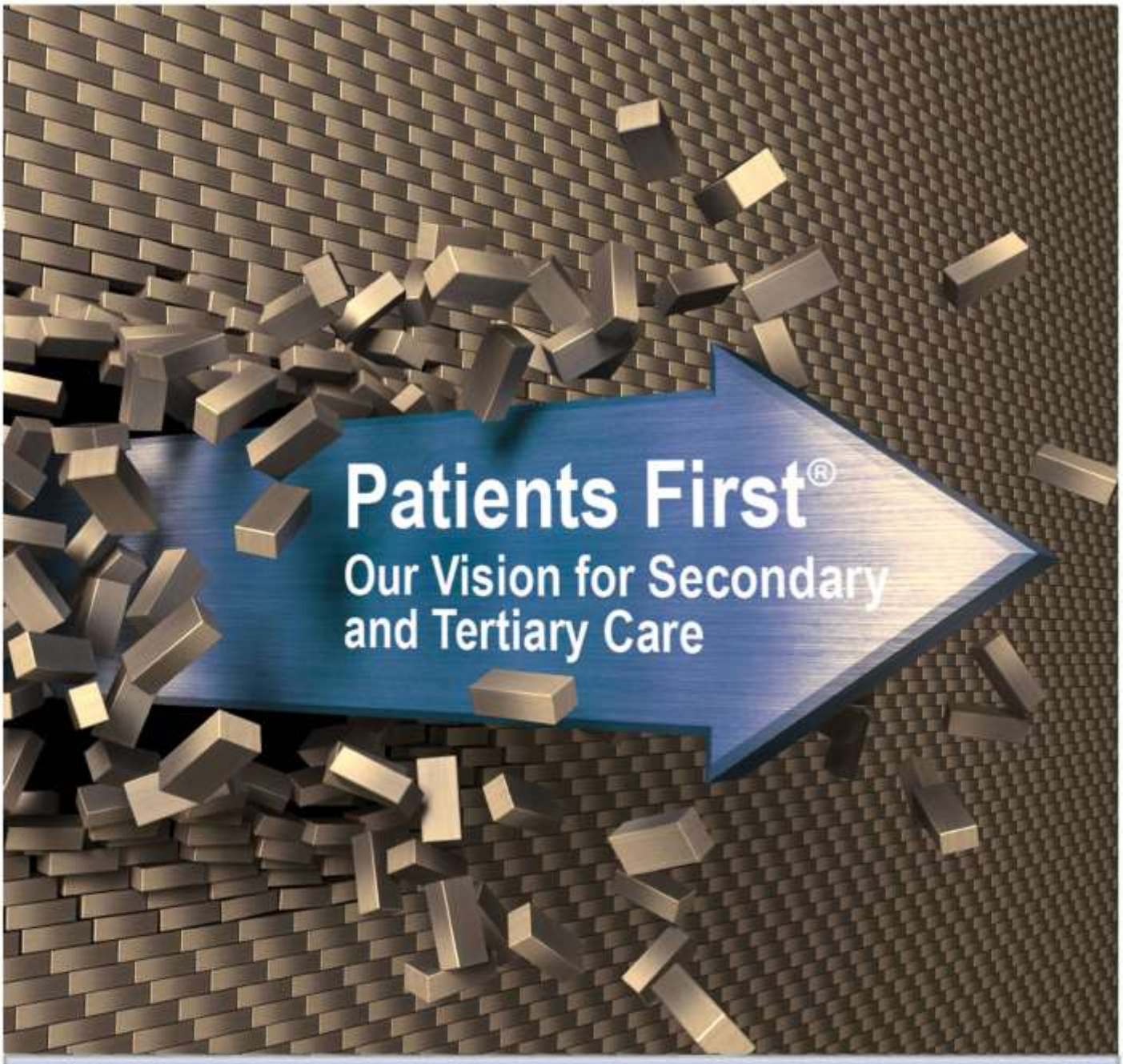
ALBERTA MEDICAL ASSOCIATION



STRATEGIC FRAMEWORK for SECONDARY and TERTIARY CARE

This Document:

- Builds upon the strategy outlined within AMA's strategic and tactical documents for secondary and tertiary care.
- Presents a framework to ensure physician involvement and solid communication between the Strategic Clinical Networks, secondary and tertiary care representatives from academic medicine, secondary and tertiary sections and other related stakeholders.
- This strategic plan has been prepared with consideration to:
  - The AMA's vision of Patients First®.
  - 2012-13 Alberta Medical Association Business Plan and Budget.

In preparing this document, it was assumed the priority areas for 2012-13 identified and discussed by the AMA Board of Directors have not changed. Some of the timelines/deadlines outlined may correspond to those dictated by external factors and other events such as AMA negotiations. Any revisions required will be undertaken.

Introduction and Background:

Historically, AMA's involvement with secondary and tertiary care has been section-by-section. There have been few initiatives or opportunities (other than those presented at Representative Forum) for issues or common interests that cut across several sections to be presented or discussed.

Recently, a proposal for a Provincial Academic Alternate Relationship Plan (PAARP), the formation of Strategic Clinical Networks (SCNs) and the Alberta Health (AH) proposed framework for negotiations has introduced an opportunity to engage physicians regarding common interests across several specialist sections. While we hope to evolve towards greater overall secondary and tertiary section support, these few areas offer opportunities to start such an effort.

Strategic Clinical Networks - Strategic Clinical Networks (SCNs) are a proposed mechanism through which Alberta can achieve on-going improvement in patient outcomes and satisfaction, health improvement and sustainability of our health system. Over the past year, support provided by the AMA has resulted in the assignments of 14 family physician primary care representatives to strategic clinical networks.

SCN's are aiming to align, support and empower teams of clinicians, strategy leaders, operational leaders, researchers, patients and other important community leaders and stakeholders with the appropriate tools, accountability, responsibility and authority for shared clinical, strategic and tactical decision-making. The combined focus will be on prevention and on improving the quality of care delivery. Among others, a key characteristic critical to the success of these networks will be engaging physicians at all levels.

Provincial Academic Alternate Relationship Plan (PAARP) - There is a nation-wide trend towards alternate payment models in place of, or supplementary to, a traditional fee-for-service model. In 2000 alternate payments comprised 10% of total physician payments and by 2009 reached 27% (source Canadian Institute for Health Information [CIHI]). This trend is evident in every province.

The current proportion of physicians in Alberta who receive some compensation through an alternate payment method has lagged behind all other provinces at 15%, compared to the national average of approximately 50% (2008-09 CIHI data). A proposal has been developed in Alberta for a PAARP that involves 3231 physicians.

AMA secondary and tertiary sections – Sections have been largely involved with INRV-type processes that have involved equity as a key objective. Lately, there has been a move nationally to look at aligning compensation with health system objectives such as access, quality, and sustainability. Recent events in other provinces and comments by Alberta's health minister indicate greater interest in issues of fee equity and relative value systems.

Proposal:

The AMA will implement activities over the next timeframe that complement the placing of physicians in leadership positions and delivering value to members. In doing so, these activities will:

- Support overall health system objectives and deliverables such as mechanisms to improve access.
- Support physicians entering new compensation models that are congruent with health system quality, access and sustainability.
- Enhance, improve and monitor the fee schedule.
- Support both specialists and primary care physicians in implementing quality improvement initiatives in their practices.

The activities will be initiated in three focal areas:

- SCNs
- The PAARP
- AMA sections

Secondary and Tertiary Care Representative Groups - Assemble two groups (one from Edmonton, one from Calgary) of 20-25 secondary and tertiary care representatives and staff to meet with the president to discuss SCNs, the PAARP and other opportunities to have AMA involvement with secondary and tertiary care. These representatives will have a broad experience in secondary and tertiary care areas (such as SCNs, the PAARP, other secondary and tertiary care areas of interest).

The discussion will not be issue-specific, rather, its purpose will be to identify various ways that AMA can support secondary and tertiary care groups. The meetings will also offer the opportunity to raise aspects of the recent government proposal (e.g., proposed changes to on-call and targeted fee reductions) and what the AMA is doing about it. The meetings will help to define secondary and tertiary care's role in the system as well as AMA's role in relation to this.

Specific Action Plans

To address the challenges noted above, a well-coordinated and comprehensive action plan will be needed. This action plan needs to address specific strategies and activities that include secondary and tertiary care physicians, AMA members, and internal and external stakeholders. Some of the key activities proposed are outlined in broad terms below.

Priority #1: Strategic Clinical Networks

The AMA will partner with SCNs towards successfully reaching organizational mandates such as access and engagement of physicians. The partnership will be developed through a number of short and longer-term initiatives:

Short-Term (Three to six months)

- **Initial engagement** - This initiative will be relationship based, providing AMA contacts from professional affairs and health economics and holding discussions with the clinical co-directors to identify various projects of common interest.
  - Overall goals:
    - To identify ways for AMA to support SCNs.
    - To identify how AMA can play a more significant role with respect to secondary and tertiary care physicians.
  - A critical part of this initiative will require the AMA to identify and provide value propositions to the SCN co-directors, e.g., identify one or two of these specific areas to work on to demonstrate proof of concept.
  - Three meetings will be held: one in Calgary and one in Edmonton with SCN co-directors and one with the clinical vice president for SCNs.
  - Co-directors are: Dr. Don Dick, Dr. Alun Edwards, Dr. Neil Hagen, Dr. Blair O'Neill, Dr. Duncan Robertson and Dr. Michael Trew.

- **Research** - AMA will research the concept of clinical networks, determining how they work in other jurisdictions, their objectives and critical success factors and how professional organizations are affiliated or involved.
  - A research paper to inform AMA staff, executive, board members and RF will be produced and circulated to fall 2012 RF.

- **Case-based funding model** – Flowing from the initial engagement, a case-based funding model will be further developed by the AMA, in keeping with the AMA's Physician Compensation Strategy (PCS).
  - Deliverables include:
    - A one-page summary of what case-based models will accomplish; a concise document clarifying the rules and mechanics of how it would work (defining scope, intent and other details beyond a conceptual).
    - Two or three specific proposals for consideration by SCNs.
  - Critical success factors will be developed and a consultant will be engaged to manage this project.

- **Communication plan** - AMA to produce a communication plan, detailing how members will be informed, involved, engaged with SCNs.

- **Fall RF panel** - AMA to organize a panel discussion at the fall 2012 RF regarding SCNs.
    - SCN panelists are asked to provide RF members with an update on specific innovative activities within their SCN, as well as ideas about how the AMA can help or be involved with SCNs. Some examples to consider are:
        - As a communication resource – a website to post reports, communications, etc.
        - To support linkages:
            - Provide advocacy for SCNs.
            - Help align compensation mechanisms with individual strategies within SCNs.
            - Help provide linkages with other physicians across sections and specialties.
        - Engagement of physicians in general or through specific mechanisms.

Longer-Term (six months to two years)

- **Opportunity initiation** – Using the research and initial engagement initiatives identified above, opportunities will be acted upon for the AMA to develop funding/compensation options that match with SCN delivery proposals.

- **Other compensation models** - Other compensation models to be discussed during the opportunity initiation, that are aligned with the AMA's PCS, such as amending the fee schedule to accommodate electronic communication, would be discussed with groups like Addiction and Mental Health and presented to AHS and AH.

- **Establishing Linkages** - AMA will explore opportunities to establish linkages with SCNs in the following areas:
    - Linkages with sections, exploring opportunity for payment alignment.
    - Linkages with general practice.
    - Linkages with quality programs such as Towards Optimized Practice, Physician Learning Program, Practice Management Program.

Priority #2: Provincial Academic Alternative Relationship Plan (PAARP)

The AMA will clarify and assert its role with the PAARP. This role will be developed through a number of short and longer-term initiatives:

Short-Term (three to six months)

- **Advisory Committee on Academic Medicine** (ACAM) – A subgroup to ACAM will be engaged to develop a set of specific ideas on how AMA gets involved. Some considerations include:
  - How to engage the profession to the PAARP issues.
  - How to manage multiple accountability requirements.
  - How to respond to the issue of relativity.

- **Provincial Academic Alternate Relationship Plan (PAARP) Environmental Scan** – Perform an environmental scan focusing particularly on other Provincial Territorial Medical Association (PTMA) involvement with initiatives similar to the PAARP, documenting:
  - The role of PTMAs with AARPs.
  - How PTMAs were able to involve themselves in this arena.
  - How the PTMA supports its membership (local vs. provincial) and through what mechanism.

  A summary document will be prepared.

- **PAARP legal review of framework document**- Perform a legal review of the PAARP framework document from the perspective of the individual physician. In doing so:
  - The impact to the individual physician (what it means to individuals) would be explored.
  - Pros/cons and any potential contractual issues would be identified.

  Phase 1:
  - Identification of physician issues arising from PAARP framework implementation.
  - Discussion of issues at RF, board, ACAM and with individual ARP physicians to focus on key issues of concern to physicians.

  Phase 2:
  - Research/seek clarification on outstanding issues.
  - Preparation of physician tool kit to support physicians joining the PAARP.

  From this work, the AMA would demonstrate an initial value proposition to all physicians that are considering their involvement with the PAARP.

- **PAARP funding model** - AMA also has the opportunity to initiate and be involved with a project that identifies revenues and in particular, a methodology behind an appropriate extraction rate (or provincial based payment rate) for the PAARP. This initiative will clarify:
  - Current methodologies of determining the clinical services contribution.
  - Other provincial methodologies in use.
  - Consideration and reconciliation of other revenues to the PAARP.
  - Options and recommendations for Alberta today and in the future.
  - Presentation to the Physician Compensation Committee (PCC), AMA Board of Directors, PAARP Steering Committee.

  From this funding model initiative, the AMA would be involved with developing an overall funding plan for the PAARP, through the role of the AMA on the PAARP Steering Committee.

- **PAARP compensation model –** Using AMA's ARP principles and AMA's PCS, the compensation model and rates for PAARP physicians will be confirmed. This project will be managed through the PAARP Steering Committee. Through AMA participation in this initiative, AMA involvement in rate setting for AARPs will be maintained.

- **Communication plan -** AMA to produce a communication plan, detailing how members will be informed, involved, engaged with PAARPs.

Longer-Term (six months to two years)

- **PAARP compensation review** - AMA will also be involved with a compensation review, a project that is currently being developed by a consultant. This involvement of the AMA includes developing an overall compensation model for the PAARP, in keeping with AMA's PCS, inclusive of a clinical services description, via:
    - Involvement of the PCC, in establishing funding methodology and compensation rates. Note: It is important that the AMA identifies its level of involvement and what it is trying to achieve.
    - The role of the AMA through the PAARP Steering Committee.
    - An AMA role in the provincial accountability framework for the PAARP (through the PAARP Steering Committee or other opportunities).

- **PAARP physician contract toolkit -** Using the results of the legal review, a toolkit will be developed and made available to physicians. This toolkit will:
    - Support the individual dealing with contract issues related to both AHS and PAARP situations.
    - Provide the results of a legal review at a provincial level regarding standard contracts such as Individual Services Agreement templates regarding boilerplate language (e.g., indemnity, termination clause, independent contractor, etc).
    - Provide several examples of contract provisions used elsewhere in the country.
    - Be provided as free information and not intended as legal advice (note: individuals will be urged to seek their own legal counsel).

- **Provide advice –** Negotiators will be available to groups regarding Individual Service Agreements in order to support the individual dealing with contract issues related to both AHS and PAARP situations.

Priority #3: Sections

Section representative group – A series of meetings will be convened with section presidents and the AMA president to identify ways that the AMA can better support secondary and tertiary care. These meetings will provide the opportunity to share some of government proposals and our action plan and get feedback. The meetings will occur in various locations throughout Alberta.

Modernization - In response to concerns expressed by AH that are closely aligned with the Ontario government unilateral imposition, AMA will be considering methods to modernize the fee schedule.

Moving from a significant focus on equity to expanded involvement with aligning system objectives to compensation models, sections (including General Practice) would be actively involved in a process to modernize the fee schedule while balancing two issues:

- Internal equity.
- Overall alignment to system objectives of quality, access and productivity.

This idea of involving sections towards modernizing the fee schedule would depend on government's willingness to be involved. It would also affect all sections, including General Practice.

AMA will also explore other opportunities to develop the Primary Care-Specialist Linkage, in terms of facilitating secondary and tertiary section involvement with the development of the primary care strategy.

Resources Anticipated:

HE will dedicate staff over the next year to lead and provide support to these activities, while ensuring its core activities such as preparation for an allocation and negotiations are still being managed appropriately. Professional affairs will also be involved with this project, specifically as related to the SCN relationship. To further develop AMA's core interests in the three focal areas, additional resources will be required related to:

- Legal fees
- Consultants
- Professional fees

Total budget requirement: To be approved on a project by project basis.

Stakeholders:

Strategic Clinical Networks leadership
PAARP members and leadership
AMA Board of Directors
AMA president
AMA's Physician Compensation Committee
Section leadership
Government
AMA professional affairs
AMA health economics

Immediate (Three Month Plan):

SCN engagement
SCN research
Case-based funding model project
Fall RF panel discussion
Academic Advisory Subgroup
PAARP environmental scan
PAARP legal review of framework document
PAARP funding model
Communication plan

Conclusion:

An investment over two years is required to significantly improve upon AMA's involvement with secondary and tertiary care areas, beyond a traditional section-by-section involvement. This investment will secure our role and provide value through a Provincial Academic Alternate Relationship Plan, the formation of Strategic Clinical Networks and a province-wide effort to modernize the fee schedule.

Appendices:

Appendix #1 - AMA Background Paper: Strategic Clinical Networks

AMA Background Paper: Strategic Clinical Networks

Overview

This paper outlines the introduction of Strategic Clinical Networks (SCNs) in Alberta in 2012. It provides background information on established clinical networks in select countries, including their successes, failures and opportunities for involvement by professional organizations such as the Alberta Medical Association (AMA). A summary provides details on both ongoing AMA participation in SCNs and opportunities for further consideration.

Introduction

SCNs are a networked system of care, centered on specific disease and population types, used to link healthcare providers across specialties and professional boundaries. These networks will act as a mechanism to engage clinicians and refocus service towards patients and quality care.

The implementation of SCNs has provided the AMA an opportunity to increase its role in secondary and tertiary care in Alberta. As a key enabler to physician engagement, the AMA will be able to provide specific expertise and enable network sustainability. In considering the specific forms this role should take, the involvement of other professional organizations in clinical networks around the world is first assessed.

Adoption of SCNs in Alberta

SCNs were introduced by Alberta Health Services (AHS) in spring 2012, building upon established clinical networks to enable a focus on patient experience and overall quality across the entire continuum of care.

The first six networks, developed around specific populations and high impact diseases, are:

- Diabetes, Obesity, Nutrition
- Bone and Joint Health
- Cardiovascular Health and Stroke
- Seniors Health
- Addiction and Mental Health
- Cancer Care

These networks will use clinician-led teams to improve upon quality through:

- Enhancing overall patient experience.
- Improving healthcare access and outcomes through best-practice medicine.
- Increasing staff and physician satisfaction and engagement.
- Reducing variability in care across population group and geographical lines .

Structure and Support

SCNs will center on a core team of clinicians, researchers, patients and community partners. These members will create formalized teams with sit-in groups, committees and working teams, led by a senior medical director and vice president. Furthermore, each SCN will be accountable to a co-leadership of the AHS

executive vice president (EVP) of strategy and performance and the EVP and chief medical officer (CMO) of quality and medical affairs.

Financial support for SCNs will cover remuneration for administrative duties as well as funding for select, high-impact projects. Additionally, a proposal is being outlined in which financial gains from quality innovation could be reinvested into a research seed fund. The intent is for this fund to act as an incentivizing mechanism for cost saving and quality improvement (SCN Primer, 2012).

Long Term Growth

AHS anticipates the addition of six more networks by spring 2013. These networks include:

- Population Health and Health Promotion
- Primary Care
- Maternal Health
- Newborn, Child and Youth Health
- Neurological Disease, ENT, Vision
- Complex Medicine (encompassing the current Respiratory Clinical Network)

Comparative Examples of Established Clinical Networks

Diverse models of quality-based clinical networks have been implemented in the United Kingdom (UK), Australia, Europe and Canada to varying degrees of success.

UK and European Networks

UK: In 1997, the UK developed network-based models of care to provide integrative, cost effective and equitable services along specialized patient pathways. These networks were largely informal in nature, with a large National Health Service (NHS) networks database allowing for interested physicians to find networks suitable to their interests and expertise.

- These networks saw variable improvements in quality, including decreases in hospital admissions for networks based around disease-type (NHS CB, 2012).

As of July 2012, NHS implemented a change over from informal clinical networks towards SCNs, along the same lines as Alberta. These new SCNs are to provide formalized national structures with focus on specific disease types and populations. The first networks to be launched include Cancer, Cardiovascular, Maternity and Children, and Mental Health (NHS CB, 2012).

Scotland: Managed Clinical Networks (MCNs) have operated since 1998 and are currently comprised of 28 national networks for specific health issues such as complex burns or cleft palate repair, with 24 regional and 100 local networks centered on broad disease-type (ie. diabetes, vascular, palliative, etc.).

- Here, a “bottom-up” structure is utilized, whereby networks are started through grassroots establishment and subsequently supported by policy makers when specific core principles are met. These core principles include clear management structure and goals, evidence-based practice and patient involvement.
- According to the National Institute for Health Research (NHIR), MCNs have allowed for professional working arrangements and cross sectional communication to improve. Quality and costs saving improvements were minimal however (NIHR SDO, 2010).

Sweden: In the early 2000's, Sweden adopted a "chain of care" network model, with contracted integration between purchaser and provider, to supply high quality care with less fragmentation.

- Each chain of care takes budgetary responsibility with volumes, costs, quality and methods of delivery outlined in commissioner agreements.
- Quality improvement and system redesign has been minimal, as implementation has been blocked by limited engagement on local levels. One study revealed this to be dependent on weak incentives for collaboration and little redistribution of power within the vertical structure (Åhgren, 2003).

Australian Networks

Building off the networked approach, Australia developed state-wide clinical networks to re-engage clinicians in the governance and planning of health services through clinical networks. The first adoption of clinical networks was in New South Wales (NSW) in 2001, followed by Queensland in 2005 and since carried through to all other states.

- The last state to adopt clinical networks was Tasmania, which launched three networks before 2010 and is in the introductory stages for 6 more networks.
- Western Australia, after introducing Health Networks in 2006, has the largest network scope in the country with 17 networks currently active (WA Health, 2012).

However, these statewide clinical networks are not all the same, as they vary in centralization, financing arrangements and focus.

- The Victorian SCN model utilized a decentralized approach, centered on disease type. This employs single fund-holder arrangements similar to Scotland's MCNs.
- In South Australia, a more centralized "coordinated care" model has been used along with a population-targeted approach (Cunningham et. al, 2010).

Canadian Networks

A number of provinces, including Ontario, British Columbia (BC) and Saskatchewan, have established quality councils with associated networks for physician engagement. Most notably, BC's Patient Safety and Quality Council (BCPSQC) was established in 2010 to provide a collaborative, patient-centered approach to health care delivery.

As a council, the BCPSQC has a direct advisory role with government and works together with health authorities and professional organizations to implement quality initiatives brought forward by numerous councils. Though these are not formal SCNs in nature, they have both similar goals and similar membership to the SCNs currently developing in Alberta (Giannasi, 2011).

SCN Development as a means for Physician Engagement

In comparing established SCNs found around the world, clinician engagement became the foundation on which all networks either thrived or failed to see impact. Differing structures and levels of stakeholder involvement, along with issues related to information sharing and funding were additionally cited as facilitative to success or failure. Ultimately, these additional themes rested upon how differing structures, financial arrangements or other support systems enabled network engagement.

Structure and Stakeholder Involvement

In a 2010 Australasian Conference on Clinical Networks, hierarchical structures were noted to come in direct conflict with clinical autonomy. Grassroots development of networks was argued as most favorable for physician engagement, with concessions for balance between "top-down" and "bottom-up" structures. This balance would ensure an appropriate base of accountability, while also allowing the networks to remain clinician led (Cunningham et. al, 2010).

Scotland: In application, the grassroots structure of Scotland's MCNs has provided a successful means for initiating and sustaining networks. Their balanced structure has allowed the focus to remain on patients and clinicians with clear two-way communication between networks and leaders. As one respondent to an MCN review stated, "If people are too focused on organizational structures, nothing happens" (NIHRSDO, 2010).

Sweden: More hierarchical examples, including Sweden's "chains of care" were noted to have broken down at the local level. A national study showed that physicians struggled to become engaged in the face of excessive departmentalization of responsibilities and top-down power structures of vertical integration. Moreover, a lack of regular participation from local authorities diminished opportunities for development (Åhgren, 2003).

Alberta: In their introduction SCNs have integrated a balanced network approach into their proposals, outlining a network structure whereby SCNs are clinician led and patient focused, yet accountable to both a senior medical director and vice president. They, in turn, are accountable to the AHS EVP and chief development officer and the EVP and CMO, quality and medical affairs.

Information Sharing

Communication and information sharing was seen as key to success in MCNs, chains of care and BCPSQC networks. Information was seen to support engagement and foster good relationships, while aiding the spread of best practice (NIHR SDO, 2010).

The British Medical Association (BMA) website provides easily accessible and informative links for SCNs. These include background information and relevant news articles, along with BMA publications, advocacy efforts and live web-casts of their annual representative meeting.

- A series of briefing papers titled "What we know so far…" are frequently updated to give BMA membership full information on relevant government proceedings and structural changes.
- BMA research available for download includes:
    - "Doctor's Perspective" papers, on organizational mergers, clinical leadership and NHS integration.
    - "Integrating Services without Structural Change", an overview of network structures.
- Advocacy efforts, including letters to government officials are posted online.

Information availability also relates to understanding physician perception of SCNs, including their interests and concerns. To accomplish this, the BMA carried out two different physician membership surveys prior to the implementation of SCNs in the UK. Results indicated the top priorities for SCNs were improved clinical outcomes and better patient experience, while cost savings was given lower priority (BMA, 2012).

The BMA identified the largest barriers to integrated care as:

- Conflicting organizational priorities

- Lack of coherent information technology systems
- Absence of managerial leadership

While they identified key enablers of networks as:

- Building good professional relationships
- Effective clinical leadership
- Collaborative work environments

Financial Support

Financial support is an ongoing issue for clinical networks, as most health authorities only include funding for administrative duties of network members. Nevertheless, if networks are to be cost saving, as reasoned by Australian clinical conference participants, additional money must be spent in order to realize long-term savings and sustainability (Cunningham et. al, 2010).

The AHS financial support proposal has so far mirrored most other networks in their remuneration of administrative duties. Though AHS' proposed commitment to funding high-impact projects along with retention of innovation-driven cost savings will add additional value (AHS Primer, 2012).

In ensuring the appropriate funding levels in networks, multiple respondents from MCNs reasoned that by using condition-specific expertise and engagement of a wide range of stakeholders, a more credible case for resource investment would be made (NIHR SDO, 2010). The presence of local advocates, including professional organizations, "provided legitimacy" to network goals and would allow for engagement with potential sources of funding.

Further Member Engagement

In addition to providing support and advocacy for membership involved in SCNs, professional organizations have aided networks in the following ways:

- Evaluation:
    - Interim reviews are typically commissioned by health authorities or by the networks themselves, as in NHS Scotland's MCN review or BCPSQC's interim report. The BMA went beyond these typical reviews however by providing a physician focused evaluation of clinical networks in their "Doctor's Perspective" papers.
- Continuing medical education:
    - As a means to engage and inform their physicians, several state medical associations have developed annual clinical network conferences as a form of continuing medical education (CME) in Australia. This allows for best practice ideas to be shared amongst different states and networks.
- Advocacy:
    - Involvement of professional organizations in clinical networks centered on continual advocacy on behalf of physician membership. Specific examples included:
        - The BMA provided support for physicians through advocating directly to government officials through published letters (Lord Howe, 2012).
        - Additionally, the BMA released a paper, "Engaging in Local Healthcare Developments: A guide for doctors on how to get involved and take the lead".

Opportunities for Involvement

In order for SCNs to become effective bodies of change in Alberta, the AMA must work with other key stakeholders to ensure physician engagement and proper support. Potential areas for AMA involvement include:

- Becoming a key information provider and access point for members regarding SCN activities by increasing the information available on the AMA website.
- Providing targeted funding toward physician engagement activity.
- Developing compensation models that are aligned with SCN strategy.
- Gauging the interests and concerns of both physician membership and the public in relation to SCNs though the AMA annual survey and other outlets.
- Further promoting the AMA and its members through communication, advocacy and involvement.

Currently, the AMA has involved itself in SCNs through:

- Initial Engagement:
    - Meetings are being planned with SCN medical co-directors and secondary and tertiary care representative in both Edmonton and Calgary.
    - These meetings will assess common interests and identify value propositions for further AMA involvement.
- Research:
    - Comparative studies on other developed clinical networks are currently underway.
- Funding
    - A case-based funding model is to be developed.
    - Other incentive-based remuneration models are currently being assessed.