Health Reform Observer - Observatoire des Réformes de Santé

Volume 10 | Issue 1 | Article 2

Implementing Primary Health Care Teams and Integrated Care in Alberta, Canada

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1 April 2022

A Provincial/Territorial Health Reform Analysis

Recommended Citation: Montesanti S, Pritchard C, Green LA, Berg S, Mallinson S, Birdsell J. 2022. Implementing Primary Health Care Teams and Integrated Care in Alberta, Canada. *Health Reform Observer - Observatoire des Réformes de Santé* 10 (1): Article 2. DOI: https://doi.org/10.13162/hro-ors.v10i1.4680

Abstract

Improving health services integration for persons living with complex health and social needs is a priority for Canadian health systems. Alberta's approach to promoting and incentivizing interprofessional team-based primary health care (PHC) has focused on creating a universal system of networks of family physician clinics or Primary Care Networks (PCNs). First implemented in 2003, PCNs aimed to improve access and quality of interdisciplinary care using PHC teams. While an interprofessional PHC team approach is considered a basic tenet of health services integration, several barriers to implementing team-based care have been identified in Alberta, such as physician and PCN funding models, lack of integrated electronic medical records (EMRs), and lack of standardized evaluation. Strategies for implementing team-based PHC policies include building on existing structures, gaining buy-in from frontline clinicians, and enabling providers to work at their full scope of practice. PCNs can improve how they provide team-based care by focusing on patient-centred care and streamlining EMRs. Further research is needed to determine optimal approaches for evaluation and performance measurement to facilitate quality improvement at the clinical level and improve performance at the system level.

L'amélioration de l'intégration des services de santé pour les personnes vivant avec des besoins sanitaires et sociaux complexes est une priorité pour les systèmes de santé canadiens. L'approche adoptée par l'Alberta pour promouvoir et encourager les soins de santé primaires (SSP) fondés sur des équipes interprofessionnelles s'est concentrée sur la création d'un système universel de réseaux de cliniques de médecins de famille ou réseaux de soins primaires (RSP). Etablis en 2003, les RSP visaient à améliorer l'accès et la qualité des soins interdisciplinaires par le biais d'équipes de soins primaires. Bien que l'approche interprofessionnelle des équipes de SSP soit considérée comme un principe de base de l'intégration des services de santé, plusieurs obstacles à la mise en œuvre ont été identifiés en Alberta, tels que les modèles de financement des médecins et des RSP, l'absence de dossiers médicaux électroniques intégrés et le manque d'évaluation normalisée. Les stratégies de mise en œuvre des politiques de soins primaires axés sur le travail d'équipe consistent à s'appuyer sur les structures existantes, à obtenir l'adhésion des cliniciens et à permettre aux cliniciens de travailler dans toute l'étendue de leur pratique. Les RSP peuvent améliorer la façon dont ils fournissent des soins en équipe en se concentrant sur les soins centrés sur le patient et en implantant les dossiers médicaux électroniques. Des recherches supplémentaires sont nécessaires pour déterminer les approches optimales d'évaluation et les mesures de performances afin de faciliter l'amélioration de la qualité au niveau clinique et d'améliorer les performances au niveau du système.

Key Messages

- The implementation of Primary Care Networks (PCNs) has been the main facilitator of team-based primary health care in Alberta.
- The 'four-cut' funding model for PCNs, however, has been identified as a major barrier to interdisciplinary care as it can lead to physician gatekeeping while the fee-for-service model can disincentivize physicians from participating in interdisciplinary teams.
- Improving communication between providers using a central Electronic Medical Record (EMR) is an important step towards integrated care and improved transitions.

Messages-clés

- *La mise en œuvre des réseaux de soins primaires (RSP) a été le principal facilitateur des soins de santé primaires en équipe en Alberta.*
- *Toutefois, le modèle de financement à quatre volets des RSP a été identifié comme un obstacle majeur aux soins interdisciplinaires, car il peut mener à un contrôle des médecins, tandis que le modèle de rémunération à l'acte peut dissuader les médecins de participer à des équipes interdisciplinaires.*
- *L'amélioration de la communication entre les prestataires à l'aide d'un dossier médical électronique (DME) central constitue une étape importante vers l'intégration des soins et l'amélioration des transitions.*

Acknowledgement: The authors thank Ashmita Rai for illustrating the Alberta PHC timeline. The study was supported by a grant from the Canadian Institutes of Health Research (#402872).

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Health services integration to address health and social needs is a priority for Alberta. Integration of services can be achieved through primary health care (PHC) teams. Primary Care Networks (PCNs) are the main model used in Alberta to promote and incentivize team-based PHC. PCNs are voluntary organizations to which physician practices belong. They are geographically based and provide PHC team support, as well as quality improvement and change management expertise to practices. Team composition and the structure of PCNs varies across the province, with one clinic comprised of physicians and other health professionals, or several clinics within a specific geography and comprised of many physicians and other health professionals (Alberta Health 2016). Non-physician team members can include pharmacists, social workers, psychologists, dietitians, chronic disease management nurses, and others. Some PCNs hire team members and place them in practices, or some have a central location for the team members and practices where patients are referred. Additionally, some PCNs incorporate mixed team-based models.

2 HISTORY AND CONTEXT

2.1 The PHC health reform agenda in Canada and Alberta

The establishment of interprofessional PHC teams was an objective of Canadian national reform in the early 2000s (Kirby 2002; Hutchinson et al. 2011). The goal of transitioning to an interprofessional PHC model was motivated by health system pressures, including increased focus on chronic disease management and preventative care, rising health care expenditures, and physician shortages (Haj-Ali et al. 2020). PHC pilot projects in Alberta between the years 2002-2006 supported team-based care practices through the Capacity Building Fund (CBF) (Health Canada 2007). The CBF supported education and training strategies for health care professionals to develop care teams and support culture change towards multidisciplinary practice. Through these projects, team members were able to get to know each other, explore ways in which they might collaborate, and build trusting relationships. While this did not necessarily lead to standardization of service delivery, it did allow for interprofessional barriers to be broken down. Figure 1 on the next page presents a timeline of key reforms and legislation in the evolution of PHC team-based care in Alberta over the past two decades.

2.2 The creation of PCNs in Alberta

In 2003, drawing on the Federal Primary Health Care Transition Fund (PHCTF) mandate, the PCNs were created through a collaborative agreement between Alberta Health, the Alberta Medical Association, and the regional health authorities (which were eventually

Figure 1: The evolution of PHC team-based care in Alberta

merged into Alberta Health Services (AHS)). The three parties signed an 8-yr (2003–2011) Trilateral Master Agreement to support Local Primary Care Initiatives. Alberta Health allocated funding to PCNs based on patient enrolment, with the expectation that funds would be used to build teams (Spenceley et al. 2013). Today, Alberta has 41 PCNs serving

close to 3.8 million residents (Alberta Health n.d.).

Initially Alberta's approach to delivering team-based PHC services existed without an overarching provincial vision or strategy—this period from 2003-2012 has been coined the 'Frontier Era' per Leslie et al. (2020). The Auditor General of Alberta's 2012 report on PCNs influenced the shift to the 'Era of Accountability' beginning in 2013. Also in 2013, the Alberta Health Primary Health Care Evaluation Framework, which outlined possible evaluation methods and standards, was created for Alberta's PCN program. It was not until 2014 that Alberta introduced their *Primary Health Care Strategy* to frame PHC reform in the province (Alberta Health 2014). The *Primary Care Network Governance Framework* was introduced in 2017 to improve integration of services between PCN services, AHS programs, and services provided by community-based organizations, and to increase alignment between primary and community services across the PCN zones (Alberta Health 2017).

Provincial PCN funding is based on the number of physician encounters with Albertans, using the 'four-cut method,' which is a way of assigning patients to one PHC provider (Alberta Health 2016). All PCN patients who have visited a physician (or nurse practitioner in select circumstances) are assigned to a patient list for that PHC provider. This funding method's focus on physician encounters inadvertently leads to physician gatekeeping (physician encounters drive funding). Even if the appropriate team member was a nurse or mental health therapist, patients are often required to see the physician first.

3 GOALS OF PHC REFORM AND THE SHIFT TOWARDS TEAM-BASED PHC

An explicit aim of PCNs was to improve access to and quality of interdisciplinary PHC using interprofessional PHC teams. Improved coordination, integration, and safe care transitions were integral for successful PCN implementation and continual improvement of PCN function. Explicit goals for team-based care also included all team members working at their optimal scope of practice and a focus on patient-centred care. Implicit goals were to decrease wait-times, reduce emergency room visits and control health care expenditures, while delivering increased value through a stronger focus on chronic disease management and preventative care (Alberta Health 2014).

4 FACTORS THAT INFLUENCED HOW AND WHY TEAM-BASED PHC MODELS WERE IMPLEMENTED

We identified a number of these factors in a recent (Lukey et al. 2021) in-depth policy analysis on integration of health services for patients with complex needs through PHC teams in which we reviewed 18 publicly available provincial policy documents published from 2009 to 2018 (see Appendix 1 for a list of these documents). The goal of the analysis was

to ascertain how macro and meso policies, structures, roles, governance and performance measures support or act as barriers to integrated service delivery through PHC team-based care for complex patients. As not all policies have equal influence, the scope of our analysis was to include formal policies—those enacted or sponsored by the provincial government or regional organizations—in order to focus on documents with enforceable mandates (see Appendix 2 for our inclusion and exclusion criteria). As a history of the PCN implementation process in Alberta has been published elsewhere (Leslie et al. 2020), we examine the formal provincial policy frameworks supporting PCNs and not the context of their implementation. Both an analysis of the broad implementation context and the formal policies that directed the formation and governance of PCNs are needed to understand how the PCNs in Alberta have come to be and the policy lessons for other provincial governments and health authorities wanting to pursue similar policy goals of integrated health services delivery through interprofessional PHC teams.

Many of the policy documents outlined strategic direction, primarily aimed at PCNs, for implementing interprofessional PHC teams, along with current challenges. Policy documents were identified by provincial policy and decision-makers on our team and via Advanced Google searches. Search terms included: ‘primary health care’ OR ‘primary care’ AND ‘Alberta’ AND ‘team’ OR ‘integrat*’ OR ‘complex patient*’ OR ‘patient engagement.’ A detailed description of the methods is published in another paper describing the findings from a cross-case policy analysis of four Canadian provinces that examined policy on interprofessional PHC teams and integrated health service delivery (Lukey et al. 2021)

Our policy document analysis highlighted that physicians in Alberta supported a shift towards a well-integrated team-based model of PHC. While an interprofessional team approach is considered a basic tenet of integration, barriers to implementing team-based care have been identified in Alberta, such as physician and PCN funding models, lack of integrated Electronic Medical Records (EMRs), and lack of standardized evaluation (Alberta Health 2014; Alberta Health 2016; Auditor General of Alberta 2017). In the 2016 *Primary Care Networks Review*, PCNs gave feedback that physician compensation funding models needed to be updated from fee-for-service to community or activity-funding to allow physicians to promote more community-based program development, leading to increased primary care access (Alberta Health 2016). This is in alignment with the kind of care that primary care physicians want to provide for patients they serve. Since physicians are heavily involved in PCNs through their joint governance with AHS, and often make up 50% of decision-making boards, support from this group of providers is key (Alberta Health 2016). The policy reports showed that physicians were convinced of the value of team-based care.

However, a major challenge outlined in implementation of PCNs was achieving the recommended interprofessional team ratio (Alberta Health 2016; Auditor General of Alberta 2017). The Auditor General’s *Better Healthcare for Albertans* identified fee-for-service physician funding model as a disincentive for physicians to participate in interdisciplinary teams, because other providers are salaried (Auditor General of Alberta 2017). The same report made arguments in favour of moving away from funding models based on quantity

or interactions to a model that incentivized results (Auditor General of Alberta 2017). This type of funding model would encourage providers to focus on preventative care, which is in alignment with providers' expressed priorities and recommendations from the Auditor General of Alberta (2017). More specific to PCNs, documents critiqued the 'four-cut' method with funding based on physician encounters for not aligning with needs for sustainable programming, nor adequately addressing complex treatments or programs in the *Primary Care Initiative Policy Manual* and the *Alberta Health Primary Care Networks Review* (Alberta Health 2016; Alberta Health 2018).

5 HOW THE REFORM WAS ACHIEVED

Strategy for implementation of these team-based PHC policies in Alberta included building on existing structures and gaining buy-in from frontline clinicians (Alberta Health 2016; Auditor General of Alberta 2017). Key to successful interprofessional collaboration was facilitating health care providers' ability to work to their optimal scope of practice. Alberta Health's *Business Plan 2018-2021* described implementing strategies that promote interprofessional collaboration and enable providers to work at their full scope (Alberta Health 2018). For instance, the Auditor General of Alberta (2014) recommended a ratio of three to four non-physicians to every physician provider, a goal that several policy documents echoed, including *Better Healthcare for Albertans: A Report by the Office of the Auditor General of Alberta* and *Alberta Health Primary Care Networks Review* (Alberta Health 2016; Auditor General of Alberta 2017).

In *Alberta's Primary Health Care Strategy*, the guidelines for PCN governance structure were flexible, and varied across PCNs (Alberta Health 2014). While this flexibility allowed physicians to focus more on local solutions to local problems (Leslie et al. 2020), this structural heterogeneity reflected significant variations in the way PCNs innovated their practice and approached issues of access, continuity of care, interdisciplinary team-based care, and health and social services integration. PCNs adopted an innovative structure providing additional features to traditional family physician office services by shifting priority of care to a preventative and outcome-based model, as well as often adopting a team-based structure of care, through either centralized or decentralized services (Alberta Health 2016).

6 EVALUATION AND PERFORMANCE MONITORING

The present 'Era of Accountability' placed demands for standardized measures. *Better Healthcare for Albertans: A Report by the Office of the Auditor General of Alberta* recommended that physicians be compensated for reporting performance measures that would verify adherence to professional guidelines (Auditor General of Alberta 2017). The same report found a lack of identification and implementation of best practices for evaluation frameworks in PCNs. Additionally, the variability of PCN programs adapted to the needs

of their community made comparisons between PCNs more difficult (Alberta Health 2016). Future research is needed to identify how to best evaluate PCNs, in order to understand how to effectively assess performance.

Where appropriate, policy documents evaluated past interventions and made predictions about how changes would impact current practice. *The Primary Care Initiative [PCI] Evaluation Summary Report* found a general lack in consistency in reporting requirements and formats of expected outcomes (Alberta Health 2011). This made comparisons between networks challenging and resulted in the lack of full cost-benefit analysis, which could have been useful for future decisions and decision-makers (Alberta Health 2011). Heavy reporting requirements also increased the workload of providers; for instance, the *PCI Evaluation Summary Report* found reporting templates had inconsistencies in level of detail and definitions and contained little information on relevant outcomes (Alberta Health 2011). This was a barrier to buy-in, as many providers were already navigating highly challenging workloads (Alberta Health 2011). The report also found that program evaluation budgets remained low over time, indicating limits of PCNs' ability to self-assess program effectiveness (Alberta Health 2011).

The *PCI Evaluation Summary Report* also found that the timing of evaluations could complicate evaluations (Alberta Health 2011). Many evaluations were completed just a single year after the clinical roll out, arguably not enough time for a clinic to show full operability and potential for improvement (Alberta Health 2011). Lack of a consistent timeframe and format of administrative data also impacted reporting and subsequent evaluation (Alberta Health 2011). The *Alberta Health Primary Care Networks Review* called for better short- and medium-term indicators to measure population health outcomes (Alberta Health 2016). In response to recommendations by the Auditor General of Alberta (2012), the Alberta Health Primary Health Care Evaluation Framework, which outlined possible evaluation methods and standards, was created for Alberta's PCN program (Alberta Health 2013).

Involving patients in the evaluation of team-based PHC was also recognized as important for achieving a more patient-centred and integrated system (Alberta Health Services 2015). PCN review documents recommended advancing health services research to allow for more evidence-based funding decisions (Alberta Health Services 2010; 2018).

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

This SWOT analysis is based on our analysis of the policies underpinning PCN implementation in Alberta. We summarize the strengths and weaknesses of PCNs in advancing interprofessional team-based PHC, what opportunities exist, and what threats to team-based PHC remain.

There is evidence that PCNs lead to improvements in care for patients, including reduc-

tion in wait times for care, and increased patient access to—and awareness of—after-hours alternatives to the emergency department. Our policy analysis also pointed to PCNs having capacity to provide programs beyond what family physicians traditionally offer alone. These are both areas of strength.

PCNs' support for interprofessional team-based models of care is an additional area of strength but we also identified some areas of weakness that have impacted their implementation and progress. One weakness is the lack of an integrated EMR in primary care clinics and PCNs in Alberta. Good communication is an important facilitator of safe care transitions but using different EMR solutions can be a threat to timely transitions between different care providers and specialists. An additional weakness identified in the policy review, and highlighted above, is the variable composition of interprofessional teams in the PCN context. Albertan PCNs do not have clear guidance on team composition and many PCNs were not achieving the recommended interprofessional team ratio of three to four non-physicians to every physician provider.

As noted above, limited evaluation of PCN performance and impact is another weakness identified by the policy analysis. Without established performance indicators the evidence to support PCN improvement is lacking. While it is a strength for PCNs to be flexible and have the capacity to respond to the needs of their geographic population, inconsistencies in governance structure make it difficult to conduct standardized evaluations. A lack of standardized performance measures also contributes to this difficulty.

In terms of threats to the PCN model, physician remuneration remains a challenge for PCNs moving towards integrated team-based care. The policy documents noted that 'four-cut' funding method can lead to physician gatekeeping and the fee-for-service model disincentivize physicians from participating in interdisciplinary teams.

Opportunities for PCNs to improve how they provide care include moving towards patient-centred care and streamlining EMRs. Many Albertan physicians already use EMRs, so the need is to work towards consistency amongst vendors in order to allow for integrated EMRs that better facilitate information sharing. Lastly, telehealth was identified in policy documents as a possible opportunity to support more integrated care and communication, but further research on its use in PCNs in required.

Table 1: SWOT analysis of policies underpinning PCN implementation in Alberta

Strengths	Weaknesses
• Reduction in wait times and increased patient access to and awareness of after-hours alternatives to the emergency department. • Provision of PCN programs such as chronic disease management support, complex care programming, diet and nutritional support and harm reduction service planning beyond those traditionally offered by physicians. • Support team-based care. • Flexible to the needs of their geographic populations.	• Lack of integrated EMRs. • Not achieving the recommended interprofessional team ratio. • Lack of clarity regarding ideal composition; ideal varies depending on population's needs. • Lack of evaluation.
Opportunities	**Threats**
• Greater inclusion of patients in decision-making as move towards patient-centred care. • 85% of Alberta physicians already use EMR—12% higher than national average; working towards consistency across EMR vendors. • Telehealth.	• Inconsistencies in governance practice. • Need improved care transitions; improved communication between providers and specialists for timely access to specialist care. • Lack of established performance measures. • Physician funding models.

8 CONCLUSION

Policy at a provincial level may facilitate the necessary environment for interprofessional PHC teams to function through governance direction and funding incentives. Further research is needed to determine optimal approaches for evaluation and performance measurement to facilitate quality improvement at the clinical level and improve performance at the system level. Moreover, further consideration is needed on how population needs may be assessed to determine interprofessional team composition to ensure needs are being met for better integrated care.

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10 APPENDIX 1: Policy Documents Examined

Title: *Alberta Provincial Health Business Plan 2018-2021*
Year: 2018-2021
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, Alberta Health Services (AHS), Health Quality Council of Alberta (HQCA)
Type of policy document: Financial plan

Title: *Primary Care Initiative Policy Manual*
Year: 2018
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, AHS, Alberta Medical Association (AMA)
Type of policy document: Operational direction

Title: *Primary Health Care Integration Network Transformational Road Map 2018-21*
Year: 2018-2021
Publishing organization: AHS
Authoring organization(s): AHS
Type of policy document: Strategic direction

Title: *The 2017-2020 Health Plan & Business Plan: Year 2*
Year: 2018-2019
Publishing organization: AHS
Authoring organization(s): AHS
Type of policy document: Strategic direction

Title: *Valuing Mental Health: Next Steps*
Year: 2017
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, Ministry of Health, AHS, Mental health stakeholders
Type of policy document: Strategic direction

Title: *Primary Care Networks Governance Framework*
Year: 2017
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, PCN physician leads, AHS, AMA
Type of policy document: Management

Title: *Better Healthcare for Albertans: A Report by the Office of the Auditor General of Alberta*
Year: 2017
Publishing organization: Auditor General of Alberta
Authoring organization(s): Auditor General of Alberta
Type of policy document: Evaluation

Title: *Alberta Health Primary Care Networks Review*
Year: 2016
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health
Type of policy document: Evaluation

Title: *The Patient First Strategy*
Year: 2015
Publishing organization: AHS
Authoring organization(s): AHS
Type of policy document: Strategic direction

Title: *Alberta's Primary Health Care Strategy 2014*
Year: 2014
Publishing organization: Alberta Health
Authoring organization(s): Minister's Advisory Committee, Professional Associations
Type of policy document: Strategic direction

Title: *Continuing Care Quality Management Framework*
Year: 2014
Publishing organization: AHS
Authoring organization(s): AHS, HQCA
Type of policy document: Management

Title: *PCN Evolution Vision and Framework*
Year: 2013
Publishing organization: AHS Alberta Medical Association Primary Care Alliance Board
Authoring organization(s): Alberta Health, AHS, AMA, Alberta College of Family Physicians, Physician leaders
Type of policy document: Advocacy

Title: *Health Business Plan 2013-16*
Year: 2013-2016
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, AHS, HQCA
Type of policy document: Financial plan

Title: *Alberta Health Primary Health Care Evaluation Framework*
Year: 2013
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health
Type of policy document: Evaluation Plan

Title: *Primary Care Initiative (PCI) Evaluation Summary Report*
Year: 2011
Publishing organization: Alberta Health
Authoring organization(s): Alberta Health, AHS, AMA
Type of policy document: Evaluation

Title: *2010-2015 Health Plan Improving Health for All Albertans*
Year: 2010-2015
Publishing organization: AHS
Authoring organization(s): AHS
Type of policy document: Strategic direction

Title: *Alberta Health Services Strategic Direction 2009-2012*
Year: 2009-2012
Publishing organization: AHS
Authoring organization(s): AHS
Type of policy document: Strategic direction

11 APPENDIX 2: Inclusion and Exclusion Criteria for Policy Document Analysis

Inclusion	Exclusion
• Primary health care (inclusive of preventive care) • Primary care (considering community-based care) • Integration (e.g., integrated health systems, integrated service delivery, coordination of care) • Patients with complex needs (two or more co-morbidities, consider multi-morbidity and recognizing vulnerability or social determinants such as low-income or homeless) • Patient engagement (specifically related to policy and teams) • Team-based care	• Children/youth population • Ambulatory care, specialty care