Alberta Lighthouse Initiative

Advisory Board Engagement Report

Identifying Opportunities to Improve Cardiometabolic Care in Alberta

Alberta

ALBERTA INNOVATES

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Executive Summary

This report synthesizes input from the Alberta Lighthouse Initiative Advisory Board Kick-Off and First Engagement Session held on January 27, 2026. The session focused on surfacing priority issues in the prevention, detection, and management of cardiometabolic conditions, and translating these into broad and actionable innovation challenges to inform the first Alberta Lighthouse funding call.

WHAT WE HEARD

- Health equity and social determinants of health (SDOH) were repeatedly identified as foundational requirements, particularly for rural/remote, Indigenous, and equity-deserving communities.
- Participants emphasized the need to balance care management with upstream prevention, including early education and stronger screening pathways, with a noted interest in self-referral models.
- Trust deficit, health literacy and misinformation were seen as critical barriers to engagement and adherence.
- Artificial Intelligence (AI) generated information requires safeguards to protect patient safety.
- Access, primary care attachment, wait times, transitions of care and follow-up were viewed as major drivers of avoidable harm and cost.
- Data sharing and interoperability were highlighted as enabling infrastructure for coordinated care, reducing duplication, and improving impact measurement across the continuum.
- Inclusion of mental health support and care were considered critical in managing chronic diseases. Further, negative consequences impact patients and systems when mental health is overlooked.

'HOW MIGHT WE' INNOVATION CHALLENGE STATEMENTS

The following 'How Might We' (HMW) challenge statements translate the session's themes into candidate innovation challenges. Each statement is framed to be broad enough for multiple Health Service Delivery Partners (HSDP) to see themselves reflected in, while still specific enough to drive actionable proposals.

HMW 1 — Equitable Early Detection & Screening Pathways

How might we enable earlier, equitable detection and risk stratification for cardiometabolic conditions so that Albertans have better health outcomes?

HMW 2 — Health Literacy and Self-Management

How might we improve health literacy and access to self-management tools so Albertans can confidently manage their health in partnership with providers?

HMW 3 — Everyday Prevention Supports and Addressing Social Barriers

How might we make it easier for Albertans to access practical, culturally relevant prevention supports that help reduce everyday barriers to cardiometabolic health (e.g., food insecurity, cost, transportation, time, and stress)?

HMW 4 — Integrated Mental Health Supports

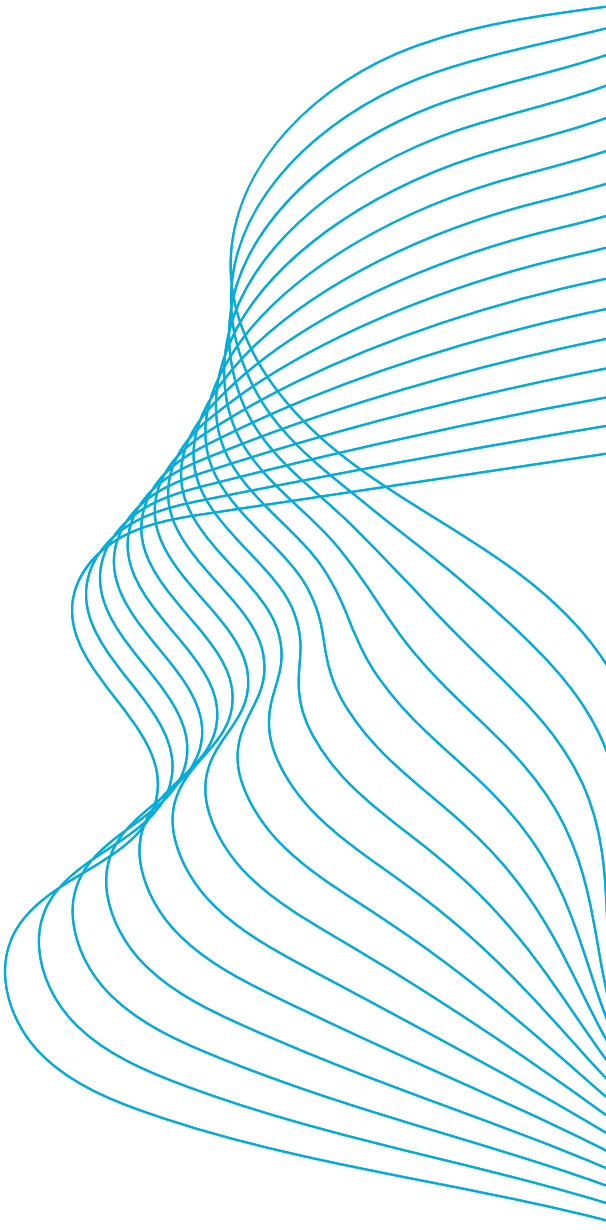
How might we sustainably integrate mental health supports into cardiometabolic care pathways to ensure patients receive coordinated, holistic care across settings?

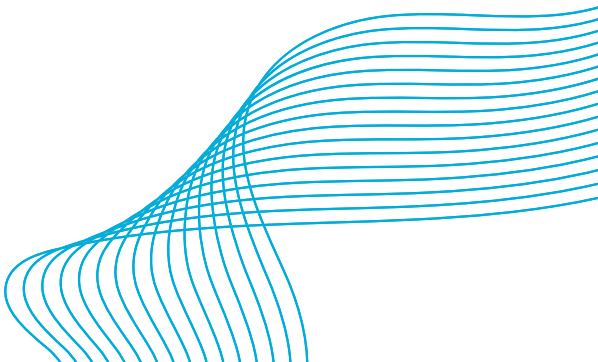
FOUNDATIONAL TAKEAWAYS

To set the Lighthouse Lead Consortium up for robust, patient-centred impact, and to attract strong, implementable innovation proposals, the following recommendations are proposed.

1. **Clarify and operationalize guiding principles and a decision lens**
2. **Invest in role clarity and trust-building with the Advisory Board**
3. **Deepen problem discovery with Health Service Delivery Partner sites before finalizing challenges**
4. **Design the challenges to embrace complexity and and enable co-design of innovative care models**
5. **Build enablement mechanisms that remove barriers for funded teams**

This report reflects insights gathered during the first Advisory Board engagement session and is intended as an input to an innovation challenge design, not a consensus view or an exhaustive assessment of cardiometabolic needs in Alberta. The themes and "How Might We" statements synthesize what was heard in that session, alongside limited contextual review, to help focus and sharpen the next phase of problem definition.





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Introduction & Session Purpose

The Alberta Lighthouse Initiative is a five-year, $4M program established through a public-private partnership led by the Government of Alberta's Ministry of Primary and Preventative Health Services (PPHS), Alberta Innovates, and Novo Nordisk Canada Inc. (collectively, the Lead Consortium), announced September 26, 2025. The initiative advances primary and community-led models of care that strengthen prevention, detection, and management of cardiometabolic conditions across Alberta.

Inspired by Denmark's Lighthouse Life Science Healthy Weight model, the Alberta Lighthouse approach uses cross-sector collaboration and innovation challenges to catalyze solutions that are designed to be sustainable, scalable, and implementable within real-world health system constraints, while also supporting economic development.

OUR PARTNERSHIP PURPOSE: WHY ALBERTA LIGHTHOUSE EXISTS

Alberta Lighthouse exists to accelerate community-led innovation that improves outcomes and reduces avoidable pressure on the health system. The partnership focuses on cardiometabolic conditions, including type 2 diabetes, obesity, cardiovascular disease (CVD), chronic kidney disease (CKD), and metabolic dysfunction-associated steatohepatitis (MASH). In practice, Lighthouse aims to:

- Promote prevention and early intervention: Support projects that encourage healthier lifestyles, early screening, and sustained health habits to prevent complications.
- Fund community-driven innovation: Provide financial support for projects proposed by businesses, academic institutions, and community organizations through structured innovation challenges.
- Strengthen Alberta's health innovation ecosystem: Build networks across sectors to foster collaboration, drive economic competitiveness, and improve population health.

ALBERTA LIGHTHOUSE CHALLENGE MODEL

The Alberta Lighthouse Challenge Model begins by identifying broad innovation challenges. These challenges are guided by the Alberta Lighthouse mandate and ministerial priorities, aligned with provincial health needs, and informed by subject matter experts and patient advocates.

Once innovation challenges have been identified, Alberta-based Health Service Delivery Partners (HSDPs) will play a lead role in scoping and shaping priority problems, in the form of clear problem statements. Each problem will be grounded in real-world workflows, capacity realities, and the needs and experiences of patients and caregivers.

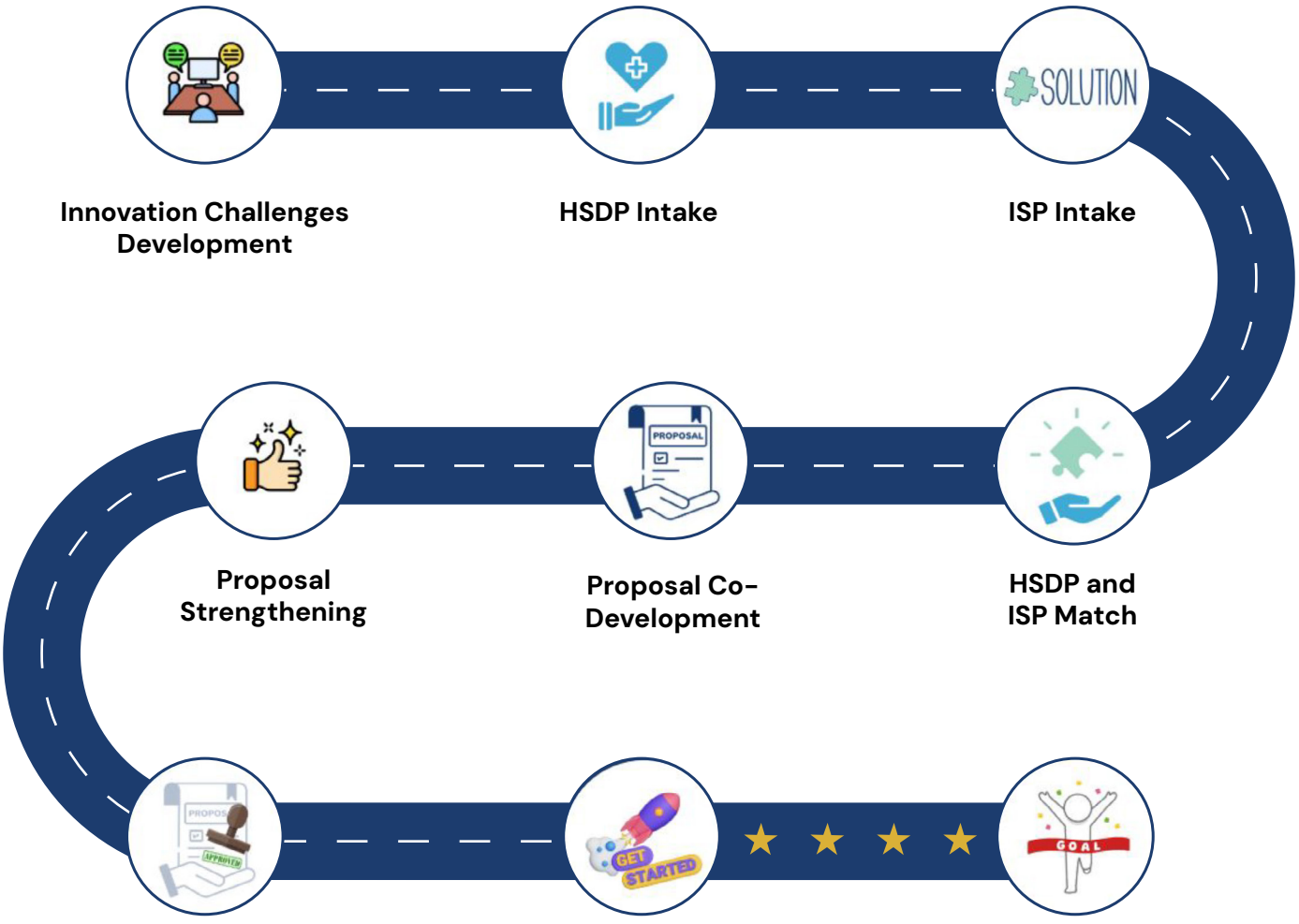
With clearly defined problem statements in place, Innovation Solution Providers (ISPs) will be invited to respond. ISPs will have the opportunity to propose targeted solutions that address the specific needs of HSDPs.

The overall process will be competitive and structured through multiple evaluation stages to ensure strong alignment with the program objectives, implementation readiness, scalability potential, and measurable impact.

Selected HSDPs and ISPs will enter into formal partnerships to implement and rigorously evaluate established, evidence-informed solutions in real-world care settings-adapting as needed to local context and generating insights to inform broader scale and spread across the system.

INITATIVE ROADMAP

Please note that this is a high-level overview, and while it outlines key steps, there are additional due diligence measures in place to support the selection of high-potential projects.



Innovation Challenges Development

HSDP Intake

ISP Intake

HSDP and ISP Match

Proposal Co-Development

Proposal Strengthening

Select Proposals Funded

Projects Start Fall 2026

Care model evaluated with potential for spread and scale

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Indicates key milestones throughout the project timeline. The number of stars is illustrative and may not reflect the actual number of milestones.

ADVISORY BOARD ENGAGEMENT

As the Lead Consortium prepares the inaugural Alberta Lighthouse funding call, it is engaging the Lighthouse Advisory Board to ground challenge design in real-world needs. The Advisory Board provides expert advice to support the partnership's objectives, including shaping and refining innovation challenges to guide the evaluation, funding, and implementation of projects proposed by industry, academia, and community organizations.

This report synthesizes relevant secondary research (Appendix A) alongside Advisory Board expertise and lived experience captured through the engagement process, to ensure the forthcoming funding call reflects Alberta's priorities and the practical realities of the healthcare ecosystem.

KEY PLAYERS

Because the Lighthouse model relies on coordinated roles, from those who surface real-world needs to those who provide solutions, alongside sponsors and advisors, the definitions below clarify the key player groups referenced throughout this report and how they fit together within the process.

Lead Consortium

The tri-party leadership group that sponsors and steers Alberta Lighthouse: Novo Nordisk Canada Inc., the Ministry of Primary and Preventative Health Services, and Alberta Innovates. They set direction and governance for the initiative, including aligning challenges to mandate/priorities and overseeing the process.

Advisory Board

A 13-member group assembled to provide expert advice and system perspective to help shape the initiative as well as offer input on evaluation and funding considerations and help with connections and engagement. Key constraint: Advisory Board members cannot apply for Lighthouse funding and must disclose conflicts of interest.

The Advisory Board was strategically composed to bring together members with diverse backgrounds in health care (particularly primary care), public health, innovation, commercialization, health care data and community engagement. The Board also includes patient advocates and individuals with lived experience.

Health Service Delivery Partners (HSDP)

An Alberta-based organization that delivers or enables health services (in the real world) and brings forward a specific, on-the-ground need that fits within the broader Alberta Lighthouse innovation challenges.

In the model, HSDPs help define the more focused problem statements and are positioned to implement/test solutions in practice.

HSDPs may work with patient advocates and individuals with lived experience, whose perspectives are essential in defining meaningful problems and ensuring solutions reflect real-world needs.

Innovation Solution Provider (ISP)

An organization (often industry, small and medium-sized enterprises (SMEs)/ startups, innovators, etc.) that can offer a targeted solution to address the specific need identified by an HSDP. In the model, ISPs respond after HSDP needs are surfaced, and the process supports matchmaking to form strong implementation partnerships.

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Methodology & Engagement Approach

This engagement used a design-thinking approach. Participants first broadened the problem space through individual reflection and group discussion, then began to converge by clustering inputs into shared themes. Facilitation emphasized psychological safety, equity of voice, and alignment with the Lighthouse innovation challenge model. Work was carried out across three phases:

1 PHASE I: PREPARATION & ENGAGEMENT DESIGN

Lighthouse program materials (including the Terms of Reference and early program framing) were reviewed, and a targeted landscape scan was completed to identify high-friction areas in cardiometabolic prevention, detection, and management. A pre-read package (Appendix A) established a shared baseline and clarified the scope of focus conditions (Type 2 diabetes, obesity, CVD, CKD, and MASH) and their downstream impacts in Alberta. A structured workshop plan and supporting collaboration materials were then developed.

2 PHASE II: ADVISORY BOARD SESSION FACILITATION

A 90-minute virtual session was held using MS Teams for dialogue and Miro for collaborative mapping and capture. The session moved from context-setting and lived experience reflections to problem identification, clarifying what the issue is, who is most affected, and why it persists.

An asynchronous feedback window was maintained after the session to accommodate schedules and ensure participants could add or refine inputs and revisit discussion points.

3 PHASE III: SYNTHESIS & FINAL REPORTING

Following the session, a thematic analysis was conducted across captured workshop inputs and committee documentation to identify recurring priorities and divergent viewpoints. These findings were integrated with the secondary research conducted to produce actionable themes and innovation challenge statements.

LESSONS LEARNED & OPPORTUNITIES TO STRENGTHEN FUTURE ENGAGEMENTS

Onboarding

Include a short on-boarding segment to ensure a shared understanding of roles, expectations, and how input will be used.

Technology readiness

Offer an optional 10–15-minute tech check and clearly communicate in advance when multiple platforms will be used, to reduce friction and support full participation.

Participation design

Create a more interactive format that enhances participation and direct dialogue.

Time and depth

The session successfully surfaced a wide range of insights; future sessions would benefit from dedicated time to explore a smaller set of priority themes in greater depth.

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Key Themes & Insights

HEALTH EQUITY AND SOCIAL DETERMINANTS AS NON-NEGOTIABLES

- Equity was raised as a core requirement for both the program design and the funded solutions (e.g., access, affordability, cultural safety, and structural barriers).
- Participants highlighted that experiences and outcomes vary by geography, changing demographics, socio-economic conditions, sex and gender, and across racial and cultural communities.
- Indigenous-specific barriers were identified, including navigating Non-Insured Health Benefits (NIHB) eligibility and recognizing that jurisdictional contexts vary for First Nations (status and non-status), Inuit, and Métis peoples; approaches should be community-led and tailored accordingly.
- There was a strong desire to centre community voice and patient co-design to enable solutions that prioritize patient needs and drive system benefit.

PREVENTION AND EARLY INTERVENTION

- A clear focus developed on meaningful prevention, rather than a sole focus on post-hoc clinical management.
- Participants highlighted early education (schools, community settings) on nutrition, movement, and risk factors.
- There was an interest in enabling earlier screening and identification (including self-referral pathways) and ensuring timely diagnosis to avoid late-stage presentation.
- The need to navigate tensions between near-term management and long-term prevention investments was clearly articulated.

TRUST, HEALTH LITERACY, AND MISINFORMATION RESILIENCE

- Trust deficit, health literacy and misinformation were seen as critical barriers to engagement and adherence.
- Participants noted that differences in health and digital literacy influence how people navigate services, interpret information, and act on care recommendations, which can affect access, follow-through, and equity in outcomes.
- Participants highlighted the need for patient-centred tools that build confidence in self-advocacy and caregiver advocacy across the care journey.
- AI was viewed as both an opportunity and a risk; its outputs reflect the quality of the input data and potential bias.

ACCESS, CONTINUITY, AND TRANSITIONS OF CARE

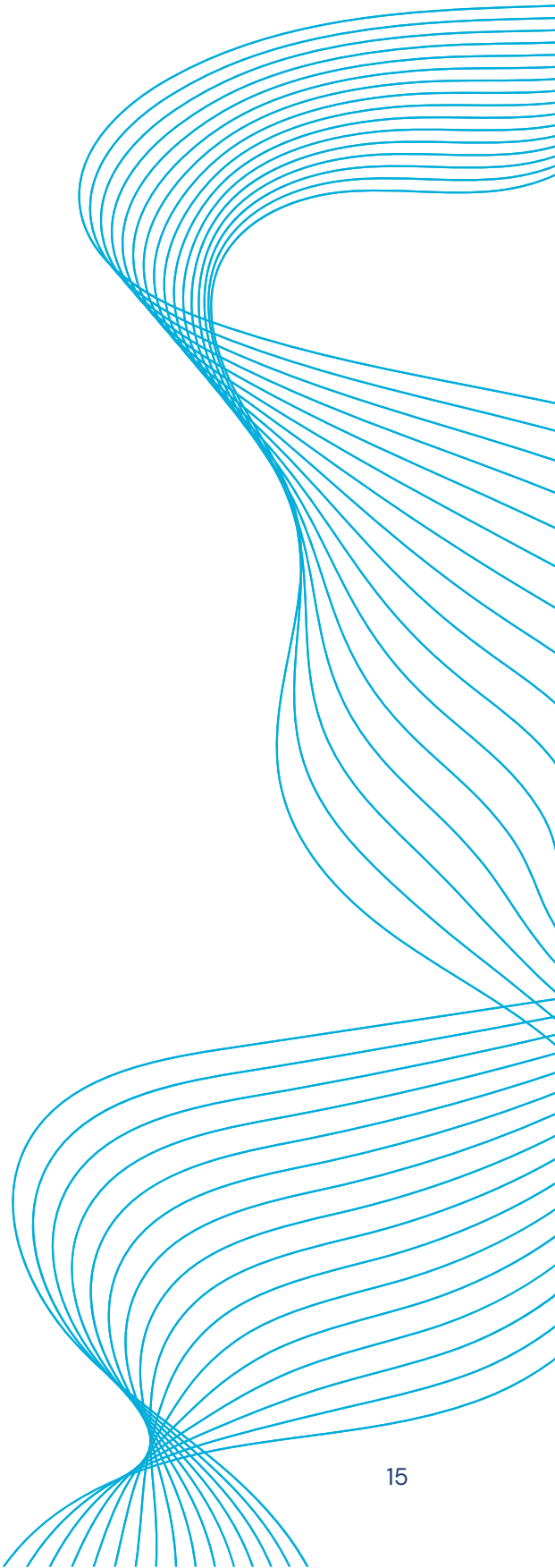
- Access challenges that were discussed included attachment to a primary care provider, wait times, and geographic/physical barriers (transportation, cost, time, etc.).
- Inadequate follow-up and weak transitions (hospital-to-community, post-event rehabilitation, pediatric-to-adult care) were identified as major gaps driving preventable harm and cost.
- Secondary prevention was highlighted (e.g., follow-up after acute events) and the integration of mental health supports into physical care pathways.

DATA SHARING, INTEROPERABILITY, AND SYSTEM INTEGRATION

- Limited data sharing and interoperability were a top theme, tied to fragmented care, duplicated services, and poor longitudinal tracking.
- Better integration of programs and services was emphasized; across care teams, sites, and patient journeys.
- Participants noted that 'pilot culture' persists; innovation occurs but is not reliably adopted.

BROAD PARTNERSHIP ECOSYSTEM AND MEASUREMENT ACROSS THE CONTINUUM

- Participants emphasized engaging partners beyond primary care physicians, including pharmacists, nurses, dentists, optometrists, as well as workplaces and insurers.
- The need to measure impact across the continuum was identified, as participants recognize that improvements in one area of health can affect another.
- Celebrating successes and sharing of learnings were viewed as important for momentum and adoption.



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Priority Innovation Challenges

The following 'How Might We' (HMW) challenge statements translate the session's themes into candidate innovation challenges. Each statement is framed to be broad enough for multiple HSDPs to see themselves reflected in, while still specific enough to drive actionable proposals.

HMW 1 — EQUITABLE EARLY DETECTION & SCREENING PATHWAYS

How might we enable earlier, equitable detection and risk stratification for cardiometabolic conditions so that Albertans have better health outcomes?

Problem & Rationale

WHO IS AFFECTED

Albertans at risk of cardiometabolic disease; priority populations may include rural/remote communities, Indigenous communities, and people facing affordability and access barriers.

WHY IT MATTERS

Late detection leads to preventable progression, avoidable acute events, higher costs, and worse patient experience and outcomes.

Key Barriers

- Primary care attachment gaps and capacity constraints
- Digital divide and uneven ability to navigate tools
- Fragmented and cumbersome screening pathways and follow-up workflows
- Capacity and time restraints for primary care providers

Key Enablers

- Emerging policy interest in self-referral pathways for screening/ diagnostics
- Community providers (pharmacies, specialty care clinics, dentists, virtual care) as accessible touchpoints
- Existing data assets that can support risk stratification when interoperable

Key Risks

- Increased screening without an appropriate follow-up capacity or planning/pathways
- Equity is harmed if self-referral privileges those with higher literacy/resources
- Privacy and consent concerns if new data flows are introduced

Potential Success Measures

- Higher rates of appropriate screening among priority groups
- Improved time-to-diagnosis and time-to-treatment
- Decrease preventable Emergency Department visits and hospitalizations caused by complications

HMW 2 — HEALTH LITERACY AND SELF-MANAGEMENT

How might we improve health literacy and access to self-management tools so Albertans can confidently manage their health in partnership with providers?

Problem & Rationale

WHO IS AFFECTED

Albertans with varying levels of health/digital literacy; patients managing chronic conditions; caregivers; and communities with low trust in systems.

WHY IT MATTERS

Misinformation and low confidence reduce preventive uptake, adherence, and engagement with care, especially for long-term conditions that require greater self-management.

Key Barriers

- Misinformation environment and stigma
- Lack of awareness and access to existing tools
- Complex, inconsistent messaging across providers and programs
- Lack of culturally safe and plain-language resources and tools

Key Enablers

- Community organizations and trusted conveyors of information
- Emergence of technology enabling plain-language, accessible tools and pathways
- Co-designed communication and resources that reflect lived experience

Key Risks

- Solutions perceived as top-down or paternalistic
- Digital-only approaches, excluding those without access
- Unregulated AI-enabled content that unintentionally amplifies bias or incorrect information

Potential Success Measures

- Improved patient activation and confidence scores
- Higher engagement in prevention programming, tools and follow-up

HMW 3 — EVERYDAY PREVENTION SUPPORTS AND ADDRESSING SOCIAL BARRIERS

How might we make it easier for Albertans to access practical, culturally relevant prevention supports that help reduce everyday barriers to cardiometabolic health (e.g., food insecurity, cost, transportation, time, and stress)?

Problem & Rationale

WHO IS AFFECTED

High-risk populations and those with early-stage disease, especially those facing affordability, access, and navigation barriers; caregivers are often impacted too.

WHY IT MATTERS

Prevention fails when the burden sits on the individual without practical, accessible supports. If we make supports easier to reach, we reduce downstream complications and system strain.

Key Barriers

- Affordability of goods and services such as food, programs, transportation, devices, and fragmented eligibility/program rules
- People do not know what exists, where to go, or how to enroll, leading to navigation burden
- Trust and cultural relevance gaps make it so that supports do not fit lived realities
- Limited capacity in primary care to connect the dots and provide holistic care

Key Enablers

- Community organizations and trusted connectors, including cultural and community leaders
- Primary care teams, pharmacies, virtual clinics, and community clinics as low-barrier entry points
- Existing social prescribing and community programs that could expand with additional support

Key Risks

- People get directed to supports that are full or inaccessible
- Potential equity harm if access relies on having a smartphone or English literacy
- Short-term pilots that lack sustainability pathways

Potential Success Measures

- Increased uptake and completion of prevention supports (improved nutrition, physical activity, stress management, smoking cessation, etc.)
- Improved patient-reported ability to complete a prevention plan (reduced burden, clear next steps)
- Early clinical and functional signals (e.g., improved blood pressure)
- Fewer avoidable acute care visits and admissions over time

HMW 4 — INTEGRATED MENTAL HEALTH SUPPORTS

How might we sustainably integrate mental health supports into cardiometabolic care pathways to ensure patients receive coordinated, holistic care across settings?

Problem & Rationale

WHO IS AFFECTED

People living with or at risk of cardiometabolic conditions—where the stress and day-to-day burden of chronic disease can impact mental wellbeing—especially those facing higher barriers to support; plus caregivers and care teams managing complex needs.

WHY IT MATTERS

Mental health and cardiometabolic conditions are bi-directionally linked; lack of integrated support undermines outcomes and adherence.

Key Barriers

- Separate funding models for mental health vs physical care
- Access and capacity constraints for mental health services
- Limited or underutilized screening and referral pathways embedded in care for chronic conditions

Key Enablers

- Collaborative care models and integrated screening within chronic disease pathways
- Community-based mental health supports
- Digital supports, when designed to be accessible and equitable

Key Risks

- Lack of mental health remuneration models
- Insufficient workforce capacity
- Fragmented coordination and unclear ownership
- Widening inequities in access and uptake

Potential Success Measures

- Timely, completed mental health support
- Improved patient-reported experience and well-being
- Better cardiometabolic care adherence and outcomes

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Implementation Landscape: Risks, Barriers, & Enablers

Implementation success will depend on the broader system context in which Lighthouse projects land. Provincial momentum, policy shifts, and strong delivery partners can help innovative cardiometabolic health solutions take hold and scale. However, common barriers and risks can slow adoption or unintentionally widen disparities, and as such must be mediated.

Funded projects will be expected to contribute to shared learning by measuring outcomes, documenting implementation insights, and identifying conditions required for scale.

CROSS-CUTTING BARRIERS

Even with strong delivery partners and clear need, Lighthouse projects will encounter common friction points that slow uptake, limit reach, or strain implementation capacity.

- Workforce and capacity constraints.
- Fragmented pathways and unclear ownership for follow-up across settings.
- Digital divide (device access, bandwidth, literacy) and platform complexity for participants and end-users.
- Unaligned incentives for prevention (prevention not consistently funded care).
- Cultural safety gaps and structural barriers affecting access and trust.
- Fragmented interoperability of systems and technologies.

CROSS-CUTTING RISKS

If left unaddressed, these risks can undermine adoption, or unintentionally widen disparities, so they should be actively monitored and mitigated throughout delivery.

- Equity is harmed if digital or self-referral approaches favour those with higher resources and literacy.
- Siloed pilots that do not get adopted, leading to limited sustained impact.
- Privacy and security concerns with expanded data sharing and AI-enabled tools.
- Scope creep: attempting to solve policy, compensation, or system issues outside the feasibility of an innovation challenge model.

CROSS-CUTTING ENABLERS

At the same time, Alberta's current environment includes several tailwinds that can help innovative cardiometabolic solutions move from pilot to sustained practice, particularly when aligned with provincial priorities and existing delivery platforms.

- Provincial momentum on prevention, primary care modernization, and deliberate focus on digital health infrastructure.
- Emerging legislative interest in self-referral, prevention and evolving public-private practice models.
- Existing system partners with reach (pharmacies, community organizations, employers, insurers) that can support prevention and navigation.
- Clear program model: problems defined by HSDPs and matched with innovation solution providers, with attention to sustainability.
- Cross-ministry, agency, public sector, and industry collaboration as an enabler for project success.

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Foundational Takeaways

FOUNDATIONAL TAKEAWAYS

To set the Lighthouse Lead Consortium up for robust, patient-centred impact, and to attract strong, implementable innovation proposals, the following recommendations are proposed.

1) Clarify and operationalize guiding principles and a decision lens

Establish a short set of guiding principles that are explicitly used to shape challenge statements, assess proposals, and make trade-offs. These should reinforce a more upstream, person-centred orientation and reduce the risk of overly system-centric or technology-first solutions.

Suggested principles to adopt and apply consistently:

- Person-centred over system-centred: designed around real-life needs, burden, and outcomes.
- Upstream prevention and early action: reduce risk and progression, not just manage late-stage disease.
- Equity, cultural safety, and relevance: solutions that work across diverse communities and contexts.
- Co-design and shared accountability: with communities and frontline teams, not top down.
- Continuous learning and improvement: test, learn, adapt, and share what works and what does not.
- Scale what demonstrates value: prioritize models showing measurable patient, provider, and system benefit.

2) Invest in role clarity and trust-building with the Advisory Board

The Advisory Board is a high-leverage asset. To fully utilize it, the Lead Consortium should spend time clarifying roles, boundaries, and decision rights, and creating a genuine feedback loop so advisors can see how their input is used.

Practical steps:

- Confirm decision-making responsibilities between the Lead Consortium, the Advisory Board, and HSDPs.
- Establish working norms, including how input is gathered, what happens when there is disagreement and how conflicts of interest are handled.
- Close the loop after each engagement: "What we heard / What we're changing / What we're not changing (and why)".

3) Deepen problem discovery with Health Service Delivery Partner sites before finalizing challenges

Challenge quality determines solution quality. Before finalizing challenge statements, conduct structured discovery with HSDP sites (and community partners, where relevant) to ensure the problems are meaningful, grounded, well-scoped, and implementable.

- Confirm who is most affected (including caregivers) and what outcomes matter to them.
- Validate feasibility constraints: accessibility, data availability, staffing, referral capacity, procurement, privacy, and timeline.
- Translate insights into a clear problem brief per challenge, including context, boundaries, success measures, and non-negotiables.

4) Design the challenges to embrace complexity and enable co-design of innovative care models

Cardiometabolic care is a complex, multi-factor environment. The Lead Consortium should explicitly position the innovation challenges as an opportunity to develop integrated approaches and encourage co-design where it improves fit, adoption, and equity.

Ways to embed this:

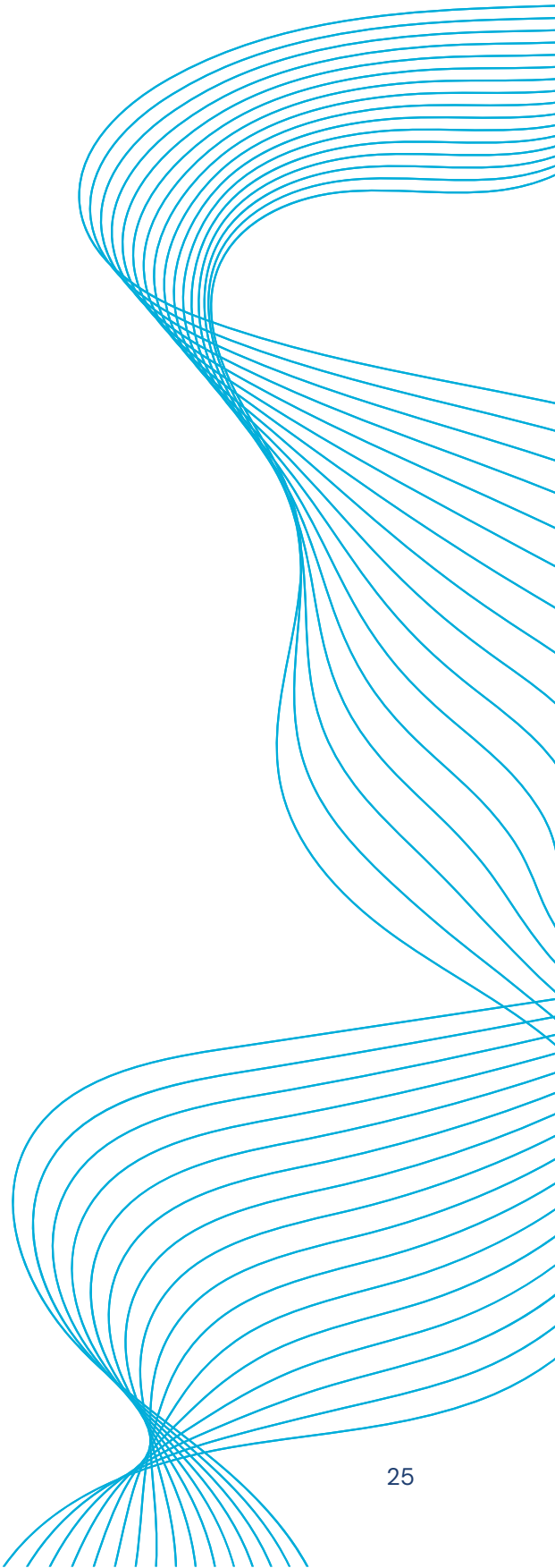
- Frame challenges to welcome multi-component solutions (e.g., workflow, navigation, and community support).
- Encourage cross-sector teams (HSDPs, community organizations, lived experience and technical partners).
- Resource early co-design and validation (discovery/prototyping phase before full build).
- Require teams to describe implementation and adoption (not just product features).

5) Build enablement mechanisms that remove barriers for funded teams

- Strong teams often fail due to execution friction, not ideas. The Lead Consortium should create a shared enablement backbone to reduce common barriers and increase the likelihood of real-world implementation.

Potential mechanisms include:

- Evaluation supports such as a shared measurement framework, ethics support, and standardized tools.
- Data access pathways including, clear processes, templates, governance support, and realistic timelines.
- Implementation and project management support such as access to key resources, onboarding, and risk management.
- Privacy, consent, and equity guidance through simple, consistent expectations and supports.
- A learning network across teams to share wins, failures, patterns, and reusable assets.



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Appendices

APPENDIX A. REFERENCES

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