, evaluation and quality improvement initiatives
- CII/CPAR is fully implemented provincially as a part of building a mature, interoperable health information technology environment
- Improved access to care through the use of virtual care or technology enabled care, especially in rural and remote areas
- Increased proportion of the population in rural, remote and Indigenous communities with access to regular high speed internet services
- Improved ability of patients to access information, schedule appointments and manage care through the use of digital tools

TARGET MILESTONES

- September 2023: Enhanced use of virtual care programs is enabled as a part of early investment opportunities
- March 2025: Development of a vendor management framework is complete including standards for EMR functionality, data architecture and interoperability requirements
- March 2025: Funding allocated for IM/IT infrastructure including incentives for common standards of use for EMRs

Rural and Remote Considerations

- Establishing a vendor partnership model for PMHs and community specialist clinics to establish:
  - Supports provided to PMHs aligned with the use of a limited number of EMRs including Connect Care which meet and adhere to a common set of standards for core functionality in EMRs across PMHs in Alberta should include rural and remote specific support packages. Rural and remote care providers should provide input into what supports would be most effective and appropriate for their context;
  - Standards for use should include functional requirements aligned with rural and remote needs; and
  - Additional training or support should be provided as needed to smaller rural and remote PMHs to ensure that smaller teams have the capacity and resources required to enable advanced EMR functions, reduce administrative

burden, and more effective information exchange.

- Optimizing and leveraging the virtual care environment in rural and remote communities should include:
  - The specific requirements of rural and remote communities for virtual care support and home health monitoring; and
  - Supporting existing care providers and facilitating integration and attachment to care rather than creating silos.

Significantly Investing in Primary Health Care

RECOMMENDATION 11: Develop and commit to a dedicated primary health care investment plan that ties defined investments to specific outcomes for people, communities and providers

WHY IS THIS IMPORTANT FOR ALBERTA?

For decades, health systems around the world have recognized that strong primary health care leads to better outcomes and lower overall spending per person. This has led to calls for strengthening primary health care, doing more to address social determinants of health, or to shift care away from hospitals to communities. However, all jurisdictions across Canada, including Alberta, remain in a situation where primary health care spending is a fraction of acute care spending. At the same time, spending in acute care has continued to increase and take up an increasing proportion of overall spending. This trend must change. **It is not a choice of whether to invest, but rather what part of the system to invest in.** The government of Alberta, and indeed all Canadian jurisdictions, face a choice between increasing investment in primary health care or continuing the spiral of rapid increases in acute care spending and continued pressures on the health system overall.

Throughout this report, significant gaps in Alberta's primary health care system are identified, including those related to workforce, capital infrastructure, and technology and information systems supporting care delivery. These gaps have resulted in inconsistent access, decreased effectiveness and increased pressure across the health system beyond primary health care. While these issues are significant in rural, remote, and Indigenous communities, they are impacting Albertans across the province.

Investment in Primary Health Care can lead to downstream savings in health care overall

There is consistent and growing evidence that primary care-oriented health care systems achieve better health outcomes, more health equity, and lower costs. The recommendations described in this report are expected to improve patient attachment to a PMH, support increased continuity between patients and their primary health care providers, and strengthen integration with other health care and social services. Specific downstream benefits include reduction in ED visits, avoidable hospitalizations and length of stay, all of which contribute to lower overall spending and improve health system sustainability. The evidence for the need for investment in primary health care is described in greater detail in the "Case for Change" section earlier in this document.

The net result of modernizing the primary health care system is that Alberta should, over the long run, spend less on a per capita basis than if these recommendations are not implemented. The burden on hospitals and emergency departments should decrease. Population and individual health outcomes should improve.

DETAILED RECOMMENDATIONS (Recommendation 11: Develop and commit to a dedicated primary health care investment plan that ties defined investments to specific outcomes for people, communities and providers)

Alberta must make immediate, significant and sustained investment in modernizing and integrating the primary health care system. Immediate investments should be made to stabilize primary health care in Alberta. Major investments should be staged over the next 3-5 years to put in place the foundation for a modern primary health care system and then be sustained to support the primary health care system over the long term. These investments should be based on a detailed plan which connects with specific objectives, outcomes and benefits for the people of Alberta, providers and the primary health care system to promote accountability.

Although additional analysis is required to provide a total estimate of the investments required, major cost drivers and preliminary assessment of the major costs have been

identified where possible. These high level assessments do not consider the timing or staging of investments. Rather, they provide a sense of scale at full implementation. A summary of areas of investment is required include:

1. **Team-based care:** Team-based care is one of the pivotal shifts in this report and a lynchpin for the potential benefits described, including enhanced access and availability, improved continuity and comprehensiveness of care, coordination of care across an increasingly integrated continuum of local healthcare and non-healthcare providers, improved evaluation, monitoring and reporting of performance and a culture committed to quality improvement. Little of this will be achieved without major investments in funding and developing interprofessional care delivery teams operating together in PMHs across Alberta.

   The Auditor General of Alberta estimated that PCN funding of $240M in 2017, after administrative and other expenses were considered, resulted in the PCN funding of 0.4 clinical FTEs per PCN family physician or nurse practitioner. Family physician leaders have estimated that, on average, each comprehensive family medicine physician in Alberta funds an additional FTE of support out of their current FFS earnings. This report recommends that interprofessional teams be developed across Alberta at up to 4.0 FTEs per family physician or nurse practitioner, significantly increasing the funding from current levels for interprofessional teams. These costs would be phased in over time as more of the health human resources forming the basis of these teams must be trained and prepared for clinical practice.

2. **Comprehensive workforce strategy:** As a part of the comprehensive workforce strategy, investment will be required to develop the educational programs and resources, providing incentives and support, addressing wage parity issues, and providing additional resources to PMH teams. The level of investment required to fund efforts to recruit and retain the right people, and to compensate will require additional analysis to estimate based on the details of the comprehensive workforce strategy.

3. **Establishing the primary health care governance structures:** It is beyond the scope of this report to develop an organization design for APHCO (or any of the related organizations described throughout this report); however, given the scale of the ambition related to service integration, planning, quality improvement, performance evaluation, monitoring and reporting, and innovation investment in establishing and resourcing this organization will be required.

   While it is envisioned that there will be fewer RPHCNs than PCNs, the scope of responsibilities, including the provision of direct clinical care through broader PMH teams, the potential operation of PMH clinics, the facilitation and coordination of IHNs and important roles in QI coaching, research, evaluation, monitoring and reporting, the reduction of administrative redundancy will be more than offset by the expanded scope and scale of responsibilities. To develop a proper estimate of net investment required, an assessment of current PCN expenditures will be necessary and a transition plan developed, including the number of RPHCNs to be established and their locations across Alberta.

4. **Create a program to offset implementation and operational costs to encourage and support adoption and use of EMRs:** The goal of this program should be to encourage the adoption and use of EMRs by offsetting one-time implementation and ongoing operational costs. Going forward, licenses would be required for all members of the expanded interprofessional team, as well as enhanced IT infrastructure to accommodate the expanded team. The program approach, focus and reimbursement principles should reflect the reality that EMRs are already in widespread use in Alberta.

5. **Quality and safety:** A comprehensive quality and safety improvement program that builds on existing capacity will require new infrastructure and investments to embed the skills and capabilities for quality and safety improvement at all levels of the primary health care system. Comparator jurisdictions have invested in this area by introducing financial incentives for provider contributions to quality and safety.[85]

6. **Innovation hubs:** Among the recommendations proposed in this report is for the government to accelerate innovation efforts by investing in the creation of Innovation Hubs and a dedicated primary health care Innovation Fund.

7. **Capital infrastructure:** Increased clinical infrastructure including physical capacity will be required to implement the recommendations. This should include:

- Investments in opening additional PMH locations.
- Investments in clinical infrastructure to support co-location of PMHs. Ongoing costs for the enhanced clinical space will also be significant as the interprofessional teams will create much greater needs for space that cannot be borne by the family physicians. Other cost drivers include:
  - Paying lease termination fees for physician groups where appropriate;
  - Actively promoting the redevelopment of government facilities for larger clinic spaces, permitting physicians to relocate (or establish their practice) over time as circumstances permit; and
  - Providing financial incentives for physician groups to co-locate in appropriate clinic space, enabling the group to allocate the incentive in a manner that eliminates barriers based on self-managed compromises (e.g., more funding to the physicians who must break leases; little or funding for physicians with no long-term clinic space obligations).
- A capital infrastructure investment plan should be aligned where appropriate to other provincial capital infrastructure investments and may require inter ministerial collaboration between Alberta Health and Alberta Infrastructure.

8. **Implementation support:** This includes investment in implementation governance, specialized knowledge or expertise required to support implementation and change management, technology and the people and resources required throughout implementation.

The total level of funding required to implement the recommendations is significant and must be sufficient to fully address the gaps noted above and implement the recommendations in this report. Sources of funding may include new spending and reallocation of spending from other parts of the health system, especially as benefits begin to be realized. This will represent a historic investment in primary health care in Canada. Alberta will initially appear out of line with other jurisdictions, but if fully funded and implemented, MAPS will also make Alberta the first Canadian jurisdiction to realize the benefits of primary health care truly being the foundation of the health system.

Investment in primary health care in Alberta should:

- Be made with appropriate oversight, governance and accountability for results and impacts. The primary health care system must have appropriate accountability through formalized structures;
- Be sustained over a long enough window of time to reorient the healthcare system toward focusing on primary health care and to implement and sustain a province-wide model with the appropriate infrastructure and support to realize the return on these investments;
- Be targeted at realizing specific outcomes for the people of Alberta with a focus on first putting in place the foundational requirements for modernization and then driving a continuous improvement and evolution of primary health care to better meet the needs of people and providers;
- Be linked with demonstration of impact across the Quintuple Aim dimensions, including measures within primary health care and to demonstrate impact across the health system. The Measures of Success section of this report includes a preliminary list of proposed measures; and
- Have flexibility to increase investment in areas that demonstrate high impact and refocus resources away from areas that have less impact.

Investments over the long term should be monitored using an evaluation framework

To monitor the performance of the primary health care system, an evaluation framework should be developed with a commitment by the government to publicly report on the progress and outcomes of the MAPS initiative as well as key health outcomes related to primary health care at provincial and regional levels. As the MAPS initiative evolves and the new governance and team-based care models are implemented and additional infrastructure is established, the local RPHCNs can build upon the scorecard to provide more detailed information about the primary health outcomes that matter most to their communities.

A preliminary set of system level outcomes aligned to the Quintuple Aim is provided as a part of the "Implementation Roadmap" further in this document. These measures may provide a preliminary direction for the establishment of an evaluation framework that can be used to monitor the impacts of modernization efforts and recommendations over time. The complexity and breadth of measurements that are required to effectively create an evaluation framework may drive the need to use third party organizations with appropriate expertise such as the Alberta Innovates Impact Action Lab to provide support or assistance.

> *"Principles and values are essential. The problem with them is they are very open to interpretation, e.g., how do you know if it is becoming more 'about people'. It is really critical that we operationalize the principles into the actions and strategies, and we have to be able to measure change."*
>
> **(Citizen perspective)**

MEASURES OF SUCCESS

- Development of a detailed investment strategy, including a capital infrastructure plan, is completed and supported by detailed costing required to implement

recommendations, clear articulation of expected benefits, and staging of investments

- Within 5-7 years primary health care funding is adequate to fully implement and sustain the recommendations made in this document
- Investment evaluation framework is developed to track outcomes and value for care for the investments made

TARGET MILESTONES

- December 2023: Detailed investment strategy is developed for the primary health care system in Alberta
- March 2024: Funding is allocated to implementation and modernization aligned to the investment plan in the provincial budget

Rural and Remote Considerations

- A provincial program to better support clinics in optimizing the functionality and interoperability of EMRs should include rural and remote specific support packages.
- The detailed investment plan should be coordinated with other provincial investments in rural and remote infrastructure, for example, provincial investments being made under the Alberta Broadband Strategy. These investments may be made alongside the Federal government and private sector investors as defined in the Alberta Broadband Strategy.

- Partners such as municipalities and AHS may play a more prominent role in rural and remote areas, especially with respect to capital infrastructure.

Implementation Roadmap

Implementation Roadmap

Introduction

As Alberta looks ahead to the future of its modernized primary health care system, it must carefully plan for the implementation of the transformation. This section presents:

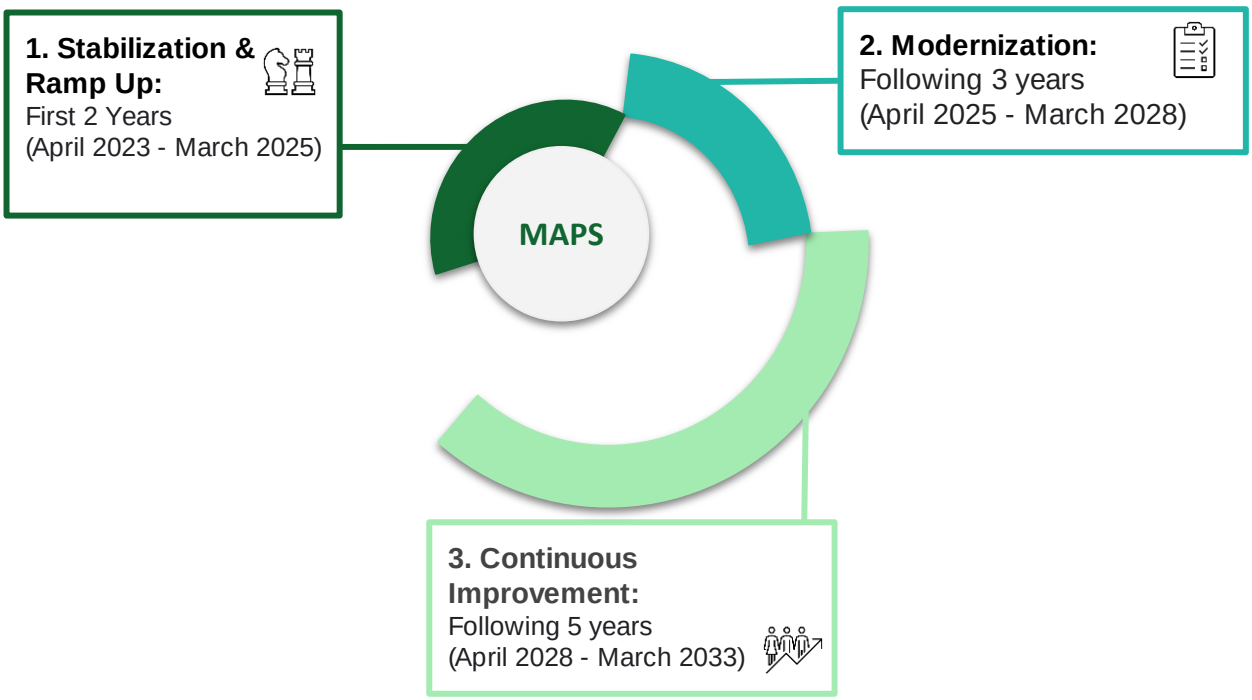
- A high-level roadmap of activities;
- Critical success factors; and
- Preliminary Quintuple Aim measures for patient, system and provincial-level MAPS outcomes.

This implementation roadmap proposes a *preliminary* perspective of the milestones that should be prioritized. It must be validated and complemented by a more detailed implementation plan.

High-Level Roadmap

This section outlines a roadmap strategy for the milestones and priority activities, which span the short, medium, and long-term. To support the government's planning cycles and sequence the scope of work, the various initiatives can generally be mapped against three stages:

1. **Stabilization & Ramp Up:** First 2 Years (April 2023 - March 2025)
2. **Modernization:** Following 3 Years (April 2025 - March 2028)
3. **Continuous Improvement:** Following 5 Years (April 2028 - March 2033)

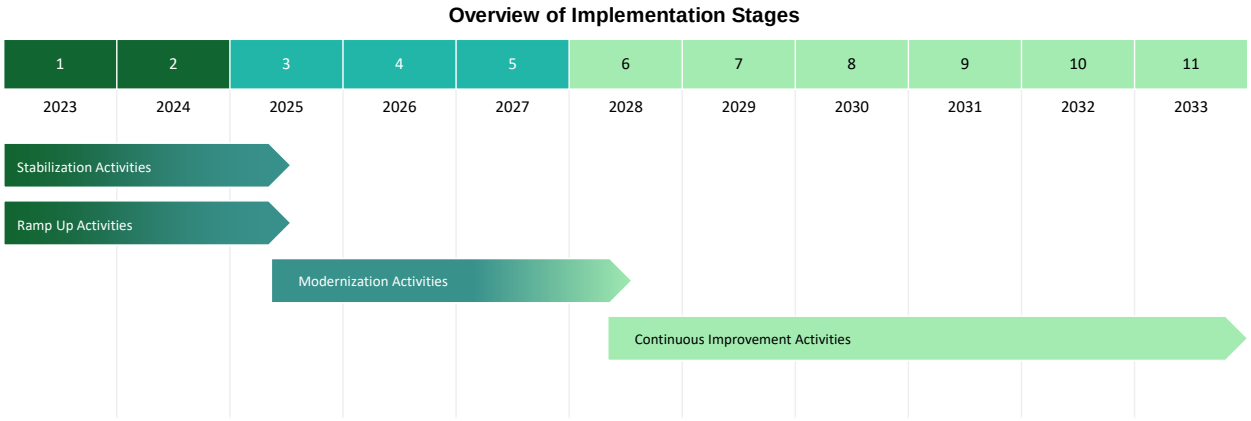


Each of these three stages of the implementation strategy are described in further detail below, including the key activities that need to happen—by what partner and when—to drive the transformation forward.

This roadmap is built on a number of underlying assumptions:

- The recommendations proposed in this report are interdependent—in other words, they enable one another—and should be considered a 'package'. This means that picking and choosing specific recommendations for implementation will miss the opportunity to realize the full potential of the MAPS transformation.
- In practice, activities may not necessarily fit neatly into one stage or another. Instead, most of the initial set up and implementation of the activities will be underway *across* the three stages—in parallel—as the province works to stabilize the primary health care system while mobilizing the implementation of the broader transformation.
- Throughout the implementation roadmap, the province must periodically assess progress against desired outcomes to inform potential changes to the roadmap and to secure ongoing funding (which will require demonstrated progress and impact).

The first stage of implementation has greater detail than the latter stages of the roadmap. This is because there is more clarity on the immediate next steps for the stabilization of the current system as well as the ramp up and mobilization of the transformation. As planning moves further into the future and uncertainty increases, less detail is provided.



Stage 1 | Stabilization & Ramp Up: First 2 Years (April 2023 - March 2025)

The first priority is to *stabilize* the primary health care system and to *ramp up* longer-term modernization activities to bring the transformation to life. In February 2023, Alberta's Minister of Health committed to investing in a portfolio of early opportunities identified by the Panel. These early opportunities, which the Panel has called for, are included in the first stage of implementation to lay the groundwork and build momentum toward the longer term recommendations presented in this report. This first stage will dictate how the province moves ahead with future stages—and when.

Stabilization Activities

A number of immediate activities must get underway (in parallel to other, more long-term non-FFS recommendations) to stabilize, and respond to the urgent challenges facing, Alberta's primary health care system, including:

Activity	Lead Partner	Target End Date
1. Target the immediate deployment of resources and people, particularly to underserved communities to enable the enhanced team-based care model *(Recommendations #4, 5):* a. Recruit physicians and nurse practitioners to serve rural and remote communities as well as vulnerable populations b. Provide other support to rural clinics in crisis, and engage municipal partners Recognizing the scarcity of Alberta's primary health care resources, prioritizing the deployment of resources and people to underserved communities and vulnerable groups will augment the capacity of the system to respond to the very real and unique challenges facing these communities today and, therefore, accelerate the implementation of the transformation in those communities.	Alberta Health	Apr 2024
2. Mobilize the implementation of early investment opportunities to lay the groundwork for the MAPS recommendations *(Recommendations #2, 3, 4, 5, 7, 10):* a. Implement stimulus funding for team-based care b. Expand the use of non-FFS compensation models for family physicians and nurse practitioners c. Expand integrated supports for vulnerable and underserved Albertans	Alberta Health	Apr 2024

Activity	Lead Partner	Target End Date
d. Enhance access through a virtual care program e. Strengthen the role of patients and caregivers f. Address social determinants of health		
3. Allocate initial funding for immediate priorities; specifically, for the: a. Overarching workforce strategy to build, and fund, primary health care teams *(Recommendation #8)* b. Design and implementation of APHCO, RPHCNs and PHIC *(Recommendation #1)* c. Information Management and Information Technology (IM&IT) infrastructure, including incentives for common standards of use *(Recommendations #4, 5, 10)* d. Capital infrastructure and supports to expand PMH capacity and assist unattached patients in locating a PMH—this may include leveraging capital to create capacity within existing infrastructure (i.e., clinic space in rural hospitals) *(Recommendations #4, 6, 11)* e. Quality improvement program and innovation development capabilities across the primary health care system *(Recommendations #7, 11)* f. Design and launch the EMR usage incentive and support program *(Recommendation #10)*	Alberta Health	Mar 2025

Stage 1 (Stabilization) activities are complete (by December 2023) when:

- ✓ *Immediate resources are deployed*
- ✓ *The implementation of early investment opportunities is mobilized to lay the groundwork for the longer-term MAPS recommendations*
- ✓ *Initial funding is allocated to immediate priorities*

Ramp Up Activities

In the short-term, a number of activities must be performed to begin to mobilize the broader MAPS transformation, including:

Activity	Lead Partner	Target End Date
4. Stand up a MAPS Transformation Management Office (TMO) to *(Early Investment Opportunities and all recommendations):* a. Define workstreams, including early opportunities, and how the province can innovate or experiment (e.g., via pilots, new approaches or models) to drive early impact and innovate while executing on the transformation b. Align leads and resources to workstreams, including early opportunities c. Oversee the end-to-end implementation of the MAPS recommendations and other initiatives in a timely manner d. Track, and report on, progress against defined metrics (this should include an exercise to establish a baseline for system performance against which progress can be measured) e. Development of a change management and communication strategy to support implementation and modernization f. Escalate issues as they emerge The TMO (which should report to an oversight body, such as a Steering Committee) should include project management, change management, and communications functions as well as the various workstream leads/teams.	Alberta Health	Jun 2023

Activity	Lead Partner	Target End Date
5. Establish governance or steering bodies (for example, a 'Steering Committee') to provide oversight and decision-making support to the TMO *(Early Investment Opportunities and all recommendations):* Given the complexity of the transformation, an interim governance structure is required in the short-term as the Alberta Primary Health Care Organization (APHCO)—is stood up. This entity can serve as an interim governance structure, and select elements of the interim governance structure should transition to APHCO, once it is established, within a set timeline. In practice, the interim and permanent entities could run in parallel for a period of time until the interim structure is no longer needed. There should also be an established intersectoral advisory group established to support implementation and detailed design of aspects of the PHC system that are intended to address broader community and social factors that influence health. From the outset, the province should clearly define the role (e.g., oversight) and timeframes (e.g., 18 months) of the interim structure so it does not evolve into a permanent stopgap, which is a common risk of interim structures. To catalyze impact in the short-term, this interim structure could begin mobilizing priorities, including initiatives specific to rural, remote, and Indigenous communities.	Alberta Health	Aug 2023
6. Build on the stakeholder consultation undertaken throughout the MAPS initiative and ensure all stakeholders are brought along the change journey by developing a stakeholder map to inform communications and change management efforts, with a focus on highly impacted stakeholders *(Recommendations #1, 2, 3, 6, 7, 8)*, including:	TMO	Sept 2023

Activity	Lead Partner	Target End Date
a. Professional associations, such as the Alberta Medical Association, College of Registered Nurses of Alberta, Nurse Practitioner Association of Alberta, and others that will be instrumental in moving the transformation forward b. Primary Care Network (PCN) leadership teams and boards c. Alberta Health Services (AHS) d. Community Care Providers e. Social Care Providers f. Government of Alberta departments g. Educational institutions h. Patient and citizen advisory groups		
7. Provide decision-making support for the government following the release of the report *(Recommendations #6, 7, 11)*, including: a. Conduct further detailed analysis b. Identify required legislative changes c. Plan for the allocation of net new funding in the context of the government's budget process d. Develop an inter-Ministerial structure to support the MAPS transformation considering that several outcomes depend on inter-Ministerial cooperation	Alberta Health	Sept 2023
8. Develop a primary health care investment strategy for the province *(Recommendation #11)*	Alberta Health	Dec 2023

Activity	Lead Partner	Target End Date
9. Build an evaluation framework to monitor progress against the implementation of the MAPS initiative *(Recommendation #11)*	SteerCo TMO	Dec 2023
10. Develop a benefits realization plan that is consistently revisited throughout the transformation *(Recommendation #11)*	TMO	Dec 2023
11. Allocate funding in the provincial budget aligned to the investment plan *(Recommendation #11)*	Alberta Health	Mar 2024
12. Build a robust workforce strategy with defined targets, including a 4:1 team-based care staffing ratio in PMHs across the province *(Recommendation #8)*	Alberta Health SteerCo TMO	Jun 2024
13. Build the capabilities required to track investments and outcomes—this should inform the QI program to enable continuous improvement efforts *(Recommendations #7, 11)*	APHCO	Jun 2024
14. Build on the interim governance structure to begin the implementation of the province's modernized primary health care system, including the new APHCO agency, RPHCNs and PHIC *(Recommendation #1)*, by: a. Securing funding and required approvals b. Planning for, and drafting, legislative changes c. Developing the entities' operating models to define how they will drive value across the province's primary health care system and what capabilities they will need to deliver that value, including detailed design and interaction model(s)	Alberta Health SteerCo TMO	Sept 2024 (approximately 18 months to transition to permanent structure following the release of the report)
15. Finalize the implementation of the province's modernized primary health care system, including the new APHCO	Alberta Health	Mar 2025

Activity	Lead Partner	Target End Date
agency, RPHCNs and PHIC *(Recommendation #1)*		

Stage 1 (Ramp Up) activities are complete (by March 2025) when:

- ✓ *A MAPS Transformation Management Office (TMO) is stood up*
- ✓ *Governance bodies are established to provide oversight and decision-making support*
- ✓ *A stakeholder engagement plan has been developed*
- ✓ *The government receives decision-making support following the release of the report*
- ✓ *A primary health care investment strategy is developed for the province*
- ✓ *An evaluation framework is created to monitor progress*
- ✓ *A benefits realization plan is developed*
- ✓ *A robust workforce strategy, which includes defined targets, is developed*
- ✓ *The new governance model (including for APHCO, RPHCNs, and PHIC) is stood up*

Stage 2 | Modernization: Following 3 Years (April 2025 - March 2028)

The second phase focuses on fully implementing the modernization initiatives, evolving the primary health care system, and expanding enabling capabilities across the province. This phase should build on the foundational investments and activities undertaken during the stabilization and ramp up phase to sustain the transformation and evolution of primary health care in Alberta.

To move forward with the modernization of Alberta's primary health care system, the province must undertake the following activities in this stage of the transformation:

Activity	Lead Partner	Target End Date
15. Develop a Quality Improvement program with an innovation pipeline as a part of building a learning primary health care system *(Recommendation #7)*	APHCO	Jun 2025
16. Implement provincial and community primary health care dashboards, including reporting on health equity, public health outcomes, and quality measures *(Recommendation #3)*	APHCO	Jun 2025
17. Implement governance structure at the provincial and regional levels that includes community and citizen representation *(Recommendation #3)*	APHCO	Jun 2025
18. Execute a robust workforce strategy with defined targets, including a 4:1 team-based care staffing ratio in PMHs across the province *(Recommendation #8)*	APHCO	Sept 2025
19. Develop a common understanding of scopes of practice in the context of a team-based care environment, and develop interprofessional curricula/training and standards of practice for team-based primary health care *(Recommendations #4, 5)*	Health profession educators; professional regulators	Jan 2026
20. Adopt team-based care remuneration models *(Recommendation #9)*	Alberta Health	Apr 2026
21. Fully implement province-wide PMH model, including provincial coverage of IHNs across the province with all PMH	APHCO	Sept 2028

participating in development activities *(Recommendations #4, 5)*		
22. Manage the benefits realization plan developed in the first stage to ensure the transformation is having its intended impact as outlined in the investment strategy *(Recommendation #11)*	APHCO	Ongoing

Stage 2 (Modernization) activities are complete (by March 2028) when:

- ✓ *A Quality Improvement program, with an innovation pipeline, is developed*
- ✓ *The workforce strategy developed in Stage 1 is fully executed*
- ✓ *A common understanding of scopes of practice, in the context of a team-based care environment, and interprofessional curricula/training and standards of practice for team-based primary health care are developed*
- ✓ *Team-based care remuneration models are adopted*
- ✓ *Capabilities required to track investments and outcomes are built*
- ✓ *The benefits realization plan developed in Stage 1 is managed on an ongoing basis*

Stage 3 | Continuous Improvement: Following 5 Years (April 2028 - March 2033)

Anticipating—and, therefore, planning for—the primary health care environment in 10 years is challenging. However, we do know that the need for primary health care will continue to evolve the demands on the province's care providers and leaders. This proposed third stage reflects this understanding and is informed by the overarching considerations described below to sustain the change, and to monitor and adapt to evolving needs in the spirit of continuous quality improvement.

Given the long-term nature of this stage, it is more about the desired outcomes and less about the specific set of activities that must occur. Throughout this final stage, the government will need to reassess the province's progress against desired outcomes, and adjust as needed.

As the transformation progresses into—and beyond—this third stage, the government should manage the benefits realization plan developed in Stage 1 and revisit its 10-year aspirations, building a plan that is Alberta-specific and adequately nimble to respond to changing conditions. At this stage, it is expected that anticipated benefits, such as improved population health outcomes, will start to materialize.

✓ *In practice, **Stage 3 (Continuous Improvement)** will never be 'done' as the province works to sustain modernization efforts and undertake continuous improvement activities—into March 2033 and beyond.*

Conclusion

Together, these three stages offer a high-level transformation roadmap. As the province plans ahead to a modernized primary health care system, it should recognize the hard work of care providers right across Alberta, which has established a strong foundation for the future. This plan, however, will only go as far as stakeholders (e.g., government, professional associations, care providers, patients, communities) are ready to go—and the most effective way to rally them is to engage them early and often.

Throughout the transformation, stakeholders must be given the opportunity to meaningfully participate in transparent decision-making that is informed by data and evaluation to foster an environment of trust and collaboration. Building collective ownership over the future of Alberta's primary health care system will harness diversity of thought and common purpose.

Critical Success Factors

The implementation of any large-scale complex transformation relies on the early identification of critical success factors, which enables proper resourcing (and related) decisions from the outset. As the province begins the work of implementation, it should consider the following:

Critical Success Factor	Description
Adequate funding to support the implementation of the transformation	• The implementation of the MAPS initiative must be adequately funded, and this can be enabled by the development of robust business cases at the outset of the transformation.
Proper governance entities to oversee transformation efforts	• Funding alone will not solve the challenges facing Alberta's primary health care system—the government must be held accountable for results (via adequate governance mechanisms) to ensure that funding and resources are being effectively deployed to drive desired outcomes.
Effective leadership	• Most large-scale transformations fail because of a lack of, or ineffective, leadership. In this way, leadership is a precondition for change, and the MAPS initiative is no exception. It requires brave leadership that is committed to the MAPS vision and supported by the right team. • In Alberta, modernizing the primary health care system must be enabled by a commitment by the province to build strong leaders to sustain the momentum, and realize the benefits, of the MAPS initiative.
Dedicated, properly resourced Transformation Management Office (TMO) to drive implementation	• The transformation won't happen on its own—a robust team with the right skill sets and adequate resources must be established to deliver the transformation. The TMO should include project management, change management, and communications functions as well as the various workstream leads/teams. Moreover, it should receive appropriate support from the government.

Appropriate approach to implementation and change leadership	• The province will need to decide what implementation approach it will leverage to bring the MAPS recommendations to life. • If possible, the implementation of the various initiatives across the three stages outlined above should not be constrained by a traditional approach that favours a linear progression of activities—from beginning to end—over a more agile methodology (otherwise, there is a risk the whole transformation could become hamstrung by setbacks in the implementation of earlier initiatives).
Approval and implementation of the full suite of recommendations	• By their very nature, most of the MAPS recommendations mutually reinforce one another, which means that failure to approve and implement one recommendation could lessen the impact of other recommendations and, ultimately, miss the opportunity to realize the full potential of the MAPS transformation.
Detailed costing and business case development	• The Government of Alberta will need to undertake a detailed costing exercise of the investment required to achieve desired outcomes once the MAPS recommendations are adopted and translated into more detailed initiatives that can be properly scoped and costed. • Related, business cases may need to be developed for select recommendations to further support the government's decision-making process (e.g., annual budget process).
Stability of current operations during the transition to the new governance model	• The transition from PCNs to RPCHNs could create instability for current PCN operations; for example, it has been challenging to recruit for PCNs (e.g., Executive Director roles). The evolution from PCNs to RPCHNs should consider, and mitigate, the potential disruption to people and operations—and this could be enabled by proper stabilization at the outset of the transformation, including standing up proper governance structures, to ensure the primary health care system isn't destabilized while the province is seeking to stabilize it.

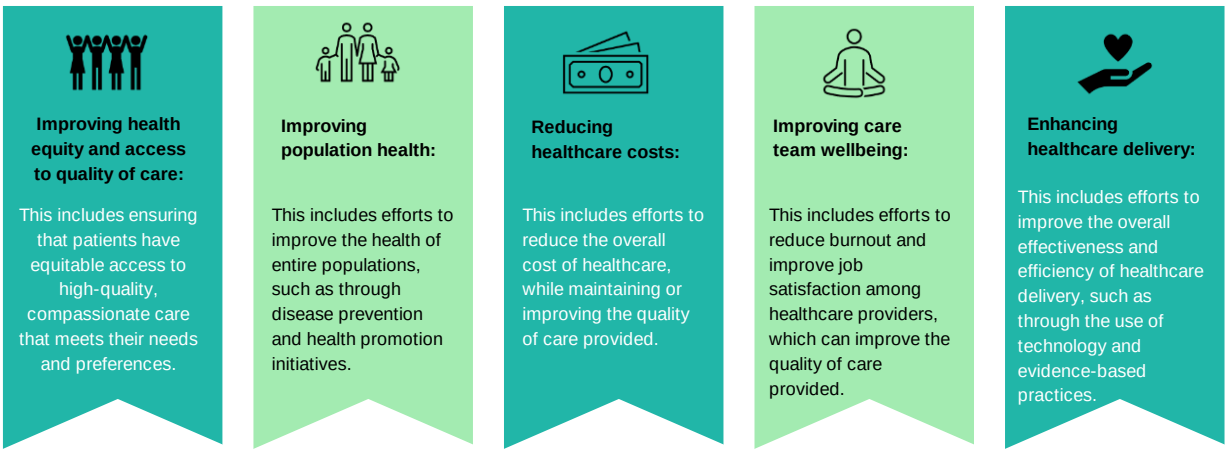
Adequate and stable primary care workforce supply	• Despite the government's interventions, workforce shortages, particularly the lack of physicians delivering comprehensive care, could impact the province's ability to implement the proposed model of cart. This could be driven not just by the supply side (i.e., workforce), but by the demand side, too (e.g., population growth). • On the supply side is the challenge of recruiting team-based supports, particularly in rural and remote communities across the province. • Related, the lack of availability of key stakeholders (e.g., already busy physicians and nurses) could miss the opportunity to effectively design and implement many of the recommendations.
Tailored approach to implementation in rural, remote, and Indigenous communities	• The implementation of the proposed recommendations—who, what, where, when, why, and how—must be tailored to the unique needs and circumstances of rural, remote, and Indigenous communities across the province to promote meaningful, appropriate change in a way that fosters trust and partnership with all the people of Alberta, from patients to care providers. • Rural, remote, and Indigenous-specific considerations must be built into the detailed roadmap activities and, indeed, throughout the longer-term transformation. • Moving forward, the province could consider building an implementation plan (or plans) specific to these communities.
Change readiness and change fatigue management	• Change readiness should be considered and managed with targeted pilots, where appropriate, and the roll-out of specific initiatives. • Given the potential magnitude of change, the transformation must recognize where people, particularly health care providers and their respective professional associations, are at in their ability to absorb more change. In this way, the transition to the desired future state must meet stakeholders where they are at. Otherwise, the province risks losing care providers, and others across the system, to change fatigue amid transformation efforts. • If the province is to truly embrace patients and citizens as partners, then it must equip them with the tools, training, and support they

	require to adapt to the change.
Robust communication across the primary health care system	• To be successful, the implementation must be open and transparent to rally stakeholders and Albertans' support. • Changes to the province's primary health care system will depend on the buy-in and support of stakeholders right across the ecosystem. Ongoing communication and engagement will promote broad adoption of new ways of working in, and interacting with, the primary health care system.
Inter-Ministerial collaboration	• Transformational change in primary health care cannot occur without inter-ministerial collaboration, including input on integrated care models and infrastructure (e.g., data-sharing). Ministries that may be required for support or input in implementation recommendations may include but not be limited to: Alberta Health, Advanced Education, Mental Health and Addictions, Infrastructure, and Technology and Innovation.
Anticipating, and managing, external forces that could disrupt the MAPS initiative	• Any potential external risks—in Alberta and beyond—will need to be identified, and mitigated, to manage their impact on the MAPS initiative, for example, the competition for physicians and nurses across Canada.
Monitoring and evaluation	• An evaluation framework should be developed in the first stage of the implementation roadmap to monitor progress against desired outcomes. • The province's progress against desired outcomes should be publicly shared with Albertans as well as other jurisdictions that can learn from Alberta's experience.

Measuring the Impact of MAPS Based on Quintuple Aim

Measuring the province's progress throughout the modernization of the primary health care system and beyond journey will be instrumental for ensuring the MAPS initiative is driving its intended outcomes. The "Quintuple Aim" is a framework that was developed to guide improvements in the healthcare system. It builds on the previous "Triple Aim" framework, which focused on improving the patient experience, improving population health, and reducing healthcare costs. The five aims of the Quintuple Aim are:

1. **Improving health equity and access to quality of care**: This includes ensuring that patients have equitable access to high-quality, compassionate care that meets their needs and preferences.
2. **Improving population health**: This includes efforts to improve the health of entire populations, such as through disease prevention and health promotion initiatives.
3. **Reducing healthcare costs:** This includes efforts to reduce the overall cost of healthcare, while maintaining or improving the quality of care provided.
4. **Improving care team well-being**: This includes efforts to reduce burnout and improve job satisfaction among healthcare providers, which can improve the quality of care provided.
5. **Enhancing healthcare delivery:** This includes efforts to improve the overall effectiveness and efficiency of healthcare delivery, such as through the use of technology and evidence-based practices.



Preliminary Quintuple Aim Measures for Patient, System and Provincial-Level Outcomes of MAPS

The following is a preliminary list of measures that can be used to guide or assist in the development of a comprehensive evaluation framework to track health system performance and the outcomes and impacts of MAPS recommendations. These metrics and measures do not represent a comprehensive or exhaustive list but rather a starting point to be further developed, expanded and refined.

Improving equitable access to and quality of care:

- Increased proportion of Albertans who report access to a regular primary care provider
- Increased proportion of Albertans formally connected to a patient's medical home
- Improved ability of Albertans to access and receive care from non-physician members of their primary health care team
- Improved ability to see a regular primary health care provider on the same or next day across all regions and communities including rural, remote and Indigenous communities

- Improved ease of access and proximity of people to primary health care including patients medical homes
- Improved ability of patients to receive quality coordinated care across multiple providers and settings
- Increased ratio of non-physicians to physicians in primary health care teams
- Increased equitable access to care along equity dimensions that include but are not limited to sex, gender, income, race or other socio-demographic characteristics, disability, Indigenous status, or stigma
- Improved ability of patients to access information and contribute to their care plans with their primary health care team

Improving population health:

- Improvement in preventative screening rates and rates of patients who have received recommended preventative screening or care
- Improvement to chronic disease management for patients with chronic conditions (ie., patients with chronic conditions, such as diabetes or hypertension, who have achieved their treatment goals)
- Improved morbidity and mortality rates for select conditions
- Improved rates of positive health outcomes across health equity dimensions including sex, gender, income, race or other socio-demographic characteristics, disability, Indigenous status, or stigma
- Decreased rates of prevalence of mental illness across the province and improved positive mental health outcomes resulting from care
- Improvement to age specific mortality rates by across health equity dimensions

- Improvements to the health environment including factors that impact the social determinants of health

Reducing healthcare costs:

- Decreased total health care spending per capita
- Increased proportion of primary health care spending as a proportion of total health care spending
- Decreasing rates of hospital readmission following an initial hospitalization
- Reduction in unnecessary emergency room visits for non-critical or non-emergent health concerns
- Decrease in per capita health expenditures across a broad range of health care expenditures (e.g., inpatient hospitalization, emergency department visits, long-term care costs, lab and diagnostic costs, or mental health costs)
- Decreased costs per episode of care including primary health care visits, acute care, continuing care or chronic disease management
- Decreased rates of patients admitted to hospital for conditions that could have been prevented or managed in a primary health care setting
- Decreased rates of unnecessary diagnostic or laboratory tests

Improving the work life of healthcare providers:

- Improved provincial primary health care workforce retention rates by zone, region, and care provider type
- Increased proportion of time that providers are able to spend with patients
- Decreased primary health care rates of burnout, stress or mental health leaves

- Improved care provider satisfaction rates and rates of care providers who report working in a supportive environment
- Decreased rates of care providers who intend to leave their positions or professions within 1 year
- Increased opportunities for professional development, training and educational opportunities
- Decreased workload management including time spent on administration or clinic management
- Increased time spent on quality improvement, training and research related activities
- Decreased primary health care provider absenteeism or sick leave

Enhancing healthcare delivery:

- Increased extent to which primary health care is centred around the needs and preferences of patients
- Increased percentage of patients who receive follow-up care within a specified timeframe after a visit or procedure, such as within 7 days for a hospital discharge
- Decreasing wait times for appointments with primary health care, specialty or chronic care providers
- Lowered rates of medication errors or preventable adverse events
- Increased time spent on quality improvement, training and research related activities such as monitoring and evaluating health care deliver or implementing changes to improve quality of care delivery or health outcomes
- Increased adoption rates for health information and technology tools or functions including advanced EMR functions

- Improved rates of adherence to clinical, safety, or cultural safety standards or protocols and patient safety outcomes
- Improved quality of coordination of care between different health care providers as indicated by positive health outcomes
- Faster rates of spread for quality improvement, safety or innovation initiatives across the health care system
- Increased total funding allocated to quality improvement and innovation within the primary health care system

While these metrics do not constitute an evaluation framework, the development of an evaluation framework was noted as a part of Recommendation 11 earlier in this document.

Ultimately, 'success' means Albertans have improved access to high quality primary health care from their primary health care team. Success means that primary health care is integrated with other health, social and community services to provide whole of person care and addresses all aspects of a person's well-being. People in Alberta should be partners in their own care working with proactive teams to achieve their health goals. Success means that care is culturally safe and appropriate and designed and delivered in a way that respects individuals and communities in meeting their health needs. Success means that primary health care is sustainably funded and effectively coordinated to deliver better value for care and improved health outcomes through an efficient and effective primary health care system.

Success means people in Alberta live healthier lives.

Conclusion

Conclusion

The modernization of Alberta's primary health care system—and the recommendations proposed in this report to get there—is not a generation away. It starts today.

The Modernizing Alberta's Primary Health Care System (MAPS) initiative was launched to strengthen primary health care in Alberta and to ensure all Albertans have access to timely, appropriate primary health care services.

Over the past six months, the MAPS Strategic Advisory Panel has studied, and consulted on, the future of Alberta's primary health care system. The outcome represents a uniquely 'made in Alberta' strategy that harnesses the unique perspectives—and potential of—rural, remote, Indigenous, urban, and suburban communities across the province.

The 11 overarching recommendations presented in this report have been put forward by the Panel to the Minister of Health to strengthen primary health care in the province and to achieve a primary health care-oriented health system that ensures:

- **Access:** All Albertans, including First Nations, Métis, and Inuit peoples, have access to timely, appropriate primary health care services from a regular provider or a team.
- **Integration:** Every Albertan has a patient's medical home that provides primary health care services and seamless transitions to other health, social and community services.
- **Quality:** Albertans receive high quality services from an accountable, innovative and sustainable primary health care system that is constantly evolving, at all levels, in response to changing needs.
- **Albertans as Partners:** Albertans and their social support networks are meaningful partners in achieving their health and wellness goals.
- **Culturally Safe and Appropriate Care:** First Nations, Métis and Inuit persons have access to high quality, culturally safe care that is free of racism, and designed and delivered in a manner that respects their unique health care needs.

Call to Action

This report puts forward a bold vision, and an even bolder call to action: that stakeholders right across the province's primary health care system, led by the Government of Alberta, immediately begin the work of implementing these recommendations.

This requires significant investment, mobilization of adequate resources, collective action, and a steadfast commitment to innovation and continuous improvement to transform primary health care and deliver improved health outcomes to the people of Alberta.

Albertans deserve no less.

The Panel wishes to extend its deepest gratitude to the Minister in directing this important work to be done and to the patients, communities, care providers, and caregivers that contributed—directly or indirectly—to this report.

Now, the real work begins.

Photo courtesy of the Government of Alberta

Appendices

Appendix - A

Appendix A: Guiding Principles

The following principles were established by the MAPS Panels to guide their design ideas for Alberta's future primary health care system and in developing the recommendations that follow. They reflect first and foremost, the principles of and perspectives of what matters to people in Alberta–patients, providers, policymakers and leaders–and are informed by global thought leadership and experiences. These design principles are a reminder that the best primary health care systems in the world are driven to achieve meaningful outcomes for people and communities. Alberta will strive for no less than best.

Guiding Principle #1: Prioritize quality–including access, equity and cultural safety

Quality is the unifying principle for modernizing primary health care. The province and primary health care leaders and providers must declare a relentless focus on quality. Every person in Alberta, despite their location, race, gender, sexual orientation, age, or health status should be able to access primary health care in an equitable manner, where approaches are tailored to their unique needs and circumstances. Appropriate consideration should be given for diverse populations who do not always have the same level of access or autonomy including Indigenous peoples, newcomers and other vulnerable or underserved populations. Quality outcomes should be defined by the people who benefit from primary health care.

Guiding Principle #2: Value patients, citizens and communities as true partners

Patients should be the centre and key partners in primary health care. This includes as a part of their individual health teams and as a part of primary health care services in their communities. Community members should feel they are represented and are able to participate if desired. Responsive primary health care begins and ends with meeting the needs of patients and communities which relies on partnerships, feedback and trusting

relationships.

Guiding Principle #3: Optimize continuity and team throughout a person's health journey

The future primary health care system in Alberta should be rooted in continuity of comprehensive, holistic care, ensuring peoples' wants and needs are heard, respected and prioritized. It should seek to deploy resources and a diverse team of practitioners with the right expertise and experience, to enable an integrated and coordinated response. The future model should minimize silos and strive for seamless continuity across each individuals' health journey. Continuity will require expectations for sharing of data and information to optimize decision-making.

Guiding Principle #4: Facilitate collaboration and integration to address social determinants of health

Meeting the health and well-being needs of people and communities requires proactive, outcomes-focused approaches to address social determinants of health. Wherever possible, avenues should be opened up for health and social serving organizations to engage and collaborate as partners to improve community wellness and population health.

Guiding Principle #5: Prioritize health promotion and prevention for patients and providers

Citizens should be empowered with the knowledge, resources and tools required to self-manage their health conditions and take ownership of their own health and well-being. A focus on health promotion and prevention will reduce demands on the broader health system and improve health outcomes of communities and the population as a whole.

Guiding Principle #6: Establish partnerships for collective impact

Primary health care leaders and providers alone cannot realize the transformational changes Alberta is considering. Existing relationships and partnerships should be strengthened, and new ones forged with other actors in the system, with the shared purpose of impacting health outcomes that matter to Albertans. Partnerships with municipalities, employers, insurers, academia, universities and education institutions, social serving agencies and organizations, and other government departments can achieve collective impact.

Guiding Principle #7: Enable a learning health system of innovation, implementation and improvement

Ongoing learning and continuous improvement are driven by evidence and data and realized by people. Innovation, implementation, and improvement science supports, capabilities and practices are at the core of modern, learning health systems. These elements are key for a resilient and sustainable primary health care system and an energized and empowered workforce.

Guiding Principle #8: Leverage technology as an enabler for improving care

As the world and with it, Alberta, changes; as societal, community and individual needs evolve; and as research, life sciences, technology and health care systems evolve, so must primary health care service delivery models and care. There is a real opportunity to harness the ability of technology and data to improve primary health care and health outcomes for Albertans.

Guiding Principle #9: Build confidence and legitimacy through well-defined governance and leadership

Creating clear accountabilities, formalized leadership, and strong governance structures

which bring together key stakeholders and diversity of thought, knowledge, backgrounds, lived and professional experiences, cultures and geography is essential for the long- term success of a modernized primary health care model in Alberta. The accountability structures should be aligned to support the needs and priorities of different communities and provide a place at the table for people and communities in local governance.

Appendix - B

Appendix B: Additional Context on Strategic Shifts

Design primary health care with and around the needs of people and communities, inclusive of health and social care

"We use the jargon of social determinants. What does that mean? It means there are other sectors in society that have a major influence on my health. My health depends on my income. My health depends on the food I eat, the water I drink, the house I live in, the neighbourhood that I am in. So, it is not only a whole person approach but a whole society approach, especially for primary health care."

(Citizen perspective)

Citizens and communities are not meaningfully involved; health and social care are not integrated

Primary health care in Alberta currently operates as a cottage industry, with significant fragmentation of services that can make it difficult for providers to organize care and for people to navigate the system and participate meaningfully in their own care as partners with their health care providers. There is also not enough recognition and systematic integration between primary health care, community care and other social services and supports. This has impacted continuity of care as services are not coordinated through a person's life and health journey, or across providers. While citizens want to be able to access services when and how they need them, their voices and experiences are not intentionally sought out as the true shareholders of the system.

Primary health care providers are increasingly being faced with managing complex health needs of their patients and many of these challenges cannot be addressed by primary health care alone. While there are pockets of excellence, such as the long-established CUPS Health Clinic in Calgary, the ALEX Community Health Centre and Radius Community Health and Healing (Boyle McCauley Health Centre) in Edmonton,

primary health care does not effectively coordinate and integrate with community health and social supports to comprehensively and holistically provide a whole of person care strategy. Without an integrated strategy, unaddressed challenges relating to social determinants of health will continue to hinder the well-being of people in Alberta and drive increasing demand on primary health care providers, and emergency department and acute care capacity.

Alberta's population is growing and is becoming more diverse, yet primary health care has not been adaptive to these changing demographics to meet the needs of all people in the province. Indigenous peoples and communities have their own needs and expectations, and there are limited and disjointed strategies for older adults, people experiencing homelessness, addiction and mental illness, LGBTQ2S+ communities, newcomers to Alberta and people with disabilities. These underserved populations and communities face barriers to accessing care, resulting in troubling inequities in health outcomes and experiences. Indigenous peoples in Alberta often do not have the degree of self-determination and autonomy that is required and experienced by other people accessing primary health care. People who live in rural and remote areas face challenges in accessing care that other parts of the province do not. People in rural parts of the province generally experience poorer overall

well-being, have less access to an interprofessional team of health and social service providers, experience longer wait times, have less choice as to where and how they can access services, and encounter a broad variation in the availability of primary health care and specialty care in their communities.

The existing fragmentation within the system makes it challenging to coordinate and navigate between health, social, and community services and providers. This consequently leads to episodic care, often delivered in a hospital facility, misinformation, miscommunication and people falling through the cracks without their needs being addressed. In order to deliver a comprehensive care approach for people in Alberta, there needs to be a shift to meaningfully…

...design primary health care with and around the needs of people and communities, inclusive of health and social care.

All people in Alberta should experience a seamless, coordinated health journey throughout the course of their lives, no matter where they live or how they self-identify. The future primary health care system must enable a community asset-based approach to co-designing services and innovative solutions that are sensitive to local needs, and to be agile to adapt to—and overcome—barriers that are faced in each community. Current funding models must be rethought and adapted.

People are at the center of the primary health care system and the system should be designed together with citizens to better meet the needs of communities. People—including patients and family caregivers—must be given the space and a voice to help build a primary health care system that is reflective of and responsive to their needs, and they should also have a say in how to make the primary health care system easier to access and navigate. This means providing community members a seat at governance and decision-making tables at provincial, regional and community levels, and empowering patients as partners in their own care.

People in Alberta should have trust and confidence in their care providers, and be assured that a holistic, comprehensive and culturally safe approach to their well-being is prioritized. This will require a coordinated approach between primary health care and social and community services to work together in addressing complex care needs and improving social determinants of health.

Create a primary health care system that is built on highly collaborative teams working together across a Health Neighbourhood with the support and resources they need to thrive

"Primary care networks were supposed to be set up as teams, but over time that has waned."

(Citizen perspective)

"We need a more integrated primary health care/ home care/ community services system. My family doctor said it's easier for him to access the team in long-term care than in the community."

(Citizen perspective)

Interprofessional teams are not the usual mode of primary health care delivery; many primary health care providers are not enabled to work to their full scope of practice or supported by an effective health workforce strategy

Existing models of care limit the ability of patients to access an interprofessional team who know their health journey and goals. In Alberta today, primary health care is predominantly delivered through private family physician offices. People make an appointment with their family doctor, if they have one, and their family doctor provides treatment or may refer them to another care provider in another clinic or facility. Most primary health care settings in Alberta are built around a physician with limited support staff.

People are often not able to access interdisciplinary care through their PMH because most providers do not work in interprofessional teams, and rarely, are co-located in the same clinic. Thus, a person will have different providers in different locations and care settings, and will often have to pay out of pocket or through privately held insurance plans to access the services they need, such as physiotherapy, psychology and optometry. Apart from family physicians, the majority of these health professionals do

not have the information they need to optimize patient care. This is held in electronic health records hosted in individual clinics and in provincial databases with limited access for health professionals that practice in the community.

Many health care providers are not trained to work together and to fully optimize their expertise and scope of practice in collaborative environments. While there have been several targeted workforce strategies in Alberta over many years, they have not been fully effective in addressing models of team-based care where interprofessional teams are trained together, work together and support each other with the necessary skills and resources. This is especially true in rural and remote parts of the province where the supply of health professionals is challenging, and primary health care employers are competing with acute care settings and private businesses. If team-based primary health care is the future, Alberta needs to…

…create a primary health care system that is built on highly collaborative teams working together across a Health Neighbourhood with the support and resources they need to thrive.

The future primary health care model must shift to team-based care as the norm and health care providers need the knowledge and skills for how they can best work together to provide comprehensive care. Team-based care in a supported team environment is essential to improving both patient outcomes and experiences. Funding models must be developed that enable and support PMHs in implementing and sustaining diverse, yet targeted team-based care that supports people in their health journey without sacrificing quality of life or well-being of the team members. Sufficient investments must be made to integrate and connect the PMH to the Health Neighbourhood—the right funding model must have the right levels of investment to sustain the outcomes the public expects.

The primary health care workforce must specifically and urgently be prioritized. A targeted primary health care workforce strategy must address the factors that are contributing to challenges with availability of health professionals in rural and remote

areas of the province, including options for educating and training in place, supporting wellness and lifestyle, availability of infrastructure and practice support, requirements for working in acute care facilities as well as community clinics, and community repatriation of recruitment incentives for foreign trained workers. Joint integrated planning between acute care, communities, primary health care services and providers is a unique challenge that requires systematic support.

Funding and governance of primary health care must consider local supply and demand of health care professionals to meet the population health needs of communities, while directing targeted investments for developing Health Neighbourhoods with and for patients and health providers. If this shift occurs, undoubtedly Alberta will see patient outcomes and experiences improve, more people wanting to work in primary health care settings, and more physicians choosing family medicine. And perhaps most importantly, people will be able to partner with their primary health care team in their Health Neighbourhood to make informed decisions about how best to meet their own health goals.

Recognize that rural and remote primary health care is different from urban centres and that all planning and decision-making should happen locally in these communities

"Rural and remote aren't the same as urban and suburban. Rural and remote primary health care aren't the same as each other. It's all different and we need to think differently about it. One size fits all won't work for anyone."

(Care provider perspective)

Services and programs are designed at a provincial level and don't reflect the unique needs of Alberta's rural and remote communities

There is no one size fits all approach that can be used to effectively organize primary health care in Alberta. There has not been enough effort to adapt strategies and approaches to meet varying needs across the province. Individuals, communities and regions of the province all vary significantly. Urban centres have different health challenges than are faced in suburban or rural areas. Remote communities face a different set of challenges still. Too often, rural and remote care are treated as the same when there are significant differences between them. Indigenous communities will have different and unique needs and expectations than the urban Indigenous population.

Primary health care in Alberta today provides limited flexibility to adapt to unique communities or regions within the province which results in equities in primary health care between different parts of the province and different demographics. Rural residents generally experience poorer overall well-being and health outcomes, have less access to an interprofessional team of healthcare professionals, have less choice of health care providers, and encounter a broad variation in the availability of primary health care and specialty care in their communities. The existing model of primary health care must shift to…

…recognize that rural and remote primary health care is different from

urban centres and that all planning and decision making should happen locally in these communities.

The differences in needs across the province are significant. What works in one rural or remote area will not work in the another—remote areas of northern Alberta are not the same as rural areas of southern Alberta. The entire system of primary health care in rural and remote areas to be designed to bridge gaps and remove barriers facing patients and care providers. People who live in rural and remote areas face challenges in accessing care that other parts of the province do not. They have lifestyles that impact how and when they are able to access care; for example, farmers are not going to access care in the same way during seeding or harvesting—care needs to be adapted in recognition of these facts of life for rural and remote communities.

The governance of primary health care in rural areas must be sensitive to local needs and embrace partnership and innovation in how they design and organize services to build on strengths and assets in the community. These assets include the primary health care providers who choose to live and work in rural and remote areas of the province. Primary health care governance and service delivery models for these regions of the province must address the factors that are contributing to challenges with retaining health care providers, including burnout, availability of infrastructure and support, and lifestyle. Creating robust team-based models of care in rural areas could reduce the pressure on primary health care providers to always be 'on' day in and day out, because then those care providers are not the only providers available. Rethinking the funding models to employ and empower different types of care providers is a critical component of a sustainable team-based primary health care model for rural and remote areas.

Enable a learning health system where quality and safety improvement is the modus operandi for providers, leaders and community members who have capabilities and teams to support implementation, measurement and innovation

"Value for citizens and patients is the overarching goal for health NOT access, cost containment, convenience or customer service. Value as the goal is what will unite all system participants."

(Citizen perspective)

Efforts related to quality and safety improvement and innovation are fragmented, with multiple organizations playing small roles

Although Alberta has several organizations and initiatives geared towards quality and safety improvement and innovation, there is no provincial framework, agenda, agency or team with a dedicated mandate for quality and innovation for primary health care in Alberta today. The current capabilities in the province are not strategically aligned, funded or delivered—and existing efforts have resulted in an inconsistent and fragmented approach. This may be surprising to many outside of the province, as Alberta has long been viewed as a leader in Canada for its long-standing, provincial-scale improvement efforts, including:

- **Health Quality Council of Alberta (HQCA):** A provincial agency mandated to promote and improve patient safety, person-centered care, and health service quality on a province-wide basis based on the Alberta Quality Matrix for Health. The HQCA has been preparing Primary Healthcare Panel Reports[5] for family doctors, clinics and all PCNs across the province since 2011 to support quality improvement at a practice level. The HQCA also publicly reports quality of care measures via FOCUS on Primary Healthcare[6] to help providers and the public

[5] https://hqca.ca/resources-for-improvement/primary-healthcare-panel-reports/

[6] https://focus.hqca.ca/primaryhealthcare/

understand the performance of the current primary health care system at a zone and PCN level.

- **Alberta Medical Association (AMA) Accelerating Change Transformation Team (ACTT):** Formed in 2016 bringing together several AMA programs working to enable system transformation focusing on the concepts of the Patient's Medical Home and the Health Neighbourhood.
- **Collaborative Mentorship Network for Chronic Pain and Addiction (Alberta College of Family Physicians):** Connects family physicians and interprofessional team members (nurses, pharmacists, social workers etc.) with colleagues who have experience and expertise treating pain and addiction. It provides an infrastructure to establish a trusted mentoring relationship in a community of practice.
- **PCN Practice Facilitators:** Many PCNs have also embedded practice facilitators to support quality and safety improvement initiatives, including change management for processes and clinical practice.
- **Practice-Driven Quality Improvement:** A component of the College of Physicians and Surgeons of Alberta's (CPSA) Physician Practice Improvement Program (PPIP) requiring Alberta's physicians to incorporate at least one personal development and two quality improvement activities into their practice over a continuous five-year cycle. Regulations for most other health professions also specifically require quality improvement as a professional competency standard.
- **Choosing Wisely Alberta (CWA):** A provincial campaign launched in 2014 to reduce unnecessary care, CWA is organized by the AMA in partnership with the Physician Learning Program, Alberta College of Family Physicians, Alberta Health, AHS, Alberta Innovates, the Institute of Health Economics, University of Alberta, University of Calgary, CPSA, and patients.
- Other quality improvement efforts and resources include AHS' Strategic Clinical Networks which have supported the spread of initiatives such as Home to Hospital to Home transitions, specialist advice services and referral processes, pathway

development and provider education opportunities.

While Alberta has invested significant resources, it has been uncoordinated, without a system-wide strategy to drive learning and improvement, and these resources tend to compete for provider attention and do not work synergistically. There hasn't been sufficient focus on the team and making improvements in the context of workflow in a clinic setting. Team-based quality and safety improvement and implementation science has not been effectively embedded into ways of working as the facilitation and change management resources needed for these efforts are limited and often unavailable. Even if they were consistently available, what is still missing is the protection of paid time for team members to engage in this kind of work and dedicated training, tools and leadership support for clinical leaders and practice facilitators.

Implementation of disparate innovations, even effective ones, inconsistently across the province over a long period of time has resulted in variation in how care is delivered and the tools being used, and frustration for primary health care providers, private industry partners, government departments and the public. Alberta is rich with innovation yet has not yet realized its full potential and capabilities as a learning health system to embrace and embed innovation. The lack of mechanisms and capabilities to implement, scale and cascade effective innovations throughout the province is a significant barrier to adopting innovations that could improve outcomes, effectiveness or efficiencies of primary health care. Innovation and improvement are as much about learning from failure as it is from successes. These learnings need to be harnessed and harvested.

Alberta has a wealth of quality data available, yet like most systems, has struggled to analyze and interpret the data to make it useful for improving patient care. Improvements and innovations are not effectively measured, evaluated and reported. They are not cascaded to the people that can analyze and use the information to prioritize improvement efforts. This is confounded by the absence of consistent feedback mechanisms for patients and providers to share their perspective on their experiences and suggestions on ways to improve. There are also significant barriers in existing privacy legislation for information and data sharing processes that must not just

be considered, but must be overcome. This reality must shift to…

…enable a learning health system where quality and safety improvement is the modus operandi for providers, leaders and community members who have capabilities and teams to support implementation, measurement and innovation.

Quality is a core strategy for high-performing health systems who aim to achieve the Quintuple Aim—improving population health, improving the care experience, reducing costs, finding joy and value in work, and advancing health equity. A relentless focus on quality can facilitate a learning health system and drive sustainable transformation. It empowers local care teams to address problems that matter to them, while also allowing a system-wide approach for implementation, measurement, and evaluation of change initiatives and innovation.

High-performing health systems build capabilities and expectations for quality improvement and embed those capabilities throughout, from governance and leadership, operational management, and front-line clinical teams. To do this, the primary health care system in Alberta must invest in building effective governance, quality improvement education, infrastructure and resources, and pathways to drive quality as a strategic imperative. Data and information must be collected and accessible to facilitate data-driven quality improvement within primary care teams, and to support evaluation, and policy and clinical research capabilities. The innovation pipeline should focus on meeting the needs of people in the community and the clinical needs of primary health care teams.

It is time to design the primary health care system around quality, safety and innovation and embed quality improvement as a driving force for a resilient learning health system. This is essential to building a system capable of learning, adapting, and evolving to better meet the needs of people and communities in Alberta.

Establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes

"Bottom up, community approach instead of top down"

(Citizen perspective)

Responsibility and authority are disjointed with no clear governance and accountability in primary health care and limited tracking of impacts and outcomes of investments

Over the years, progress has been made in building governance structures for primary health care in Alberta at the provincial, zonal, regional and clinic levels. At the provincial level, Alberta Health is ultimately accountable but the major governance structure, the Provincial Primary Care Network Committee, is advisory with no decision-making authority. It has become the default provincial structure for all primary health care issues, despite being constructed with a narrower mandate related to PCNs. There are several other provincial-level committees, but they are often disconnected and have limited decision-making authority or access to resources. A similar situation exists at the zonal level where committees exist, but they have very limited authority and must rely on resources from PCNs to fund zone-level improvements. PCNs are not accountable to zone-level structures, and even more problematic, the physician members of PCNs have almost no recourse (short of leaving the PCN) if PCNs are unable to support them adequately. In this complex structure, many challenges have manifested, including lack of provincial standards for primary health care delivery, ineffective or missing accountabilities in service delivery, and lack of provincial performance management and evaluation frameworks over primary health care.

At the root of these issues is that there is no strategic approach to governing primary health care in Alberta where structures have responsibility, but lack authority or resources to meet those responsibilities. There is no solely accountable body

responsible for setting the strategic direction and vision for primary health care. The decisions around resource allocation, workforce strategy, and services are made in silos or across multiple bodies without an aligning central strategy or single point of accountability. Complexity in the governance model makes it difficult to build a cohesive, responsible provincial approach to primary health care where resources can be secured to address key pressures and accountability can be demonstrated. This undoubtedly is impacting patient and provider experiences, and health outcomes of Alberta's diverse communities.

The complexity and misalignment of accountabilities, responsibilities and authority in the current governance model impacts the quality of our primary health care system. Health outcomes and experiences of communities are not being effectively monitored, responded to or anticipated in ways that are at the heart of primary health care that embraces health promotion and prevention as core underpinnings. Providers and communities at the coalface of primary health care do not feel that they have a say in how services are funded or organized, despite seeing the opportunities on a daily basis. While there have been merits to the current governance model, the reality is that it has unintentionally diminished morale and increased the frustrations of a dedicated, yet debilitated workforce. Alberta's can realign from a top-down hierarchy to…

…establish primary health care governance that is oriented to give agency to people, communities and providers with clear accountabilities, formalized leadership, and transparent and meaningful public reporting of outcomes.

The future primary health care system must be built as just that—a system—with clear accountabilities that are defined within a formalized governance structure and framework. The governance model must be simplified and strengthened to ensure that the primary health care system achieves the intended outcomes for people, communities and the province while always acting in the public interest. Agency must be given to providers and communities in the form of decision-making authority over how services are organized and delivered locally, and influence over how resources are

allocated to meet the unique needs of each community across Alberta. Effective governance is key for setting strategic policy frameworks that are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability over strategic direction, roles, performance and outcomes.

Strategic planning and decisions around resource allocation, workforce strategy and sustainability, and quality and safety improvement and innovation will be more effective with clearly defined accountabilities, leadership authorities and a single unifying direction to follow. A modernized and strengthened governance structure will allow for the development and execution of a team-based, patient-oriented primary health care strategy for Alberta.

Appendix - C

Appendix C: Overview of MAPS Initiative

Engagement Approach and Objectives

In order to derive effective recommendations that contribute to the achievement of the five overarching initiative outcomes, a robust engagement approach was developed. Leaders and experts with hands-on experience in primary health care and health systems improvement, both inside and outside of Alberta, were gathered and asked to examine the current landscape, and draw on their expertise to propose innovative improvements that have the potential to strengthen primary health care in Alberta.

This expert group was divided into three panels to ensure a balanced set of perspectives, streamline communication and enable ideation. The Panels[7] are:

1. **Strategic Advisory Panel:** Consisting of local primary health care leaders and experts who understand the Alberta context and were responsible for developing the overall recommended strategy and roadmap.
2. **Indigenous Primary Health Care Advisory Panel:** Composed of Indigenous health experts and leaders, present to ensure that Indigenous perspectives and wisdom were utilized to develop a separate set of recommendations specific to Indigenous health and wellness needs.
3. **International Expert Panel:** Made up of national and international experts who provided insights from other jurisdictions to inform the work of the Strategic Advisory Panel.
4. **Written Submissions:** A number of stakeholder organizations and groups were asked to provide their inputs via written submissions. This included organizations like the University of Alberta, University of Calgary, Alberta College of Pharmacy, College of Alberta Psychologists, Refugee Health Coalition and more.

[7] Further details around the roles and responsibilities of each panel can be found in the *Methodology* section.

5. **Innovation Forum:** On January 16 and 17, 2023, a two day Innovation Forum was launched which brought together citizens, patients, health care providers, community members, and policymakers to identify, in concrete terms, the practical actions that will move Alberta's primary health care system forward.

In parallel to the work of expert panels, communicating the learnings and insights from the MAPS initiative to Albertans was top of mind. The MAPS initiative set out clear external engagement outcomes to ensure that transparency was maintained and that Albertans were provided the opportunity to have their voices heard as the project progressed.

The guiding communication objectives included:

- Ensure that the voices of all Albertans are heard throughout the process around the challenges faced while trying to access primary health care: this includes First Nations, Métis, and Inuit peoples and those living in rural and remote areas of the province.
- Demonstrate how the MAPS initiative will take action to solve the aforementioned challenges.
- Affirm the commitment to a strong primary health care system where all Albertans, including rural Albertans and Indigenous peoples, have access to high quality and culturally appropriate care.
- Build awareness of the challenges and opportunities facing primary health care in Alberta, and the broader impact on the health care system.
- Maintain high levels of good will and transparency with healthcare partners throughout the life of the initiative to build a strong foundation for the successful implementation of recommendations, both in the short-term and over the next 10 years.
- Recognize the value and necessity of partner input: encourage partners to share feedback that will be integrated into the final report.

- Utilize local, Alberta-specific data where possible to inform the initiative.

Organizing Framework and Analysis

To make the most effective use of the resources and time available for the MAPS initiative, there was a need to develop a framework to assist with structuring and organizing the complex interrelated parts of the primary health care system. This organizing framework was defined carefully to focus the efforts of those involved. It consisted of three separate but related components of the primary health care system and was used to structure the engagement, analysis and research conducted throughout the MAPS initiative:

- **Business / System Models:** Centered on understanding and identifying opportunities related to the broader organization of the PHC system, governance and funding;
- **Service Delivery Models:** Focused on improving elements of primary health care related to patients, providers and how care is delivered; and
- **Enablers:** Identified key required supporting capabilities, infrastructure, process, and technology-related opportunities to modernize primary health care in Alberta.

The analysis and engagement activities completed as a part of the MAPS initiative is summarized below:

Scope	Description
Engage primary health care expertise through Advisory Panels	• Work with the International Expert Panel to access insights, learnings and leading practices within primary health care in other jurisdictions. • Work with the Strategic Advisory Panel of local primary health care leaders and experts who understand the Alberta context to identify recommended actions to strengthen and improve Alberta's primary health care system.

Scope	Description
Engage Indigenous expertise and perspectives[8]	• Work with an Indigenous Primary Health Care Advisory Panel to recommend actions to strengthen and improve Alberta's primary health care system for Indigenous peoples living in Alberta. • Engage Indigenous expertise and community perspectives in understanding how Alberta can improve primary health care for Indigenous peoples.
Gather insights from Albertans, Government of Alberta, and primary health care stakeholders	• Engage primary health care providers to understand their perspectives on challenges within primary health care and solicit their suggestions on how it can improve. • Gather public, caregiver, and patient perspectives on challenges within primary health care and how it can improve. • Gather insights from key personnel within Alberta Health, Alberta Health Services, and across government ministries as inputs to the work.
Identify early opportunities for improvement	• Identify immediate improvement opportunities through assessment of evidence, application of leading practice, stakeholder engagement, and advice from Advisory Panels. • Create business cases to support prioritization and decision making on implementation of identified opportunities.
Review and assess evidence about the current system	• Provide information and evidence for the consideration of Advisory Panels. • Analyze primary health care data to identify and inform opportunities for improvement. • Complete supplemental analysis as required.

[8]The Indigenous Primary Health Care Advisory Panel led a separate MAPS initiative. Thus, this report does not directly include Indigenous expertise and perspectives.

Scope	Description
Apply insights and leading models from other jurisdictions	• Conduct research and gather information about leading practices, effective primary health care models, and primary health care transformations in other jurisdictions. • Integrate insights from the International Expert Panel into deliberations by the Strategic Advisory Panel and Indigenous Primary Health Care Advisory Panel. • Apply leading models and insights to development of business cases for improvement opportunities.
Convene forum to explore primary health care innovation	• Bring together diverse perspectives in a collaborative (forum) setting to generate innovative approaches to improve primary health care in Alberta.
Reporting	• Create a portfolio of actionable improvements that can be implemented beginning in the 2022/23 fiscal year. • Create a MAPS Strategy (Final Report) by March 31, 2023 that recommends actions to the Minister of Health over the next 5-10 years, provides an implementation roadmap, and outlines costing.

Out of Scope

Activities that were not within the scope of this project include:

- Detailed implementation planning for actions that may be taken based on the MAPS initiative
- Broad engagement of all Albertans
- Internal organizational changes in light of recommended directions from the MAPS Final Report
- Recommendations to other orders of government, or to First Nations or Métis governing bodies
- Changes through collective bargaining processes

MAPS Initiative Timeline Overview

The MAPS initiative took place over the course of an eight month time period from September 2022 to April 2023, and was divided into four key phases:

- **Phase 0 - Project Set Up (September 2022):** Project approach and governance was established, and advisory panels were appointed.
- **Phase 1 - Diagnose and Early Opportunities (October 2022 - February 2023):** Established an understanding of the current state of primary health care in Alberta through research and analysis, stakeholder interviews and focus groups, advisory panel meetings, and evaluation of written stakeholder submissions. From the current state, this phase focused on narrowing down early investment opportunities (recommendations) for the modernization of Alberta's primary health care system.
- **Phase 2 Analysis and Strategic Direction (October 2022 - March 2023):** Gathered and analyzed information from stakeholder engagements, and hosted a large scale Innovation Forum to further ideate primary health care transformation in Alberta. Following this, data was compiled into a Portfolio of Early Investment Opportunities which highlighted short-term recommendations that would provide immediate stabilization support to Alberta's primary health care system.
- **Phase 3 - Action and Synthesis (October 2022 - April 2023):** Synthesized the findings and priorities determined in previous stages to produce actionable ideas for the MAPS initiative to move forward with. Final stakeholder engagements were conducted to support the refinement and development of recommendations to be compiled into the Final Report.

MAPS Methodology

The MAPS initiative is a complex undertaking, with various workstreams, priorities and deliverables. To manage the initiative effectively, a comprehensive approach was developed to systematically lead towards the intended outcomes. The following sections detail the methodology used to effectively navigate this initiative, beginning with the governance structure (including roles and responsibilities), and followed by the steps taken to develop the recommendations laid out later in this report.

Governance of the MAPS Initiative

In creating the initiative's governance structure, a strong priority was placed on selecting a diverse group of individuals who represent Albertans and their experiences, while also bringing depth of primary health care knowledge and expertise. As a result, physicians, nurse practitioners, medical academics, health system researchers and experts were chosen and organized into four levels of governance, each serving a unique role within the MAPS initiative. These include:

- Oversight Committee,
- Strategic Advisory Panel,
- International Expert Panel, and the
- Indigenous Primary Health Care Advisory Panel.

Committee Detailed Responsibilities	
Oversight Committee	• Advise on the approach for the MAPS initiative, including engagement, internal review, and panel processes • Champion the initiative and enlist support • Review and approve Initiative Charter • Review and provide input to the Portfolio of Early Opportunities and the Final Report before they are submitted to the Minister of Health • Anticipate and address significant issues and risks for the initiative by providing advice, direction, resources, or support as necessary • Support communications regarding the MAPS initiative through existing channels for communicating with staff and stakeholders • Facilitate access to key stakeholders and colleagues or experts from other jurisdictions, where necessary, to explore topics in greater depth or understand the experience in other jurisdictions

Strategic Advisory Panel	• Understand the current state of primary health care in Alberta by reviewing data and evidence, and receiving presentations and documents and provide additional context through their own experiences • Work with members of the International Expert Panel to: – Identify and inform early investment opportunities, including analysis of impact, feasibility, risks and costs; – Guide the development of comprehensive long-term recommendations to bring transformative improvements to Alberta's PHC system; and – Develop a roadmap towards the identified future state of Alberta's PHC system • Support the development of a comprehensive recommendations report to be given on their behalf to the Minister of Health, encompassing the actions required to modernize Alberta's PHC system • The Co-Chairs attend/participate in public announcements with the Minister of Health, as requested • Participate in the Innovation Forum

Indigenous Primary Health Care Advisory Panel[9]	• Through the expertise and contributions of First Nations and Métis health practitioners, clinicians, administrators, and academics, the Panel will advise Alberta Health on matters relating to Alberta's primary health care system that are affecting First Nations, Métis, and Inuit peoples in Alberta, and will recommend to the Minister of Health innovative approaches that could be implemented. • Members will identify: – issues, gaps, and barriers impacting Indigenous patient access to primary health care; – new or emerging activities, strategies and innovations to improve primary health care access for First Nations, Métis, and Inuit peoples in Alberta; – opportunities for creative partnerships and collaboration including with other service providers, public/private partnerships, and other orders of government; – indicators, performance measures and benchmarks to measure change, and ensure transparency, accountability, and continual improvement primary health care services; and – options and make recommendations on how primary health care initiatives could be successfully implemented to meet the needs of First Nations, Métis, and Inuit peoples. • Participate as required in engagement with Indigenous leadership and partners to gather advice and validate actions recommended by the Panel

[9] **The Indigenous Primary Health Care Advisory Panel led a separate MAPS initiative. Please see the recommendations report prepared by this Panel.*

International Expert Panel	• Provide advice based on experience and research outside of Alberta to help identify opportunities to improve PHC, models from other jurisdictions that could be effective, and other insights for consideration by the Strategy Advisory Panel • The Co-Chairs attend/participate in public announcements with the Minister of Health, as requested • Understand the current state of PHC in Alberta by reviewing data and evidence, and receiving presentations and documents • Participate in the Innovation Forum • Attend meetings over the course of the Panel's work, potentially including one or more joint meetings with other MAPS Advisory Panels • Leverage additional experts where necessary to explore topics in greater depth or understand the experience in other jurisdictions • Review and comment on draft Interim and Final Reports by the Strategic Advisory Panel

Overall Approach to Development of Recommendations

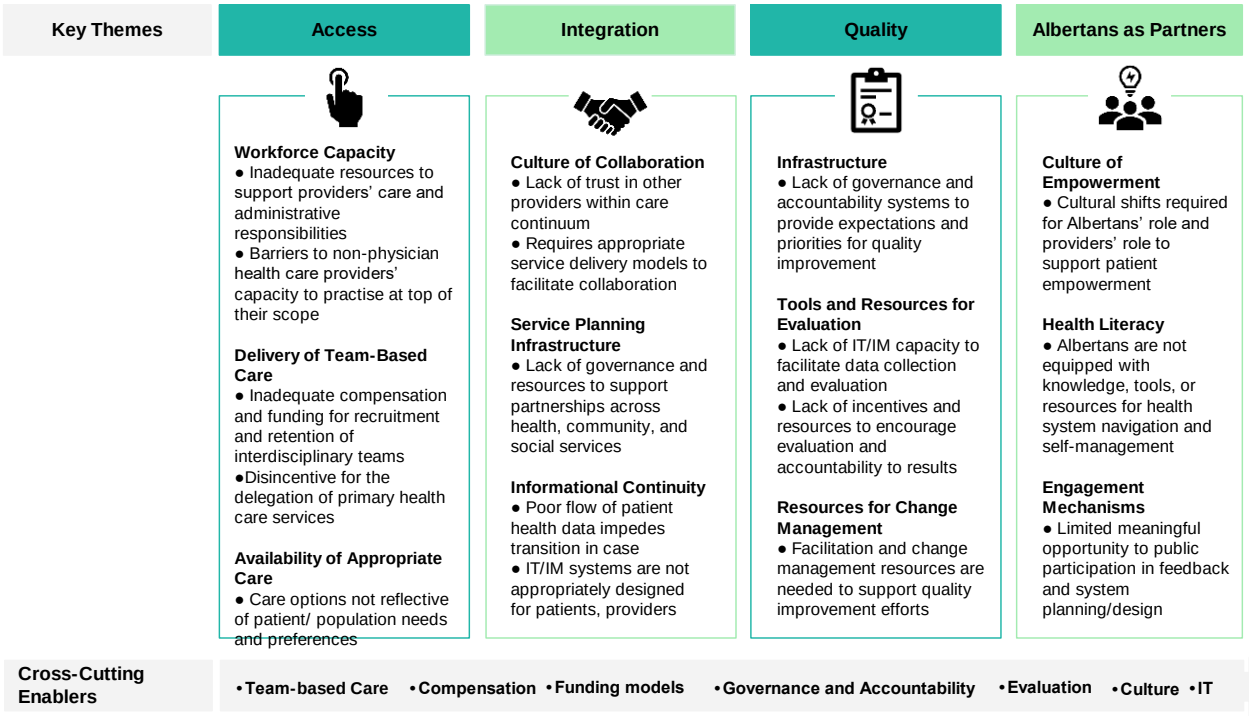
i. Stakeholder Engagement

a. Summary of focus groups and key informant interviews

Key informant interviews and focus groups served to engage leaders and experts with direct experience in primary health care and health systems improvement. This process drew on their expertise to examine and propose innovative improvements that will strengthen primary health care in Alberta. The objectives of the interview were to obtain participant perspectives on:

- Defining core issues for primary health care in Alberta
- Which early opportunities for action are most important to consider

39 interviews and focus groups were conducted with over 25 organizations and 122 stakeholders from across public and patient groups, health care partners, social and community organizations, and government. Some common themes emerged during these conversations, these are highlighted below.



b. Written submissions

A number of stakeholder organizations and groups were asked to provide their inputs via written submissions. This included organizations like the University of Alberta, University of Calgary, Alberta College of Pharmacy, College of Alberta Psychologists, Refugee Health Coalition and more. The intent of these written submissions was to gather stakeholder perspectives on:

- What the core issues are in Alberta's primary health care system
- Existing primary health care initiatives or pilots and their assessment of whether these can be scaled in Alberta (based on readiness, complexity, resources, timelines and costs)
- Potential immediate actions and long-term direction that are important to consider in achieving the outcomes outlined for the MAPS initiative

A total of 26 written submissions were received, which were used to inform the long-term recommendations within this report.

ii. Early Implementation

A key interim output of the MAPS initiative was a Portfolio of Early Investment Opportunities, which highlighted short-term, actionable recommendations to modernize Alberta's primary health care system.

Utilizing all engagement activities from the beginning of the initiative, the following sources were used to identify potential opportunities for early investment:

- Ministerial direction
- Stakeholder engagement (i.e. key informant interviews, focus groups, written submissions, Provincial Primary Care Network Committee workshop)
- MAPS leadership (including Oversight Committee)
- Alberta Health proposals
- MAPS initiative subject matter experts

Following the development of a list consisting of 65 potential early opportunities, steps were taken to shortlist initiatives, beginning with a comparison against preliminary triage criteria, which included:

- Out-of-scope
- Clear longer-term considerations
- Would require reopening of the AMA agreement
- Opportunity/initiative is being addressed through other tables/processes

Step one eliminated 21 identified opportunities. A high-level two-stage assessment was then completed by the MAPS Project Team and Strategic Advisory Panel to categorize

and prioritize the remaining 44 opportunities. The evaluation framework provided a preliminary assessment to prioritize proposals on the readiness for further consideration and analysis of each potential opportunity for investment. Stage one of the evaluation focused on short-term impact (e.g., alignment with Ministerial Direction and MAPS Outcomes, timelines of impact) and feasibility (e.g., infrastructure, human resources, readiness), while Stage 2 evaluation domains focused on key risk domains (financial, operational, political/reputation) and estimated cost.

This preliminary assessment also identified proposals that: indicate potential short-term impact and/or feasibility but require additional research or planning; require a business case or should be considered for long-term planning. The project team gathered and prepared summaries of the rationale and evidence, where available, for each proposed initiative.

After carrying out these evaluations, seven recommendations surpassed both stages and were put forward as final outputs of the report.

iii. Innovation Forum

On January 16 and 17, 2023, an Innovation Forum was launched as a part of the MAPS initiative. The purpose of this event was to identify, in concrete terms, the practical actions that will move Alberta's primary health care system forward. The Forum provided an opportunity to bring together citizens, patients, health care providers, community members, and policymakers. It intended to expand thinking around innovative ideas, leverage data-informed evidence to co-create solutions, and discuss potential actions for modernizing Alberta's primary health care system. Throughout the two-day event, there were speaker sessions and keynotes with the full group, in addition to working group sessions where attendees were divided into four groups to discuss central themes to the MAPS initiative: rural and remote communities, underserved populations, team-based primary health care, and Indigenous health and wellness. The vast array of

thought, perspective, and insight gathered throughout the Innovation Forum was used to help inform the recommendations described later in the report.

Key messages from the Innovation Forum[10]

There were recurring themes that emerged from the various discussions throughout Innovation Forum and across the different working sessions. It was broadly recognized that in order for transformative change to be realized, there are some significant and fundamental strategic and cultural shifts that have to be made in the province. These shifts and themes highlight the major challenges and opportunities that exist in modernizing Alberta's primary health care system for the future, making them a valuable input to the initiative's final recommendations.

At a high level, the six notable themes from discussion were:

1. Strengthening governance in primary health care
2. Redefining team-based care to support integrated patient-centric care
3. Facilitating intersectoral collaboration to address social determinants of health
4. Rethinking funding models to enable and sustain team-based care
5. Improving access to timely, appropriate care in rural parts of the province
6. Embracing technology-enabled care as a foundation

These messages played an important role in recommendations development by the Panel and are embedded throughout the rest of the report.

[10] The MAPS Innovation Forum Summary Reports can be found on the Alberta Health MAPS webpage at https://www.alberta.ca/modernizing-albertas-primary-health-care-system.aspx.

iv. Research and analysis

Primary and secondary research, including literature reviews and stakeholder engagement were conducted to better understand the current state of Alberta's primary health care system, its environmental context, and best practices in other jurisdictions. Secondary research efforts prioritized using information and studies done within the last ten years, based in Canada, ideally Alberta where possible; The Canadian Journal of Rural Medicine, the Journal of Rural Health, the Canadian Family Physician Journal, and the Journal of Interprofessional Care Research are notable data sources.

Alberta Health also submitted a significant amount of provincial data that underwent rigorous assessment and analysis. This contributed to the understanding of the current local context, and informed the future state discussed in this final report. External jurisdictional examples were selected based on context alignment to Canada such as population health care structure, and the relevance of their health care success to the MAPS initiative outcomes. The research and analysis of these topics has been completed to ensure data-driven and evidence-based recommendations. In addition, using a comprehensive research approach contributed to affirming their relevance and tangible value.

Appendix - D

Appendix D: Research, Analysis, Rationale and Considerations for Recommendations

Research, Analysis, Rationale and Considerations for Recommendation 1: Reform primary health care governance by strengthening and clarifying accountabilities

Alberta Primary Health Care Organization (APHCO)

Other Key Considerations:

- APHCO's structure should ensure that it has the appropriate independence to manage, operate, and fund according to its strategic priorities. Consideration should be made to delineate the agency's autonomy as well as its accountability to the Minister of Health.
- APHCO would be responsible for establishing a system of provincial monitoring and reporting of performance of the primary health care sector. APHCO may consider whether this function and responsibility should be housed inside of APHCO or be outsourced to an arm's length, independent entity such as HQCA.
- APHCO will support Alberta Health as it engages in intersectoral coordination and collaboration with other Ministries across the Government of Alberta that have relevance to primary health care and the social determinants of health, such as the Ministry of Seniors, Community and Social Services and the Ministry of Children's Services. Examples of potential collaboration could include developing shared priorities, integrating planning, exchanging performance data and jointly funding initiatives.

- The precise composition of the APHCO Board of Directors has not yet been determined, but guidance should be developed to ensure that its membership is representative of the broad set of stakeholder interests that are present within primary health care delivery in Alberta (including health care providers, public members, etc.).
- Implementation of APHCO would also very likely require the establishment of key working groups and an implementation coordination committee which would be directed by the APHCO Board to do the heavy lifting of setting up the structure and processes of APHCO. The exact composition of the implementation arm of the APHCO would need to be determined later during the earliest phase of implementation.

Transition from PCNs to New Governance Model

- It is important to ensure that PCNs are provided with clear and proactive communication and support to manage their transition into the new governance model.
- Support to the current PCNs will be pivotal to a successful transition. Some PCNs may be currently aligned in their infrastructure to expand their mandate and capacity, while others may merge, and new entities may come to form.
- A maturity model/roadmap to support this transition for PCNs will be important and should include transition support for the PCN workforce, service/program delivery (i.e., prevent loss of services in the transition between funding models or merging with other PCNs), and physicians currently enrolled in a PCN.
- The RPHCNs structure and activities will maintain several of current PCN functions, including:
  - Funding and operating specialized clinics where needed (e.g., chronic disease management, medication reviews, youth mental health).

  - Supporting quality improvement for PMHs by providing practice facilitators and supporting physician champions (health transformation workforce).
  - Providing supplementary clinical staff for the broader PMH team, shared network-level clinical resources and RPHCN operated clinics.

- With the evolution of the network model, these organizations will have expanded resources and structure:
  - Risk-adjusted capitation-based funding with flexibility to plan, coordinate, and allocate based on local needs.
  - Governed by a Board with representation of key stakeholders (e.g., health care providers, AHS, community organizations, social services, municipalities, public members).
- Depending on regional need and practice model, RPHCN responsibilities that would expand on the functions of today's PCNs include:
  - Responsible for ensuring primary health care services to unattached populations residing in the region.
  - Funding all or parts of practice infrastructure, administration roles, clinical leadership, health professional remuneration, change management and quality improvement.
  - Provide "backbone support" to health care providers, community organizations, social services, municipalities, and public members to facilitate integration across the IHN.
  - Provide appropriate support to ensure standardization, quality, and uptake of innovation across primary health care clinics.
  - Maintain bilateral accountability arrangements with PMHs.

Research, Analysis, Rationale and Considerations for Recommendation 3: Embrace citizens and patients as partners

People must be at the center of the province's primary health care transformation. Modernizing Alberta's primary health care system presents an opportunity for the province to embrace patients and citizens—and all people in Alberta—as partners in shaping the primary health care model of the future—one that is designed around their unique needs, and one they can be proud of.

Primary health care should be something that happens *with* people—not something that happens *to* them. People should be empowered to participate in, and manage, their own health care journey as the leader of their primary health care teams. They should have full and timely access to their own health records, culturally safe care, appropriate navigation supports, health literacy education, digital health and self-management tools, and clear communication channels. Citizens[11] and patients must be meaningfully seen and authentically valued as true partners at *every* level—in their own health team within a PMH, their health neighbourhood, and the broader primary health care system.

Albertans as Partners in their Patient's Medical Home (Patient-Provider Level)

All people interact with the primary health care system at some point in their life. This occurs at the point of care as a relationship with their primary health care provider from birth through to end of life. Relationships are based on personal interactions, where agency is held equally and based on mutual respect and trust.

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[11] Imagine Citizens Network uses the term "citizen"' to refer to all people living in the province of Alberta. While much of the rhetoric in health care talks of 'patient or person-centred' the term citizen is meant to be more inclusive of all aspects of an individual's life, including but by no means limited to their experience as a patient.

Citizens have varied interests in health and health care and sometimes not directly linked to personal

experience as a patient.

Based on the Commonwealth Fund 2020 survey[12] Albertans are not engaged in their care to the extent they want. This limits the development of a trusting relationship with their health care providers.

- 66% of Albertans reported that their regular provider always involves them as much as they want in decisions.
- 68% of Albertans reported that their regular provider always explains things in a way that is easy to understand.
- 55% of Albertans reported that their regular provider always spends enough time.

A continual provider-patient relationship is how primary health care adds value to a person's quality of life, and patients and their family caregivers should be viewed as equal partners and as a part of their own care team. Individuals experience their health every day, and thus, are the experts in their own symptoms and responses to treatment. The simple question of "*What matters to you?*" is the basis for identifying a person's health goals and expectations and how primary health care can (or can't) help them meet them. A person's life experience must be heard, valued and acted upon by the entire primary health care team—including community-based health and social service providers.

There are many ways to improve the patient and citizen role as a partner in their own health in a relational model. One way that has long been the basis of the patient-provider primary health care level of knowledge transfer is patient self-management of chronic health conditions. Effective chronic disease management services focus on supporting patients with building self-management skills and empowering them to monitor their symptoms and manage the impact that their condition has on them physically, emotionally, and socially. Patients who self-manage understand their condition and treatment options, and are actively involved in the development and evaluation of their care plan. Self-management support encompasses the actions and behaviors that others, such as health professionals and family, carry out to assist an individual with a chronic health condition to self-manage. It also links patients and their

[12] Commonwealth Fund, "2020 International Health Policy Survey of the General Population."

family caregivers to patient-oriented community resources to help patients and families to better cope with the challenges of living with chronic health conditions.

Another important example, particularly for people with vulnerabilities, is social prescribing, a holistic approach to health care that brings together the social and medical models of health and wellness. It provides a formal pathway for health providers to address the diverse social determinants of health, using the familiar and trusted process of writing a prescription. Social prescribing programs provide non-medical referral, or linking services, to help people identify their social needs and develop 'well-being' action plans to promote, establish or reestablish integration and support in their communities, with the aim of improving personal well-being.

Social determinants of health contribute up to 50% of overall health and wellness while health care is responsible for 25%.[13] A study in the UK suggests that 20% of patients consult their family physician for primarily social problems and 15% of patients visit for advice on welfare-benefits. [14] Locally, Alberta's family physicians are more likely to screen patients for social need, but less likely to coordinate with social services or other community providers when compared to the Canadian and Commonwealth Fund averages; only 39.7% providers frequently coordinate care with social services or other community providers, compared to the Canadian average of 42.8%.[15] Social prescribing enables deeper integration between clinical care, interprofessional teams and social support, and enhanced capacity of the community through co-creation.[16]

Alberta currently has a number of social prescribing models in place, for example:

- **Alberta PCNs' Prescription to Get Active Program**: An integrated partnership

[13] RIFS Infographic. Available at: https://actt.albertadoctors.org/health-system-integration/keeping-care-in-the-community/Documents/RIFS%20Infographic%20-%205%20Pages.pdf

[14] Wildman, J.M., Moffatt, S., Steer, M. et al. "Service-users' perspectives of link worker social prescribing: a qualitative follow-up study", 2019.

[15] Commonwealth Fund, "2020 International Health Policy Survey of the General Population."

[16] Social Prescribing in Ontario. The Alliance for Healthier Communities. March 2020

between primary care and recreation to support patients becoming more physically active through behavioural change[17]

  - Physicians and health care providers can participate as 'prescribers' to prescribe physical activity to promote participation in movement and exercise in the community, on-line and within recreation/fitness facilities to promote the importance of regular physical activity

- **Seniors Community Services Partnership + Community Connect, Lethbridge, Alberta**: SCSP is a partnership between six service organizations that support seniors in navigating health care and social resources, access financial benefits and housing, and provide emotional support and care for those with complex psychosocial needs[18]
  - Clients are referred to a lead intake worker, and are then assigned to a Senior System Navigator to create a care plan and link them to a community partner or to services at the Lethbridge Senior Citizens Organization. This SSN then provides ongoing one-on-one support up until discharge.
  - Community Connect is an outreach program that runs in parallel with the SCSP. The goal of this program is to conduct outreach to seniors who are experiencing isolation and loneliness, and provide them with social infrastructure and mental health resources.

Understanding patient experiences of care is a core component of continuous improvement of any health system. Today, Albertans leverage various formal and informal channels to share their experiences. These range from reporting patient feedback or concerns to their PMH, submitting a complaint to a professional licensing body, connecting with the Office of the Alberta Health Advocates, responding to surveys by provincial organizations like the Health Quality Council of Alberta or Alberta Medical Association[19], or even taking to social media. These channels can be complex, don't

[17] Prescription to Get Active. Available online. Link.

[18] Bridgeable. Social Prescribing in Canada. Available online. Link.

[19] https://www.albertadoctors.org/make-a-difference/patients-first/albertapatients

easily cross jurisdictions, and are not always transparent or easy to access.

Albertans as Partners in their Integrated Health Neighbourhood

At the local level, responsive primary health care is about fulfilling the diverse needs of communities. In practice, this can be realized by deepening relationships between care providers and communities within an IHN, and building partnerships between them. Creating opportunities for a robust feedback mechanism that leverages feedback from all people in the community can help ensure that services are culturally appropriate and reflect the unique health and social needs of that community.

Traditional health care systems rely heavily on patient care surveys. For example the HQCA surveys patients about their experience with the primary health care system through the Primary Care Patient Experience Survey[20]. While providing insightful and sometimes useful information, surveys are often too rigidly structured and narrowly focused and may not be timely, which means they can fall short of effectively capturing the very real stories of patient experiences. Moreover, there is rarely a feedback loop to track any changes or improvements that have been made as a result of someone reporting their experience. Likewise, where positive feedback is shared by patients, there is rarely a system-wide mechanism for recognizing, and building on, those strengths.

This means that despite best intentions, even when patient input is collected using a validated tool and intended for quality improvement, it may not actually be contributing to learning or improvement efforts for health care providers (who value and rely on timely information for clinical and care decisions) and for health systems (who value and rely on data and information to monitor performance and make evidence-informed policy decisions).

[20]https://hqca.ca/resources-for-improvement/surveying-patients-about-primary-care-experience/

Albertans as Partners at a System and Policy Level

There are unique challenges facing the province's broader system level, including the health literacy of the population and the public's ability to navigate the health system. Having access to information and knowing how to navigate the province's health care system—independently and/or with support—is critical to accessing quality care in a timely manner. Challenges in navigating the system often arise during transitions, when managing chronic illness or disability, or in personal or public crisis situations, such as the COVID-19 pandemic. When people lack the ability to effectively navigate the system, it can have negative impacts on the quality, safety and timeliness of care they receive, and their interactions with their care team and the health system as a whole. These navigation challenges are typically more pronounced with newcomers and ethnocultural groups, marginalized populations, and rural and remote communities—making these populations less than ideally served by the primary health care system.

Today, patient navigation and health literacy is hindered by a lack of:

- *Meaningful engagement:* It is not uncommon for service providers or even support organizations to narrowly focus their health promotion or health literacy initiatives to creating and circulating health information.
- *Understanding of peoples' and communities' complex needs:* Most people, including racialized communities, rely on their health care provider as the primary source of health information. However, health care providers may not have a deep understanding of the unique needs, including the cultural needs, of the people they are serving.
- *Alignment with community needs:* Efforts to promote health literacy cannot be treated as a one-off. Without proper engagement and coordination, efforts are not always aligned with community needs, which reduce their efficacy. Collecting qualitative and quantitative data could unlock insights (e.g., on access to quality care and social determinants of health) to inform policy responses and approaches to service delivery.
- *Coordination between programs and services:* There are many well-meaning service

providers who provide advice to people about how to access the services they need. This is often done in isolation of each other without expectations or the capacity to collaborate to optimize support for people navigating the system. This can be confusing and frustrating for everyone.

Efforts are underway to address these and other system navigation and health literacy challenges. For example, PCNs in Alberta have joined forces to offer a Alberta Find a Doctor directory[21]. The Imagine Citizens Network (ICN)—an Alberta-based network of people and community-oriented partners that offers collaboration pathways to deliver person-centered healthcare—had partnered with Alberta Health and others to develop iKNOW Health[22], online and resources to help Albertans independently navigate the health care system and advocate for themselves. ICN and others with a like-minded mission are building a trusted network of ICN Connectors[23] to support people and communities to overcome health navigation and advocacy challenges, share knowledge and information, and address the barriers hindering Albertans' health literacy.

Experiences from Other Jurisdictions:

- During COVID-19, the Association of Family Health Teams of Ontario extended the use of the interRAI Check-Up self-assessment tool to primary health care practices to help identify people with complex health and social needs who might be especially vulnerable and require more urgent or comprehensive care.
- Participants in the Alliance for Healthier Communities' research pilot in Ontario reported a 49% decrease in loneliness, 12% increase in mental health outcomes, and

[21] https://albertafindadoctor.ca/

[22] https://myhealth.alberta.ca/iKNOW-Health

[23] https://imaginecitizens.ca/iknow-health/

a 19% increase in engaging social activities.[24]

- A study of UK social prescribing programs found that participants saw a 14% decrease in emergency department visits and 40% decrease in family physician visits, resulting in a 20.8% reduction in costs to the health care system.[25]
- Care Opinion[26] is an innovative online platform created to provide a mechanism for patients and families to share their experiences when seeking or receiving health-related services and where care providers can respond in a two-way fashion. Originally created in 2005 in the United Kingdom (UK), the platform has been invested in and scaled across England, Ireland, Scotland, Northern Ireland, and Australia. Care Opinion is run as a not-for-profit, subscription based service. The founding philosophy is citizen-led care improvement and seeks to advance patient-centred care by enabling transparent sharing of knowledge gleaned through lived experience. Research and evaluation is a major component of Care Opinion in both the UK and Australia for both patient and provider experiences. Targeted research has also been done exploring the impact of Care Opinion on strengthening relationships between patients, the public and the health care delivery organization or care team. Research on the impact of Care Opinion has identified that high quality responses to patient stories can act as drivers for organizational learning, quality improvement and patient empowerment[27].

[24] Social Prescribing in Ontario. The Alliance for Healthier Communities. March 2020

[25] Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities, British Journal of General Practice, November 2018

[26] https://www.careopinion.org.uk/

[27] Baines R, Underwood F, O'Keeffe K, Saunders J, Jones RB. Implementing online patient feedback in a 'special measures' acute hospital: A case study using Normalisation Process Theory. DIGITAL HEALTH. 2021;7. doi:10.1177/20552076211005962

Research, Analysis and Rationale for Recommendations #4 & 5: Ensure every Albertan has a Patient's Medical Home that is connected within an Integrated Health Neighbourhood

Recommendation # 4: Accelerate efforts to ensure every person in Alberta can be connected to team-based primary health care using patient medical home principles

Recommendation # 5: Systematically connect every patient's medical home to a broader health integrated neighbourhood to enable whole of person care

Primary health care requires more than just having the ability to schedule and go to an appointment. There are many other factors regarding accessibility of care, including access to team-based approaches, access to diverse types of primary health care, advanced access, virtual access, and continuity of care to ensure patients can be seen by the most appropriate provider when they need to be seen.

The PMH is a primary health care model defined by enabling patients to access primary health care from a diverse, integrated team of care providers with resources and support required to meet their medical and health goals over their lifetime. It is based on the premise that family physicians, nurse practitioners and their colleagues in other health professions work together to provide comprehensive, continuous and compassionate care when and where it is needed to meet the health needs of the population they

serve. The panel envisions that all PMHs in Alberta aim to achieve the pillars of the PMH as described by the College of Family Physicians of Canada[28] .

This vision is built on the principles of collaboration and teamwork including the patient's participation in their care alongside interprofessional primary health care teams supported by the appropriate infrastructure and policies. The trusting relationship built with patients over time can produce better health outcomes. A growing body of evidence demonstrates that these models of care lead to better care, decreased costs to the healthcare system and higher satisfaction for both providers and patients.

Primary health care begins in the community and in order to be effective it must be connected to the community. Just as each community has different needs and assets, integrated health neighbourhoods will also vary in form. This is especially important for people with complex needs that cannot be addressed by physicians or primary health care teams alone. The future primary health care system in Alberta should be based on PMHs for every person, supported by well-established health neighbourhoods.

Access to team-based primary health care in Alberta today is a challenge

Access to primary health care providers and services is a critical challenge. Approximately 13% of Albertans reported they did not have a regular health care provider in 2021[29]. The number of Alberta doctors accepting new patients dropped by half — from 907 to 446— between May 2020 and January of 2022, according to data provided by the primary health care networks.

The challenges with regular access to primary health care providers is having impacts on other parts of the healthcare system and on individual health. An HQCA survey conducted in November 2022 revealed that:

- 46% of respondents without a regular family physician sought healthcare through other channels

[28] The College of Family Physicians of Canada, Patient Medical Home, https://patientsmedicalhome.ca/

[29] Statistics Canada, "Canadian Community Household Survey," 2021

- 46% went to a walk-in clinic or medi-centre for care,
- 27% spoke to a pharmacist and
- 22% sought care at a hospital or an emergency room.

This data suggests that even connected patients don't have access to primary health care when and how they need it. Rural Albertans experience a lack of after-hours services, including community support, and often must rely on emergency departments to access care.

Team-based care can be effective in addressing common challenges and reducing downstream negative impacts to the health care system and patients. Analysis of data from over 400,000 patients in Alberta and found that team-based care was associated with a number of positive outcomes. Specifically, the study found that patients in team-based care had:

- A 5.9% lower likelihood of being hospitalized
- A 7.9% lower likelihood of visiting the emergency department
- A 9.4% lower likelihood of being referred to a specialist
- Better blood pressure control, with a 1.4% absolute reduction in the percentage of patients with uncontrolled blood pressure
- Improved management of chronic conditions, such as diabetes, with a 1.8% absolute reduction in the percentage of patients with uncontrolled diabetes

Patients not connected to a PMH experience a broad range of health impacts including an increased burden to manage their own care, increased patient costs, lack of medical follow ups, lack of access to prescriptions and referrals, incorrect, missed or delayed diagnosis and condition specific health impacts[30].

The Rural Sustainability Primary Care Task Force identified a number of barriers to

[30] Marshall, Emily & Wuite, Sara & Lawson, Beverley & Andrew, Melissa & Edwards, Lynn & MacKenzie, Adrian & Woodrow, Ana & Peddle, Sarah. (2021). What do you mean I can't have a doctor? This is Canada! - The myriad of consequences for unattached patients: health outcomes, mistrust, and strategic efforts to self-manage health and gain access to primary health care. 10.1101/2021.07.07.21260143.

primary health care access in rural communities. These barriers are multifaceted and include geographic remoteness, transportation, long distances, low population densities, less availability of a range of health services providers, and inclement weather conditions[31].

Other primary health care service delivery design, planning, and community involvement challenges include:

- A lack of essential and comprehensive primary and acute care services and infrastructure,
- Limited availability of inter-professional health care teams
- An absence of decision making processes that effectively address barriers to accessing health services in rural areas[32]

The patient's medical home being effectively integrated with the health neighbourhood is critical

A study, published in the Journal of Interdisciplinary Care in 2020, analyzed data from over 18,000 patients in Alberta and found that health neighbourhoods were associated with improved access to care and increased patient satisfaction. Specifically, the authors found that:

- Patients in health neighbourhoods had a 23% higher likelihood of having a same-day or next-day appointment with their primary health care provider
- Patients in health neighbourhoods had a 12% higher likelihood of rating their primary health care provider as "excellent"

[31] Provincial Primary Care Network Committee. (2022, March). Rural Sustainability Primary Care Task Force Recommendation Report.

[32] Rural Health Services Review Final Report, March 2015. Rural Health Services Review Committee. Government of Alberta

- Patients in health neighbourhoods had a 15% higher likelihood of reporting that their care was coordinated across different levels of the health care system

Professional siloes, unclear roles and responsibilities, and power dynamics between health care disciplines create additional barriers to effective coordination:

- 17% of Albertans reporting conflicting information from different healthcare professionals and
- 27% report their regular doctor not being fully informed about care received from specialists.

Intersectoral collaboration between government agencies is also lacking, with a lack of co-investment in programs and services that address social determinants of health and improve health outcomes for people and communities.

Continuity of care

Continuity of care is critical to providing comprehensive care for a patient throughout their life. The current primary health care system (physicians and non-physicians) is made up of a cottage industry of individual businesses and organizations with fragmented funding models. Beyond family physicians, the current model of primary health care in Alberta makes it challenging to find and navigate between health, social, and community services and providers—this has become increasingly frustrating and confusing for Albertans.

The current primary health care system is composed of individual businesses and organizations:

- 42% of Albertans report their regular provider arranging care from other providers or specialists.
- 40% of Albertans stating that their provider does not frequently coordinate with social and community services that address health and well-being needs

Alberta case studies

There are several examples in Alberta of clinics that function consistent with patient medical home pillars, including being well integrated with other health care and social services. Examples include Community Health Centres, Family Care Clinics, University Department of Family Medicine clinics, and several clinics that have moved to non-fee for service compensation models to enable greater team-based care. While there certainly are examples of clinics where physicians are compensated on a fee for service basis and deliver high quality, integrated care, this is also often cited as a barrier.

While more research within Alberta would be very helpful, one evaluation of Taber Clinic (TC) and Crowfoot Village Family Practice (CVFP) concluded that both clinics provide comprehensive, cost-effective care that creates value for the health system. The primary and community care services delivered by the two clinics are more expensive than their rural and metropolitan peers. However, under the capitation-based ARP, both clinics have been able to use a team-based practice model that offers more cost-effective care, particularly when downstream health system costs such as emergency department use and inpatient hospital stays are considered. In 2016-17, the practice models delivered by TC and CVFP realized health system cost savings of $7.2 million and $4.3 million respectively.

Research, rationale and analysis for recommendation 6: Reduce the financial risk of clinic ownership and administrative burden

Primary health care providers today spend a significant amount of time on administration related to patient care activities, managing medical records and patient information, managing referrals, and meeting administrative requirements through PCN and research related activities. And for many clinic owners, there is an added burden of managing "the business" of primary health care, including the cost, labor and risk involved in opening and owning a clinic. Administrative burden on physicians and other healthcare professionals is proven to have a negative impact for patients, providers and the broader health care system:

Administrative burden on physicians and other healthcare professionals is proven to have a negative impact for patients, providers and the broader health care system including decreased time for providing primary health care services, negative impacts to patient outcomes, increased stress and burnout, decreased efficiency and increased costs.

Investments into interventions and providing standardized infrastructure and support targeted at reducing both clinical and operational administrative burden is a key enabler to unlocking significant overall improvements to the primary health care system including improved patient outcomes, increased capacity to care for patients, reduced overall system costs and improvements to provider experience.

Impact of reducing administrative burden

In recent years, numerous studies have described a physician workforce increasingly experiencing signs of burnout. It is a common perception that burnout is the result of working many long days for an unsustainable period of time, but the evidence on burnout makes clear that this is a relatively small contributor to burnout. Burnout is

defined by symptoms of emotional exhaustion, depersonalization, and a low sense of personal accomplishment at work.

Burnout is the most commonly reported and consistently measured form of psychological distress and studies have shown that it affects between a third to over half of the physicians in North America. Providing care to patients and running the operational aspects of a clinic both contribute to administrative burden, which is seen as a significant contributor to burnout among Canadian physicians. Larger integrated healthcare systems in the US, for example, have the capabilities and scale to develop tools that not only improve the quality of referrals and communications to patients, other providers and third parties but which also make production of these important clinical outputs much more efficient.

In addition to the development of standardized tools for clinical administration, support could be developed to assist physicians in streamlining some of the business and operational tasks associated with running their practices. Physicians operating in proper group practices benefit in many ways. Among those benefits is an ability to share the burden of operational administration. The scale of a physician group can make employing administrative staff cost-effective, permitting the physicians to devote less time to this work and invest more of their time in providing services to patients, producing both more revenue and more satisfaction.

Investing in these tools can also make it more straightforward and safer for the physician to delegate much of these tasks to others, requiring a standardized set of inputs to be handed off to an administrative support staff who can then produce the documentation.

Impact of care related administrative activities and EMRs on Providers

In a 2017 study[33] analyzing the influence of EMRs on physician burnout found a strong connection between care related activities and EMR usage:

- 37% of practicing physicians were experiencing at least one symptom of burnout
- 75% of these individuals attributed EMR as a contributor to their burnout

A study published in the Journal of the American Medical Association found that for **every hour spent on EHRs, physicians reported a decrease in overall satisfaction with work-life balance of about 6%** (Journal of the American Medical Association).

A number of care related administrative pressures have been identified[34] to drive poor job satisfaction and increased levels of burnout in care providers including:

- Pressure to document
- The stress associated with documentation
- The lack of time allocated for documentation

Administrative burden relating to care activities or operations is time that is spent away from working with their patients and teams to meet healthcare needs and is contributing to negative impacts to patient outcomes, increased burnout and workload for providers, and increased overall health system costs.

Impacts to patients

Administrative burden can have negative impacts on patient outcomes both directly and indirectly. Administration is driving increased workload for care providers which contributes to burnout and decreased quality of care. There is a clear connection between high administrative burden, increased overall health care costs and negatively

[33] Robertson SL, Robinson MD, Reid A. Electronic health record effects on work-life balance and burnout within the I3population collaborative. *J Grad Med Educ* 2017;9:479–84. 10.4300/JGME-D-16-00123.1

[34] Gesner E, Gazarian P, Dykes P.. The burden and burnout in documenting patient care: an integrative literature review. *Stud Health Technol Inform* 2019; 264: 1194–8.

impacted patient outcomes. Conversely there is a clear connection between reduced administrative burden and improved patient experience and outcomes.

- **Physician burnout is associated with higher healthcare costs and lower quality of care.** A study found that physician burnout was associated with a 2.6-fold increase in the odds of a patient experiencing a medical error and a 2.3-fold increase in the odds of a patient being admitted to the hospital (Annals of Internal Medicine).
- **Reducing administrative burden has been shown to lead to improved outcomes for patients.** A systematic review published in the Annals of Family Medicine found that interventions aimed at reducing administrative burden were associated with improved patient satisfaction, decreased physician burnout, and increased efficiency.

Examples from other jurisdictions:

The following models can be tailored to provide a blueprint for how investments into infrastructure and support can be made to improve patient outcomes, reduce provider workload and burnout and reduce costs to the broader health care system by providing standardized infrastructure and support packages to primary health care providers.

Nova Scotia, Canada

In Nova Scotia, there are three different types of contracts available for General Practitioners to operate or be involved in Collaborative Family Practice Teams (CFPT) (Nova Scotia Health, 2021). These different contract types include varying levels of support:

- **Turn-key model:** Nova Scotia Health (NSH) manages clinic activities, provides clinical team members, and sets up all infrastructure and activities. Participating family physicians pay overhead to NSH.
- **Co-leadership model:** NSH provides clinical team members employed by Nova Scotia Health and provides some funding for overhead costs (e.g., supplies, start-up equipment).

- **Contracted services model:** NSH provides funding to hire team members and operating costs and is involved in monitoring performance and accountability.

This model may provide a blueprint that can be tailored to provide a blueprint for how investments into infrastructure and support can be made to improve patient outcomes, reduce provider workload and burnout and reduce costs to the broader health care system by providing standardized infrastructure and support packages to primary health care providers.

Kaiser Permanente, USA

Through the KP model, primary care and specialist care is delivered through medical centres (734 medical offices) that comprise group of interprofessional physicians (23,656 physicians – general practitioners and specialists) and medical staff (65,005 nurses, 75,000 allied health professionals) (Kaiser Permanente, 2022) . Most KP health facilities (e.g., physician offices, hospitals, labs,

pharmacists) are co-located (Kaiser Permanente Institute for Health Policy, 2022) . Kaiser is internationally regarded as an integrated system of care comprising coordinated inpatient and outpatient care through its hospitals and medical centres in each region.

Existing market supports

There are already several independent providers of back-office support in the marketplace that can be utilized to reduce practice administration by providing administrative, billing, and medical staff to reduce administrative burden by handling scheduling, invoicing, IT/EMR, medical support, premises, supplies, and other tasks.

Research, rationale and analysis for recommendation 7: Invest in quality, safety and innovation capabilities and capacity as a strategic priority within the primary health care system

Quality, safety and innovation should be seen as a core part of everyone's job—to care and to improve care. Empowering people with the knowledge, skills, tools and support for quality and safety improvement and innovation can improve employee engagement and wellness, combat burnout, and create joy in work. Quality, safety and innovation programs have been shown to increase patient and provider satisfaction, optimize care processes and improve health outcomes by enabling participants to share experiences, test new ideas, accelerate learning and spread best practices. Systematic reviews of quality, safety and innovation strategies to change providers' behavior or improve care processes have shown improvements in wait times, continuity of care, screening, patient self-management, care processes, chronic disease management and health outcomes when compared with no intervention. These programs—ideally including the entire primary health care team—use data to assess and improve practice, evaluate the quality of services, and measure outcomes. The results are shared with people in ways that matter to them, including funders, leaders, physicians and primary health care teams, and patients and communities.

Many organizations and groups currently have an active role in quality, safety and innovation in primary health care Alberta, including the HQCA, AHS, PCNs, AMA, CFPC, PLP, [RS1] Alberta Innovates and the health professional and medical regulatory colleges. These groups have established many notable collaborations and directed coalitions to develop and implement provincial quality, safety and innovation initiatives, and to spread and sustain them. Some of these examples include:

- **Improving access and quality measurement:** Established in 2007, Alberta AIM (Access Improvement Measures) introduced the provincial Practice Management Program (PMP) that helped build the groundswell of interest in quality and safety in

primary health care. It was initially directed at primary health care office practice redesign and the AMA established the role of Improvement Facilitator to help support physicians and their office staff with change and improvement efforts. In 2014, AIM was expanded to support panel management efforts, in partnership with the HQCA and PLP, and to support capacity building for quality improvement with implementation of the AMA's Towards Optimized Practice (TOP) clinical practice guidelines. In 2018, the previous AMA PMP and TOP, and the PCN Program Management Office (PCN PMO), were merged to create the AMA Accelerating Change Transformation Team (ACTT)[35]. ACTT's mission is to enable system transformation focusing on the "patient medical home" and health neighbourhood. An important priority initiative for ACTT is Community Information Integration – Central Patient Attachment Registry (CII-CPAR)[36] to improve continuity of care for patients between their PMH, primary health care team, and the broader health neighbourhood.

- **Improving health promotion and prevention in primary health care:** Personal risk factors contribute to about 4 in every 10 cancers in Alberta and many other conditions including dementia, cardiovascular disease, diabetes, and stroke. Primary health care providers and teams play an important role in advising and counseling patients and their families on how to modify these risk factors and improve health. Building on the success of Alberta Screening and Prevention (ASaP) in Primary Care Networks (PCNs) across Alberta, ASaP+[37] has been designed to support primary health care teams and PMHs with ongoing quality improvement efforts in addressing modifiable risk factors including active tobacco use, alcohol consumption, physical inactivity, nutrition and obesity. The intent of ASaP+ is "to address the most

[35] https://www.albertadoctors.org/services/programs/actt

[36] https://actt.albertadoctors.org/CII-CPAR/cii-cpar-primary-care/Pages/CII-CPAR-for-Primary-Care.aspx

[37] https://actt.albertadoctors.org/PMH/organized-evidence-based-care/asap/Pages/default.aspx

important screening interventions, for most people, most of the time", meaning the health conditions that contribute to more than three-quarters of all deaths.

Quality and safety improvement in patient's medical homes

Every PMH and its team members need to feel agency to address issues that are impacting quality of care for their patients. They need capacity and time to address the issues that matter most to staff and patients, and to be aware of and supported by the provincial coordinating body or agency to adapt and implement quality improvements at a local level. This means that every PMH and primary health care team members has:

- A designated physician or NP leader to champion primary health care quality and safety improvement, with protected and paid time to do this;
- Access to dedicated practice/change facilitators or improvement coaches to help with ongoing quality and safety improvement activities and processes;
- Easy to access, real time patient-level data and data analysis for clinical quality improvement initiatives;
- A community of practice and other connected opportunities to network, learn and share with peers and other teams on topics of common interest
- Regular quality improvement, change management and leadership training and education, and timely practice resources; and
- Access to quality and safety experts at a regional or provincial level to assist when needed.

Quality and safety improvement in integrated health networks

Every IHN should have the agency to address issues that are impacting quality and safety within their community. They should share a mindset and knowledge base around quality and safety appropriate to the current pressures and priorities. This means that every IHN has:

- Community-level data and analysis to look for gaps in health and wellness that might be addressed through collaboration and coordination with other community health and social service providers;
- Opportunities for team-based quality improvement education and training; and
- Connections with other IHNs to share and learn from the experience and approaches of others facing similar challenges or working on similar initiatives, including cohort-based learning and improvement collaboratives.

Quality and safety improvement in regional primary health care networks

Every RPHCN should have the capabilities and capacity to support the improvement efforts at the PMH and IHN levels. RPHCNs should be able to identify gaps and desired improvements relevant to their context and geography and have the ability to help PMHs and IHN's set an improvement agenda. To achieve this Regional Networks must have:

- Quality as a strategy built into their business plans and show how quality, safety and innovation is supported;
- Robust aggregated data at regional and community levels to inform and monitor the quality and safety improvement priorities;
- Designated quality and safety clinical and administrative leadership dyad partners whose primary responsibility is connecting and supporting PMHs and maintaining local communities of practice;
- Support innovation testing by identification of sites with readiness to test innovations in primary health care delivery and funding them to do so;
- Fellowship-level health researchers (knowledge translation, implementation science, evaluation, health services and policy) embedded into the network; and
- Expectations and capacity to publish and share data and outcomes provincially and beyond.

Quality and safety improvement at a provincial/system level

At a provincial level, the APHCO will be mandated to set the provincial quality and safety strategic directions, in alignment with direction from Alberta Health. This includes organizational policies and supportive infrastructure to execute provincial priorities. Provincial leadership for quality and safety will reside within APHCO, however, PHIC will also serve as a coordinating body to ensure collaboration between APHCO and AHS on shared priorities and targets. Provincial-level capacity for quality and safety improvement must ensure that:

- APHCO sets the strategic direction and enabling policies. This includes the establishment of a provincial quality and safety framework based on Alberta's Quality Matrix for Health[38];
- PHIC is mandated to convene provincial stakeholders to establish and monitor annual priorities, measures and targets;
- APHCO leadership is trained and skilled in quality and safety and can incorporate quality and safety into planning and implementation; and
- Interprofessional team training and education resources related to quality and safety are accessible to all levels of the APHCO and the RPHCNs.

An executive leader is given accountability and authority for quality and safety improvement, with a dedicated team of improvement advisors with deep knowledge and abilities to support all levels of the organization, where needed.

Key considerations for implementation

Enabling grassroots quality and safety improvement and innovation within patient's medical homes:

Provincial coordination, accountabilities and authority are needed for the success of this strategy, however, quality and safety improvement and innovation happens locally. This

[38] https://hqca.ca/about-us/our-mandate/the-alberta-quality-matrix-for-health/

means that local primary health care teams and providers need support in their practice to leverage best evidence in their clinical and administrative practices, and to monitor and improve their performance and results. Coaching and practice facilitation is well-established in Alberta, and needs to be invested in so that quality improvement facilitators and coaches are directly embedded in PMHs as valued and consistent team members.

Quality and safety improvement is also about learning and sharing. Beyond a PMH, local communities of practice can be supported within an IHN, ideally with infrastructure and leadership from the RPHCNs. A deliberate investment in communities of practice based on quality improvements and shared learning is essential, particularly in rural and remote communities, to address workforce challenges.

Capacity required from existing stakeholder groups and/or in-depth system involvement for implementation:

Prioritization of primary health care quality and safety improvement initiatives could initially be identified and funded through the AMA ACTT, building on their capacity for and experiences with previous initiatives in both rural and urban settings. The ACTT are connected with the current PCNs and have zonal Physician Champions and Project Physician Leads who support the design, testing, and implementation of initiatives. In-depth involvement of the AMA ACTT will be required at the outset of establishing the integrated, interdisciplinary quality and safety improvement agenda.

Capacity is required from PCNs for the facilitation of quality and safety improvement initiatives. PCNs would be required to identify quality and safety improvement needs and establish additional resources to provide practice-specific support for quality and safety improvement activities. Resources may include hiring, training, and developing practice facilitators, and establishing funds/stipend for physicians' participation in prioritized quality and safety improvement activities. Capacity is required from the physician and their clinic team to undertake the work associated with quality and safety improvement activities, even with support from practice facilitators

Research, rationale and analysis for Recommendation 8: Establish a comprehensive primary health care workforce strategy aimed at building and sustaining a diverse workforce who are supported in providing team-based care across the province

Supply of health care providers in Alberta

Between 1990 and 2020, the supply of family physicians in Alberta increased by 38%, which represents the second highest increase in Canada after British Columbia. On the face of it, this is a positive development. However, during the same period, the total population of Alberta grew by 73%, which resulted in a per capita decrease of family physicians in the province. Compounding this per capita decrease of family physicians is a shrinking of comprehensive family physicians relative to the province's population growth. The overall proportion of family physicians in Alberta compared to all physicians has also steadily declined from 51% in 2013 to 49% in 2022[39].

Beyond family physicians, the supply of other care providers in Alberta varies by discipline. The current overall ratio of non physician team members to physicians in PCNs is less than one interprofessional team member for every two PCN physicians. The province has a lower supply of Physician Assistants and Nurse Practitioners compared to other provinces in Canada (it is ranked third and fourth, respectively). Moreover, Alberta is ranked second (after Saskatchewan) for the supply of pharmacists (including acute care and primary care). As of January 1, 2023, there were 4,137 pharmacists and 780 pharmacy technicians practicing in community settings and 1,631 community pharmacies in Alberta[40].

While these rankings are helpful for understanding Alberta's workforce relative to other provinces, they do not consider if the workforce supply is adequate for meeting the

[39] Canadian Institute of Health Information (Health Workforce Quick Stats Data Tables)

[40] National Association of Pharmacy Regulatory Authorities: https://www.napra.ca/resources/national-statistics/

health care needs of the population. Moreover, reliable data may not be readily available on the services (e.g. comprehensive care) these providers are delivering or the settings (e.g. primary care versus hospital) in which they are practicing.

Supply of care providers in Alberta

Type of Care Provider	Total in 2012	Total in 2021
Family Medicine Physicians	4,326	5,423
Physician Assistants	0	55
Nurse Practitioners	306	633
Pharmacists	4,235	5,814
Population of Alberta	*3,874,548*	*4,443,773*

While the supply of family medicine physicians has increased on pace with population growth over the long term, this masks the challenges with per capita supply of family medicine providers since 2018 and the distribution of providers across the province.

Over the past three years, there has been a small decrease in the overall number of family physicians practicing comprehensive family medicine in Alberta (approximately 120) while the population has grown by approximately 150,000. The impact of this misalignment of physician and population growth is an overall decrease in family physicians practicing comprehensive family medicine per 10,000 from 7 to 6.5.

Distribution of Health Care Providers in Alberta

An analysis of the supply of health care providers in Alberta must account for the distribution of those providers across the province. There is considerable disparity in the

distribution of physicians in Alberta. For example:

- The supply of family physicians ranges from 90 physicians per 100,000 people in the North Zone to 142 physicians per 100,000 people in the Calgary Zone
- The North Zone ranks 89 out of 98 total health zones nationally in terms of the number of physicians per 100,000 people compared to the Calgary Zone, which ranks 38

Access to physicians in rural and remote communities has been a long-standing challenge for the province's primary health care system, and the supply of physicians in rural and remote communities has remained consistently low.

Rural and remote health zones in the province have been impacted more significantly than others by the decrease in supply. Edmonton and Calgary health zones have seen an increased median FTE of family physicians from 2012 to 2022 from 0.63 to 0.69 and 0.7 to 0.74 respectively. At the same time, the South zone median FTE of family physicians has decreased from 0.74 to 0.65 and the North zone has fallen from 0.61 to 0.55. Central zone has remained steady at around 0.6 median FTE of family physicians.

As of 2021 only 12.5% of family physicians practiced in rural regions despite 19% of the population living in rural and remote communities. Nurse Practitioners are even less equitably distributed across the province. In 2021, rural and remote communities in Alberta accounted for only:

- 6.8% of Nurse Practitioners
- 15.4% of Licensed Practical Nurses
- 11.5% of Pharmacists
- 7.3% of Physiotherapists

A 2018 study published in the Canadian Journal of Rural Medicine revealed that having a rural background is a major predictor of rural practice location for family medicine residents in Canada. The study surveyed family medicine residents in their final year of training and found that 63.3% of students with a rural background intended to practice in a rural community compared to only 9.7% of students with an urban background.

Another study published in the Rural and Remote Health Journal in 2019 found that rural students who participated in rural exposure programs during medical school were more likely to choose a career in rural medicine and to return to rural areas after completing their education. The study surveyed medical students who participated in a rural exposure program and found that 70% of participants were interested in rural medicine compared to only 47% of the general medical student population.

Recruitment and Retention

The supply of health care providers in Alberta is informed by the number of candidates the province graduates every year that can be recruited into medical professions.

Alberta graduates students from a variety of health care programs in post secondary every year, the retention of these care providers in the province remains a challenge:

- Only 62.7% of family physician graduates (2015-2019) from Albertan institutions registered in Alberta in 2021 (18.3% registered in BC while 14.5% registered in Ontario)[41].
  This is lagging retention of new family physician graduates in BC (78.1%), Ontario (84.7%), Quebec (74.4%) and Manitoba (72.2%)

- 89% of Registered Nurse graduates (2017-2021) from Albertan institutions registered in Alberta.
  This lagging BC (97.6%), Ontario (96.1%), Manitoba (94.7%), Saskatchewan (90.8%), Nova Scotia (91.5%), Quebec (98.2%), and Yukon (100%)

Even after practitioners have been recruited into primary health care roles, it is not uncommon for the province to experience high workforce turnover. This turnover is

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partially driven by burnout, which is caused by the pressures of working in relatively small teams that are responsible for delivering care to entire communities.

Compared to larger urban or suburban centers, care providers in rural and remote communities are more likely to experience limited support and resources, including infrastructure, equipment and technology, and people. This can make the practice of medicine and other health professions more difficult and less appealing. For example:

- The shortage of other primary health care providers as part of a team-based care approach contributes to the workforce challenges experienced by practitioners in rural and remote settings. If there is a robust team-based approach, recruitment and retention of the various roles becomes easier because the job is more sustainable, less isolated, and more fulfilling for members of that team. The more the province can reduce the concentration of pressure and distribute care to an organized and coordinated network of care providers, even in small communities, the more attractive these communities will be to start and sustain a career.
- Unreliable access to high speed Internet is a barrier to delivering comprehensive care and can contribute to the burnout and turnover of health care providers in rural and remote settings. It could even hinder the recruitment of a high quality, diverse workforce.

Wellness of the primary health care workforce

A survey of College of Family Physicians of Canada™ (CFPC)[42] members revealed that almost half were either exhausted or burnt out while another survey by the Canadian Medical Association indicated that over half of family physicians are burnt out. As a result, **over half of family physicians report being likely to reduce or modify their clinical hours**, and some are retiring early or simply leaving the profession. Left

[42] Canadian Medical Association. *National Physician Health Survey 2021*. Ottawa, ON: Canadian Medical Association; 2022. Accessed October 11, 2022. https://www.cma.ca/sites/default/files/2022-08/NPHS_final_report_EN.pdf

unchecked, burnout will continue to compromise the viability of the health workforce stretched beyond its capacity.

Another survey by the Canadian Medical Association reported that:

- Approximately 1 in 5 physicians went into work **at least 5 times** feeling physically ill or distressed
- 53% reported they were dissatisfied with the efficiency and resources in their workplace
- **Rates of burnout have increased 170%** from the previous survey in 2017

A report from Statistics Canada found that stress and burnout are having a major impact on supply and turnover of nurses across healthcare settings including primary care and acute care:

- 25% of nurses reported the intention to leave their jobs within the next 3 years
- 70% of those who plan to leave nursing cited stress or burnout as a major factor

A report released by the Registered Nurses's Association of Ontario[43] that assessed the health and well-being of nurses across Canada reported that:

- 75% of nurses could be classified as burn out
- 26% had to take time off to manage stress, anxiety or mental health issues to prevent burnout
- 42% planned to leave the nursing profession within 5 years

Healthcare workforce wellness is a significant contributor to turnover and supply challenges.

These workforce challenges, particularly in rural and remote communities, are complex and multi-faceted. While there is no one single solution, there is an opportunity to address these challenges by enabling a comprehensive team-based care model that

[43] Registered Nurses' Association of Ontario. (2022). Nursing Through Crisis: A Comparative Perspective. May 12

brings together interprofessional primary health care approaches to meet unique individual and local health needs.

Findings of the Rural Sustainability Primary Care Task Force (RSPCTF)

The Rural Sustainability Primary Care Task Force highlighted a number of barriers that rural face in recruiting and retaining g physicians and other health care providers:

- Isolation
- Limited health facilities, or a lack of employment,
- Lack of extra-curricular activities, and
- Education opportunities for their families and children

Evidence suggests the medical education system can play an important role in the recruitment and retention of rural physicians and other providers if the curriculum has rural medicine components, such as rural learning and residency opportunities for students, and communities are involved with the recruitment and retention processes.

The RSPCTF also highlighted a number of barriers that impact rural and remote primary health care that must be considered including:

- Lack of essential and comprehensive primary and acute care services and infrastructure,
- Limited availability of inter-professional health care teams
- An absence of decision making processes that effectively address barriers to accessing health services in rural areas

The RSPCTF noted that rural practice is much more complex and all encompassing in nature, requiring rural health professionals to have broad scopes of practice and the capacity and skill sets to provide a wide range of services. Rural-based medical practices are often built around and include features of ‘generalism,’. which is meant to describe comprehensiveness, community-based, patient-centred, preventive care, primary care, and the provision of continuing comprehensive whole-patient medical care that must be provided as a part of primary health care in rural areas.

A comprehensive workforce strategy must incorporate and consider how to sustain and support team-based care across the province, address the health and wellness of the workforce, support the families of care providers particularly in rural and remote settings and build in rural and remote specific tactics and programs to address the unique needs of those communities and care providers.

Research, analysis and rationale for recommendation 10: Accelerate the implementation of actions that make the e-health environment more functional and robust for primary health care teams and patients.

Evolution of Virtual Care Environment in Alberta

The COVID-19 pandemic has rapidly shifted the requirements of access to primary care, affecting family physicians and their community-based practices. Data shows that in Ontario, Manitoba, Saskatchewan, Alberta and British Columbia, the proportion of family physician consultations and visits provided virtually between March 2020 and June 2021 averaged between 27% and 57%.[44]

Patients are becoming more accustomed to virtual care as an option for accessing comprehensive and continuous care through family practices that complements (rather than replaces) the in-person delivery of primary and other healthcare services.

- Alberta Health currently provides physician compensation through Clinical ARPs for three programs that deliver virtual primary care services to Albertans: TELUS Health MyCare, Maple Virtual Primary Care Program, and the Alberta Indigenous Virtual Care Clinic
- 811 Health Link is a telephone service providing free 24/7 nurse advice and general health information for Albertans including nurse triage, system navigation, dementia advice service, tobacco helpline, and addictions information and referral.
- The Virtual Opioid Dependency Program (VODP) virtually connects individuals who are interested in starting addiction treatment with remote physicians who can assess them and prescribe opioid agonist therapy (OAT). This enables clients in all areas of the province to access treatment quickly (and in some cases, in the same day).

[44] Canadian Institute for Health Information. Overview: COVID-19's impact on health care systems. Accessed March 2, 2022

- South Zone Virtual Option for Palliative Care: Program providing a virtual option for palliative care physician appointments to conduct assessment and follow-up for palliative home care clients

The emergence and expansion of virtual care across Alberta has been effective in meeting some of the access and availability challenges that exist for patients in the province. Expansion of virtual care has also lead to some challenges including:

- Disconnection and lack of integration between in-person models of care and primary health care providers
- Impacts to continuity of care for patients which has impacts to effectively meeting patient goals and broader downstream impacts on primary and acute health care system demand

Core challenges with e-health, technology and information systems today

Lack of strategic vendor partnerships:

It has been challenging to engage and drive vendors to deliver on provincial initiatives. Performance management and accountability of vendors is a challenge today. There is no mechanism by which EMR vendors can be held accountable to deliver on provincial initiatives. EMR integration requires data and integration standards and a mechanism to hold EMR vendors accountable to these standards and prevent lock-in of data.

The province does not meaningfully partner or collaborate with the vendor community to develop tailored solutions to meet provider and citizen needs proactively. Most clinic settings have procured and contracted with EMR providers directly without provincial standards or support Collaboration with the EMR vendor community will be critical in developing and designing the eHealth ecosystem.

Use of EMRs is not optimized and integrated

Use of EMRs today has not been optimized in clinical settings across Alberta. The use of EMRs varies across the province with many care providers negotiating for and opting into different features and functionalities without consistent standards or requirements. Clinics contract directly with vendors in the current environment which results in inconsistencies and variations even when clinics may have procured with the same EMR providers.

While Alberta's adoption rates for EMR systems are the highest in Canada at over 91% for primary care physicians, the core issue is integrating EMRs with provincial assets enabling digital information and services to be available seamlessly at point of care:

- 28% of Albertans reported that specialists did not have basic medical info/test results from their regular doctor (vs. 15% Canadian avg.)
- 27% reported their regular doctor did not seem informed on care received from a specialist (vs. 20% Canadian avg)

Electronic Medical Record Landscape In Alberta

The primary health care landscape in Alberta is complex. There are approx. 7,500 community-based physicians (GPs, FPs, and specialists) and NPs in Alberta, located in about 1,700 offices. Despite the complexity, adoption rates for EMR systems are the highest in Canada at over 91% for family physicians. Alberta is an open market for EMR providers but with a high concentration of physicians on three main vendors:

- 60% on TELUS Health Solutions,
- 20% on QHR Technologies,
- 17% on Microquest (AB-only vendor)
- 3% on a combination of smaller local and national providers

Alberta has already invested in finding ways to connect and share information between EMRs across the province. The Community Information Integration/ Central Patient

Attachment Registry Initiative (CII/CPAR) is a strategic initiative designed to enable two-way exchange of information between EMRs and Alberta Netcare enabling more comprehensive data exchange and communication between community-based providers, their patients and the extended care team. Uptake of this initiative has been steady although slower than desired likely due to a mismatch between barriers and value propositions to community providers. There are other factors that are impacting two exchanges of information including not all EMRs are integrated with CII/CPAR and ERMs not being kept updated appropriately.

EMR vendor partnership to achieve provincial integration:

EMR integration requires data and integration standards and a mechanism to hold EMR vendors accountable to these standards and prevent lock-in of data. It has been challenging to engage and drive vendors to deliver on provincial initiatives. Performance management and accountability of vendors is a challenge today. There is no mechanism by which EMR vendors can be held accountable to deliver on provincial initiatives.

The province does not meaningfully partner or collaborate with the vendor community to develop tailored solutions to meet provider and citizen needs proactively. Collaboration with the EMR vendor community will be critical in developing and designing the eHealth ecosystem.

Alberta's 2021 Provincial eHealth Strategy recommended establishing a provincial EMR program and working in partnership with the EMR vendor community, AHS, and the AMA to validate and co-design required EMR functionalities for data sharing and integration with key provincial assets

Interoperability

Integration and interoperability of systems for information sharing and communication across the continuum of care is lacking, including with community specialists, mental

health, and home care providers. There is minimal or no information sharing from primary health care with social service providers. Legislative, policy, infrastructure and process related barriers are among the factors that are contributing to challenges with information sharing and interoperability.

Interoperability between systems is a significant challenge today. The disparate use and lack of coordination between the technology and platforms within primary health care are driving technological fragmentation and impacting the ability for providers to share information. Technology and platform vendors drive primary health care IM/IT in Alberta. Procurement plans are not based around what people and providers need but rather what is available on the market. The system and technologies used have not been designed or developed with providers, patients or communities input or needs in mind.

> *"What use is recording information if users don't have the time or resources to review and use the information to deliver better, safer care?"*
>
> **(Citizen perspective)**

Need for expanded use of technologies to improve access and bring care closer to home or remove barriers

While there are effective programs or initiatives in place that use virtual or technology enabled care options in Alberta many of these programs have not been expanded or implemented widely. Improved access to continuous care can be enabled and supported with virtual health care as an option to access and communicate with primary care teams. Virtual care is an option to expand or enable appropriate access when in-person care options are not available.

Virtual and distance-delivery care is an emerging area of clinical and technical innovation. The COVID-19 pandemic has rapidly shifted the requirements of access to

primary care, affecting family physicians and their community-based practices. Patients are becoming more accustomed to virtual care as an option for accessing comprehensive and continuous care through family practices that complements (rather than replaces) the in-person delivery of primary and other healthcare services.

- Alberta Health currently provides physician compensation through Clinical ARPs for three programs that deliver virtual primary care services to Albertans: TELUS Health MyCare, Maple Virtual Primary Care Program, and the Alberta Indigenous Virtual Care Clinic
- 811 Health Link is a telephone service providing free 24/7 nurse advice and general health information for Albertans including nurse triage, system navigation, dementia advice service, tobacco helpline, and addictions information and referral.
- The Virtual Opioid Dependency Program (VODP) virtually connects individuals who are interested in starting addiction treatment with remote physicians who can assess them and prescribe opioid agonist therapy (OAT). This enables clients in all areas of the province to access treatment quickly (and in some cases, in the same day).
- South Zone Virtual Option for Palliative Care: Program providing a virtual option for palliative care physician appointments to conduct assessment and follow-up for palliative home care clients

Virtual care can be effectively delivered to provide a positive experience for patients and providers. Satisfaction with virtual care during the first part of the pandemic was high among patients and just marginally below that reported for in-person care. A nationwide survey of 1,800 people conducted by the CMA[45] in May 2020 showed:

- 91% of those polled were satisfied or very satisfied with the care they had received virtually
- 56% of respondents felt their family doctor was using virtual care or telehealth services effectively

[45] Canadian Medical Association Survey, What Canadians Thinks About Virtual Care, May 2020 https://www.cma.ca/sites/default/files/pdf/virtual-care/cma-virtual-care-public-poll-june-2020-e.pdf

Results from a survey of just over 2,000 physicians conducted for Canada Health Infoway and the CMA in April and May 2021 and released in August 2021 showed that almost all Canadian physicians who responded to the survey said they will continue to use virtual care after the pandemic, and 64% said they will maintain or increase their current level of use.

A review completed[46] found that telehealth has been shown to positively reduce a number of the access challenges faced in accessing primary care when in person options may not be readily available, particularly in rural and remote areas including:

- Decreased travel time
- Improved access to care
- Improved communication with providers
- Improved ability of patients to manage chronic conditions

Virtual or technology enabled care options that may be effective in removing barriers to care for vulnerable populations and those with limited access to in person primary and health neighbourhood care providers across the province. The use of virtual care and technology enabled care options has not yet reached maturity as a part of an integrated, accessible primary health care system.

Integrated information case studies from other jurisdictions:

Health Information Exchange, Sweden

Health Information Exchange is Sweden's national platform to facilitate communication between different health information systems. It provides a single point of connectivity for various EMR systems that exist, making it appear as if there was a national EMR system.

[46] Kruse CS, Krowski N, Rodriguez B, Tran L, Vela J, Brooks M. Telehealth and patient satisfaction: a systematic review and narrative analysis. *BMJ Open*. 2017 Aug 03;7(8):e016242. doi: 10.1136/bmjopen-2017-016242.

- The implementation of this database required a shift in the perspectives of healthcare providers, requiring them to be more open in providing direct access to care and provision, and to embrace this change that supports the national aim of ensuring patients have immediate access to their healthcare records
- Journalen is the eHealth patient record site. Through the general site, users can search information about illnesses, symptoms, treatments, and healthcare in a particular region. As well, users can find and compare health clinics, use e-services to contact healthcare providers, manage (request, cancel, or reschedule) appointments, and refill prescriptions. The Journalen function of the site allows users to view all electronic health data in one place, even if it has been recorded on multiple EMR systems

Key Considerations for E-health

Integration:

A core issue in primary care is integrating EMRs with provincial assets enabling digital information and services to be available seamlessly at point of care. Meaningful and integrated EMRs can have significant positive impacts on the quality of care. Data from EMR's should be structured and connected to enable a number of key system and clinic level capabilities including but not limited to the following:

- **Identifying trends and patterns:** EMR data should be structured to enable identification of trends and patterns in the health of a population or in the care being provided to individual patients. This can be useful for identifying areas where care may be falling short and opportunities to improve care.
- **Evaluating the effectiveness of interventions:** EMRs and integrated records should enable evaluation of the effectiveness of different interventions or treatments, such as medications or therapies, and to identify those that are most effective. This is critical in enabling and improving value based care. This may include sharing data to support research at the clinical, regional or system level to support QI or broader

research in life sciences

- **Allocating funding and resources:** Demographic data and medical records should enable informed decision-making in terms of allocating population-based funding for individual clinics, as well as regions to support sustainable team-based care and infrastructure requirements. This can also help determine whether or not there is a need for additional health care providers, and what structure of resources may be the best fit
- **Identifying high-risk patients:** EMR data should be used to identify patients who are at high risk for certain conditions or who may require more intensive care. This can be useful for targeting interventions or for developing care plans that are tailored to the needs of individual patients.
- **Improving communication and coordination:** EMR data should be used to improve communication and coordination among different healthcare providers, which can help to ensure that all relevant information is available when needed and that care is delivered in a timely and effective manner.
- **Supporting research and quality improvement:** EMR data should be used to support research and quality improvement efforts, such as by identifying trends and patterns that may be useful in developing new treatments or improving care processes.

Data architecture and integration aligned to enable specific objectives and functions

The data collection, sharing and infrastructural requirements should be designed to enable specific objectives including QI functions and population and health analytics. The government of Alberta should invest in and enable developing a "one person, one record" capability for medical records that can be accessed by providers and people in Alberta.

A "one person, one record" is a key enabling capability for both system wide innovations and effective use of technology and analytics but also for ensuring continuity and quality of care.

Research, rationale, and analysis for recommendation 11: Develop and commit to a dedicated primary health care investment plan that ties defined investments to specific outcomes for people, communities and providers

The MAPS initiative identifies areas of investment that are required, however, investment must be tracked with their specific impacts measured both through modernization efforts and as a part of sustaining and continuously improving the primary health care system province wide. Major drivers of required investment include:

- **People and team-based care:** Investing in interprofessional teams of primary health care providers within PMHs including investments required in building the workforce and sustainably funding teams within team-based care aligned patient medical home principles.
- **Program:** Investments made in significant programs required to modernize the primary health care system. This may include programs to strengthen or implement QI capabilities throughout the primary health care system or programs targeted at recruitment or training for rural specific primary health care.
- **Capital infrastructure:** Capital infrastructure required to provide access to primary health care including basic infrastructure such as PMH locations in communities or embedded within other assets (embedded near emergency departments in hospitals).
- **Information management and technology:** Investments are required in building IM/IT capabilities as a part of building and integrating a true provincial primary health care system, expanding existing health information and technology initiatives at the system, regional, and clinic levels and in providing support to empower people to be active participants in their own care.
- **Leadership:** Developing and standing up the leadership of the Alberta primary health care organization and the related capabilities.

Not all of these investments require new net money in addition to the current spending on health care. Many of these investments are partially funded or fully funded in current health care spending plans.

Tracking the impact of investments in modernization and sustainment of the primary health care system is critical in providing important information to policymakers for evidence-based policy development and for the Alberta Primary Health Care Organisation and providers to define the outcomes being targeted and define the impact and value of the strategic investments being made.

The existing structures of accountability for primary health care have fragmented decision making over the allocation of resources and investments with siloed funding and accountability. Investments have generally not been made with a whole of primary health care system view on targeted outcomes and in longitudinal measurement of impact. The ability to track and monitor outcomes and impact is an essential requirement in the effective and efficient functioning of the primary health care system in Alberta and achievement of provincial health-related goals.

Alberta must invest immediately and over time to modernize the primary health care system in Alberta. Investments that are made must have appropriate oversight and monitoring and to measure the impacts of investments on outcomes for patients, providers, and the broader provincial primary health care and health care systems.

Investment in primary health care is necessary

There is consistent and growing evidence that primary care-oriented health care

systems achieve better health outcomes, more health equity, and lower costs.[474849]. The evidence for the need for investment in primary health care is described in greater detail in the "Case for Change" section earlier in this document.

Investments that are made should be targeted at realizing specific outcomes, either at a system, regional or local level. The impact of some investments into primary health care do not have equal impact on system effectiveness, patient outcomes or public health. Some areas of investment offer a greater likelihood of significant value for the investment made for the people of Alberta.

There is mixed evidence on the impact of primary care investment on health system performance and downstream system costs. There is minimal evidence that primary health care spending alone or that all primary health care spending will reduce total spend, or slow spending growth.[50].

However, there are several examples of high-impact investments in primary care that have seen benefits to both health system performance and downstream system costs. This suggests that strategic, evidence-based investments in primary health care are required to improve health system performance and reduce downstream costs. The Patient's Medical Home model of care is an example of a high impact investment that has been shown to improve patient outcomes while reducing costs.

It is important as Alberta invests in modernizing the primary health care system in Alberta systematically and strategically. Investments should be made based on driving specific outcomes within the primary health care system. In order to realize the

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[47] Shi L. Primary care, specialty care, and life chances. Int J Health Serv. 1994;24(3):431-458. 2.

3. Macinko J, Starfield B, Shi L.

[48] Rasmussen SR, Thomsen JL, Kilsmark J, et al. Preventive health screenings and health consultations in primary care increase life expectancy without increasing costs. Scand J Public Health. 2007;35(4):365-372.

[49] Starfield B. Primary care and health: a cross-national comparison. JAMA. 1991;266(16):2268-2671. 4.

[50] Song A. and Gondi S. "Will Increasing Primary Care Spending Alone Save Money?" 2019.

objectives of modernizing the primary health care system in Alberta significant investments must be made.

Staging investments:

Jurisdictions that have successfully driven improved system and patient level outcomes through increased investment in primary healthcare have typically done so by increasing and staging total investment over several years.

Examples of staged investment in primary health care

United States of America

Several U.S. states, which significantly increased primary care spend as a proportion of total healthcare spend, staged investments over multiple years:

- Rhode Island statutorily required insurers to increase the proportion of health care spend on primary care by 1% per year for 5 years
- Delaware increased proportional spend by 1.5% per year for 3 years
- Colorado made 1% annual increases over 3 years

Blue Cross Shield of Michigan created a *Physician Group Incentive Program* rewarding adopting/ delivering on quality measures and implementing PMH capabilities (e.g., patient registries); The incentive program was funded at a set percentage of total payments to healthcare professionals starting at 0.5% in 2005 and increased to 4.7% in 2012 ($110M in 2012).

Investing in Capital Infrastructure to Enable Co-Location

The PMH model articulated in this report is built on three fundamental building blocks: team-based care, prompt access to care and continuity of care.[51] The teams envisioned

[51] Bodenheimer T. Lessons from the trenches—a high-functioning primary care clinic. N Engl J Med. 2011;365:5-8.

by the recommendations in this report reflect a composition of clinicians whose training permits them to understand various aspects of care, especially for patients with complex healthcare needs due to the prevalence of chronic disease with multiple comorbidities. [52] These teams are associated with improved patient outcomes, higher-quality care, cost efficiencies, and improved staff satisfaction.[53, 54, 55, 56]

The investment plan developed should include investments in capital infrastructure and physical space to enable co-location of PMHs.

Shifting from solo-practice family medicine to team-based primary health care results in a significant increase in the communication, coordination and teamwork skill requirements for all participants. Co-location involves the logistical integration of professionals working together in the same facility.[57] Relational coordination theory proposes that relationships of shared goals, shared knowledge, and mutual respect help to support frequent, timely, accurate, problem-solving communication, and vice versa, enabling stakeholders to effectively coordinate their work across boundaries.[58] The application of relational coordination in clinical teams is known to result in improved communication which, in turn, can have important benefits to both patients and providers.[59] Relational coordination focuses on maintaining work relationships among

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[52] Ibid.

[53] Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. Ann Fam Med. 2013;11:272-278.

[54] Walsh JM, McDonald KM, Shojania KG, et al. Quality improvement strategies for hypertension management: a systematic review. Med Care. 2006;44:646-657.

[55] Shojania KG, Ranji SR, McDonald KM, et al. Effects of quality improvement strategies for type 2 diabetes on glycemic control: a meta-regression analysis. JAMA. 2006;296:427-440.

[56] Reid RJ, Coleman K, Johnson EA, et al. The Group Health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. Health Aff (Millwood). 2010;29:835-843.

[57] Bonciani M, Schäfer W, Barsanti S, Heinemann S, Groenewegen PP. The benefits of co-location in primary care practices: the perspectives of general practitioners and patients in 34 countries. BMC Health Serv Res. 2018 Feb 21;18(1):132.

[58] Bolton, R., Logan, C., & Gittell, J. H. (2021). Revisiting Relational Coordination: A Systematic Review. The Journal of Applied Behavioral Science, 57(3), 290–322. https://doi.org/10.1177/0021886321991597

[59] Noel PH, Lanham HJ, Palmer RF, Leykum LK, Parchman ML. The importance of relational coordination and reciprocal learning for chronic illness care within primary care teams. Health Care Manage Rev. 2013;38:20-28.

interdependent employees with varying functions. Care teams are characterized by a focus on problem solving, accuracy, and frequent and timely communication, with mutual respect, shared knowledge, and shared goals.[60] They can benefit from work processes based on relational coordination and this is best accomplished through co-location, where team members can see and hear each other.

One group of authors, physicians in a Mayo Clinic facility in Jacksonville, Florida describe the benefits of collocation with some pragmatic clarity:[61]

- Collocation in our department has allowed for prompt answers to questions regarding access and optimal scheduling. If the patient's physician is present, that physician is often able to clear an appointment slot if notified early. Co-location enables near immediate, usually same-day resolution of pressing patient issues that would often take more than 24 hours to resolve in traditional family physician clinics.
- Less complex problems can be addressed by teams in collocation and not necessarily by physicians in clinic, allowing more time for the latter to address more complex issues.
- With more patients using electronic communication, it is important to achieve faster response times to questions and appointment needs. Effective teams are known for high-quality communication, and collocated teams may obtain physician input more quickly and respond to patient inquiries more quickly.
- Preclinic huddles provide time for planning and are an important part of the PCMH. Collocation facilitates ongoing smaller huddles, enabling knowledge-sharing more quickly, reinforcing goals. Although registered nurses, licensed practical nurses, and medical assistants are very knowledgeable, stalemates in decision making still occur, which are expeditiously resolved in collocation, compared to when physicians, in particular, were situated in offices or separate precepting areas.

[60] Gittell JH, Godfrey M, Thistlethwaite J. Interprofessional collaborative practice and relational coordination: improving healthcare through relationships. J Interprof Care. 2013;27:210-213.

[61] Pujalte GGA, Pantin SA, Waller TA, et al. Patient-Centered Medical Home With Collocation: Observations and Insights From an Academic Family Medicine Clinic. Journal of Primary Care & Community Health. 2020.

- Mutual respect among team members is another benefit; this has been apparent in our department, as the trust level regarding care provided by each member has increased with collocation allowing for problems to be raised and solved immediately. The physicians witness the abilities of team members and are immediately privy to management decisions.
- Camaraderie and staff satisfaction are other potential benefits; both have been improved, in part, by collocation in our department. The decreased volume of electronic communications has also led to positive implications for burnout.

The benefits of collocation of physician groups and the interprofessional teams that support them within the PMH are clear, impactful and arguably self-evident. The complications associated with transitioning from countless small clinical operations, many owned by the physicians practicing in them, to consolidated PMH clinics housing physician groups and the team of healthcare professionals and administrative support staff managing a larger panel of patients together as a team cannot be understated.

Need for larger space

In most cases in Alberta today, family physicians pay for their clinic costs out of their FFS billings. Their clinic space is sufficient to support their individual practices with limited administrative support or physical presence of other clinicians. If interprofessional teams were offered to these clinics tomorrow, it is unlikely that very many would have the physical space to support those teams. If interprofessional teams of 2-4 FTEs per family physician FTE are established, clinic space requirements could double. It is unrealistic to expect family physicians to pay for this expanded space out of their FFS billings, especially when care provided by the interprofessional team cannot be billed. This issue is only amplified when you consider that the recommendations in this report seek to establish physician group practices with a ideal size of 3-5 family physician FTEs in the group. For example, if five family physicians self-organize into a PMH and seek to co-locate with an interprofessional team of 4 FTEs per family physician, their collocated clinic space requirement could be ten to fifteen times the previous independent clinics.

Transitioning existing space

Many family physicians in Alberta own their own clinical space. Others may occupy the space under commercial lease arrangements that last for 5 to 10 years. In either case, abandoning the existing clinical space may create significant losses for the family physicians who own or lease the space, presenting a potentially insurmountable barrier to collocation. This barrier to collocation may be permanent for physicians who own the space and who may not be able to sell the space in smaller communities or where the clinic space is highly specialized and could not be easily repurposed.

What policy remedies or investments may facilitate collocation? Government will have many policy options to consider, including:

- Paying lease termination fees for physician groups where appropriate
- Actively promoting the redevelopment of government facilities for larger clinic spaces, permitting physicians to relocate (or establish their practice) over time as circumstances permit
- Providing financial incentives for physician groups to collocate to appropriate clinic space, enabling the group to allocate the incentive in a manner that eliminates barriers based on self-managed compromises (e.g. more funding to the physicians who must break leases; little or funding for physicians with no long-term clinic space obligations)

Regardless of the approach taken, an expansive policy that seeks to achieve collocation across Alberta will require a very significant capital investment and will need focused and long-term coordination and support from Government. Ongoing costs for the enhanced clinical space will also be significant as the interprofessional teams will create much greater needs for space that cannot be borne by the family physicians from their FFS billings.

Appendix - E

Appendix E: Details and Analysis of Case for Change

Population and Health Status of Albertans

- Alberta's population was 4.44M in 2021[62] and is projected grow between 1.0% (low scenario) to 2.1% (high scenario) annually from 2022 to 2046[63]
    - Alberta Health Services organizes Alberta into five geographic zones: North, Edmonton, Central, Calgary, and South; Calgary (1.6M) and Edmonton (1.4M) have larger populations than the remaining three zones (300K – 500K range)[64]
- 22% of the population lives in remote or rural settings based on data from 2020/21[65]
- Alberta has a relatively younger population compared to the rest of Canada; However, the baby boomer cohort will have a significant impact on population aging in the coming years:
    - Among comparator provinces (ON-west), Alberta had the second lowest median age (38.1), nearly 3 years younger than the Canadian median (41.0)[66]; The median age ranged from 36.0 in the North Zone to 39.8 in the Central Zone. All of Alberta's health zones had a median age below the Canadian median.

[62] Alberta Treasury Board and Finance, "Alberta Population Projections, 2022 to 2046 – Alberta and Census Divisions – Data Tables," Updated July 5, 2022.

[63] Alberta Treasury Board and Finance, "Alberta Population Projections, 2022 to 2046 – Alberta and Census Divisions – Data Tables," Updated July 5, 2022

[64] Alberta Health Services, "AHS Map and Zone Overview," 2020-21 Report to the Community.

[65] Alberta Health Services, "AHS Map and Zone Overview," 2020-21 Report to the Community.

[66] Statistics Canada, "Population estimates on July 1st, by age and sex," Table 17-10-0005-01. 2022.

  - In 2021, the baby boomer age cohort (born between 1946 to 1965) accounted for 20% of Alberta's population. The cohort will have a significant impact on population aging.[67]

- 23% of Albertans identify as an immigrant or permanent resident; 27% of the workforce in Alberta are immigrants, and by 2050 it is estimated half of Edmonton's population will be immigrants.[68]
  - There are 970K immigrants and permanent residents in Alberta; Of those, nearly 124K are refugees (47% in Calgary, 41% in Edmonton, and between 1.5% - 2.5% in Lethbridge, Brooks, and Red Deer).
  - Syria, Eritrea, Ethiopia, Somalia, and Iraq are the most common countries of birth for refugees arriving to Alberta in the last 5 years.
  - Refugees in Alberta come from diverse backgrounds, they speak numerous languages, and have complex pre-migration journeys.
- There are several lifestyle factors in Alberta, which negatively impact health and well-being:
  - Rates of obesity in Alberta (29.7%) was in line with the Canadian average (29.2%) in 2021[69]
  - Among comparator provinces (ON-west), Albertans reported the 2nd highest rates of daily smoking (8.1%), heavy drinking (16.0%), and the highest rate of daily or almost daily cannabis use (6.7%)[70]

[67] Alberta Treasury Board and Finance, "Alberta Population Projections, 2022 to 2046 – Alberta and Census Divisions – Data Tables," Updated July 5, 2022.

[68] Refugee Health Coalition. Written Submission to MAPS. December 2022.

[69] Statistics Canada, "Canadian Community Household Survey," 2021.

[70] Statistics Canada, "Canadian Community Household Survey," 2021.

- 35% of Albertans had a chronic health condition in 2020/21; The burden of chronic disease varies across the province:[71]
  - Albertans reported rates of chronic disease below the Canadian average for COPD, diabetes, and high blood pressure, and above the Canadian average for asthma (unadjusted for age)[72]
  - Age-standardized prevalence of chronic disease was highest in the North Zone for three out of the four conditions reported (COPD, diabetes, high blood pressure); The South Zone reported the highest age-standardized prevalence of asthma[73]
- Albertans reported high rates of stress and have high prevalence of mental health conditions contributing to poor self-perceived mental health:
  - Among comparator provinces (ON-west) in 2020/21, Albertans reported the highest rates of most days being quite/ extremely stressful, 2nd highest rate of fair/poor perceived mental health, and 2nd highest prevalence of mood disorders[74]
- Income is one of the most influential social determinants of health. Individuals dealing with financial stress are twice as likely to report poor overall health. [75]
  - 5.5% of Alberta's population was reported to have low income in 2020.[76]

[71] AHS, "MAPS Baseline Data Chapter," August 2022.

[72] Statistics Canada, "Canadian Community Household Survey," 2021.

[73] Alberta Health Interactive Data Application. Available online.

[74] Statistics Canada, "Canadian Community Household Survey," 2021.

[75] Alberta Health Services, Financial Strain 101.

[76] Statistics Canada. Table 11-10-0135-01 Low-income statistics by age, sex and economic family type.

- Patients who live in poverty are at a higher risk for cardiovascular disease, diabetes, and depression.[77]
- Avoidable illness and reduction in life expectancy due to lack of financial resources are particularly evident for vulnerable populations and Indigenous peoples.[78]

[77] Centre for Effective Practice. Poverty. November 2016.

[78] MAPS Internal AH Consultation

Appendix - F

Appendix F: Glossary of Acronyms

Acronym	Meaning
AbSPORU	Alberta SPOR Support Unit
ACFP	Alberta College of Family Physicians
ACSC	Ambulatory Care Sensitive Condition
ACTT	Accelerating Change Transformation Team
ACTT	Accelerating Change Transformation Team
AH	Alberta Health
AHS	Alberta Health Services
AIM	Access Improvement Measures
AMA	Alberta Medical Association
APHCO	Alberta Primary Health Care Organization
ARP	Alternative Relationship Plan
ARPAP	Alberta Rural Physician Action Plan
ASaP	Alberta Screening and Prevention
ATR	Assess Treat and Refer
BC	British Columbia
BCM	Blended Capitation Model
CaRMS	Canadian Resident Matching Service (CaRMS)
CFPC	College of Family Physicians of Canada
CFPT	Collaborative Family Practice Team
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institute of Health Research
CII	Community Information Integration
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)
CPAR	Central Patient Attachment Registry

CPSA	College of Physicians and Surgeons of Alberta
CREMS	Crisis Response and EMS
CVFP	Crowfoot Village Family Practice
CWA	Choosing Wisely Alberta
ED	Emergency Department
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENMOC	Enabling New Models of Care
ERP	Enterprise Resource Planning
FCC	Family Care Clinic
FFS	Fee-for Service
FTE	Full-Time Equivalent
HELP	Human-centred Engagement and Liaison Program
HQCA	Health Quality Council of Alberta
HSI	Health System Impact
ICN	Imagine Citizens Network
IHN	Integrated Health Neighbourhood
IM	Information Management
IT	Information Technology
KP	Kaiser Permanente
LGBTQ2S+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Two-Spirit
MAPS	Modernizing Alberta's Primary Health Care System
MRP	Most Responsible Provider
NP	Nurse Practitioner
NSH	Nova Scotia Health
OAT	Opioid Agonist Therapy
OECD	Organization for Economic Cooperation and Development

ON	Ontario
PCN	Primary Care Network
PCN PMO	PCN Program Management Office
PHC	Primary Health Care
PHIC	Provincial Health Integration Commission
PLP	Physician Learning Program
PMH	Patient's Medical Home
PPCNC	Provincial PCN Committee
PPIP	Physician Practice Improvement Program
QI	Quality improvement
REAP	Rural Education Action Plan
ROMI	Rural Outreach and Mentorship Initiative
RPHCN	Regional Primary Health Care Network
RRI	Recruitment and Retention Initiative
RSPCTF	Rural Sustainability Primary Care Task Force
SCSP	Seniors Community Services Partnership
SPOR	Strategy for Patient Oriented Research
SSN	Senior System Navigator
TC	Taber Clinic
TMO	Transformation Management Office
TOP	Towards Optimized Practice
UK	United Kingdom
US	United States
VODP	Virtual Opioid Dependency Program
ZPCNC	Zone PCN Committees

Appendix - G

Appendix G: References

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Appendix - H

Appendix H: MAPS Background Document

Modernizing Alberta's Primary Health Care System (MAPS): Project Backgrounder

Last updated: November 7th, 2022

Overview and Background

Purpose

The purpose of this document is to provide Strategic Advisory Panel Members and International Expert Panel Members from outside of Alberta with background on primary care (PC) and Primary Health Care (PHC) in Alberta. The document summarizes relevant topics across the PHC spectrum and is meant to introduce and provide a high-level overview of each topic. This document is meant to be objective and non-evaluative.

Background on MAPS

In September 2022, Alberta Health launched the Modernizing Alberta's Primary Health Care System (MAPS) initiative to recommend both short-term actions to strengthen the primary health care (PHC) system, and a 10-year strategy to achieve a PHC-oriented health system for the province. MAPS recommendations will be centred around ways to achieve a system that delivers the following outcomes:

- **Access** - All Albertans have access to timely, appropriate primary health care services from a regular provider or team. Care options are flexible and reflect individual and population health needs.
- **Integration** - Every Albertan has a health home that provides primary health care services and seamless transitions to other health, social and community services. Coordination and communication between providers and organizations is promoted and facilitated by service planning and the provincial governance structure.
- **Quality** - Albertans receive high quality services from an accountable, innovative and sustainable primary health care system. Health service delivery is evidence informed, follows best practices, and uses resources efficiently.

- **Albertans as Partners** - Albertans and their social support networks are meaningful partners in achieving their health and wellness goals. Health services are proactive, recognize and address underlying influences on health outcomes, and respect individual needs and preferences.
- **Culturally Safe and Appropriate Care** - First Nations, Metis and Inuit persons have access to high quality, culturally safe care that is free of racism, and designed and delivered in a manner that respects their unique health care needs.

Primary Care and Primary Health Care

Primary Health Care (PHC) is the main place people go for health or wellness advice and programs, treatment of a health issue or injury, and diagnosis and management of health conditions through every stage of life. PHC coordinates between primary care and social and community care.

Primary care is a part of PHC and includes clinical services like diagnosis and treatment of non-urgent conditions, and chronic condition prevention and management. Effective primary care integrates health care delivery across the continuum of care by improving coordination of primary care services with other health care services including hospitals, long-term care, and specialty care services.

Key Roles in Primary Health Care

The Minister of Health is an elected member of the Legislative Assembly of Alberta who is responsible for the Ministry of Health, including Alberta Health Services, Alberta Health, and the Health Quality Council of Alberta. The Minister works as part of Cabinet to set the policy direction for the Ministry.

Alberta Health (AH) is the government department that sets the policy, legislation, and standards for the health system in Alberta. It is also responsible for allocating funding and administering provincial programs such as the Alberta Health Care Insurance Plan (AHCIP). In 2014, Alberta Health released the Primary Health Care Strategy which

describes the principles, strategic directions, goals, and outcomes to further enhance the delivery of care, change the culture within the system, and put in place the building blocks for long-term sustainability. The strategy sets out a vision for a primary health care system that supports Albertans to be as healthy as they can be. Alberta is working to achieve that vision through creating a health home where PHC services will be seamlessly provided wherever Albertans are receiving health services and through policies and programs focussed on the five outcomes above.

Alberta Health Services (AHS) is the provincial agency, enabled through the Regional Health Authorities Act, and tasked with planning and delivering many of Alberta's publicly funded health services, including programs and services at facilities such as hospitals, clinics, continuing care facilities, cancer centres, mental health facilities, and community health sites. AHS, through the board, is accountable to the Minister of Health.

Primary Care Networks (PCNs) are Alberta Health-funded joint ventures between a group of Family Physicians who form a non-profit corporation (NPC) and AHS. The joint venture partners govern the PCN and are accountable to the Ministry of Health through the grant agreement, which is the legal authority and direct line to the Minister of Health. The province provides grant funding to operate PCNs to meet PCN Program Objectives in accordance with PCN Program Policies. PCNs provide non-physician team-based services, population health services, quality improvement as well as evaluation, monitoring and reporting. There are currently 40 PCNs in Alberta.

PCNs were originally established under the 2003-11 Trilateral Master Agreement between Alberta Health, the Alberta Medical Association (AMA) and the Regional Health Authorities (now AHS) and were developed as a governance/organization mechanism centred around the physician-led clinical model. PCNs are the most common mechanism to promote team-based care in Alberta, with more than 80 per cent of Family Physicians registered in a PCN.

Document Overview

This document will cover the following topics:

1. **Primary Health Care Service Delivery Models** summarizes the Patient Medical Home, Health Home, common service delivery models and the PHC workforce.
2. **Primary Health Care Governance** describes the accountability and oversight structures for PCNs, the integrated nature of governance and planning, and governance of Indigenous models of PHC.
3. **Health Information Sharing and Technology** summarizes the variety of eHealth services in Alberta and the enabling strategies surrounding the use of these services.
4. **Mechanisms for PHC Integration** highlights a variety of initiatives that enable integration between PHC and other health services.
5. **Performance Reporting** summarizes a variety of reports and tools used to assess PHC system performance.
6. **Primary Health Care Spending** provides a preliminary view of PCN and NP funding and funding models as well as describes physician compensation models in Alberta.
7. **Patient and Public Involvement** describes the mechanisms of involvement for the broader community in AHS, PCNs, and AH; involvement of Indigenous communities in PHC is discussed.
8. **Primary Health Care Research** summarizes the key research networks and groups conducting, supporting and sharing research related to PC and PHC.

1. Primary Health Care Service Delivery Models

The following section will outline PHC service delivery models in Alberta, including:

- Service delivery concepts;
- Service delivery models;
- PHC workforce.

1.1 Service Delivery Model Concepts

The Patient Medical Home (PMH) and Health Home (HH) concepts have been entrenched in Alberta's strategies and priorities for PC and PHC for at least 10 years, guiding the province's PHC transformation towards principles of integrated, comprehensive, and person-centered care. In Alberta, there are several different PHC service delivery models that support patients' access to a PMH/HH.

1.11 Patient Medical Home

The **PMH** is an approach to delivering high-quality and comprehensive PC developed by the College of Family Physicians of Canada. The framework of the PMH envisions teams led by Family Physicians to promote partnerships between providers, patients, and families to improve patient health outcomes through communication, engagement, and team-based care.[79] The PMH provides appropriate care, access and attachment for patients, and is often the first place that people go to receive support for diagnosis and treatment of non-urgent conditions and chronic condition management.

1.12 Health Home

The **HH** is a person-centered model of care that facilitates access to integrated, comprehensive PHC services across the continuum. This includes PC, community health services (e.g., public health, home care, allied

health/rehabilitation, addiction, and mental health) and community-based social services. A major focus of the HH is to have highly coordinated transitions in care between PHC, specialist, acute, and tertiary care.

1.13 Features of the PMH and HH Models

[79] Nielsen, M., Buelt, L., Patel, K., Nichols, L. M., & Fund, M. M. (2014). The patient-centered medical home's impact on cost and quality. *Annual review of evidence*, *2015*, 202014-2015.

There are four key features of the PMH and HH models: **access**, **attachment**, **continuity of care**, and **comprehensive care**. As such, the PMH or HH work to directly provide, or provide access to, a set of acute, community, and primary services for their patients.

The primary care provider plays a key role coordinating care services for patients. This coordination is made easier if the patient has a long-term care relationship (i.e., are attached) with the provider (i.e., **'relational continuity of care**'), through which '**informational continuity of care' (**the timely availability of relevant information through shared medical records and the accumulated knowledge about the patient's preferences, values and context) and '**management continuity of care**' (communication of patient-related information across healthcare teams, institutional and professional boundaries and between healthcare providers and patients) flows. These three aspects of continuity are associated with better patient outcomes and experiences of care.

1.2 Service Delivery Models in Alberta

In Alberta, there are several different PHC service delivery models that support patients' access to a PMH/HH. The current challenges of recruitment and retention of primary health care providers in rural and remote communities and other unmet needs, such as culturally safe and appropriate care for Indigenous people, may require flexibility in existing models and/or development of new models to achieve the five outcomes.

The core PHC service delivery models in Alberta are described in Table 1 below:

Patient Medical Home and Health Home Service Delivery Models	
Delivery Model	**Description**
Physician and Nurse Practitioner Clinics	• Approximately 1,000 primarily independent clinic settings owned and operated by Physicians, compensated through AH through either fee-for-service (FFS) or an Alternative Relationship Plan (ARP)

	• Physicians can join a Primary Care Network (PCN) by registering with a Non-Profit Corporation (NPC) that is associated with a PCN
Virtual Primary Care	• Alberta Health has Clinical Alternate Relationship Plans (ARPs), including TELUS Health MyCare, Maple Virtual Primary Care Program, and Indigenous Wellness Program (virtual arm), which enable physicians to deliver insured medical services virtually **TELUS Health MyCare:** • Operates several clinics, some of which may be for-profit • Alberta Health's involvement limited to Telus Health MyCare clinic; free mobile app got Albertans to consult with physicians remotely **Maple Virtual Primary Care Program:** • A virtual, distance-delivery of care platform to deliver and improve access to primary care services to Albertans, particularly those in rural communities, with limited mobility and/or no family physician **Indigenous Wellness Program (virtual arm):** • Operate the Alberta Indigenous Virtual Care Clinic (AIVCC) through Clinical ARP funding • Deliver virtual primary care services and wellness support to First Nations, Metis, and Inuit people and their families **AHS Indigenous Wellness Program:** • Supports the Alberta Indigenous Virtual Care Clinic (AIVCC) through funding physicians under the Clinical Indigenous ARP • Provides primary care and wellness support to First Nations, Metis, and Inuit people and their families who live in the North Zone through their 1-800 Indigenous Support Line: Walk with Me, Talk with Me Learn with Me
Community Health Centres (CHC)	• Community-based health care and social support centres that integrate team-based PHC with programs that address social barriers to health • Generally governed by non-profit boards with community representation and can receive funding from various sources

	• CHCs' community-governance model provides process and structure to guide the organization and is used as a strategy to engage communities and enable community members' voice • Currently three CHCs operating in Alberta
Family Care Clinics (FCC)	• Three clinics operated by AHS to provide primary care and social services to underserved or high-risk populations not attached to a primary care provider and/or have chronic health condition(s), mental health, or other social needs • FCCs are different from traditional primary health care settings as individuals are not required to see a physician for access to many of the services
University Departments of Family Medicine Clinics	• May be independent or co-located within AHS facilities • Clinics have a teaching role (i.e., supervising residents in primary care training) • Geographic Full Time family physicians in the University of Alberta, Department of Family Medicine (DoFM) are members of the Academic Medicine and Health Services Program (AMHSP) • AMHSP maintains DoFM's distributed training and supports DoFM's clinics in providing care for a disproportionately high-need, older, and more complex patient population.
Other Primary Care Delivery Models	
Delivery Model	**Description**
Indigenous Health Service Delivery Models	• First Nations' health services on-reserve are delivered by the local First Nation, Tribal Council and/or First Nations Inuit Health Branch • Off-reserve Indigenous health services are delivered through a variety of models, including through PCNs, CHCs, and other customized models
Mobile Health Clinics (MHC)	• MHCs target and can reach underserved populations by delivering services directly at the curbside in communities of need
Health Link Virtual MD	• Is not a PMH/HH service delivery model in its own right; a service which improves access to a Physician to support the PMH/HH • An on-call physician service provided between the hours of 1000h-

	2200h to take consults with patients via phone/video
Pharmacy-led delivery	• **Pharmacists** generally work in private pharmacies and are paid out of the income generated from the sale of prescriptions • Pharmacists also receive remuneration through the Alberta Blue Cross Pharmaceutical Services Provider Agreement, which sets out payment for pharmacies and pharmacist services and includes funding for certain primary care services such as authorization to prescribe certain types of drugs and administer drugs by injection
Virtual care with non-physician providers	• Health Link (811) provides access for Albertans to registered nurses 24/7 for telephone advice and manages the health information online at MyHealth Alberta. • AHS also offers access through the Rehabilitation Advice Line (1-833-379-0563), that provides assessment of a person's needs and advice for ongoing self-management, at no cost

1.2 Primary Health Care Workforce

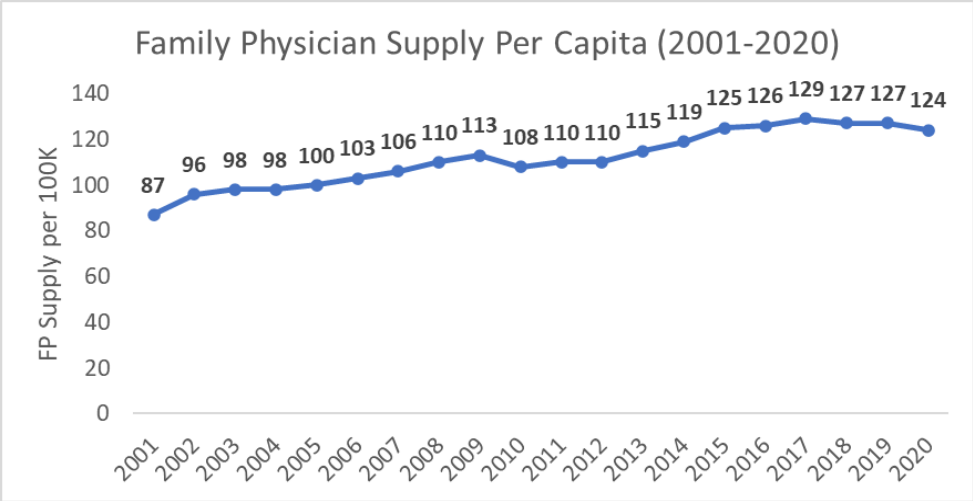
There are several health care providers that are involved in the delivery of PC and PHC services in the province, including:

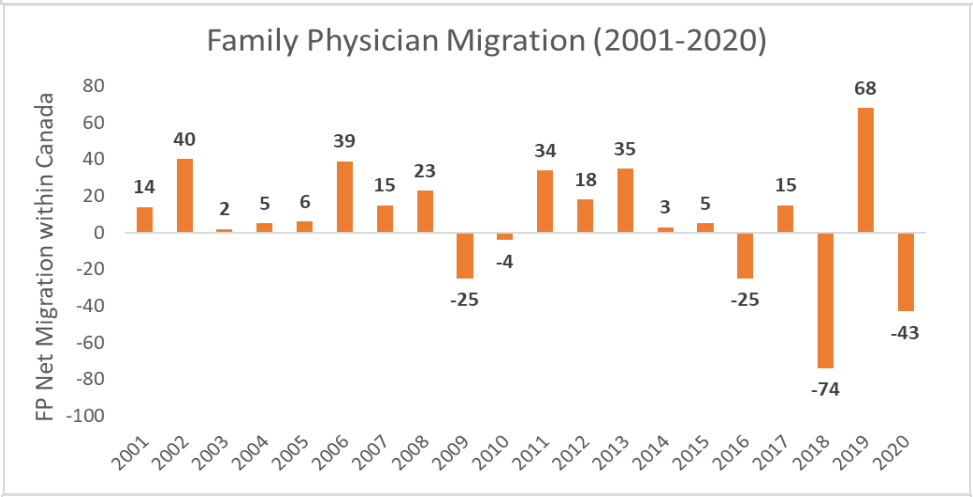
- Physicians;
- NPs;
- Nurses (registered nurses and licensed practical nurses);
- Other providers (e.g., pharmacists, dieticians).

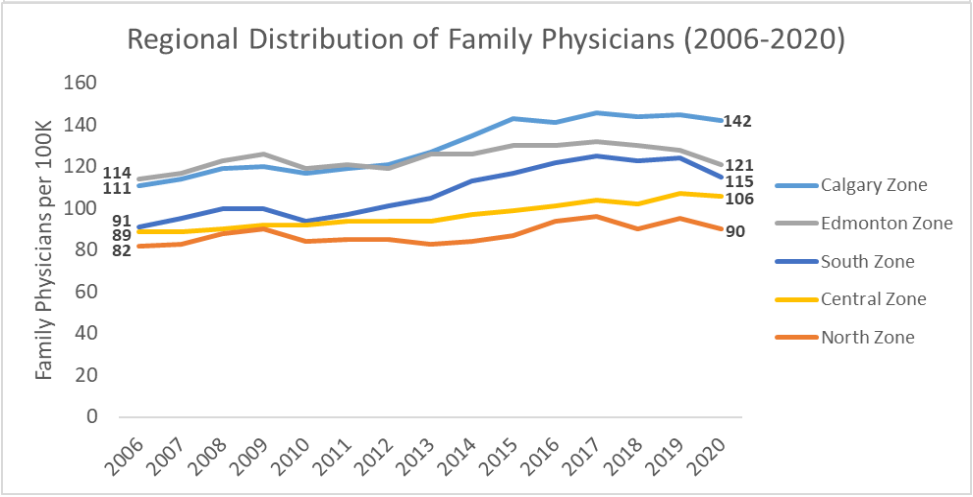
The largest proportion of the primary care workforce is within the approximately 1,000 physician offices, including both physicians and other members of the teams such as medical office assistants and nurses. Physicians are independent practitioners who operate their own practices and are mainly paid on a fee-for-service basis. They are generally free to choose where they wish to practise and which patients they treat. Physicians also determine the types of clinics they wish to operate, hours of service and appointment types. As of 2019, 17% of family physicians practiced in rural areas.

A high-level overview of headcount and FTE by zone for a subset of providers is outlined in the tables below. A more detailed analysis of primary health care providers (e.g., NPs, Pharmacists) will be conducted during the MAPS initiative.

1.31 Physician Workforce Overview[80]







[80] Canadian Institutes for Health Information (CIHI). (2021). *Supply, Distribution and Migration of Physicians in Canada, 2020.* Retrieved from https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34

1.32 Other Primary Health Care Providers

PCNs, described previously, include physicians as well as other health care providers. FTEs for NPs, Nurses, and other clinical providers and non-clinical support staff are shown below.

Table 2: Primary Care Network Workforce

Zone	Number of PCNs	Number of Clinics	Nurse Practitioner FTE	Nurse (RN and LPN) FTE	Other Clinical FTE	Non-Clinical FTE
South	2	68	5.6	104.2	56.8	16.5
Central	12	85	11.4	83.3	110.6	30.7
North	11	95	9.9	72.2	90.1	24.5
Edmonton	8	381	17.8	173.0	350.8	99.7
Calgary	7	504	13.5	121.8	540.1	131.3
Total	**40**	**1,133**	**58.1**	**554.5**	**1,148.3**	**302.6**

Non-physician clinical (e.g., nurses, behavioural health consultants, patient navigators) and non-clinical (e.g., project managers, panel managers) FTEs for the 16 AHS clinics are shown below (note - some AHS clinics are also part of PCNs shown above).

Table 3: Alberta Health Services Clinic Workforce

Zone	Clinical FTE	Non-Clinical FTE	Total FTE
Edmonton	23.3	4.8	28.1
North	21.7	36.4	58.1
Calgary	56.2	62.7	118.9
Total	**101.2**	**103.9**	**205.1**

Notes:

1. FTE data above represents budgeted amounts.
2. There are no AHS-run clinics in primary care in South and Central Zones.

2. Primary Health Care Governance

The following section outlines PHC governance, including:

- PCN Accountability
- PCN Governance structure
- Governance of Indigenous PHC;
- Integrated Governance and Planning.

2.1 Primary Care Network Accountability

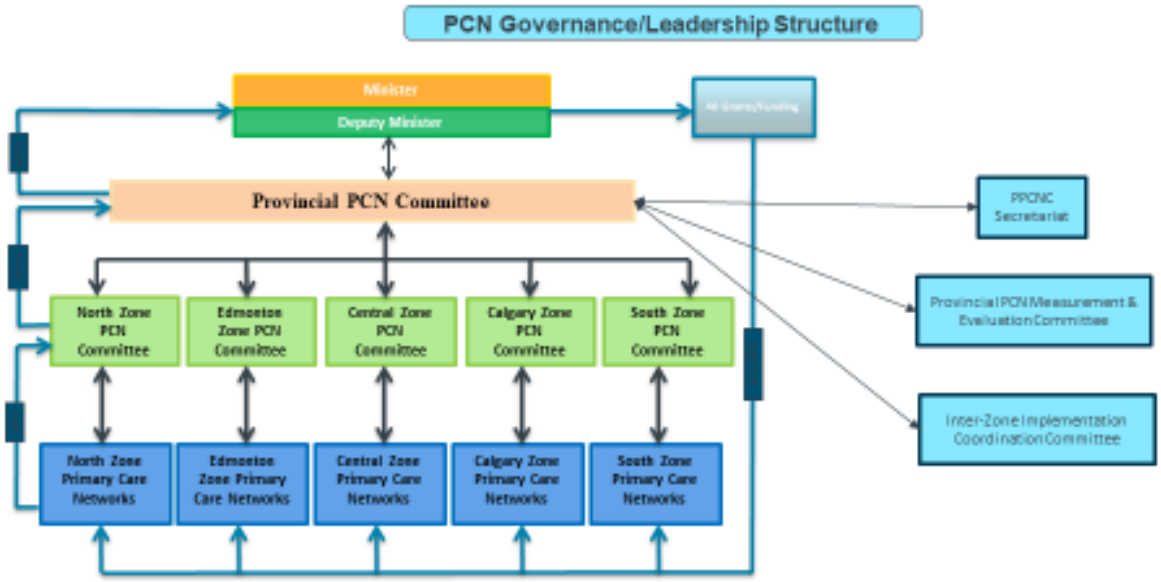
PCNs are accountable to Alberta Health through three-year grant agreements, made under Ministerial Grant Regulation, which is the legal authority and direct line to the Minister of Health. The province provides grant funding to operate PCNs to meet PCN Program Objectives in accordance with PCN Program Policies.

2.2 Primary Care Network Governance Structure

Through a Ministerial Order (June 2017, refreshed in Sept 2020 for five years), the **Provincial PCN Committee (PPCNC)** and five **Zone Primary Care Network Committees (ZPCNC)**. The PPCNC was established to gather input and provide advice to the Minister of Health on issues relating to PCNs.

The PPCNC is chaired by Alberta Health, and includes representatives from Alberta Health, the PCN Physician Leads, AHS provincial and zonal, Alberta Medical Association, Alberta Federation of Regulated Health Professionals, and a community representative. The community representative position has been vacant since the beginning of the second mandate of the PPCNC and is currently in process to fill.

Figure 1: Primary Care Network Governance Structure



The ZPCNCs report to the PPCNC and advise the Minister of Health through the PPCNC on PCN program policy, areas of common priorities and standardization, and Zone PCN service plans. The five ZPCNCs cover all geographic areas of the province and include representatives from AHS, PCNs, and the community (i.e., public members).

The **Inter-Zone Implementation Coordination Committee (IZICC)** is a sub-committee of the PPCNC. IZICC functions as a coordination and liaison body within the PCN governance structure as it supports both ZPCNCs and PPCNC by enabling and advancing PPCNC priorities through coordination, providing robust multi-directional communication and feedback, and liaising with other health and social care partners. The primary objective of I-ZICC is to allow for the ZPCNCs to collectively set minimum standards, consistency, and alignment provincially.

The PPCNC established the **Measurement and Evaluation Committee (MEC)** to provide recommendations to PPCNC on a measurement and evaluation framework for the provincial PCN governance structure, including performance indicators and measures, at

the levels of the entire province, each zone and each PCN, as per the mandate of the PPCNC.

2.3 Governance of Indigenous Primary Health Care

There are no overarching governance structure for Indigenous PHC services in Alberta. The federal government is responsible for funding public health care services for First Nations on reserve, primarily delivered under the authority of the local First Nation, tribal council, and Indigenous Services Canada. Many of the larger First Nations in the province have assumed responsibility for most on-reserve healthcare services through transfer agreements with the federal government.

The province is responsible for funding health care services for all residents of Alberta, and provides First Nations (off-reserve), Métis, and Inuit peoples the same access to health care services as non-Indigenous Albertans. Those services may be provided through AH (e.g., Physician services) or AHS (e.g., acute care services).

Where family physicians who provide services to Indigenous people belong to a PCN, some PCN services may also be tailored to First Nation and Metis communities.

2.4 Integrated Governance and Planning

2.41 Zone PCN Service Planning

Zone PCN Service Plans (ZSPs) are currently the main deliverable of ZPCNCs, as per the Terms of Reference of the PPCNC. The goal of ZSPs is to identify opportunities and gaps related to zone-wide alignment and integration of AHS and PCN services, and to address priority health needs of the population. ZSPs are collaboratively developed by ZPCNC members and support teams, including representatives from PCNs, AHS and community-based organizations.

2.42 AHS Zone Health Care Planning

AHS, working with Alberta Health, has established a framework and methodology to guide the development of comprehensive, zone-wide strategic health service plans, called Zone Health Care Plans. These long-range plans are designed to and address the needs of communities with a continued focus on appropriate quality care, patient safety and access to services.

3. Health Information Sharing and Technology

Information sharing is essential for the introduction of team-based and community-based care, and for involving Albertans as participating members in their health care teams. Over the last 20 years, Alberta has continued to invest in the province's digital health ecosystem. The following section outlines health information sharing and technology in PHC, including:

- eHealth services in Alberta;
- Enabling strategies and legislation.

3.1 eHealth Services in Alberta

The table below provides an overview of the major eHealth services available in Alberta.

Table 4: eHealth Services in Alberta

eHealth Service	Users	Description
Alberta Netcare	Health care providers	• Provincial electronic health record (EHR) system; any individual who has a personal health number and receives health care has an EHR in *Alberta Netcare* • Allows health care providers to access consolidated key patient health information
MyHealth Records (MHR)	Patients	• Allows patients to access personal health information • Allows patients to track/manage data and share to health care providers electronically or printed reports
Connect Care	Health care providers	• To be fully implemented across AHS by Fall 2024 • Allows health care providers to access patient information who receive care from AHS
Electronic Medical Records (EMR)	Health care providers	• Patient record specific to a single clinical practice

Community Information Integration/Central Patient Attachment Registry (CII/CPAR)	Health care providers	• Voluntary systems; clinics register to participate • CII transfers patient information from specific EMRs from community-based clinics to *Alberta Netcare* • CPAR allows family physicians to identify and coordinate roles and responsibilities in care provision • CPAR provides eNotifications to providers when patient is hospitalized or visits an emergency department
Netcare eReferral	Health care providers	• Electronic referral system that provides a provincial health service catalogue and standardizes the referral and triage criteria for specialties • Offers: 1) non-urgent in-person specialist consultation for a patient and 2) non-urgent clinical specialist advice request with a response within 5 calendar days
ePrescribe (PrescribeIT®)	Prescribers	• Enables community-based prescribers to electronically transmit a prescription directly from an EMR to the patient's community retail pharmacy of choice • Currently being beta tested in Alberta
Pharmaceutical Information Network (PIN)	Health care providers	• Application in *Alberta Netcare* that provides access to patient's active and previous medications • Community and out-patient pharmacies provide dispensing data, notes, and pharmacy care plans via batch data submissions or real-time integration
AHS eDelivery Service	Health care providers	• Allows health care provider to order patient results from a data source (e.g., lab, diagnostic imaging, transcribed reports) and receive directly to the health care provider's EMR

3.2 Enabling Strategies and Legislation

3.21 Virtual Care Action Plan

In partnership with Health Canada, Alberta Health has developed a Virtual Care Action Plan to build on the province's groundwork on virtual care to improve remote health service delivery.

3.22 Alberta Provincial eHealth Strategy

The Provincial eHealth Strategy establishes a vision for eHealth, identifies key steps to achieve this vision, and aims to bring more alignment amongst stakeholders. A primary strategic goal of the Provincial eHealth Strategy is to empower patients by leveraging *MyHealth Records* as a patient portal so that all Albertans are digitally able to interact with the eHealth ecosystem through a unified experience. To achieve this vision, Alberta Health has undertaken the aforementioned service initiatives. The Strategy is in the process of being published.

3.23 Health Informant Act (HIA)

HIA governs the collection, use and disclosure of health information by custodians and affiliates. Higher level of protections under the HIA are specifically designed to support the needs of the health sector and maintain public trust that their health information is secure.

HIA establishes legal obligations and functions as principles to guide custodians' management of health information from collection to disposal. Specific authorities were included to support information sharing to individuals and organizations outside the health sector (e.g., physician disclosing limited information to police services for an investigation or Alberta Health disclosing health information to Children's Services to support determining if a child in care requires immunizations).

3.24 Alberta Primary Health Care Strategy

In 2014, Alberta Health released the Primary Health Care Strategy which describes the principles, strategic directions, goals, and outcomes to further enhance the delivery of care, change the culture within the system, and put in place the building blocks for long-term sustainability. The "Establishing building blocks for change' strategic direction includes a goal of "Putting in place common information management and information technology" and recognizes that these are essential for team-based care and integration of PHC within the health system and with social and community services.

3.25 Alberta Medical Association Agreement

The recently ratified AMA agreement provides funding to support Physicians with IMT-related change management, including to integrate EMR systems with CII/CPAR. The goal of integrating EMRs with CPAR is to improve patient and provider experience through better integration of health information required to deliver quality patient care.

4. Mechanisms for Primary Health Care Integration and Quality

There are a number of mechanisms, including networks, initiatives, and governance and planning, which are working to improve the integration of PHC in Alberta. The following section will outline mechanisms for PHC integration in Alberta. For the purpose of this document, we have provided an overview of specific initiatives targeting PHC integration.

4.1 Primary Health Care Integration Initiatives

4.11 Specialist Link and Connect MD

Specialist Link is a service that offers a real-time tele-advice line for family physicians in the Calgary area to request non-urgent specialist advice and access best practices for clinical care pathways. The service was developed through a partnership between AHS and seven PCNs with the goal to improve communication and collaboration between primary and specialty care.

ConnectMD is a telephone advice line which gives primary care providers in the Edmonton and North Zones access to community specialists for non-urgent advice. The specialist has two business days to call back and to be connected with the family physician. Connect MD also provides clinical care pathways as evidence-based guidelines to assist in the physician's management of a patient's specific conditions.

Specialist advice services are currently being spread as part of the Alberta Surgical Initiative, both geographically and to remaining specialists, to ensure provincial coverage.

4.12 Primary Health Care and Addiction Mental Health Integration

Since 2017, the Provincial Addiction and Mental Health (PAMH) and PHC teams have collaborated on joint priorities to enhance the integration of addictions and mental health with PMH and PHC. The Building Addiction and Mental Health (AMH) Capacity and Capability in Primary HealthCare grant was created with the goal to increase training and confidence of primary care providers to provide AMH services in their practice. The Zone PCN Committees are working with their member Primary Care Networks (PCNs) to determine the most appropriate use of the funds in their zones.

4.13 Primary Health Care Integration Network

The Primary Health Care Integration Network (PHCIN) is a customized Strategic Clinical Network established to improve the integration between AHS and community-based PC providers. Key integration initiatives supported by the PHCIN include:

- Home to Hospital to Home **(H2H2H)**: A guideline for the system-wide approach to safe patient transitions
- Alberta Surgical Initiative **(ASI)**: A plan to improve access to surgical care through five strategies across the patient journey; particular focus on implementing a Specialty Access Bundle (including specialist advice and pathways) and launching a Provincial Pathways Unit to facilitate coordinated development and implementation of pathways provincially
- Reducing the Impact of Financial Strain **(RIFS):** A program to screen and support patients with financial strain

4.2 Primary Health Care Quality Initiatives

4.21 Health Quality Council of Alberta Panel Reports

Health Quality Council of Alberta (HQCA) is a provincial agency mandated to promote and improve patient safety, person-centred care, and health service quality on a province-wide basis based on the Alberta Quality Matrix for Health. HQCA produces Primary Health Care Panel Reports as an optional resource to support quality

improvement at the individual provider, clinic, and PCN, zone levels, as well as to inform program planning and panel management for providers, clinics and PCNs.

5. Performance Reporting

PHC performance in Alberta is reported on in a variety of ways, including:

- PCN Grant Reporting;
- Zone PCN Service Plans and reporting;
- PPCNC Annual Reports to the Minister of Health.

5.1 Primary Care Network Grant Reporting

Alberta Health reviews and approves accountability documents as part of reporting and submission timelines in the PCN Grant Agreements. PCNs submit operational planning documents for Alberta Health's review to ensure financial accountability and compliance with program policies and objectives.

These documents are a requirement of the PCN Grant Agreements:

- Three-year Business Plans set out how PCNs will meet PHC needs of their community, fulfill service responsibilities and key objectives due March 31;
- Annual Budgets due March 31;
- Annual Reports due June 30 and includes Schedule B: Primary Health Care Indicator Set (also known as Schedule B Indicators). An overview of PCN Schedule B Performance Indicators is provided in Appendix B;
- Mid-Year Reports due October 31; and
- Business Plan Amendments.

5.2 Zone Primary Care Network Service Plan Progress Report

Three-year rolling PCN Zone Service Plans are developed by ZPCNCs utilizing AH approved templates and guides to improve integration between PCN services, AHS programs, and services provided by community-based organizations. Zone PCN Service

Plan bi-annual Progress Reports provide a summary to Alberta Health, through the PPCNC, on the key actions, activities, and milestones achieved to date.

5.3 Ministerial Order Annual Report

The Annual Report is a requirement under the Terms of Reference of the PPCNC to report to the Minister of Health on PPCNC's progress toward achieving their mandate. It provides information about the PPCNC and ZPCNC's key achievements, challenges, and next steps in terms of future achievements.

6. Primary Health Care Spending

The following section outlines PHC spending in Alberta, including:

- Physician compensation models
- PCN funding model
- PCN and NP Support Program funding

PHC spending is typically comprised of funding for services directly related to the provision of PC services to patients and services related to referrals/coordination within and between PC and other areas.[81] In Alberta, PHC spending includes compensation for physicians providing PC and funding PHC service delivery models and organizations, including, as aforementioned, PCNs and its NP Support Program, CHCs, and clinics in communities and FCCs that are operated by AHS.

A key objective for the Ministry of Health is to develop and implement strategies that support the fiscal sustainability of the health system to bring Alberta's health spending more in line with national norms. To achieve this, several initiatives are underway, including compensation agreements with physicians, encouraging physicians to join alternative compensation models, and making more use of Nurse Practitioners to develop an efficient and effective health care system.

6.1 Physician Compensation Models

In Alberta, physicians are compensated for services through the Fee-For-Service (FFS) model and Alternative Relationship Plans (ARPs). In addition, PCNs are provided annual per-capita grant funding based on the number of patients attached to the physicians in a PCN. The Alberta Health Care Insurance Plan (AHCIP) coverage is provided for medically-required physician services and some dental and oral surgical services in accordance with the Alberta Health Care Insurance Act. The Schedule of Medical

[81] Government of Canada. (2012, August 23). *About primary health care*. https://www.canada.ca/en/health-canada/services/primary-health-care/about-primary-health-care.html

Benefits (SOMB) is the fee schedule and list of medical benefits insured under AHCIP with over 3,000 fee codes representing physician services.

The FFS model is currently used to provide approximately 90% of physicians' compensation in Alberta. ARPs are alternative payment plans for physicians that allow them flexibility for innovative delivery of care.

The table below describes the four main funding types of ARPs, please note that all payments are gross payments (including overhead):

Table 6: Alternative Relationship Plan Types

ARP Type	Description
Annualized Model	• **Compensation:** based on the number of physician full-time equivalents (FTE) needed for clinical services • Current clinical ARP rate for general practitioner (GP) providing primary care is $364,582.42 (FTE of 1,928 Program Service Hours)
Sessional Model	• **Compensation:** intended for part-time participation in delivery of clinical services for up to 2 days/week on average for the fiscal year at $221.73/hour • Applies to small, specialized programs and can include primary care programs that provide services to underserved populations.
Blended Capitation Model (BCM)	• **Compensation:** based on a combination of patient-based capitation payments and volume-based FFS payments • Designed to support physicians and clinics who align with the Patient's Medical Home model
Academic Medicine and Health Sciences Program (AMHSP)	• **Compensation (Clinical):** related to the number of physician FTEs needed to deliver service • Current rate of GP physician providing primary care is $364,582.42 (FTE of 2,300 hours) • **Compensation (Non-Clinical):** provided through the University of Alberta/University of Calgary, AHS, and Alberta Health

The average compensation or range for each of these arrangements are provided in the tables below for 2021-2022.

Table 7: Number of Physicians and Average Gross Payment per Physician in ARPs (2021-22)

Description	Total Payments	# of Physicians	Average Payment
AMHSP	$12,017,815.28	86	$139,742.04
Clinical ARP	$132,067,941.31	1,329	$99,373.92
TOTAL	**$144,085,756.59**	**1,415**	**$101,827.39**

Notes:

- Some physicians in ARPs may also earn income from FFS; physicians who receive payments under multiple compensation models may be counted more than once
- Physician count between AMHSP and Clinical ARP is not distinct

Table 8: Number of Physicians and Average Gross Payment per Physician in FFS (2021-22)

Description	Total Payments	# of Physicians	Average Payment
FFS only	$1,431,810,632.65	4549	$314,752.83
Blended	$91,764,607.11	576	$159,313.55
TOTAL	**$1,523,575,239.76**	**5125**	**$297,282.97**

Notes:

- Physicians in the blended category participated in both FFS and ARPs
- Physician count between FFS and ARPs is not distinct

6.2 Primary Care Network Funding

6.21 Primary Care Network Funding Methodology

Funding is provided through the grant agreement for PCNs to hire non-physician health providers and to deliver services and programs that are not included in the Schedule of Medical Benefits. Alberta Health provides PCNs with annual per-capita grant funding of $62 for each patient that the province attributes to a physician member of the PCN. The funding goes to the physician Non-Profit Corporation (NPC) or the PCN NPC depending on the legal model of the PCN.

Funding for PCNs is determined through a four-cut methodology that is based on physician
interaction with patients, measured at two points annually (March and September).

Four-Cut Funding Methodology

Patients are assigned to a physician for funding purposes based on the first of the below steps that applies to the patient's primary care visits.

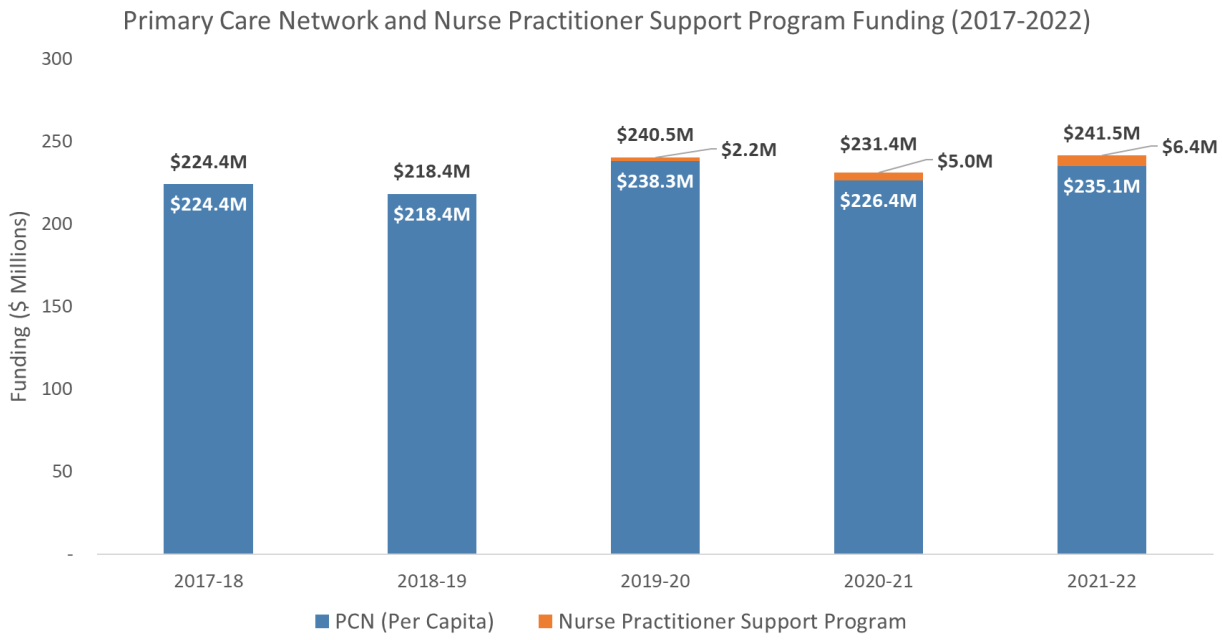
Step 1: Patients who have seen only one physician are assigned to that physician.

Step 2: Patients who have seen more than one physician, but where one physician is predominant, are then assigned to that physician.

Step 3: Patients who have seen multiple physicians the same number of times are assigned to the Physician who did the most recent physical exam.

Step 4: Patients who have seen multiple physicians the same number of times and had no physical examination done are assigned to the most recent physician seen.

6.22 Primary Care Network and Nurse Practitioner Support Program Funding



Notes:

- PCN per capita funding amounts reflect the total per capita funding based on the number of patients attributed to Physicians in a PCN. Funding does not include clinical compensation (e.g., FFS, ARP) for Physicians.
- The PCN Nurse Practitioner Support Program was introduced in 2019.

7. Patient and Public Involvement

Efforts across the PHC system have and continue to be made to engage and partner with patients, families, caregivers, and citizens to improve safety, quality and patient care. The following section will outline patient and public involvement with a focus on:

- Community involvement in:
  - AHS
  - PCNs
  - AH
  - Other PHC
- Indigenous community involvement in PHC

7.1 Community Involvement in AHS

There are many zone-, site-, program-, and project-based patient and family advisory groups spread across AHS. These are not exclusive to PHC. The following are a few examples of patient and public involvement with AHS.

Patient and family advisors (PFA) from across the province draw on their health care experience as a patient, family member, or caregiver to suggest improvements in quality, safety, and patient care practices within AHS. These advisors are involved in councils, committees, working groups, and quality improvement projects.

The **Strategic Clinical Networks (SCN) Patient Engagement** also supports engagements across SCNs and the Patient Engagement Reference Groups, although not exclusive to PHC. As of September 2022, 136 PFAs are involved in SCNs. The Primary Health Care Virtual Patient Engagement Network also has 123 members.

7.2 Community Involvement in PCN

Patient and community involvement is woven through different levels of PCN work; however there is not a provincial standard for how patient and community involvement

is planned for or achieved. The PPCNC, all ZPCNCs, and PCNs within each zone have community member representation. PCNs also often have PFAs involved in project-based initiatives.

7.3 Community Involvement in Alberta Health

Community involvement is a goal for Alberta Health, such as in governance (e.g., PPCNC community member which is currently in process for filling) and various task forces and working groups (e.g., Rural Sustainability Primary Care Task Force).

7.4 Indigenous Community Involvement

The **Indigenous Wellness Core (IWC)** is an example of Indigenous community involvement in PHC in Alberta. This program partners with Indigenous peoples, communities and key stakeholders to provide accessible, culturally appropriate health services for First Nations, Métis and Inuit people in Alberta. It is also guided by the advice of a First Nations, Métis, and Inuit Wisdom Council. The Wisdom Council is appointed by and reports to AHS. AHS appoints individuals who apply on their own behalf, similar to other AHS patient and community groups. Nominations for Wisdom Council membership are not sought from Chiefs and so the Wisdom Council is not established as a formal connection with First Nations communities. The individuals appointed provide guidance and recommendations to help AHS plan and implement culturally appropriate and innovative health service delivery for Indigenous Peoples.

7.5 Other Community Involvement Mechanisms

Other key stakeholders and mechanisms promoting patients and public involvement include:

- Office of the Alberta Health Advocates
- Health Quality Council of Alberta's Patient and Family Advisory Committee
- IMAGINE Citizens Network

- Alberta SPOR Support Unit (AbSPORU)
- Patient and Community Engagement Research
- Alberta Resident and Family Councils (long-term care and licensed supportive living facilities), enacted through the Residents and Family Councils Acts
- Alberta Continuing Care Association (ACCA)
- AHS Patient Concerns & Feedback
- Alberta Ombudsman & Patient Concerns Resolution Process

8. Primary Health Care Research

To achieve high quality PHC, effective PC delivery and PHC research are essential. Advancements in PC and PHC require innovation, research and the effective transfer and application of knowledge. The following section describes research networks and groups in Alberta focused on PC and PHC.

8.1 Research Networks and Groups in Alberta

There are a significant number of primary care research networks and groups in Alberta to drive, support, and share such research. Below is a table of the major research networks and groups in the province.

Table 9: Research Networks and Groups in Alberta

Research Network/Group	Description
Alberta College of Family Physician Networks – Research Community (ACFPN-RC)	Online research engagement platform to share resources and connect with members, including family physicians, researchers, allied health care providers, students and residents
Alberta Primary Health Care Research Network (APHCRN)	PHC research in Alberta is carried out through multiple networks, mostly in partnership with each other to identify research priorities and support relevant PHC research
Alberta SPOR Support Unit (AbSPORU)	Specialized, multidisciplinary research service centres across Canada providing infrastructure to assist patient-oriented research. Provides access to data platforms and services, tools, methods, and training
Alberta Strategic Patient Oriented Research (SPOR) Primary Care Research Network (PHCRN)	Interdisciplinary and intersectoral network that collaborates on generating solution-focused innovations in PHC delivery
Applied Research and Evaluation Services (ARES)	A division within AHS Primary Health Care provincial program that provides scientific expertise for evidence-based decision making

Canadian Primary Care Sentinel Surveillance Network (CPCSSN)	Canada's first multi-disease electronic medical record-based sentinel surveillance system. Collects anonymized data of selected representative samples of family physicians and their patients. Participating Physicians can request reports of their clinic data, to support monitoring/evaluation
Indigenous Primary Health Care and Policy Research Network (IPHCPRN)	Alberta-based network for improving PHC with Indigenous peoples
Pragmatic Trials Collaborative	Group of practising PC providers working to evaluate whether practice changes introduced affect important patient-oriented outcomes
Primary Health Care Integration Network Scientific Office (PHCIN-SO)	Advances research in PHC in Alberta by creating scientific evidence, fostering relationships among researchers, decision makers, and health care providers, building research capacity in Alberta, and facilitating the application of research evidence in decision making
Southern Alberta Primary Care Research Network (SAPCReN), Northern Alberta Primary Care Research Network (NAPCReN)	A multidisciplinary collaboration of PHC providers, academic primary care researchers addressing clinical practice research questions
Tarrant	Conducts influenza surveillance in Alberta and assesses vaccine effectiveness

Backgrounder Appendices

Appendix A

Primary Care Network Service Responsibilities

Article 8 of the Primary Care Initiative (PCI) Agreement itemizes the service responsibilities and categorizes them into direct services, and linkages to services within and between primary care and other areas. As well, it is the responsibility of a Primary Care Network to accept into its patient population, and provide service responsibilities to, an equitable and agreed-upon allocation of unattached patients.

Services directly related to the provision of primary care services to the patient population

- Basic ambulatory care and follow-up
- Care of complex problems and follow-up
- Psychological counseling
- Screening/chronic disease prevention
- Family planning and pregnancy counseling
- Well-child care
- Obstetrical care
- Palliative care
- Geriatric care
- Care of chronically ill patients
- Minor surgery
- Minor emergency care
- Primary in-patient care including hospitals and long-term care institutions
- Rehabilitative care
- Information management, and
- Population health

Services related to linkages within and between primary care and other areas

- 24-hour, 7-day-per-week management of access to appropriate primary care services
- Access to laboratory and diagnostic imaging, and
- Coordination of:
  - Home care
  - Emergency department services
  - Long-term care
  - Secondary care, and
  - Public health

Appendix B

Schedule B - Primary Care Network Performance Indicators

Primary Health Care System Outcome	Delivery Site Outcome	PCN Level Performance Indicator
Attachment All Albertans have a health home.	Attachment	1. Percentage of patients going to a different provider or different clinic for a subsequent visit
Access Albertans have timely access to a primary health care team	Timely access to PHC	2. Percentage of Physicians measuring Time to Third Next Available Appointment (progress measure for actual mean time to TNA).
Quality Clinical and social supports are brought together to promote wellness, provide quality care based on proven courses of action, and effectively manage chronic disease.	Early detection of risk and disease	3. Average of patient responses to the question "Overall, how would you rate the care you received in your visit today?"
		4. Percentage (or percentages) of compliance of Physicians in screening or offering screening to their panel of patients, as described in a menu of screens recommended by Alberta Screening and Prevention Initiative (ASaP).
Self-management of Care Albertans are involved in their care and have the supports needed to improve and manage their health.	Patient self-management	5. Percentage of patients with a chronic condition who were offered self-management supports during the fiscal year.
Health Status and Care Experience Albertans are as healthy as they can be, have better health overall, and report positive experiences with primary health care.	Enhanced patient experience of PHC	6. Percentage of patients with a chronic condition who report maintaining or improving quality of life as measured by the EQ-5D Health Questionnaire during the fiscal year.
Provider Engagement and Satisfaction	Enhanced provider experience	7. Percentage of identified team members responding to a team effectiveness survey

Providers satisfied and happy with their work lives and able to provide quality care.		
Leadership and Governance PCN leadership and governance is effective.	Effective governance	8. PCN board completion of all three components of self-assessment during the fiscal year: • Self-assessment of PCN board as a whole • Self-assessment of individual PCN board members • Performance improvement plan
		9. PCN board assessment of the performance of the PCN administrative lead and all other staff members reporting directly to the board for the prior fiscal year.

Thank you!

Photo courtesy of the Government of Alberta