RAPID ACCESS CLINICS

SERVICE MANUAL

Version 1.5 (17th June 2025)

TABLE OF CONTENTS

Alberta Health Services

1 PREFACE

The *Service Manual*, referenced in the Agreement for provision of Rapid Access Clinic services, guides the delivery of **Rapid Access Clinic (RAC) Services** and is part of the Service Agreement for contracted RAC providers. Please replace original sections with updates that are distributed from time to time. Replaced documents must be kept in this manual under "Expired Sections" as a record of the guidelines that were in place at any point in time.

The **Rapid Access Clinic** program is an important service in the continuum of musculoskeletal care in Alberta. As a Provider, knowledge of related AHS and community services will help you direct Albertans appropriately where required. Information related to these other services can be found on the AHS website: http://www.albertahealthservices.ca.

2 INTRODUCTION

2.1 CONTACT INFORMATION

2.1.1 AHS RAC Implementation & Support Team

Institute for Improved Health Outcomes Contacts

Role	Name	Email
Project Director	Sebastian Lackey	slackey@iiho.ca
Project Manager	Rukhsar Jetha	rjetha@iiho.ca
Business Analyst	Max Cleary	mcleary@iiho.ca
Business Analyst	Safiyyah Allison	sallison@iiho.ca

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Role	Name	Email
North Zone Representative	Brandy Giesbrecht	brandy.giesbrecht@ahs.ca
Edmonton Zone Representative	Heather Carew	heather.carew@ahs.ca
Central Zone Representative	Jessica Graham	jessica.l.graham@ahs.ca
Calgary Zone Representative	Rachel Rouble	rachel.rouble@ahs.ca
South Zone Representative	Jill Denman	jill.denman@ahs.ca
AHS RAC Consultant	Jason Martyn	jason.martyn@ahs.ca

2.1.2 Data Support Team

For support with the Ocean platform, data linkages with the Institute for Improved Health Outcomes, or integration with your Electronic Medical Record, contact Max Cleary at mcleary@iiho.ca

Please note: Specific client-identifying information (e.g., name, Personal Health Number (PHN), date of birth, etc.) should never be sent over email. Service Providers in violation of this policy will be required to participate in security breach reporting and investigation with AHS' Information & Privacy department.

2.2 RAPID ACCESS CLINIC TOOLKIT & RESOURCES

The Rapid Access Clinic toolkit and resources provides details about the RAC model of care, training resources, orientation resources, patient education information, referral form and pathway, billing templates, and many other program specific resources. Clinical providers can access the toolkit online at:

https://toolkit.albertaboneandjoint.com/rac/

2.3 AHS DIRECTIVES, POLICIES AND PROCEDURES

Relevant AHS directives, policies and procedures will be provided to the Provider upon request.

Information on doing business with AHS can be accessed through the AHS website under "*About Us > Doing Business with AHS*": https://www.albertahealthservices.ca/about/Page207.aspx

Vendor Guide to Doing Business with Alberta Health Services:

https://www.albertahealthservices.ca/assets/about/org/ahs-org-cpsm-guide-doing-business-with-ahs.pdf

For specific inquiries related to Service Agreements and procurement processes, contact Paulina Ziccarelli, Director, Direct Patient Care and General Services, CPSM at Paulina.Ziccarelli@albertahealthservices.ca.

3 DEFINITIONS

Advanced Practice	Refers to any secondary care setting in which specialists are involved in the assessment and management of a patient.
Agreement	Refers to the "Services Agreement" and all Schedules annexed to this Agreement and otherwise incorporated in the Services Agreement.
AHS	Refers to "Alberta Health Services" and has the meaning ascribed to it in the preamble of the Agreement.
Assessment	Means the initial Attendance by an Individual for each new Episode of Care at which an Individual receives a musculoskeletal (MSK) assessment by an EMA who is in good standing with their respective Professional Governing Body and has completed the EMA Training Program
Attendance	Any in-person or virtual service encounter at the Location in which the Provider provides an assessment, education, or treatment to an Individual or Client presenting with a problem or condition reasonably requiring RAC care.
Client	Means any Individual who has received an Assessment and is eligible for a follow-up Attendance(s) in accordance with the treatment eligibility criteria outlined in the *Service Manual*, as amended from time to time.
Client Year	The one-year period following a client's initial assessment for a new problem, during which time they are eligible to return for follow-up treatment.
Deliverables	All content, documentation, material, or data, in any form or notation to be provided by the Provider to AHS in connection with the Agreement.
Episode of Care	Means a minimum of one Assessment and the number of treatment Attendances associated with each distinct musculoskeletal problem or condition per body site.
Equipment	All equipment, instruments and/or supplies used by the Provider to provide services.
Expert Musculoskeletal Assessor (EMA)	Any clinician providing AHS funded musculoskeletal services on behalf of the Rapid Access Clinic. Classified as either a Class 1 or Class 2 EMA and outlined in Section 6. Business Standards.
FAST Office	Refers to the Facilitated Access to Specialist Treatment (FAST) program and the Zone based teams. It is the Alberta-specific implementation of a Central Intake and Access system for managing referrals for surgical consultation. The FAST office is a light touch point which standardizes (via a standardized referral form) and centralizes the intake of surgical referrals in the province. In the context of RACs, the FAST office will receive the standardized referral prior to distribution to a RAC. Referrals requiring a direct surgical consult will be flagged and sent directly to the next available surgeon or requested

surgeon, rather than through the RAC.

Individual	Means any Individual who is eligible for an Assessment in accordance with the eligibility criteria set out in the *Service Manual*, as amended from time to time.
Information System	The system described in Section 10, Information System Processes, of this manual.
Service Manual	Means the document that guides the operational processes and delivery of Services as may be amended and updated from time to time by AHS.
Professional Governing Body	Means any governing body having legislative authority to admit, control or regulate any of the persons engaged in performance of services.
Rapid Access Clinic (RAC)	Describes the designation of the Provider during the Term of this agreement
Referring Provider	Refers to the health care professional who has sent a referral (through the FAST office), on behalf of an Individual, to receive Services by the Provider.
Service Expectations and Business Standards	The requirements to be met and satisfied by the Provider in the performance of services as set forth in the *Service Manual*.
Services	The services to be performed by the Provider as more particularly set out in **Schedule "A"** and the *Service Manual*. Services also include any deliverables.
Service Model	RAC services as described in Section 4 and 5 of the *Service Manual*.
Provider	Refers to the facility that holds a current contract with Alberta Health Services to provide RAC services, as outlined in **Schedule "A**".
Spoke Site	Refers to the physical location where the patient attends to receive a virtual assessment with a RAC clinician.
Staff	Means all Individuals employed or otherwise retained by the Provider for any purpose related to the provision of services including the Provider's employees, officers, directors, volunteers, agents, and all other third-party Providers retained by the Provider hereunder.
Surgical Consult	Refers to the final assessment by a surgeon with the goal of determining whether the patient is suited for and will ultimately proceed with surgery.
Visit Ceiling	The total number of client visits allotted for a particular zone and musculoskeletal area, over any given period, as determined by AHS in its sole discretion.
Zone	A geographical service area defined by AHS for the purposes of administering health services.

4 RAPID ACCESS CLINIC MODEL OF CARE

In Alberta, wait times for orthopedic surgery consultation are too long. Most Albertans with bone and joint conditions referred for an orthopedic consult are ultimately not surgical cases. This means that most patients wait a long time for an orthopedic consult only to find that they are best suited for non-surgical management of their condition. Many of these patients stay on consult wait lists for a year or longer, sometimes with serious consequences. Getting properly assessed earlier in the process will allow patients to be promptly initiated on an appropriate non-surgical management plan and avoid altogether the delays and frustrations of sitting on a waitlist.

Rapid Access Clinics (RACs) are formally designated and contracted clinics that offer an access point for primary care providers to refer patients with a musculoskeletal (MSK) problem who may need surgery or secondary specialist care. The RAC model has been developed to bolster MSK assessment capacity to reduce patient wait times. Capacity is expanded by utilizing and funding non-physician, expert MSK assessors (EMAs) who can assess patients within a multidisciplinary clinical environment with specialist physician tutelage and oversight. EMAs may be, but are not limited to physiotherapists, chiropractors, nurses, and athletic therapists.

The RAC multidisciplinary team will provide:

Initial Visit

A. A prompt (receipt of referral to appointment time of under 4 weeks) initial MSK assessment with the RAC team (i.e., an EMA and/or a physician), a diagnosis, a determination of need for a surgical consult and any requisitions or referrals that are needed.

B. If the patient is deemed non-surgical, or if the clinician deems it appropriate, they will be provided with an appropriate non-surgical management plan including education, exercises, referrals, treatments. Rehabilitation treatments or services recommended in the patient's plan are not included in the RAC funding.

Follow-up Visit *(capped at 1 per patient)*

C. For non-surgical patients following a defined period of rehabilitation, a follow-up assessment with the RAC team (i.e., an EMA and/or a physician) to monitor progress, re-assess, modify the non-surgical management plan as required or direct onto surgical consult as required.

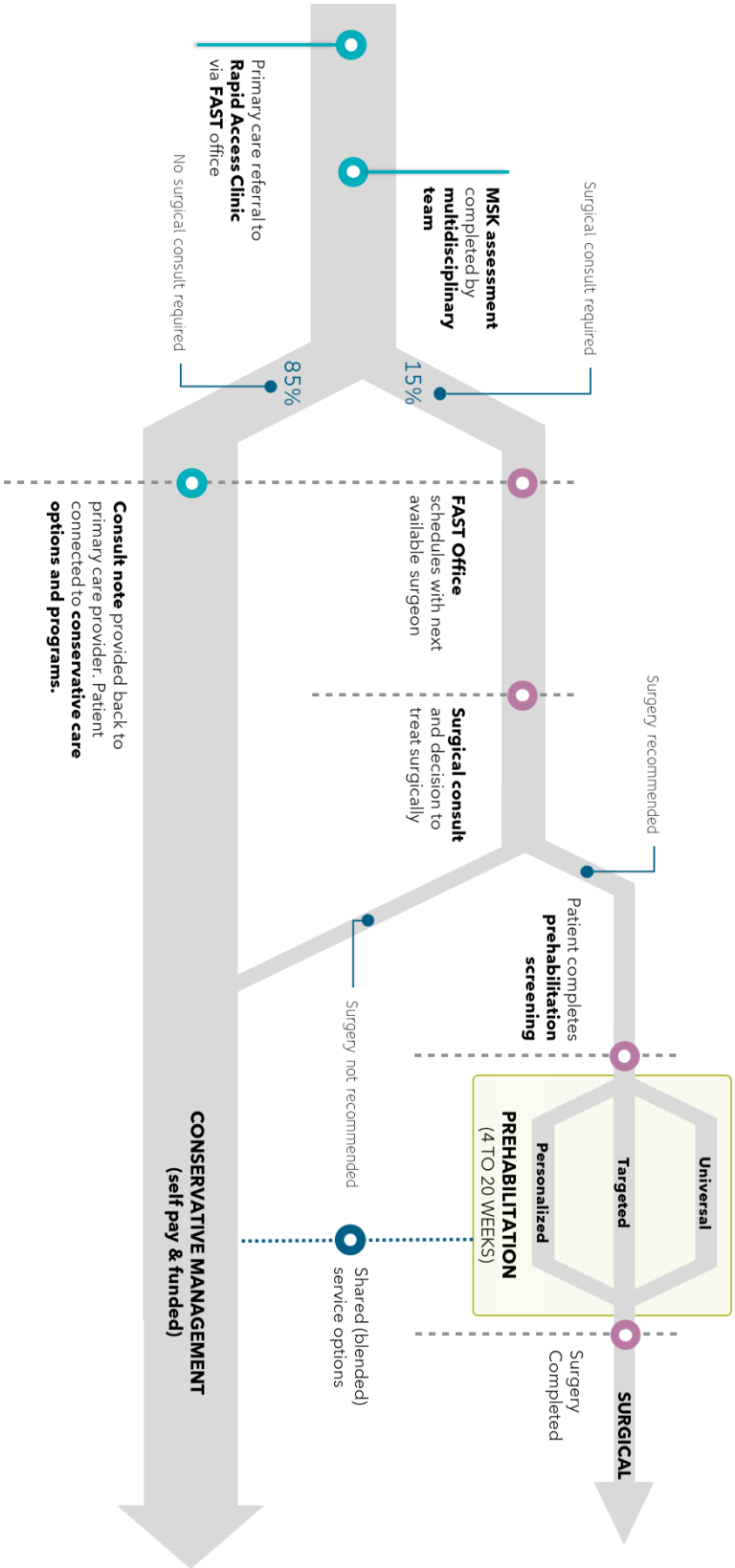

Figure 1. Flow map representation of RAC Assessment Model

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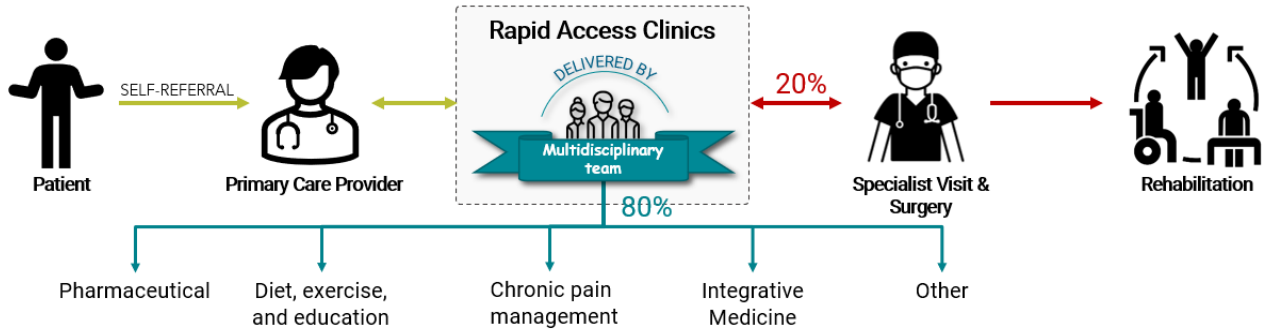
4.1 WHAT IS THE RAPID ACCESS CLINIC MODEL OF CARE?



There are five key dimensions that outline the RAC model of care. They are:

1. **Patient Intake**

   The patient intake process considers how patients are referred to the clinic, the requirements for referral, and connections to FAST offices. Refer to Section 5 for details.

2. **Clinical Services**

   The clinical services offered in a Rapid Access Clinic include the assessment, diagnosis, and management of patients who are referred from primary care for the purpose of a surgical consult. In addition to clinical triaging for a surgical consult, clinical services may include a combination of publicly and privately funded services targeted at providing non-surgical management options to the patient. Examples include specialist physician consults and physiotherapy. Refer to Section 5 for details.

3. **Clinical Team**

   The multidisciplinary specialty team (MST) forms the core clinical team of the Rapid Access Clinic. It can be composed of any combination of specialist physicians and expert MSK assessors (EMAs). The MST collaborates to provide assessment and management to patients and streamline care to surgeons and physician specialists.

4. **Surgical Referral**

   The MST is integrated into the surgical referral process to improve surgical yield in the surgeon's office. Hand-over points must be formalized within the clinic to ensure prompt communication between providers, and to ensure patient safety with the process. Key clinical assessment skills are provided in the EMA training modules for clinicians involved in the screening process for a surgical consult.

5. **Data & Technology**

   Data sharing agreements with IIHO and AHS enable Rapid Access Clinics to embed quality improvement within their processes. The use of digital health solutions such as EMRs and Map-to-Motion give providers insight to patient and health system outcomes. Virtual care solutions may be included to connect the MST to patients that are unable to attend in-person appointments or would otherwise commute long distances to receive care. Refer to Section 5, Section 10 and Section 11 for details.

4.1.1 Key Principles

The following gives an overview of the key principles for Rapid Access Clinics:

1. Optimized patient intake model allowing patients to access a rapid MSK assessment by relevant clinicians, including non-physician experts (goal of less than 4 weeks)
2. Utilizes multidisciplinary teams to conduct MSK assessments to determine the need for a surgical consult and provide streamlined and coordinated access to a network of advanced care specialists.
3. Enables timely access to specialty physicians including surgeons and sports medicine physicians.
4. Real time data collection and analytics underlies the clinic processes.
5. Utilization of digital health solutions to provide local access to rural and remote patients.

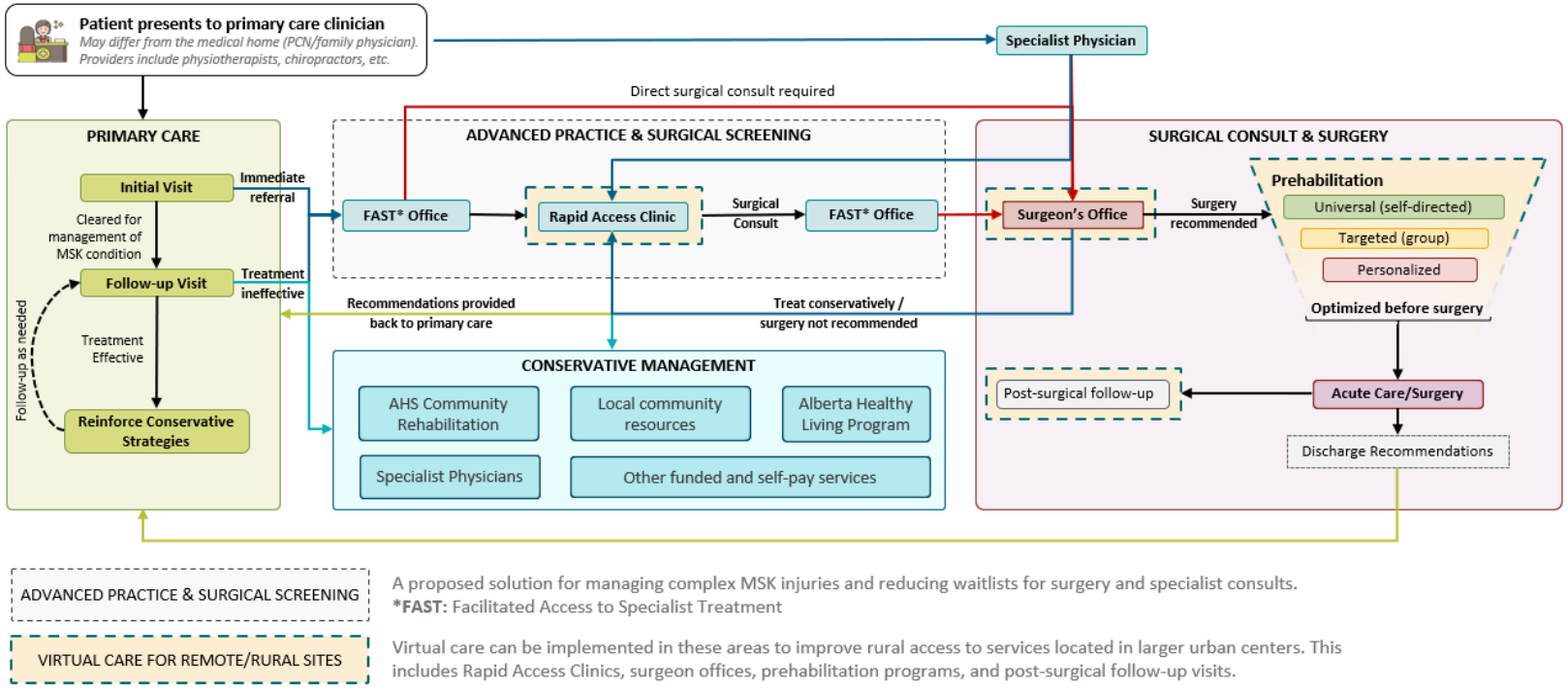


Figure 2. Conceptual Pathway for Musculoskeletal Care in Alberta

4.2 AHS RAC IMPLEMENTATION & SUPPORT TEAM

The RACs contracts will be held between respective AHS Zone Operational Leaders and the RAC clinics themselves. Support for the RAC initiative implementation is being provided by the Institute for Improved Health Outcomes (IIHO), formerly the Alberta Bone and Joint Health Institute (ABJHI). Since RACs are a novel formalized model of care within the Alberta healthcare landscape, a RAC Implementation and Support Team has been established to assist all parties, particularly new RACs with all aspects of launching and operating as a RAC. As the RAC initiative advances any questions or support requests can be directed to the individuals listed in Section 2.1.1

5 SERVICE EXPECTATIONS

"A service standard is a public commitment to a measurable level of performance that clients can expect under normal circumstances." Government of Canada, 2018

Service standards provide common expectations for how a service is delivered for a defined health condition or a specific population. Standardized services are supported by clinical pathways and may be reinforced by practice support documents and EMA training programs.

Service standards support evidence-based assessment and management, improve client and family experience, promote safety, and support financial sustainability. Service standards are integrated into the available clinical pathways and facilitate decision making and navigation of the health system.

EMAs delivering services on behalf of AHS will be expected to provide care in alignment with the Rapid Access Clinic service standards, clinical pathways, and service model eligibility criteria. EMAs must ensure their practice aligns with standards of practice and ethics outlined by their professional governing body.

Following the assessment, EMA visits are expected to focus on:

1. Providing education and information about the diagnosis, prognosis
2. Building the client's self-management skills
3. Facilitating independent exercise and rehabilitation programming
4. Providing patients with diagnostic imaging requisitions, specialist referrals, and treatment options (either in-house or external to the RAC); and,
5. Discussing how clients may transition to community programs as appropriate.

An overview of the recommendations must be documented in a consultation note that is provided back to the patient and referring provider, to promote continuity of care and give awareness about the recommendations made for the client.

KEY POINTS

1. AHS funded EMA assessments must also include the provision of client education, discussion of self-management strategies, and provision of requisitions for diagnostic imaging, specialist consults, or other adjunct treatments.

2. Any required follow-up visit should allow for sufficient time to ensure treatment recommendations can be completed.

3. Providers may provide to the client additional adjunct treatment services during the episode of care, which may be privately funded or billed to private insurance, so long as those services are additional to the service standards set out in Schedule "A" of the Service Agreement and do not interfere with the service requirements outlined in this Service Manual.

5.1 GENERAL ELIGIBILITY AND EXCLUSION CRITERIA

ELIGIBILITY CRITERIA	EXCLUSION CRITERIA
GENERAL 1. Be referred from a primary care provider with a Health Practitioner ID, such as a physician, physiotherapist, or chiropractor. 2. Require Services for a shoulder, soft tissue knee, spine, or hip and knee osteoarthritis condition, with the primary intent of screening the need to consult a surgeon. 3. Have a valid Alberta Health personal health number (PHN); and, 4. Be able to participate with the Services provided (along with a caregiver, if applicable) to achieve a positive outcome	The individual is eligible for coverage by other health payers: • *Workers Compensation Board (WCB)* • *Department of Veterans Affairs, Health Canada, or other federal programs* • *Services provided under Automobile Accident Insurance Benefits* • *Persons with health coverage in other provinces*

ELIGIBILITY CRITERIA NOTE

All individuals at the time of assessment visit **must present a valid** Alberta Health Care card (Personal Health Number (PHN). Individuals aged 18 and older must provide an additional piece of official identification at the time of their initial visit to be eligible for funding.

If the Provider has a question about the validity of a PHN, call Alberta Health and Wellness at 1-888-422-6257 and follow the prompts to verify whether an Alberta Personal Health Number is in effect.

5.2 RAC SERVICE COMPONENTS

5.2.1 Patient Intake

The patient intake process considers how patients are referred to the Provider, the requirements for the referral, and the requisite use of FAST offices to distribute the referral to the Provider. The Provider must communicate receipt of referral and appointment booking information to the patient and referring provider.

New referrals of individuals from Primary Care to the Provider must be sent to a FAST office for distribution to the Provider. The referral form can be found in Appendix 13.1. Pilot RAC sites are permitted to serve patients already on their waitlists awaiting assessment.

The minimum requirements for the referral will include the referral form and a letter. The minimum investigations to accompany the referral are outlined in the AHS Orthopedic and Spine Referral Pathway available online at: https://www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-asi-orthopaedics-qr.pdf. The referral pathway is a living document and will undergo regular review with the Alberta orthopedic surgeons and referring providers as the RACs and associated processes evolve. The AHS FAST team will not gather any additional investigations or information for the RACs outside that which has been outlined in the referral form and referral pathway. AHS, via the Alberta Surgical Initiative Specialty Access and RAC initiatives, will support communication and change management of this process to referring providers.

Upon receipt, the AHS FAST teams will complete clerical triage. Clerical triage includes: review the referral for completeness, enter the information into Alberta Netcare eReferral if possible, and assign the referral to the RAC based on the distribution and routing rules determined in collaboration with the Zone Orthopedic Section Leads, AHS Operational Leads, RAC clinic managers and Primary Care Specialty Access Leads. Upon assignment of the RAC, the FAST team will fax back a letter to the referring provider notifying which RAC the referral has been routed to. The referral package will be faxed to the assigned RAC. AHS is expected to complete referral processing and distribution to the RAC within 3 business days of referral receipt. The referral acceptance and assigned RAC will be viewable on Alberta Netcare for both patients and referring providers to monitor.

Upon receipt of referral at the RAC, the clinic employs their review and intake processes. Appropriate and eligible clients are to be scheduled with the next available RAC clinician, unless a specific provider is requested by the Primary Care Provider on behalf of the client.

Upon booking the patient for their initial visit, the provider must exhaust reasonable effort to encourage all clients scheduled for an assessment to complete all required baseline PROMs prior to their initial visit, as outlined in Section 5.4.

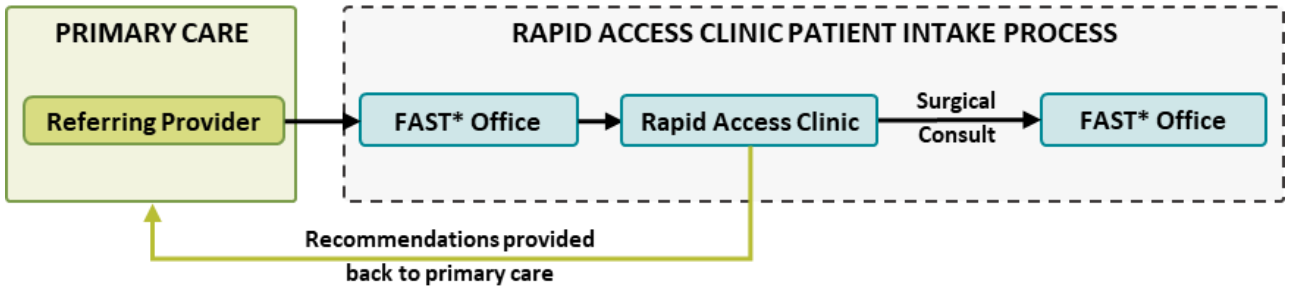


Figure 3. Rapid Access Clinic Patient Intake Process

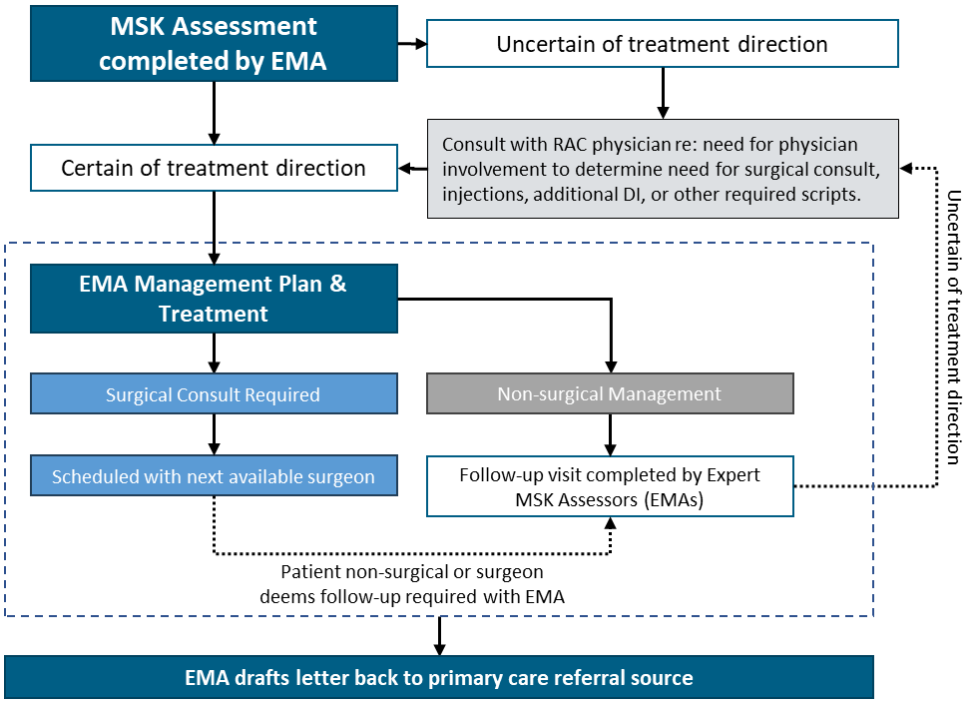
5.2.2 Care Models & Visit Types

EMAs are split into 2 categories, Class 1, and Class 2, as detailed in Section 6.1. Note that Class 2 EMAs are not funded to provide EMA Assessment and Diagnosis.

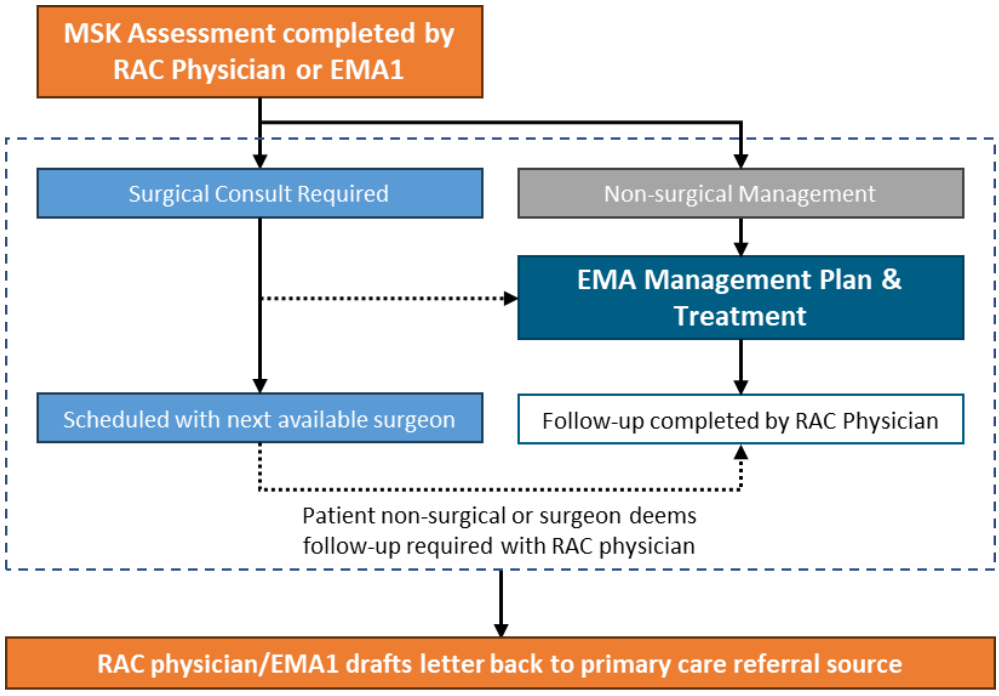
KEY POINTS

1. The Class 1 EMA can provide assessment and diagnosis of the client (Section 5.2.2.3) and has the competency to decide on the need for requisitions for specialists and surgeons (Section 5.2.3), diagnostic imaging (Section 5.2.4), and advanced treatments (Section 5.2.5). In addition, they can provide a management and treatment plan for the client's diagnosis (Section 5.2.2.4).
2. The Class 1 EMA can provide a follow-up visit for the purpose of re-assessment of the client's condition and revision of the treatment plan (Section 5.2.2.5).
3. The Class 2 EMA can only provide the management and treatment plan (Section 5.2.2.4), following the assessment and diagnosis by a RAC physician or Class 1 EMA.

5.2.2.1 Class 1 EMA Care Model



5.2.2.2 Class 2 EMA Care Model



Alberta Health Services

5.2.2.3 EMA Assessment and Diagnosis

At the initial assessment, the EMA, in coordination the RAC physician team, will at minimum, provide the client:

- Requisitions for diagnostic imaging, specialist consults, and treatments, as required.
- Reinforcement of Patient Reported Outcome Measures (PROMs) and screening tools, as outlined in the RAC Service Manual.
- Diagnosis or differential diagnosis of the Client's condition.
- Determination of need for a surgical consult, with any needed surgical consults processed promptly.
- Recommendations or referrals for any relevant community services.

5.2.2.4 EMA Management Plan and Treatment

Following the initial assessment and diagnosis of the client, and once the determination of need for a surgical consult is made, the client regardless of whether or not they are being referred on for a surgical consult may receive a management plan that consists of:

- Education and information regarding diagnosis, prognosis, self management strategies
- A rehabilitation program consisting of therapeutic exercises in the form of a home exercise program, adapted to the client's condition.
- Additional in-house treatments that may include hands-on therapy, such as massage, manual therapy, bracing, or needling.
- Recommendations for referrals for any relevant community services

5.2.2.5 EMA Follow-up

Upon completion of the initial assessment, a client may be scheduled for a follow-up visit, up to a maximum of one (1), as determined to be required by the EMA or primary assessor, or as initiated by the client. The follow-up visit allows for re-assessment of the client's status and must include:

- An assessment of the current patient condition in comparison to expected clinical progress based on treatment plan in the initial session.
- Any necessary diagnostic imaging, consultations, and referrals for the client.
- A revised treatment plan, as required; and,
- A revised set of PROMs and related measures.

5.2.3 Referrals to Specialists & Surgeons

Key clinical assessment skills for EMAs to appropriately determine when to send a referral to the surgeon will be established and maintained by the operating clinic. All referrals to surgeons must meet provincial referral requirements (e.g., use of referral form and consult letters).

Following the completion of an Assessment by the EMA, if the patient is determined to require a surgical consult, the EMA must complete all necessary documentation for referral to a surgeon and must send the referral within the next business day.

For subsequent surgical consult referrals not directed back through FAST (e.g., RAC referral to in-house surgeons and any direct referrals to external surgeons), consult referral data must be communicated to FAST.

RAC clinicians are to provide pre-operative guidance for management of the Client's condition. (e.g., Prehabilitation, connection to community programs, etc.)

5.2.4 Diagnostic Imaging

Primary care providers making ortho/spine referrals in to FAST, and potentially RACs, are obliged to adhere to the required investigations (including Diagnostic Imaging) and mandatory information outlined in the Alberta Referral Pathways. If the RAC clinical team determines that further diagnostic imaging or other investigations are required it is the responsibility of the RAC team to facilitate, receive and incorporate the findings into their care of the patient.

5.2.5 Advanced Treatments

If the RAC clinical team determines that additional specific or adjunct treatments or therapies are advisable (e.g., injections, or bracing), it is the responsibility of the RAC team to facilitate those treatments. RACs may either deliver these services in-house or make the required referrals to external providers. Any costs for treatments that fall outside of the RAC service components, outlined in this service manual, shall not be reimbursed through RAC funding (i.e., these services may be covered through other funding providers, including AHS, private-insurance, patient out-of-pocket, or a combination thereof).

5.2.6 Role of the RAC EMA

The role of the RAC EMA is dependent on the clinical model employed by the contracted provider (see Section 5.2.2.1 and Section 5.2.2.2). If the contracted provider employs the use of Class 1 EMAs, the EMA may be the responsible clinician in charge of assessment, diagnosis, and management of the client. For Class 2 EMAs, the EMA works alongside a RAC physician or Class 1 EMA to provide management and treatment plans for clients that require them following the assessment and diagnosis by the RAC physician or Class 1 EMA.

In either case, EMAs are a key member of the RAC multidisciplinary specialty team outlined in Section 4.1. EMAs work alongside other members of the team to provide the best possible management plan for their clients.

5.2.7 Role of the RAC Physician

The RAC physicians are another key member of the RAC multidisciplinary specialty team. RAC physicians work alongside EMAs to provide support for the assessment, diagnosis, and management of patients, as well as to provide any physician-based services that augment the RAC service model. RAC physicians include general

practitioners, sports medicine physicians, emergency physicians, physiatrists, rheumatologists, and surgeons, among others. Services completed by a RAC physician should be billed to the Schedule of Medical Benefits. See Section 5.2.5 for requirements around advanced treatments.

In some instances, a RAC physician may consult with a Class 1 EMA for the purpose of advising on the direction of care for a client. In these cases, the RAC physician should only bill the Schedule of Medical Benefits if the Physician is deemed to be the 'primary assessor'.

5.2.8 Communication to Referring Provider

Following the client's visit to the contracted provider, it is the responsibility of the EMA and/or RAC physician to provide a consult letter back to the referring provider that details, at minimum:

- The client's demographics.
- Presenting condition and diagnosis.
- Recommendations for treatment and community supports.
- The need for any surgical or specialist consultations.
- The need for any further diagnostic imaging; and,
- Any required follow-up by the contracted provider or referring provider.

5.3 CLINICAL PATHWAYS

5.3.1 Shoulder

The Shoulder Clinical Pathway can be found at:
https://toolkit.albertaboneandjoint.com/pathways/

5.3.2 Soft Tissue Knee

The Soft Tissue Knee Clinical Pathway can be found at:
https://toolkit.albertaboneandjoint.com/pathways/

5.3.3 Spine

The Spine Clinical Pathway can be found at:
https://toolkit.albertaboneandjoint.com/pathways/

5.3.4 Hip & Knee

Not currently available.

5.4 PATIENT REPORTED OUTCOME MEASURES (PROMs) and PATIENT REPORTED EXPERIENCE MEASURES (PREMs)

5.4.1 General Principles

Patient-reported outcome measures (PROMs) are used to assess a patient's health status at a particular point in time. PROMs are to be completed three times during the address of a given health condition. In some cases, using pre- and post-intervention PROMs can help measure the impact of that care.

PROMs and patient-reported experience measures (PREMs) are increasingly recognized as providing valuable and essential information for achieving health system goals. Both PROMs and PREMs are measured from the patient's perspective, and they can be used together to assess quality of care more fully. Information from the patient's perspective is essential to supporting a patient-centered approach to care, as outlined in the RAC Measurement Framework (11.2).

PROMs are also used to complement traditional sources of data, such as clinical administrative data, to inform policies, programs, and value-based health care delivery. They are essential to understanding whether health care services and procedures make a difference to patients' health status and quality of life.

PROMs provide quantitative and qualitative information on aspects of patients' health status that are relevant to their quality of life, including symptoms, functionality, and physical, mental, and social health.

Many PROMs tools are available, and they can be categorized as either generic or condition specific. Typically, generic and condition-specific tools are administered at the same time as they provide complementary information.

PROMs are used by:

- **Patients and clinicians** — to inform clinical care, and to improve patient–provider communication and patient involvement in decision-making.
- **Health system decision-makers** — to inform health services programming, planning and policies, as well as for performance measurement and quality improvement initiatives.
- **Researchers and policy-makers** — to conduct comparative and cost-effectiveness analyses, as well as to answer other research questions.

5.4.2 RAC PROMs and PREMs Capture

To ensure that RACs are providing the best possible care, each RAC continuum has a Measurement Framework that outlines the key performance indicators (KPIs), PROMs and evaluation methods that are to be employed. The respective Measurement Frameworks are governed and curated by a continuum specific Clinical Committee that sets the PROMs framework based on the practical evaluation demands of all relevant stakeholder groups.

RACs are mandated to solicit PROMs and PREMs from all RAC patients in accordance with the respective PROMs and PREMs framework for each continuum (specifics below). RAC PROMs and PREMs capture is facilitated by the Ocean online platform which allows PROMs and PREMs surveys to be sent directly to patients at set times throughout their care journey. The collection of PROMs and PREMs is facilitated by the Ocean online platform.

Ocean enables surveys to be sent directly and automatically to patients at specific points during their care journey. To ensure automated survey distribution via Ocean, clinics are strongly encouraged to collect patients' email addresses prior to their initial appointments. If a clinic cannot integrate with Ocean or if a patient does not have a valid email address, PROMs and PREMs can still be collected. In such cases, clinics will be provided with URLs and QR codes to share with patients for survey access. The clinic will be responsible for the distribution of the URL and QR codes to the patients.

5.4.2.1 OCEAN

The cost of the Ocean license for each RAC is paid directly by IIHO to Ocean if the clinic's EMR is eligible to integrate with OCEAN. Ocean integrates with 4 commonly used EMR types allowing simple, seamless adoption into business workflows. There is also an Ocean solution for RACs that do not use an integrated EMR. Further details and logistics of initiating RAC PROMs capture using the Ocean platform can be found in the Ocean Implementation Guide (Appendix 13.5). The IIHO team will support all RACs with their Ocean implementation. All patients are to be sent their PROMs and PREMs links according to the schedule in 5.4.2.1, and RACs are obliged to inform patients about the value of PROMs participation. Section 5.4.2.2 to 5.4.2.4 outline the required PROMs for each continuum of care.

PROMs and PREMs distribution schedule:

Baseline PROM	Prior to initial appointment (RAC A)
PREM	Three days after initial appointment (RAC A)
3 Month PROM	90 days (3 months) after initial appointment (RAC A)
1 Year PROM	365 days (1 year) after initial appointment (RAC A)

5.4.2.2 Shoulder PROMs

EQ-5D - EuroQol- 5 Dimension	https://euroqol.org/publications/user-guides/
SSV - Shoulder Subjective Value	The SSV is defined as a patient's subjective shoulder assessment expressed as a percent- age of an entirely normal shoulder, which would score 100%.
SPADI - Shoulder Pain & Disability Index	https://www.sralab.org/rehabilitation-measures/shoulder-pain-and-disability-index

5.4.2.3 Soft Tissue Knee PROMs

EQ-5D - EuroQol- 5 Dimension	https://euroqol.org/publications/user-guides/
KOOS – Knee Injury and Osteoarthritis Outcome Score	https://www.sralab.org/rehabilitation-measures/knee-injury-and-osteoarthritis-outcome-score

5.4.2.4 Spine PROMs

EQ-5D - EuroQol- 5 Dimension	https://euroqol.org/publications/user-guides/
ODI – Oswestry Disability Index	https://www.sralab.org/rehabilitation-measures/oswestry-disability-index

5.4.2.5 Hip & Knee PROMs

EQ-5D - EuroQol- 5 Dimension	https://euroqol.org/publications/user-guides/
OHKS - Oxford Hip/Knee Score	https://www.sralab.org/rehabilitation-measures/oxford-hip-scale https://www.sralab.org/rehabilitation-measures/oxford-knee-score

5.5 VIRTUAL RAC SERVICES

Virtual RAC services may include provision of care for when the Client's travel is a burden to attending an in-person clinical appointment. The virtual RAC services must be completed according to the Virtual RAC Service Manual Addendum and will be made available to RACs when completed.

5.6 INFECTION PREVENTION AND CONTROL

Specific infection prevention and control (IPC) Provider obligations are outlined in **Schedule "D"** "Infection Prevention and Control" of the Agreement. The following is a summary provided for reference:

5.6.1 Provider Obligations

a) The Provider will obtain copies of the IPC Standards described in section 1.1(a) of this Schedule annually from the Alberta government website at:

   https://www.alberta.ca/infection-prevention-and-control.aspx

b) The Provider shall comply with all regulations set out by any Professional Governing Body regarding operations and provision of services.

In addition to the standards referred to in section 1.1 of **Schedule "D"** "Infection Prevention and Control" of the Agreement, the AHS Allied Health Infection Prevention & Control Resource Manual provides information, support, and evidence-based resources applicable to allied health practices in the community. It can be accessed at:

http://www.ahs.ca/assets/healthinfo/ipc/hi-ipc-community-based-services-resource-manual.pdf

It is expected that Providers will develop IPC processes that are relevant to equipment use, staff practices, and clinical and non-clinical space. These processes will:

- Manage environmental contamination.
- Establish, record, track and audit routine practices, hand hygiene practices and use of personal protective equipment.
- Establish, record, track and audit cleaning and disinfecting processes suitable to the type and use of equipment.

The Provider shall provide AHS with a report on IPC related indicators from time to time upon request by AHS and in any event, no less than 30 days of each fiscal year of the term. Refer to the *Annual Reporting* section of this manual.

5.7 EQUIPMENT MAINTENANCE

All equipment must be kept in a safe working order and be maintained in accordance with the equipment manufacturer's specifications and guidelines subject to review and acceptance by AHS. The frequency of maintenance reviews and inspections is at least annually and more frequently if required by the manufacturer's specifications. All equipment manuals, inspection and equipment service records must be kept on site and be available for reference at the request of AHS.

6 BUSINESS STANDARDS

The contracted facility must maintain sufficient staffing of EMAs to ensure clients may access RAC services within 4 weeks (20 business days) of referral from a referring provider.

Where the contracted provider is unable to offer an assessment within 4 weeks (20 business days) of the initial request, individuals seeking AHS RAC visits should be directed to another provider, if available, that has the capacity to offer timely assessment and treatment.

The contracted provider is responsible for ensuring there is a clinic director and medical director available at the clinic to oversee the quality of services provided by the EMAs at the RAC.

6.1 RAC ROLES & RESPONSIBILITIES

6.1.1 Medical Director

During the full Term of the Service Agreement, the Provider **must have** a qualified physician serve in the role as Medical Director for the Location. The Clinic Director and the Medical Director may be the same person. The Medical Director may also operate as a RAC physician to provide services at the RAC. The Medical Director must:

- Be an accredited specialist physician in a field related to one of: orthopaedics, sports medicine, physiatry, rheumatology, or neurology.
- Be available to AHS RAC representatives.
- Ensure all EMAs have access to a physician for consultation about patient management decisions and to order diagnostic imaging or other services that require a physician to refer.
- Engage and maintain relationships with the surgeons that receive referrals from the Provider.

6.1.2 Clinic Director

During the full Term of the Service Agreement, the Provider must have a designated Clinic Director. The Clinic Director and the Medical Director may be the same person. The Clinic Director:

- Oversee and guide the Services administered at the Location.
- Be available to AHS RAC representatives.
- Ensure all EMAs have completed the EMA Training Program prior to providing Services at the Location.
- Be responsible for ensuring EMAs have the competencies required to provide Services at the Location.
- Be empowered to ensure Services are provided according to the RAC Service Manual.
- Are responsible for the quality of Services delivered by all EMAs.
- Ensure Services are accurately represented in the visit summary report (see Section 7, Financial Processes)

6.1.3 Expert Musculoskeletal Assessors (EMAs)

EMAs are the clinicians responsible for carrying out musculoskeletal assessments for the purposes of the services outlined in this Service Manual. EMAs are classified as:

6.1.3.1 Class 1 EMA

Any non-physician health care professional identified in the Health Professions Act, who is licensed by a Professional Governing Body, including, but not limited to: Physiotherapists, Chiropractors, Registered Nurses, Physician Assistants.

Class 1 EMAs who are eligible to do so are strongly encouraged to obtain Health Care Practitioner ID to aid them with making referrals to additional clinical services, as appropriate and in collaboration with RAC physicians, as needed.

In addition, and at the sole discretion of the Medical Director, Professional Kinesiologists (registered with the Alberta Kinesiology Association), Certified Athletic Therapists and International Medical Graduates (IMGs) may be classified as a Class 1 EMA, provided the additional requirements below are met. Unregulated health care practitioners are ineligible for a Health Care Practitioner ID and must collaborate with RAC physicians to obtain necessary requisitions for the patient.

The following additional requirements for a Class 1 EMA are:

- Must be a licensed member of their respective college or association*
    - Kinesiologists must be registered as a Professional Kinesiologist with the Alberta Kinesiology Association. Athletic Therapists must be certified by the Canadian Athletic Therapists Association.
    - IMGs are not required to be a licensed member of a respective college or association.
- Professional liability insurance in line with the standards set out by the Professional Governing Body, or for unregulated health care practitioners, $5,000,000 per each claim/patient and at least $5,000,000 per policy period.
- Must be employed or contracted by the Provider for the purpose of conducting Services under the oversight of the Medical Director (as outlined in Section 4 of Schedule “A”)
- Must be deemed competent by the Medical Director to provide Services, as outlined in this Agreement.
- Must complete the EMA Training Program, as outlined in Section 1.1 (f).

Note: Class 1 EMAs may practice independently and manage care autonomously, at the discretion of and with oversight from the Medical Director. As an independent practitioner, they may interact with the patient without a RAC physician for the purpose of assessment and clinical decision making for surgical consult and provision of conservative management programs, and at any stage may consult with a RAC physician or other member of the multidisciplinary team to coordinate requisitions for diagnostic imaging, specialist consults, and treatment.

Note 2: Class 1 EMA status does not authorize a clinician to perform restricted activities and/or make requisitions and referrals beyond those that they are otherwise qualified and/or authorized to perform.

Note 3: The Medical Director must be confident in the ability of any Professional Kinesiologist, Certified Athletic Therapist, or International Medical Graduate that they impart Class 1 EMA status upon, to assess and recognize

musculoskeletal conditions as a Class 1 EMA and is responsible for the care provided by those clinicians.

6.1.3.2 Class 2 EMA

Any non-physician health care professional who demonstrates competency in providing musculoskeletal care but does not meet Class 1 criteria.

The following additional requirements for a Class 2 EMA are:

- Must be a licensed member of their respective college or association*
    - Kinesiologists must be registered as a Professional Kinesiologist with the Alberta Kinesiology Association. Athletic Therapists must be certified by the Canadian Athletic Therapists Association.
    - IMGs are not required to be a licensed member of a respective college or association.
- Professional liability insurance in line with the standards set out by the Professional Governing Body, or for unregulated health care practitioners, $5,000,000 per each claim/patient and at least $5,000,000 per policy period.
- Must be employed or contracted by the Provider for the purpose of conducting Services under the oversight of the Medical Director (as outlined in Section 4 of Schedule "A")
- Must be deemed competent by the Medical Director to provide Services, as outlined in this Agreement.
- Must complete the EMA Training Program, as outlined in Section 1.1 (f).

Note: Class 2 EMAs must consult with a RAC physician or Class 1 EMA to confirm assessment findings, diagnosis, and management plan. Class 2 EMAs cannot operate independently of a RAC physician or Class 1 EMA.

6.1.4 RAC Physician

The following outlines the role of a RAC physician:

- Be an accredited physician in one of: family medicine, emergency medicine, orthopaedics, sports medicine, physiatry, rheumatology, or neurology.
- Provide consult or arrange for another RAC physician to provide consult to cases where the clinical complexity makes the determination of surgical appropriateness or treatment plan by an EMA challenging.

6.2 PROVIDER ONBOARDING

Providers must attend any orientation meetings with AHS or IIHO. An initial orientation meeting will consist of an overview of all required steps to start seeing patients. This includes a review of important documentation, business standards, financial processes, and data gathering processes. Follow-up orientation sessions will be scheduled with the clinic to facilitate data affiliation agreements and to further orient the provider to the quality assurance process.

6.3 ORIENTATION OF STAFF TO SERVICES

The Provider is responsible for orienting their staff on the service expectations and business standards as outlined in this manual and in the Service Agreement. This orientation must include information that helps staff to communicate the parameters of the services accurately to the public.

6.3.1 EMA Training & Registration

All EMAs will undergo standard testing that will consist of reading material and online modules. The Provider must ensure that all EMAs who provide RAC services register for and complete any online EMA Training Programs made available to the provider. The guide on how to access and complete this training can be found in Appendix 13.4. The training **must be** completed prior to assessing patients.

There is no fee for enrolment in the EMA Training Program. The Provider must track training completion certificates for each EMA and inform IIHO and the AHS zone representative of any EMA providing AHS funded RAC services, including their:

- Full name; and,
- Professional Designation

6.4 VISIT MANAGEMENT

In the event AHS zone leadership implements a visit ceiling, the service provider will be responsible for monitoring their allotted number of visits. Assessments and follow-up visits will be administered on a first come, first serve basis, until capacity for the zone has been reached. Visit ceilings are applied on a per zone, month to month basis. To help determine if there are any remaining visits available, the provider may reach out to their AHS Zone representative for clarification.

It is expected that contracted providers will offer appointment times within 4 weeks to individuals seeking AHS funded RAC services.

Service providers are expected to make reasonable attempts to ensure the individual meets the general eligibility criteria for the service model. This includes:

1. Assessments for the purpose of triaging the need for a surgical consultation.
2. Follow-up visit spaced appropriately to allow sufficient time for the patient to work through any treatment recommendations; and,
3. Client education with respect to appropriate and transparent representation of care that will be provided within the service standards.

6.5 EPISODE OF CARE DURATION

For each service category, there is an administrative limit of 52 weeks to the duration of the episode of care, i.e., the follow-up visit must happen within 52 weeks of initial assessment.

After 52 weeks, the episode of care will be considered terminated. Up until that time, a client may present for a follow-up visit for the same episode of care. The Provider will not be able to bill for any unused follow-up visits within that service request after 52 weeks.

If a client presents to the Provider after the episode of care has terminated or completed, a new referral from the referring provider is required to initialize a new episode of care.

6.6 CONCURRENT EPISODES OF CARE

A **concurrent episode of care** is initiated when a client seeks a second assessment through a contracted Provider within a year of their initial assessment for AHS funded service, whether the second condition is related to the first or not. A concurrent episode of care requires the client to obtain a new referral from the referring provider.

6.7 REQUESTS FOR EXTRA VISITS

Within the same episode of care, follow-up visits are capped at one (1). No additional follow-up visits will be granted. However, a new episode of care may be initialized if the client is again referred by their referring provider.

6.8 INFORMATION PRIVACY REQUIREMENTS

The AHS Health Information poster (to be supplied by AHS) will be prominently displayed in the waiting area of the facility once received. If the poster is not displayed, the information provided by the poster must be made available to the client. Email privacy@ahs.ca to request a digital copy of the poster.

All privacy requirements are outlined in detail in the Agreement. Providers should refer to the AHS Policy "Transmission of Information by Facsimile or Electronic Mail", available through the following link:

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-transmission-information.pdf

> **Please note:** Specific client-identifying information (e.g., name, Personal Health Number (PHN), date of birth, etc.) should never be sent by email. Providers in violation of this policy will be required to participate in security breach reporting and investigation with AHS' Information & Privacy department.

7 FINANCIAL PROCESSES

7.1 BILLING

7.1.1 Monthly Billing Expectations

With support from IIHO, the Provider will produce a visit summary report from information entered in the Provider's EMR. **The Provider will submit this visit summary report to their AHS RAC representative by the 15th business day of each month**. This report reflects the Service activity performed in the previous month. This report forms the basis of an Excel workbook (see Appendix 13.6) that becomes the Provider's monthly invoice that is provided to AHS Zone Accounts Payable to trigger payment to the Provider (the "Invoice"). It will be the responsibility of the Provider to ensure information is entered into the provided Excel workbook accurately to ensure there are no issues processing any payments. The Excel workbook and necessary data requirements found in Appendix 13.6. There is no financial reimbursement for patient no shows.

> **Important Note:**
> Failure to submit a complete visit summary report will result in non-payment for the services provided. If the visit summary report is incomplete for a prior billing cycle, a request can be made by the Provider to the AHS zone representative, to submit the missing visits during the next billing cycle, as a part of the visit summary report. There is no funding for patients who do not attend sessions (no shows).
>
> AHS shall not be liable for any service fees not paid because of a Provider's failure to properly enter client data into the Visit Summary Report Excel workbook (Appendix 13.6).

7.2 PAYMENT PROCESSES

AHS shall issue payment to the service provider within 45 days after the 15th business day of the month for services rendered in the previous month. Payment will be based on the invoice generated from the visit summary report.

7.3 FEE STRUCTURE

Maximum billed total per patient case: $266.30

RAC Service Fees				
Service	**Fee**	**Class 1 EMA**	**Class 2 EMA**	**RAC Physician**
EMA Assessment & Diagnosis (A)	$107.80	✓	*n/a*	*SOMB*
EMA Non-Surgical Management Plan and Treatment (B)	$62.40	✓	✓	n/a
EMA Follow-up (C)	$96.10	✓	*n/a*	*SOMB*

7.4 BILATERAL ASSESSMENTS

Bilateral Assessments on the same joint "type" e.g. left knee OA + right knee OA, are to be billed and paid as a single assessment/case. This applies only to bilateral joint assessments on the same joint "type" i.e. L shoulder + R shoulder, L hip + R hip, or L knee + R knee performed during the same day visits.

Multi-joint assessments of different joint "types" e.g. Any shoulder + any knee OR any knee + hip performed on the same day are still eligible to be billed as separate cases.

8 INCIDENT REPORTING

8.1 OVERVIEW

The incident reporting process is **Schedule "C"** of the Agreement. It is included here for ease of reference.

Providers are required to report all situations where Individuals or clients have suffered harm or experienced close calls or hazards with associated potential harm and to report on them in accordance with the instructions below.

Event	When to Report	Contact Person
Hospital Transfers	To be reported immediately, irrespective of level of harm	AHS Zone Representative
Severe Harm (critical incident)	To be reported immediately in reasonable detail, with follow-up reports in complete detail to be submitted within 24 hours of event	
Moderate and Minimal Harm	To be reported in complete detail with 72 hours of event	
No Apparent Harm, Hazards, and Close Calls	To be reported in complete detail within 30 Days of event	

8.2 DEFINITIONS

"Close Call" means a situation where an individual or client was nearly harmed, but for one or more reasons, the individual or client was 'saved' from harm.

"Harm" means an unexpected or normally avoidable outcome relating to the Provider's services that negatively affects an individual or client's health and/or quality of life and occurs while the individual or client is at the facility or within ten (10) days of the individual or client's visit, including but not limited to:

- Severe Harm (critical incident) - Individual or client attempts suicide, suffers death, complete loss of limb or organ function or requires intervention to sustain life.
- Moderate Harm - Individual or client suffers partial loss of limb or organ function.
- Minimal Harm - Individual or client suffers any form of harm that is less extensive and does not involve death,

loss of limb or organ function, and may include clusters of infections among individuals at the facility or clients treated in the facility.

- No Apparent Harm – at the time of the event or reporting of the event, the individual or client does not appear to suffer any harm but could do so in the future e.g., Potential for a skin reaction or bruise.

"Hazard" means something that has the potential to contribute to harm or something that could harm an individual or client and includes any circumstance not described herein and considered a "reportable incident" at any time.

9 CLIENT CONCERNS RESOLUTION PROCESS

This information and other Provider requirements are outlined in **Schedule "E"** "Individual or Client Concerns Resolution Process" of the Agreement. This summary is included here for ease of reference.

9.1 CLIENT CONCERNS REGARDING PROVIDER: RESOLUTION PROCESS

Providers must first work with their patients to help resolve any concerns, prior to pursuing resolution through AHS.

The following is a summary of the AHS Client Concerns Resolution Process. The Provider will:

1. The client expresses concern to the Provider either by contacting Provider administrative staff or Provider clinicians. If the concern is expressed to the provider administrative staff, the concern must be highlighted to the client's treating clinician. This must occur within 3 business days including acknowledging the concern directly back to the client.

2. The treating clinician must consider and evaluate ALL relevant information to determine whether there is indeed a connection between the facts presented and the concerns of the client. ALL relevant information includes a discussion with the client on the facts associated with the concern.

3. The Provider will then inform the client of the actions to be taken to address their concern and state the frequency of updates that will occur and as well as document all actions (i.e., phone calls, meetings, etc.) taken towards resolution.

4. The treating clinician should inform their direct supervisor of the client concern if it is not resolved following the initial discussion with the client.

5. The Provider will ensure that the resolution timeline is suitable to the nature of the complaint.

6. The Provider must maintain all documentation regarding the client concern and share with AHS upon request/as required.

7. If the client remains dissatisfied with the outcome of the concern at the clinic level, the Provider will contact the AHS Zone representative to collaboratively resolve the concern.

If a patient concern involves both the Provider and AHS, AHS Rapid Access Clinic zone program leadership will collaborate with the Provider in resolving the client concern to ensure a seamless process for the client. The

Provider and AHS will make decisions about the portion of the concern pertaining to their service only. AHS will follow its patient resolution policy and procedure.

10 INFORMATION SYSTEM PROCESSES

In providing the Services, the contracted provider must use those information systems provided by AHS and IIHO to transmit required activity and billing information.

The Provider shall ensure, at its own cost, that its information technology is compatible with AHS' and IIHO's systems to ensure efficient transmission of all required information and data. In addition, the Provider must have the ability to accommodate the Map to Motion Platform and access the RAC Services website at https://toolkit.albertaboneandjoint.com/rac/ for training and information updates.

10.1 CLINIC EMR DATA

10.1.1 Data Requirements

To accommodate the requisite reporting requirements for the RAC initiative all RAC physicians and EMAs, as the defined custodians of the health data, must enter an IIHO Data Affiliation agreement with IIHO for QA/QI purposes (see below). Following this, IIHO will engage with the RAC to perform a current state evaluation of their clinic data and EMR process to determine how best to establish data pipelines. The data requirements mapping process is essential to ensure that data obligations can be met.

10.1.2 Data Affiliation

All RAC physicians and EMAs, as the defined custodians of the health data, must enter an IIHO Data Affiliation agreement with IIHO for QA/QI purposes. RACs must commit to the adequate (staff) resources to engage with IIHO in the establishment of the requisite data pipelines to securely transfer RAC data to IIHO's repository. Each RAC physician and EMA needs to fill out the agreement. The agreement can be found in Appendix 13.2.

10.1.3 Establishing EMR Data Pipelines

The Clinic Data Requirements (Appendix 13.3) will be provided to the clinic during the first orientation meeting. Following completion of the document, the Business Analyst, and a Project Manager from IIHO will visit the clinic to discuss the clinic's methodology of data collection and labelling in their EMR. After THE creation of a query, the Business Analyst will then guide a representative at the clinic to run a data query and upload onto OwnCloud, submitting the data to the IIHO repository.

10.1.4 Reporting to FAST

Specific RAC visit data elements that are required by FAST will be collected by IIHO from RACs and will be automatically shared with FAST. RACs are not required to share these RAC data elements directly with FAST. However, as per Section 5.2.3, if a surgical consult referral is not directed back through FAST the consult referral information must be copied directly to FAST.

10.2 OCEAN PLATFORM

RACs must adopt the Map to Motion/Ocean platform for facilitated patient PROMs. IIHO will provide i.e., pay for the Ocean subscription required to enable integration of PROMs capture with the clinic's EMR via the Map-to-Motion platform. All surveys will be created by IIHO for clinic use. Clinics will be instructed on integration with their EMR and how to use patient messaging. The guide for registering and setting up Ocean can be found in Appendix 13.5.

10.2.1 Patient Reported Data

Clinics are required to solicit and exhaust reasonable efforts to encourage patients to complete their PROMs. PROMs measurement frameworks will be defined by Alberta Health Services Clinical Committees for each respective continuum and will consist of the EQ5D-5L, validated condition-specific tools, e.g., OHS, SSV, WOOS, WORC, KOOS, etc., and patient satisfaction.

10.3 PROCESS TO RESOLVE INFORMATION SYSTEM ISSUES

10.3.1 Ocean Support and Troubleshooting

Technical Issues:

For challenges regarding subscription and errors within Ocean, please contact Ocean directly at 1-(888)-864-8655.

Content Queries:

If you have content questions about the surveys – please contact Max Cleary (mcleary@iiho.ca) or Rukhsar Jetha (rjetha@iiho.ca) at IIHO.

10.3.2 EMA Training Support and Troubleshooting

Please contact Jason Martyn (jason.martyn@ahs.ca) for any issues you encounter with the EMA training platform.

10.3.3 EMR Data Support and Troubleshooting

For any questions related to your EMR Data, including troubleshooting, please contact Max Cleary (mcleary@iiho.ca) at IIHO.

11 QUALITY ASSURANCE AND KEY PERFORMANCE INDICATORS

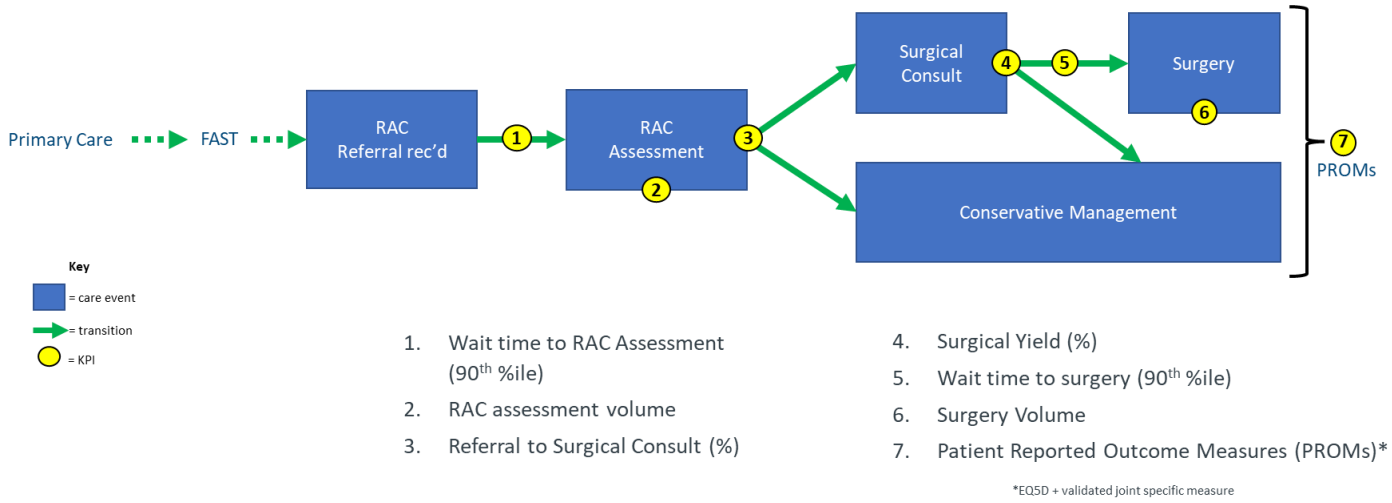


Figure 4. KPI Schematic

11.1 GENERAL PRINCIPLES

Quality Assurance (QA) is an approach in maintaining care at a known standard through an audit or review process. Quality assurance identifies if services and care processes are running as expected and outlines any outliers.

Quality Improvement (QI) is an approach focusing on processes and outcomes when:

- a standard is consistently not being met
- seeking elevated performance beyond standards
- a gap in standards exists

Quality Improvement identifies if services, care processes and tools are meeting the needs of patients and the health care system.

The RAC initiative is underpinned by robust QA/QI principles with accountability and quality of healthcare delivery being of paramount importance. The RAC implementation team is utilizing a suite of tools, methodologies, and processes over the course of the initiative to help guide the program to verify it will meet the objective and the stakeholder needs and expectations. RAC providers are expected to participate in quarterly quality review sessions with Zone lead and IIHO.

11.2 RAC MEASUREMENT FRAMEWORK

A genericized RAC measurement framework has been developed to ensure that comparable operational KPIs can be applied and evaluated across all implemented continuums (see Figure 4.). Continuum specific KPIs and PROMs will fall under the governance purview of the respective Clinical Committees.

RAC KPIs:

1. **Wait Time to RAC Assessment**

   Definition: 90th percentile wait time (in days) from when referral is received by the RAC to date of assessment, per quarter.

2. **RAC Assessment Volume**

   Definition: Number of RAC assessments completed per quarter

3. **Referral to Surgical Consult**

   Definition: Percentage of patients who are referred on to a Surgical Consult following RAC Assessment

4. **Surgical Yield**

   Definition: Percentage of surgical consults that proceed to surgery (Note: requires surgical consult data [i.e. not RAC data] from all surgeons within the zone for a given continuum)

5. **Surgery Wait Time**

   Definition: 90th percentile wait time (in days) from Surgical Consult (Decision to Treat) → Surgery, per quarter.

6. **Surgery Volume**

   Definition: Number of surgeries performed per quarter

7. **PROMS**

   Definition: The respective PROMs Frameworks are governed and curated by the continuum specific Clinical Committees that sets the PROMs framework based on the practical evaluation demands of all relevant stakeholder groups.

12 EXPIRED SECTIONS

This section is included for each Provider to house the previous versions of sections of this manual, document, or forms. Because this manual is referenced in the Agreement, retaining expired versions is important so the guidelines relevant to a particular time can be accessed.

13 APPENDIX

13.1 RAC REFERRAL FORM (PROVINCIAL ORTHO & SPINE REFERRAL FORM)

https://toolkit.albertaboneandjoint.com/rac/wp-content/uploads/bilateral-Ortho-Referral-Form.pdf

13.2 ABJHI DATA AFFILIATION AGREEMENT

https://toolkit.albertaboneandjoint.com/rac/wp-content/uploads/Affiliate-Agreement.pdf

13.3 RAC CLINIC DATA REQUIREMENTS FORM

https://toolkit.albertaboneandjoint.com/rac/wp-content/uploads/RAC-Clinic-Data-Requirements-Form-2.pdf

13.4 EMA TRAINING GUIDE

https://toolkit.albertaboneandjoint.com/rac/wp-content/uploads/EMA-Training-Guide.pdf

13.5 OCEAN IMPLEMENTATION GUIDE

https://toolkit.albertaboneandjoint.com/rac/wp-content/uploads/Ocean-Implementation-Guide.pdf

13.6 RAC VISIT SUMMARY REPORT – TEMPLATE

Please visit https://toolkit.albertaboneandjoint.com/rac to download the fillable template.