InnovateHealth

Understanding Innovation Adoption in Alberta Primary Care: A Qualitative Study of Experiences and Perspectives

A report by:

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Background

Primary care in Alberta is under intense pressure to innovate while managing physician shortages, administrative burden, limited resources, and rising patient expectations. Advances in digital health, artificial intelligence, and team-based care offer promise but are difficult to implement in already strained settings. Most innovations, even evidence-based ones, fail to take hold in primary care not because of lack of will, but because teams lack the time, skills, and organizational conditions to identify, test, and sustain change.

Alberta's primary care system is highly fragmented, with independent physician practices working alongside Primary Care Networks, alternative relationship plans, and an emerging regional structure through Primary Care Alberta. Unlike acute care, there is no unified governance, electronic medical record, or standardized processes, which enables local creativity but complicates spread and scale. Recent reforms, including the establishment of Primary Care Alberta in 2024 as the first provincial primary care agency in Canada, place primary care at the center of health system transformation while simultaneously increasing expectations to innovate with limited additional capacity.

Despite this critical moment, little is known about how Alberta primary care teams and leaders experience innovation adoption, what competencies enable success, and what organizational conditions support or hinder implementation. This study addresses that gap by exploring the experiences and needs of primary care leaders across Alberta. Through in-depth interviews with physicians, executive directors, practice facilitators, and system leaders, we aimed to understand innovation as a lived experience shaped by individual qualities, team dynamics, organizational culture, and system structures, and to generate insights to inform training and policy decisions to build innovation capacity in primary care.

Methods

This qualitative study used semi-structured interviews with primary care leaders across Alberta. Participants were purposively sampled to capture diverse perspectives, including PCN executive directors, physicians, clinical leaders, practice facilitators, and system-level leaders from urban and rural settings.

Interviews explored experiences with innovation adoption, competencies for success, and organizational enabling conditions. Nineteen interviews were conducted between August and October 2025, audio-recorded, and transcribed verbatim. Thematic analysis involved independent coding by two researchers followed by collaborative theme development. The study received ethics approval from the University of Calgary Research Ethics Board (REB25-0958), and participants provided informed consent; all quotes are anonymized.

Key Findings

For busy readers, the analysis highlighted several key patterns in how innovation is experienced in Alberta primary care:

- **Innovation definitions are contextual.** In Alberta's context, foundational integration (unified EMR, standardized processes, team-based structures) is the innovation priority before advanced technologies. What counts as "innovation" varies by setting, with rural and urban teams innovating in different ways based on their constraints and opportunities.

- **Relational skills are foundational.** Change moves at the speed of trust. Technical skills and tools matter, but active listening, coaching, storytelling, and creating psychological safety are what enable teams to engage with and adopt innovation in practice.

- **Frontline-driven approaches work;** mandates falter. Sustainable innovation emerges when physicians, teams, and communities help define the problem and co-design solutions, rather than having changes imposed top-down. Participants emphasized that innovation "sticks" when it is rooted in local realities and shared purpose.

- **Compensation and capacity are decisive constraints.** Fee-for-service and workload pressures create constant trade-offs between seeing patients and investing time in improvement work. Without protected time and resourcing, even highly motivated leaders struggle to participate in, test, and spread innovations.

- **Innovation is a team sport requiring embedded support.** Diverse roles, skilled facilitation, peer networks, and consistent external partners were seen as essential for moving from pilots to sustained change. Intermittent or project-based support, by contrast, was experienced as destabilizing and contributed to "pilot fatigue."

Nineteen primary care leaders contributed to these findings, spanning PCN executive directors, physicians and clinical leaders, practice facilitators, and system-level leaders from urban and rural settings across Alberta. Together, their perspectives show how individual competencies, team dynamics, organizational culture, and system structures interact to shape innovation adoption in primary care.

These patterns are explored in more depth in the following themes, illustrated with examples from participants.

Theme 1: Defining Innovation – Context Matters

Participants challenged narrow, technology-focused definitions of innovation, instead describing it as purpose-driven, contextual, and operating across multiple levels of the system. Innovation was seen less as "shiny tools" and more as thoughtfully changing how care is delivered to better serve patients and providers.

Purpose-driven, measured change

Innovation was consistently framed as solving real problems or anticipating emerging needs rather than adding "busywork." Participants emphasized being clear about the "why," focusing on changes that improve processes or human experience, and using data to guide choices rather than relying on subjective impressions. One leader described effective innovation as "skating to where the puck is going," choosing initiatives that are feasible but have a meaningful long-term impact.

A spectrum from basic to transformative

Leaders highlighted a wide spectrum of innovation, from simple efficiency improvements to advanced technologies. Examples ranged from adding a printer in each exam room or using structured team huddles to moving away from manual faxing and piloting AI tools. Rural participants stressed that innovation can look different outside urban centers, where limited staff, funding, and technology push teams toward creative, low-cost solutions that still meaningfully improve care.

Innovation across system levels

Participants described innovation at micro, meso, and macro levels - within patient encounters, across teams and organizations, and at broader system levels. They noted that as initiatives move "up" in scale, potential impact increases but direct control decreases, making alignment and role clarity critical. Several leaders pointed to gaps between high-level conversations about innovation and what feels actionable in day-to-day practice, and stressed the need to tailor strategies to each level's sphere of control.

Mindsets, time, and Alberta's reality

Innovation was seen as requiring shifts in mental models, not just new tools. Participants emphasized that meaningful innovation takes time, especially at a systems level, creating tension with short political and performance cycles. In Alberta's current context, many felt the most urgent innovation priority is foundational integration, such as improving communication structures, aligning EMRs, and standardizing core processes, even if this work appears less glamorous than cutting-edge technologies.

Key Takeaway

Innovation in Alberta primary care is context-dependent and grounded in solving meaningful problems. Foundational integration and coordination are the critical enablers of future innovations across the system.

Theme 2: Individual & Team Competencies for Innovation

Participants identified a constellation of personal qualities, relational skills, and team conditions that enable innovation, emphasizing that no single person can carry this work alone.

Personal qualities of innovators

Leaders described innovators as curious, reflective, and willing to question the status quo while staying open to new evidence. Curiosity with "healthy skepticism" involved asking why things are done a certain way and looking at how others succeed, while "holding strong ideas loosely" as new data emerge. Courage was defined less as fearlessness and more as "being okay to say these are the things we need" and taking risks despite uncertainty. Innovators were also seen as self-aware and strengths-based, recognizing their own blind spots and "not assuming that because you have or don't have a particular role you can't be innovative," but instead helping others see the skills and value they bring.

Storytelling emerged as a critical capability for mobilizing support. Effective leaders used narrative to connect changes to shared values and "help people see the bigger picture… there's a bigger purpose of why I want to be a part of this," making innovation feel meaningful rather than purely technical.

Relational and communication skills

Relational skills were described as foundational rather than optional. One system leader captured this with: "Change moves at the speed of trust," highlighting the need to intentionally build relationships, especially in rural settings where "if you don't have a relationship, they won't answer the call." Leaders emphasized active listening, asking good questions, and facilitating conversations that surface concerns and align people around a common purpose.

Skilled facilitation was seen as a specific, teachable competency. Participants spoke about the importance of leaders who can "create safe space for respectful conversations, mediation, and disclosing key messages around purpose," and contrasted this with experiences where meetings lacked structure and support: "We haven't had anyone with any skillset facilitating those meetings…change is the event, but transition is the experience. We need somebody to be there to hold your hands through that process."

Purpose-driven coaching: helping others "find their why"

A distinctive leadership competency was helping people articulate their own "why" for engaging in change. Leaders described intentionally working with resisters and skeptics to connect innovation to what matters to them - whether financial benefit, time savings, learning, or patient care. As one physician explained, the goal was to "help them figure out a why that may not be the same why you're doing it for, but get them to the same end point…find a why that is going to get them to consider expending their energy towards it."

This applied to leaders themselves as well. One participant reflected on sustaining their own engagement in the face of burnout and workload: "You're finding your why…still finding your way to find a passion, still finding a way to help others come along and sell that why to others."

Key Takeaway

Importance of **connecting innovation efforts to their own values and motivations.** Rather than assuming a common reason for change, effective leaders helped individuals identify their own purpose and understand how innovation aligned with what mattered most to them.

Team dynamics, diversity, and psychological safety

Participants were unequivocal that "innovation is a team sport." Successful initiatives relied on diverse roles and thinking styles - visionaries, skeptics who act as a "brake," values guardians, analysts, project managers, and patient voices - with clear role clarity and appreciation of differences. Leaders valued hearing "alternative approaches" and "critical comments" because they strengthened change efforts rather than derailing them.

Several explicitly referenced Rogers' Diffusion Curve, emphasizing the importance of supporting early adopters and using peer influence instead of investing disproportionate energy in entrenched naysayers: "It doesn't start with the naysayers…that's not how we're going to innovate and change the system."

Psychological safety was described as the foundation that allows all of these competencies to function. One practice facilitator summarized it as: "If you are afraid to speak up…afraid I'm going to lose my job…don't want to feel dumb or be dismissed…without safety, people won't share ideas, ask questions, or take risks." Leaders spoke about creating environments where people can "voice objection without fear of repercussion" and disagree without damaging relationships. Without this safety, participants felt that the very people most inclined to innovate "shut down" and withdraw from change efforts.

Key Takeaway

Innovation extends beyond the skills or expertise of any one individual. Leaders emphasized that trust, collaboration, diverse perspectives, and psychological safety are essential to successful innovation.

Theme 3: Organizational Culture & Enabling Conditions

Innovation success depended on organizational culture, structural enablers, and change management capacity working together. Leaders described the need for explicit cultural values, tangible resources, frontline engagement, and intentional approaches to managing transitions.

Innovation as an explicit organizational value

Several PCN directors described innovation as a lived value rather than a slogan: "Innovation is one of our values…we talk about it on a daily basis." This commitment showed up in a culture of iteration and continuous improvement: "We regularly celebrate taking an existing process, examining what's not quite right, and modifying it. We don't often throw something out entirely." Celebrating small wins, formally and informally, provided a psychological boost and helped maintain momentum over the long timelines required for change.

Frontline-driven innovation: bottom-up, not top-down

Participants emphasized that sustainable innovation is designed and owned by frontline teams rather than imposed from above. One executive director described an innovation grant model that started with clinic priorities: "We don't know what you want for innovation…your clinic is the private independent operator. So tell us." Another leader reflected that co-designing with urgent care and family physicians meant that when data shifted the problem definition, "we actually changed the whole focus of that group and it was totally okay" because teams had been involved from the start. One participant summarized this philosophy as, "Change is not something we deliver to communities. It's something that emerges when communities lead."

In Alberta's context of independent physician practices, leaders noted that mandates rarely work: "We're not dictated…we rely on people getting on board." Successful initiatives relied on co-design, piloting with willing early adopters, and peer-to-peer spread, which helped transform initial skepticism into shared ownership.

Structural enablers: funding, time, and infrastructure

Despite tight budgets, some PCNs deliberately carved out resources to support innovation. Examples included dedicating a portion of the budget to "Medical Home Optimization" with quality improvement facilitators, EMR consultants, and pilot roles, or offering innovation grants to clinics with criteria such as scalability and potential for spread. These investments signalled commitment and reduced financial barriers to experimentation.

Time and internal expertise were equally important. One physician described shifting from seeing meetings as a "$1000 wasted meeting" to recognizing that "failing to plan is planning to fail," reframing structured huddles and project meetings as essential investments. Leaders also highlighted the importance of peer-to-peer structures - "nurse telling colleagues, doctor telling doctor"- and communities of practice, noting that relationship-based influence was far more effective than administrative directives.

Change management as a core competency

Participants stressed that innovation requires explicit change management skills, not just good ideas, and pointed to the importance of trust, culture, and intentional support for transitions. Leaders referenced frameworks such as ADKAR, PDSA cycles, and Rogers' Diffusion Curve to emphasize that awareness, desire, ability, and reinforcement all need to be addressed, and that telling people "the right thing to do" is insufficient if it is not also the easy, supported thing to do.

Several participants expressed concern that large-scale reforms were proceeding without adequate facilitation: "We're about to go through the greatest transition and evolution of primary care in the province, and yet we haven't had anyone with any skillset facilitating those meetings…we need somebody to be there to hold your hands through that process." When stakeholders disagreed, patient-centredness provided a unifying anchor - 'it's about the patient' - allowing leaders to align diverse interests around shared values and purpose.

Key Takeaway

Community-led change

Change is not something we deliver to communities. It's something that emerges when communities lead.

Theme 4: Barriers to Innovation Adoption

Despite strong commitment to improving care, participants identified systemic, financial, and cultural barriers that constrained innovation at every level, from individual clinicians to provincial infrastructure.

Compensation and capacity constraints

The fee-for-service model was described as a fundamental barrier. Physicians "are running small businesses," and cannot afford to donate large amounts of unpaid time to meetings, pilots, and redesign work when "if they're not seeing patients, it's challenging…if there is no other compensation available." Innovation activities often had no billable codes, effectively penalizing those who invested in improvement.

Beyond funding, leaders highlighted lack of time, energy, and mental bandwidth as "our biggest threat right now" to primary care transformation. Innovation work frequently fell to physicians "who then don't really get reimbursed for a lot of that work," leaving them on a "treadmill" where they lacked the capacity to pause, redesign, and restart differently. Participants also described innovation fatigue as multiple worthy projects competed for attention: without primary care "at the top of the food chain" to set priorities, teams were overwhelmed by externally driven requests.

Technology fragmentation and infrastructure gaps

Alberta's fragmented EMR environment created major obstacles. Leaders noted that "we don't even have a single EMR…most of our innovation is actually just working in a more integrated and aligned manner," positioning basic interoperability as the current innovation imperative. Variation in technology use - from paper charts to advanced EMR functions - meant that the feasibility and impact of potential innovations differed significantly across settings.

Lack of interoperability and coordination led to parallel processes, manual workarounds, and duplicated effort. Innovations that should streamline work instead added clicks and duplicate data entry. Participants expressed frustration that teams were "reinventing" solutions already developed elsewhere, asking why common tools and training were not more consistently shared.

Cultural and change-related barriers

Participants described cultural barriers, including historical physician skepticism, hierarchical norms, and fear of imperfection. Some physicians were "not typically your early adopters," shaped by past negative experiences with imposed changes, which left them wary of new initiatives. Hierarchical dynamics, especially when acute care partners joined primary care tables, made people hesitant to speak without organizational "permission," undermining the lateral collaboration innovation requires.

Leaders also noted that a desire to "get it perfect" before involving users or testing ideas limited learning and slowed change. The tension between wanting to improve and fearing missteps made teams reluctant to try small experiments, gather feedback, and adjust course - approaches participants saw as essential for innovation in complex, real-world primary care settings.

System-level fragmentation and short-termism

Systemic fragmentation and the "land of a thousand pilot projects" were described as major obstacles to spread and scale. Autonomy enabled local innovation but also led to "lack of cohesion and lack of scalability and sustainability" when pilots were not designed with spread in mind. Participants contrasted research-style "one variable" thinking with the reality of complex systems where changes interact in unpredictable ways.

Finally, political instability and short planning cycles were seen as undermining foundational work. Several leaders felt that the system was "grasping at things that are a little bit more shiny and more appealing in the four-year election cycle," rather than addressing root causes and sustaining integration work over the longer timelines it requires.

Key Takeaway

Conditions, not just motivation, limit innovation
Even when primary care teams are interested in improving care, fee-for-service pressures, limited capacity, fragmented EMRs, cultural fear of missteps, and short-term political cycles make it difficult to start, sustain, and spread change.

Theme 5: Partnerships and External Support

Participants were clear that primary care teams cannot innovate in isolation. Successful innovation depended on external partners who combined technical expertise with relational capacity, understood primary care realities, and provided consistent, embedded support rather than one-off projects.

External expertise: technology and people skills

Leaders emphasized the need for outside expertise in both technology and collaboration skills. Some felt their internal IM/IT teams were not sufficiently innovative and described looking "outside our organizations…to upskill ourselves" and to access organizations that specialize in innovation. Technical solutions alone were not enough; effective partners "led with empathy," recognized that primary care is "rebuilding the airplane while it's flying," and adapted to clinics' bandwidth and starting point rather than assuming ideal conditions.

Embedded, trusted support

Participants strongly preferred embedded support models over distant, transactional help. What "worked" was "relationship on the ground with frontline teams, someone physically in their clinic that they trust." Practice facilitators were highlighted as a good example: they worked closely with privately owned clinics, understood variation in technology use (from paper charts to advanced EMRs), and met teams where they were rather than judging readiness.

Embedded partners often helped with evaluation, grant-writing, and storytelling - "filling in some of those areas that are difficult" for teams to do alone - while building capacity rather than doing the work for them. Leaders noted that when roles like coordinators or facilitators were funded consistently, teams "surged ahead," but grant-dependent positions created boom-and-bust cycles where momentum stalled when funding ended.

Peer networks and communities of practice

Peer-to-peer learning and practitioner networks were seen as powerful supports because they aligned with how clinicians naturally learn - from colleagues they trust. Participants described drawing on zone-level groups, clinic manager networks, EMR user networks, and quality improvement collaboratives. "Peer-to-peer learning is incredibly important," one leader noted, and endorsement from respected peers often mattered more than administrative direction.

However, awareness, time, and capacity limited use of these networks. Some teams did not know what was available, and others felt "stuck on that treadmill" without enough breathing room to pause and engage. External partners could play a valuable role in actively connecting clinics to existing networks rather than assuming they would find them on their own.

Research, evaluation, and community partnerships

Research and evaluation partners were valued for bringing objectivity, simple evaluation frameworks, and help with data storytelling so teams could show impact to funders, municipal councils, and communities. Industry and academic partners who involved primary care early in co-design and tailored solutions to the end user were seen as much more effective than those who arrived with predetermined products.

Beyond health, community agencies - such as mental health and addictions services, social services, home care, and local nonprofits - were described as essential partners, especially for addressing social determinants and bridging acute and community care. Participants also stressed that "the most important partners are patients themselves," who are often forgotten unless intentionally engaged from the outset.

What external partners must bring

Across interviews, participants converged on clear expectations for external partners: openness and humility ("a willingness…to get a 'no' and for primary care to say, 'here's a tidbit you can get started with'"), respect for primary care's authority to set priorities, and alignment with patient-centred values. Partners were most helpful when they reduced overwhelm rather than adding to it - recognizing that "everyone wants to work with primary care" and helping to focus energy on what matters most.

Leaders also pointed to the need for provincial support infrastructure that connects local innovation with system policy, creating a bidirectional flow between "folks right on the ground" and decision-makers. Finally, several felt that investment in culture, team-building, and innovation support should be built into how organizations are stood up and funded, rather than relying on voluntary effort: these supports "should be the first thing you think about," not the last.

Key Takeaway

Partnership is a core condition, not a nice-to-have
Primary care teams cannot innovate in isolation; innovation is strengthened when embedded, trusted partners are present in clinics, bring both technical and collaboration skills, align with patient-centred values, and help build capacity rather than delivering one-off projects or adding to overload.

IMPLICATIONS FOR POLICY AND PRACTICE

These findings suggest that building innovation capacity in Alberta primary care requires coordinated action at four levels: individual skills, team and organizational culture, system structures, and external partnerships.

For training and capacity-building programs

Innovation training should move beyond technical skills to treat relational competencies as foundational. Programs should focus on active listening, facilitation, purpose-driven coaching to help teams "find their why," storytelling to mobilize support, and skills for creating psychological safety. Training should explicitly introduce practical change management frameworks (for example, ADKAR, PDSA, Rogers' Diffusion Curve) and support leaders to apply them in real settings.

Programs also need to emphasize that innovation is a team sport. Rather than developing "innovation heroes," training should help leaders understand their own strengths and blind spots, build complementary teams, and use early adopters and peer influence strategically.

For PCN and organizational leaders

Frontline-driven, bottom-up approaches were more successful than top-down mandates. Organizations can support this by creating structured mechanisms for frontline engagement, such as innovation grants where clinics propose solutions, physician advisory committees, discipline-specific working groups, and community partnerships to surface needs.

Innovation should be an explicit organizational value backed by resources: dedicated budgets, protected improvement time, and skilled facilitators, not just aspirational language. Leaders can normalize continuous improvement by celebrating small wins and treating refinement as success rather than failure. At the same time, they should advocate for compensation models that do not penalize time spent on innovation and seek creative ways to resource improvement work within existing constraints.

For system-level policy and Primary Care Alberta

System-level actors should prioritize foundational integration - EMR interoperability, standardized core processes, and coordinated knowledge-sharing infrastructure - so primary care teams are not continually reinventing solutions. Provincial platforms that spread tools, protocols, and lessons learned can help move successful pilots to scale and reduce the "land of a thousand pilots" problem.

There is a need for embedded, consistent support such as practice facilitators, quality improvement teams, and evaluation partners funded on a sustainable basis rather than through short-term grants that create momentum and then collapse. Primary care also needs a stronger voice in setting innovation priorities - "at the top of the food chain" rather than responding to a constant stream of external requests - to prevent innovation fatigue and focus limited capacity on what matters most.

For external partners and funders

Partners supporting primary care innovation must bring both technical expertise and relational capacity. Solutions that do not account for primary care's operational realities, bandwidth constraints, and variable starting points are unlikely to be adopted. Effective partners are present and trusted in clinics, lead with empathy, and build capacity alongside teams rather than doing work for them.

External partners and funders should demonstrate openness, humility, and alignment with primary care's patient-centred mission. Sustainable innovation was most often associated with collaborations that respected primary care's authority over its own priorities and co-designed approaches, rather than imposing predetermined projects or timelines.

ACKNOWLEDGEMENTS

We extend our sincere gratitude to the primary care leaders who generously shared their time, experiences, and insights for this study. Their candour and wisdom made this work possible.

This research was funded by Alberta Health through the Primary Care Innovation Fund and administered by Praxus Health.