Alberta College of Family Physicians

Modernizing Alberta's Primary Health Care System

Ensuring every Albertan has a family physician

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Recommendation:

Ensure every Albertan has access to a family physician and a primary health care team by implementing the Patient's Medical Home.

Supporting Recommendation 1: Fund the expansion of family practice teams at the point of care.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? There is a need for basic team-based primary care for a community to provide wellness and preventative care, regular screening, chronic disease management, and mental health. Family physicians spend too much time on administrative work, duplicative forms, inefficient electronic medical records (EMRs) and referral systems and not enough time on patient care. Access to equitable care for often vulnerable, unattached patients is not factored into current primary care funding. Current Primary Care Network (PCN) funding do not consistently and adequately, across the province, provide funding for team members in a PMH (i.e., family practice) Alberta's family physician population, family medicine residents, and medical students do not see comprehensive family practice as a viable or sustainable career option.	• Employ immediate strategies to ensure there is access to a family physician for every Albertan by creating an environment where family physicians, residents, and medical students see comprehensive family practice as welcoming, well supported, viable, and sustainable • Eliminate disincentives for implementing optimal team-based care. Such disincentives include physician fee for service as the dominant remuneration for care provided, daily caps, medico-legal liability issues, limited understanding of scopes • Develop directory of scopes of practice of interdisciplinary team members, with examples and contacts to people willing to share their experiences embedding team members in practice • Add team members (patient-facing and administrative) to clinics where possible by providing ear-marked funds to pay primary care health professionals and administrative teams competitive rates either though clinics or PCNs • Engage and incentivise existing family practice clinic staff to work at the top of their scope to catch up on screening, manage stable chronic diseases, and address care deficit • Provide immediate expanded program funding for intradisciplinary continuing professional education that exists to improve complex clinical patient-oriented outcomes in community practice including mentorship, training, ECHO and case-based learning, complex mental health, and chronic disease management	• Work with Alberta Medical Association's (AMA's) Section of Family Medicine and Section of Rural Medicine using "model office" calculations to ensure that evidence-based funding models are in place to ensure viable and sustainable access to team-based care for a population (i.e., ratio of three to five providers per physician) • Provide new population-based funding to PCNs and primary care and community-based clinics to set up innovative ways to provide primary care in the community including support for unattached patients • Establish and fund a competitive staff compensation grid for each type of health team member (e.g., dietitians, social workers, nurses, pharmacists, etc.) • Provide support for education and quality improvement (QI) for community practices like the support provided in the acute care system • Provide support for community practices to have community navigators/link workers who do social prescribing as part of the intradisciplinary team	• Using newly established health authority(ies) (see Supporting Recommendation 2), flow sustainable and dedicated funding to support family medicine as the foundation for a healthy Alberta • Develop "The Alberta Primary Care Services Act" with a multistakeholder consultation process. By having its own legislation, the funding of the primary care workforce will be permanent • Fund and support changes in training and education that establish best practices for high functioning team-based care from college and university training, medical school, and through residency • Support and leverage advancing the use of technology within the PMH and externally for lab, diagnostics, and specialty consultants to increase capacity and efficiencies for both patients and teams. Some examples: medical scribes, virtual assistants, smart forms, and secure text, email, and document transfer • Provide program funding through professional colleges and universities for interdisciplinary team effectiveness and team-based learning dedicated to care in the PMH and medical neighbourhood (i.e., faculty development, mentorship, observership, shadowing, workshops, and training sessions) • Establish and maintain a workforce planning bureau with the respective professional colleges/associations to monitor and predict health professional supply and demand

Recommendation:

Ensure every Albertan has access to a family physician and a primary health care team by implementing the Patient's Medical Home.

Supporting Recommendation 2: Create community-based health authorities with engaged leadership, patient-based funding, and accountability for the delivery of longitudinal preventative care, chronic disease management, and seamless transitions of care to all Albertans.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? Primary care in Alberta does not currently work as a system or within the whole health and social system. Alberta Health Services (AHS) is primarily an institution and acute care administrative body; it does not understand the key issues of primary care. Public health, home care, and other outpatient services would operate more efficiently and enable local needs to be better served under a provincial primary care governance model. AHS top-level decisions have significant impact in communities and primary care; it is difficult to deliver community-based health services within the current fragmented and unintegrated system. Complex patient care pathways are fragmented and referrals and consultation with specialty are difficult, time consuming, delayed, inefficient, and ineffective.	• Create a full-time compensation package for a Zone PCN leadership dyad (AHS Zone and PCN Lead) that are tasked with zone-level service planning and a core budget to begin early actions for population needs and improved access • Mandate AHS to work with PCN leadership to plan early actions and collective solutions to reallocate existing AHS and PCN resources to address local gaps in patient access to community health and social services • Invest in collective and intersectoral zonal and regional solutions through collaboration with AHS Zones, PCNs, and other service partners in an integrated system (e.g., schools, friendship centres, community centres, social programs, housing, link workers, patient navigators) • Build on the successes of Specialist Link and Connect MD, and the focus on the Alberta Surgical Initiative to increase access to specialist consultation and rapid referrals to community and hospital-based specialists as screening and chronic disease management processes in primary care are ramped up	• Design a regional governance model to support funding and accountability for the delivery of all community-based care in a geographic area that accounts for proven care corridors used by its population (i.e., current zones may not be ideal – divide North into Northwest and Northeast Alberta, and South into Southwest and Southeast) • Ensure all transformational suggestions require incentives for building longitudinal patient/family physician/ clinician relationships and continuity of care (i.e., incentivise attachment and longitudinal patient-team relationship while working to serve unattached patients with funding allocated to ensure equitable access to primary care) • Ensure adequate funding through a contract to achieve its annual business plan where its goals and deliverables have been approved. Budget management for the authority will have the flexibility within its funding envelope to make allocation decisions across the organization to achieve its priorities and goals within the global budget	• Ensure that "The Alberta Primary Care Services Act" secures funding and infrastructure support for primary care and establishes the community-based health system as the foundation of the health system • Establish and implement transformations in training and education for primary care team members to better support increased clinical complexity, leadership, and business management skills within the team-based care model • Policy is required to establish a shared accountability and purposeful design for diagnostic and lab service outside of hospital settings for direct and timely access by primary care providers and avoid using emergency departments for access • Establish a contractual and/or performance agreement between the community-based health authority and the hospital-based health authority to assure timely flow of patients from community to hospital services and then back from hospital services to primary services

Recommendation:

Ensure every Albertan has access to a family physician and a primary health care team by implementing the Patient's Medical Home.

Supporting Recommendation 3: Supply multiple and timely sources of system and practice-level information to assist in clinical care, quality improvement (QI), and business decision making.

	Now (within 1-3 months)	Next (within 3-6 months)	Later (within 1 to 5 years)
Why invest here? Physicians, clinics, PCNs, and Zone leadership are asked to make decisions about QI and clinical practice without access to system-level data or teams who can analyse it. Clinical data assists in making practice-level QI and supports research for complex clinical challenges. During clinical and public health crisis, needed clinical and public health crisis surveillance data has been difficult to access by those providing care. Privacy impact assessment (PIA) delays or costs are a huge barrier to uptake of Central Patient Attachment Registry (CII/CPAR). Information management/ information technology (IM/IT) change management has been slowly progressing through the pandemic and facilitation workforce disruptions occurred over the last several years. There is no way currently for primary care to assess current supply and skillset of physicians, nurses, nurse practitioners, pharmacists, social workers, physician assistants, medical office assistants and others who could support the teams in their practice or surrounding health neighbourhood.	• Continue to support the efforts of CII/ CPAR and build a network of EMRs to move toward one fulsome patient record that all providers and points of care can access • Reduce delays at the level of the Office of the Information and Privacy Commissioner of Alberta (OIPC) to review and approve the PIAs to support uptake of CII/CPAR • Provide current billing data and analytics to the Inter-Zone Implementation Coordination Committee (I-ZICC), Zone PCN leadership and primary care partners; the billing data and analysis will clarify some of the current workforce population and trends in full-time/part-time, scope, focused practice, however we will also need to collect real-world data on existing team members in primary care clinics including nurses, social workers, pharmacists, nurse practitioners, and medical office assistants (MOAs) to further define the primary care community-based workforce	• Continue improvement and refinement of Connect Care-downloaded information to community EMRs to reduce the redundancy and sheer volume of information not relevant to clinical care and follow up in the community • Create a mechanism for EMR clients to deal with vendors to achieve collective impact and more timely customer-responsive changes and enhancements to their products • Provide funding for a dedicated primary care data analytics team to support the planning, measurement, performance management, and service resource assessment • Decisions made regarding resourcing are supported by recommendations developed by strategic leadership and data analytics teams • Provide funding to local clinics and PCNs for data analyst support providing timely data, from clinic EMRs to guide QI and clinical programming and improvement initiatives	• Embed analytics teams in new health authorities and have a provincial team that supports data analysis for creating recommendations and highlighting points of interest for deeper dives and spread and scale • Create data analytics that will enable linking upstream practices in primary care with short-term and long-term downstream outcomes. Both clinical outcomes and costs should be available to support informed planning, system re-design, and QI to achieve the health outcomes expected of a world class primary care system • Continue to support the change management and training in primary and community care with incentives including funding and practice facilitation to implement new practices, workflow, and technologies • Renew the Health Information Act to support new ways of using data for QI, clinical improvements, and for business decision making

Overview:

Background

Evidence from around the world conclusively identifies high-performing health systems as having strong primary care foundations that provide accessible, cost-effective, and equitable health care for all.[1] This was acknowledged and identified five years ago through the Auditor General of Alberta's report *Better Health Care for Albertans*.[2] In this report, the lack of progress toward effective integration of health care in Alberta was attested to not prioritizing system structure, integration, and coordination with team members at all levels of care and not ensuring inter-connected clinical information systems and access to data.

Central to successful primary care delivery are the ongoing relationships between a family physician and their patients.[3] **The need for Albertans to have timely access to high-quality comprehensive, continuous primary care, as provided by family physicians working in an interdisciplinary team is more essential than ever before.** As our population grows, as our population ages, and as patient care becomes more complex, the demand for care will increase. There is a health workforce crisis now and it will continue to worsen if we do not respond to it immediately while establishing systems to monitor and respond continuously.

As the Government of Alberta develops its Modernizing Alberta's Primary Health Care Strategy (MAPS), the Alberta College of Family Physicians (ACFP) submits that system reform must support the adoption of new models of primary care delivery with a highly-skilled and agile workforce. Family physicians can significantly transform access to care if given time to train, are supported by proper health system infrastructure, and appropriately resourced to support team-based care in practice. Teams must include the patient and family and compassionate family physicians, nurses, nurse practitioners, social workers, pharmacists, care coordinators, administrators, and other needed contributors providing comprehensive primary care in clinic-based family practices, as well as hospital coverage, emergency, maternity, and long-term care.

About the ACFP

The ACFP, representing 5,400 family physicians, medical students, and family medicine residents, is committed to improving primary health care by working to ensure family medicine supports access to effective, safe health care for Albertans across the continuum of care. ACFP plays a vital role by certifying and supporting advancement of family physicians and their role as members of a team where all health care professionals can provide the most appropriate care for their skill set. The ACFP believes strongly that evidence is clear on what is needed to advance and modernize Alberta's health care system.

ACFP's Primary Recommendation:

Ensure every Albertan has access to a family physician and a primary health care team by implementing the Patient's Medical Home (PMH).

The ACFP recommends that every Albertan has access to a family physician and a primary care team as described in the College of Family Physicians of Canada's 2019 Patients' Medical Home Vision.[4] The PMH is an evidence-backed model of primary care that allows family physicians to provide better care by working with a team. The PMH is the future of family practice in Canada. In this vision, every family practice across Canada offers the care that patients want–readily accessible, centred on the patients' needs, provided throughout every stage of life, and seamlessly integrated with other services in the health care system and the community. Learn more www.patientsmedicalhome.ca/vision

We believe that family medicine is the foundation of a high-functioning health system and a healthy population. Without the foundations described in the PMH Vision (see figure 1), appropriate infrastructure, connected care, and administration and funding models, family practices cannot feasibly provide a PMH for every Albertan. Every Albertan deserves a PMH that provides access, continuity, community adaptiveness, social accountability, and patient-centred care. In addition, family medicine will not be able to evolve and adapt to the needs of the population without supports for quality improvement, training, and education.

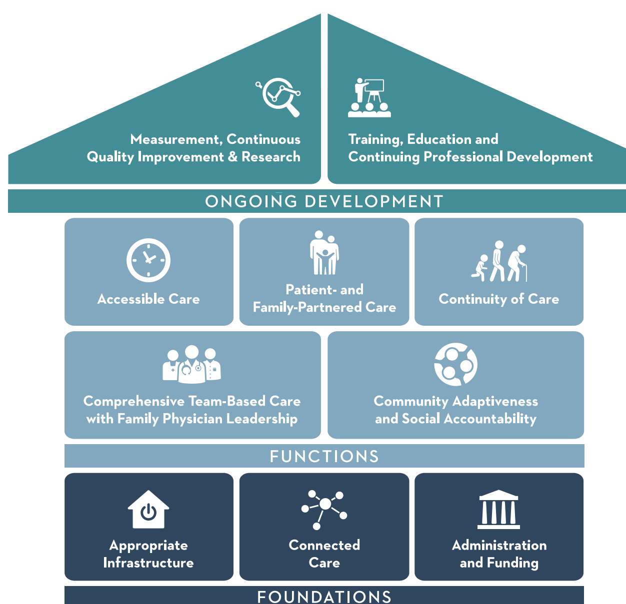

Figure 1

Supporting Recommendation 1:

Fund the expansion of family practice teams at the point of care.

The ACFP strongly believes that family medicine is the foundation for a healthy Alberta and that family physicians are highly skilled resources to their communities. Currently, Alberta's family physicians, family medicine residents, and medical students contrast supports in primary care with those experienced in the acute care and within AHS. The challenges of comprehensive family medicine without adequate team support discourages that choice for trainees and is driving practising family physicians into easier niche practice or early retirement. Family medicine has had a steady decline in applicants for its residency programs, with some of the largest unfilled positions in the country occurring in Alberta.[5]

Family physicians spend too much time on administrative work, duplicative forms, inefficient EMRs and referral systems, and there is not enough time spent on patient care.[6] Solutions that focus on the PCN, AHS Zone, and provincial programs will not solve this issue. Resources need to go to the coalface for direct patient care. Resources are needed in the PMH, which is the family practice clinic.

There is a need for basic team-based primary care for a community to support wellness and preventative care, regular screening, chronic disease management, and mental health. For an attached panel of patients, much of preventive care and stable chronic disease management can be delegated under medical supervision enabling timely access to a physician for undifferentiated illness and managing complexity. This maximizes and optimizes the scope for all team members.

At best, current PCN funding subsidizes a primary care team at a provincial average ratio of half of full-time equivalent (FTE) team member per family physician, whereas studies show that the ideal ratio is three to five FTE team members per family physician.[7] Where possible, these teams should be co-located with the attending physician in the community-based primary care clinic. From the patient's perspective, there is not equitable access to high-quality primary care in the province, especially for socially vulnerable, unattached patients as they are not a priority in the current PCN funding agreements. PCNs are funded for panelled patients only. As a result, people that are unhoused, people who use substances, people with complex social and health needs are not well served within the PCN funding models as their attachment is difficult due to life circumstances. Team support is also essential for population health interventions to these groups.

> *"Maybe it's not surprising that in the current climate, family doctors increasingly are leaving practice altogether or focusing their practice away from comprehensive primary care to something that feels more manageable. Sadly, when one family doctor leaves, the burden grows for all the others – and for the patients left behind." Noah Ivers, Healthy Debate 2022*[8]

Immediate Actions:

To address the issues described above, the ACFP suggest that Alberta Health employ immediate strategies to ensure Albertans can access a family physician by first ensuring an environment where family physicians, residents, and medical students see comprehensive family practice as welcoming, well supported, viable, and sustainable, including the following actions:

1. **Eliminate disincentives** for implementing optimal team-based and comprehensive care. Such disincentives include physician fee for service as the dominant remuneration for care provided, permanently remove daily caps, and address medico-legal liability issues related to team-based care[9]
2. **Develop a directory describing scopes of practice** of all interdisciplinary team members, with examples and contacts to people willing to share their experiences embedding team members in practice
3. **Add team members** (direct patient care and administrative) by providing accountable funding to pay primary care health professionals and administrative teams competitive rates either though clinics or PCNs. These team members should also include scribes, referral managers, health/peer coaches[10–12])
4. Where capacity exists, engage and **incentivise existing family practice clinic staff to work at the top of their scope** for screening, stable chronic disease management, and addressing care deficit for minor episodic care (UTIs, otitis, etc.)

5. Provide immediate **expanded program funding** for access to certified, multi-modal, inter-professional continuing professional education for team-based care to improve complex clinical patient-oriented outcomes in community practice including mentorship, virtual and in-person training workshops, and cased based learning (i.e., ECHO) on priority clinical areas such as mental health and chronic disease management and complex health and social care needs.[13–16,51]

Medium-Term Actions:

As the recommended immediate actions are being prioritized, the ACFP recommends that planning and resources need to be focused on the next set of actions to improve resourcing at the family practice level:

6. Work with AMA's Section of Family Medicine and Section of Rural Medicine using "model office" calculations to ensure that evidence-based funding models are in place to ensure viable and sustainable access to team-based care for a population (i.e., ratio of three to five providers per physician), aligning with the needs of that population[7]
7. In addition to current PCN funding, provide new population-based funding to PCNs and community-based clinics to set up innovative ways to provide access to primary care in the community including support for unattached patients, and patients with complex social and health needs[17–21]
8. Establish and contribute funding for a competitive staff compensation grid for each type of health team member (e.g., nurse practitioners, nurses, pharmacists, dietitians, social workers, etc.) and fund their compensation based on the number of FTEs approved in annual clinic/PCN business plans
9. Provide support to the family practice for education and QI at a similar level of investment provided in the acute care system[22–26]
10. Provide support for community practices to have community navigators/link workers who do social prescribing as part of the interdisciplinary team[17–21,27]

System Transformation Required:

In the years ahead, new policy and structure will need to be put in place to solidify and reduce the risk of repeating the primary care workforce crisis and resulting care deficit. In keeping with the previous actions, the following actions are broader and will require more substantive political and health system leadership commitment to change:

11. Using newly established health authorities (see Supporting Recommendation 2), annually budget for and flow adequate, sustainable, and dedicated funding to support family medicine as the foundation for a healthy Alberta
12. Develop "The Alberta Primary Care Services Act" with a multistakeholder consultation process. By having its own legislation, the funding of the primary care workforce will be permanent
13. Fund and support changes in training and education that establish best practices for high functioning team-based care from college and university training, medical school, through residency and into independent practice [28]
14. Support and leverage advancing the use of technology within the PMH and externally for lab, diagnostics, and specialty consultants to increase capacity and efficiencies for both patients and teams. Some examples:

    a) medical scribes[10,53]
    b) virtual assistants[29]
    c) smart forms[30]
    d) secure text, email, and document transfer

15. Provide program funding through professional colleges and universities for interdisciplinary team effectiveness and team-based learning dedicated to care in the PMH and medical neighbourhood (i.e., faculty development, mentorship, observership, shadowing, workshops, and training sessions)[11,13,16]
16. Establish and maintain a workforce planning bureau with the respective professional colleges/associations to monitor and predict health professional supply and demand (This recommendation also aligns and is dependent on Supporting Recommendation 2 and 3)

Supporting Recommendation 2:

Create community-based health authorities with engaged leadership, patient-based funding, and accountability for the delivery of longitudinal preventative care, chronic disease management, and seamless transition of care to all Albertans.

Primary care in Alberta does not currently work as a system or within the whole health and social system. It lacks standardization, services are disparate, and Albertans cannot access care in an equitable or sustainable way across the province. AHS is an institution that is designed to administer and support acute care facilities and programs and does it well. However, the realities of care in the community outside of AHS, where approximately 70% of health care occurs,[31] are not well understood within the AHS structure and leadership. Front line primary care has continued to be a low priority for AHS as joint venture partner with Alberta PCNs. Community care priorities are often based on acute care needs, and not the priorities of citizens, community family practices, and community health and social care systems and organizations. Public health, home care, and other outpatient services would operate more efficiently and enable local needs to be better served under provincial primary care governance.

Transitions of care from home to hospital to home remain fragmented and unintegrated under AHS control despite investments to date. Complex patient care pathways are fragmented and referrals and consultation with specialty can be difficult, time consuming, and delayed. Albertans need a dedicated, well-resourced, and professionally managed system to fully support community-based comprehensive primary health care.[32]

The key feature of a high functioning primary care system is the focus on the longitudinal relationship of the citizen with their PMH. Relational, management, and informational continuity needs to be reflected in all aspects of the system. It is critical in the modernization of the system, that all transformational changes occur through this lens of continuity of care.[33–37]

Immediate Actions:

Within the current system, while contemplating new structures for organizing primary care within an integrated health system, there are opportunities for immediate investments and actions that would alleviate some pressures and optimize successful features of the current Zone PCN model of governance.

1. Create a **full-time compensation package for a Zone PCN leadership** dyad (AHS Zone and PCN Lead) that are tasked with zone-level service planning and a core budget to begin early actions for population health needs and improved access to community family practices and appropriate social care
2. Mandate **AHS to work with PCN leadership** to plan early actions and collective solutions to reallocate existing AHS and PCN resources to address local gaps in patient access to community health and social care services
3. Invest in **intersectoral zonal/regional solutions** through collaboration with AHS Zones, PCNs, and other service partners to establish working relationships in an integrated system (e.g., schools, friendship centres, community centres, housing, seniors care, social programs, link workers, patient navigators)
4. Build on the successes of **Specialist Link and Connect MD**, and the focus on the Alberta Surgical Initiative to increase access to family medicine and developed clinical pathways, rapid telephone specialist consultation, and rapid referrals to community and hospital-based specialists as screening and chronic disease management processes in primary care are ramped up. (Connect MD survey showed 43% of referrals avoided, reduced imaging by 30% [38], Specialist Link telephone consultation resulted in 40% of patients being managed in their medical home, saving of 190 dollars per call in an economic analysis.[39])

Medium-Term Actions:

As the immediate actions on supporting the current primary care system are initiated, the ACFP suggests that Alberta Health consult with PCN Zone entities and non-PCN stakeholders who provide community-based care to design the new health authority, including:

5. Design a regional governance model to support funding and accountability for the delivery of all community-based care in a geographic area that accounts for proven care corridors used by its population (i.e., current zones may not be ideal – divide North into Northwest and Northeast Alberta, and South into Southwest and Southeast)
6. Ensure all transformational suggestions, at their core, require incentives for building longitudinal patient/family physician/clinician relationships and continuity of care while working to serve unattached patients with funding allocated to ensure equitable access to primary care
7. Ensure adequate funding for the regional health authority through a contract to achieve annual business plans where goals and deliverables have been approved. Budget management for the authority will have the flexibility within its funding envelope make allocation decisions across the organization to achieve its priorities and goals within the global budget

System Transformation Required:

In order to fully enable progressive transformation and an evolution of a well governed and accountable community-based health system, new legislation and resulting inputs and enablers will be required.

8. Ensure that "The Alberta Primary Care Services Act" secures funding and infrastructure support for primary care and establishes the community-based health system as the foundation of the health system
9. Establish and implement transformations in training and education for primary care team members to better support increased clinical complexity, leadership, and business management skills within the team-based care model[28,40–43]
10. Policy is required to establish a shared accountability and purposeful design for diagnostic and lab service outside of hospital settings for direct and timely access by primary care providers and avoid using emergency departments for access
11. Establish a contract and/or performance agreement between the community-based health authority and the hospital-based health authority to ensure timely flow of patients from community to hospital services and then back from hospital services to primary services[44–46]

Supporting Recommendation 3:

Supply multiple and timely sources of system and practice level information to assist in clinical care, quality improvement (QI), and business decision making.

Currently clinical and system level data and analytics are not available to leaders and decision makers in primary care. Clinics, PCNs, and Zone leadership are asked to make decisions about system level priorities, practice, and system quality improvements without access to sufficient data and analysis.

Clinical crises continue to occur. The drug poisoning crisis and the COVID-19 pandemic are the most recent which required significant collaboration between public health and community based primary health care providers. Integration of primary care and public health has been identified as a critical component in system response to these crises.[47–49] The needed clinical and public health surveillance data has been difficult to access to those providing care. Timely surveillance data assists in supporting community and practice-level recommendations to patients and families as well as allows responsive workforce strategy to be implemented in time to respond. During the opioid crisis and the pandemic, it was evident that ineffective communication between information systems and lack of high-level surveillance made it excessively difficult to respond proactively resulting in poor patient outcomes.

Primary care has prioritized the need to have all independent EMRs being used in family practice to be connected and supported through CII/CPAR so that patient records can be shared across points of care in Alberta. The change management has been only slowly progressing through the pandemic and as change management workforce disruptions occurred over the last several years. In addition, issues such as PIA delays or costs incurred to adopt CII/CPAR have made it difficult during a time of strain and stress on the whole system.

As we reflect on the current state of the primary care workforce and how we constantly compete for the same skilled workforce that is needed in acute care, we have been unable to fully analyse our current workforce and look forward to the challenges and changes that need to be addressed through strategy, planning, and focused recruitment and training. There is currently no way for primary care to assess current supply and skillset of physicians, nurses, nurse practitioners, pharmacists, social workers, physician assistants, medical office assistants and others who could support the teams in their practice or surrounding health neighbourhood.

There is not consistent team and funding available in primary care to collect and analyse any data in a timely way. If Alberta is to have a high functioning health system, as with any industry, data and analytics are essential to ensure informed and evidence-based decision making.

Immediate Actions:

The ACFP recommends immediate action to ensure that data and analytics are enabled in clinical practice, PCN, AHS Zone, and Provincial design and decision making.

1. Continue to **support the efforts of CII/CPAR**, including financial incentives (i.e., pay for PIAs, fund staff to implement) and build a network of linked and compatible EMRs in the community that contribute seamlessly to one fulsome patient record that all providers and points of care can access when needed. Continue to ensure the connectivity of the current EMR vendor products to minimize disruptions in clinical practice routines as well as loss of patient-care time and resources in migrating patient records to another system
2. **Reduce delays at the level of the Office of the Information and Privacy Commissioner of Alberta** (OIPC) to review and approve the PIAs to support uptake of CII/CPAR
3. **Provide current billing data and analytics** to the I-ZICC, Zone PCN leadership and primary care partners; the billing data and analysis will clarify some of the current workforce population and trends in full-time/part-time, scope, focused practice, however we will also need to collect real world data on existing team members in primary care clinics including nurses, social workers, pharmacists, nurse practitioners, and MOAs to further define the primary care community based workforce for today and the future

Medium-Term Actions:

System-level processes and structures will be required with dedicated resourcing, expertise, and planning to support the ongoing use of data and analytics in the evolution of a high functioning world class community-based health system.

4. Continue improvement and refinement of the Connect Care-downloaded information to community EMRs to reduce the redundancy and sheer volume of information not relevant to clinical care and follow up in the community
5. Create a mechanism for EMR clients to deal with vendors to achieve collective impact and more timely customer responsive changes and enhancements to their products
6. Provide funding for dedicated primary care data analytics teams to support the planning, measurement, performance management, and service resource assessment[32,50,51]
7. Decisions made regarding resourcing are supported by recommendations developed by strategic leadership and data analytics teams
8. Provide funding to local clinics and PCNs for data analyst support providing timely data from clinics EMR to guide QI and clinical programming and improvement initiatives[23,26,50,51]

System Transformation Required:

Establishing a strong culture of evidence-based clinical improvements for patient-centred care and well-informed business decision making will require well designed and robust system supports.

9. Embed analytics teams in new health authorities and have a provincial team that supports data analysis and creating recommendations and highlighting points of interest for deeper dives and spread and scale
10. Create data analytics that will enable linking upstream practices in primary care with short-term and long-term downstream outcomes. Both clinical outcomes and costs should be available to support informed planning, system re-design, and QI to achieve the health outcomes expected of a world class primary care system
11. Continue to support the change management and training in primary and community care with incentives including funding and practice facilitation to implement new practices, workflow, and technologies
12. Renew the Health Information Act to support new ways of using data for QI, clinical improvements, and for business decision making

Conclusion

The MAPS initiative and consultation process will show to the Government of Alberta that the primary care system is not an isolated system that required specific focused improvement, but it will require a whole system of redesign over time. This commitment to transformation will require years of work and dedication from government, health care leaders, family physicians, other health professions, and the public. We need a plan of action that will sustain momentum through political changes and public health crisis. Family Medicine is the foundation for a healthy Alberta, but family physicians will not be able to continue to provide comprehensive care in the current context. Collaboration, commitment, and change is required.

While top-down system level re-design is needed to establish accountable processes for new investment in primary care, it is imperative, given the current crisis, to provide parallel grassroots support and funding at the front lines now. Primary care has waited too long for this support. Front line investment for co-located collaborative teams is needed now. There are existing community-based primary care clinics that aspire to the medical home model of care and practise with quality and integrity. They need to be supported by the immediate actions outlined in this recommendation to affect change and a collaborative government to foresee and co-design a new primary health care system for Alberta.

The ACFP requests a seat at the tables where decisions are made about our members and their ability to provide care to patients across Alberta. We are committed to being a key contributing stakeholder in modernizing Alberta's primary health care system and value patient-centred care, evidence, inclusiveness, collaboration, collective impact, and advancing excellence by design and hard work.

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