Primary Care Networks

Alberta
Find a Doctor

Draft Plan 2023 – 2026

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This draft plan has been prepared for the Calgary and area PCN Zone Business Unit and the Alberta Find a Doctor Steering Committee

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Executive Summary

The Alberta Find a Doctor (AFAD) website was formed in 2019 after two similar sites were created earlier to support patient attachment to family doctors in the Calgary and Edmonton zones. The provision of a provincial resource has significantly advanced the search for a family doctor in Alberta despite the current shortage of family doctors accepting new patients, although it remains a Calgary and Edmonton centric, and funded, service.

Developing this draft plan (the "Plan") involved 50 stakeholder interviews, a comprehensive review of historical AFAD documentation and a review of the published literature. The interviewees were primarily from Alberta and represented a broad audience with numerous perspectives. This included cohorts representing current stakeholders familiar with the operations and funding of AFAD, family doctors, other primary care health professionals, and public/patients of various ages.

There was a consensus view among the interviewees that building on AFAD is a tremendous opportunity for Alberta. All interviewees recognized the value of the site even when primary care provider supply is low. There was no consensus on the scope nor what services should be available to a user when on the website.

This Plan outlines how AFAD can capture the potential envisioned by the interviewees through four objectives, 16 strategies and 34 tactics.

Importantly, AFAD must become a stand-alone provincial entity with its own governance structure, funding, and operations staff. The service must become less PCN-centric and expand to include all family doctors in the province, with or without PCN membership. It must grow beyond family medicine and include nurse practitioners and prescribing pharmacists to ensure access to primary care in areas with little or no family doctor supply. And it must build a trusted reputation upon data integrity and strong, recognized, and committed stakeholders.

AFAD's service must expand beyond family doctor attachment and support patient access to episodic primary care. This can be achieved by accurately describing care locations as urgent care, walk-in, or by appointment clinics and developing a tiered service that moves from a self-serve map search to more complex needs.

For the time being, and despite the call for non-physician providers on the site, AFAD should retain its current name. The public is comfortable and familiar with this brand, and despite the health system's preferred use of "team" or "clinic", patients seeking care will go looking for a doctor. Access to NPs and/or pharmacists can be directed from within the site once a user has made the connection. The name may evolve to something different in the long term.

Four Objectives

1. Become the trusted resource to seek out a primary care provider in Alberta.
2. Be a true patients' first website.
3. Become sustainable and built to evolve with changes to the health system.
4. Be the model for health system collaboration.

AFAD needs to be a true users' first website. Maintaining data accuracy on the site is paramount to user satisfaction. It also needs to be more accessible to those who are more vulnerable and inclusive. It needs levels of support to help meet users where they are at, when they are using the site. Most will only use the self-serve function, but a minority will need to have direct contact and additional care.

It is estimated that about $1.65 million annually is needed to operate a re-imagined AFAD, not including the upfront cost to revamp the website. The operating costs are driven by staff costs to maintain data accuracy and assist those who need assistance beyond the self-serve map function.

This is an ideal time for AFAD to evolve. The federal government has announced an increase in health transfer payments to the province and Alberta Health has recently announced an increase in funding for primary care. Timely patient access to health services, particularly primary care, is a high priority for Alberta's health system and AFAD has the potential to be an integral component to this process.

AFAD can, and should, be a leader in this space. It is already a valued asset in our provincial healthcare offerings. With additional focus and development, it has the potential to be an internationally recognized resource that supports patient access and attachment to primary care.

Vision

While it is not within the scope of this work to provide a far-reaching vision, the contributors to this Plan believe that over the next three years the evolution of Alberta Find a Doctor (AFAD) is possible, necessary, and needed. A focused, trusted, and simple-to-use platform that supports any Albertans' search for primary care or a primary care provider can be an integral tool to the effectiveness of Alberta's primary health care system.

The work of defining the overarching vision and mission of the AFAD site needs to be a participatory process involving both its staff and the members of its governance structure. These stakeholders must map out a compelling future state far into the future. This Plan does not presume to create a vision for AFAD for these reasons.

However, it is eminently feasible that this site is heavily relied on, referenced, and widely shared by 2026 because it consistently provides value to Albertans.

AFAD can become a tool Albertans routinely seek out and use because they know they will leave with options on how and where to seek care from a primary care provider, rather than empty-handed, frustrated and feeling they have no place to turn.

The following mission option is provided as a starting point from which to then build a vision for AFAD.

Connecting Albertans to primary care

Method

This Plan was compiled after reviewing existing AFAD information and reports, interviewing stakeholders and patients from across Alberta, a small number of individuals from outside the province, and a literature search on the broad theme of patient attachment in primary care.

The results and recommendations are an aggregate of the information reviewed and collected. There is no attribution provided to any person or article. The results reported here are heavily weighted to the comments and opinions of the interview subjects.

Specifically, this Plan builds from the following sources:

- Key stakeholder interviews. Fifty people were interviewed over the course of 35 virtual interviews and one written submission. The majority of these interviews were held between December 21, 2022, and February 2, 2023, with one final interview on February 27, 2023. Eleven interviews were conducted by both consultants, and then each did an additional 12 interviews independently. Refer to Appendix I for the list of interview participants.

- Alberta Find a Doctor documents and reports. Alberta Find a Doctor (AFAD) Evaluation Plan (December 2021), AFAD Annual Plan 2020-21, AFAD Action Plan (2021-22), AFAD Terms of Reference (2019) plus various briefing notes, summary of attaching data, and applications for support.

- Published literature. Twenty-one studies were found and reviewed on various topics including the use of centralized wait lists in Canada and internationally, role of digital technologies in primary care, articles on coordinating access, rural physician supply and retention, how marginalized youth access healthcare, and the role of patient navigators. Refer to Appendix II for the list of publications.

Current Environment and Noteworthy Observations

The Alberta Find a Doctor website was launched in March 2019 and built on work first done in the Calgary area ('Need a Doctor' website) in 2010 and shortly after in the Edmonton area (the 'Edmonton Area Docs' website). This history is notable and influences future development of the site in the following ways:

- The AFAD program has developed and been supported out of goodwill and best intentions from some Primary Care Networks (PCN). Funding support comes from a minority of PCNs, despite competing priorities. PCN funding is directly linked to the number of panelled patients, and not from supporting unattached patients. This lack of funding priority can be justification for some PCNs to not contribute either financially or in-kind with timely updated data. The few PCNs that support the current site are among the province's larger PCNs, which are better positioned financially to do so and because they believe it is the right thing to do. Still, such support comes with the need for continual justification.

- The name "Alberta Find a Doctor" is clear and obvious, and yet limiting. The current name is descriptive and well understood by the general public. Many contributors to this Plan, however, want a new title that is more contemporary such as "care team", "health home", or "primary care provider". Many also want to see the inclusion of other primary care providers such as nurse practitioners and prescribing pharmacists. Yet, this is not the language most Albertans know or use at this time. Despite shifts in policy toward team-based care, and some professional and provider bias toward a more inclusive name, the general public understands "find a doctor", and is comfortable with this name.

There is no known comparable technology from which to learn. There are examples of government-run, centralised wait lists across Canada and in some European countries, but none were found that promote a decentralized, patient-controlled setting.

- Seven provinces have developed centralized wait lists (CWL); six coordinated by their Health Ministries provincially (PEI, NS, NB, PQ, ON, MN), and one distributed and delegated to the various health regions (BC). An interview with one of the lead national researchers in this area, indicated all lists continue to grow faster than they can be reduced, and the development and maintenance of such lists comes with a substantial cost and the need to manage user expectations. It was noted that in provinces that segment and prioritise their list based on need to allow for better support, they are more likely to be attached. It is worth noting that incentives for physicians to take unattached patients from CWLs generally do not seem to work and, in fact, often introduce unintended consequences of gaming the system.

- There are a few for profit options that allow providers to advertise their services such as Medimap, which is occasionally used by HealthLink. However, no others were found with the same mandate, scope, or opportunity as AFAD provincially, nationally, or even internationally.

There is tremendous opportunity for Alberta to build upon the current AFAD website and configure it to meet local needs and expectations. The challenge will be in defining those needs and expectations.

- All interviewees recognized the value of the site and noted that it still helps to educate patients even when primary care provider supply is low. Surprisingly, there was limited acknowledgement, even when pushed, of the frustration that is created for users in this era of a scarcity of resources, particularly when inaccurate data is provided. With all-time peaks in traffic volumes to the site occurring as this work was completed, thousands of Albertans are clearly seeking to find care and are stymied by the inability to find it.

- There was no consensus on the scope of service people would like to see on AFAD. Opinions ranged from just "find a doctor" as in the name, up to and including a universal primary health care portal that would bring awareness and access to any of the multitude of 'doors' people walk through into primary care.

- There was also no consensus on the exact nature of services that should be directly linked to the site other than maintaining the search function. Suggestions for additional functionality included a triage function, the addition of other team members and/or resources, the addition of a phone number for those to access who need more help or do not use the internet, adding wait times, and the ability to contact a clinic directly or, even better, to schedule an appointment online directly with a provider.

This history, the uniqueness of AFAD, and the interviewees' comments describe a highly successful means by which Albertans can search for primary care services. Continued focused investment and stakeholder engagement in AFAD will enhance this patient resource such that it becomes a national and international example for healthcare system collaboration and, most importantly, an effective tool to help Albertans find the primary care they need.

Objectives

The scope of this paper is to create a strategic plan for AFAD for the three-year period to the spring of 2026. With this timeline in mind, there are four overarching objectives.

1. Become the trusted resource to seek out a primary care provider in Alberta

There are three components to this first objective: credibility, focus and accuracy.

Credibility
Users must be able to trust the site, know it is credible, and understand what it can, and cannot, do. Many of the key stakeholders are already involved, which is how it has achieved its current status and hitting all-time highs of over 30,000 map searches a day (January 2023). These relationships can, and should, be strengthened and promoted to establish credibility as soon as the site loads so users are reassured upon arriving that they have come to the right place.

Focus
This site needs to be clear on its purpose and what it can do. AFAD needs to narrow its focus to the reason that brings Albertans to it in the first place – which is seeking help to find a doctor when they have a health concern.

The site must acknowledge that it cannot be all things to all people; to try to do so will doom it to mediocrity at best, irrelevance at worst. People visit this site when they need help; most likely when they, or a family member, are not feeling well. They do not know the terminology of "primary care provider", "nurse practitioner", "health homes", "patient's medical home", or even of "primary care". They are just seeking help and for many that means "a doctor".

AFAD must focus on primary care[1] *access* to a doctor (with access to other primary care providers once the person is on the site), and simultaneously support *attachment* to a primary care provider in the process, where possible. No one visiting this site should leave frustrated and uninformed; the site needs to evolve to ensure Albertans leave with options to find care.

Accuracy
It is imperative that AFAD's content be current and accurate. One of the key complaints of the current site is its data accuracy. Keeping information current on hundreds of clinics and thousands of doctors, when a status can change within days, if not hours, is difficult. While PCNs, as a collective, have been doing their best, the processes used and the funds dedicated to doing so, vary widely. This needs to change and improve.

2. Be a true patients' first website

"Patient-centred" is common language in healthcare, but less so in implementation.

A site that truly puts the user at its centre needs to broaden the definition of who is classified as a provider beyond PCN members. It also needs to manage user expectations of what it can, and cannot, do. There is a tremendous opportunity to help educate Albertans on the challenges the system faces as well as broaden their definition of who is qualified to provide care. It also needs to explain the difference between episodic care and the value of an on-going relationship.

[1] "Primary care, which includes clinical services like diagnosis and treatment of nonurgent conditions, chronic disease prevention and management, and mental health and addiction treatment, is one part of primary health care. Primary health care is a broader concept than primary care, that emphasizes prevention and wellness, and recognizes that success in improving people's health is largely determined by factors in their daily lives, such as: lifestyles, housing, relationships, spiritual beliefs, income, and workplaces." Alberta's Primary Care Strategy, **Alberta Health**, January, 2014

The site *must* be accessible for vulnerable populations and for those who need more help, not just those who speak English and are internet savvy. It needs to provide varying levels of support and access ranging from the self-serve function most will use through to direct involvement with a live advocate that a minority of site users will need.

3. Become sustainable and built to evolve with changes to the health system

AFAD can unquestioningly evolve to be part of the solution for improved access and attachment. It will need to be funded directly and appropriately to achieve its potential. Governance and operations of the site should continue as a provincial body to ensure a broad view and collective wisdom and decision-making.

Given the limited resources and small number of people dedicated to the current site, most of whom do so 'off the sides of their desks' and with an unsecured budget, it is remarkable how well this site has developed. The few who have maintained the site and acted as its primary champions, are to be celebrated and thanked. More importantly, their system knowledge should be leveraged into the future version of AFAD.

Despite its success, AFAD is unsustainable in its current state. It will not meet the expectations of the public, the participating providers, nor those PCNs that support it in years to come.

Patient access to care is a central tenet in a strong healthcare system. Although Alberta Health (AH) has not funded it directly, it has long acknowledged the importance of access and attachment. And even now, as of this Plan, AH has announced its intentions to invest heavily in primary health care[2], and is deeply involved in the Modernizing Alberta's Primary Health Care System (MAPS) initiative where improved access is its stated goal. AFAD can be an essential element of this work.

4. Be the model for health system collaboration

There is a tremendous opportunity to further expand on the collaborative nature of AFAD and the services it offers by working with others, and not in competition. AFAD can lead by example of what is possible.

Most other provinces are tackling the shortage in primary care providers through the creation, and maintenance, of centralized wait lists. Rather than taking the paternalistic approach of compiling expensive lists of citizens and their health concerns and making them wait until the 'right' provider, as determined by others, is found for them, Alberta prefers to put the information in the user's hands and empower them to find a solution that works best in their situation.

Bucking the healthcare habit of developing silos, AFAD has established a shared, provincial service involving numerous organizations representing funders, health service delivery, and health professionals. This is thanks to the collaborative efforts of many PCNs, AHS and other stakeholders and should be further built upon.

[2] Record investment in Alberta's primary health care, February 21, 2023.

Strategic Direction and Operational Tactics

The following section expands on each objective. Recommended strategic directions and operational tactics are listed as a roadmap to move from objective into reality.

Objective #1: Become the trusted resource to seek out a primary care provider in Alberta	
Strategic Direction	**Operational Tactic**
(a) Increase the credibility and trust people have with the site and manage user expectations	• Improve the credibility and trust with the site with the active buy-in, branding, labelling and endorsement from AH, AHS, and the primary care provider Colleges. This support should be prominent on AFAD, easily visible on the home page near the top so that it is clear that this service is part of Alberta's public health system. The sponsors' clear support will eliminate any confusion with other competing sites, particularly for-profit endeavours. AFAD should also be linked to, and from, each organisations' respective website. • Improve how AFAD manages user expectations. As traffic soared in January, content was added to note supply is limited with an explanation as to why, but the link to this information was not obvious. As well, the "find" in the name implies there are resources to be found, thereby disappointing many when they realize the search for support is not that easy.
(b) Narrow the mission and focus of the site to primary care providers (not primary *health* care)	• Focus the site's messaging to help those looking for a primary care provider. Allied health support, PCN information, and workshops should not be a site priority. • Prioritize accurate information for the primary providers who are listed. There should be no plan to expand the site beyond this basic priority until the data accuracy problem is addressed. • Increase the number of primary care providers on the site. Include all family physicians regardless of PCN affiliation, nurse practitioners (NP), and prescribing pharmacists. This site needs to be less PCN-centric if it is to be effective and supportive across Alberta. At present 80 to 85% of family physicians and NPs are part of PCNs, which means there are another 15 to 20% who could be listed on the site, some of which are no doubt accepting patients. While restricting the site to PCN physicians was appropriate given the PCNs investment in it, this should be revised, particularly if funding for this initiative no longer comes through PCNs. AH would need to help identify non-PCN physicians and NPs and assist with communication to this subgroup. Nurse practitioners (NPs) who are members of PCNs who maintain a panel of patients are already included. Prescribing pharmacists should be added. This subset of pharmacists is providing primary care services, particularly in areas where access and attachment are poor.

	• Provide a regular AFAD update (i.e., quarterly) to all those listed on the site. Routinely ask providers to help support new attachment and be given the option, if they do not want the information to be public on the site, to let AFAD staff know they would be open to accepting a specific number of patients when vetted by AFAD staff.
(c) Expand the scope of assistance beyond attachment to also include access	• Include access to primary care options in addition to attachment to a primary care provider. Episodic primary care needs to be included for those who have no other option or for those who prefer it. With so few doctors opening their panels and so many areas of the province without any possibility to attach, AFAD is not currently providing effective support to those in need. To that end, the site needs to include access. These options can be made possible by: o Differentiate and categorize clinics into those that provide comprehensive care (attachment) vs those that focus on episodic care (access). This may be difficult and controversial for some, as many walk-in clinics are members of PCNs and may not appreciate such a classification. Presume that walk-in clinics provide episodic care, unless proven otherwise. o Within the episodic classification include: ▪ All walk-in clinics, after hour clinics, and urgent care centres, including AHS' Family Care Clinics (FCCs) offering these services. Consider including ERs in rural and/or remote areas when that is only one of the options available. ▪ Prescribing pharmacists. As with including and defining episodic care, this may be controversial; it certainly elicited a mixed reaction from the interviewees. However, particularly in rural and remote locations, the ability to access a pharmacist for prescription renewals and support for the management of chronic disease are options that should be considered on a site that is patient centred. • Continue to support patient attachment and provide education and build awareness on why it is important. • Include publicly funded providers only. As AFAD is publicly funded and many Albertans seek out healthcare services with no cost at the point of care, the providers on the site should be restricted to those who are also publicly funded. For profit ventures should be excluded, at least at this time. • Ensure virtual care is an option, if the inclusion of all the above still does not address a user's primary care need. AFAD staff would need to be directly involved and gather appropriate information at this stage to coordinate this support. The delivery of virtual care should be through a partner agency that has the infrastructure. Ideally this is 811, who has some experience in this area and where health records could be maintained for some continuity; fortunately, they are open to such a partnership. If not, there should be a connection to a third party (such as Maple or Babylon), paid for by Alberta Health. Either way, there should be a process to directly schedule an appointment or to provide a warm hand off.

(d) Improve data accuracy	• Maintain data accuracy on the site. As noted, the limited number of resources available to site users is already frustrating. Poor data quality compounds this situation when they reach out to those listed as accepting patients only to be told they are not. Three issues contribute to poor data quality, (1) poor processes to verify data accuracy (i.e., relying on clinics to self-report), (2) slow processes to verify data accuracy (i.e., PCNs calling clinics four times a year, or at irregular intervals, for status updates), and (3) clinics who claim to take patients but then only take certain patients. The latter goes against best practice and is a probable violation of CPSA standards. AFAD cannot ensure compliance but should be attuned to this threat to data quality. • AFAD should: o Move all the work of updating clinic information in-house and contact all clinics on a regular basis. It may be possible to share this responsibility with an engaged PCN if they can demonstrate that their data is accurate. Do not accept self-reporting or slow processes. o Direct AFAD staff to make changes and update listings changes in real time, as they are found. o Include a timestamp on all listings of providers who are taking patients, so users can see the currency of this information. o Institute an automated time limit (i.e., two weeks) paired with the timestamp whereby listings are automatically removed if not updated. o Include a "Find a Problem?" link for users to notify the site if a listing is incorrect. Make it easy for users to complete with a drop down of options of what the problem is, then follow up with the clinics appropriately to verify. o Include an easy-to-follow link that enables providers to directly report changes to their status. This can also serve to enable AFAD to verify reported changes. o Investigate artificial intelligence (AI) options that will automatically update and/or complete a reminder call to clinics for status updates. o Educate staff on what to do if they learn directly, or through a site user, that a provider may be 'cherry picking' (such as directing the user to contact the appropriate College). • Display relevant and meaningful metrics. The site needs more data transparency for the users; this also helps with credibility and trust. Consider including a dashboard of the metrics that matter most. Alberta's 211 has an impressive real time report.
(e) Re-evaluate the name and brand	• Continue using the name "Find a Doctor" in the short-term. While not inclusive of NPs and prescribing pharmacists, which are being recommended for inclusion on this site, AFAD is a recognized and well-used domain. It is terminology that most Albertans know and with which existing users will have familiarity. This traction should not be lost. • Engage communications experts to explore and recommend a more inclusive name and the process and timeline for the change. Start with the current name and migrate from a "doctor" to a "team" or "clinic" over time. Whatever is selected needs to be self-explanatory and easy to understand. This migration must be well supported by a promotion campaign. It has been stated that the word "find" is misleading in this era of scarcity and that "need" would be more accurate. NeedADoctorinAlberta.com/.ca, NeedAlbertaDoctor.com/.ca, NeedAClinic.com/.ca, AlbertaPrimaryCareProviders.com/ca were available as of February 14, 2023. Regardless of what is selected (if it does change), albertafindadoctor.ca should still be

	maintained and forwarded to any new name. A basket of related domain names should be acquired to fully capture the potential search parameters and to dominate the space. • Migrate the branding away from a PCN centric website. AFAD needs to be more focused on what users are looking for and need, rather than what providers want them to know. • Promote the website in every emergency room and urgent care centre in this province. Posters and wallet sized cards should be available everywhere and anywhere people go seeking a primary care provider. This includes free of charge materials for social not for profit organizations (i.e., Edmonton Mennonite Centre for Newcomers, CUPS in Calgary).

Objective #2: Be a true patients' first website	
Strategic Direction	**Operational Tactic**
(a) Improve site accessibility; be of help to the public regardless of their health need or level of literacy	• Design the site with users' preferences the top priority. Research shows that the more vulnerable in our society are less likely to be attached to a primary care provider and have worse healthcare outcomes. This site should be designed with those users in mind so that the site is accessible to them from the start, not after the fact. It needs to meet people where they are at and make it easy for them to gather the information they need. • AFAD should: o Make the site warm, welcoming, and inclusive with its language and approach throughout. o Enable the user to convert the content into various languages. This function needs to be prominently located. o Provide a 1-800 number for those who would rather talk to someone directly. This must be a free call from anywhere in Alberta (and on all marketing materials). o Write the website content at a low, and very accessible literacy level (grade four to six). Include numerous images and white space. o List Indigenous-specific healthcare options available (such as the North Zone 1-800 Line: Walk with Me, Talk with Me, Learn with Me; Alberta Indigenous Virtual Care Clinic, Indigenous Wellness Core as well as federally provided options). o Provide the users with meaningful search parameters that make sense to them (gender of provider, specialty interests, language spoken) and do away with those that are less important to their immediate needs (PCN affiliation). o Ensure that the list of languages spoken is an accurate representation of the languages spoken by the participating providers. Avoid internet generated languages lists, which exclude Indigenous languages spoken in Alberta, such as Cree or Blackfoot.
(b) Support those who need more help when they need it	• Create a tiered user experience depending on the user's needs. *Level 1. Self-serve*. Most users already navigate the site successfully on their own and need no further assistance. This level is the entry into the site and users should not need to provide any data to be able to access and use the site. There should be no barriers to access at this level.

	This self-serve function will not work for all, and for those who need more help, there should be two additional levels that users can progress to. *Level 2. Chat box*. This functionality (ideally provided in different languages) should be accessible while the person is visiting the site. An enhanced version could be AI delivered and would be an option for users 24/7. Live support could augment or be used to help the AI 'learn'. *Level 3. Patient Attachment Assistant (PAA).* Direct contact with a PAA, accessed via email, a virtual call, or through a 1-800 number. The Edmonton Zone PAA model (currently 2.5 FTE) can be leveraged and extended to a provincial resource. While it is acknowledged that having dedicated staff will be the driver of AFAD's operating costs, evaluation studies show that for those who use this service, it is effective and highly valued. The PAAs would be able to provide customized care and, if possible, work to attach users with providers not listed on the site as taking patients. For those seeking to access this level of support, additional data should be gathered in particular: age, location, if they have any complex health issues, and if the user is already attached. The Patient Attachment Assistant title and job description should be considered for change since this name is not accurate for a re-imagined AFAD. Consideration could be given to Primary Care Guide, Client Care Assistant, or Care Connection Assistant, for example.
(c) Provide service delivery when Albertans are looking for it	• Recruit a dedicated team to support AFAD users. Putting the user in the centre means providing care when they need it, not when providers prefer to work. As service is ideally provided when the user is on the site, staff should be scheduled when traffic is heavier along with a queue function or the option to email or leave a message, when a PAA is not immediately available. Staff must be scheduled to work evenings and weekends and be available when the data indicates the site is used most. Investigate the use of AI technology to provide support and assistance through the chat box function when outside of traditional office hours.
(d) Keep the focus on attachment	• Maintain a focus on patient attachment to a primary care provider. The importance of attachment should not be lost in the provision of episodic care options. The value of attachment should still be a primary goal of the site with access options posed more as a "while you wait" approach. That said, users know what would work best for them and should be allowed to direct their own care once fully informed. • Establish a process to engage and assist with attachment. When PAAs have repeat visitors, effort should be made to help people understand the benefits of attachment and encourage them in this direction. PAAs could reach out to the local PCN and seek their assistance with attaching the individual, if there are no providers in the user's area.

(e) Educate users in a non-threatening way	• Build in information and processes to educate about primary care. Provide users with the information they want, but do not lose the chance to educate and inform. There is opportunity to teach people about different types of providers (FP, GP, NP, a prescribing pharmacist, etc.), the value of attachment, what a multidisciplinary team is / does, what a PCN is and where to find them, even an explanation of how healthcare works and is accessed in Alberta. Information should be tailored to various audiences, such as young adults and immigrants who have little exposure to the system.

Objective #3: Become sustainable and built to evolve with changes to the health system	
Strategic Direction	**Operational Tactic**
(a) Become a stand-alone entity with its own governance structure, dedicated staffing, and funding	• Create a new provincial stand-alone entity and governance structure. The "owners" of AFAD should be limited to those who are directly involved either through program delivery or funding; a 'pay to play' model', if you will. Governance should reflect ownership and mimic a traditional not for profit corporation (if it does not evolve to be one on its own). AH, AHS and PCNs should all be represented on the Board of Directors, along with ex-officio representation from the senior staff who oversee program development and delivery. • Secure dedicated and expanded operational funding. Ownership and funding needs to better align with AH priorities. While there is appreciation that the default solution for any healthcare need is AH funding, there is a good argument for AFAD in this case. If patient access is a high priority, and there is no indication otherwise, then the solution should be funded directly and appropriately. The current funding approach, to filter operational funds through stakeholders with other priorities and away from their core programming is not sustainable. The timing of this work is fortuitous given the Premiers and Federal government recent agreement (February 13, 2023) to increase federal health transfers and AH's primary care funding announcement (February 21, 2023). Funding should be sufficient to expand AFAD and enable it to grow, rather than merely taking over the current budget. An example budget is provided later in this Plan.
(b) Tweak the website now for the greatest gains with the least disruption/costs while preparing for a total rebuild	• Make minor, but effective changes to the site now while simultaneously preparing for a complete rebuild. AFAD's leadership needs to review the list of suggestions and prioritize those that are critical to AFAD's ongoing, short-term success. With expert technical support as necessary, the leadership must then develop a plan for what can be implemented within the limits of the current site's structure and update AFAD. • Simultaneously, a plan for the development of a new AFAD site must be developed, due to the extent of the proposed changes.

(d) Do not just build a site for three years out, but for 10	• Build AFAD with tomorrow's needs in mind. Anticipated changes in technology should be considered (artificial intelligence primarily) to help automate as much as possible if users can be supported appropriately. Any rebuild needs to not just look at what is proposed in this Plan, but for the next evolution. Once the system improves data accuracy and user support, it needs to continue to evolve to stay abreast of the user. The design should be flexible enough to allow for an evolution from "a doctor" to "a multidisciplinary team / clinic" And further out, to move to a broader primary health care perspective. Prepare not only for what is on the horizon but what is over the horizon.

Objective #4: Be the model for health system collaboration	
Strategic Direction	**Operational Tactic**
(a) Acknowledge and embrace this as a true, provincial, shared service	• Conduct an environmental scan and gap analysis of all those working to help attach users and improve frontline access. Part of this work should be to define roles and value differentiation. Work with those where there is overlap to better define who is the most appropriate provider to ensure that public dollars are best used to address the need, rather than duplicate effort. • Expand on collaboration with key stakeholders. In particular: PCNs: These organizations have the best relationship with the family medicine practices in the province. Enhance and develop these relationships, particularly for the Patient Attachment Assistants (PAA) to leverage when they need help attaching Albertans who live in a PCNs catchment area. AHS (811): Both AFAD and 811 have well established brands and role definition. These strengths should be capitalized and expanded on to further support Albertans. As 811 staff already use AFAD to seek out primary care providers, it would be helpful if the information could flow the other way such as allowing PAAs to directly transfer a call without requiring the user to repeat their information over, and by 811 expanding their service offerings to include more virtual care appointments that PAAs could book directly. 811 is open to such collaboration. AHS (Acute care): Posters and cards should be available in every AHS site where patients may gather to access care that could have been dealt with in the community (emergency rooms, urgent care centres during traditional office hours, etc.). This activity must be prominent and continual within AHS locations. Ideally, it would be a measurable deliverable for those who manage these locations. 211 / InformAlberta / MyHealth.Alberta.ca / Others: Build relationships with all key players who act as a resource to allow referrals and linkages, as appropriate. It also will be important to form reciprocal, beneficial relationships, to learn from one another on how they provide information and educate and engage with their customers.

(b) Become a success story in primary care access and attachment	• Develop an evaluation framework and reporting cycle. In collaboration with partner organizations such as the Health Quality Council of Alberta, plan and evaluate AFAD's performance and share the results widely, particularly with the site's users. • Seek to publish results.
(c) Seek out advice and new relationships	• Create an Advisory Panel. In addition to those who comprise AFAD's governance structure, AFAD should develop an advisory council or "friends of" classification with other key partners who can bring insight and leadership to access and attachment in primary care, professional standards relating to primary care, professional interests that could influence primary care, and the public's perspective on health care services generally and primary care, specifically. Advisory council representation may include professional colleges (i.e. Alberta College of Family Physicians, College of Physicians and Surgeons of Alberta, College of Registered Nurses of Alberta, Alberta College of Pharmacy), professional associations (i.e. Association of Nurse Practitioners, Alberta Medical Association, Alberta Pharmacists' Association), patient advocacy groups (i.e. Health Advisory Councils, Imagine Canada Network), and other referral and navigation tools (i.e. MyHealthAlberta, InformAlberta, 211, 311). The list of potential value-added relationships is extensive and plans to engage with these organizations should be included in AFAD's management's duties.

Risks

As this Plan was created, the following risks, and associated mitigation strategies, came forward.

The scale and complexity of Alberta's health system requires a purposeful design for a tool such as AFAD to work effectively. Notably, the supply side of primary care, namely family doctors, nurse practitioners and prescribing pharmacists, and in particular, their personal preferences, practice hours and practice locations are outside AFAD's control. The site will need a complex structure and process to accurately upload, list, and maintain all appropriate primary care providers.

> *Mitigation: Build a technical solution that can curate the supply side variabilities into a cohesive user interface.*

Tolerance for inaccurate and/or out-dated physician data by site owners compromises the integrity of the site, lowers the credibility of those affiliated with the site, invites criticism, and reduces the site's value with users.

> *Mitigation: Institute policies and website systems that strictly govern the upload and maintenance of user-data, clinic classifications, provider obligations, and visitor expectations.*

A site that attempts too much is at risk of failure. The site's owners may receive recommendations and pressures to ensure the site is "all things to all people" in primary health care. The broader the options on the site, the harder it will be to maintain data integrity and flexibility in response to visitors' expectations and technological advances.

> *Mitigation: Maintain the sites focus on primary care, specifically access and attachment.*

An independent, stand-alone provincial entity to operate the site will have start-up challenges, including recruiting and retaining effective leadership and staff, building HR, finance, and operational policy, for example.

> *Mitigation: Build from existing AFAD technology. Second current AFAD talent where possible. Leverage mature relationships with AFAD knowledge.*

Seeking too much personal data from site visitors for research and/or policy purposes may turn them away from the site, thereby eliminating the site's potential value.

> *Mitigation: Work to simplify the site's structure by keeping to its narrow focus on access and attachment. Always consider technical, administrative, and reputational risk when assessing the need for data. Consider a tiered approach to data collection where additional visitor information is captured (required) as the visitor pursues more supports through the site (i.e., self-serve to find a walk-in clinic v. booking a virtual care appointment).*

HIA compliance, particularly if user data is collected (i.e., PHN, health information, etc.)

> *Mitigation: Build AFAD in layers depending on users' needs. Refrain from collecting health information from users of self-serve functions and where possible, divert users who need to disclose such to others' sites (i.e., HealthLink) where secure medical record keeping is available. Design and build strict data control parameters into the website that conform to all privacy laws. Once operational, continually educate AFAD staff on privacy, conduct security audits of the system, and keep firewalls and other security systems current.*

Doctors or clinics that are selective about accepting patients (walk-in or attachment) and are "cherry picking" those considered less complicated are creating levels of preferred access to primary care. This is against the ethos of our publicly funded health system, which promises barrier free universal access and creates a risk of division amongst site users and a reputational risk in the public.

> *Mitigation:* Educate staff on what to do if they learn directly, or through a site user, that a provider may be 'cherry picking' (i.e., directing the user to contact the appropriate College).

Creating a province-wide, stand-alone website operation may create an isolated silo that is not fully engaged with family medicine, PCNs, and other integrated primary care providers and services.

> *Mitigation:* AH, AHS and PCNs should all be represented on the Board of Directors, along with *ex officio* representation from the senior staff who oversee program development and delivery. This form of governance will bring accountability for AFAD's structure, processes, and results.

Single site creates an "all eggs in one basket" situation, at risk should funding or health policy priorities change.

> *Mitigation: Establish aggressive build timeline for AFAD v2; build upon existing AFAD value, capture current positive momentum and policy priorities, and demonstrate enhanced value. The collaborative nature of its ownership should also help weather any policy changes.*

Bureaucratic burden could be layered on to operations by creating a new entity to build and operate the site.

> *Mitigation: Establish AFAD within the existing and well-understood primary care system. Mimic not-for-profit structures familiar to current stakeholders. If a new entity is not feasible, then expand or re-organize current organizational structures to include AFAD responsibility and accountability. The key is to have stand-alone and accountable operations that are sufficiently funded.*

Empowering Albertans to 'self-serve' their care respects that each Albertan is in charge of their health. In the process, it is recognized that some will seek the wrong care or care at the wrong time. Self-directed care decisions create risk of missed and/or inappropriate care.

> *Mitigation: Include medical oversight and content review as part of the governance and operations structure. Build collaborations and partnerships with qualified partners whose medical information and advice can be trusted. Accept some risk with respect to patient choice.*

Continuity of care may be lost if a patient receives care from too many providers during a series of episodic care visits. Frequent, single visit uses of the site by those who choose not to have a primary care provider, or cannot find a primary care provider, works against the ideal standard of continuity of care. This may be particularly risky for those people with chronic and/or complex health conditions.

> *Mitigation: Establish a follow-up or call-back procedure to proactively support individuals with frequent use of the site, who want to be attached, in an effort to directly assist them with finding a primary care provider.*

Expanding attachment to include access may discourage some from feeling the need to attach to a provider for an on-going relationship

> *Mitigation: Continue to provide education on the site that reinforces the importance of attachment and seek ways to promote this but accept that a small portion of the population is not, nor will ever be, interested in attachment.*

Example Budget & Resources

The creation of a stand-alone entity for AFAD will incur new start-up costs and increased operating expenses. What follows is an example budget *for preliminary discussions only*.

For context, the current site's 2023/24 budget is about $250K. This includes about $45K from the Calgary Zone Business Unit, and about $157K for Patient Attachment Assistants (2.5 FTE in Edmonton and a planned 0.6 FTE in Calgary).

These figures do not include the indirect expenses, in-kind contributions and 'off the sides of the desk' time and support provided to maintain and operate AFAD. While not an exhaustive list, the following are not included in the above funding:

- Project management, administration, evaluation, and IT support, provided by the Calgary and area PCN Zone Business Unit.
- Steering committee members' time in meetings and in implementing action items for the site's leadership and operations.
- Infrastructure (computers, office equipment, benefits, etc.) and oversight costs (management, performance management, payroll, hiring, etc.) of PCN and Business Unit staff supporting AFAD.
- The time required from 40 PCNs to update their clinic and workshop information.

Given AFAD is the most developed provincially shared service at this time, the assumption in developing this budget was that a new stand-alone organization would only encompass AFAD. As other primary care programs and services spread provincially and outgrow their PCN confines (such as the Red Deer PCN's successful Happiness Basics and Anxiety to Calm workshops and specialty inquiry supports such as Specialist Link in the Calgary Zone and ConnectMD in Edmonton Zone), the possibility would exist that they join this stand-alone organization. This would allow for cost efficiencies in shared costs in accounting, payroll, HR supports, oversight, communications, and so on.

The following assumptions are included in the proposed AFAD budget.

- AFAD becomes a stand-alone entity.
- This organization would run virtually with all staff working out of home offices from various locations around the province.
- Face to face staff meetings would be held quarterly.
- No costs are shared with any other provincial programs at this time, given AFAD is likely in the best position to be established first.
- Patient Attachment Assistants are included and are available for extended hours.
- Staff would be a mix of employees and contractors.
- The proposed resources are sufficient to ensure they have the capacity to call clinics directly to support the collection of current and accurate data, and to facilitate patient attachment on a case-by-case basis.
- Cost estimates are included for operational needs only, such as website hosting, maintenance, upgrades, software licenses for staff, and activity database development, for example.

The proposed budget does not include costs to overhaul the current site or to build a new website. These would be one-time costs emanating from a bid process involving multiple vendors and should be budgeted separately.

Staffing	$1,125 K	12 FT PAA, 1 administrative support, 1 executive director
Contracting	$175 K	IT, Communications, bookkeeping / accounting, and auditing
Office	$150 K	Phone, internet, quarterly face to face meetings with staff, marketing materials, home office expenses, etc.
Website and IT	$200 K	Hosting, Google map costs, licencing, modifications, payroll etc.
	$1,650 K	**Estimated Annual Operating Costs**

Defining Success in 2026

A theoretical vision is one thing. Practical reality is another. AFAD will need to develop a full evaluation framework with metrics, and then gather and analyse all the appropriate data to know if it is moving towards its desired future state.

This Plan focuses on the success metrics only; the tangible outcomes that would demonstrate that the strategic plan has been successfully implemented. Note that this list is not exhaustive.

Objective	**Tangible Outcomes Achieved**
1. Become the trusted resource to seek out a primary care provider in Alberta	• Formal links established with AH / AHS / related Colleges • Improved education on the site to explain the number of providers, resulting in less user frustration and fewer complaints • Focus of the site narrowed to only include primary care providers for comprehensive care; no longer limited to just PCN members • New classification added that details access options throughout the province (walk in clinics, after hour clinics, ERs, prescribing pharmacists) • Data accuracy has significantly improved (information verified more consistently, user can tell when last updated, ability to report a problem) • Dashboard metrics available for users to view • Name change incorporated; marketing materials available and posted in all after hours clinics and all AHS urgent care and ER sites
2. Be a true patients' first website	• Site is more accessible for vulnerable populations (more inclusive language, lower literacy level, ability to translate into different languages, explanations on how the health system works, separate page of options specific to Indigenous peoples) • Chat box functionality, 1.800 number, and the ability to connect via email / phone / Zoom with someone directly for additional help all added; staffing aligns with website usage and demand
3. Become sustainable and built to evolve with changes to the health system	• AFAD has become a stand-along organization, funded directly • New governance structure ensures key players (AH, AHS and PCNs) are all appropriately represented and have clear roles and responsibilities • Funding is sufficient to ensure Patient Attachment Assistant staffing levels are appropriate to keep up with demand • Website modifications made in 2023 with a new build completed thereafter; using new technology (artificial intelligence) as it makes sense and positively supports users
4. Be the model for health system collaboration	• Enhanced relationships with providers, key stakeholders, and advisors • Publications and positive media coverage on the success of AFAD • Other provinces and countries reach out to find out more about how AFAD has achieved its success

Beyond 2026

This Plan started with a vision of what is possible within the next three years to 2026; it ends with looking well beyond that.

One of the interviewees mused about why it is so hard to find and book an appointment with a primary care provider when it is possible to choose a city nearly anywhere in the world and book a flight to get there, arrange for a hotel, and make a dinner reservation for the first night there, all within a few minutes.

If banking, which for many is as confidential and safely guarded as personal health care information, can be integrated, automated and so securely accessed over the internet to the point many now take it for granted, surely the way we access the healthcare system can be changed for the better.

Our health care system needs to meet the needs of its users, in a way that matters to them. Like our interviewee above, many talked about the desire for a more seamless future state of possibility, particularly our youngest interviewees.

Our youth do not understand why it is not possible now to find a provider, link to their clinic and book an appointment, all within less than five minutes and not needing to call, wait, or talk to anyone. Others, not unreasonably, wanted third next available (TNA) statistics and/or wait time data for each provider / clinic available, so users could better understand the options available even before they connect to make an appointment.

The coronavirus pandemic proved that healthcare could make wide scale change; the acceptance and convenience of virtual appointments alone proves that. More can, and should, be done and healthcare providers and administrators need to be preparing for that or face being left behind, like the video-store rentals, point and shoot cameras, and the record business.

This is not a question of "if" but "when".

Alberta Find a Doctor needs to be prepared and ready to embrace it when it arrives. It should leverage its use of technology along with its collaborative approach to be a national, even international, example of what is possible when providing patient access and attachment to primary care services.

AFAD can, and should, be a leader in connecting Albertans to primary care.

Appendix I - List of Interview Participants

Ayre-Jaschke, Leslie, Imagine Citizen Network, Director

Bahler, Brad, Dr., Alberta Medical Association, Accelerating Change Transformation Change (ACTT) Medical Director, Family Physician

Bandaru, Chaitanya, Lakeland PCN, Executive Director

Beckles, Paula, Edmonton Zone PCN, Alberta Find a Doctor, Patient Attachment Assistant

Berg, Shannon, Alberta Health, Primary and Community Health Branch, Executive Director

Birdsell, Judy, Imagine Citizen Network, Board Chair

Bradford, Keith, Calgary Zone PCNs, Director of Communications; Alberta Find a Doctor, Project Manager

Breton, Mylaine, Dr., Université de Sherbrooke, Professor and Researcher

Chambers, Patricia, AHS, HealthLink, Senior Director with Virtual Care, Access and Navigation

Chee, Elizabeth, Alberta Health, Health Workforce Partnerships Branch, Executive Director

Craig, Jason, Ballard Power, Senior Engineer

DeChamplain, Edna, Edmonton Southside PCN, Central Office Administrative Lead

Dowhy, Judd, North Zone PCNs, Communications Lead

Ewanicke, Yvonne, AHS, HealthLink, Provincial Director for 811

Fakuade, Oyinkansola (Inka), Alberta Health, Primary and Community Health Branch, Manager

Fielding, Sheri, Nurse Practitioner

Garland, Andrea, College of Physician and Surgeons of Alberta, Acting Director Communications

Gill, Amrit, Edmonton Zone PCN, Alberta Find a Doctor, Patient Attachment Assistant

Greyvenstein, Ernst, Dr., Calgary Zone PCNs, Physician Lead and Executive Sponsor, Family Physician

Guenter, Tim, Alberta Medical Association, Accelerating Change Transformation Change (ACTT) Consultant

Hansen, Brian, Calgary Zone PCN, Evaluation Lead

Ho, Kevin, Calgary Zone PCNs, Senior Consultant

Humphreys, Linda, Prairie Mountain Health Advisory Council, Chair

Hundal, Vishav, Edmonton Zone PCN, Alberta Find a Doctor, Patient Attachment Assistant

Huynh, Vinh, South Calgary PCN, IT Manager

Jennings, Jake, Calgary Foothills PCN, Executive Director

Jess, Ed, College of Physician and Surgeons of Alberta, Chief Innovation Officer

Johnson, Angela, Alberta Medical Association, Accelerating Change Transformation Change (ACTT) Director

Kennedy, Andrew, AHS, Senior Consultant (Governance)

Klassen, Treena, Palliser PCN, Executive Director

Leisen, Bruce, College of Physician and Surgeons of Alberta, Director Registration and Physician Health Monitoring

Letwin, Nadine, Dr., EZ PCN, Physician Lead Executive, Family Physician

Luelo, Christine, Dr., Calgary Zone PCN, Medical Lead, Family Physician

McCallum, Genevieve, McMaster University, Medical Student

McRee, Nadine, AHS, Indigenous Wellness Core, Director

Milkovich, Lorna, Red Deer PCN, Executive Director, Alberta Find a Doctor, Steering Committee Co-Chair

Osbaldeston, Kristine, Edmonton Zone PCNs, Project Manager; Alberta Find a Doctor, Steering Committee Co-Chair

Potter, Terri, Alberta College of Family Physicians, Executive Director

Prendergast, Susan, Nurse Practitioner Association of Alberta, President

Regehr, Sonya, Alberta Indigenous Virtual Care Clinic, Medical Director, Family Physician

Rinaldi, Fredrykka, Dr., AMA President, Family Physician

Scrimshaw, Cathy, Dr., South Zone PCN, Family Physician and many other places

Sheppard, Linda, Imagine Citizen Network, Member

Skrypnyk, Rob, Alberta Health, Executive Lead, Primary Health Care Modernization

Stolee, Barb, Imagine Citizen Network, Member

Strilchuk, Stacey, College of Physician and Surgeons of Alberta, President

Thesenvitz, Jodi, Central Zone PCN, Operations Lead; South Zone PCN, Project Manager

Tinnis, Candra, Leduc Beaumont Devon PCN, Communications Director

van Walsum, Morghan, Queen's University, Student

Walbridge, Judy, Prairie Mountain Health Advisory Council, Vice-Chair

Williams, Kienan, AHS, Indigenous Wellness Core, Program Lead

Appendix II – List of Publications Reviewed

Sorted by year of publication

Kraschnewski JL., Gabbay RA. Role of Health Information Technologies in the Patient-Centered Medical Home, J Diabetes Sci Technol 2013;7(5):1376–1385

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