
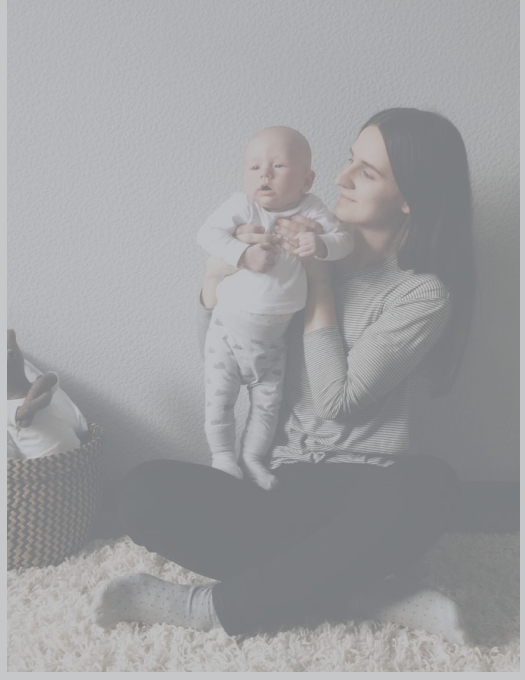


THE INTEGRATED HEALTH NEIGHBOURHOOD OF THE FUTURE

White Paper on Transforming Primary and Community-Based Care

Primary Care Alliance



About the Primary Care Alliance

The Primary Care Alliance (PCA) provides a forum for the unified voice of primary care physicians to advance their common interests and shared goals in primary care. The Alliance's goal is to foster a coordinated and aligned approach to meet the needs of patients, caregivers, families, primary care teams, PCNs and the healthcare system today and into the future.

https://www.albertadoctors.org/leaders-partners/innovation-in-primary-care/primary-care-leaders-partners/pca

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- Dr. Jon Hilner, AMA Section of Family Medicine
- Dr. Samantha Myhr, President; Dr. Edward Aasman, Past President, AMA Section of Rural Medicine
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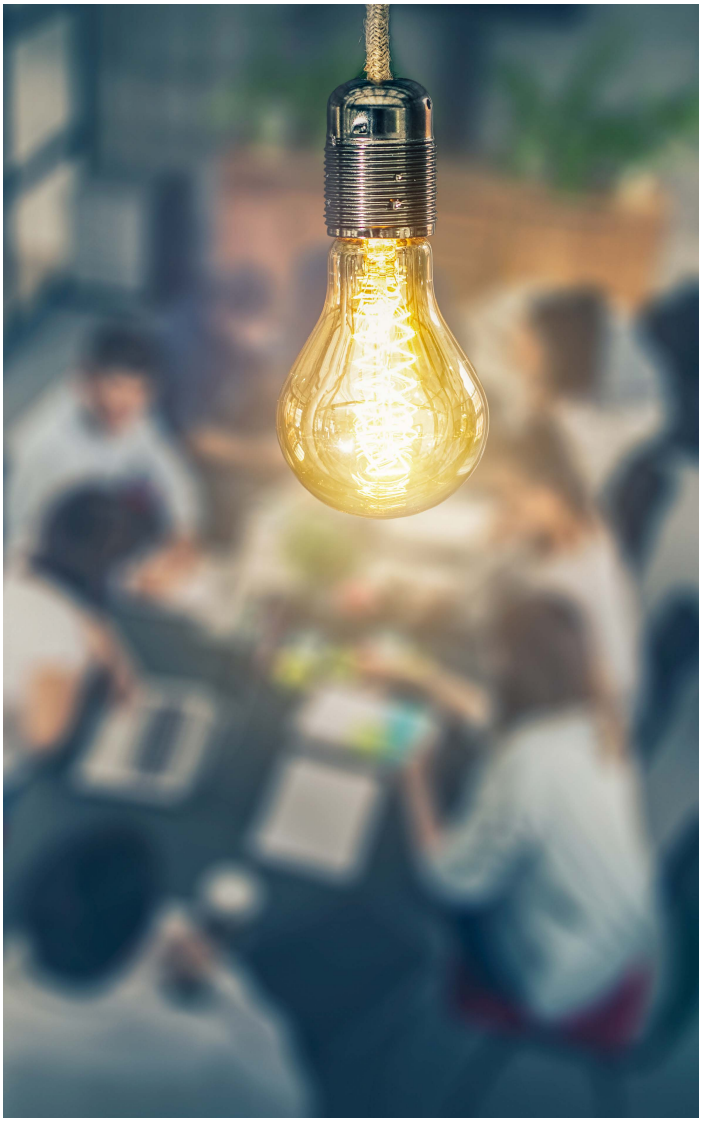
The Challenges

Most Albertans agree that the current way in which health care is organized and delivered in our province will not meet our needs in the future, and the pressures facing the health system need to be addressed now. Transformation and innovation have occurred around the edges, but we need to move past incremental change and invest in large-scale transformative change. Some of the fundamental challenges that need to be addressed include:

1. A siloed and fragmented system, due to misaligned funding and compensation models and inadequate coordination and continuity of care
2. A system not driven from a population and social determinants of health perspective
3. An acute and episodic hospital focus to the detriment of primary and community-focused approaches to care
4. Workflows and the way in which services are delivered that do not reflect optimized delivery of care and patient preferences
5. Inconsistent quality of care, including limited standardized clinical care pathways and protocols, and insufficient uptake and supports for quality improvement at the frontline
6. Insufficient measurement and accountability
7. Inadequate implementation and adoption of technology, including limited interoperability
8. Resistance to change at the system and service levels among administrators and clinical disciplines
9. A lack of a clear vision for the health system that is co-created and shared by all, with inadequate community, patient and caregiver engagement and broadly representative governance

There are also issues facing our health system that pertain to certain groups:

- ***The public*** wants a high-performing universal care health system that meets their needs, but many of their needs are either not recognized or unmet. It wants government and health services to be stewards of the system to ensure its sustainability. The public wants transparency and to know that decisions at all levels are being informed by the best evidence and good data – not politics.
- ***Patients*** want their experience to be at the forefront of planning, design and service delivery. While some progress has been made in this direction, there remains much to do. Many do not have a regular primary care provider and accessibility, wait times and having a dedicated provider matter most to patients. They want a consistent relationship with health care professionals who know them and their medical history. Moreover, Albertans don't just want access; they want services that reflect their values and preferences and show them respect as individuals. As well, many are not receiving the quality of care they deserve and experience disjointed care or fall through the cracks. They want better collaboration and communication among providers and improved links between health and social care services.
- ***Alberta Health (AH)*** is concerned about the mismatch between per capita spending and expected outcomes. Currently, there is inadequate accountability cascading throughout the health system. AH wants a better sense of how dollars are spent and to have more predictable budgetary costs. While AH promotes a robust primary and community-based care sector, it continually points to unmet needs in the acute care sector as the reason it cannot make the required fundamental shift.
- ***Alberta Health Services (AHS) and other health administrators*** are the interface between Alberta Health and much of health service delivery. They are accountable to government and the public. However, there is overlap and confusion related to roles and responsibilities and competing priorities between AH and AHS in terms of developing strategy, funding, managing and monitoring primary and community-based care. Health administrators across the system are often faced with mixed messages and a number of unnecessary barriers to improving care quality and processes. Importantly, the health system needs transformational, supportive and visible administrative leadership, with improved connections with frontline staff.
- ***Health care professionals*** generally support a comprehensive Patient's Medical Home to improve patient experience and outcomes. But, many primary care physicians do not work in optimized interprofessisonal teams and are not well-integrated with other community-based services and clinicians. Physicians and AH have failed to acknowledge the negative aspects of fee-for-service and adopt new remuneration models, which would provide greater income predictability and facilitate teamwork and interprofessional care. Workplace and job satisfaction are important to providers. However, many are frustrated because the best experience, care and outcomes are not ensured for their patients as they transition through the system. Many experience burnout trying to meet patient needs, with inadequate system structures and resources, including interoperable health information systems.



As well, a greater understanding of health system workforce recruitment and retention is required, and competencies developed in the health workforce education system must meet future needs. Workload and the recent experience of physicians in Alberta have resulted in declining interest in family medicine. Not all health care professionals agree on the type of change needed, and there are differing views among disciplines about the best way forward and who should be involved. A new culture, mindset and approach with regard to leadership, governance and service co-design among health professionals are required.

The Primary Care Alliance has developed this white paper to advance primary, specialist and community-based health and social care in Alberta to a transformed state in 2030 and beyond. This white paper addresses the reasons transformation is required and proposes a new way forward. It proposes significant shifts in Alberta's health system organization, service delivery and relationships. **The recommendations challenge the status quo and serve as bold, thought-provoking tools.** There are opportunities and challenges ahead for all those working in health care. Some ideas and proposals herein will make government, health care providers, organizations and patients uncomfortable. **But, it is time for all Albertans to consider some fundamental shifts if publicly-funded universal health care is to remain a viable and preferred option.**

"The prevailing culture surrounding Alberta's health system is defined by many as being risk averse. The level of transformation envisioned by Alberta's future vision for better and more sustainable healthcare will require responsible, but bold action" (EY 2019).

Foundation for a Transformed Health Care System

This white paper is anchored in the lessons learned from Alberta's past and current primary and community-based health care transformation journey. It builds on these lessons, with applicable learnings and evidence from high-performing health systems, and the knowledge and experience of the members of the Primary Care Alliance and other health care thought leaders in Alberta and elsewhere. While health care systems may differ in their structure and delivery systems, there are several key attributes that ensure high performance. This white paper acknowledges and embraces these attributes throughout. The Patient's Medical Home and integrated health neighbourhood are integral concepts in this paper. The Patient's Medical Home model – which emphasizes team-based, comprehensive, high-quality primary care – is the foundational and aspirational model for Alberta and has been the basis of primary care transformation efforts in the province to date. The concept of an Integrated Health Neighbourhood takes comprehensive team-based care in the medical home even further. With the Patient's Medical Home as a hub, care is integrated and coordinated within the neighbourhood among other local health services, specialists, hospitals and home care, and broader social and community supports, such as community-based mental health and addictions, public health and social services.

A Transformed Health Care System

Transforming Alberta's health care system requires both a new system and service design.

A transformed system design will be characterized by evolving health care organizations and infrastructure, which increasingly will be community and population-driven and have a primary and community-based care orientation. In a transformed health neighbourhood with an integrated service design, primary, specialist and other community-based health and social care will have patient-preferred services, cohesive, versatile and motivated teams, information and management continuity, and continuous quality improvement.

A New System Design

High-performing health systems are integrated, with streamlined funding and service delivery, and they are community and population health driven, with a primary care orientation.

Better quality, population and patient outcomes and value for money can be achieved through a reallocation of resources and changed health system structures and processes. The proposed new design for Alberta's health care system entails an evolution from existing organizational structures towards full integration, with an important first step of integrating and improving primary and community-based services.

Evolving Organizational Structures

A New Provincial System Design – Alberta Community Health Care Services

To achieve health system transformation goals, changes to the existing provincial, regional and practice-based organizational structures are required.

We propose a newly integrated funding, administrative and delivery system for primary and community-based health care services, with oversight by a new provincial agency called Alberta Community Health Care Services (ACHCS). Taking on some of the services currently under Alberta Health and Alberta Health Services' mandate, ACHCS will provide province-wide strategic leadership and planning for community-based care within a global budget – including primary care, community specialists and other community-based services. AHS will provide similar oversight for acute care, urgent care, long-term care, laboratory services and other facility-based care. A Joint Commission will set overall system standards, performance frameworks and clinical pathways; support information technology infrastructure; facilitate the provision of bundled services across health sectors; and support the evolution towards greater system integration (Figure 1).

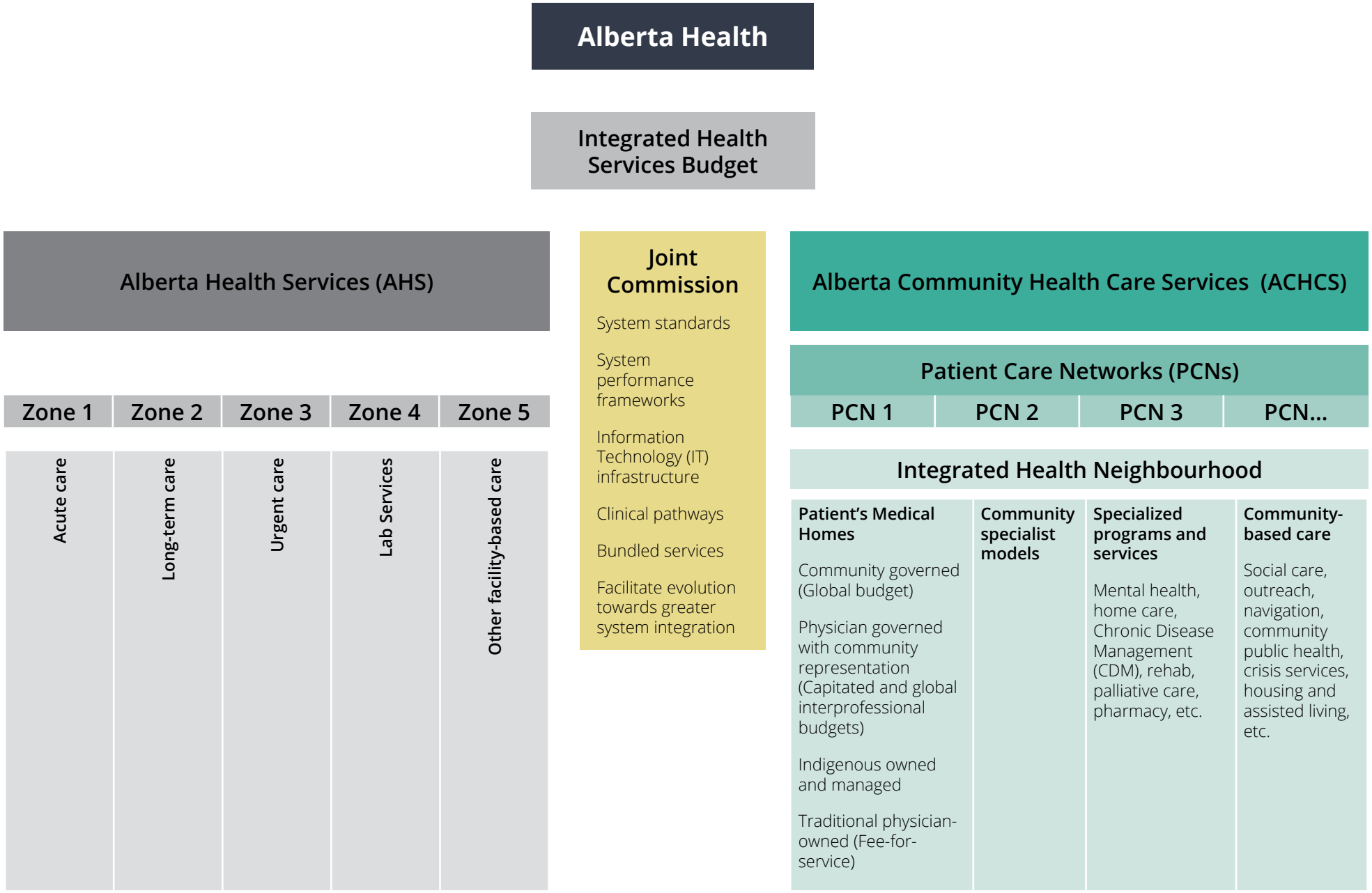
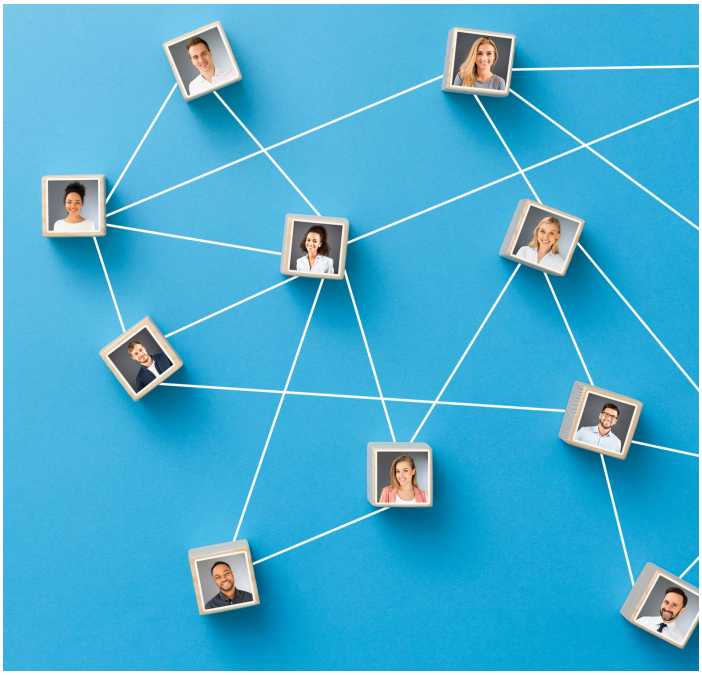


Figure 1. A new system structure and design

The establishment of ACHCS will be an initial transformational step towards a fully integrated system design, first allowing for a focus on the integration of primary and community-based services and a strong voice from local health services and community members in service design and implementation. Having dedicated infrastructure will give primary, community specialist and community-based care a place to define their vision, plan and develop new models for addressing the problems they face.



A New Regional System Design – Patient Care Networks

Patient Care Networks will be responsible for planning, funding and oversight of all local community-based health services – Patient's Medical Homes (including physicians and expanded interprofessional teams), community specialists, specialized programs and services (e.g., mental health, home care, community pharmacy) and other community-based care (e.g., outreach, navigation, community public health and some social care). They will facilitate service integration across the health neighbourhood, guide and oversee service delivery, potentially deliver some services directly, and ensure consistency and interaction among Patient's Medical Homes. They will also consult and formally partner with other community-based agencies, social services, Non-Governmental Organizations (NGOs), municipalities, schools, housing, justice and other services.

The Patient Care Networks will have inclusive, transparent governance models that support collaborative decision making. Governance responsibilities will include: defining and living by the vision and goals; financial management and resource allocation; monitoring shared accountabilities, integrated service performance, and quality and impact measures; reporting; and dispute and conflict resolution. The governance structure will be two-tiered with both a strategic and management/ implementation arm and designed to ensure leaders from health and social services in the health neighbourhood, health care professionals, community members and organizations, and patients and caregivers are able to engage in deliberative, consensus-oriented decision making.

The proposed Patient Care Networks will entail a significant change and will go far beyond the current Primary Care Network mandate, incorporating existing PCNs into an expanded, integrated network of community-based service delivery. Several high-performing PCNs will be able to expand their mandate and evolve into Patient Care Networks; others may merge and expand their mandate in this regard. In some instances, new entities may need to be formed.

Table 1. Summary of the attributes of a new system structure and design

	ACHCS (Provincial)	Patient Care Network (Regional)	Patient's Medical Home (Local)	Specialists (Local)	Specialized Programs and Services & Community-based Health Care (Local)
Mandate	• Province-wide strategic leadership and direction • Stakeholder engagement, joint planning and collaborative partnerships	• Strategic, and some operational planning • Funds and oversees health service delivery within a geographic area • Stakeholder engagement and joint planning	• Comprehensive, integrated primary health care delivery • Primary care (potentially including mental health, home care, palliative care, specialists, etc.)	• Integrated community specialist services • Comprehensive specialist services based need and availability	• Specialized services, e.g., mental health, home care , CDM, rehab, palliative care, community public health, outreach, care navigation, social care, etc.
Governance	• AH subsidiary (like AHS) • Independent legal liability and Board • Separate leadership and management	• Independent corporation • Local health care services and providers and community representatives • Flexible within set ACHCS parameters	• Independent, self-governed incorporated entities • Community representation	• Integrated within the Patient's Medical Home (PMH) *or* • Self-governed incorporated group of specialists	• Contracted by PCN *or* • Employed and managed by the PCN
Budget	• Sets a risk-adjusted per capita global budget for each PCN based on PCN proposals • Sets budgetary and financial accountability requirements	• Allocates a budget for primary, specialty and community-based health care within the network • Sets budgets for PMHs and other health services based on submitted budgets and business plans • Provides fiscal oversight based on ACHCS financial accountability requirements • Supports shared back office services • Supports joint ventures, e.g., cross-sectoral bundled care	• Develops a budget and operational plan for submission to PCN • Manages a budget for a defined patient population • Allocates budget based on local circumstances, within ACHCS/ PCN parameters • Budget includes: clinic infrastructure; administration roles; clinic leadership; physicians; interprofessional teams; change management, Quality Improvement (QI)	• Integrated into the PMH budget *or* • Manages a budget for defined patient population • Covers administration and service delivery	• Manages a budget for defined patient population *or* • Funded and managed by the PCN *or* • Integrated into the PMH

Table 1. Summary of the attributes of a new system structure and design con't.

	ACHCS (Provincial)	Patient Care Network (Regional)	Patient's Medical Home (Local)	Specialists (Local)	Specialized Programs and Services & Community-based Health Care (Local)
Accountability	• Defines fiscal accountability and performance frameworks • Monitors and audit PCNs	• Formal service agreements and contracts with service providers • Direct employment of some providers • Management and monitoring based on provincial accountability and performance frameworks	• Accountability and performance contract with the PCN • Performance measurement and reporting to PCNs • Joint accountability across the neighbourhood	• Accountability and performance agreement with the PCN • Performance measurement and reporting to PCNs • Joint accountability across the neighbourhood	• Accountability and performance contract with the PCN • Performance measurement and reporting to PCNs • Joint accountability across the neighbourhood
Service delivery	• Sets provincial service delivery framework, regulatory alignment, clinical standards and requirements, directives • Health human resource planning	• Guidance on and oversight of service design and delivery • Depending on region, may directly fund and deliver care, incl. mental health, home care, CDM, social care, rehab, palliative care, community public health • Ensures a regional approach to coordination of care across PMHs and neighbourhood	• Designed for local circumstances based on provincial regulations and guidelines and PCN guidance • Mandate and key components outlined in contractual agreements	• Co-located within PMH *and/or* • Specialist group practice • Mandate and key components outlined in collaborative care agreement	• Designed for local circumstances based on provincial regulations and guidelines and PCN guidance • Mandate and key components outlined in contractual agreements
Remuneration	• Sets provincial health provider pay scales • Sets physician payment	• Allocates PMH and other service budgets based on provincial pay scales and remuneration agreements	• Develops a budget and pays staff based on provincial pay scales and remuneration rates	• Salary or Fee-For-Service (FFS) paid by PCN *or* • Fixed rate or salary paid by PMH • Based on provincial pay scales and remuneration rates	• Staff budget based on provincial pay scales and remuneration rates

A New Integrated Health Neighbourhood

There will be a shift in orientation. Community-based services and supports will reflect population needs and patient preferences. There will be change in how health professionals work and new collaborative care pathways.

The Patient's Medical Home

Patient's Medical Homes will be central to the integrated health neighbourhood. They will be expected to design services that reflect their patients' needs and will have the flexibility to allocate their budget and deliver services in a way that meets those needs. While they will vary within and among networks, medical homes will ideally house a significant portion of the services in the integrated health neighbourhood and serve as the hub for access to other health and social care services. They will be accountable to the Patient Care Networks to demonstrate that they have achieved their goals.

Recognizing the significant evidence that the traditional standalone, fee-for-service models are not conductive to comprehensive primary care, three additional types of Patient's Medical Home models are proposed (Table 2). The current fee-for-service structure would remain as an option in the interim, recognizing that moving to new models will be an evolution and that there may be a continued role for fee-for-service models in certain circumstances.

Table 2. Future Patient's Medical Home models

Model	*Contract and Budget*
Community governed Patient's Medical Home	Contractual and accountability agreements with the PCN (Could be managed by the PCN in certain instances) Budget allocated within provincially and PCN set parameters Budget based on an operational plan and defined basket of services One contract and global budget for **salaried clinical staff (physicians and interprofessional team)**, management and administration, clinical leadership roles, overheads, quality improvement, IT, etc.
Physician governed Patient's Medical Home, with community representation	Contractual and accountability agreements with the PCN Budget allocated within provincially and PCN set parameters Budget based on an operational plan and defined basket of services Two contracts and budgets: 1) Contract with the PCN for **physician services** and an age, sex and risk group **adjusted capitated budget set based on a patient roster**, including physician remuneration and basic infrastructure, such as overheads, administration, after hours, Electronic Medical Records (EMRs), etc. Physicians could be paid on a salaried, capitated or other basis and monies allocated based on agreement among physician owners 2) Contract with the PCN, similar to the community governed model contract, which includes **funding for interprofessional team member salaries**, clinical leadership roles, overhead, management and administrative support for the team, change management, and quality improvement Another option could be an adjusted per capita global budget that includes physician remuneration based on the patient roster and covers overheads, administration and the interprofessional team
Indigenous owned and managed Patient's Medical Home	Design, contract and remuneration models will be **defined by Indigenous leaders and PMHs based on a provincial framework** developed by Indigenous community leaders that outlines the unique features of Indigenous owned and managed health services and addresses and harmonizes the intersection between federal and provincial funding The Indigenous PMHs would enter into an agreement with the PCN based on a mutually agreed upon performance and accountability contract
Traditional physician-owned Patient's Medical Home	Contractual and accountability agreements with the PCN, with many of the same – but not necessarily all – contractual requirements as the other models **Fee-for-service payment** based on fee codes Would have access to interprofessional teams and other community-based services based on a model designed and implemented by the PCN and the same contractual and performance requirements as the other models

Community Specialists

Community specialists will share the budget and have joint accountability along with the rest of the services within the Patient Care Network. Rather than Alberta Health, they will be funded by and have contractual agreements with the Patient Care Networks and/or Patient's Medical Homes. Over time they will become increasingly integrated into medical home and neighbourhood teams. They may work exclusively within a large Patient's Medical Home or for a group of medical homes. As they become a part of a seamless integrated team, they will benefit from shared operational, quality improvement, technology and infrastructure supports. Their hospital-based services will continue to be funded by Alberta Health Services.

Community-based Health and Social Services

Community-based health and some social services will share the overall Patient Care Network budget and accountability with Patient's Medical Homes and specialists. Health professionals in the integrated health neighbourhood will serve one or multiple medical homes, funded either by the Patient Care Networks or Patient's Medical Homes. Community-based providers and services will be represented on, and expected to bring their perspectives to, network governance and decision making.

Acute Care and Other Facility-Based Services

The new agency, Alberta Community Health Care Services, will work with Alberta Health Services and through the Joint Commission on initiatives to improve information management and transitions in care between the acute and community-based care sectors. Ideally, this work will be advanced by standardized performance and accountability frameworks, clinical pathways and information technology. The Patient Care Networks and services within the integrated health neighbourhood will work with other health services (e.g., acute and other facility-based care) to find ways to optimize communication, coordination and continuity of care. Through this interaction, they will identify opportunities for designing and implementing approaches to improve integration that make sense within their jurisdiction, including introducing bundled care models in select areas. These efforts will lay the groundwork for a formally integrated system and service design in the future.

Future Role of the AMA

The Alberta Medical Association (AMA) will maintain its role of a health transformation advocate, including advancing the vision and concepts outlined in this paper and playing a consultative role in the set-up, operation and refinement of the ACHCS and Patient Care Networks. The AMA would also maintain a strong role in negotiating and stewarding the provincial framework for physician compensation, regardless of delivery model. The association will grow its expertise to support physician groups through the contracting processes outlined in this paper and in taking on expanded accountabilities that require new types of measurement, reporting and human resource management. Lastly, AMA, through the Accelerating Change Transformation Team (ACTT), will support and facilitate change management and quality improvement. In particular, it will play a supporting role in the implementation, coordination and streamlining of Patient's Medical Home models and services within the integrated health neighbourhood.

Evolving Organizational Structures that are Community and Population Health-Driven

Health care structures must be designed to reflect the communities they serve and a population health approach.

Frank has Parkinson's disease and significant decline in his physical and cognitive functioning. He and Muriel struggled to manage his condition. Muriel was given the opportunity to co-design a new service model and now has easy access to information and advice online or by phone. Muriel now has the agency to monitor Frank's vitals, adjust medications, ascertain what activities Frank can tolerate and determine whether they need to seek health care services.

Community-Driven: Patients and Community as Partners in Health Service Design

The new system will be built on partnerships, collaboration, trust, communication and mutual respect among communities, patients, caregivers and providers. New health care organizations will be community adaptive, characterized by bottom-up innovation driven by local need. Community members will become partners throughout the health system and patient engagement will be embedded into the culture of health services. Community and patient involvement will run across a spectrum of intensity from advocacy and consultation to increasing representation, co-design and leadership (Figure 2).

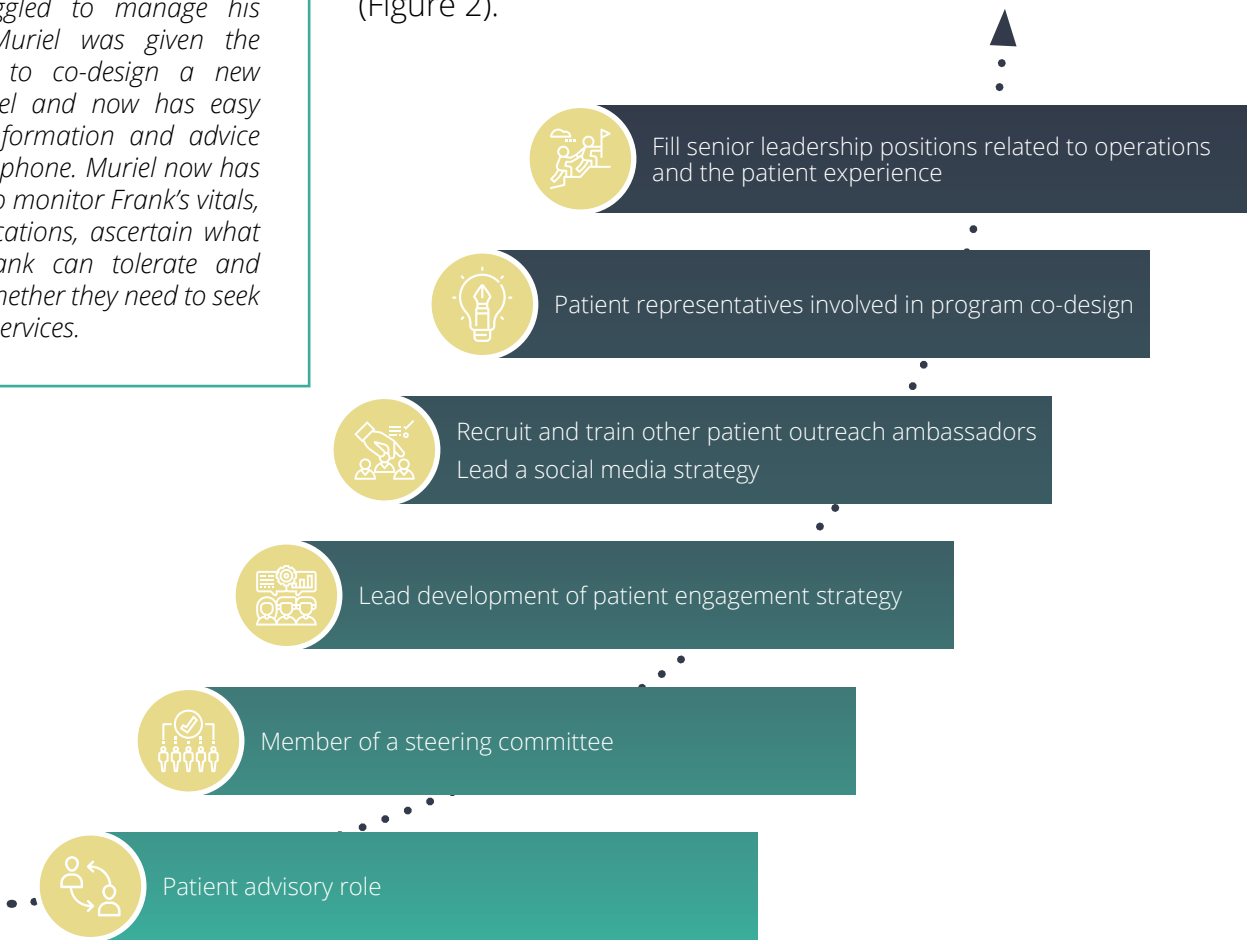


Figure 2. Spectrum of community and patient involvement

Population and Social Determinants of Health Driven

Al wants to focus on finding a stable income and housing, as well as food security, before quitting smoking and further addressing his health issues. A dedicated team member in the medical home helps him do so.

The new health system structure will help to improve the health status of Albertans by addressing the interrelated conditions and factors that affect health. Attention will be given to health equity, social justice, human rights and the most vulnerable – a broader focus on the moral determinants of health. A population and determinants of health approach will mean realigning planning and funding to incent new approaches to care across the integrated health neighbourhood, underpinned by a performance and accountability framework. Planning and resource allocation will be community and evidence-driven.

Evolving Organizational Structures with a Primary Care and Community Orientation

The evidence is clear; a health system with a primary and community-based care orientation has better patient outcomes, better access, reduced health inequities and lower costs.

According to the World Health Organization (WHO), high performing health care systems spend between a third and a half of their total health expenditure on primary and community-based care – more when expenditures related to the broader social determinants of health are taken into consideration. In the future, Alberta will invest more in primary and community-based care.

A system oriented to primary and community-based care is characterized by a highly engaged sector, with a strong voice in system planning, design and management. The new system will be an enabling environment and health care organizations and professionals will have input throughout the system, including in key leadership roles. In addition to representation in Patient Care Network and Patient's Medical Home governance structures, there will be opportunities for engagement at various intersections in the system. Greater value will be placed on formal and informal clinical leadership, with new supports for skills and capacity building and remunerated positions within the Patient Care Networks and integrated health neighbourhood. Additionally, increasing attention will be paid to clinical microsystems (groups of frontline staff and processes that provide direct patient care) and new models of leadership (e.g., dyads and other forms of distributed leadership).

A New Integrated Service Design

A New Integrated Service Design
in the Patient's Medical Home, Specialist Services and Health Neighbourhood

- Medical Homes for the Future
- Community Specialist Care for the Future
- Integrated Community-based Care across the Health Neighbourhood

that has/is:

- Patient Preferred
- Cohesive, Versatile, Motivated Teams
- Information and Management Continuity
- Continuous Redesign with Embedded Change Management and Quality Improvement

Changes to the nature of health services are needed to achieve transformation goals for the future.

A new integrated service design will include fully realized Patient's Medical Homes, seamless care with community specialists, and collaborative community-based care across the integrated health neighbourhood.

Patient's Medical Home

The Patients' Medical Home will be Albertans' point of access to the health and social care systems, and where a dedicated team of health professionals support them in accessing and navigating care to meet their health needs.

Everyone in the Patient's Medical Home will have equitable and timely access to their own family physician or nurse practitioner, as well as members of a core team (e.g., nurse, social worker, medical office assistant) tailored to meet their needs. As required, they will also have access to a broader team within the medical home (e.g., dietitian, pharmacist, gerontologist, social care) and navigators/care coordinators who will ensure coordination and continuity of care among the core and broader team members, as well as across the integrated health neighbourhood (Figure 3).

Patients will have timely, multimodal access to care based on their needs and preferences and clinical appropriateness. New team structures, processes and funding models will facilitate the seamless integration of virtual care into practice. In addition to face-to-face access, patients will have access to synchronous virtual care via telephone or videoconferencing. Asynchronous virtual care will also be available via secure messaging, virtual monitoring, online apps and websites that provide self-management support. Attention will be paid to addressing digital inequities and varying levels of patient technological literacy.

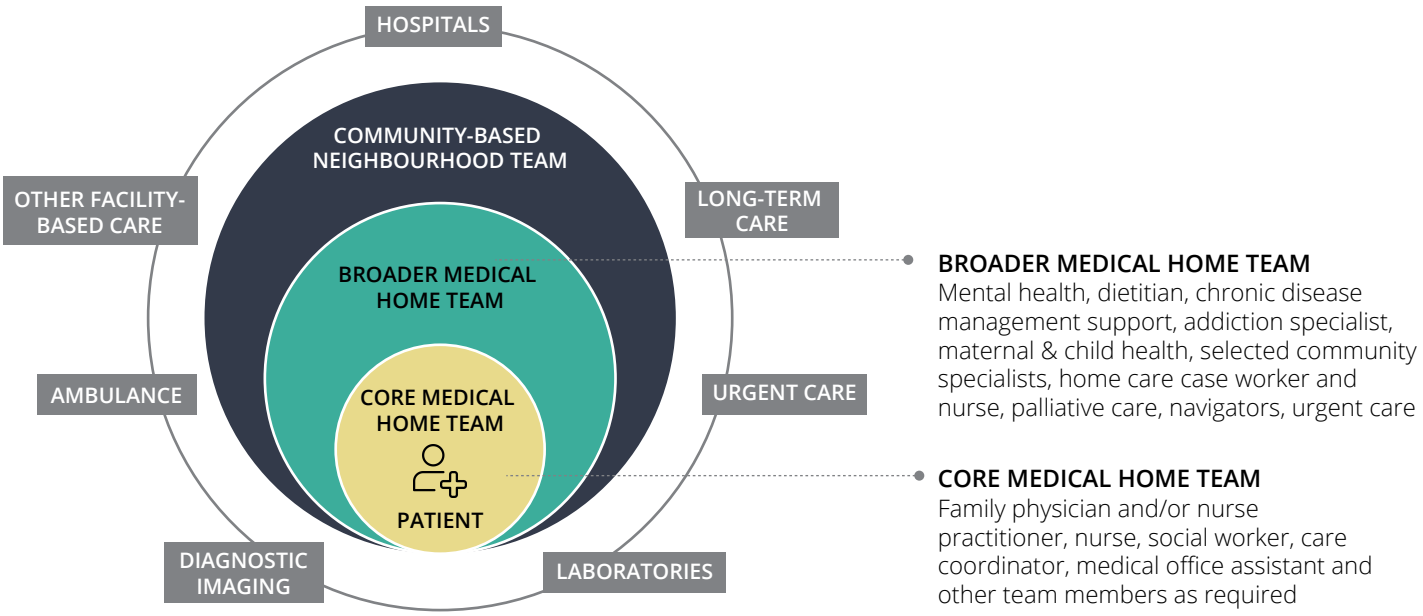


Figure 3. Core and broader Patient's Medical Home team members

Appointment and referral processes – in the medical home and across the integrated health neighbourhood – will be equitable and customer-focused, with service-oriented reception, online appointment booking options, standardized patient referral pathways and flow processes, and wait time standards and guarantees using state of the art queue management. After-hours services will be widely available either within the Patient's Medical Home or through their collaboration with other medical homes and services in the health neighbourhood, supported by 24/7 teletriage.

Preventative services: *Kris visits her medical home with Jay for a well-baby visit with Jean, a nurse in her core team. Jean examines Jay and also checks in on how Kris is doing. Kris is finding it more stressful than with her first two children and shows signs of postpartum depression. The family physician joins briefly to check on the baby, discuss Kris's concerns and refer her to the mental health team member. Jean checks in by phone over the coming weeks.*

Patient-preferred chronic care: *Sana was diagnosed with Type 2 diabetes after going to the clinic because she was feeling rundown. Her core medical home team is a nurse practitioner, chronic care nurse and healthy lifestyle coach who work with Sana to develop a care plan around her goals. She attends most appointments virtually and accesses self-guided care, lifestyle coaching sessions, education and tailored research on her condition online. She takes her own vitals and enters them into the patient portal and monitors other test results online.*

Community Specialist Care

A lack of timely access to specialists, communication challenges and the siloed nature of care are a great challenge to patients and providers alike. There will be a fundamental shift from a referral model to community specialists having an integrated role in supporting health care delivery in the medical home and across the integrated health neighbourhood through new roles and innovative consultation relationships in as close to real time as possible. Initially, many community specialists will maintain standalone practices (groups of one or more types of specialists) and hold collaborative care agreements with other services. But, without duplicating roles, they will increasingly become embedded as part of the broader Patient's Medical Home team. Assisted by patient navigators/care coordinators and optimized information continuity, they will participate in managed and shared care with other team members, providing guidance and timely e-consults.

Integrated Community-based Care across the Health Neighbourhood

Health and social care services will be part of an integrated community-based neighbourhood team. Services will be designed to ensure patients experience seamless transitions across providers and care settings, and include specialized (mental health, rehabilitation, pharmacy, palliative care, home care) and other community-based services (outreach, navigation, community public health, social care) (Figure 4).

Sylvie, an older woman with multi-morbidities is not interested in videoconference appointments or researching her various health conditions. She wants a dedicated point person and to have "one-stop-shop" in-person appointments. She is grateful that her team helps her organize the various community supports she needs to stay in her home, as well as increased social interaction with other women living on their own.

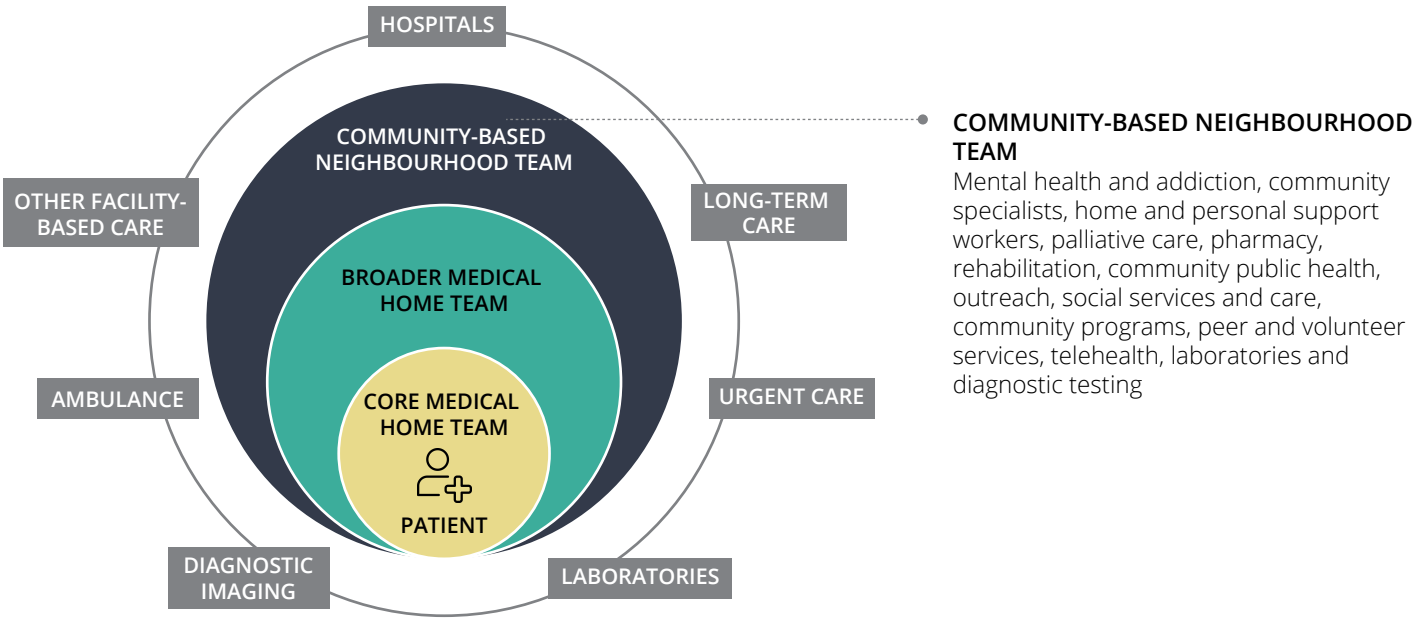


Figure 4. Potential community-based neighbourhood team members

While ideally many of the services in the health neighbourhood would be fully integrated into the Patient's Medical Home, budgetary and service integration will evolve over time, with many services co-located at least some of the time. Integration will be supported by: shared accountability; effective leadership and management across the health neighbourhood; common standards for care and safety; quality improvement; an emphasis on communication and coordination; information and management continuity; and optimized technology that includes virtual care and home-based monitoring. Patient Care Networks will play a key role in developing formal and informal partnerships to develop and coordinate services with community-based agencies, social services, NGOs, municipalities, schools, housing, justice and other services external to the network.

The Case for an Integrated Health Neighbourhood in the Provision of Complex and Chronic Care

Team-based complex and chronic care planning and delivery improves patient and provider satisfaction, self-care, medication management, and relational continuity. In the future, this care will be patient-focused and evidence-driven. Table 3 outlines the evidence and key attributes for the design of future complex and chronic care.

Many of these attributes apply to other types of health and social care. Ensuring they are in place for the most complex patients can inform and serve as a foundation for designing other services and supports.

Table 3. Attributes for the future design of complex and chronic care

The services

1. Comprehensive, person-centred care reflecting patient preferences
2. Care coordination and continuity are prioritized
3. Integrated health and social services, and physical and mental health care
4. Proactive risk assessment and identification of patients in greatest need (including those with highest risk factors, multi-morbidities and the most complex)
5. Holistic models of care
6. Shared care planning and tailored care plans
7. Self-management programs and patient activation
8. Support for caregivers
9. Mutually agreed upon care pathways and decision support, including personalized approaches to multi-morbidity
10. Virtual and home-based monitoring
11. Strong quality improvement component
12. Funding and remuneration structured to incent meeting patients' needs

The team

1. Activated and empowered patients with agency
2. Team-based care coordinated through the Patient's Medical Home
3. Adequate supply of family physician generalists
4. Key nursing roles
5. Key social work/mental health roles
6. Care coordinators/navigators
7. Strong linkages with specialists
8. Peer support
9. Clinical and change management training and support

Information and communication

1. Emphasis on communication
2. Integrated information continuity
3. Optimized technology
4. Ready patient access to applicable health information and their own health information

Benita has advanced congestive heart failure. Her care is formally shared and coordinated among the broader Patient's Medical Home team, home care, the cardiologist, the cardiac care centre, a palliative care team and a dedicated care coordinator. The tailored care plan reflects the option for Minimally Disruptive Medicine. Office visits are minimized because there is ongoing home monitoring and virtual care.

Patient Preferred Experience

The Patient's Medical Home and integrated health neighbourhood of the future will put patients' needs and preferences at the forefront. Albertans will be supported by health care professionals who respond to the unique needs of individuals, families and communities and respect their perspectives and choices (Figure 5 and 6). There will no longer be a typical mode of service delivery for all patients; services will be designed to meet the preferences of individual patients and the needs of archetypal patient groups.

Social circumstances
Based on social and economic circumstances, population and risk group, risk factors, etc.

Delivery mode preferences
Single point of contact to access providers
Desirable service locations, environment and design
Access on the day and at the time wanted
Multimodal: in-person, telephone, video, group, portals

Personal preferences
Tailored to a diversity of culture, values, beliefs and perspectives

A tailored team
Access to a core and broader medical home, as well as neighbourhood, team
Access to preferred providers
Navigation and seamless care coordination supported by optimized technology
Family and caregiver roles

Care needs and preferences
Evidence based
Type and extent of intervention
Level of engagement in care decisions

Figure 5. Patients' pathways to care that reflect their needs and preferences

1. ***Social circumstances*** will be a primary consideration in how patients receive health services. Such care will support individuals in the context of their socioeconomic status; gender and identity; race and ethnicity; immigrant status; disability; frailty; housing status; community environment; childhood experiences; and exposure to violence and trauma. Appropriate support and care are achieved by understanding the root causes of inequity and that exposure to a combination of risk factors can result in greater morbidity and differentiated outcomes in certain populations.

2. ***Delivery mode*** of health services will take a "customer-focused" approach and rival that of other key service sectors. Patients will have an easily accessible point of entry to care, but no longer simply at the clinic. The practice location, design and environment will optimize their experience. There will be an equitable distribution of health facilities, buildings will be accessible and their design welcoming, comfortable and allowing for efficient patient flow. Their team will know them well, and care processes will be respectful, effective and convenient.

3. ***Personal preferences*** such as patients' values, beliefs and perspectives will be reflected in care. Providers will have the competencies necessary to understand the patients they serve and what influences their health beliefs and behaviours. Adapting health services to meet social, cultural and linguistic needs could include: cultural tailoring of interventions; interpreter services; delivery with compassion and respect; recruitment and retention of minority staff; cultural competency and anti-oppression training; building patient capacity in treatment decision making; and including patients, family and community members in service design.

4. ***A tailored team*** with ready patient access to a core and broader team in the Patient's Medical Home, as well as integrated health neighbourhood. The configuration of the team will be tailored to the patient. Patients will be ensured navigation and seamless care coordination among team members, supported by optimized technology.

5. ***Treatment and care needs and preferences*** will be reflected in more comprehensive and holistic services tailored to preferences and risk factors. Patients will have informed options in terms of service format, type and extent of the intervention. They will experience positive client-provider relationships and have the option to take on new roles and partnerships with their health care team members.

Sol struggled during the COVID-19 pandemic. He lives alone and works part time as a carpenter. Previously, he had limited interaction with the health care system, but realizes he needs to focus more on his health as he ages and takes steps to be more proactive.

Social circumstances
Sol wants to improve his diet, but money is sometimes an issue as he only works part time

Delivery mode preferences
Sol makes an online appointment
After a telephone consult, an in-person appointment is recommended

Personal preferences
Sol prefers to have a friend attend the appointment with him
He wants to be involved in all decision making

A tailored team
A core team is identified after Sol is diagnosed with hypertension
Sol selects the social worker as his main point of contact because she will also help him find income and social services

Care needs and preferences
Sol prefers to first try and manage his blood pressure with diet before starting medication
He is equipped to self-monitor his blood pressure at home
His friend acts as a peer support mentor

Figure 6. Sol's preferred pathway to care

While individual patients will experience services uniquely based on their needs and preferences, teams will also be equipped to effectively support archetypal patient groups (with typical patterns of symptoms and care) in a consistent, comprehensive, evidence-based, state-of-the-art manner. Approaches to collaborative, coordinated service delivery will vary, but patients will receive care guided by standards, performance frameworks and accountability for fulfilling service goals. Recognizing that many patients do not fall into a single category, providers will be mindful of biases in predetermining care pathways and ensure patients receive the highest standard of care, while tailoring care to their unique needs and preferences.

Cohesive, Versatile, Motivated Teams

The Patient's Medical Home and integrated health neighbourhood of the future will be characterized by cohesive, versatile and motivated teams that collaborate for the patient. Flexible and adaptive care teams will become the norm. Table 4 summarizes teams' new way of thinking and working together. Team members will be empowered with new roles and responsibilities, and distributed leadership will positively impact team effectiveness and the delivery of care. Within the team, health care professionals will optimize their respective skills and scope of practice, with their roles reflecting their practice settings, requirements of the funder or employer, and the needs of their patients.

Table 4. Collaborative teams of the future

New ways of thinking and working together	Supported by:
• A collective vision and mindset • Responsiveness to the population served • New working culture • Collaborative, proactive core and broader team that has each other's back • Transdisciplinary teams, with both generalist and specialized skills • Clear, yet flexible, team roles • Empowered with new roles and responsibilities • Interdependence • Shared decision making • New roles for peer and lay workers	• Confidence patients' needs are being met • Clearly defined joint accountabilities to patients, the public and the system • Distributed leadership • Trusted and sharing relationships • Working to full scope of practice • Clinical pathways throughout the system • Shared care plans • Shared medical records across the system • Optimized information and management continuity • Continuous embedded quality improvement • Adequate data and measurement, with audit and feedback • Patient and family feedback

Health human resource planning is critical to meeting the requirements of the new integrated service design. Patient Care Networks will work with stakeholders to ensure there are fully-funded teams whose number, mix and type of providers reflect community and practice needs. Planning will include determining the right mix of comprehensive and specialized (e.g., addiction medicine, geriatric services, palliative care and chronic pain) family physicians and the range of interprofessional providers required. Attention will be given to providers' experience and their capacity to deliver requisite services.

Health human resource planning is supported by health care professionals with skills that align with working in new service delivery models. Enhanced training will include a broader set of clinical skills – transdisciplinary skills – which will allow professionals to provide a greater scope of services and to step in to support other team members when needed. As well, team members working in the new service design will require competencies that go beyond their traditional training, and ongoing supplemental training and team learning will be built into practice. Required are enhanced skills related to: professionalism; communication; patient-centredness and preferences; collaboration and teamwork; leadership; project management; population health; health equity; advocacy; continuous quality improvement; research; patient safety; cultural competency; and IT.

Brian (a registered nurse and chronic care specialist), Mia (a mental health and social work professional), and Yaritza (a medical office assistant) are part of the core medical home team that works with Dr. Ava Tarr. Each works to their full scope of practice and takes on a wide range of roles, based on their own expertise and interests. There is a blurring of boundaries of their scopes of practice in many instances, and their skills are utilized in effective and innovative ways. They are full partners in patient care with Ava and work closely with her in delivering direct patient care, (e.g., patient education, taking vitals, reviewing laboratory results, wound care and other procedures, case conferences, following up on referrals, etc.).

Both changes to the regulatory framework and expanded protocols for delegated acts (e.g., some medical procedures, ordering laboratory tests, prescribing medications and vaccinations) have proved foundational in terms of the team broadening their scopes of practice, using their skills effectively and integrating new roles into the practice. For many patients, Ava is not the first point of contact; the team has developed expertise in closely matching patient needs with the most appropriate service provider. As a team, they monitor chronic patients, run group programs, provide triage services, manage the virtual care services, and conduct home visits. They work collaboratively with patients to address their health concerns and use group sessions to focus on common risk factors and healthy lifestyles.

The team also works with their broader team of clinicians to offer well-baby and well-women clinics, smoking cessation and other specialized programs. A member of the team can often be readily available during the day, so patients can phone them or see them that same day. Standard communication protocols, warm handoffs between team members and a truly interdependent work flow are keys to this team's success.

Although Ava is the most responsible provider (MRP), the team seamlessly provides much of the ongoing support and care, especially for patients with chronic conditions. Brian monitors patients with chronic conditions that are generally well-controlled based on a mutually agreed upon algorithm, whereby Ava sees the patient at least once a year and the team provide the remainder of the care. Brian provides the initial education to newly diagnosed patients and sees them regularly as they adjust to their medication and lifestyle changes. When minor changes to medications are required Brian is able to make those changes and keeps Ava informed. If patients experience difficulty managing their chronic condition, they see Brian and the team for more intensive treatment and support. When Brian determines that there are psychosocial issues, he refers patients to Mia. She also steps in as required to provide education and lifestyle counselling. Yaritza supports patients when they need services elsewhere in the medical home or externally, and has a breadth of skills to support Mia and Brian with patient care.

Information and Management Continuity

Patient care will be coordinated and connected through exchange of information and care plans among providers. Patients will no longer have to repeat their health history or take the same tests multiple times. Their health information will be accessible to them and their providers when needed. Seamless patient transitions will be supported by well-connected care networks and facilitated by standardized patient referral, pathway and flow processes, and by patients being reconnected to their core team after receipt of other services. Importantly, information and management continuity will be supported by the requisite technical infrastructure. Technical integration will improve clinical workflows, patient safety, quality, health outcomes and overall patient experience. The technology will be easy to use and intuitive, with clinical priorities and processes driving the technology introduced. Clinicians will interact with rest of the health system digitally through their EMR, with the information they need all in one place. Information sharing will be facilitated by patient health summaries and problem lists generated within the common Electronic Health Record (EHR) that can be augmented and updated by providers and patients (to ensure accuracy and their preferences are reflected). As well, all patients will have ready access to an integrated, interactive portal that holds their complete medical records. This portal will also support appointment making, secure messaging, uploading clinical information, monitoring, and interactive apps and health queries. To achieve integration, EMRs will meet provincial standards for interoperability. As well, an overarching provincial data governance strategy, outlining how the data should be housed, managed and used, and who is allowed to use it and for what purposes, is needed. Legislation will be updated to enable integrated data and information continuity across the system, including outlining who is responsible for its management and accuracy, and how cybersecurity will be maintained.

Technology will empower patients in the future. Gary accessed the portal using his tablet, reviewed his International Normalized Ratio (INR) results, uploaded his home monitoring data, and entered his medication dosage. An out-of-normal range entry triggered a clinical alert and Gary was seen by his team soon after. After his appointment, Gary used the portal to message his clinician, check his lab results and upload his Blood Pressure (BP) and weight. He also uses an app available on the portal to help him manage his various conditions.

Continuous Redesign and Embedded Change Management and Quality Improvement

A Focus on Excellence and Catalyst for Innovation

A continuous quality improvement ethos, with a focus on value and outcomes of importance to patients, will be promoted, supported and required throughout the health system. Alberta has made significant strides in quality improvement and primary care practice redesign. However, many Albertans are not receiving the highest quality of care possible. Building on existing initiatives, quality improvement will be an integral part of the integrated health neighbourhood and embedded in all clinical work. There will be a renewed focus on clinical pathways, guidelines and evidence-based care, and services will be able to respond to new evidence and areas identified for improvement with accelerated and rapid cycle change. Proactive approaches to care will have greater prominence, including prevention, risk stratification and identification of patients at risk for and living with chronic conditions. Change and improvement efforts will be driven by patient needs and preferences, with attention to health equity and patients as partners in change. There will also be greater public reporting on health service performance.

The Requisites for Supporting Change and Improvement

Seven critical features will support change and improvement going forward:

- ***Accountability:*** standardized system and tailored sector accountability frameworks reflecting system principles and goals, as well as clinical priorities. Frontline teams, including patient representatives, will be engaged in identifying measures that are meaningful to them and link to the accountability frameworks.
- ***Transformation Champions:*** a network of clinical leaders, quality improvement champions, practice facilitators, patient representatives and decision makers aligning to a common vision and leading change. Each Patient Care Network will have dedicated transformation champions who will recruit, train and support current and emerging leaders and medical home and health neighbourhood teams. Transformation champions based in the Patient's Medical Home and other services in the health neighbourhood will be supported by practice facilitators.
- ***New Roles on the Ground:*** new quality improvement roles for patients and health care team members. Team roles will be flexible and evolving. All team members will play a role as quality improvement efforts become part of daily practice.
- ***Centralized Guidance and Support:*** support from the provincial level for skills development and province-wide change efforts. Concerted programs have the capacity to keep abreast of international innovations, develop strong evidence-based approaches and build on learnings, while adapting to the Alberta context and creating local solutions.
- ***Practice Facilitation:*** building and sustaining capacity at the practice level and support for scaling up successful efforts. Practices are more likely to be successful with facilitation. Patient Care Networks will have dedicated practice facilitators who will provide training, assessment, coaching, technical assistance and feedback to health services on the ground. They will be part of a provincial program that provides standardized training and improvement guidelines and tools.

- ***Patients as Partners in Change:*** Patient needs and preferences will drive quality improvement initiatives. In the new system and service design, patients' roles as partners in design, development and implementation will continue to evolve.
- ***Measuring, Learning and Acting:*** Health services and quality improvement efforts will have comprehensive, actionable data to guide them. Further integration of patient and system data will support the creation of a Learning Health System. The closer connection between service delivery and data gathering will allow for continuously generated knowledge that drives health care delivery and outcomes improvement. Optimized EMRs will allow ready access to data on individuals and patient populations to identify trends and outliers and respond quickly with the changes required. A central repository of de-identified patient data will support research and analyses at the local and system level. Provincial-wide data improvement initiatives and alignment of measures will support these efforts, as will artificial intelligence (AI) as it evolves (Figure 7).

Kim was diagnosed with colon cancer because of proactive data and panel management. She didn't make appointments for routine screening. But a "POET" (Proactive Office Encounter Technician) who manages the panel and uses the EMR to identify patients due for screening sent Kim a Fecal Immunochemical Test (FIT) test. It came back positive. She was referred to a specialist, had a colonoscopy and entered the cancer care system, maintaining a navigator and links to her core team. They are all contributing to her health record and care management.

Learning health systems and participatory research

Patient activation and input on health system and service improvement

An entire health care team endeavour

Communities of practice

Fixing the data gap: more and better data

Measures that matter to patients and make sense to providers (including patient and provider co-design and reporting)

Improved data standards and infrastructure

Optimized EMR functionality, including registries, clinical decision support, prompts and reminders

Easily accessible, real-time patient and population queries and analytics

A new role for AI, including identifying trends and supporting diagnoses

Turning data into information and action

Supporting patient care, quality improvement and health service and resource planning

Skills building and training across the team

Evaluation supports and data-driven decision making at all levels

Clinical audit and tailored feedback to guide action and change

Dashboards and comparative feedback

Public reporting

Recognition of excellence

Figure 7. Steps to measuring, learning and acting

Factors Facilitating Transformation

There has been much learning in Alberta over the past two decades. Change takes time and is incremental – from the early pilot projects and creation of Access Improvement Measures (AIM) to the numerous recent Patient's Medical Home initiatives. Importantly, the incremental change has been dotted with major change events that have helped accelerate transformation, such as the creation of PCNs and the COVID-19 pandemic, which required the immediate implementation of virtual care. We are proposing a combination of transformative change, supported by incremental evolution in service design and delivery.

Real transformation cannot occur in siloes. A collaborative effort, with strong alliances and governance structures and clarity of roles and purpose, is a critical ingredient. Over the past 20 years, developing the right governance structures has taken time and experimentation to find the appropriate balance. There will be many factors to consider when launching and implementing this transformation. While much has been written about managing change, too often the advice is not followed and efforts stall when the hard work starts and there are not quick wins.

The following are some of the critical first steps for laying the groundwork:

1. Find leaders who excel in complexity and uncertainty
2. Have the difficult conversations
3. Gain buy-in and engage those who are averse to change and feel they have something to lose
4. Have all voices at the table
5. Create new organizational structures and infrastructure
6. Plan to ensure reorganization truly results in improved quality and integration of care

Considerations when Initiating Change

The following are additional considerations and actions to take when initiating transformation:

- Make a compelling case for change
- Define a clear and common vision among stakeholders
- Show commitment to the Patient's Medical Home and health neighbourhood from top leadership
- Have consistency of purpose and focus, as well as support, along all implementation phases
- Address context, pre-existing norms, values and relationships among stakeholders, including power and trust dynamics
- Ensure representative planning and governance structures
- Outline clearly the various requirements and processes for system restructuring
- Clarify roles and responsibilities
- Define how the funds flow
- Develop realistic estimates of the costs of transformation and provide resources for change
- Allow adequate time for change to take place

Levers for Change

Evidence and experience show a number of levers support health system transformation. Some of the key levers for change are:

- Acknowledge and address barriers to change
- Address the intrinsic and extrinsic motivators of change
- Get the financial and other incentives right
- Change culture with a transformational shift thinking
- Create a change ethos and culture of quality
- Develop a foundation for integrated, shared decision making and collaboration
- Establish skilled and engaged leadership, including clinical champions and opinion leaders
- Achieve meaningful stakeholder (administrator, provider, organizational, patient and community) engagement and participation
- Develop professional standards and well-defined norms
- Put in place performance frameworks that outline goals and assess performance using milestones, trends, benchmarks, clinical audit, report cards and accreditation
- Realise the right balance between prescription and experimentation
- Train and develop skills development for transformation

Transformed Organizational Development and Management

The transformation proposed in this white paper will require significant efforts in organizational redesign and management. Critical areas for focus and development include:

Managing health organizations for transformation, including navigating complexity and uncertainty

- Address structural and organizational barriers to change
- Develop an enabling environment
- Promote organizational learning
- Elevate thinking from individual performance to organizational and system performance
- Increase collaboration with system partners

Planning for and implementing change at the service delivery level, including reorganization and business process reengineering

- Consider physical requirements, such as architectural design of clinical space, information and communication technologies
- Consider size of practice groups and types of arrangements
- Develop and train a health transformation workforce
- Hire for cultural fit
- Empower team members to act, take risks and innovate

Ensuring continuous quality improvement

- Focus on patient and provider experience (as part of the Quadruple Aim)
- Standardize clinical and management systems to support change
- Renew focus on evidence-based care and best practices
- Provide mentorship and facilitation
- Evaluate, using appropriate frameworks

Conclusion

Alberta's health care system is faced with multiple challenges that require a concerted bold response. To meet the health needs of Albertans in the future, a transformational change to the structure of the health system and the way in which services are designed and delivered is vitally needed. In this white paper, the Primary Care Alliance seeks to work with partners and stakeholders to challenge the status quo. It proposes significant changes to ensure a system that is primary and community-based care oriented, population health driven, seamlessly integrated, team centred, technology and innovation supported, and focused on – and accountable to – values and outcomes of importance to patients. It is time to push through the political, institutional and professional barriers and work together to change and create a system that benefits all Albertans.