APRIL 1, 2023-MARCH 31, 2026
CALGARY ZONE PRIMARY CARE NETWORK
SERVICE PLAN

Contact Information

Please identify a key point person who can answer questions and provide follow-up as needed.

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It is expected that this Zone PCN Service Plan (ZSP) is completed using the Zone PCN Service Plan Companion Guide V5 for additional guidance, tools and resources, such as size limits, definitions, and additional specifications.

• EXECUTIVE SUMMARY

Provide a high-level summary of the ZSP, with the following key pieces of information:

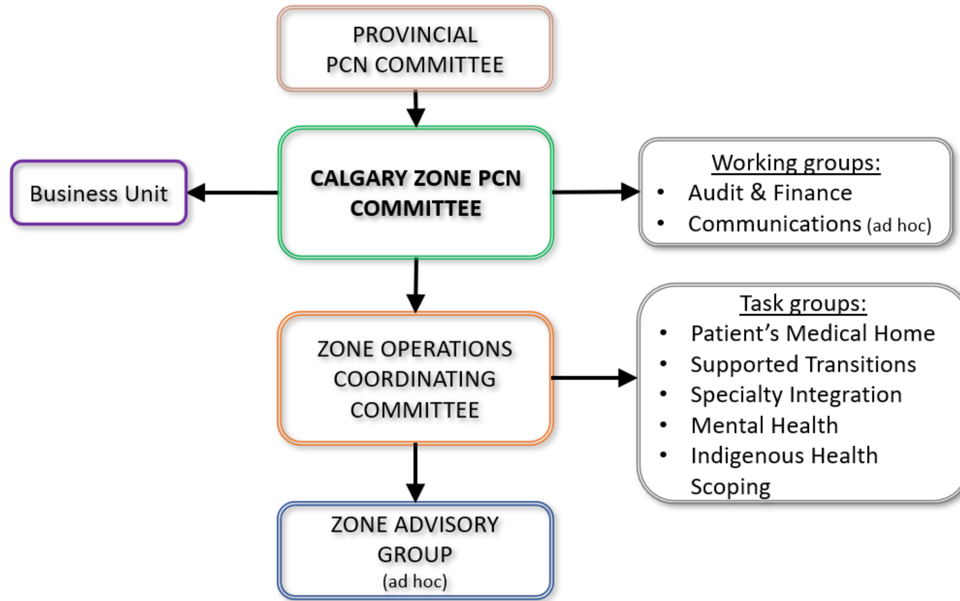
- *Brief overview of the Zone PCN Committee structure, financials and stakeholders who collaborate in the Zone PCN. (Summary of Section 1 of this ZSP)*
- *Population health needs and the needs to be addressed by priority initiatives. (Summary of Section 2 of this ZSP)*
- *Priority Initiatives and major implementation activities (Summary of Sections 3 and 4 of this ZSP)*
- *Highlights of alignment of ZSP with strategic targets (Summary of Section 5 of this ZSP)*

INTRODUCTION

This Zone Service Plan covers the period of April 2023 to March 2026. While this is a new document, it builds on the existing collaborative work conducted in the Calgary Zone, with some additions and changes, most notably alignment of Zonal initiatives to provincial initiatives, such as Community Information Integration/Central Patient Attachment Registry (CII/CPAR), Home to Hospital to Home (H2H2H), and the Alberta Surgical wait times Initiative (ASI). The executive summary aims to summarize the priorities jointly selected by the Calgary Zone, and the mechanisms by which the Zone feels it can best address the primary care needs of the population. In addition, this summary also covers the Zone governance structure, financial considerations, and alignment with other strategic targets.

ZONE STRUCTURE

The Calgary Zone's governance structure is outlined in the diagram below:



The Calgary Zone PCN Committee, with guidance from the Provincial PCN Committee, sets the direction and strategy for the Zone. Operational responsibilities are delegated to the Zone Operations Coordinating Committee (ZOCC), and financial oversight responsibilities are delegated to the Audit & Finance Working Group.

There are four main operational task groups and one operational working group: the Patient's Medical Home task group, the Supported Transitions Task Group, the Specialty Integration Task Group, the Mental Health Task Group, and the newly formed Indigenous Health Scoping working group.

The Business Unit, a team of Zone staff, supports these groups to facilitate collaboration and provide additional capacity and capability to the collaborative structures. The staff members are employees of a PCN designated as the Home PCN.

The work contained within the Zone Service Plan is funded collaboratively by all seven Calgary Zone PCNs, with each PCN contributing approximately 1.8% of their budget to the Zone budget, housed and managed by the designated Zone banker PCN. The total Zone budget anticipated for the 2023-24 fiscal year is $2,095,000.

Many stakeholders collaborated in the formation of this Zone Service Plan. An extensive stakeholder engagement campaign was completed that included over 58 and 61 respective participants in two separate strategic retreat days, called Elevation Day(s). More than 73 stakeholders representing many different organizations, who were engaged in either interviews, task group meetings, surveys, focus groups, or other committee meetings. Those included all seven Calgary Zone PCNs, Alberta Health Services (PCN board representatives, Calgary Zone PCN Committee representatives, and Zone support staff), the Alberta Medical Association's Accelerating Change Transformation Team, G4 Health (Indigenous), Alberta Health, and public members of the Prairie Mountain Health Advisory Council.

POPULATION HEALTH NEEDS

As of 2019, the Calgary Zone was home to almost 1.7 million Albertans distributed among urban, rural, and First Nation communities, of whom about 1.5 million patients are paneled to a physician in the Zone. There is substantial variation, however, in the size of communities across the Zone. In 2016, 21% of Alberta's Indigenous peoples lived in the Calgary Zone and 1.2% of the panel population in the Zone identify as First Nations or Inuit, which is less than the overall provincial proportion.

A substantial proportion of individuals in the Calgary Zone experience mental health challenges. Risk factors for chronic diseases and other poor health outcomes are prevalent in the Calgary Zone, including the level of physical inactivity and healthy eating habits. In general, the age-standardized prevalence rates of chronic conditions in the Calgary Zone are marginally lower than those in the rest of the province, as is the mortality rate. The most common causes of death include issues of the circulatory system (29%), cancer (27%), mental and behavioural (10%), injury (9%), and respiratory (8%).

The most common reasons for emergency department (ED) visits in 2019-20, in descending order of frequency, include acute upper respiratory infections, chest pain, abdominal/stomach pain, gastroenteritis and colitis, and urinary tract infection. Approximately 15% of ED or urgent care (UC) visits were for health conditions that may be appropriately managed at a family physicians office.

Note: References for data mentioned in this Executive Summary can be found in the body of this report or Attachment 12

PRIORITY INITIATIVES AND ACTIVITIES

There are seven Priority Initiatives, with 18 different activities, spanning 2023-26. Alberta Health mandated priorities: CII/CPAR, H2H2H, and the Alberta Surgical Initiative have been integrated into the work and aligns closely with existing work in the Calgary Zone.

The figure below represents a summary of the Zone Service Plan priorities, activities, and support structures, aimed at addressing the population described above.

The accountabilities for these activities are split between the Calgary Zone PCN Committee, the Zone Operations Coordinating Committee, task groups, and the Zone Business Unit. Some activities have a provincial component and guidance/direction will be given via provincial committees.

<table>
<tr><th colspan="6">Provincial PCN Committee - Service Plan Objectives</th></tr>
<tr><td></td><td>Improved Integration</td><td colspan="2">Increased Alignment</td><td colspan="2">Shared Services</td></tr>
<tr><td rowspan="9">Shared Zone Supports (zone business unit): Leadership, Communications, Project Management, Evaluation, Finance, Administration, Governance</td><td colspan="5">Calgary Zone PCN Committee / Council</td></tr>
<tr><td colspan="5">Zone Priorities</td></tr>
<tr><td>Patient's Medical Home</td><td colspan="2">Indigenous Health</td><td colspan="2">Specialty Collaboration</td></tr>
<tr><td>Access and Attachment</td><td colspan="2">Mental Health</td><td colspan="2">Zone programs</td></tr>
<tr><td colspan="5">Zone Operations Coordinating Committee (ZOCC)</td></tr>
<tr><td>Patient's Medical Home Task Group</td><td>Supported Transitions Task Group</td><td>Specialty Integration Task Group</td><td>Mental Health Task Group</td><td>Indigenous Health Scoping Working Group</td></tr>
<tr><td>CII/CPAR implementation</td><td>Home to Hospital to Home (H2H2H)</td><td>Alberta Surgical Initiative (ASI)</td><td>Mental Health Assessment</td><td>Health scoping</td></tr>
<tr><td>and others</td><td>and others</td><td>and others</td><td>and others</td><td>and others</td></tr>
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ALIGNMENT WITH STRATEGIC TARGETS

The Calgary Zone 2023-26 Zone Service Plan addresses all the strategic priorities from the province.

ACCESS

- Access to care is addressed in all parts of the Zone Service Plan, whether at a high level or a more operational level. For example, access is an explicit priority in the Access and Attachment Priority Initiative, through implementation of different elements of the Home to Hospital to Home guidelines, coordinating access (and attachment) of patients between other parts of the health system and primary care, or developing an overall access and attachment strategy in the Zone
- Mental Health activities are centered on improving access to mental health supports in the Zone
- The Patient’s Medical Home (PMH) Task Group is working towards a coordinated approach to PMH activities in the Zone, whether developing a consistent process for PCN supporting CII/CPAR adoption, shared measurement, health team utilization, or shared approaches.
- The Zone also operates centralized Zone programs that facilitate access, such as the Alberta Find a Doctor website and the Specialist Link website

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- There are groups dedicated to scoping access for the Indigenous population

INTEGRATION

- Alignment with provincial initiatives increases consistency and integration across the Zone and between Zones; much of this work is done with other PCN partners, including Alberta Health Services
- A more coordinated and consistent Patient's Medical Home (PMH) model across Calgary Zone will help system integration and increase access by enabling partners (including patients) to know what to expect
- Zone programs aim to integrate different parts of the health system, Specialist Link will continue to enable family physicians to manage patients with more acuity in primary care, thus reducing wait times for specialty care. Standardized pathways help ensure appropriate care is given. Current programs aim to provide patients with safe and seamless transitions between sites and services

QUALITY

- The Zone structure, established in the previous Zone Service Plan, remains and there are continuous efforts to ensure sustainability of this structure, improve accountability, and increase the use of evidence-informed decision making
- Efforts are focused on consistency and standardization, such as having a unified process for PCN support of CII/CPAR adoption, quality improvement activities or Zone communications, Zone-wide measurement and tracking activities, evaluation initiatives, and alignment to provincial initiatives

ALBERTANS AS PARTNERS

- An increased focus on Indigenous Health will prioritize greater accountability and evidence-informed delivery through co-development of actions that are more appropriate for Indigenous populations
- Care provided in the Patient's Medical Home by physicians and their multidisciplinary teams, supported by evidence-based care pathways that are designed by staff and patients, will maximize outcomes and improve experience of care
- Enhanced primary health care pathways will enable physicians to care for their patients within the PMH with specialist support, rather than referring them to the care of a specialist
- Improved relational continuity between a patient and primary care physician and their team results in improved health outcomes and increased patient and provider satisfaction

Additionally, the Zone Service Plan also addresses other strategic goals:

SHARED SERVICES

- An extensive and comprehensive Zone budget was developed and approved in which all PCNs share funds and resources, including (but not limited to) line items for physician time, the Zone

Business Unit team, Home PCN costs, Banker PCN costs, long-standing Zone programs, and shared contract arrangements
- In addition, PCN staff are represented on most task groups and working groups and this support is offered in-kind

CROSS-ZONE PCN ALIGNMENT

- This Zone Service Plan has aligned Zone priorities with provincial priorities, such as the adoption of CII/CPAR, implementing H2H2H, or achieving ASI objectives
- Zone leads / Zone staff meet regularly to discuss alignment, knowledge sharing, and collaboration

• ZONE PCN COMMITTEE OVERVIEW

2A ZONE PCN COMMITTEE ENDORSEMENT

This 2023-26 Calgary Zone PCN Committee Service Plan was endorsed by the Calgary Zone PCN Committee on *Dec 21, 2022*.

The Zone PCN Committee membership at time of endorsement is attached (Attachment 1).

Complete the table below demonstrating all PCNs in the Zone PCN had the opportunity to review and provide input to the Zone PCN. Include a row for all PCNs in the Zone PCN. Enter the date the joint PCN Board reviewed (Joint Governance Committee in legal model 1 and PCN Non-Profit Corporation Board in legal model 2), and the name of the PCN's physician lead or appropriate designate and an AHS Governance representative representing the joint PCN Board.

	Joint PCN Board review		
Primary Care Network	Date (YYYY/MM/DD)	PCN Physician Lead or appropriate designate (Name, position)	AHS governance representative (Name, position)
South Calgary PCN	2022/12/16	Dr. Rakesh Patel, board chair	Amy Good, SOO, Community, Rural and Continuing Care, Calgary Zone
Calgary Rural PCN	2022/12/01	Dr. Cassandra Hoggard, board chair	Janet Chafe, Executive Director, Addiction, Mental Health, Corrections Health

Mosaic PCN	2022/12/08	Dr. Marsha Kucera, board chair	Laurie Blahitka, Executive Director, Community, Rural, and Continuing Care, Calgary Zone
Calgary Foothills PCN	2022/12/13	Dr. Heather La Borde, board chair	Laurie Blahitka, Executive Director, Community, Rural, and Continuing Care, Calgary Zone
Bow Valley PCN	2022/11/23	Dr. Kendra Barrick, board chair	Barb Shellian, Director, Rural Health, Calgary Zone
Calgary West Central PCN	2022/11/15	Dr. Nicola Chappell, vice chair	Dr. Mike Spady, Medical Leader for Community Health, Calgary Zone
Highland PCN	2022/11/21	Dr. Avneet Brar, board chair	Scott Holland, Executive Director, Rural Health, Calgary Zone

2B ZONE PCN GOVERNANCE

Provide an overview of the Zone PCN's governance structure (e.g. organizational chart). Attach endorsed Terms of References for working groups, refer to the attachments in the text. Provide a summary of Zone PCN resourcing/staffing.

The governance structure that supports the Zone Service Planning process is shown below. The overall structure remains the same as previous years. The Zone Business Unit, a shared services initiative that aims to facilitate the work of the Task Groups, enables effective coordination between different stakeholders, reduce redundancy in communications, and enhance capability (e.g., project management, evaluation).

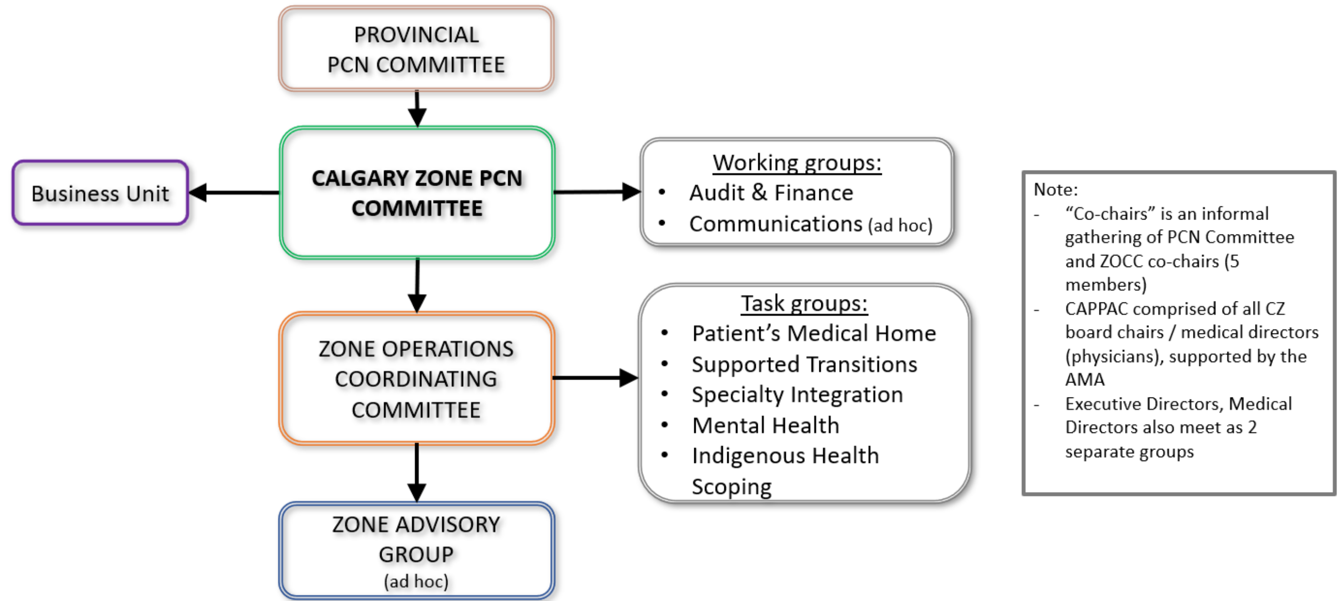

Figure 1 – Calgary Zone PCN Governance Structure

See Attachment 1 for the Calgary Zone PCN Committee membership (including sub-groups)

See Attachment 2 For the Zone Operations Coordinating Committee membership

See Attachment 3, 4, 5, 6, 7, 8 for the Terms of References for the bodies above.

Zone PCN Staffing	***FTE***
Director of Operations	*1.0*
Director of Communications	*1.0*
Zone Medical Director	*0.2*
Senior Consultant (Governance)	*1.0*
Senior Consultant (Project Management)	*1.0*
Evaluation Lead	*1.0*
Administrator	*1.0*
Program Manager (Home PCN)	*0.9*
Program Coordinator	*1.0*
Zone Banker services	*N/A*
Home PCN services (Privacy officer, HR, IMIT)	*N/A*

Table 1 – Calgary Zone PCN staffing

2C ZONE PCN SERVICE PLAN FINANCIAL OVERVIEW

Provide a high-level summary of forecasted expenses and revenue sources for Zone PCN Service Planning initiatives. Refer to instructions in companion guide and complete the 2023-2026 ZSP Template Financials Overview template in Excel and attach as a pdf.

The Financial Overview is attached as Attachment 11.

Provide additional information, for example, In Kind resources: • In-kind resources to support Zonal activities are provided by all seven Calgary Zone PCNs (eg. staff, supplies, expertise)

2D KEY STAKEHOLDERS

- For the Calgary Zone, nine types of stakeholders were identified for engagement:
  - Primary Care Networks (Executive Directors and Medical Directors from seven (7) PCNs in the Calgary Zone – Bow Valley, Highland, Calgary Foothills, South Calgary, Calgary West Central, Calgary Rural and Mosaic
  - Frontline providers (Family physicians and clinical staff representatives)
  - Alberta Health Services (Calgary Zone and provincial primary health care representatives)
  - Alberta Medical Association (Accelerating Change Transformation Team)
  - Patient representatives
  - Community advocates
  - Indigenous advisors
  - Health professional associations
  - Community organizations that provide direct support to displaced, elderly, and/or 2SLGBTQI+ individuals
- 112 people from eight stakeholder groups were engaged over six months

• NEEDS ASSESSMENT

3A ZONE PCN GEOGRAPHY AND DEMOGRAPHICS

Provide an overview of unique features of the Zone PCN such as geography, included municipalities, and an overview of demographics. Identify which Zone PCN Service Planning sub-populations are prominent in the Zone PCN.

As of 2019, the Calgary Zone was home to almost 1.7 million Albertans distributed amongst urban, rural, and First Nations communities,(1) of whom 1.5 million patients are paneled to a physician in the Zone.(2) The largest municipalities in the Zone by PCN panel size include Calgary, Airdrie, Okotoks, Cochrane, and Chestermere, which together comprise 91% of the total paneled patient population.(2) There is substantial variation, however, in the size of communities across the Zone, with Calgary home to over 1.2 million paneled patients and

Carseland home to just 1,172 paneled patients (as of the 2018-19 fiscal year, the last date that comprehensive data are available).(2)

The median age in the Calgary Zone is 38 years,(1) and the age distribution of the Calgary Zone's panel population mirrors that of Alberta, more broadly. Most patients (42.5%) are between 35-64 years of age (n=637,102) while 22.6% (n=338,855) are between 18-34 years, 20.8% (n=312,488) are between 1-17 years, and 1.2% (n=17,586) are infants (under 1 year). (2) 12.9% of the panel population (n=194,606) are seniors aged 65 years or older, (2) and this is projected to increase to 17% of the Zone population by 2029.(1) Females make up a small majority (51.3%) of the Zone's panel population.(2)

In 2016, 21% of Alberta's Indigenous population lived in the Calgary Zone,(1) and 1.2% of the panel population in the Zone are First Nations or Inuit, which is less than the overall provincial proportion (2.5%).(2) Almost one-third (31%) of residents in the Zone belong to a visible minority, with South Asian (26%), Chinese (19%), and Filipino (16%) comprising the top three ethno-cultural groups.(1) Overall, there are over 420,000 immigrants in the Calgary Zone, 23% of whom are recent immigrants within the past five years (2011-2016 data).(1) Linguistically, 16% of people in the Calgary Zone speak a language other than English or French, and 2% speak neither English nor French.(1)

The Calgary Zone generally benefits from a strong economic environment; 69% of post-secondary aged residents have a certificate, diploma, or degree and the average after-tax household income was $111,000 in 2015, which is greater than the provincial average.(1) However, approximately 5% of individuals in the Calgary Zone have a Canadian Deprivation Index score in the top two quintiles, indicating a relatively higher level of material deprivation based on home ownership, education, and food security.(3) In addition, 12% of the Zone's population are "sometimes" or "often" worried about running out of food before they can afford to buy more and 4% have reported past experiences of homelessness.

The Calgary Zone also scores well on social environment indicators. 93% of people are satisfied with life, 96% feel safe, 83% have good social relations with their neighbours, 90% have trust in public institutions, and 47% are engaged in community associations or other civic activity.(4) A positive social environment helps create the supportive conditions for better health and wellbeing.

The health of the Calgary Zone's population is further supported by access to health services, which play an important role in maintaining health and preventing disease. 90% of Calgary Zone residents have a family doctor, and 89% have visited a doctor in the past year.(4) 87% of individuals in the Zone report being satisfied with their health, and 86% feel that their quality of health is good, very good, or excellent.(4)

3B POPULATION HEALTH NEEDS OVERVIEW

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Provide an overview of the population health needs in the Zone PCN, providing data as appropriate. If a sub-population has high health needs in the Zone PCN, it would be considered a priority sub-population.

A substantial proportion of individuals in the Calgary Zone experience mental health challenges. 41% report experiences of anxiety or depression and over one quarter (26%) report their daily stress is quite stressful or extremely stressful.(4) Stress and mental health challenges are not evenly distributed, however, as 61% of those who are most deprived (i.e., Canadian Deprivation Index score of 5) report having “too much stress” compared to only 24% of those who are least deprived (i.e., Canadian Deprivation Index Score of 1).(4)

Risk factors for chronic diseases and other poor health outcomes are prevalent in the Calgary Zone. For example, the majority of individuals (74%) in the Calgary Zone are not meeting Canada’s guidelines for physical activity and people are spending, on average, 6.6 hours sitting each day.(4) More than half (53%) eat insufficient fruits and vegetables; 79% consume alcohol, with 32% engaging in heavy drinking; and 12% of individuals smoke daily or occasionally.(4)

In general, the age-standardized prevalence rates of chronic conditions in the Calgary Zone are marginally lower than those in the rest of the province. (2) In 2018, the most common chronic conditions, in descending order of prevalence, included high blood pressure, asthma, diabetes, ischemic heart disease, and chronic obstructive pulmonary disease.(1) 10% of people in the Calgary Zone are living with at least 2 chronic health conditions.(1)

The age-standardized mortality rate (per 100,000) in the Calgary Zone was 644.2 in 2017, less than the provincial rate (702.2 per 100,000).(1) Mortality rates are greater among males (764.5 per 100,000) than females (543.3 per 100,000) in the Zone.(1) The most common causes of death include issues of the circulatory system (29%), cancer (27%), mental and behavioural (10%), injury (9%), and respiratory (8%).(1)

Emergency Departments (ED) and Urgent Care (UC) play an important role in the overall health system. The most common reasons for ED visits in 2019-20, in descending order of frequency, include acute upper respiratory infections, chest pain, abdominal/stomach pain, gastroenteritis and colitis, and urinary tract infection.(1) 15% of ED or UC visits were for health conditions that may be appropriately managed at a family physicians office (i.e., family practice sensitive conditions (FPSC)), with the most common FPSC being acute respiratory infections (19%), acute pharyngitis (7%), follow-up exam after treatment (5%), other medical care (5%), cough (5%), and orthopedic follow-up care (4%).(1)

3C ENGAGEMENT

- The process for engagement of stakeholders to develop, validate and finalize the plan involved stakeholders both within and outside of the Zone

- More than 100 stakeholders took part in a series of engagement exercises, including design days, interviews, focus groups, surveys, working groups, task groups, and two targeted multi-stakeholder events – Elevation Day 1 and Elevation Day 2.0
- Stakeholders included representatives from seven Primary Care Networks – Bow Valley, Highland, Calgary Foothills, South Calgary, Calgary West Central, Calgary Rural and Mosaic), frontline providers, Alberta Health Services, Alberta Medical Association and the Accelerating Change Transformation Team, patient representatives, community advocates, Indigenous advisors, health professional associations and community organizations that provide direct support to displaced, elderly and / or 2SLGBTQI+ individuals
- Between July – October 2022, stakeholders were invited to:
  - Validate the strategic priorities identified through the data gathering and evaluation mechanisms and Elevation Day 1 – May 2022
  - Identify gaps in the priorities identified, clarify objectives, and propose projects to achieve objectives
  - Engage in final planning on relevance, accountabilities, and timelines at Elevation Day 2.0 (October 14, 2022)
- Groups identified for engagement in future iterations are newcomers to Alberta, immigrants, local government, and people living with complex or complicated health issues

3D NEED FOR PRIORITY INITIATIVES

3.1 Coordinating Patient's Medical Home

The Patient's Medical Home (PMH) is a patient-centered, team-based, comprehensive structure in which the primary care provider (PCP) is a personal family physician or a team or network of providers that has a family physician working alongside other physicians, practice facilitators, nurses, nurse practitioners and other skillsets. (5) Ongoing relationships with a PCP have been proven to lead to early and more accurate diagnoses, improved compliance with treatment regimens or follow-up /specialists' appointments, improved chronic disease management, and higher levels of preventative care and patient satisfaction. (6) The PMH is also often the first point of interaction for patients with mental health conditions. (7)

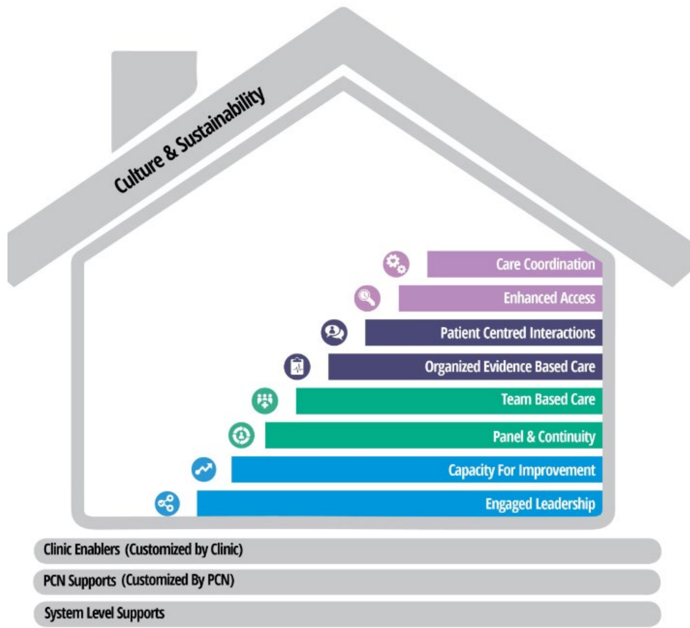

Figure 2 - Visual of Patient Medical Home, https://actt.albertadoctors.org/PMH/Pages/default.aspx

The coordination of the patient journey within the health neighbourhood is a central goal within the Calgary Zone. Within the PMH, the patient journey is dependent on continuity of care, informational continuity, access, attachment, and access to specialist care. (7) Successful features in a Patient's Medical Home incorporate use of electronic medical records, quality improvement for patient care and coordinated care within multi-disciplinary teams. (7) In Alberta, the PCN evolution strategy is exploring strategies to evolve primary care, such as expanded access, enhanced teams and accountability and coordinated technology, among other areas. (8)

The Calgary Zone has examined the national and provincially recommended approaches and has developed activities that will be defined zonally but implemented under individual PCNs. The approach will also be adapted based on the findings and recommendations from the Modernizing Alberta's Primary Health Care System (MAPS) initiative, launched in 2022. (9)

3.2 Access & Attachment

Statistics Canada reported that 4.6 million Canadians (14.5% of total population) indicated they did not have a regular health care provider. (10) This refers to the population aged 12 and over who do not have a health care provider they regularly see or talk to when they need normal care or advice for their health. In Alberta, primary care is supported by more than 3,800 doctors and 1,000 health care providers, of which 40% are based in the Calgary Zone. While the percentage of Canadians in Alberta without a regular health care provider did improve between 2015 (19.5%) and 2019 (14.9%) (10), population changes, and loss of primary care providers has seen an increase in the number of unattached patients in the province, and within the Calgary Zone.

The numbers of unattached are projected to grow significantly. In 2022, Alberta:

- Recorded the highest net gain in interprovincial migration, with most people moving from Ontario, Manitoba, and Saskatchewan (11)
- Remains receptive to larger than average influxes of international migrants, recording over 12,000 immigrants in the first quarter. Migrants, through federal and provincial

migration programs, consist of immigrants, non-permanent residents (students, foreign workers, and evacuees), emigrants and asylum seekers. The province reported above average year-to-year growth for population increases at 1.40% vs. 1.3% national average (11)

- Continues to have the highest natural growth rate of the provinces at 0.09% and recorded a positive natural growth rate in the first quarter of 2022 (12)
- Has a growing number of “orphan” patients, who lost their attached status due to the retirement or relocation of physicians in the Zone

Alberta recorded 4.4 million individual registrants covered by Alberta Health Services, with 1.7 million residing in the Calgary Zone. (13) The provincial population is projected to grow by an additional 2 million people between 2022 and 2046, an estimated 100,000-person increase from 2021-2046 projections. Of this figure, four-fifths of people are expected to live in the Edmonton/Calgary Zones, with larger numbers projected for Calgary. (12)

Stakeholders stated that access in the Calgary Zone led to the risk of the population being underserved at some point due to current capacity. Data gathering on unattached patients is often limited to walk-in data or findings from acute care. The main challenges reported continue to be primary care physician shortages, funding tied to attachment, physician burnout and limited shared services across the Zone. (7)

As of August 2022, less than 130 family doctors (8%) were accepting patients in the Calgary Zone (14), compared to 298 in May 2021 and 389 in June 2020. Solutions are needed to address access and continuity of care within, from, and to primary care. This requires that priority is placed on sustainable systems to identify and support patients facing limited access, and improved collaboration between clinical and non-clinical stakeholders.

3.3 Specialty Collaboration

Primary care pathways are designed to deal with high-demand, low risk conditions. (16). Content for pathways is driven by the Patient’s Medical Home, with co-designed and developed pathways between primary care, specialists, and other key stakeholders. Pathways promote knowledge translation of best practices and procedures to treat conditions and are prompted by a review of population health data generated in primary care.

In the Calgary Zone, the development of evidence-based pathways started in 2019. More than 40 pathways have been developed to date. This process has been supported by the Specialty Integration Task Group, the Business Unit, Calgary Zone, specialty care individuals, and AHS Strategic Clinical Networks. (17). Upon completion, pathways are posted on the Zonal website – Specialist Link. Pathways are scheduled for review every three years, to determine efficacy, relevance and alignment to new processes and treatments.

The Alberta Surgical Initiative (ASI) is an Alberta Health Services (AHS) led initiative, in partnership with Alberta Health. It focuses on improving the patient’s surgical journey, from

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primary care – specialist – surgery and rehabilitation. (17). The initiative requires collaboration with family physicians during consultation, and care coordination post-surgery. In the Calgary Zone, wait times for procedures range from one to eight weeks (18) and the Zone is in the process of working with AHS to identify governance structures and processes to support ASI rollout. This work has supported the launch of Urology, Orthopaedics and Spine under Facilitated Access to Specialized Treatment (FAST) in October 2022 (19).

3.4 Indigenous Health

Calgary Zone is within the Îyâxe Nakoda (Chiniki, Bearspaw and Wesley First Nations) and the Tsuut'ina First Nation, as well as the Métis Nation of Alberta, Region 3. More than 30,000 Indigenous people live in the Calgary Zone (20), making it the second highest Indigenous population in Alberta, second only to Edmonton. First Nations and Métis make up more than 90% of the Indigenous population in the Calgary Zone, with First Nations representing more than 50% (21).

Life expectancy among Indigenous people is lower than the non-Indigenous average (81.4 years or males and 87.3 years for females), ranging from 70 – 76.9 years for males and 76.1 – 82.3 years for females from First Nation, Métis, and Inuit people. (22). Self-reported general and mental health was also lower among Indigenous groups, with chronic health conditions ranging from 50.5 – 64.4%, highest among First Nation females on reserve. (22).

Access to and use of health care services by Indigenous group, 2017 (% of respondents)

Aboriginal identity group	Does not have regular medical doctor	Has not received dental care last three years	Health care required in last 12 months but not received
First Nations Registered or Treaty	20.8	14.0	13.7
First Nations Not Registered or Treaty	15.9	20.5	18.1
Métis	15.9	19.7	14.1
Inuit	66.8	19.4	16.0

Source: Adapted from Statistics Canada (2021b). Data are from the Aboriginal Peoples Survey.

Figure 3 - NCCIH - National Collaborating Centre for Indigenous Health > Home > NCCIH PUBLICATIONS

More than 60% of Canada's Indigenous population is under the age of 25, with over 80% of First Nations living in "remote" or rural communities[1]. The diverse traditions, culture, and language of Indigenous peoples, as well as social determinants can influence the access to and efficacy of primary health care (Figure 1).

[1] Remote refers to extreme distance from basic services. (22)

The work under the Calgary Zone is guided by the 2018 United Nations Declaration on the Rights of the Indigenous Peoples (UNDRIP) and the 2015 recommendations of the Truth and Reconciliation Commission of Canada. This priority initiative will also align with recommendations from Alberta Health's Indigenous Panel, that is currently supporting the development a strategy towards modernization of Alberta's primary health care system. (23).

3.5 Mental Health

Mental illness is estimated to cost around $50 billion per year to be both medically treated or requiring a response (24), with more than 6.7 million people with a reported mental health condition (25). In 2020, poor mental health, related to "moderate" or "severe" generalized anxiety disorder were more likely to be reported by visible minority groups than whites (27.8% vs. 22.9%). (26). In the same year, women were more likely than men to report higher levels of anxiety, in large part to the effects of the pandemic. Four times as many men are likely to commit suicide than women, but women are three times more likely to attempt suicide than men (24).

Since that time, vulnerable populations continue to be "disproportionally affected" by the pandemic, with suicidal ideation most prevalent among those who identify as Indigenous, 2SLGBTQ+, or among younger (18 to 34 years), single people, or those with pre-existing mental health concerns (27). The pandemic catalyst has led to extensive waitlists and negative coping mechanisms, with increased suicide-attempts and substance-abuse admissions on the rise (28). Strong predictors of mental health and substance use are gender, age, sexual diversity, employment status and income (29).

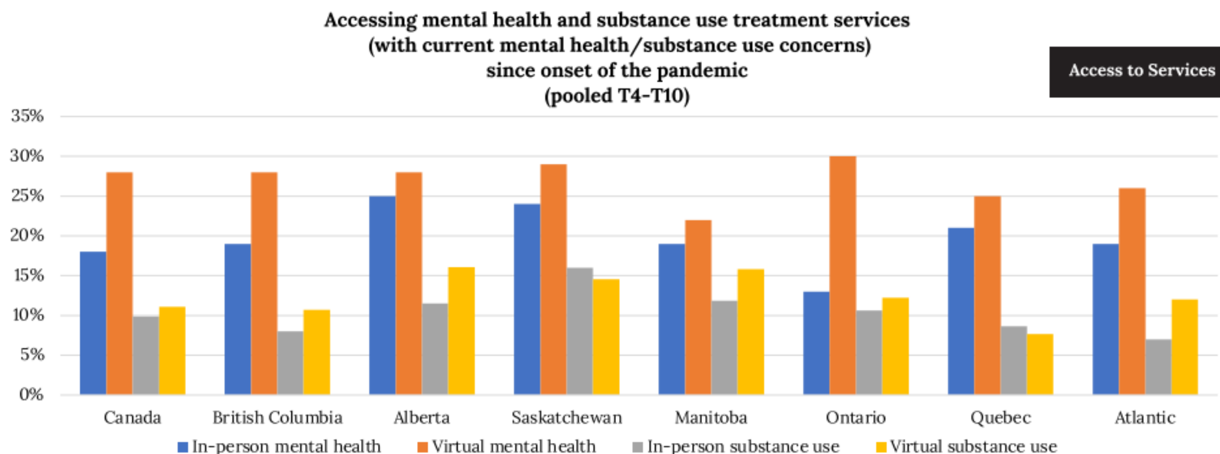

Figure 4 - Source: https://mentalhealthcommission.ca/wp-content/uploads/2022/10/Leger-poll-Regional-Spotlight-and-Key-Factors.pdf

During stakeholder engagement, respondents expressed a need for a project-oriented mental health plan that was zonally focused. There was acknowledgement that mental health has existing infrastructure, but there was a need for more collaborative partnerships with AHS related to psychiatry and making space for psychiatry and nurse practitioners to support patients, as well as family physicians. Creating benchmarks for physician awareness and training were also discussed by some respondents.

There was a preference for an integrated service model within the Zone that incorporated direct access, health teams, and communities of practice for physicians. One gap that needs further investigation is measuring rates of access to virtual and in-person mental health services (29), as well as the need for long-term psychiatric support.

3.6 Zone Programs

In conjunction with the development of primary care pathways, the Calgary Zone will continue its Specialist Link service that "connects family doctors, nurse practitioners and specialists in the Calgary area." Specialist Link offers real-time, physician-only tele-advice line, clinical care pathways and other resources for family physicians (30). In the second quarter of 2022, Specialist Link recorded more than 17,000 visits to the website, from more than 14,000 users. Urology and orthodpaedic access pathways were downloaded most often, followed by geriatric medicine and endocrinology pathways (31). The COVID-19 pathway was the most downloaded enhanced pathway. More than 5,000 calls requesting 53 specialties were recorded between July and September 2022, averaging 1,900 calls per month.

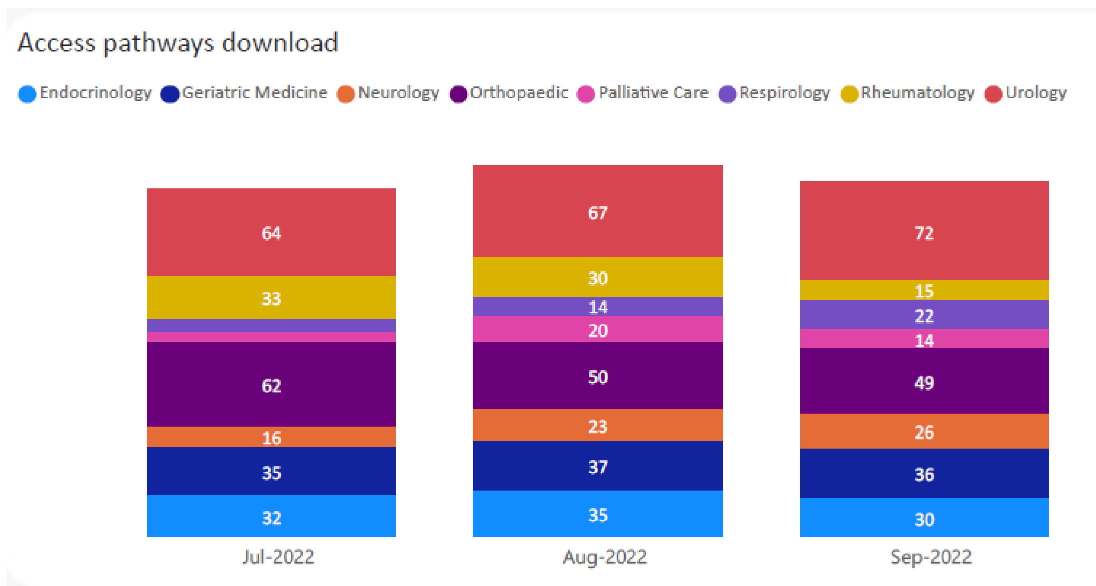

Figure 5 - Specialist Link Q2 report, Calgary Zone Business Unit

Classification: Protected A

Alberta Find a Doctor (AFAD) is a provincial service with an operational arm in the Calgary Zone. This ongoing program will continue to support patients who are looking for a family doctor to identify primary care providers who are accepting new patients. Since launch, more than 2.7 million page views were recorded by 807,442 users (up to October 31, 2021). (32). AFAD is directed by a provincial steering committee that completed an evaluation of the program in 2021. Consistent with the recommendations resulting from that evaluation, the Calgary Zone will undertake activities to develop a strategic plan that will support and guide future directions for AFAD.

AFAD is strategically aligned with Alberta Health's objective of connecting patients to primary care and is grounded in evidence supporting the patient's medical home. (32).

3.7 Shared Services

Shared services are one mechanism by which the Calgary Zone achieves its vision of being "Better Together." Past Zone Service Plans have established a foundation for shared services, including the development of the Calgary Zone Business Unit, that provides backbone support for the Calgary Zone's priority initiatives. The stakeholder engagement conducted as part of this service planning cycle noted a need to expand on this foundation and develop clear guidance and direction that can support decision making and action planning in the Calgary Zone. As such, the Calgary Zone Strategic Plan is planned as an activity to support and guide the development and implementation of shared services into the future.

4 IMPLEMENTATION PLAN

4A PROPOSED PRIORITY INITIATIVES

High level summary of proposed Priority Initiatives (will be elaborated upon in other sections).

For this document, the following definitions are used:

- Priority Initiative: an overarching bucket of work to address a need on a macro scale (e.g., transitions of care)
- Activity: refers to projects or programs (e.g., Alberta Find a Doctor [program] or Access and Attachment Coordinator [project]) that have their own project charter)
- Note: within each activity are many actions and deliverables, considered too operational for this document but major milestones have been summarized in section 4b.

Priority Initiative (PI)	Ongoing or New	Brief Description

1. Shared Services	*Ongoing*	This includes backbone support for the Calgary Zone (e.g., administration, project management, governance, evaluation, and communications), facilitating communities of practice, overall collaboration support and strategic planning.
2. Zone Programs	*Ongoing*	This includes ongoing operationalization of three Calgary Zone programs: Alberta Find a Doctor, Specialist Link, and Enhanced Hospital Discharge.
3. Coordinating Patient's Medical Home	*Ongoing*	This includes a series of seven new projects focused on foundations, functions, and ongoing development of the Patient's Medical Home. The aim of these projects is to produce standardized outputs to support PCNs with advancing the Patient's Medical Home.
4. Mental Health	*Ongoing*	This includes a new project to conduct a brief pilot and test a centralized assessment clinic model.
5. Specialty Collaboration	*Ongoing*	This includes two activities: the Alberta Surgical Initiative (ASI) and clinical care pathways. Both activities engage various partners towards system alignment or primary care practice change, leveraging clinical pathways as knowledge translation and change management tools, as well as the development, launch, and maintenance of clinical care pathways. The ASI activity will focus on governance structures and processes that facilitate the implementation of ASI.
6. Access & Attachment	*New*	This includes six activities: Four projects aim to coordinate the implementation of two home to hospital to home (H2H2H) elements (confirmation of primary care provider & follow-up to primary care); one project is a pilot of a new coordinated access and attachment hub that involves the use of Alberta Find a Doctor as an access point. The final project is the development of an access and attachment strategy, and accompanying action plans, for the Calgary Zone.
7. Indigenous Health	*New*	This includes working with a stakeholder group that includes Indigenous partners to identify potential actions that PCNs can take to improve primary care for Indigenous persons.

4B PRIORITY INITIATIVES KEY ACTIVITIES AND TIMELINES

Complete a table for each Priority Initiative the Zone PCN plans to implement. Add or delete tables as required.

1. Priority Initiative (PI): Shared Services

Need to address: Shared administrative services

Population targeted: N/A

Municipalities / geographic areas: Calgary Zone, Administrative

PI - Activity	Milestones	Timeline
List the key activities to implement the priority initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
1-1. Calgary Zone Business Unit operations	Annual Calgary Zone budget approved by Calgary Zone PCN Committee	Annually
	Zone Service Plan reporting deliverables submitted to Alberta Health	Ongoing
	Zone Service Plan is implemented	Ongoing
1-2. Calgary Zone strategic plan	Complete environmental scan (PESTLE)	04/23-07/23
	Complete internal analysis (SWOT)	04/23-07/23
	Develop strategic plan evaluation framework	11/23-01/24
	Strategic plan completed	11/23-03/24
	Implementation plan complete	04/24-03/26

2. Priority Initiative (PI): Zone Programs

Need to address: Access to primary care (2-1), access to specialty care (2-2), informational continuity (2-3)

Population targeted: Unattached Albertans, primary care providers

Municipalities / geographic areas: Alberta (2-1); Calgary Zone (2-2 & 2-3)

PI - Activity	Milestones	Timeline
List the key activities to implement the priority initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
2-1. Alberta Find a Doctor	Maintain program delivery (ongoing)	04/23 – 03/26

Classification: Protected A

2. Priority Initiative (PI): Zone Programs

   Need to address: Access to primary care (2-1), access to specialty care (2-2), informational continuity (2-3)

   Population targeted: Unattached Albertans, primary care providers

   Municipalities / geographic areas: Alberta (2-1); Calgary Zone (2-2 & 2-3)

PI - Activity	Milestones	Timeline
	Non-PCN physicians and nurse practitioners added to website	04/23 – 09/23
	Three-year strategic plan for Alberta Find a Doctor presented to I-ZICC	04/23 – 03/24
	Submit I-ZICC intake form to shift governance to I-ZICC	04/23 – 03/24
	Independent funding secured	04/23 – 03/24
2-2. Specialist Link	Maintain program delivery (ongoing)	04/23 – 03/26
	Continuous quality improvement activities completed, as required	04/23 – 03/26
2-3. Enhanced Hospital Discharge	Ongoing monitoring and adjustment to service delivery as Connect Care launches occur	04/23 – 10/23
	Complete program summary report	10/23 – 01/24

3. Priority Initiative (PI): Coordinating Patient's Medical Home

   Need to address: Implementation of the Patient's Medical Home across the Calgary Zone

   Population targeted: Primary care providers

   Municipalities / geographic areas: Calgary Zone

PI - Activity	Milestones	Timeline
List the key activities to implement the Priority Initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
	Complete identification of existing processes used by PCNs	11/22-03/23

3. Priority Initiative (PI): Coordinating Patient's Medical Home

Need to address: Implementation of the Patient's Medical Home across the Calgary Zone

Population targeted: Primary care providers

Municipalities / geographic areas: Calgary Zone

PI - Activity	Milestones	Timeline
3-1. Physician paneling & CII/CPAR adoption project	Complete development and documentation of a unified process for PCN support of CII/CPAR adoption	11/22-03/23
3-2. Physician peer-mentorship strategy project	Complete current state assessment	11/22-03/23
	Complete development of a shared physician champion strategy	11/22-03/23
3-3. Common roles and responsibilities for MDT project	Complete review of all PCN roles and responsibilities	11/22-03/23
	Complete development of a standardized document(s) outlining standard scope of practice for MDT roles	11/22-03/23
3-4. Standardizing tracking of health team staff utilization project	Complete inventory of how PCNs current track utilization	11/22-03/24
	Complete documentation of areas where a consistent approach is beneficial	11/22-03/24
	Complete development of a reporting mechanism agreed upon by all PCNs	11/22-03/24
3-5. Establishing common expectations around PMH support for physicians project	Complete documentation of a list of supports agreed upon by all PCNs	03/23-03/26
	Complete formation of a standardized PMH accountability agreement	03/23-03/26
3-6. Linking patient care approaches to QI strategies project	Complete development and documentation of a zonal QI approach	03/23-03/26
3-7. Consolidating focus on ASaP screening and core chronic diseases project	Complete document outlining which ASaP maneuvers and chronic diseases are high priority Complete development and documentation of a unified process for PCN support of ASaP screening	03/24-03/26
	Complete current state assessment	03/24-03/26

4. Priority Initiative (PI): Mental Health

Need to address: Patients' access to mental health supports (4-1); Primary care providers access to mental health resources (4-2)

Population targeted: Patients with urgent mental health needs (4-1); Primary care providers (4-2)

Municipalities / geographic areas: Calgary Zone

PI - Activity	Milestones	Timeline
List the key activities to implement the Priority Initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
4-1 Centralized mental health assessment project: Scoping	Jurisdictional scan for comparable intervention models completed	12/22 – 03/23
	Complete gap analysis of existing services and service requirements	12/22 – 03/23
	Evaluation framework for pilot project developed	12/22 – 03/23
	Implementation of pilot project completed	01/23 – 06/23

Classification: Protected A

<table>
<tr><td colspan="3">5. Priority Initiative (PI): Specialty Collaboration

Need to address: Access to specialty care

Population targeted: Primary care providers (5-2)

Municipalities / geographic areas: Calgary Zone</td></tr>
<tr><th>PI - Activity</th><th>Milestones</th><th>Timeline</th></tr>
<tr><td>List the key activities to implement the Priority Initiative.</td><td>List significant milestones related to the key activity.</td><td>List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).</td></tr>
<tr><td rowspan="2">5-1. Alberta Surgical Initiatives</td><td>Individuals assigned primary care roles as directed by ASI governance</td><td>04/23 – 03/26</td></tr>
<tr><td>Develop change management plan as defined by the ASI governance</td><td>04/23 – 03/26</td></tr>
<tr><td rowspan="5">5-2. Primary Care Clinical Pathways</td><td>Complete ongoing work on two primary care clinical pathways and upload to Specialist Link:
• Alcohol Use and Disorder
• Osteoporosis</td><td>11/22 – 03/24</td></tr>
<tr><td>Develop three new pathways and upload to Specialist Link:
• Dementia / cognitive impairment
• Attention Deficit Disorder management
• Pain management - Orthopaedics (provincial)</td><td>11/22 – 03/24</td></tr>
<tr><td>Review 9 primary care pathways scheduled for review and update as required.</td><td>04/23 – 03/24</td></tr>
<tr><td>Review 13 primary care pathways scheduled for review and update as required.</td><td>04/24 – 03/25</td></tr>
<tr><td>Review 12 primary care pathways scheduled for review and update as required.</td><td>04/25 – 03/26</td></tr>
</table>

Classification: Protected A

6. Priority Initiative (PI): Access & Attachment Need to address: Access to primary care Population targeted: Unattached patients (6-3 & 6-4) Municipalities / geographic areas: Calgary Zone		
PI - Activity	**Milestones**	**Timeline**
List the key activities to implement the priority initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
6-1 Confirmation of the Primary Care Provider (H2H2H – Element 1)	Pilot project launched in one urban acute care unit	04/23 – 03/26
	Pilot project launched in one rural acute care unit	04/23 – 03/26
	Patient education recommendations created	04/23 - 03/26
	Patient education campaign in three PCNs	04/23 - 03/26
	Patient education campaign in remaining four PCNs	04/23 - 03/26
6-2 Follow-up to primary care in the Calgary Zone (H2H2H – Element 6)	Existing processes for risk assessment of paneled patients at hospital discharge in the Calgary Zone reviewed	11/22 – 06/23
	Recommendations for a minimum standard practice for use of risk stratification in primary care for paneled patients developed	07/23 – 12/23
	Change management process developed to support adoption of recommended risk stratification practices	07/23 – 12/23
	Promote awareness, adoption, and use of the baseline standard for identification of high-risk patients at hospital discharge and subsequent follow up in primary care set out in the Alberta Medical Association ACTT H2H2H change package.	04/23 – 03/26
	Staffing in place for high-risk unattached patient navigation coordinator pilot project	03/23 – 12/25
	Mid-project evaluation of referral intake and patient experience under navigation coordinator pilot	03/23 – 12/25

Classification: Protected A

6. Priority Initiative (PI): Access & Attachment Need to address: Access to primary care Population targeted: Unattached patients (6-3 & 6-4) Municipalities / geographic areas: Calgary Zone		
PI - Activity	**Milestones**	**Timeline**
	Adapt navigation coordinator project using recommendations from mid-project evaluation	03/23 – 12/25
	Change management processes under navigation coordinator pilot	03/23 – 12/25
	Terminal evaluation for pilot project	03/23 – 12/25
6-3. Coordinated access and attachment project	Coordinated attachment pilot initiated	04/23 – 06/23
	Complete Privacy Impact Assessment (PIA) review and submit amendment to OIPC, if required	04/23 – 09/23
	Pilot project evaluation summary report complete	10/23 – 12/23
	Action plan (including metrics, timelines) for Year 2 completed	01/24 – 03/24
6-4. Calgary Zone Access and Attachment Strategy	Environmental scan of organizations operating in primary care space who have responsibility for access and attachment completed	04/23 – 05/23
	Design workshop facilitated	04/23 – 05/23
	Terms of reference presented to ZOCC and working group formed	06/23 – 07/23
	Internal analysis (SWOT) completed	06/23 – 07/23
	Evaluation framework developed	07/23 – 10/23
	One-year action plan complete	01/24 – 04/24
	Completed strategic plan presented to ZOCC	04/24 – 12/24
	Implementation plan written	12/24 – 02/25

7. Priority Initiative (PI): Indigenous Health Need to address: Health inequities in Indigenous populations Population targeted: Primary Care Networks, Patients who identify as Indigenous Municipalities / geographic areas: Calgary Zone		
PI - Activity	Milestones	Timeline
List the key activities to implement the priority initiative.	List significant milestones related to the key activity.	List the timeline for each key activity, using month and year format (i.e. 04/23 - 03/26).
7-1. Indigenous Health Scoping working group	Recommendations completed to support implementation of calls to action from the Truth and Reconciliation commission, and the primary care components of the Calgary Zone Indigenous Health Strategy	04/23 – 03/24

4C PRIORITY INITIATIVE EVALUATION PLAN

1. Priority Initiative: Shared Services			
PI-A*	Outcome	Data to be collected	Data Collection Method
1-1	Calgary Zone budget is approved by Calgary Zone PCN Committee	Calgary Zone budget approved (yes/no)	Document review (Calgary Zone PCN Committee minutes)
		Annual financial review of Calgary Zone finances completed (yes/no)	Document review (Audit & Finance Committee auditor's report)
	Primary Care stakeholders feel informed of Calgary Zone activities	# of communication products distributed (by communication product)	Administrative data (communications output tracking)
		# of respondents indicating they are somewhat/very informed of Calgary Zone activities	Calgary Zone PCN Committee annual survey
	Calgary Zone governance structures are supported	# of meetings held	Document review (Calgary Zone PCN Committee minutes, task group minutes)
		# of agendas prepared	Document review (Calgary Zone PCN Committee agenda, task group agendas)
		# of minutes completed	Document review (Calgary Zone PCN Committee minutes, task group minutes)
		# of overall awareness of Calgary Zone's strategic objectives	Calgary Zone PCN Committee annual survey
		# of Calgary Zone reports submitted to Alberta Health (by report)	Document review (Calgary Zone reports, various)
	Calgary Zone initiatives have quality implementation	# of Calgary Zone projects with a project charter	Document review (ZSP bi-annual reports; project charters)
		# of projects with defined milestones/timelines	Document review (project charters)
		# of eligible milestones met/missed	Administrative data (project management tracking)
		# of projects with evaluation plans	Document review (project evaluation plans)
		# of projects evaluated	Document review (project evaluation reports)
	Calgary Zone utilizes a	# of project charters that incorporate population health data	Document review (project charters)

1. Priority Initiative: Shared Services			
PI-A*	Outcome	Data to be collected	Data Collection Method
	population health approach to planning	# of project charters with health equity impact assessments completed	Document review (project charters)
1-2	Calgary Zone PCN Strategic Plan is developed	Strategic plan developed (yes/no, approval date)	Document review (Calgary Zone PCN Strategic Plan)
		# of strategic plan objectives with key performance indicators defined	Document review (Calgary Zone PCN Strategic Plan)
	PCN Stakeholders are engaged in strategic planning process	# of stakeholders engaged (by stakeholder group)	Administrative data (project tracking)
		# of stakeholders satisfied/very satisfied with engagement	Post-hoc stakeholder survey
		# of overall awareness of strategic plan's objectives	Post-hoc stakeholder survey

2. Priority Initiative: Zone Programs			
PI-A*	Outcome	Data to be collected	Data Collection Method
2-1	A three-year strategic plan for Alberta Find a Doctor is developed	Strategic plan complete (yes/no)	Document review (Alberta Find a Doctor strategic plan)
	Alberta Find a Doctor is operationalized	Provincial governance structure of Alberta Find a Doctor established (yes/no)	Document review (Alberta Find a Doctor terms of reference)
		% of Alberta Find a Doctor funding from sustainable sources	Document review (Alberta Find a Doctor budget)
	Calgary Zone patients have access to information on PCN providers and services	# of PCNs with physicians listed on Alberta Find a Doctor	Administrative data (Alberta Find a Doctor program data)
		# of workshops listed on Alberta Find a Doctor	Administrative data (Alberta Find a Doctor program data)
		# of PCNs listing workshop information	Administrative data (Alberta Find a Doctor program data)
	Improved user access to information about primary care providers	# of primary care providers accepting patients on Alberta Find a Doctor (by type: physician, nurse practitioner)	Administrative data (Alberta Find a Doctor program data)
	Patients in the Calgary Zone can search for a family doctor	# of unique website users	Website utilization data (Google analytics)
2-2	Maintain access to specialist advice for family physicians	# of specialty groups on Specialist Link	Administrative data (Specialist Link dashboard)
		# of specialists participating (by specialty)	Administrative data (Specialist Link dashboard)
		# of tele-advice calls (by specialty)	Administrative data (Specialist Link dashboard)
	Increased access to clinical care guidelines	# of primary care pathways on Specialist Link	Administrative data (pathway and resource uploads to Specialist Link)
		# of new primary care pathways available on Specialist Link (past 12 months)	Administrative data (pathway and resource uploads to Specialist Link)
		# of updated primary care pathways available on	Administrative data (pathway and resource uploads to Specialist Link)

2. Priority Initiative: Zone Programs			
PI-A*	Outcome	Data to be collected	Data Collection Method
		Specialist Link (past 12 months)	
		# of physician resources available on Specialist Link	Administrative data (pathway and resource uploads to Specialist Link)
		# of new physician resources available on Specialist Link (past 12 months)	Administrative data (pathway and resource uploads to Specialist Link)
	Maintain use of Specialist Link services	# of pathway downloads (by pathway)	Website utilization data (Google analytics)
		# of Specialist Link users	Website utilization data (Google analytics)
		# of participating primary care providers using tele-advice service	Administrative data (tele-advice users' PracID)
2-3	Maintain informational continuity between acute care and primary care for patients attached to providers who are not on e-delivery	# of admit and discharge notifications (by: site; notification type)	Administrative data completed by discharge clerks (Alchemer survey) Administrative data (PIEM list)
	Maintain informational continuity between ED and primary care for patients attached to providers who are not on e-delivery	# of ED notifications (by: site; notification type)	Administrative data completed by discharge clerks (Alchemer survey)
	Increase attachment for unattached patients	# of unattached referrals (by site)	Administrative data completed by discharge clerks (Alchemer survey)

Classification: Protected A

3. Priority Initiative: Coordinating Patient's Medical Home			
PI-A*	Outcome	Data to be collected	Data Collection Method
3-1	Common approach to promoting CII/CPAR adoption is developed	Common approach developed (yes/no)	Document review (Calgary Zone CII/CPAR approach)
	PCNs adopt common approach with family physicians	# of PCNs reporting implementing approach with family physicians	Administrative data (project output tracking)
3-2	Current state assessment of physician peer-mentorship activities completed	Current state assessment developed (yes/no)	Document review (Physician champion current state assessment)
	Calgary Zone physician champion strategy developed	Physician champion strategy developed (yes/no)	Document review (Physician champion strategy)
	PCNs adopt physician champion strategy	# of PCNs agreeing to adopt strategy	Administrative data (project output tracking)
3-3	Standard scope of practice for multi-disciplinary health team members in the Calgary Zone is defined	# of multi-disciplinary health team roles with standardized scope defined	Document review (MDT standardized scope summary)
3-4	Inventory of health staff utilization tracking is completed	Staff utilization inventory developed (yes/no)	Document review (staff utilization inventory)
	Standardized reporting of health staff utilization is adopted by PCNs	# of PCNs implementing common approach to reporting health staff utilization	Administrative data (project output tracking)
3-5	Calgary Zone PMH accountability agreement completed	Standard physician/PMH accountability agreement developed (yes/no)	Document review (PMH accountability agreement)
	PCNs adopt PMH accountability agreement	# of PCNs implementing accountability agreement with their members	Administrative data (project output tracking)
	PCN member physicians are clear what is required of them to receive PCN support to	# of PCN member physicians with a signed PMH accountability agreement (by PCN)	Administrative data (project output tracking)

3. Priority Initiative: Coordinating Patient's Medical Home			
PI-A*	Outcome	Data to be collected	Data Collection Method
	build/sustain their PMHs		
3-6	Calgary Zone Quality Improvement approach developed	Calgary Zone QI approach developed (yes/no)	Document review (Calgary Zone QI approach)
3-7	High priority chronic diseases in the Calgary Zone are identified	Calgary Zone chronic disease summary report complete (yes/no)	Document review (Chronic disease summary report)
	PCN support for ASaP screening is standardized in the Calgary Zone	Common process for PCN support of ASaP screening developed (yes/no)	Document review (Calgary Zone ASaP Screening)
		# of PCNs adopting Calgary Zone ASaP screening process	Administrative data (project output tracking)

4. Priority Initiative: Mental Health			
PI-A*	Outcome	Data to be collected	Data Collection Method
4-1	Mental Health Assessment Clinic supports patients with urgent mental health concerns	# of patients referred to clinic	Administrative data (patient referrals)
		# of referred patients with pre-screening completed (e.g., PHQ/GAD)	Administrative data (patient chart review)
		# of patient referrals that are appropriate	Administrative data (patient chart review)
		# of referred patients who meet with a mental health care provider within 3 days of presentation to primary care practitioner	Administrative data (patient chart review)
	Patients receive diagnostic clarity about mental health concerns	# of patient interviews completed by clinic (by: virtual, in-person)	Administrative data (patient chart review)
		# of clinic patients who meet with psychiatrist (by: virtual, in-person)	Administrative data (patient chart review)
		# of patients reporting increased understanding of mental health concerns	Post-hoc patient survey
	Primary care practitioners have increased ability to manage patients' mental health concerns	# of patients with care plans prepared	Administrative data (patient chart review)
		# of patients with follow-up appointment with primary care provider	Post-hoc patient survey
		# of referring care providers accessing follow-up support from clinic staff	Post-hoc primary care provider survey
		# of referring care providers reporting increased confidence providing patient care	Post-hoc primary care provider survey
	Patients have improved mental health outcomes	# of patients with improved mental health assessment scores (e.g., PHQ/GAD)	Post-hoc patient survey

5. Priority Initiative: Specialty Collaboration			
PI-A*	Outcome	Data to be collected	Data Collection Method
5-1	Primary Care involvement in ASI	# of primary care representatives in ASI governance groups	Document review (terms of reference)
		# of primary care representatives participating in ASI working groups	Document review (terms of reference)
	Change management plan for ASI is complete	Change management plan completed (yes/no)	Document review (change management plan)
5-2	Improved availability of up-to-date clinical care guidelines for primary care providers	# of primary care pathways created and uploaded to Specialist Link	Administrative data (project output tracking)
		# of scheduled primary care pathway reviews completed	Administrative data (project output tracking)
		# of applicable primary care pathways updated/not-updated	Administrative data (project output tracking)

6. Priority Initiative: Access & Attachment			
PI-A*	Outcome	Data to be collected	Data Collection Method
6-1	Acute care patients have their primary care attachment status identified prior to discharge	# of patients admitted to pilot site units	Administrative data (project output tracking)
		# of admitted patients with primary care provider confirmed	Administrative data (project output tracking)
	Recommendations for patient education campaign created	Recommendations for patient education campaign materials developed (yes/no)	Document review (Patient education campaign)
	PCNs adopt patient education campaign	# of PCNs implementing patient education campaign	Administrative data (project output tracking)
	Patients have increased understanding of the importance of a primary care provider in their health	# of respondents who indicate increased awareness about the function of primary care providers in their overall health	Campaign survey
6-2	Risk stratification approaches used in the Calgary Zone are identified	# of interviews conducted with PCN providers about risk stratification	Administrative data (project output tracking)
		# of stakeholders participating in an interview about risk stratification (by: stakeholder type)	Administrative data (project output tracking)
	Minimum standard practice of risk stratification developed	Risk stratification recommendations for PCNs are developed (yes/no)	Document review (Risk stratification recommendations)
	PCNs adopt risk stratification standard of practice	Change management process to support adoption of recommendations developed (yes/no)	Document review (Risk stratification recommendations)
		# of PCNs implementing at least one risk stratification recommendation	Administrative data (project output tracking)
	High-risk unattached patients are identified prior to hospital discharge	# of patients with LACE score completed (by: LACE score)	Connect Care
	Patients are connected to non-clinical community resources in their health neighbourhood	# of patients with referrals to non-clinical community resources (by: resource)	Administrative data (project output tracking)
		# of referrals made (by: referral type)	Administrative data (project output tracking)
	Patients are supported with	# of patient requests for a family doctor submitted to Calgary	Administrative data (project output tracking)

Classification: Protected A

6. Priority Initiative: Access & Attachment			
PI-A*	Outcome	Data to be collected	Data Collection Method
	connecting to primary care	Zone PCN attachment coordinator	
		# of patient requests for a primary care follow-up appointment supported by system navigator	Administrative data (project output tracking)
		# of patients with follow-up appointment booked with a primary care provider post-discharge	Administrative data (project output tracking)
		# of patients who attend follow-up appointments	Administrative data (project output tracking)
6-3	Patients receive accurate information, within a timely manner, about physicians who are accepting new patients	# of patient requests	Administrative data (Alberta Find a Doctor program data)
		# of patient requests responded to within [time period]	Administrative data (Alberta Find a Doctor program data)
	Patients receive information about physicians who align with their identified needs	# of survey participants who indicate physician matches were appropriate/very appropriate	AFAD user follow-up surveys
	Patients are able to identify physicians who are accepting new patients	# of survey participants who agree/strongly agree that attachment coordinator helped their search	AFAD user follow-up surveys
	Patients have a positive experience searching for a family physician	# of survey participants reporting positive/very positive user experience	AFAD user follow-up surveys
6-4	Access and Attachment Strategy Completed	Access and Attachment Strategy completed (yes/no)	Document review (Access and Attachment Strategy)
		# of strategic plan objectives with key performance indicators defined	Document review (Access and Attachment Strategy)
	Access and Attachment Strategy Adopted	# of PCNs agreeing to adopt strategy	Administrative data (project output tracking)

7. Priority Initiative: Indigenous Health			
PI-A*	Outcome	Data to be collected	Data Collection Method
7-1	Implementation recommendations completed	Recommendations completed (yes/no)	Document review (Indigenous Health Action Plans)

Additional information relating to evaluation:

The evaluation outcomes and accompanying indicators described in section 4c are selected to align with the phase of the project implementation cycle that each activity (i.e., projects and programs described in section 4b) is at. At present, some activities are in the early planning and design phases, while others are in the implementation phase, and existing Calgary Zone programs (such as Specialist Link and Alberta Find a Doctor) are in the maintenance phase of implementation.

Evaluation activities in the Calgary Zone will utilize a combination of the RE-AIM and Quadruple Aim frameworks to structure evaluation work. The RE-AIM framework monitors five essential program elements to improve the impact and sustainability of interventions. These include:

- Reach: The number of individuals from the target population who receive an intervention
- Effectiveness: The effect of an intervention on intervention outcomes
- Adoption: The characteristics of agents who deliver intervention components, and the extent to which multiple agents have implemented an intervention
- Implementation: The consistency or adaptation of the processes by which an intervention is implemented.
- Maintenance: The extent to which an intervention is able to be maintained and produces long-term effects on outcomes/impact. (33)

The RE-AIM framework has been applied to numerous health and social service evaluations and it supports multi-level evaluations. At the individual-level, RE-AIM assesses the degree to which programs reach the target population and effectively produce outcomes and long-term impacts. At the organizational-level, RE-AIM determines the degree to which programs have been implemented as intended, and the extent to which the program's processes are being implemented in a fashion that can be effectively maintained. At a systems-level, RE-AIM measures the adoption of a program, or the extent to which it is successfully scaled or spread. (34).

The Quadruple Aim Framework (QAF) provides a complimentary model for structuring evaluative work aimed at optimizing health systems. The QAF consists of four domains for measuring effectiveness: improved patient experience, improved provider experience, better

outcomes, and lower costs. Each of these domains are concerned with measuring effectiveness within distinct aspects of the health system.

4D RISK REGISTER

Complete the below table outlining the potential risks and mitigation plan for the implementation activities the Zone PCN is planning to implement.

Priority Initiative	Specific Risk/Assumption	Mitigation Plan
All	Committing to Zone work by all PCNs with no funding increase, resulting in tremendous in-kind contributions by PCNs and a strain to fund both PCN and Zone activities	• Establishing a predictable, stable budgeting process each year with budget line items mapped to Zone activities • Advocating for Zonal work • Giving feedback to PPCNC re: sustainability
All	Due to the number of priorities, the service plan might not be able to address all priority needs for all the priority populations identified	• Consolidate priorities and consider modifying the structure to support priorities • Submit a Zone BPA to request use of unexpended grant funding (if available) to support Calgary Zone initiatives and projects • Continue to support the Business Unit which supports Zone planning and sustained programs • Set clear goals and targets for implementation • Evaluation strategies to ascertain needs are being met • Create a clear communication and prioritization process
All	Mismanagement of Funds	• Calgary Zone PCN Committee Audit and Finance Working Group oversight • Financial controls • Clear accountabilities • Allocate funding to conduct an annual external audit of Zone funds
All	Unable to fund physician participation	• Ensure knowledge of financial policy for reimbursement for physicians before asking for participation

Priority Initiative	Specific Risk/Assumption	Mitigation Plan
		Comply with AH requirements for physician participation
All	Occurrence of a deficit or surplus with Zone budget	• Financial Controls • Calgary Zone PCN Committee regularly updated on committee financials • Clear operational accountabilities and oversight • Regular variance report provided to key stakeholders • Ongoing adjustment of priorities
All	Funding and priorities do not align with organizations at PCN, Zone or provincial level	• Ensure collaborative planning and stakeholder engagement as part of formation of the Zone Service Plan • Participation by all PCN Chairs at the Calgary Zone committee level • Zone Dyad to take concerns to Provincial PCN Committee as needed
All	Security of financial, intellectual and physical assets	• Oversight by Audit and Finance Working Group • Policies in place to determine who has access • Infrastructure with appropriate permissions (e.g., shared drives, SharePoint, etc.)
All	Inability to recruit and retain qualified staff to sustain initiatives, at both PCN and AHS level	• Ensure that clear accountabilities are in place and strategies to support staff at all levels • Support staff engagement and development • Ensure that comparable compensation packages are developed • Review job descriptions and adjust as needed • Review compensation packages and working conditions
All	Inability to recruit and retain physicians to sustain initiatives, at both PCN and AHS level	• Ensure that clear accountabilities are in place and strategies to support physicians at all levels

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Priority Initiative	Specific Risk/Assumption	Mitigation Plan
		• Review of physician compensation rates • Collaborate with partner organizations (e.g., AMA) to ensure support, such as peer mentorship or networks
All	Zone PCN Committee, subcommittee, working group or task group conflict	• Terms of Reference and Code of Conduct • Ensure future business plans align with the Zone Service Plan
All	PCNs unable to deliver on their individual business plans because of resources taken “in-kind” or “secondment” of PCN employees to do Zone work	• Continued support of zonal Business Unit with personnel responsible for zonal activities • Strong prioritization processes to support setting zonal priorities and balancing zonal work with PCN local work • Communication with PCN Boards to ensure alignment between zonal and PCN initiatives
All	Inconsistent decision making due to lack of experience in making collective decisions	• Zone PCN Committee structure • Governance training for all members. • Ensure key advisors are present when making decisions • Zone Business Unit responsible for facilitating a strategic vision for the Zone
All	Ineffective data sharing between stakeholders due to lack of access in public domain as well as organizational involvement (i.e., AHS)	• Zone Business Unit to facilitate data sharing between organizations • Issues to be escalated to PPCNC as needed
All	Chosen Zone initiatives no longer address population needs	• Literature review • Population Needs Assessment • Continuous evaluation of data to support decision making • Annual review and updates of the Zone Service Plan
All	Demand for resources and services exceeds supply	• Re-evaluate and triage resources • Develop strategies to address shortfalls, including partnering with other organizations

Priority Initiative	Specific Risk/Assumption	Mitigation Plan
		• Consult Zone PCN Committee if service changes are required, escalate to PPCNC as needed
All	Individual PCNs resistant to the Zone Service Plan implementation	• Zone PCN Committee structure • AH Primary Care initiative accountabilities • Engagement and communication with all Calgary Zone PCN Boards • PCN participation policy • Committee, Zone Business Unit to work with PCN Board and Governance to understand barriers and enablers and develop solutions
All	Business Planning and Zone Service Planning timelines out of sync	• Business plan amendments to increase alignment • Zone business unit to analyze work and sequence the work • Give feedback to PPCNC as needed
All	Lack of Indigenous voice	• Work with key Indigenous leaders to develop an engagement plan • Engage population when developing Zone Service Plan, year over year • Participate in indigenous led planning activities • Obtain family and patient lived experience • Use newly formed Indigenous Health Scoping working group as a starting point
All	Lack of accountability to identified reporting requirements and deliverables	• Ensure consistent Terms of Reference are developed • Ensure clear governance structures are put in place • Conduct internal reviews of collaborative structures and act on problem areas
CII/CPAR, H2H2H	Technology changes and challenges (e.g., EMRs, Connect Care)	• Communication with Connect Care leaders and have primary care leaders involved • PIA Agreements in place

Priority Initiative	Specific Risk/Assumption	Mitigation Plan
		• On-going communication with Connect Care shared with stakeholders • Issues escalated to PPCNC as needed
Access and attachment	AHS privacy/legal review creating a risk for informational continuity which is impacting the ability to continue with hospital notifications, and PCN risk stratification.	• Ongoing work with AHS to identify issues, and work collaboratively on solutions • Issues to be escalated to PPCNC as needed
Access and attachment	There are fewer family physicians accepting patients	• Development of a strategy that helps define the scope of PCN work and where there may be opportunities to partner with other organizations • Issues to be escalated to PPCNC as needed
Linkages	Communication, governance, and funding related to ASI unclear	• Define clear accountabilities within the zone and clear Terms of Reference • Ensure key stakeholders are present when making decisions at zonal activities, and advocate for Zone representation at provincial tables • Issues to be escalated to PPCNC as needed
Mental Health	Staff and physicians are feeling depleted and many are experiencing burnout	• Focus on grant deliverables; further work to be done incrementally • Re-evaluate and triage resources • Develop strategies to address barriers (i.e. Zone webinars), including partnering with other organizations

5. ALIGNMENT TO OBJECTIVES

Describe how your priority initiatives align with the following objectives:

Objective:	Example of Alignment
Alberta Health Primary Health Care (PHC) Strategic Outcomes	Provide at least one example of how the Priority Initiatives planned will help address each of the below objectives.
Access – All Albertans have access to timely, appropriate PHC services from a regular provider or team. Care options are flexible and reflect individual and population health needs.	• **Coordinating Patient's Medical Home** will have activities focused on improving paneling and enhancing multi-disciplinary teams towards appropriate and enhanced access • **Access and attachment** will focus on systems to improve access through structured safety visits post-discharge from acute care and long-term attachment to a PCP. • **Zone Programs** such as AFAD and Specialist Link are designed to be centralized services that enhance access to primary care providers and specialists for patients within the Zone.
Integration – Every Albertan has a Health Home that provides PHC services and seamless transitions to other health, social and community services. Co-ordination and communication between providers and organizations	• **Coordinating Patient's Medical Home** integrates PHC within and between PCNs in the CZ through physician peer mentorship, training, and common expectations around PMH support. • **Shared Services** focuses on backbone support to integrate approaches under the other initiatives, through collaboration, strategic planning, administrative support and facilitation of communities of practice. • **Access and attachment** activities foster coordination and communication between PCPs, zonal supports, and patients.
Quality – Albertans receive high-quality services from an accountable, innovative and sustainable PHC system. Health service delivery is evidence-informed, follows best practices, and uses resources efficiently.	• **Coordinating Patient's Medical Home** has activities designed to standardize tracking of health team staff, ASaP screening, and linking patient care approaches to quality improvement. • **Indigenous Health** will prioritize more accountability and evidence-informed delivery through co-development of actions that are appropriate for Indigenous persons. • **Specialty Collaboration** develops, monitors and updates pathways to reflect current innovation and best practices.
Albertans as Partners – Albertans and their support networks are meaningful partners in achieving their health and wellness goals. Health services are proactive, recognize and address	• **Coordinating Patient's Medical Home, Indigenous Health** and **Access and Attachment** will incorporate activities that examine and address underlying influences on health outcomes, such as linking patient care approaches, coordinated attachment support to primary care providers for patients, and co-designed actions that respect the needs and preferences of indigenous communities.

Objective:	Example of Alignment
underlying influences on health outcomes, and respect individual needs and preferences.	• **Mental Health** will build on existing social and other community support mechanisms as partners to primary health care, incorporating approaches that address mental wellness, diagnosis, and treatment.
Zone PCN Service Planning goals	
Improved Integration between PCN services, AHS programs, and services provided by community-based organizations of services between AHS and PCNs.	• **Access and attachment,** through H2H2H will foster improved integration between PCPs, acute care and community-based organizations. • **Shared Services** will advocate for and negotiate agreements and areas for collaboration with AHS in support of other priority initiatives • **Coordinating Patient's Medical Home** will support panel improvements through the implementation of CII/CPAR.
Increased Alignment of services across communities within a Zone, to prevent duplication and to ensure there are no gaps.	• **Zonal Programs** and Access and attachment each have activities that integrate PCPs with specialists and patients and encourage alignment. • **Shared Services** will provide backbone support to foster collaboration and will facilitate increased alignment through the creation of a Calgary Zone strategic plan.
Shared Administrative Services across the Zone, where deemed appropriate by mutual agreement between joint partners.	• **Shared Services** through the Business Unit, Calgary Zone, will support governance structures through task groups and committees. The Business Unit will be financed under contributions from all seven PCNs within the Zone, as well as other targeted financing to meet all priority initiatives. •
Cross Zone PCN alignment	
Describe how this ZSP aligns with other provincial priorities	• The ZSP captures initiatives related to provincial priorities of ASI, H2H2H and work related to several pillars of the Patient's Medical home
Describe how this ZSP aligns with other Zone PCN Committees' proposed ZSPs	• Project Managers/ZSP Leads meet frequently to discuss opportunities for alignment and collaboration across Zones • Ongoing discussion for opportunities for inter-zone alignment that may include IM/IT, Communications, Evaluation

6. OTHER INFORMATION

Share additional information about this Zone PCN Service plan:

The Calgary Zone Service Plan has been developed after extensive consultation with stakeholders throughout the Zone. It represents new and ongoing priorities, as defined by

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those engaged at the time of its writing. This service plan has been developed within the current primary care context and may require revision if that context changes.

This Zone Service Plan also does not include undefined or unpredictable priorities that may emerge in the future, including any future policy directives that are not already captured within this plan. Any such work would therefore be considered an unbudgeted expense.

This Zone Service Plan also contains several priority initiatives and activities that are not project based; they are ongoing activities that make up day to day Zone operations. As such, defining milestones or timeframes for these activities were difficult. These activities were still included in this document, as it still represents cooperation by all PCNs and their partners to deliver services at a Zone level.

ATTACHMENTS

Attachments should be succinct pdfs.

Attachment #1 – *Zone PCN Committee membership as of Dec 2022*

Attachment #2 – *Zone Operations Coordinating Committee membership as of Dec 2022*

Attachment #3 – *CZ PCN Committee Terms of Reference*

Attachment #4 – Audit and Finance Working Group Terms of Reference

Attachment #5 – Zone Operations Coordinating Committee Terms of Reference

Attachment #6 – Patient's Medical Home Task Group Terms of Reference

Attachment #7 – Supported Transitions Task Group Terms of Reference

Attachment #8 – Specialty Integration Task Group Terms of Reference

Attachment #9 – Mental Health Task Group Terms of Reference

Attachment #10 – Indigenous Health Scoping Working Group Terms of Reference

Attachment #11- 2023-2026 ZSP Template Financials Overview pdf

Attachment #12 - References

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