other programs and service sectors of AHS, with the aim of improving overall population health. In addition, both the provincial and zone level divisions develop annual operating plans that integrate with the AHS Health and Business Plan priorities.

With regard to dental health services strategic planning, a revised version of the provincial Oral Health Action Plan (OHAP) was launched by AHS in 2016. The current OHAP 2016 document includes updated initiatives and objectives to meet population needs and ensures sustainability of initiatives already implemented.

The OHAP recommends standardized, evidence-based prevention and treatment services for children, seniors, and low income individuals across the province to address oral health inequities. The plan focuses on a comprehensive population health approach with special attention to groups of the population that are more vulnerable. The 2016 OHAP can be found at: https://www.albertahealthservices.ca/assets/info/oh/if-oh-action-plan.pdf

Provincial publicly-funded dental health services are delivered by AHS' dental health outreach program. The program provides free dental prevention and treatment services to school-aged and vulnerable Albertans and contributes to AHS' goal of improved patient and population health outcomes outlined in its 2017-2020 business plan.

11. What is being done specifically with respect to investment in prevention?

Population and public health interventions are our best defence against disease, illness and injury. Investing in health promotion and illness/injury prevention can reduce the amount we spend on treating diseases and managing illnesses in the future.

The Ministry of Health invested $650 million in population and public health in 2017/2018 and $668 million is budgeted for 2018/2019. Alberta Health invested in a variety of prevention programs including $56 million to address the opioid crisis, $9.6 million in cancer prevention, $6 million in grant funding to community organizations, and $59.5 million towards the provincial immunization program. Key highlights include:

- The government response to the current opioid crisis in Alberta is focused on key priority areas of prevention and harm reduction, as well as treatment. Investments included establishing supervised consumptions services, to reduce overdoses and deaths and also help prevent HIV, hepatitis C and bacterial infections.
- Alberta Health also funded the Alberta Community Council on HIV, Boyle Street Services Society, and Calgary Sexual Health Centre to support health promotion, and harm reduction activities to indigenous population, LGBTQ2S, and youth.
- In 2017/18, our investments in cancer prevention and screening projects served more than 100,000 Albertans and 12,000 indigenous Albertans. These projects are funded by the Alberta Cancer Prevention Legacy Fund.
- The Communities ChooseWell (CCW) initiative strengthens community action by promoting healthy living and wellness as a pathway to disease prevention. In 2017/18 CCW supported an active network of 250 communities.
- Ever Active Schools and the Alberta Healthy School Community Wellness Fund supports Alberta schools in implementing a comprehensive school health approach. These initiatives have funded 2200 schools in Alberta in 61 school districts.

- The Injury Prevention Centre (IPC) equips communities with the skills and knowledge to reduce their risk of injury. Preventable injuries are a leading cause of injury and death in Alberta.
- In 2017/18, the Early Hearing Detection and Intervention Program (EHDI) newborn hearing screening was fully implemented in all Neonatal Intensive Care Units. It is anticipated to be in place for all eligible infants by October 2018.
- Alberta has one of the most comprehensive immunization programs in the country and invests $56 million on the procurement of vaccines annually.

12. Is there a population health plan available for the last 10 years?

Over the last 10 years, Alberta Health has looked at a multitude of factors (social, physical and economic environments and conditions that lie outside an individual's control), in the prevention of illness and injury, promoting wellness and caring for people in their communities. This approach is used when developing policies, strategies and actions to reduce barriers and improve supports for people to achieve their full health potential. This approach uses a variety of strategies and settings (including community, school, and workplace) to address the root causes of health in collaboration with those outside the health sector. (http://www.health.alberta.ca/initiatives/vision-2020.html)

Alberta Health and AHS have worked together to ensure a stronger, more integrated, province wide, sustainable health care system. An action plan aimed at improving health outcomes, health quality and length of life, particularly for the most vulnerable people in our province has been developed. (http://www.health.alberta.ca/initiatives/5-year-health-action-plan.html)

In 2014, a framework to support the health and wellness of Albertans by addressing the risk factors and determinants of health that contribute to the incidence and prevalence of injuries and diseases was created.
(https://open.alberta.ca/dataset/9781460108659/resource/937b3839-be43-49d8-a2ce-4e1566b62534)

13. What is being done in emergency rooms to reduce the time spent by Emergency Medical Services staff waiting to transfer patients from the ambulance stretcher to a hospital stretcher?

Emergency Medical Services (EMS)/Emergency Department (ED) 90/90 initiatives were implemented provincially in 2015 and are designed to result in ambulances and crews returning to the community from Emergency Departments in 90 minutes of arriving, 90 percent of the time. The 90/90 initiatives are among many quality improvement initiatives underway across AHS targeted at improving transfer of patient care through community and acute care services.

Since 2015/16, over 200 initiatives across community, acute, EMS and continuing care services have been trialed or implemented to improve patient flow. Overcapacity protocols, 90/90, and most recently, Enhancing Care in the Community are among the larger province-wide initiatives targeted at improving flow across the system. Other recent and key initiatives

have been focused on enhancing care in the community and on facilitating immediate transfer of care from EMS to ED staff.

Early results of enhancing care in the community are positive. The number of inpatients assessed and waiting for continuing care placement has decreased from 896 at the end of Q2 to 766 at the end of Q3 (14.5% lower) for 2017-18. The number of unique home care clients has grown to 106,887, compared to 104,907 clients for the same Q3 period last year. The proportion of clients placed in continuing care living options from community settings (rather than from acute care) has increased from 32.2% to 33.8% in Q3 of 2017/18.

Other EMS Initiatives:

- Community Paramedic teams
- City Centre teams
- Crisis Response teams
- Community Health and Pre-Hospital Support Program
- Community based palliative and end-of-life care support
- Assess, Treat and Refer Program
- Transport to Urgent Care Centres

EMS Results:

- Avoidance of 5,862 events in Calgary; and 5,185 in Edmonton (Provincial total: 11,047)
- An estimated 80% of Community Paramedic (CP) events prevent an EMS and ED admission.
- Provincially 8,837 beds saved in 2017
- 35,348 hours of released ED time (based on an average of four hours per ED admission)
- Over $9.7M in cost avoidances, based on an estimated cost difference between a CP visit and EMS/ED admission

14. Has AHS completed a staff satisfaction survey since 2014 and how have staff attitudes, work conditions, and environment improved?

AHS measures staff satisfaction using workforce engagement surveys, which include employees, volunteers, and physicians. In October 2016, the most recent engagement survey was conducted.

Engagement Survey:

- The October 2016 engagement survey was the first using a new vendor, Gallup, after AHS' contract with the previous survey company had expired. As such, the new methodology for defining and measuring engagement is different from the previous vendor and the 2016 survey results are not comparable to results from previous years.

Engagement Survey Participation Rates		
	2014	**2016 (% change)**
Employees	35%	41.9% (+6.9%)
Physicians	16%	30.1% (+14.1%)
Volunteers	18%	30.8% (+12.8%)

- Analysis of the data shows that participation itself is an indication of engagement. The increase in participation in the 2016 engagement survey indicates improvements in workforce engagement since 2014. AHS engagement rates are above those of the average Canadian workplace.

15. Is there a set of indicators available to identify whether or not there have been improvements in mental health and addiction services?

AHS tracks the overall performance of AHS addiction and mental health services by providing a snapshot of selected performance measures. These measures align with broader strategic direction set by AHS and Alberta Health. It also aligns with the Alberta Quality Matrix for Health framework. Results cover a broad range of areas including service use, wait times, client satisfaction, continuity of care, and clinical outcomes. The reports are available on AHS's website: https://www.albertahealthservices.ca/info/Page2773.aspx.

Alberta Health is developing additional indicators to monitor performance in this area; including quantitative and qualitative measures. For example, Alberta Health will look at 30-day readmissions rates (an existing measure) as an evidence-based indicator of continuity of care.

16. How many Albertans know that they are rostered within a primary care network and their doctors are paid $62 per year on that basis?

Primary Care Networks (PCNs) are groups of physicians working collaboratively with teams of health care professionals – such as nurses, dietitians and pharmacists – to meet primary health care needs in their communities. Per capita funding to PCNs is provided by Alberta Health to facilitate programs and service delivery, including the hiring of multi-disciplinary team members. PCNs are expected to provide their patients with information about their PCN and the programs and services that are available to them.

Currently, Alberta Health does not monitor if Albertans know that they are rostered to a PCN. Patients are not officially "rostered" in the sense that there is a formal agreement between the patient and physician. As of March 31, 2016, the total number of Albertans enrolled in a PCN was 3,553,837.

Alberta Health is working toward continuity of care, and attachment to a health home (FP/NP and team) is associated with better care continuity. This includes physicians, or a member of the health home team, confirming with the patient that they consider themselves a patient of the family physician, and being provided with information about the services they have access to through the family physician and PCN. The Provincial PCN Committee has established an indicator and target to monitor how many Albertans are paneled to family physicians. This target is set at 80% of PCN family physicians by 2019. As of 2017, 43% of PCN family physicians were meeting this requirement and 26% were working towards establishing this process.

In addition, CPAR will be implemented in partnership with Alberta Health, the Alberta Medical Association, Alberta Health Services and Blue Cross to identify and maintain patient

panel lists and present a provincial view of relational continuity. Under CPAR, PCNs will have efficient registry processes and greater informational continuity with minimal impact on clinic workflow.

Albertans are able to find general information about PCNs on the Alberta Health website: www.health.alberta.ca/services/primary-care-networks.html. Information related to PCN policies, programs and physicians may also be found on the Primary Care Network Program Management Office (PCN PMO) website: www.pcnpmo.ca/alberta-pcns/Pages/default.aspx.

17. Under the new compensation model for physicians, including 15 pilot projects and projected savings of $100 million, have those savings been achieved and how are they accounted for?

The Blended Capitation Model (BCM) Demonstration Project is a new compensation model which aims to provide patients with increased access to primary health care, by supporting stronger and long lasting relationships with their family doctor.
The model gives doctors the flexibility to provide services in different ways so they can spend more time with patients and deliver a full range of care that encourages health promotion, wellness and the delivery of team based care.

The effect of this model on the health system overall – including further consideration of its effects on outcomes such as patient health status, reductions in emergency room and inpatient admissions, and improvements in quality of care – as well as its longer-term health economic effects will take years to emerge. These should be considered along with other changes in the delivery and planning of primary health care services.

To date, learnings from the BCM Demonstration Project include: a better understanding of the importance of change management to support changes to physician practice and remuneration models; the importance of a feedback loop for effective communications; and enable all partners and stakeholders to react quickly to challenges and issues.

Please see answer #25 to see how the Gastroenterology pilot supports the blended capitation model by highlighting successful changes in the planning and delivery of physician services that increased access and decreased wait times/lists.

The BCM Demonstration Project has undergone two clinic recruitment cycles to date; currently there is one clinic participating. Strategies to increase participation in the BCM demonstration project are under consideration along with our partners like the AMA. Due to limited uptake, the department is unable to determine what the cost savings would be to the system, the BCM was not expected to result in cost-savings in the short-term. Over the long-term, it is projected that the BCM will reduce system costs and provide budget stability and predictability.

Utilizing other initiatives under the Amending Agreement with the AMA, approximately $300 million in savings were projected over two years (2016/17 and 2017/18). These are

dollars Alberta Health would have had to spend if the Amending Agreement had not been reached.

Those savings have come through partnership with the AMA on cost containment, for example at-risk benefits and changes to the schedule of medical benefits. Savings can be attributed to:

- At risk pay, attached to a reconciliation process, which links benefit and compensation increases to performance on other cost savings measures.
- Changes to fees using best evidence, developed in collaboration by Alberta Health, the AMA and physicians.
- Physician Resource Planning initiatives to better align physician resource planning with population needs.

18. Why are long-term care beds so expensive in comparison to beds under the Affordable Supportive Living Initiative program?

It is generally too simplistic to compare continuing care projects on a "cost per bed" basis. It is important to note that each capital project is unique and based on the distinct needs of the community and the anticipated complexity of patient needs. Project budgets may include costs associated with developing space for outpatient and inpatient programs and services.

There are a number of reasons as to why construction costs can vary considerably from project to project:

- The total area per unit varies significantly for public builds, depending on the services intended to be offered within the facility.
- Public builds tend to be built above and beyond minimum construction standards to extend the longevity and overall performance of the facility (materials, design elements, unit size).
- Full public builds are often built for specialized populations or have advanced clinical programming requiring more complex design elements. These elements often require more program and administrative space as well as incur additional costs that are not related to the number of beds in the facility. Private operators are less receptive to building to this level of complex care.
- Public continuing care builds can be a component of a larger capital project, which may impose design factors that differ from a stand-alone project.
- In general, projects in northern Alberta, and in rural or remote locations, tend to be more costly to construct due in part to the cost of deploying labour and materials. The Government of Alberta is committed to ensuring that continuing care facilities are located where people live and in reasonable proximity to other required health services so rural/remote facilities tend to be more public than private builds, as private operators may not want to incur the additional costs inherent in these builds.

19. How many people have requested medical assistance in dying, how many doctors who initially agreed to perform the procedure have opted out, and what is the level of mental health stress on doctors?

The cumulative total of formal requests (where a Record of Request was submitted) from June 17, 2016 to April 30, 2018 is **588**.

Data collection is broken up into two sections and is updated as often as data is available provincially. Specific information is available on the AHS website in the Health Canada reports under the "Data" tab https://www.albertahealthservices.ca/info/Page14930.aspx).

a) How many doctors who initially agreed to perform the procedure have opted out?

AHS worked with their regulatory partners and Alberta Health to develop a provincial system for provision of medical assistance in dying. This program operates both within and outside of AHS and does not require physicians to register or identify themselves to AHS or Alberta Health in order to be involved in either the assessments of individuals for eligibility, or the provision of an assisted death.

In February 2016, in preparation for implementation of the program, AHS proactively did a survey to identify an initial cadre of physicians to participate. This was repeated in June/July 2016 when the legislation was passed.

Of the initial respondents, AHS has not tracked how many actually went on to either provide an assessment or provide an assisted death. Just as there is no requirement to identify interest to AHS or Alberta Health, there is also no mechanism for a physician to identify to either party that they may have been interested and have since "opted out". Participation remains entirely at the discretion of the practitioner.

b) What is the level of mental health stress on doctors?

AHS does not trace the level of stress as physician participation in MAID is not tracked. In preparation for the program, AHS and Alberta Health worked with the Alberta Medical Association's Physician and Family Support Program (PFSP) who agreed to be the primary provider of support to physicians and their families.

20. Please provide the cross jurisdictional comparison/data regarding administrative costs for health.

As measured by the Canadian Institute for Health Information, administrative costs can be measured in the context of healthcare provision. "Administrative Service Expense" is defined as total expenses that were spent in administrative care provision departments such as administrative, finance, human resources and communications.

Administrative Service Expense as a Percentage of Total Expenses

Comparator	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
Canada	4.7	4.6	4.5	4.4	4.5
Alberta	3.7	3.4	3.3	3.1	3.3
British Columbia	3.6	3.6	3.4	3.7	3.6
Manitoba	4.4	4.3	4.5	4.4	4.4
Ontario	6.1	6.0	5.8	5.8	5.8
Saskatchewan	4.5	4.6	4.7	4.3	4.3

21. How has access to health and mental health outcomes in rural communities improved in this reporting period?

Alberta Health Services has increased access has approved by implementing the following programs:

- A palliative home care program was established in the Calgary Zone, which focuses on rural areas. This program supports families and caregivers by ensuring resources are available to support end of life care in client's homes.
- The Centennial Centre for Mental Health and Brain Injury, which operates a Rural Opioid Dependency Program, provides access to opioid dependency treatment to 56 communities across rural and suburban Alberta as a telehealth service.
- Rural areas are investigating the use of alternative methods, such as telehealth and peer support networks, to provide and support children's mental health services.
- Wait times for outpatient addiction treatment has shown improvement compared to last year. Work continues to address issues related to the complexity and acuity of cases referred and wait times in areas without walk-in clinics.
- Working together with the AHS Wisdom Council, Indigenous communities and government, Indigenous health services are delivered throughout the province with the goal of providing an effective, patient-centred approach to improving care to First Nations, Métis and Inuit Peoples and communities.
- The establishment of midwifery privileges at the Elbow River Healing Lodge in Calgary supports access to obstetrical services for Indigenous, vulnerable and rural populations.
- Cancer patients have access to a larger space and new treatment areas with the opening of the newly renovated and expanded High River Community Cancer Clinic.
- Terminally ill residents located in Sundre and surrounding rural communities are provided support enabling them to die at home. A new, one-of-a kind palliative program was created in partnership with AHS that helps patients remain in their homes by maximizing local resources, as well as using a multidisciplinary team approach. The team works together to provide care and assistance/advice in an expedited fashion, including after-hours and weekend.

- A Provincial Community & Rural Maternity Care Plan was completed and approved for implementation. The plan focuses on keeping maternity care closer to home while maintaining principles of safety and best practice.
- Zones continue to reduce emergency department stat toxicology in rural areas and to ensure appropriate use of antipsychotics and benzodiazepines in addiction and mental health patients (Choosing Wisely).
- Screen Test celebrated 25 years of mobile breast cancer screening services, reaching over 117 communities, including 26 Indigenous communities. Screen Test has seen a 67% increase in First Nations clients since 2013. This year, the program sent approximately 800,000 letters to Albertans and their healthcare providers on cancer screening status and recommended actions.

22. Cost overruns in infrastructure for the centralized lab services building proposed for Edmonton, which is double the cost of the Willow Square facility in Fort McMurray - please provide the rationale for the increase in costs for all these buildings?

There is no increase in cost for the Edmonton Clinical Laboratory Hub:

- To date, the Edmonton Clinical Lab Hub project is on track. The project was within the approved $595 million at the completion of the business case stage and the completion of functional programming stage.
- The project is expected to be within budget at the schematic design phase which is expected to be completed in the coming weeks.
- Alberta Infrastructure, in consultation with Alberta Health and AHS, is responsible for the project delivery of this approved project.
- The GOA and AHS continue to work to ensure that the project is completed on time and within the approved budget of $595 million.

The Willow Square project is in schematic design, has a budget of $110 million and is intended to include 144 beds (108 beds, and shelled space for an additional 36 beds). The two projects (the Clinical Laboratory and Willow Park) are substantially different in scope and services, as the Willow Square project is a continuing care project and the Edmonton Clinical Laboratory is a regional lab facility that will provide routine and complex laboratory servicing needs in Edmonton and across the province.

The value of the project is dependent on several factors including but not limited to the intended purpose, services provided, complexity of the project delivery and the geographical location.

23. Of the 54 recommendations in the 2015 rural health services review, how many have been implemented?

The report continues to provide the Ministry of Health with very useful information on the perspectives of rural Albertans and the challenges of accessing health care experienced in some of these communities. In addition to numerous actions that address specific recommendations, we have taken action in all major areas outlined in the report, including primary health care, continuing care, mental health and addictions, EMS and accountability. Our work to shift to a system of community-based health care will further help to reduce services gaps and ensure as many services as possible are available closer to where Albertans call home.

The following are some key highlights of recent and ongoing activities that are aligned with the report's recommendations.

Access

General - Health and Alberta Health Services (AHS) continue to engage communities to identify and address their health priorities. Engagement at the community level has resulted in improved access to health services outside metro areas, in large part through expanded after-hours clinics and new urgent care models. A recent example is the opening of the Sylvan Lake Ambulatory Care Centre, which provides enhanced care 16 hours a day, including evenings and weekends.

At the same time, Alberta Health and AHS continue to build and strengthen relationships by respectfully engaging Indigenous communities, leaders and Regional Indigenous Organizations in the design, delivery and stewardship of health services.

Primary Care - Improvements to the Primary Care Network governance structures at the provincial and zone levels are helping to build a more integrated health system through better service coordination to meet the unique health needs of Albertans in each zone. The PCN governance structure significantly improves Alberta's ability to achieve collaborative team-based primary health care that meets the needs of Albertans, including in rural communities.

The province also continues to work towards enhancements to health information technology that will improve care and patient experiences for patients in rural areas. To advance technological enhancements, the Government of Alberta is providing $400 million to support implementation of a Clinical Information System (CIS) across AHS facilities. The CIS will create a single, comprehensive and accessible AHS electronic health record for every Albertan.

The department also continues to work closely with the Alberta Medical Association to explore alternative compensation models to support collaborative practice within a team-based environment/

Mental Health and Addictions - Under *Valuing Mental Health: Next Steps* there are over 100 initiatives underway to improve mental health services for Albertans, including for people in rural and remote areas. In 2017-18, more than $50 million was committed to increase community-based delivery of addiction and mental health services, including grant funding to the Canadian Mental Health Association Alberta Division to support creation of mental health networks and action plans in 150 rural communities.

As the largest provider of mental health services in the province, AHS provides a wide range of addiction and mental health services and supports in rural communities, including mobile mental health services to children, youth and family members. Twenty-eight of 37 Mental Health Capacity Building programs are located in rural and remote geographic areas with 14 of those programs having formal connections to Indigenous communities.

Continuing Care - Alberta Health also continues to focus on expanding home care to improve access for clients in rural and remote areas. *Budget 2017* committed increased funding for home and community care so that more Albertans, particularly in rural and remote areas, can receive care in their homes and remain independent.

Increased funding has already resulted in enhanced supports for caregivers, community paramedic initiatives and improved access to home care services, including palliative and end-of-life care. Meantime, new and recently opened continuing care spaces in both urban and rural areas are providing more care options for Albertans closer to home, and government continues to advance work on a new continuing care capital funding approach that will focus on areas of high need.

Specialized Services - Several initiatives are underway to improve access to specialist services at several levels. A new provincial framework for Academic Alternative Relationship Plans will allow more movement to offering various incentives for care delivery and measurement of results, particularly for specialist care in hospitals and academic settings. As well, AHS has launched a new Primary Healthcare Integration Clinical Network to support closer integration of services between primary healthcare and other parts of the healthcare system such as specialty care, acute care and continuing care.

EMS - The Ministry of Health continues to work closely with AHS to ensure that rural communities have the most effective possible emergency medical services coverage. Relative to specific items in the Rural Health Services Report, AHS EMS has developed response time performance guidelines for urban, rural and remote geographic locations that are monitored and reported on; non-emergency transfer vehicles have been deployed throughout the province to help keep ambulances free to respond to emergencies; and through AHS' provincial Medical First Response Program, medical first responders receive standardized training, protocols, supplies and other support required to provide safe and effective medical care to patients.

Transportation and Telehealth - AHS telehealth services connect patients at more than 1,600 AHS sites to health services via videoconferencing, providing efficient, timely health services to people in rural communities.

Accountability

Alberta Health made recent enhancements to system accountability with AHS to enhance the monitoring of key expectations and performance of the health system. In addition, alignment between Alberta Health and AHS planning processes have also been improved.

Sustainability

Recruitment and Retention - In partnership with key stakeholders, including the Alberta Medical Association, the college of Physicians and Surgeons of Alberta and Alberta's medical schools and medical students associations, Alberta Health has led the way on several Rural Health Workforce Planning Initiatives intended to get health care professionals to areas of greatest need, including rural areas:

- Physician Resource Planning is addressing, among other issues, the distribution of physicians across Alberta;
- Rural Health Professions Action Plan offers various rural programs and initiatives to support the attraction, recruitment and retention of health professionals.
- Rural medical education programs at both of Alberta's medical schools support medical students and residents' experience in rural health care; and
- Rural Remote Northern Program provides financial compensation to physicians who practice in communities deemed "rural or remote".

Infrastructure - With support from Alberta Health and AHS, Alberta Infrastructure is leading the Rural Health Facilities Design project. This project will assist government in developing a standardized approach to programming health services and managing the operating costs of rural health facilities by providing consistency and applying evidence-based best practices in space planning, programming and design across rural health facility projects.

Foundations, Auxiliaries and Trusts - AHS Foundation Relations continues to work closely with foundations across the province to align goals and enhance patient care and will continue to work to build these important relationships in Alberta's health care system.

Economic impact - Alberta Health recognizes the important economic value of health care to communities and continues to take community input carefully into account when considering any health care changes that may affect local economies. This approach is in line with government's broader commitment to managing costs while also protecting front-line services and associated jobs.

As the above demonstrates, Alberta Health has taken number of significant steps to support rural health services since the Rural Health Services Report's release in 2015. Working closely with communities, Indigenous peoples and health partners, the department will continue to fund and advance programs, services and supports that strengthen access to health services for Albertans in rural and remote areas, enhance accountability and provide for the long-term sustainability of health services for people in rural and remote areas.

24. What is the ministry doing to alleviate the pressures on hospitals, particularly the Red Deer Regional, and the resulting wait times for surgical procedures like hip and knee surgeries?

The Red Deer Regional Health Center (RDRHC) surgical program has supported the transferring of over 3,000 surgical procedures to rural surgical sites over the past three years, and continues to promote and support ongoing enhancement of rural surgical sites. An additional 144 arthroplasty-funded procedures have been received by RDRHC to support this patient population in Central Zone. Additional emergency Operating Room (OR) time has been incorporated in the OR schedule to improve access to service and decrease patient wait times and length of stay for urgent and emergent surgeries.

More broadly about patient flow through RDRHC and the Central Zone:

1. Seven zone-wide repatriation and transfer initiatives involving clinical and operations leaders from all 30 sites in the zone
2. The introduction of Referral, Access, Advice, Placement, Information and Destination (RAAPID) Reverse Referral process across all Central Zone sites allows the patient can be transported back to the sending hospital directly from the Emergency Department without delay, instead of admitting to RDRHC.
3. Clinical pathways Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Transitions in Care have resulted in improvements and standardization of care in high-volume, chronic-disease populations and improved linkages with Primary Care within communities across the Zone.
4. Two programs that were funded by Enhancing Care in the Community (ECC) recently rolled out in the City of Red Deer:

- The Intensive Home Care program, specific for patients at RDRHC, was implemented at the beginning of April, 2018.
  - In its first week, this program was able to make a marked difference in freeing up acute care spaces.
- The MIH program, also known as the Community Paramedic program, went live at the end of February, 2018 in Red Deer at all Long Term Care and Supportive Living sites.
  - This program's call volume is increasing each month, whereby a paramedic can provide more urgent treatment to a client at the Long term care facility or Supportive Living. This avoids a transport to the local ER department in Red Deer and a potential admission.

5. On June 4, 2018, the Sylvan Lake Advanced Ambulatory Care (SLAAC) opened to support care within the community and closer to home. This will reduce the number of less complex patient care visits to RDRHC that did not have an option prior to the SLAAC opening.

25. Referencing the capitation and gastroenterology pilots, how has learning from these pilots improved and what evidence there is that there is systemic improvement and learning from these pilots?

The goal of the Blended Capitation Model (BCM) Demonstration Project is to provide patients with increased access to primary health care, by supporting stronger and long lasting relationships with their family doctor. The model gives doctors the flexibility to provide services in different ways so they can spend more time with patients and deliver a full range of care that encourages health promotion, wellness and the delivery of team based care.

The BCM Demonstration Project is a 36-month pilot project. In the short-term, we will use physician and patient satisfaction rates, changes in physician referral patterns, and changes in physician business practices to help understand if the model is effective.

The effect of this model on the health system overall – including further consideration of its effects on outcomes such as patient health status, reductions in emergency room and inpatient admissions, and improvements in quality of care – as well as its longer-term health economic effects will take years to emerge. These should be considered along with other changes in the delivery and planning of primary health care services.

To date, learnings from the BCM Demonstration Project include: a better understanding of the importance of change management to support changes to physician practice and remuneration models; the importance of a feedback loop for effective communications; and enable all partners and stakeholders to react quickly to challenges and issues. These learnings and others will help us to grow the blended capitation model in the years that follow the BCM Demonstration Project, and are also applicable to other projects that see us working shoulder to shoulder with stakeholders on the front-lines of our health system.

The gastroenterology pilot showed a dramatic 98 percent wait-time reduction for patients with non-urgent gastrointestinal (GI) issues in the Calgary Zone. Many local and area residents with non-urgent GI issues are now receiving timely care from their family physician and are not waiting to see a specialist.

This wait-time reduction is a result of the Enhanced Primary Care Pathways developed by the AHS Section of Gastroenterology, Calgary Zone and PCNs in Calgary and treat more patients in a primary care physician's office.

The pathways are comprehensive, evidence-based guidelines that equip family doctors with the knowledge and support to determine if a patient needs an urgent referral to a GI or if the patient is better served within the doctor's practice. Waitlist numbers dropped from 2,742 patients in January 2016 to 29 patients in December of 2017 with no costs incurred for this program implementation.

AHS is currently evaluating opportunities to see if the GI pilot and its improvements can be expanded to other parts of the province.