AHS Outpatient and Community Physiotherapy Services

Process Manual for Contracted Physiotherapy Providers

Last Revised: June 2025

Alberta Health Services

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Preface

The Process Manual, referenced in Schedule B of the Agreement for Provision of Contracted Community Physiotherapy Services, guides the delivery of the AHS Outpatient and Community Physiotherapy Services and is part of the Clinical Service Agreement for contracted physiotherapy providers. Please replace original sections with updates that are distributed from time to time.

The Outpatient and Community Physiotherapy Services (OCPS) program is an important service in the continuum of rehabilitation services provided by Alberta Health Services (AHS). Knowledge of related AHS and community services will help you direct Albertans appropriately where required. Information related to these other services can be found on the AHS website: http://www.albertahealthservices.ca.

Contact Information

AHS Outpatient and Community Physiotherapy Services Team

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Strata HealthFirst Support Team

Information System Contact Information (Strata Health):

System Support Line:	1-866-556-5005
System Support e-mail contact:	Strata-support@vitalhub.com

Note: Specific client-identifying information (e.g., name, Personal Health Number (PHN), date of birth) should not be included on fax cover sheets never be sent over email. Providers in violation of this policy will be required to participate in security breach reporting and investigation with AHS' Information & Privacy department.

Definitions

Agreement	Refers to the "Clinical Services Agreement" and all Schedules annexed to this Agreement and otherwise incorporated in the Clinical Services Agreement.
AHS	Refers to "Alberta Health Services" and has the meaning ascribed to it in the preamble of the Agreement.
Assessment	The initial attendance by an Individual for each new Episode of Care at which the Provider provides a physiotherapy assessment on an Individual by a licensed physiotherapist in good standing with the College.
Attendance	Any in-person or virtual service encounter including an assessment, education, or treatment to an Individual or Client presenting with a problem or condition reasonably requiring physiotherapy care.
Client	Any Individual who has received an Assessment and is eligible for further Attendance(s) in accordance with the treatment eligibility criteria outlined in the Process Manual & Guide, as amended from time to time.
Client Year	The one-year period following a client's initial assessment for a new injury.
Close Call	A situation where an individual or client was nearly harmed, but for one or more reasons, the individual or client was 'saved' from harm.
College	Refers to the College of Physiotherapists of Alberta, or its successor organization.
Concurrent Episode of Care	Any additional episode of care for a distinct diagnosis or condition that falls within the same client year of a previous episode of care.
Deliverables	All content, documentation, material, or data, in any form or notation to be provided by the Provider to AHS in connection with the Agreement.
Episode of Care	A minimum of one Assessment and the number of treatment Attendances associated with each distinct physiotherapy problem or condition per body site as defined in the Manuals.
Equipment	All equipment, instruments and/or supplies used by the Provider to provide services.
Group Visit	A service encounter with a group of clients who have undergone a hip or knee arthroplasty. Clients have been assessed by a physiotherapist and deemed appropriate to participate in a group rehabilitation class.
Hazard	Something that has the potential to contribute to harm or something that could harm an individual or client and includes any circumstance not described herein and considered a "reportable incident" at any time by the College of Physiotherapists of Alberta or any other professional governing body having jurisdiction or under any applicable laws.

Harm	An unexpected or normally avoidable outcome relating to the Provider's services that negatively affects an individual or client's health and/or quality of life and occurs while the individual or client is at the facility or within ten (10) days of the individual or client's visit, including but not limited to: • Severe Harm (critical incident) - Individual or client attempts suicide, suffers death, complete loss of limb or organ function, or requires intervention to sustain life. • Moderate Harm - Individual or client suffers a partial loss of limb or organ function. • Minimal Harm - Individual or client suffers any form of harm that is less extensive and does not involve death, loss of limb or organ function, and may include clusters of infections among individuals at the facility or clients treated in the facility. • No Apparent Harm – at the time of the event or reporting of the event, the individual or client does not appear to suffer any harm but could do so in the future e.g., Potential for a skin reaction or bruise
Individual	Any person who is eligible for an Assessment in accordance with the eligibility criteria set out in the Process Manual and Guide, as amended from time to time.
Information System	The system described on page 30, Information System Processes, of this manual.
Mature Minor	A person aged less than 18 years who has been assessed and determined as having the intelligence and maturity to appreciate the nature, risks, benefits, consequences, and alternatives of the proposed treatment/procedure(s), including the ethical, emotional, and physical aspects.
New Injury	A distinct problem or condition for which a client requires a physiotherapy assessment, based on the recent occurrence of a specific event (e.g., second surgery or fall).
OCPS	The Outpatient & Community Physiotherapy Services at AHS under which the Services are provided.
Physiotherapist	An Individual who holds a valid certificate of registration and a current practice permit from the College of Physiotherapists of Alberta as required under the Physical Therapy Profession Act or successor legislation.
Process Manual	The document that guides the operational processes and delivery of Services which may be amended and updated from time to time by AHS.
Professional Governing Body	Any governing body having legislative authority to admit, control or regulate any of the persons engaged in the performance of services and includes without limitation and where applicable, the College.

Provider	Refers to the facility that holds a current clinical services agreement with Alberta Health Services to provide Outpatient and Community Physiotherapy Services.
Rehabilitation Advice Line (RAL)	Health Link affiliated telecare assessment and risk stratification process for individuals who are requesting outpatient physiotherapy services for general conditions.
Service Expectations and Business Standards	The requirements to be met and satisfied by the Provider in the performance of services as outlined in the Process Manual.
Services	The services to be performed by the Provider as more particularly set out in Schedule “A” and the manual. Services also include any deliverables.
Service Model	Physiotherapy services as described in the Process Manual, as well as in the service standards and practice guidelines found in the Guide to AHS Standardized Services and Approaches.
Staff	All Individuals employed or otherwise retained by the Provider for any purpose related to the provision of services including the Provider’s employees, officers, directors, volunteers, agents, and all other third-party Providers retained by the Provider hereunder.
Strata HealthFirst	Used interchangeably with HealthFirst throughout this document, this is the information system used by Outpatient and Community Physiotherapy Services.
Visit	An in person or virtual service encounter following an initial assessment. The visit should include physiotherapist re-evaluation of client responses, adjustment or progression of treatment interventions, provision of client education and exercise prescription to facilitate client self-management. The physiotherapist is responsible and accountable for the physiotherapy services provided by personnel working under their supervision (supervisees). AHS clients can expect that they are informed of the role of supervisees and that the services provided by supervisees are supervised by the physiotherapist**.** The Physiotherapist must be present and accessible to the client and supervisee during the visit.
Visit Ceiling	The total number of client visits allotted for a particular zone, care type and period. This is determined by AHS at its sole discretion.
Zone	A geographical service area defined by AHS to administer health services.

AHS Directives, Policies, and Procedures

Relevant AHS directives, policies, and procedures will be provided to the Provider upon request.

Information on doing business with AHS can be accessed through the AHS website under “About Us > Doing Business with AHS”:
https://www.albertahealthservices.ca/about/Page207.aspx

The URL for the Vendor Guide to Doing Business with Alberta Health Services is:
https://www.albertahealthservices.ca/assets/about/org/ahs-org-cpsm-guide-doing-business-with-ahs.pdf

For specific inquiries related to service Agreements and procurement processes, call the **Director of Clinical Services Contracts, and CPSM** at 780-342-0341.

Service Expectations

The OCPS program is intended to support clients in the early stages of recovery from fractures, surgeries and general musculoskeletal injuries. AHS funded physiotherapy visits are expected to focus on building self-management skills, supporting independent exercise programming, and preparing clients for transition to community programs, where appropriate.

To encourage active client participation, discharge planning should begin early in the care process. This ensures clients are aware of their options and can smoothly transition to community-based programs when ready.

Key Points

1. AHS funded physiotherapy services should align with the AHS Guide to Standardized Services and Approaches for Outpatient and Community Physiotherapy and the College of Physical Therapists of Alberta practice standards.
2. The initial AHS-funded physiotherapy assessment should include client education, discussion of self-management strategies and a review of expectations that the condition may not fully resolve during the course of physiotherapy.
3. Modalities, needling, and manual therapy are considered adjuncts to the main goals of the program, which should focus on active exercise-based treatment strategies and self-management.
4. Providers are expected to plan visits effectively and seek client participation to support functional gains between sessions. As such, physiotherapy visits should be spread out appropriately (ideally at least one week between visits) to allow for tissue healing and progression of the self-management program.
5. Ideally, clients will finish their AHS funded episode of care prior to participating in episodes of care through self-pay or private insurance.

General Eligibility and Exclusion Criteria

Eligibility Criteria	Exclusion Criteria
General 1. The individual is requesting a single discipline PT assessment and treatment funded by AHS under Outpatient and Community Physiotherapy Services 2. The individual has a valid Alberta Personal Health Number and can provide an additional piece of photo identification (if 18 years or older). 3. The individual has a functional need that limits activity and participation in their community. 4. The individual and, if applicable, his/her caregiver, can actively participate in the rehabilitation process required to achieve a positive outcome. **Diagnostic** The individual has a condition or needs that are approved under the Outpatient and Community Physiotherapy Service Model listed in Appendix A	1. The individual is eligible for coverage by other health payers: • Workers Compensation Board (WCB) • Services provided under Automobile Accident Insurance Benefits • Department of Veterans Affairs, Health Canada, or other federal programs • Persons with health coverage in other provinces 2. The individual is currently receiving PT through a Primary Care Network (PCN) for the same diagnosis. 3. The individual is currently receiving PT services for the same diagnosis from another AHS-funded program (i.e., Home Care, multidisciplinary, or specialized rehabilitation programs.) 4. Clients who are receiving services for specialized, complex, and chronic pediatric conditions through AHS Pediatric Outpatient and Community Rehabilitation programs or AHS contracts. Search: Pediatric Rehabilitation | Alberta Health Services

Visit Management

In the event AHS zone leadership implements a visit ceiling, the Provider will be responsible for monitoring their allotted number of visits. Once assessed, clients will have access to treatment attendances on a first-come, first serve basis unless capacity for the zone has been reached. Visit ceilings are applied on a per zone, month-to-month basis. To determine if there are any remaining visits available during the selected period, the provider should choose the “Funding Availability” link on the left-hand menu in Health First. HealthFirst will calculate the remaining visits for that period.

It is expected that contracted providers will offer appointment times within ten business days to individuals seeking AHS-funded physiotherapy. Appointment times should include morning, afternoon, and evening options.

Providers are expected to make reasonable attempts to confirm that individuals meet the eligibility criteria for the service model (e.g., ensuring orthopedic surgery/fractures are scheduled within the 12-week eligibility, if known).

Providers should explain how visits will be spaced (ideally at least 1 week apart), emphasize the importance of active participation, and set realistic expectations that the condition may not fully resolve during the course of physiotherapy.

Individual Access Delays

When the Provider is unable to offer an assessment within 2 weeks (10 business days) of the initial request, Individuals seeking AHS-funded physiotherapy visits should be directed to another provider that can offer timely assessment and treatment. This direction includes the provision of a comprehensive Provider list.

Individuals are encouraged to commence services as soon as possible to optimize their recovery. If a client chooses to wait for services at a specific clinic or with a specific provider and that decision takes them out of the recommended time frames for initiating their treatment this will not be accepted as an appropriate reason for delay in commencing treatment and will not be approved for OCPS funding.

Client Transfer Between Providers

If an Individual seeking physiotherapy at a new clinic has received services at another clinic within the past calendar year, the HealthFirst system will prevent the new clinic from entering the Individual's demographic information. A message will appear in HealthFirst directing the Provider to:

Fax a completed "Client Specific Communication Sheet" to the regional Outpatient and Community Physiotherapy Services PT consultant.

The Client Specific Communication Sheet is found on the main page of the HealthFirst information system.

The information provided is required to determine whether a new injury has occurred or if the Individual is transferring to another clinic in the middle of an episode of care. In the latter case, only the remaining number of eligible visits will be provided to the new clinic. As defined above, this first visit to the new Provider will be the assessment visit and will be funded as such.

A second assessment will not be funded when the client is receiving care from the same physiotherapist at a second clinic location within the same episode of care.

One (1) transfer will be supported per episode. Transfer requests must be submitted to the zone PT consultant for review.

General Musculoskeletal Conditions

The General Musculoskeletal (MSK) Condition funding is in place to support low-income Albertans who require PT service for general, non-surgical, MSK conditions.

An Individual may access a **maximum of two AHS funded physiotherapy episodes of care for unique MSK concerns** in a 12-month period with the exception of acute polytrauma cases where **up to** 3 episodes of care may be considered.

The goal of this program is to optimize function and reduce disability for low-income Albertans with general MSK concerns. The services provided should target the client's level of need and result in improved functional outcomes, decreased utilization of other health services, and improved pain management.

Accessing Funded Visits

To access funded visits, an Individual initiates care by calling the Rehabilitation Advice Line (RAL) (1-833-379-0563). RAL will screen the Individual for program eligibility and will redirect to other levels of care as needed.

Eligible individuals must schedule an appointment with a provider within 2 months of their initial phone call to RAL. Zone PT consultants will terminate any unassigned service requests older than 2 months.

Income Verification and Approval Processes

RAL provides the eligible Individual with an emailed link to the Low-Income Declaration Form. The form can be printed off by the Individual and brought to the first appointment OR the Provider can provide a copy of the form to the Individual if the client is not able to print it before the first appointment.

Access the Low-Income Declaration Form at https://www.albertahealthservices.ca/frm-21824.pdf

Income status can be verified by presenting the clinic with proof of benefits from any of the following government programs:

- Canada Revenue Agency GST Credit
- Alberta Adult and/or Child Health Benefit
- Assured Income for the Severely Handicapped (AISH)
- Alberta Seniors Dental & Optical Assistance Program
- Alberta Seniors Benefit
- Alberta Works – Income Support
- Federal Guaranteed Income Supplement (GIS) for Seniors
- Special Needs Assistance for Seniors (Alberta)

Provider Verification of Low-Income Status and Strata Entry

Once an eligible Individual attends a Provider, they are asked to review and sign the Low-Income Declaration Form. To qualify for funding, the Individual must provide proof of their low-income status and complete the demographic information section. Providers are responsible to review the supporting documentation, including annual letters or current benefit cards confirming receipt of government benefits. For a list of the qualifying government programs and the required documentation, please visit the following link: Government Subsidy Programs

Provider staff must review and sign off on the supporting low-income documentation and confirm the Individual's eligibility for service. Please return the documents to the Individual and retain only the signed Low Income Declaration form in the client's clinical record.

Once low-income status is verified, the clinic can proceed by searching for the Individual's PHN in the HealthFirst system and completing the episode of care entry.

If the Individual fails to present supporting documentation or if, on review, they do not meet low-income criteria, then the Provider should inform the Individual they are ineligible for AHS-funded services at this time and should terminate the request on HealthFirst by searching for the Individual's PHN and selecting the unassigned episode of care. The Provider may offer a self-pay option to the Individual.

Immigrants: Recent immigrants to Alberta may need to self-report their income as at or below Low Income Cut Off (LICO) levels. If an Individual can produce a signed Confirmation of Permanent Resident document or a Permanent Resident Card issued by Immigration, Refugee and Citizenship Canada (IRCC) and can report their family income as at or below LICO levels for the same year, they can qualify.

Contracted providers must choose Section A: Letter from a registered SW with AHS or affiliated agency in the Low-Income Verification drop-down menu. The clinic staff must verify these requests on PHN/Name search in HealthFirst before booking the initial assessment.

Individuals under the age of 18 years: Will be considered eligible for General Musculoskeletal services if they live in a low-income family (as assessed by the Low-Income Declaration form).

Individuals over 18 not in receipt of government benefits listed on the Low-Income Declaration Form and who are claimed by their parents as "dependents" for tax filing must be assessed for low-income status based on the family's receipt of the Canada Revenue Agency GST Credit.

Incarcerated Individuals: AHS Corrections Health Teams are responsible for managing the healthcare needs of incarcerated clients and will email the Rehabilitation Advice Line with their requests for physiotherapy episodes of care. Incarcerated Albertans cannot provide evidence of low income. Contracted providers must choose Section A: Letter from a registered SW with AHS or affiliated agency in the Low-Income Verification drop- down menu. The clinic staff must verify these requests on PHN/ Name search on HealthFirst before booking the initial assessment.

General MSK Polytrauma

General MSK polytrauma is when an acute incident has occurred resulting in multiple injuries, none of which are fractures or injuries requiring surgery.

RAL staff will create **one** HealthFirst entry detailing the most significant body area of concern. A comment will be entered in the **AHS Feedback** section to notify providers of additional body areas of concern.

- E.g. “Polytrauma including left shoulder, right knee and right wrist. Please assess and discuss with PT consultant for additional body areas.”

Upon assessment, the provider is responsible for contacting the zone PT consultant to discuss body areas that may require concurrent episodes of care. The situation must require a distinct assessment and treatment plan for each affected body area.

The PT consultant may approve up to 3 concurrent episodes of care in cases of polytrauma. Concurrent episodes will be approved as MSK 2 care type(s). Alternatively, the PT consultant may way-find to appropriate multi-disciplinary programs if the individual requires extensive care.

If multiple episodes of care are approved, the distribution of visits should be planned collaboratively with the patient to ensure alignment with their needs and recovery goals. Each episode may vary in duration and intensity, with treatment visits scheduled on different days as appropriate. A distinct treatment plan and corresponding charting should be established for each episode of care or body area. Providing patients with dedicated time to focus on recovering individual injury areas is essential to supporting program goals, including achieving independence with exercise and self-management.

Note: Individuals with bilateral conditions expected to benefit from the same intervention are excluded from consideration for polytrauma.

Concurrent Episodes of Care for General MSK Conditions

For General MSK conditions (excluding polytrauma) an individual may access a **maximum of two AHS funded physiotherapy episodes of care for unique MSK concerns** in a 12-month period.

If RAL determines that the client has accessed AHS-funded physiotherapy in the past year, they will complete their screening as usual. If it is determined the client is appropriate for AHS funded physiotherapy, they will advise the client:

- to contact a clinic to book an assessment, and
- the treatment visits will not be approved until a PT consultant reviews the assessment findings.

Providers should enter relevant information regarding a **new injury or condition in the provider note section of Strata HealthFirst** following their assessment.

The provider will be notified when the request for an additional episode of care is approved.

If the service request is approved, the number of visits will align with the risk stratification category identified by RAL.

General MSK Type 2: Medium Risk – 1:1 assessment & up to 3 visits.

General MSK Type 3: High Risk – 1:1 assessment & up to 4 enhanced visits (see Guide to Standardized Services for details)

Note: Clinics should have a process in place to ensure therapists are aware of the client's risk stratification level in order to provide the required type and length of intervention.

Post-Operative Orthopedic Surgery and Post Fracture Conditions

Orthopedic Type 1: Post Orthopedic Surgery & Procedures (including Hip Arthroplasty)
1:1 assessment & up to 4 treatments (ability to apply for up to 2 complexity visits)

Inclusion Criteria: Any eligible individual who underwent orthopedic surgery or qualifying procedures in the last 12 weeks. See Approved Conditions in Appendix A

Note*:* Bilateral conditions with the same management are typically covered under the same episode of care. **Knee Arthroplasty is included under Orthopedic Type 4.**

Orthopedic Type 2: Post Fracture and Non-Orthopedic Surgery
1:1 assessment & up to 3 treatments (ability to apply for up to 3 complexity visits)

Inclusion Criteria: Any eligible individual having suffered a fracture in the last 12 weeks. See Approved Conditions in Appendix A.

Note: Bilateral conditions with the same management are typically covered under the same episode of care

Orthopedic Type 3: Group Arthroplasty Rehabilitation (Hip and Knee Arthroplasty)
1:1 assessment and up to 6 group sessions

Clients make the choice of whether they access group rehabilitation or 1:1 physiotherapy for post-operative hip and knee arthroplasty rehabilitation.

Group programming is available at providers with AHS clinical service agreements that include group arthroplasty rehabilitation.

Note*:* Bilateral conditions with the same management are typically covered under the same episode of care.

Please see the Guide to AHS Standardized Services and Approaches for further information.

Orthopedic Type 4: Knee Arthroplasty ONLY
1:1 assessment and up to six treatments (no complexity visits available)

Inclusion Criteria: Any eligible individual who underwent orthopedic knee surgery or qualifying procedures in the last 12 weeks. See Approved Conditions in Appendix A.

Note: Bilateral conditions with the same management are typically covered under the same episode of care.

Request for Additional Funded Visits – Complex Orthopedic Type 1 & 2

To request additional funded visits for an existing episode of care for a complex fracture or orthopedic surgery, the Provider must complete the form in HealthFirst by clicking on the "Complexity Criteria Met" button found on the request detail screen.

The following information should be provided:

- The client's ongoing functional and physical limitations that will be addressed with the additional funded visits, with a brief description of the complexity of their condition.
- Current score of the selected functional measure. Include objective measurements and other relevant test results.

Please see the Guide to Standardized Services and Approaches for a list of qualifying complexity criteria.

Notification of approval or denial of the request for an extension will be made via HealthFirst in a timely manner.

It is the Provider's responsibility to review the outcome of the request in HealthFirst and respond to any requests for additional information or resubmissions. Information on the outcome of the request will be available by clicking on the "details" link of the "extra visit request section."

It is the Provider's obligation to develop a process to communicate decisions to the treating physiotherapist(s) in a timely manner.

Conditions for PT Consultant Review (i.e. conditions that will end up on the pending dashboard)

1. Post-surgery or fracture after 12 weeks. Providers will be responsible to describe the medical reason for delay in access to care.

2. Other muscle, tendon or other joint/ligament surgeries. Providers will be responsible to specify the surgery performed.

3. Cancer related surgeries for breast, tumors of bone or muscle. Providers will be responsible to specify the surgery performed.

4. Non orthopedic surgeries with MSK complications. Provider will be responsible to enter a surgical description and MSK complication that arose as a direct result of the surgery.

Proof of Surgery for Orthopedic Type 1, 2, 3 and 4 care types

PT Consultants MAY need to verify the surgical/medical details including the date of surgery for service request approvals and may utilize clinical applications like Netcare and Connect Care. This proof can include referral for physiotherapy with detail that includes the date and type of surgery. The providers can upload medical reports and supporting documentation into HealthFirst.

Concurrent Episodes of Care for Post-operative Orthopedic Surgery and Post Fracture Conditions

The definition of poly trauma is an individual who has suffered multiple surgeries or fractures. Individuals with polytrauma may have **up to 3** concurrent episodes of care approved. In cases where the treatment approach is the same (e.g., bilateral knee replacements), only one episode of care will be considered.

Episodes of care cannot be "banked" or accumulated. When a concurrent service request is submitted for the same body part, any existing episodes of care for that body part will be terminated. The assessment of the new episode of care will be the date of the client's first visit after the date of onset.

Considerations for Approval

1) Multiple surgeries or fractures on **distinct body areas** (e.g., left wrist ORIF and right ankle fracture resulting from a fall) – Multiple episodes considered

2) **Bilateral surgeries or fractures** with the same management and **same date** of onset – 1 episode of care approved

3) **Bilateral surgeries or fractures** with the same management and **different dates** of onset (e.g., right knee replacement in March, left knee replacement in April):
    a. If **all** visits from the 1st episode have been used a second episode will be considered
    b. If **some** of the visits from the 1st episode have been used, the 1st episode will be terminated and a second episode will be approved for both sides
    c. If the client has **not yet accessed** the 1st episode of care, only 1 episode will be approved

Note: Providers are encouraged to request complexity visits for Ortho Type 1 & 2 episodes prior to referring clients back to RAL for consideration under the General MSK standard. If clients still have significant functional or physical limitations after an Ortho episode of care, and they meet low-income criteria, they may be considered for a General MSK episode for the same body area provided it has been at least 3 months since the date of their last visit. **Clients should be encouraged to continue with their self-management plan for a period of 3 months prior to seeking a General MSK episode of care.**

Delay in Commencing Treatment

A service request dated more than 12 weeks following orthopedic surgery or fracture requires a medical rationale for the delayed access as well as ongoing physical or functional limitations to be considered for approval. Medical reasons for late access must be adequately described and communicated in HealthFirst.

The provider should include as many details as possible such as date of cast removal, date of lifting of surgical restrictions to activity, and reasons that the patient was unable to access outpatient physiotherapy.

Note: Clients should access physiotherapy services within 2-3 weeks of surgical restrictions being lifted or clearance from the surgeon.

The Provider must ensure that the individual is aware that requests for AHS-funded visits past the 12-week window are subject to this approval process and that patients are responsible for the cost of any visits if the request is denied.

If you are unsure if the patient would qualify given their rationale for delay in accessing services, please feel free to contact your PT consultant.

General Processes

Administrative Duration

Clients are considered self-discharged from OCPS-funded treatment if they stop attending for 3 months or more without prior arrangement. This policy should be clearly communicated during the assessment, as ongoing participation is required for continued eligibility.

If the client is considered self-discharged, please contact your zone PT consultant to terminate the episode of care in HealthFirst.

Each service request, no matter for which service type, has an administrative duration limit of 52 weeks. After 52 weeks, the provider will not be able to enter visits associated with the service request and the service request will automatically terminate in HealthFirst.

The 52-week period is automatically calculated in HealthFirst, based on the start date of the service request. The Provider should ensure the start date is adjusted in HealthFirst so that it is the same as the assessment date. **Note:** The start date cannot be adjusted for MSK care types.

Discharge Outcome Data Collection

On the last scheduled visit attendance funded by AHS, the provider is required to have the client complete an outcome measure tool. This tool should be the same outcome measure tool utilized at the time of the assessment. Providers will not be able to validate the final attendance until the outcome measure score is entered into HealthFirst.

HealthFirst will automatically direct the provider to enter this information when they validate the

final visit. The system will navigate the provider to the “Discharge Page.” It is the Provider’s obligation to develop a process to communicate to the treating physiotherapist(s) that the outcome measure tool must be completed on the final AHS-funded attendance.

Follow-up and Discharge

The final follow-up visit should include a comprehensive review of the client’s self-management plan, including strategies for managing flare-ups. It should include a review of the client-specific home exercise program with guidance on progressions, recommendations for continuing exercise, and referrals to relevant community programs as appropriate.

Infection and Prevention Control

Specific infection prevention and control (IPC) Provider obligations are outlined in Schedule “G” “Infection Prevention and Control” of the Agreement. The following is a summary provided for reference:

Provider Obligations

a) The Provider will obtain copies of the IPC Standards described in section 1.1(a) of this Schedule annually from the Alberta government website at:
Infection prevention and control | Alberta.ca

b) The Provider shall comply with all regulations set out by Physiotherapy Alberta College + Association regarding operations and provision of services. See:
Infection Control — College of Physiotherapists of Alberta

In addition to the standards referred to in section 1.1 of Schedule D “Infection Prevention and Control” of the Agreement, the AHS Allied Health Infection Prevention & Control Resource Manual provides information, support, and evidence-based resources applicable to allied health practices in the community. It can be accessed at:

AHS IPC Community Based Services Resource Manual

It is expected that Providers will develop IPC processes that are relevant to equipment use, staff practices, and clinical and non-clinical space. These processes will:

- Manage environmental contamination.
- Establish, record, track, and audit routine practices, hand hygiene practices, and use of personal protective equipment.
- Establish, record, track, and audit cleaning and disinfecting processes suitable to the type and use of equipment.

The Provider shall provide AHS with a report on IPC related indicators from time to time upon request by AHS and during the annual reporting period. Refer to the Annual Reporting section of this manual.

Equipment Maintenance

All equipment must be kept in safe working order and be maintained following the equipment manufacturer's specifications and guidelines subject to review and acceptance by AHS. Equipment manuals must be kept on site for the lifespan of the equipment.

Maintenance reviews and inspections are to be completed at least annually and more frequently if required by the manufacturer's specifications. All inspection, and equipment service records must be kept on-site for a period of 5 years and be available for reference at the request of AHS.

Virtual Services

Provision of Virtual PT Services is to be provided subject to alignment with Schedule K of the Clinical Services Agreement.

Providers must have a private and secure phone line in their contracted clinic space. AHS will **not** fund Virtual PT Services if they are provided from a location other than the contracted clinic.

Providers providing Virtual PT Services must:

- Use reasonable efforts to adopt blended models of service delivery using telerehabilitation visits to augment judicious use of in-person care as appropriate to achieve the best patient outcomes possible.
- Recognize when physiotherapy assessments or treatments cannot reasonably be delivered via telerehabilitation. This format of service delivery may be appropriate for many patients; however, it is unlikely to be appropriate for all patients seeking physiotherapy services.
- Only consider telerehabilitation as the sole means of service delivery when indicated by the patient's condition and/or the risk assessment.

With respect to a telerehabilitation session:

- A telerehabilitation session must have a specific clinical purpose and be documented thoroughly in the chart notes and be available for review by AHS on request.
- Assessment and treatment attendances need to be captured in the HealthFirst information systems, observing the usual entry timelines, to be captured for visit limits and clinic payment.
- Clinical interventions provided in a telerehabilitation assessment and/or treatment attendance must align with the Service Standards outlined in the Guide to AHS Standardized Services & Approaches for Outpatient & Community Physiotherapy.

Financial Processes

Fees payable for Virtual PT Services are set out in Schedule B of the Clinical Services Agreement. Please contact your zone PT consultant if you have questions on out-of-zone access to virtual physiotherapy services.

Business Standards

The contracted facility must maintain a minimum of two licensed full-time (2022 hours per year) physiotherapists or four part-time physiotherapists (equaling 4044 hours/year) available per site to provide services. **This excludes provisionally registered physiotherapists and physiotherapists who are registered but do not provide client care services.**

The site must prove that two physiotherapists are working concurrently for the day the service is offered. Except as provided below, the physiotherapy clinic shall be open a minimum of 31 hours per week.

Clinics in rural areas that are unable to maintain 31 hours per week must request approval through AHS zone Allied Health leadership.

When Providers must reduce their hours of operation due to extenuating circumstances or vacations, the Provider must clearly communicate this to clients and persons seeking services. As well, the Provider must provide alternate treatment options if requested by the client and must refer the client to another Provider if this is in the best interest of the client.

The reduction in capacity or business hours must be communicated by email to the zone PT Consultant at the earliest (ideally before the reduction of hours or capacity as permitted by circumstances).

Information and Privacy Requirements

The AHS Health Information poster will be prominently displayed in the waiting area of the facility once received. If the poster is not displayed, the information provided by the poster must be made available to each client. Email privacy@ahs.ca to request a digital copy of the poster.

All privacy requirements are outlined in detail in the Agreement. Providers should refer to the AHS Policy “Transmission of Information by Facsimile or Electronic Mail,” available through the following link:

AHS Policy Transmission of Information by Facsimile or Electronic Mail

> **Note:** Specific client-identifying information (e.g., name, Personal Health Number (PHN), date of birth) should not be included on fax cover sheets and should never be sent over email. Providers in violation of this policy will be required to participate in security breach reporting and investigation with AHS’ Information & Privacy department.

Billing Standards

The College of Physiotherapists of Alberta's standards of practice mandate that registered physiotherapist providers maintain accurate and complete financial records related to the provision of services. As a result, the provider will bill through HealthFirst only for dates that client service was provided. This must be reflected in client documentation. Any violation of this standard will be considered fraudulent practice and noncompliance with the College of Physiotherapists of Alberta's standards of practice.

AHS will perform routine audits to ensure adherence to the above-mentioned standard. Any fraudulent entries will not be reimbursed, and any payments made for such entries will be recovered.

Daily Billing Expectations

Client visit information should be submitted daily through HealthFirst. Validated visits provide the basis of the Outpatient and Community Physiotherapy Services accounts payable report. Accuracy of this data entry is critical and a requirement of both the clinical services agreement with Alberta Health Services and the College of Physiotherapists of Alberta's practice standards.

> **Note:** If the client has been approved for 2 or more episodes of care concurrently, the Provider may only enter one (1) assessment visit per day. The exception will be made for clients who underwent multiple distinct surgeries or sustained multiple fractures up to a maximum of two (2) assessments per day. A treatment visit cannot be billed for the same day as the assessment on the same episode of care. The Provider may enter up to two (2) treatment visits per day, on two different approved episodes of care.

Late Entries

Providers will receive information annually regarding important dates that indicate when Providers must have all entries in for the previous month.

This is reflective of the 6-business day change window in the HealthFirst system. In exceptional circumstances only, required information changes to HealthFirst that fall outside the 6-day entry window can be requested by faxing a date change form within the invoicing cut-off deadline as indicated in the "Important Dates" memo.

The Visit Date Change Form is found on the main page of the HealthFirst information system.

Payment Processes

Using HealthFirst, the Provider shall electronically submit the following data:

- For all new clients admitted to the service, the Provider shall be required to submit client identifying information, and service information.
- For clients attending subsequent visits, the Provider shall only be required to submit the date of attendance, the type of service provided, recent functional measurements (on the last approved visit), and the length of the visit. The length of the visit should represent the duration of time the client spends in either direct contact with, or under the direct supervision of their treating physiotherapist.

- HealthFirst will provide mandatory text boxes when additional information is required.

The Outpatient and Community Physiotherapy Services program shall issue payment to the Provider within 21 days after the first business day of the month for services rendered in the previous month. Payment will be based on the current data entered and validated in HealthFirst for the month.

The Outpatient and Community Physiotherapy Services program will only accept corrections or adjustments relating to client-specific data (e.g., demographics, diagnostic codes, initial outcome scores, etc.). HealthFirst will not accept retroactive changes to service visit dates beyond six business days. In exceptional circumstances, changes can be made to the payment for the next month. This would require that a date change form be completed and faxed to the Outpatient and Community Physiotherapy Services zone-specific fax number for processing. The Provider is strongly advised to minimize the use of this approach and to report attendances accurately in HealthFirst daily.

Reconciliation Process

On the monthly invoicing date, it is recommended Providers run a “Visits by Date Range” report. A link to this report is found at the “Reports” link on the left-hand menu in HealthFirst. This will allow the provider to identify the specific visits that were used to create the accounts payable report used by the Outpatient and Community Physiotherapy Services program.

Monthly invoicing dates can be found in the “Important Date’s Memo” on the Provider’s “Main” page in Health First.

Incident Reporting

The incident reporting process is Schedule F of the Agreement. It is included here for ease of reference.

Event	When to Report	Contact Person/Info
Hospital Transfers	To be reported immediately, irrespective of the level of harm	Zone PT Consultant
Severe Harm (critical incident)	To be reported immediately in reasonable detail, with follow-up reports in complete detail to be submitted within 24 hours of the event	
Moderate and Minimal Harm	To be reported in complete detail within 72 hours of the event	
No Apparent Harm, Hazards, and Close Calls	To be reported in complete detail within 30 Days of the event	

Note: There is no specific AHS documentation form for incident reporting. Providers should have a process for documenting incidents and follow-up actions. This information must be provided to the PT consultants within the timelines listed above.

Client Concerns Resolution Process

This information and other Provider requirements are outlined in Schedule H “Individual or Client Concerns Resolution Process” of the Agreement. This summary is included here for ease of reference.

Client Concerns Regarding Provider

Providers must first collaborate with their patients to help resolve any concerns, before pursuing resolution through AHS.

The following is a summary of the AHS Client Concerns Resolution Process:

1. The client expresses concern to the Provider either by contacting Provider administrative staff or Provider clinicians. If the concern is expressed to the provider’s administrative staff, the concern must be highlighted to the client’s treating clinician. This must occur within three business days including acknowledging the concern directly back to the client.
2. The treating clinician must consider and evaluate all relevant information to determine whether there is indeed a connection between the facts presented and the concerns of the client. This includes a discussion with the client on the facts associated with the concern.

3. The Provider will then inform the client of the actions to be taken to address their concern and state the frequency of updates that will occur and as well as document all actions (i.e., phone calls, meetings) taken towards resolution.
4. The treating clinician should inform their direct supervisor of the client's concern if it is not resolved following the initial discussion with the client.
5. The Provider will ensure the resolution timeline is suitable to the nature of the complaint.
6. The Provider must maintain all documentation regarding the client's concern and share it with AHS upon request/as required.
7. If the client remains dissatisfied with the outcome of the concern at the clinic level, the Provider will contact the AHS Zone PT consultant to work towards collaboratively resolving the concern.

If a patient concern involves both the Provider and AHS, AHS Outpatient and Community Physiotherapy zone program leadership will collaborate with the Provider in resolving the client's concern to ensure a seamless process for the client. The Provider and AHS will make decisions about the portion of the concern about their service only. AHS will follow its patient resolution policy and procedure.

Reporting Requirements

The following table provides an overview for Providers of the required data and reports, the timing and frequency of each, and the format for delivering the information to AHS.

Information	Frequency	Format
Individual & Client specific data as outlined in Strata Information Requirements (Appendix A) in the Outpatient and Community Physiotherapy Services Process Manual	Within one working day of the attendance	HealthFirst
Conflicts of interest	Immediately	Written notice by email or fax
Change in ownership or control or updated corporate profile, including as applicable: • Correct legal name • History of the corporation • Head office address • Certificate of incorporation • Ownership structure • List of shareholders, directors, and officers of the corporation Revised certificates of insurance for professional liability insurance and comprehensive general liability insurance following the terms of the Agreement noting the applicable change of name, location, etc. as applicable.	Immediately	Written notice by email or fax
College of Physiotherapists of Alberta – Annual practice permit for physiotherapists providing services that are funded by AHS.	Immediately on commencement of Services and annually thereafter, or with any changes to practice status.	Copy of certificate or print out of status from the College website. Annual: CPSM survey Mid-year change: fax or email to PT Consultant
Any deficit in service expectation is defined as minimum staff levels.	Immediately on shortage of minimum staffing levels or staffing levels that affect the capacity to provide AHS contracted community physiotherapy services as outlined in service expectations.	Notification by fax or email to the appropriate zone PT Consultant

Individual and Client incidents	As per Incident Reporting Process	As per Incident Reporting Process
Individual and Client Concerns	Following Client Concerns Resolution Process	Telephone notice, Fax may be requested by AHS for any client-sensitive information.

Annual reporting:
• Insurance certificates:
  ○ Clinic commercial liability
  ○ Clinic professional liability
  ○ Employers' liability insurance (if not covered by Workers Compensation legislation)
• Annual certificates of all physiotherapists providing services
• Emergency management plan
• Business continuity plan
• Incident reporting
• Infection prevention and control manual
• Client concerns and resolution process
	Annually by January 30 following the end of each year of the term	Uploading documents into a secure electronic survey (link provided by CPSM).

Annual and Other Reporting

Providers will be expected to participate in evaluation activities when relative to provider clinics as related to AHS goals: improve patient experience, improve patient outcomes, improve the safety and experience of clinicians, and improve financial health and value for money.

The Provider will be required to share information with AHS PT consultants and AHS Clinical services agreement monitoring by uploading documents into a secure electronic survey. Information requested pertains only to the services provided in the facility under the AHS Clinical Services Agreement. AHS Clinical services agreement Monitoring shall review additional elements of Provider performance in alignment with the Clinical Services Agreement.

Information System Processes

Information System Users

The information system in use by Outpatient and Community Physiotherapy Services is the Strata Health Solutions HealthFirst web-based application. Information system users must be using Microsoft Edge as a minimum requirement, and the more recent version is preferred to optimize system function. Browsers including Chrome, and Firefox are also known to work but are not officially supported.

Each Provider staff member entering data in HealthFirst must have their own login, which must not be shared between individuals. Staff members are prohibited from entering their own or immediate family members' information into the HealthFirst system and must not access any information unrelated to their job and clinical responsibilities. It is important to note that all entries in HealthFirst form part of the client health record and must comply with provincial legislation requirements for privacy and confidentiality. Quarterly privacy audits are conducted on the HealthFirst system to ensure compliance with these standards.

Each Provider is responsible to have a Local Region Authorizer (LRA), a clinic leader authorized to approve new account requests for their clinic. The list of LRAs is maintained by the zone PT consultants. If an LRA changes or leaves the Provider's employment, the Provider must promptly notify the zone PT consultants.

New Access Requests:

To request new access, complete the "Strata HealthFirst Non-AHS User Access Request Form" available on the HealthFirst system "Main" page. The form must be signed by the LRA and emailed to: Strata-support@vitalhub.com.

Deactivating Accounts:

When a staff member or user with an active HealthFirst login leaves the Provider's employment, the Provider's LRA must notify the HealthFirst team as soon as possible to disable their login. Submit the "Strata HealthFirst Non-AHS User Access Request Form" with the relevant information for account deactivation.

Inactive Accounts:

If a user does not log in to HealthFirst for 60 days, their account will be automatically disabled. In such cases, the user must contact HealthFirst have their login re-enabled.

User Manual for Information System

Information related to the operation of HealthFirst is contained in provider training videos. General topics covered include navigation through the application, understanding terminology, data entry, and running reports.

The Outpatient and Community Physiotherapy Services program administrators aim to collaborate with Providers to achieve the correct utilization of HealthFirst. If your questions

cannot be answered through a review of HealthFirst training videos, contact your zone PT Consultant or Strata Health Solutions using the contact information provided in the introduction of this manual.

Process to Resolve Information System Issues

Please call the HealthFirst system helpline for all operational issues and all password and login related issues.

1-866-556-5005 (6:00 to 22:00 MST)

Orientation of Staff to Services

The Provider is responsible for orienting their staff on the service expectations and business standards as outlined in this manual and in the Clinical Service Agreements, which may change from time to time. This orientation must include information that helps Provider staff to communicate the parameters of the services accurately to the public.

Materials to support orientation can be found on the OCPS provider website:

Outpatient & Community Physiotherapy Services | Alberta Health Services

Expired Sections

This section is included for each Provider to house the previous versions of sections of this manual, document, or forms. This manual is referenced in the Service Agreement. Providers should retain expired versions to access guidelines relevant at a particular time.

The most current version of this Process Manual may be accessed through a link on the main page of Strata HealthFirst or via the OCPS provider website:

Outpatient & Community Physiotherapy Services | Alberta Health Services

Appendix A: Strata HealthFirst Clinician Diagnostic Code Picklist

Purpose: To provide a comprehensive list of HealthFirst drop down options for accurate reporting of the conditions eligible for funding through AHS Outpatient & Community Physiotherapy Services.

For questions related to the diagnostic categories, please reach out to your Zone PT Consultant.

The following conditions are excluded from Ortho Type 1, Ortho Type 2 and General MSK care types:

- Any surgery for cosmetic purposes including scar revisions, cosmetic TMJ surgery, and breast reduction or implants not related to cancer surgery
- Laparoscopic abdominal surgery
- Concussion
- Neurological conditions or neurosurgery
- Dermatological conditions
- Vestibular conditions
- Pelvic health conditions

General MSK Service Type 2 (Med) or 3 (High) = Assessment & up to 3 visits (MED) or 4 visits (HIGH); Not eligible for complexity visits		
Region		**Diagnosis**
Head / Neck		1. Nerve root compression, spinal stenosis & disc pathology
Trunk		2. Peripheral nerve disorders and neuropathic pain
General Debility		3. Muscle strains & tears, tendinopathies, impingements, bursitis, epicondylitis and cysts
Bilateral / Left / Right	Shoulder	4. Ligament, meniscal or labral sprains & tears
Bilateral / Left / Right	Elbow	5. Degenerative joint conditions
Bilateral / Left / Right	Wrist/Hand	6. Connective tissue disorders and inflammatory arthritis
Bilateral / Left / Right	Hip	7. Chronic or non-specific pain
Bilateral / Left / Right	Knee	8. Deconditioning (e.g. post-hospital, post-viral)
Bilateral / Left / Right	Ankle/Foot	9. Other: including postural abnormalities, joint deformities, instability, joint or muscle contractures, dislocation

The following conditions or procedures are excluded from Ortho Type 1 & Ortho Type 2 care types. Requests for physiotherapy related to these will be considered to be a General MSK care type.

- Needle only procedures (e.g. steroid shots, tenotomy, barbotage)
- Surgery for bone/tendon graft donor site
- K-wire removal only
- Subchondral insufficiency fractures and bone bruises (micro-trabecular fractures)
- Surgery for wounds (e.g. skin grafts & wound debridement)

<table>
<tr><th colspan="3">ORTHO TYPE 1: Follow-up After Orthopedic Surgery & Other Specified Procedures = Assessment & up to 4 visits; ability to apply for up to 2 complexity visits</th></tr>
<tr><th>Arthroscopy</th><th>Other MSK Surgery</th><th>Surgical Repair of Complex Fracture</th></tr>
<tr><td>Shoulder (including RC repair)</td><td>*Amputation</td><td>*Open reduction internal fixation (ORIF)</td></tr>
<tr><td>Hip</td><td>*Back/neck (incl. discectomy, laminectomy, fusion)</td><td>*Requiring external fixation</td></tr>
<tr><td>Knee (including ligament repairs)</td><td rowspan="2">*Joint fusion (not spinal or toe) [Note: Spinal -> Back/Neck option above; Toe fusions –> Ortho Type 2]</td><td>Other Procedures</td></tr>
<tr><td>Knee (excluding ligament repairs)</td><td rowspan="2">*Manipulation under anesthetic</td></tr>
<tr><td>Ankle</td><td>*Muscle/tendon (repairs/reconstruction/transfers)</td></tr>
<tr><td>Joint Replacement</td><td>*Osteotomy (not including surgery for toe alignment) [Toe surgery -> Ortho Type 2]</td><td>Cancer Surgery</td></tr>
<tr><td>Total shoulder</td><td>*Joint or ligament (not described elsewhere)</td><td>*Tumor removal from bone or muscle</td></tr>
<tr><td>* Other (NOT HIP or KNEE)</td><td>*Surgically repaired crush injuries</td><td>Breast (including lumpectomies, partial & full mastectomy and reconstruction)</td></tr>
<tr><th colspan="3">ORTHO TYPE 1: Hip Arthroplasty = Assessment & up to 4 visits; ability to apply for up to 2 complexity visits</th></tr>
<tr><td>Hip Arthroplasty 1:1</td><td colspan="2"></td></tr>
</table>

**Please provide detail on the specific body area and procedure or surgery type in Strata HealthFirst submission.*

ORTHO TYPE 2: Follow-up After a Fracture, non-Orthopedic Surgery = Assessment & up to 3 visits; ability to apply for up to 3 complexity visits	
Fracture	**Surgery**
Skull and/or facial bone(s)	*Hardware removal (must be within one year of ORIF)
Temporomandibular joint	*Major non-orthopedic surgery with MSK complication (i.e. cardio-thoracic, open hernia repairs, major abdominal surgery) **Note**: Details of specific MSK complication(s) must be provided in HealthFirst
Sternum (i.e., breastbone)	
Rib(s)	Mastectomy related to gender reassignment
Spine (incl. compression fracture)	*Reconstructive foot surgeries including bunionectomy
Clavicle (i.e. collarbone)	*Fasciotomy
Scapula / part of scapula (i.e. shoulder blade, acromion)	Dupuytren's contracture releases
Humerus	*Peripheral nerve releases
Ulna (with or without radius)	Carpal tunnel release
Radius	*Other soft tissue releases (incl. De Quervain's and trigger finger releases)
Carpal(s) / metacarpal(s) (i.e., hand)	*Cyst removals (neuromas or ganglions)
Finger phalanx	
Pelvis	
Femur	
Patella (i.e., kneecap)	
Tibia (with or without fibula)	
Fibula alone	
Tarsal or metatarsal (Foot)	
Toe(s) (phalanx)	
ORTHO TYPE 3: Hip & Knee Arthroplasty Group Rehabilitation = 1:1 Assessment & up to 6 Visits	
ARTHROPLASTY: FOR SPECIFIC CLINICS WHERE AUTHORISED	
Hip arthroplasty	Other hip/knee arthroplasty (e.g., hemi-, uni-compartmental)
Knee arthroplasty	
ORTHO TYPE 4: Follow-up After Knee Arthroplasty = 1:1 Assessment and up to 6 treatment visits	
Knee arthroplasty	

**Please provide detail on the specific body area and procedure or surgery type in Strata HealthFirst submission.*

Appendix B: Strata Information Requirements

The list below summarizes the information required by AHS to facilitate reporting to Alberta Health. This information is collected through Strata HealthFirst.

Clinic Identifying Information

Delivery organization	A site identifier as defined by AHS
Program number	As defined by the AHS

Patient Identifying Information

Client name	
Alberta Personal Health Number (PHN)	Nine (9) digit numbers assigned by Alberta Health & Wellness
Postal Code	
Birth date	YYYY-MM-DD
Gender	M / F / Other

Service Information

Date of service	YYYY-MM-DD
Mode of service	Face-to-face, virtual, group
Main and secondary diagnoses	Category-based coding
Type of treatment	In-person, virtual
Functional Measurement	Dependent on service (listed in information system)
Length of visit†	<20 min, 20-40 min, or >40 min
Visit disposition	Scheduled, approved, or complete

† Length of visit describes the amount of time the PT is in direct contact with the client or is available (i.e., not with another client) for consultation with the client.