PRIMARY HEALTH CARE INTEGRATION NETWORK

Integrated Provincial Program

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Key Partners
Alberta Health
Virtual Patient Engagement Network
Alberta Medical Association
Accelerating Change Transformation Team
Primary Care Network Leadership
Primary Care Network Members

Major initiatives and achievements, 2021-2022

Over the past year, medical leaders within the Primary Health Care Integration Network (PHCIN) have collaborated extensively with AHS and primary care to increase understanding of key issues impacting integration, at a system level, between primary and specialty care. For example, through the advocacy of PHCIN medical leaders, appreciation and understanding has improved regarding the impact of implementing Connect Care and the Alberta Surgical Initiative (ASI) on primary care providers and their workflows. The PHCIN continues to support AHS in implementing these province-wide initiatives while minimizing any disruptive impact on primary care providers and their teams. The end goal is to enable accelerated and appropriate access to specialists, achieve information continuity, and enhance care continuity.

System Foundations for Integration: Connect Care Implementation

Through 2021-22, the PHCIN and Provincial Program have continued to support to the rollout of AHS' Connect Care initiative, Community Information Integration (CII), Central Patient Attachment Registry (CPAR), enhancements such as eDelivery, and other provincial information systems, that together make up the entire patient record.

This work will enhance information continuity for healthcare providers and patients (e.g., enabling AHS primary care clinics to submit patient panels to CII/CPAR and allowing other healthcare providers to identify when AHS is a patient's primary care provider). In addition, new and more efficient processes have been created that allow AHS to hear and address community providers' concerns and suggestions.

Linking to Specialists and Back – ASI: Provincially Aligned Solutions for Care Pathways and Specialty Advice

Following more than two years of extensive engagement and consultation with diverse stakeholders, a new Provincial Pathways Unit (PPU) will be established and co-led by AHS PHCIN and the Strategic Clinical Networks™. The PPU will be a coordinating hub for the development, integration and management of clinical pathways. It will help implement provincial clinical pathways for providers and patients, starting with pathways used in the patient's medical home that shape demand for specialty care and improve referral processes. The PPU will centralize access to pathways, simplify clinical workflows, and create standards and processes around pathway development, design, maintenance and evaluation.

Equally extensive engagement and consultation was undertaken to design a provincially aligned approach for providing non-urgent telephone advice. The approach leverages existing advice programs, including ConnectMD, Specialist Link, and RAAPID, and will support a coordinated Urban/Rural Model that ensures consistent access to non-urgent telephone advice across Alberta. Planning related to implementation and service standards will begin shortly.

Transitioning from Home-to-Hospital-to-Home (H2H2H): Implementation of Alberta's H2H2H Guideline & the Work of the Patient Transitions Resources Team

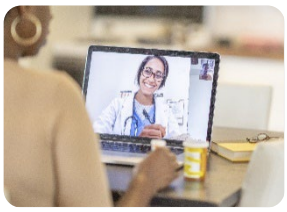
Over the past year, there has been significant collaboration between the Provincial H2H2H Implementation team and zone operations in both primary and acute care to facilitate a coordinated rollout of Alberta's H2H2H guideline. This included working with each zone to establish the governance structure (e.g., H2H2H Provincial Implementation Network, Zone Transitions of Care Committees) and support the Acute Care Bundle Improvement work that will see 14 of the largest AHS acute care sites implement the guideline. H2H2H is one of eight acute care initiatives being implemented in an integrated learning collaborative (ILC). A pilot of the ILC is underway at two sites.

Partnering with patient and family advisors (PFAs) ensured the patient voice was at the heart of the H2H2H guideline. One way this has been achieved is through the formation of the Patient Transitions Resources Team, which includes four PFAs and three PHCIN staff members from across Alberta. This team outlined recommendations for Alberta's health system leaders to use in implementing the H2H2H guideline, co-designed a patient-focused discharge checklist for COVID-19, and developed a resource to guide patient partnership, engagement and co-design.

Alberta Health Services
Inspiring solutions. Together.
Strategic Clinical Networks™

Excerpted from 2021-2022 SCN Annual Impact Report

AHS Virtual Care Evaluation Framework



In 2021 and early 2022, the PHCIN has worked collaboratively with the AHS Virtual Health Program to create the 'AHS Virtual Care Evaluation Framework: A Guide for Programs and Services in AHS.' The framework supports a common vision and understanding within AHS about the goals of virtual care, processes needed for optimal delivery, and desired outcomes. Moving forward, a common evaluation approach will enable providers and managers to compare and share learnings, build organizational wisdom, and guide best practice approaches.

This work was guided by patient representatives to ensure their voices were reflected in the final product. Albertans participated in three patient focus groups, shared insights with the Evaluation Framework Working Group, and participated in Conversation Cafés with AHS providers, managers and patients. Representatives from community organizations serving new Canadians and Albertans who might feel less digitally connected were also interviewed to better understand challenges and barriers to virtual care. Such a broad co-creation process was vital to ensure a diversity of input, experience, and perspectives to identify what is most important to evaluate moving forward.

Other highlights

Reducing the Impact of Financial Strain (RIFS)

The RIFS project is a ground-breaking collaboration between AHS (PPPH, PHCIN, IWC, and Zones), Alberta Medical Association (AMA), communities and their PCNs. It aims to reduce financial strain as a barrier to health, particularly in areas of cancer, chronic-disease-management, and prevention. Learn more

Over the past year, four community teams and their PCNs have tested ways this could be addressed. Patient stories have been shared on a new website to help care teams learn the impact financial strain has on patients and how to create safe spaces for open, honest dialogue and upstream action with community partners, patients and their care teams.

Work has also focused on developing a Population Health Needs Framework and accompanying User's Guide. A task force with more than 100 community participants shaped the objectives within the framework. It also includes a section on how to focus on health equity when planning services for Albertans. This framework is unique in Canada and applies across the whole continuum of care.

"I encourage more healthcare providers to look at the whole person and consider factors that affect a patient's health beyond what they see in the exam room."

Sandra Campbell, Patient Advisor, RIFS Project

Impact on health and care in Alberta

- Improved transitions, especially from home to hospital and back to home
- Better coordinated, faster access to specialist care when appropriate, informed by clinical pathways and guidelines
- Patients, families, caregivers and community members more actively engaged with care providers and other partners to co-create innovative solutions for care coordination challenges
- Improved informational and care continuity

Actions and areas of focus

- Transitions from Home to Hospital to Home (H2H2H and collaboration with Cancer Care Alberta)
- Linking to specialists and back (ASI)
- Keeping care in the community
- Reducing the impact of financial strain
- Supporting a common vision, processes and evaluation framework for virtual care
- System foundations for integration (Connect Care,CII,CPAR)

PRIMARY HEALTH CARE INTEGRATION NETWORK

Grants and Publications

4
Peer-reviewed Publications

$2.4M
Research Grants

Engagement

11
Workshops & Presentations

115
Research Members

Outcomes and Impact

Co-designed digital tools, guidance documents, and patient and provider resources that aim to:

- ✓ improve patient transitions and continuity of care and information
- ✓ provincially align care practice and access to non-urgent telephone advice services
- ✓ enhance virtual care use evaluation
- ✓ reduce the impact of financial strain on health in Alberta
- ✓ improve focus on health equity

www.ahs.ca/phcin

Excerpted from 2021-2022 SCN Annual Impact Report