Palliser Primary Care Network

(Go live date August 1, 2006)

Annual Report

Sections 1 and 2

For the period

April 1, 2022 to March 31, 2023

To be submitted to Alberta Health **no later than June 30, 2023**

Section 1

Summary of PCN Highlights

The Palliser PCN is in its 17th year of operation and sees maximization in the number of participating physicians, the number of clinics, the number of in-clinic PCN professional staff, and the number of patient enrollees.

Figure 1 - Active in-clinic PCN professional staff, 2017-2023

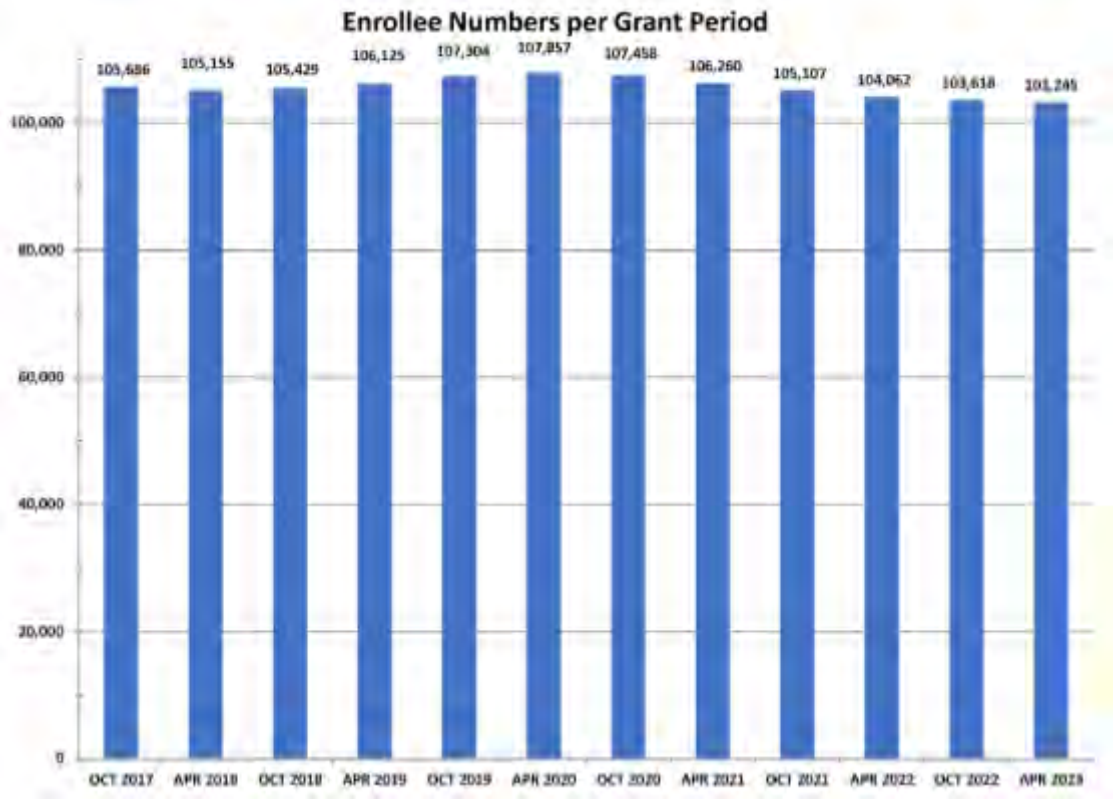

Figure 2 – PCN Enrollee numbers per grant period, 2017-2023

Over the reporting period, the PCN refined its Framework to guide its activities to meet the four PCN Provincial Objectives, including evaluation of these activities. As the PCN plans its future activities and reassesses its current initiatives, it seeks to align with at least one of the four PCN Provincial Objectives. In order to operate as a responsible steward of public funds and ensure service excellence, it must seek to engage in activities that are aligned as described.

Below are the four objectives visualized within the Framework (legibility not intended – detailed under each Objective in Section 2.a, including evaluation highlights of activities under each objective).

Figure 3 - Palliser PCN Framework: activities aligned with each PCN Objective

(Objective detail images not intended for full legibility)

In April 2021, the PCN initiated a new method to determine PCN physician eligibility for PCN professional staffing. This occurs by assessing an interested physician's profile of family practice and reviewing their PCN-measured EMR-sourced active family practice panel, with cross-panelled patients (patients identified on more than one family practice panel across the PCN) removed.

This new physician profile method has allowed teams to grow their multidisciplinary team more quickly than in the past. Using the new method, during the reporting period, 10 PCN physicians newly qualified for PCN staffing. Only two physicians would have qualified using the prior method. Since the establishment of the new profile method in April 2021, a total of 19 PCN physicians newly qualified versus four that would have qualified using the prior method. This has enabled the PCN to accelerate its work toward achieving the Patient's Medical Home PCN provincial objective.

Period Overview

Name of priority initiative: Professional Support Within Health Homes (approx. 90% of PCN expenditures)			
Elements	Planned Achievement	Status*	Status Explanation**
Addition of RNs / Other Professionals to Physician Offices	Ongoing development of interdisciplinary family practice teams/programs to support family practice physicians in the delivery of services to patients. The resources available from the PCN are insufficient for each physician to manage all problems and therefore physicians will concentrate on those issues that are most applicable to significant numbers of their patients (most often this is chronic disease prevention and management).	Ongoing	**1. Family Physicians:** The total number of participating physicians this reporting period is 90 (compared to budget of 90 physicians). **2. Other Health Providers:** Total FTE at the end of this reporting period of 44.22 FTE, comprised of: 1.2 NP, 34.44 RN, 2.2 LPN, 6.38 Behavioural Health Consultant, and 0 Dietitians (compared to budget forecast of 47.10 FTE) **3. Multi-disciplinary Teams** Percentage of physicians working in a multi-disciplinary team within their clinic is 94%. Explanation: All but three core family practice physicians are working in a multi-disciplinary team within their clinics. These physicians are offered PCN staffing twice annually, at minimum, and additionally throughout the year when the opportunity presents. Minority family practice physicians not currently qualifying for PCN staffing are offered PCN practice improvement support to increase their panel size if they are interested in qualifying for PCN staffing.

*Completed, On-going, On Target, Delayed, Deferred, or Discontinued
**Briefly describe achievements or explain delays, deferrals, or discontinuations.

Name of priority initiative: Measurement and Practice Improvement

(approx. 10% of PCN expenditures)

<table>
<tr><th>Elements</th><th>Planned Achievement</th><th>Status*</th><th>Status Explanation**</th></tr>
<tr><td>Support Health Home teams and implement practice improvement methodologies including panel identification and management.</td><td>Engage 5.0 FTE to support the development of the Health Home in participating clinics. Key achievements include clinic team development, EMR optimization, identifying and optimizing clinic efficiencies, and clinic linkages with specialists and the community</td><td>On Target</td><td>
1. Practice Improvement Staffing
Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement.
2. Collaborative Learning Sessions
Two health home teams (three physicians and five clinic team members) participated in one PCN-led Health Home Development Series – a 3-session series with in-clinic meetings between sessions to support teams with knowledge and tools to take practical steps towards health home optimization.
• 2022-23 Series
o November 10, 2022: Session 1 – Getting to Know Your Panel
o January 13, 2023: Session 2 – How to Use Your Team to Improve Access
o February 10, 2023: Session 3 – Strategies & Processes to Improve Clinical Care
Successful participation in this series is expected to increase motivation and readiness to pursue improvement activity beyond the Health Home Development Series.
Additionally, clinics are regularly exposed to non-collaborative-based practice improvement activities based on state of Health Home Optimization and their readiness for change.
3. Facilitated Education Events:
<table>
<tr><th>Event</th><th>Participants</th><th>Satisfaction</th></tr>
<tr><td>Shampoos, Tattoos, BBQs (May 11, 2022)</td><td>49</td><td>95%</td></tr>
<tr><td>Building Resilience (June 3, 2022)</td><td>36</td><td>91%</td></tr>
<tr><td>AMI (September 14, 2022)</td><td>38</td><td>84%</td></tr>
<tr><td>Dissipating Distortions (October 21, 2022)</td><td>38</td><td>90%</td></tr>
<tr><td>Beyond the Number</td><td></td><td></td></tr>
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			(November 18, 2022)	39	97%
			Health Home Development Series 2022/2023 – Session 3 (February 10, 2023)	8	96%
			Cardiopulmonary Connections (February 16, 2023)	41	95%

*Completed, On-going, On Target, Delayed, Deferred or Discontinued
**Briefly describe achievements or explain delays, deferrals or discontinuations.

Restricted Grants and Central Allocation Key Activities: (E.g. Evaluation, IT, etc.)			
Activities	Planned Achievement	Status*	Status Explanation**
Restricted Grants: The Palliser PCN did not receive any Capacity Building, Specialist Linkages, or Pharmacy Project grants during the year. Capacity Building Grants received in the PCN's early years had been fully expended at March 31, 2008.			

*Completed, On-going, On Target, Delayed, Deferred or Discontinued
**Briefly describe achievements or explain delays, deferrals or discontinuations.

SECTION 2.a.: EVALUATION

Contextual Questions:

Does your PCN have an existing evaluation framework?	Yes		The PCN has a comprehensive Evaluation Handbook which provides a framework / guidance for evaluation within the PCN. Additionally, the PCN has a detailed Health Home Optimization conceptual model which is accompanied by a matrix of behaviors which can be expected at different stages of Health Home Optimization within clinics from Beginner to Expert (based on the Dreyfus model of skill development).
Does your PCN have an existing PCN-level logic model?		No	The PCN does not use a logic model in a pure form as the PCN does not offer any PCN-wide clinical programs (i.e. all clinical services are offered within the Health Homes). Having said this, the AH Primary Health Care System Logic Model was used to inform the PCN Evaluation Handbook and Health Home Optimization conceptual model as described above.
Does your PCN have dedicated resources (e.g., FTE, funding) allocated to evaluation?	Yes		Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement.

Evaluation by PCN Objective:

Objective 1 Accountable and Effective Governance

Initiatives/Achievements:
Over the reporting period, the PCN developed a Framework to guide its activities to meet the four PCN Provincial Objectives, including evaluation of these activities. A summary of its Objective 1 section oriented within the overall framework can be seen below:

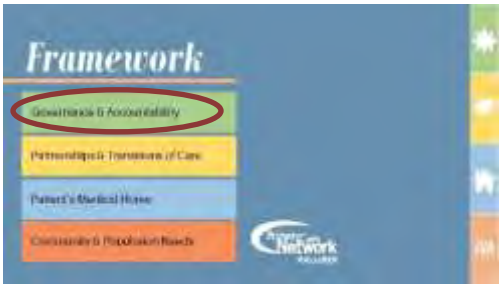


Figure 4 - PCN Framework with Governance and Accountability Objective circled

Below is a summary of the PCN activities related to meeting Objective 1:

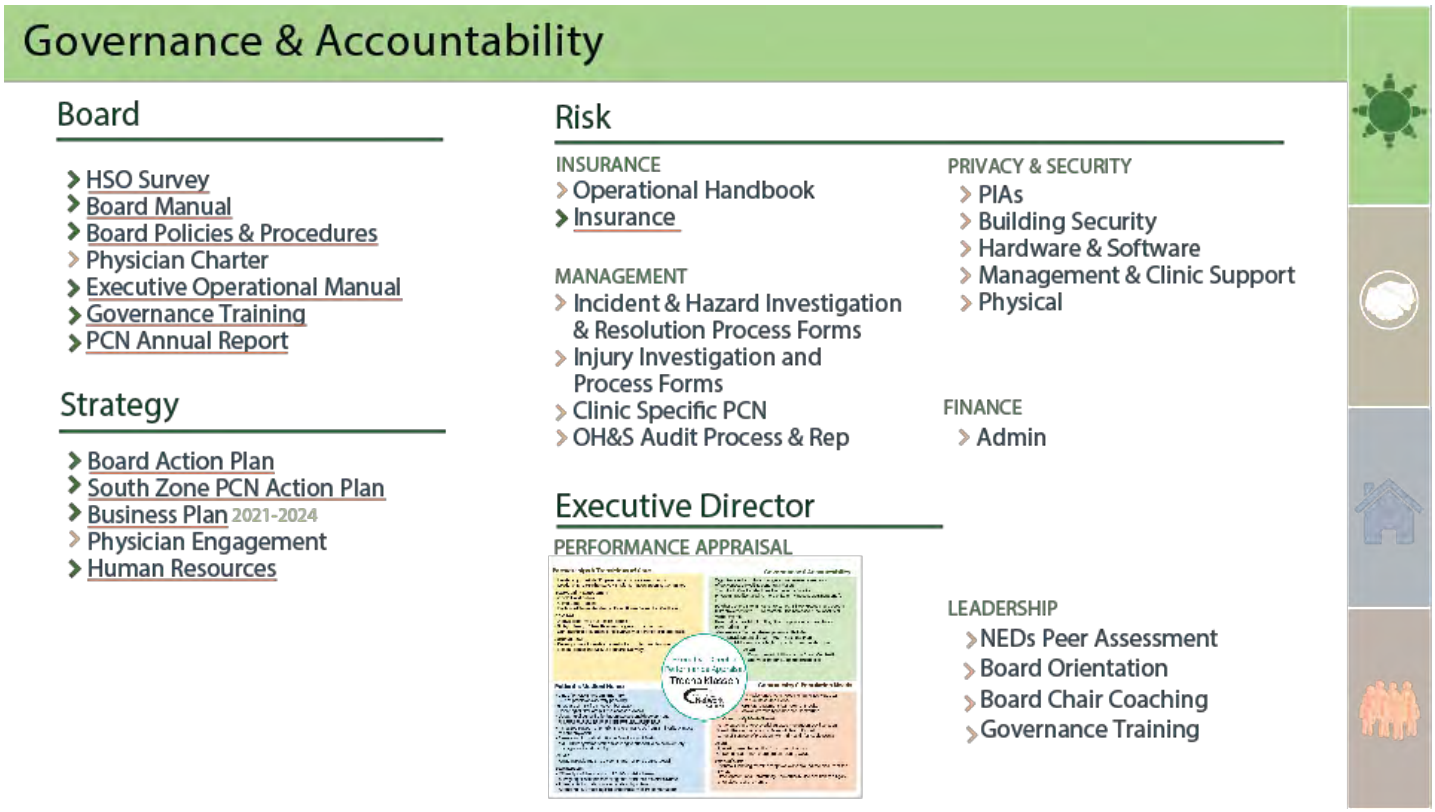


Figure 5 - Governance and Accountability Objective Activities
(performance appraisal detail not intended for legibility)

Highlights of the PCN's achievements related to Objective 1 during the reporting period (next page):

Governance & Accountability

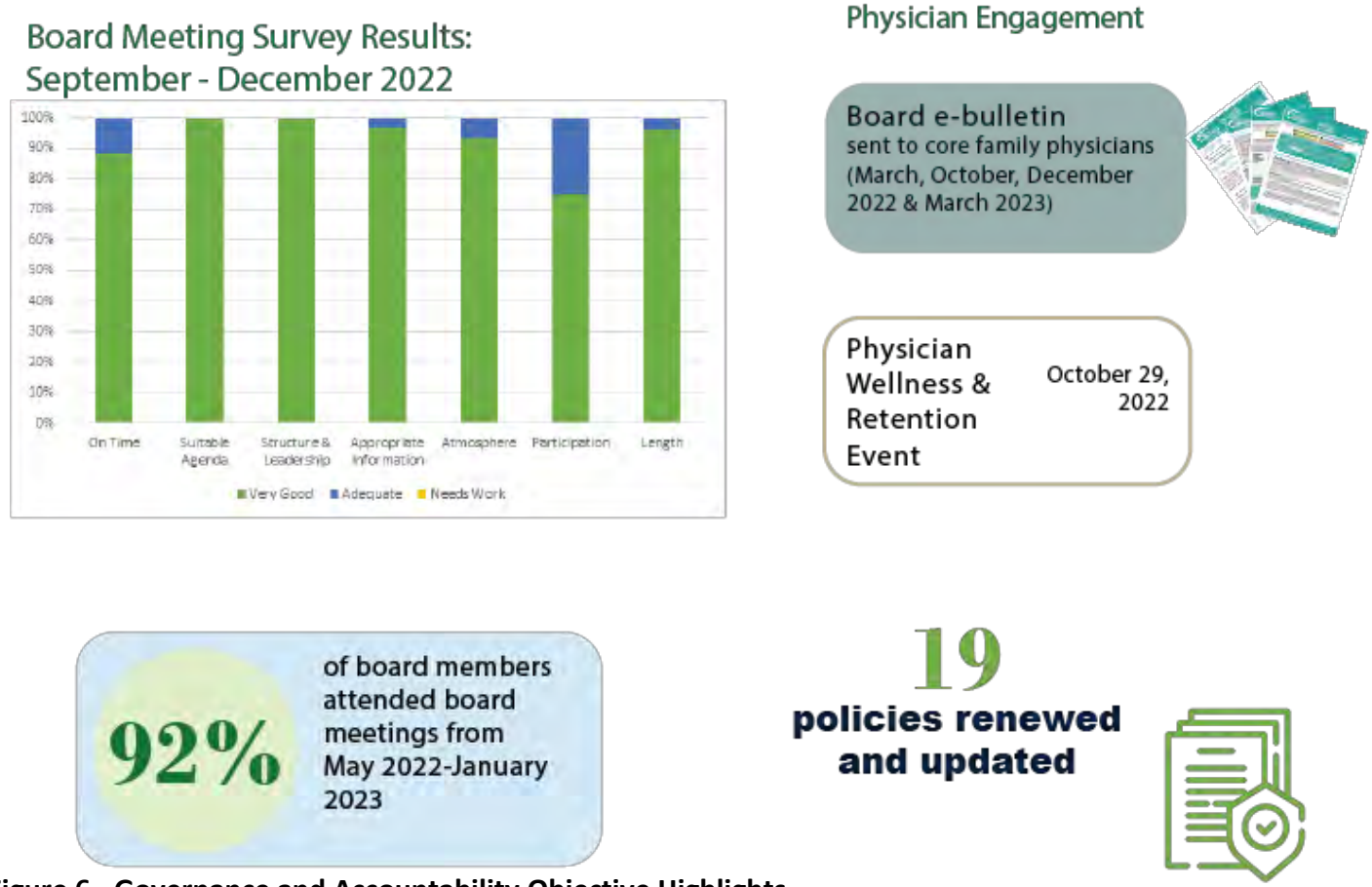


Figure 6 - Governance and Accountability Objective Highlights

Details related to Objective 1 highlights:

- Example of PCN board accountability survey and attendance items reflected back to members
- Multiple activities during the reporting period to increase physician engagement: in-person and electronically
    - o May 2022 Physician CME
    - o October 2022 Board e-bulletin: Physician recruitment/retention, Alberta Surgical Institute, AGM Summary
    - o October 2022 Physician Networking Event: local physicians recognized by Pattison Media
    - o December 2022 Board e-bulletin: CII/CPAR, Business Planning, Physician Profiles
    - o March 2023 Board e-bulletin: DynaMed, DynaLife, AGM information
    - o March 2023 Physician Town Hall: Business Planning 2024-2027

<u>Barriers</u>

- Time and human resources to increase/accelerate initiatives/achievements

Analysis of Schedule B Indicator Results requested in guidelines:

Governance Indicator:

Palliser PCN has engaged in governance training and goal setting for several years. The Accreditation Canada tool was used again in FY 22/23 and although improved from previous iterations it was still found to be minimally useful in improving governance training and goal setting compared to previous tools used.

GOVERNANCE INDICATOR	FY 2022/23	FY 2021/22
Did the PCN Non-Profit Corporation Board / Joint Governance Committee complete **both** the following activities during the year? 1) Collective self-assessment of the PCN Non-Profit Corporation Board / Joint Governance Committee as a whole. 2) Performance improvement plan for the PCN Non-Profit Corporation Board / Joint Governance Committee.	YES	YES

Figure 7 – Governance Indicator

Leadership Indicator:

The PCN Board chose to move away from a retrospectively scored performance evaluation to a prospective-focused improvement conversation. The PCN developed and led an Alberta PCN Executive Director Peer Assessment (*Developing Executive Director Competency in Organizational Effectiveness in PCNs*, March 2018; report available upon request). This produced some tangible achievement/performance goals for Palliser PCN, e.g. more robust occupational health and safety guidelines. The PCN Executive Director has been an AMA Governance Facilitator which has led to some improved PCN processes including mechanisms to engage physician membership. The PCN Executive Director has completed a Doctor of Business. All coursework and thesis focused on primary care action research.

LEADERSHIP INDICATOR	FY 2022/23	FY 2021/22
Was a performance assessment completed during the year for the PCN Administrative Lead and all other staff members directly reporting to the PCN Non-Profit Corporation Board/Joint Governance Committee?	YES	YES

Figure 8 - Leadership Indicator

Objective 2 Strong Partnerships and Transitions of Care

Initiatives/Achievements:
Over the reporting period, the PCN developed a Framework to guide its activities to meet the four PCN Provincial Objectives, including evaluation of these activities. A summary of its Objective 2 section oriented within the overall framework can be seen below:

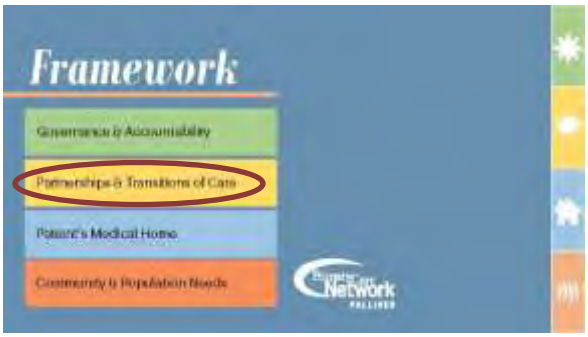


Figure 9 - PCN Framework with Partnerships and Transitions of Care Objective circled

Below is a summary of the PCN activities related to meeting Objective 2:

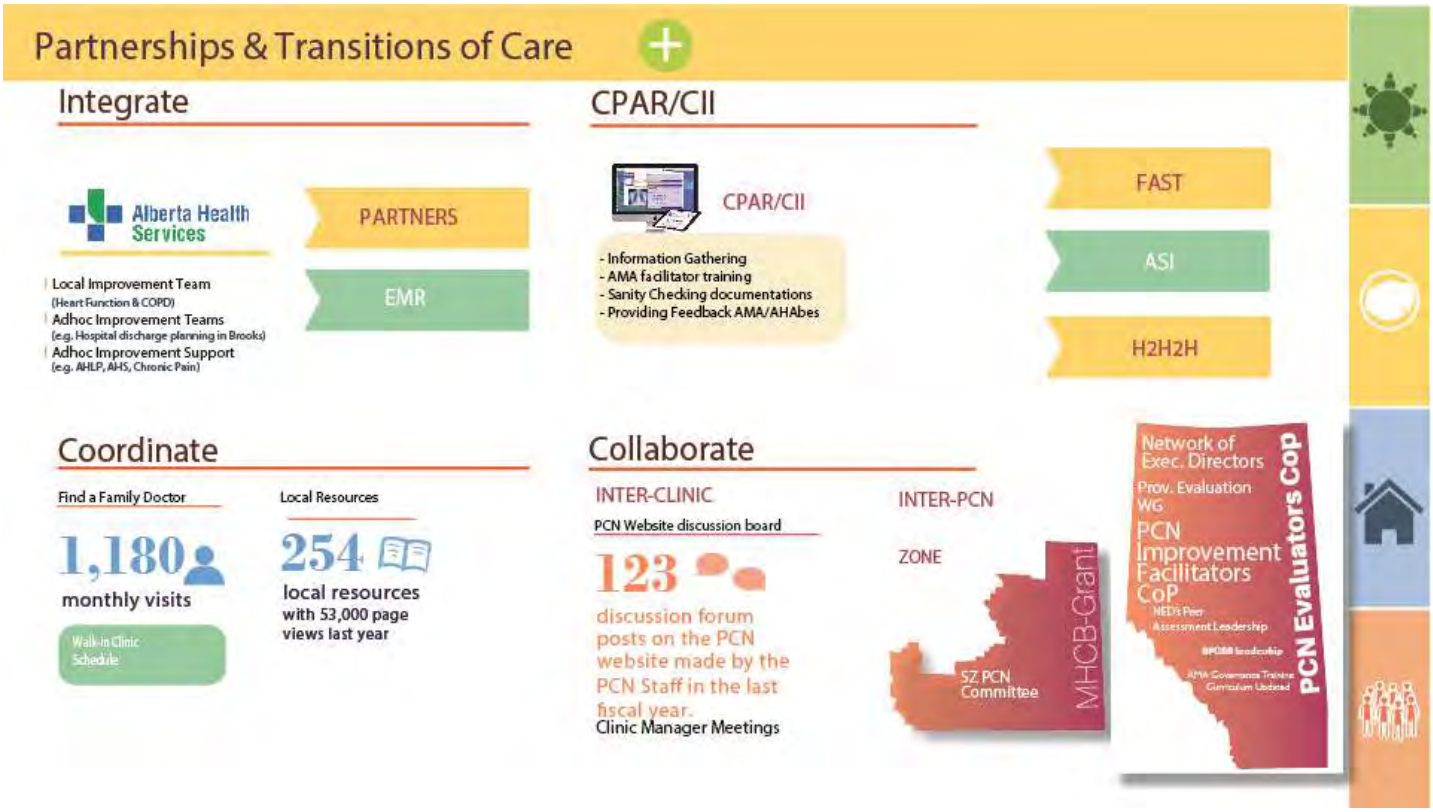
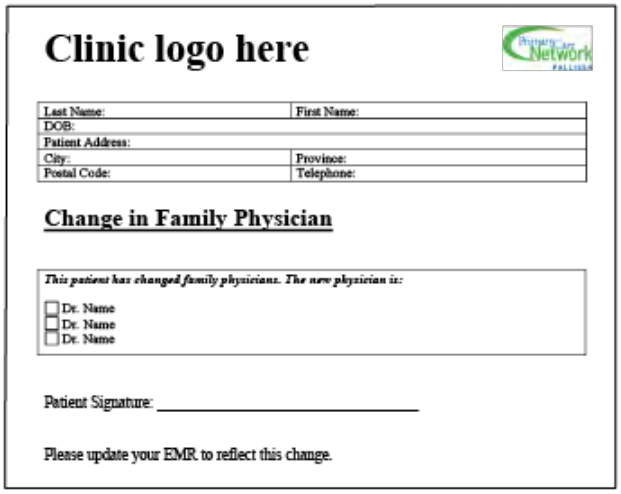


Figure 10 - Partnerships and Transitions of Care Objective Activities

Highlights of the PCN's achievements related to Objective 2 during the reporting period (next page):

Partnerships & Transitions of Care



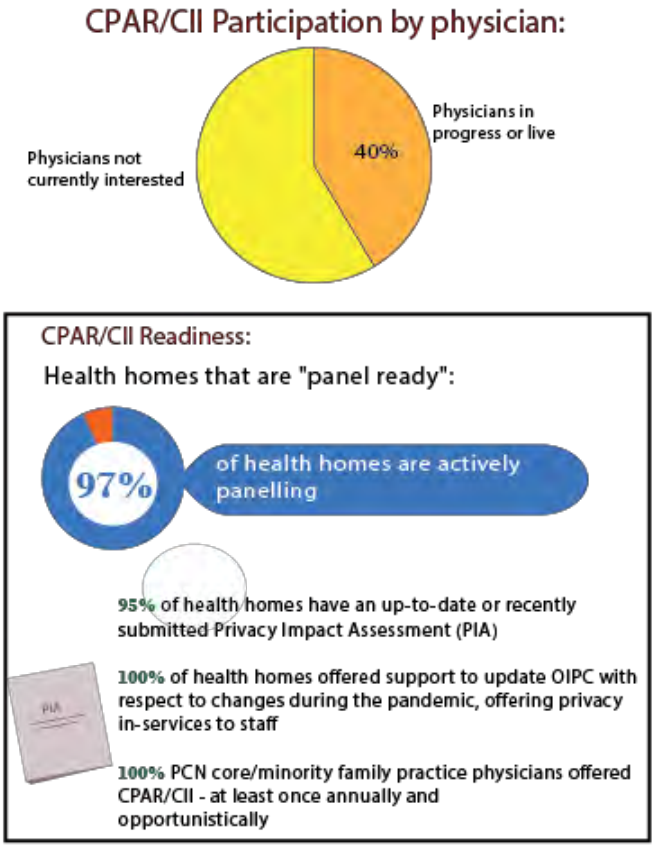


Figure 11 - Partnerships and Transitions of Care Objective Highlights

Details related to Objective 2 highlights:

- PCN has prioritized supporting member physician participation in CPAR/CII.
- Panel readiness and PIA update pre-requisites have been met to a significant degree across health homes.
- Privacy in-services led by PCN facilitators support PCN staff and health home staff awareness of physical, technical and administrative safeguards to protect patient health information.
- 29 physicians live or in progress on CPAR/CII across 15 health homes
    - 40% of PCN physicians with active family practice panels
- Additional CPAR/CII participation anticipated with:
    - Reduction in Accuro EMR enrolment backlog and CII component coming live (significant barrier for potential Accuro clinics)
    - Increased provider awareness of display of CPAR Primary Provider information in Netcare
    - Provider awareness of increased local participation in CPAR – increased value of conflict reports
- Some of the methods used by Palliser PCN to approach physicians and teams re: CPAR/CII interest:
    - PCN staff meeting discussions, celebrating successes of participating teams in PCN Chronicles Newsletter, follow-ups from PCN staff PA process
    - Follow-ups from PCN staff PA process, discussion at clinic manager meetings

Additional initiatives/achievements:

1. The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.
    - PCN provides monthly updates to ER and walk-in clinics of family physicians accepting new patients; also updated on Palliser PCN website (13,500 annual page views)
    - PCN website connects to Alberta Find a Doctor website to enable data synchronization between PCN website (source of truth) and AFAD website (secondary website)

i. Annual AFAD website visits from patients geo-located within Palliser PCN geographic area: 13,100 annual page views
ii. Uncertain # of Palliser PCN patients visiting PCN website and AFAD website (patients would be unaware that AFAD source data is the Palliser PCN website)

2. Shared health record within physician clinic.
   - Ongoing optimization of EMR usage with family physician clinics supported by PCN Central Office Administration team
   - 100% remote access to health home EMRs for Evaluation and Improvement purposes
3. Increased awareness of and access to transition supports.
   - Optimization of the use of electronic referral documents integrated into health home EMRs, adoption of electronic referral processes e.g. eFax, internal EMR e-referral
   - 254 Community Resources listed on Palliser PCN website: bidirectional communication between PCN and community services ensures website is up-to-date and accessible
     i. Examples include caregiver support groups, newcomer supports, day programs, financial support
   - Third-party supports, e.g. Alberta Facilitated Access to Specialized Treatment (FAST) Program
     i. Physician awareness of FAST Program is high but local adoption of Alberta FAST Program is limited due to minimal specialty rollout (urology and orthopedics) and reliance on personal relationships between health homes and specialists.
4. AHS and community NPC partnering via workshops, staff meetings, online discussion board, and face-to-face front line provider interactions.
   - AHS attends the Palliser PCN fall staff meeting to provide updates on influenza immunization including provisioning process and troubleshooting
   - Other AHS programs and community NPCs attend staff meetings on an ad hoc basis including:
     i. Non-Violent Crisis Intervention (four sessions throughout year)
     ii. City of Medicine Hat
     iii. Canadian Nurses' Association
     iv. Adoption Options
     v. Alberta Surgical Initiative
     vi. Alberta Health Services Homecare
     vii. Bridges Family Services
     viii. Intercultural Association of Medicine Hat
5. Increase linkages with existing zone programs (including secondary, tertiary, and long-term care services)
   - Where the PCN identifies a gap in service or learning need, the PCN provides clinical learning opportunities for health home teams ensuring local service providers are considered.

Barriers:
Some health home supports (e.g. Connect Care, FAST, Netcare, EMR vendor products) promise services that are not currently or widely accessible to Palliser PCN health home teams. This is related to: geography, cost, IT literacy and health home IT infrastructure.

Objective 3 Health Needs of the Community and Population

Initiatives/Achievements:
Over the reporting period, the PCN developed a Framework to guide its activities to meet the four PCN Provincial Objectives, including evaluation of these activities. A summary of its Objective 3 section oriented within the overall framework can be seen below:

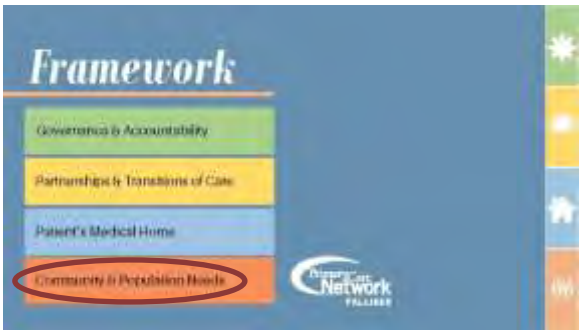


Figure 12 - PCN Framework with Community and Population Health Objective circled

Below is a summary of the PCN activities related to meeting Objective 3:

Figure 13 - Community and Population Health Objective Activity

Highlights of the PCN's achievements related to Objective 3 during the reporting period (next page):

Community & Population Needs

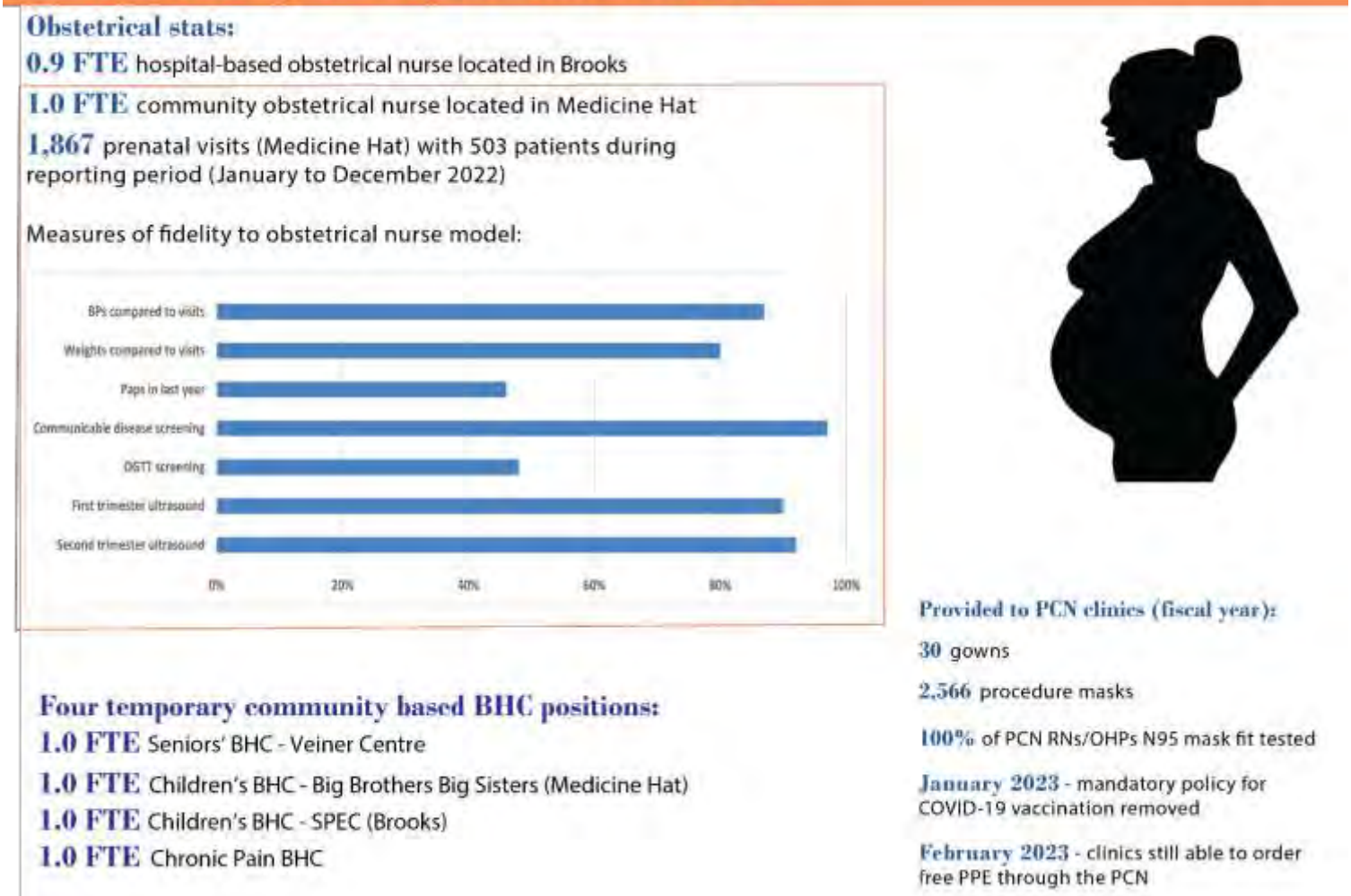


Figure 14 - Community and Population Health Objective Highlights

Details related to Objective 3 highlights:

- PCN airborne illness support to health homes included:
    - N95 mask fit testing for PCN RNs/OHPs; offered to PCN physicians and clinic staff, and dissemination of key messages to health home teams, & support with patient messaging.
- 1.0 FTE obstetrical nurse utilized to support prenatal care in Medicine Hat and co-located in four health homes, supported prenatal visits including referrals for necessary screening, and completion of Alberta Prenatal Record

Additional initiatives/achievements:

1. Support health home teams to evaluate population health data at a variety of levels and funnel it down to a health home panel-level population health improvement goal.
    - Individual health home teams are supported by PCN facilitators to set population health goals on an ongoing basis (see 4g: Capacity for Improvement).
    - Physicians are supported to engage in clinical practice improvement work to achieve their CPSA mandated quality improvement activities (Physician Practice Improvement Program).
2. Utilize high level reports when and where appropriate, predominantly for PCN planning purposes.
    - Consider HQCA, AH, AHS, local community reports (e.g. City of Brooks Quality of Life, Medicine Hat Vital Conversations report, Modernizing Alberta's Primary Health Care System, Alberta's Home to Hospital to Home, Primary Care 2023-White Paper Report).
3. Utilize health home data sets predominantly for clinical practice improvement purposes.
    - Ongoing support of health homes to leverage existing data and systems for continuous improvement
        - Domains of panel
        - Access
        - Screening

- Transitions
- Health management.

4. Stay abreast of the health needs of the community and population by:
    - participating in Medicine Hat not-for-profit Executive Director Network,
    - engaging with Zone PCN Committee, and
    - meeting with community groups when invited (e.g. Health Advisory Council, Friends of Medicare).

Figure 15 - Palliser PCN Collaboration

5. Advancement of the Behavioural Health Consultant (BHC) model
    - Nine distinct BHC staff during the year, 6.38 FTE at the end of this reporting period
    - Using PHQ-9, GAD-7, BHC-7 (Palliser PCN-developed) and Burns Anxiety/Depression Inventory Assessments (*Patient Reported Outcome Measures – PROMs*) for clinical care:
        - 6,700 BHC Initial or Follow-up visits with 2,100 patients in the reporting period
            - 1,700 Initial and 5,000 Follow-up visits
        - 6,200 BHC-7 Questionnaires completed during these visits
            - With an expectation of a BHC-7 completed during each BHC visit, model fidelity during the reporting period is estimated at 93%.
            - This is higher than the previous reporting period's estimated model fidelity of 83% (2020/21 period: 76%); potential factors: model fidelity increased related to decrease in average BHC utilization compared to 2021/22 reporting period (19% decrease – previous period: 69 minutes/visit; 2021/22 period: 65

minutes/visit; 2020/21 period: 76 minutes/visit); model fidelity increased due to increased BHC familiarity/comfort with model, unrelated to decrease in BHC utilization

- Decrease in BHC utilization may be due to an increase in smaller FTE BHC co-locations (as low as 0.08-0.1 FTE in a single health home) – this can cause increased no-show rates and challenges with team integration.
- Individual BHC staff review this measure (comparison of BHC visits to BHC-7 assessments) during their annual performance assessment. Staff supported to identify barriers that occurred during the reporting period and set practice improvement goals with support of PCN facilitators and supervisors.

    - Additionally, 6,450 PHQ-9, 3,800 GAD-7 and 810 Burns Anxiety Inventory Assessments completed by patients who saw these providers.

    - BHC checklists and EMR charting workflows refined during the reporting period (e.g. charting template enhancement, including reminder to ask patient about last flu shot).
    - Summary of BHC information seen in Figure 16 (to follow).

6. EQ-5D *PROM* collection continued for all non-BHC PCN clinical staff during this reporting period.
    - Practice Improvement Facilitators continue to assist PCN staff to develop PDSAs to maximize EQ-5D assessments (e.g. embedding into EMR workflows to increase clinical utilization, adding to clinical care checklists where these are used) to achieve goal of one EQ-5D assessment per patient per year.
    - 11,300 EQ-5D scores on different patients were collected during the reporting period.
    - Compared to 15,900 EQ-5D scores in 2021/22, 12,500 EQ-5D scores in 2020/21, 5,800 EQ-5D scores in 2019/20, 3,700 EQ-5D scores in 2018/19
    - 29% decrease in EQ-5D collection since previous reporting period. Potential reason: re-establishment of in-clinic EQ-5D collection process, given previous reporting period may have included significant virtual visit EQ-5D collection (during pandemic).
7. Crisis Prevention Institute Nonviolent Crisis Intervention and Prevention First Training
    - 4 classes were held April 2022-Mar 2023 to support 20 PCN employees, physicians and clinic staff to learn de-escalation techniques and interventions for patients in a crisis.
    - CPI training will continue to be held on an ongoing basis as needed. Certificate is good for 3 years.
8. Facilitate patients seeking a family doctor with access to accurate information regarding physicians accepting new patients.
    - PCN updates a listing of doctors accepting new patients every month.
    - Over 13,500 visits to this listing on the “Find a family doctor accepting new patients” link on PCN website homepage.
    - Approximately three family physicians are accepting new patients at any time.

Barriers/Potential Challenges:

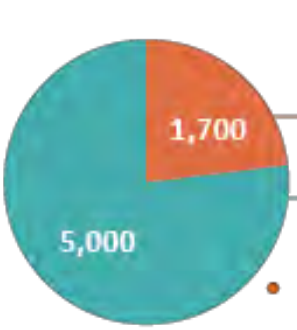
1. Health workforce shortage
    - All professions; shortage in workforce size and reduction in existing workforce wellness
2. Challenges in deriving actionable community and population health information from data sources that vary in:
    - Age: e.g. Alberta Health “PCN Dashboard” last updated in March 2023 but data ends March 31, 2021
    - Level of aggregation – data not always specific to PCN or community: e.g. some Alberta Health Community Profile data cannot be drilled down beyond the zone level, other data cannot be subdivided beyond the LGA, down to individual cities/towns

Advancement of the BHC Model

Primary Care Network PALLISER

6,700 visits with **2,100** patients

Return Visit Rate (RVR) = 3.2



- Ratio of follow up visits to initial visits = 3:1
- Goal = 1:1

9 BHC Staff across 19 Health Homes with **6.4** FTE — 82 minutes/visit (Approximately 6 patients a day)

93% Estimated model fidelity = **93%** BHC visits with a BHC-7 PROM score

96% BHC visits had a PHQ-9 PROM score

57% BHC visits had a GAD-7 PROM score

~970 annual BHC-7 assessments done per 1.0 FTE

Figure 16 - Advancement of the BHC Model

Objective 4 Patient's Medical Home (PMH)

Initiatives/Achievements:
Over the reporting period, the PCN developed a Framework to guide its activities to meet the four PCN Provincial Objectives, including evaluation of these activities. A summary of its Objective 4 section oriented within the overall framework can be seen below:

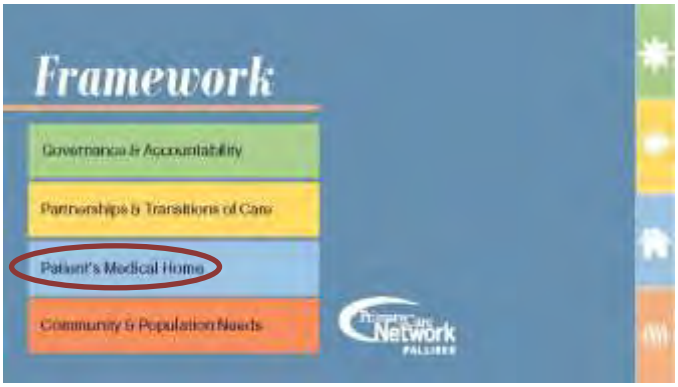


Figure 17 - PCN Framework with Patient's Medical Home Objective circled

Below is a summary of the PCN activities related to meeting Objective 4:

Figure 18 - Patient's Medical Home Objective Activities
(embedded images not intended for full legibility)

Highlights of the PCN's achievements related to Objective 4 during the reporting period (next page):

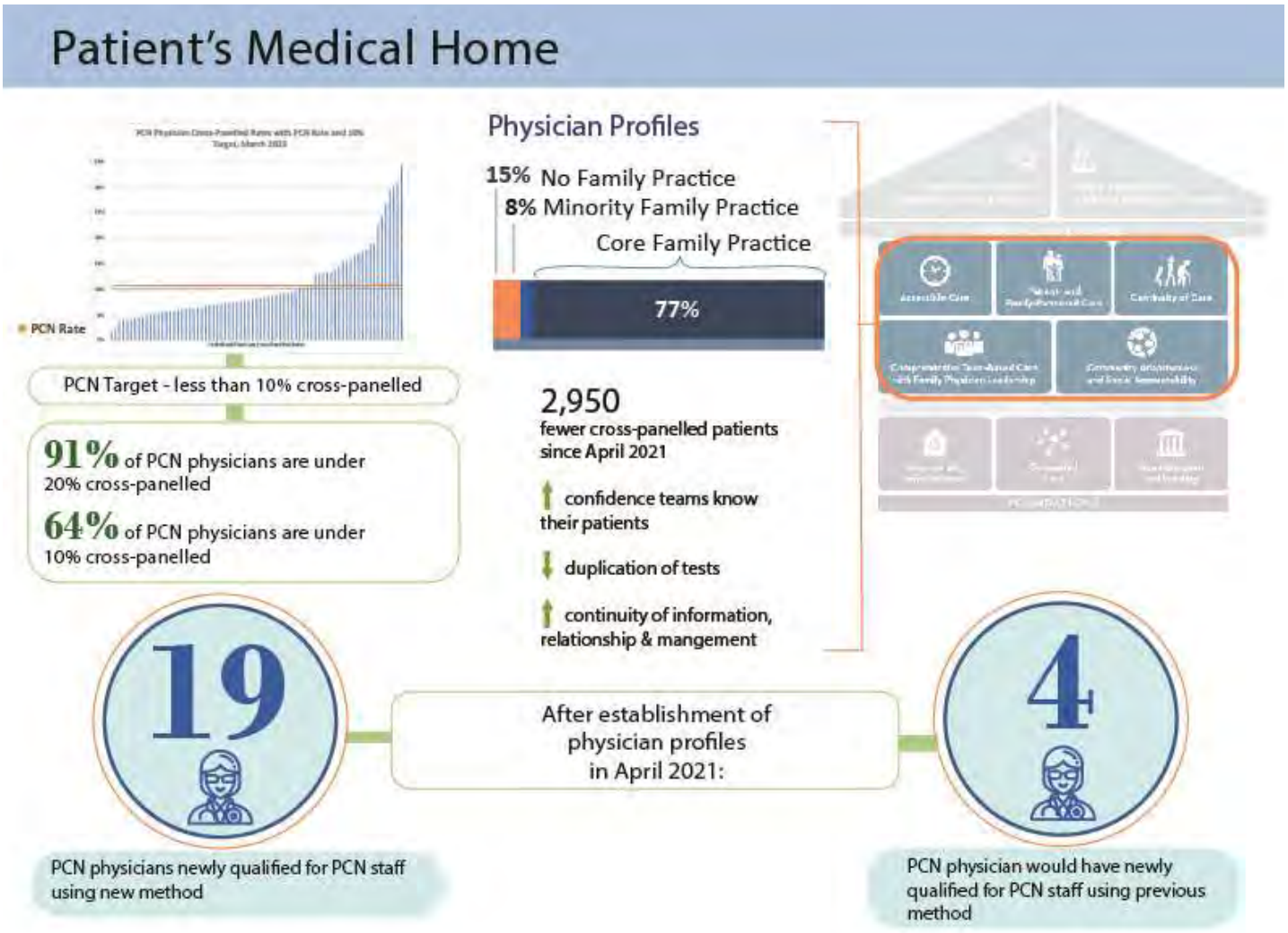


Figure 19 – Patient's Medical Home Objective Highlights
(embedded images not intended for full legibility)

Details related to Objective 4 highlights:

- PCN introduced a new method to assess each physician's profile of practice based on the EMR family practice panel. Socialized to PCN physicians through physician engagement activities described in Objective 1. Beginning April 1, 2021, this method was used to determine eligibility criteria for allotting PCN employees to individual Health Homes (physicians).
- Measurement of the EMR family practice panel excludes cross-panelled patients (11% of panels at the PCN level, compared to 13% in FY 2021-2022). I.e. patients that are on more than one EMR family practice panel are excluded from calculation.
- The PCN offers strategies and support to all health homes (physicians) to increase and/or stabilize their panel numbers, including to those physicians who will need to make an FTE reduction and have a two year notice period in which they are supported to increase their panel. This includes supporting teams to review panels, contact patients, and administratively inactivate patients who have not been in to the clinic in three years. (Typically three years is chosen as patient fidelity to a health home has been experientially noted to drop off significantly if a patient has not presented during this time).These strategies combine to develop and sustain processes to buttress panel accuracy.
- Health homes that anticipated the addition of new physicians were supported to establish processes to clearly identify family practice patients as the new physicians arrived – processes which align with the CPSA standards of practice regarding establishing the patient-provider relationship.
- CPAR/CII participation is offered to all health home teams and framed as an activity that supports this work (see Objective 2 summary).
- Increasing panel accuracy and minimizing cross-panelled rate supports achievement towards the Patient's Medical Home Model functions of Continuity of Care, Accessible Care, Patient- and Family-Partnered Care, Comprehensive Team-Based Care, and Community Adaptiveness and Social Accountability.

Achievements and initiatives cross-referenced with related PMH pillars:

1. Addition of RNs / Other Professionals to Physician Offices (related PMH pillars: *4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h*)
2. Increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient, and care of patients with chronic disease (related to pillars *4a-4h*)
3. PCN professional staff training (pillars *4c-4h*)
4. Office Practice Redesign including:
    a. Panel identification & management (pillars *4f-4g, 4i*)
    b. Form and support Health Home teams and implement practice improvement methodologies including panel identification and management (pillars *4e-4g, 4i*)
5. EMR optimization within the PCN Health Home Optimization Model (pillars *4a, 4b, 4d-4g, 4i*)

Pillars of the PMH (Initiatives/Achievements related to each PMH pillar identified above; pillars discussed below, analysis of Schedule B Indicator Results requested in guidelines embedded below):

4a: Care Coordination
Please see discussion in Objective 2: Strong Partnerships & Transitions of Care for further details regarding Palliser PCN initiatives to advance this pillar. Highlight made above related to CPAR/CII readiness and participation support.

The annual Palliser PCN physician survey contains a question regarding transitions of care. With feedback gathered through the PCN employee performance assessment process and PCN facilitator support offered to health homes to increase efficiency of care coordination (e.g. CPAR/CII participation, establishment of referral processes), a triangulation of perspectives regarding the current state of care coordination in Palliser PCN health homes was made possible.

Annual Physician Survey Results:

- Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (91% return rate). When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes.

Personal Experiences/Multi-disciplinary Team: "*During the past 12 months, my **patient transitions** into/out of acute and/or specialty care have been more closely followed"* resulted in an average rating score of 85%.

4b: Enhanced Access

Third Next Available Appointment measurement maximized among PCN physicians.
Additionally, **100% of PCN RNs/OHPs** measured Time to Third Next Available Appointment. This activity is supported by PCN Practice Improvement Facilitators, Supervisors, and the PCN Analyst. Please see pillar 4g below for a general discussion of Palliser PCN's process to align measurement for improvement with health homes' improvement activities.

THIRD NEXT AVAILABLE APPOINTMENT INDICATOR		FY 2022/23	FY 2021/22
Proportion of physicians measuring time to third next appointment	Numerator	89	89
	Denominator	90	90
	Proportion	98.9%	98.9%

Figure 20 - Third Next Available Appointment Indicator

Integration of PCN staff within 88% of health home teams is an enabler of enhanced access. The annual Palliser PCN physician survey contains a question related to use of this PCN staff which support increased access to the health home:

Annual Physician Survey Results:

- Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (96% return rate).

Personal Experience / Multi-disciplinary Team: "*During the past 12 months, I have felt that the administrative burden of having PCN staff in my office is acceptable."* resulted in an average rating score of 90%.

The annual Palliser PCN patient survey contains a question related to access:

Annual Patient Survey Results:

- Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (80% return rate). When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes.

Access: "*During the past 12 months, I have found it easier to access care from my health home team."* resulted in an average rating score of 92%.

4b.1: To increase the proportion of residents with ready access to primary care
Referring back to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.

Palliser PCN provides monthly updates to:

- emergency departments
- walk-in clinics
- Stabilization & Transition Clinic
- 24 different community resources (by email)
- *Alberta Find-A-Doc* website administrators

Regarding family physicians currently accepting new patients. This information is also updated on Palliser PCN website as shown below:

(Annual patient visits to "Find a family doctor accepting new patients" link on PCN website homepage: **13,500**)

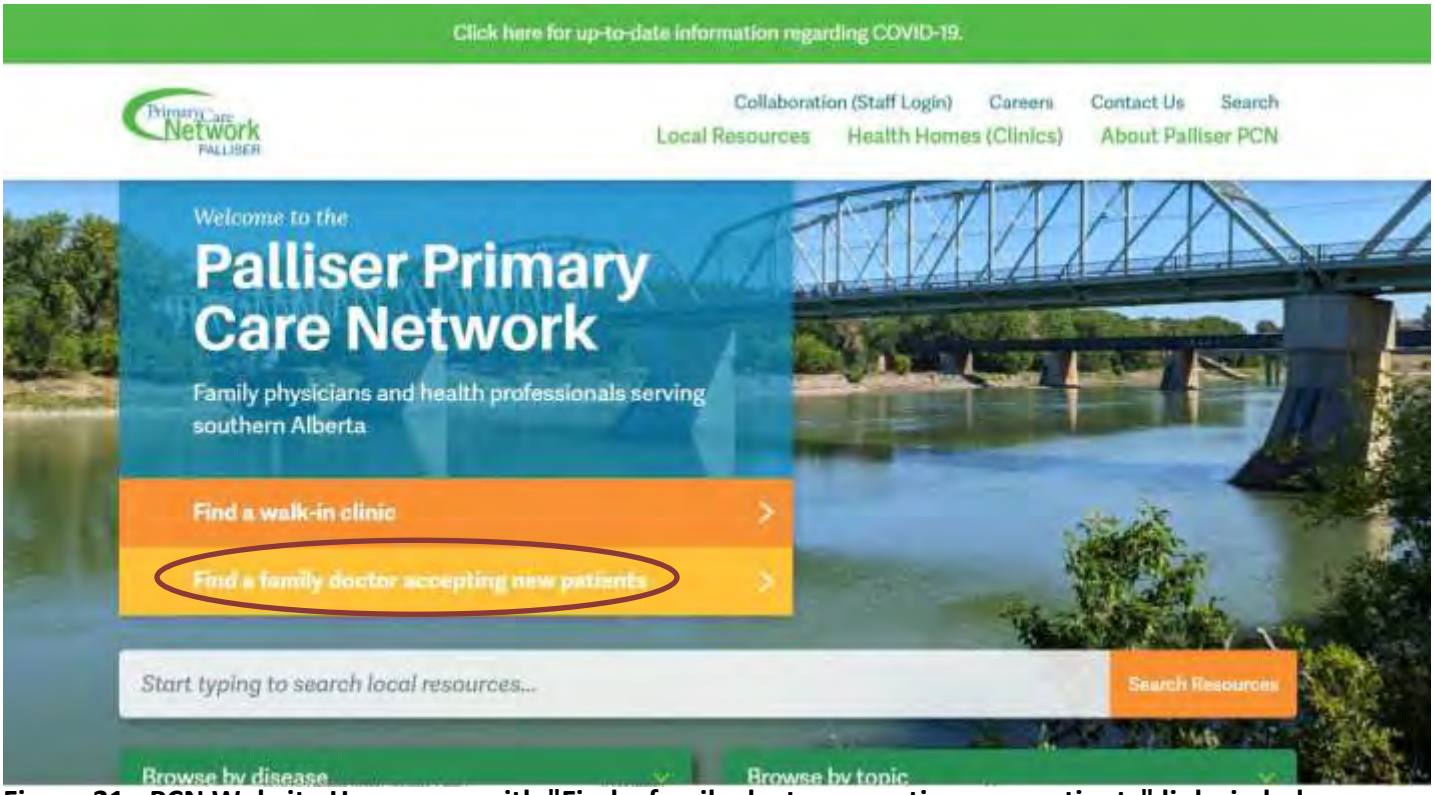


Figure 21 - PCN Website Homepage with "Find a family doctor accepting new patients" link circled

Since 2015, the PCN has assisted public walk-in clinics to be listed on the PCN website, including hosting their schedule if they agree to keep it up-to-date. Annual patient visits to PCN Website walk-in pages: **11,700**.

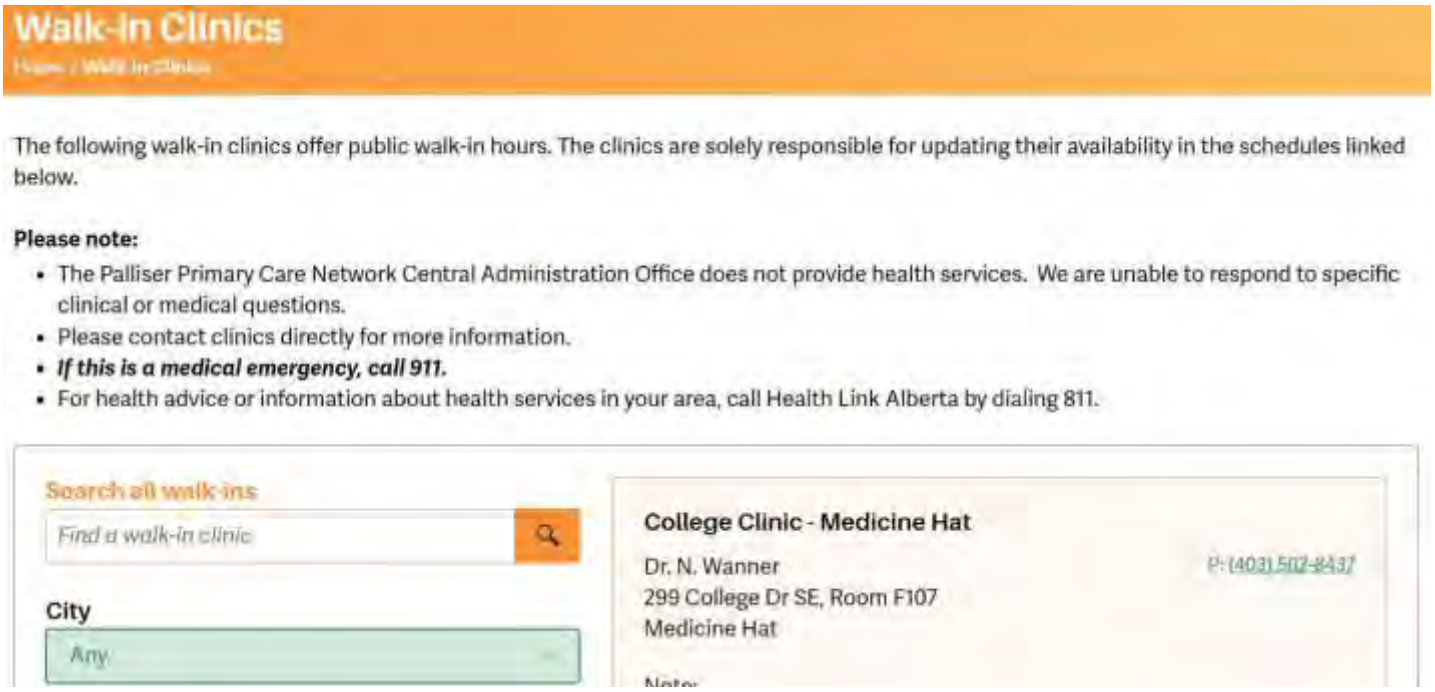


Figure 22 - PCN Website Walk-in Clinics landing page

There are 254 (down from about 300 in last reporting period) local community resources currently listed on the Palliser PCN website. Examples of listed resources include local caregiver support groups, newcomer supports, day programs, and financial supports. Bidirectional communication between the PCN and community resources ensures website is up-to-date. The PCN also mass-contacts all listed resources each summer to ensure accuracy of posted information. Annual PCN website local resources section page visits (all pages): **53,300**.

Figure 23 - PCN Website Local Resources landing page

10 most accessed PCN Website Local Resources, 2022/23:

1. Alberta Seniors Benefit Program
2. Allowance for People Aged 60 to 64
3. Rainbow Medical Centre
4. Foot & Ulcer Care (Calgary)
5. AHS Collection Sites & Diagnostic Labs
6. Alcoholics Anonymous
7. Addictions & Mental Health Outreach Services Medicine Hat
8. Children's Allied Health (Formerly CHADS)
9. Holy Family Parish – St. Vincent de Paul
10. Alberta Healthy Living Program – Classes & Education

4b.2: To provide coordinated 24 hour, 7-day-per-week management of access to appropriate primary care services

Please refer to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.

PCN DASHBOARD INFORMATION (USE X TO INDICATE RESPONSE)

#	PROVISION OF SERVICE	YES	NO
1	Do any of the clinics in your PCN provide Service after Hours?	X	
2	Do any of the clinics in your PCN provide Service on the Weekend?	X	
3	Do any of the clinics in your PCN provide Service both After Hours and on the Weekend?	X	
4	Does your PCN have On Call Programs?		X
#	**PATIENT GROUPS**	**YES**	**NO**
1	Do any of your clinics provide Indigenous health services?	X	
2	Do any of your clinics provide Refugee/Immigrant health services?	X	
3	Do any of your clinics have Seniors Care Programs?		X
4	Do any of your clinics have Pediatric Care Programs?		X
5	Do any of your clinics have Maternal Care Programs?	X	
6	Do any of your clinics have Fitness Care Programs?		X
#	**MENTAL HEALTH SERVICES**	**YES**	**NO**
1	Do any of your clinics provide Mental Health Services?	X	
2	Do any of your clinics have Opioid programs?		X
3	Do any of your clinics have Child/Youth mental health Programs/Services?	X	
#	**REFERRAL**	**YES**	**NO**
1	Does your PCN use e-referral to send requests to specialists?		X
2	Does your PCN use e-referral to accept requests from member clinics or specialists?		X
#	**Other General Information**	**YES**	**NO**
1	Does your PCN have Programs/Services that support Caregivers?	X	
2	Does your PCN have programs/Services that support Transitions of Care (Hospital-Community/Home)?	X	

DISCUSSION

Questions appear to be phrased to suggest PCNs should have "programs" to meet these population care needs as opposed to integrating care within existing holistic services.

Palliser PCN health homes integrate seniors care, pediatric care, fitness care into holistic patient care services.

Please see discussion above re: programs vs. services.

Questions appear to be phrased to suggest PCNs should operate as a form of intermediary to send and receive referrals between primary and specialty care.

Palliser PCN operates in a decentralized model with co-located RNs/OHPs in PCN member physician health homes. It has not identified a gap related to transmission of referrals.

Figure 24 – PCN Dashboard, Schedule B

4c: Patient Centred Interactions

The existing Palliser PCN patient survey asks patients to review their experiences over the past 12 months. Highlights are provided below:

PATIENT SURVEY RESULTS
Prepared January 2022

Return Rate: 80%

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total Responses
Weights	100%	75%	50%	25%	0%	

PCN Average Satisfaction Score		
2022	2021	2020

Topic	*"During the past 12 months:"*	Number of Survey Responses								
Patient Satisfaction	1. Overall, I have been satisfied with the care that I've received.	1073	143	6	1	4	1227	96%	96%	96%
Self-Management	2. My confidence to manage my health has improved through the support I receive from my PCN provider (e.g. RN, NP, BHC, Dietitian).	933	253	27	1	5	1219	93%	93%	92%
Patient Satisfaction	5. I have felt that my PCN provider is knowledgeable regarding my health.	1039	170	12	0	4	1225	96%	96%	96%
Quality of Life	8. Overall, I felt that receiving care from my health home team has improved my quality of life.	936	244	24	2	5	1211	93%	93%	92%

The Schedule B Patient Experience Indicator could not be integrated into the existing Palliser PCN Patient Survey:

- The mandated question is related to the current patient visit, whereas the existing survey asks over the last 12 months
- The mandated question is rated on a 6-point Likert Agreement scale, whereas the existing survey uses a 5-point Likert Agreement scale. The most recent Schedule B Patient Experience Indicator Toolkit did not indicate that PCNs could adjust the 6-point scale.

During the reporting period, Palliser PCN supported administering an independent Patient Satisfaction Survey containing one question - the Schedule B Patient Experience Indicator, as seen in the below figure:

Figure 25 - Clinic Patient Single Visit Satisfaction Survey

Results from the Patient Experience Indicator question (resulting from the Patient Satisfaction Survey) are shown below:

PATIENT EXPERIENCE INDICATOR		FY 2022/23	FY 2021/22
Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	33	100
	Denominator	33	110
	Proportion	100.0%	90.9%

Figure 26 - Patient Experience Indicator

Four PCN health homes (five physicians) were approached and agreed to support this survey. The process included:

- A PCN administrative staff member stood in each health home waiting room and asked patients to complete the single question survey after their visit.
- Results were tallied for each health home.

The PCN's process minimized burden to health home staff. In-clinic surveying required 10 hours of administrative time from Central Office administrative staff, surveying a total of 33 patients, meaning 3.3 patients were surveyed per hour of administrative staff time. Due to the per-patient cost of conducting this survey, the PCN did not expand with further physician volunteers. No actionable information could be derived from the survey results.

The PCN anticipates individual participating clinics will vary in their engagement to administer this single question survey to patients, irrespective of mode.

4d: Organized Evidence Based Care

All PCN workshops (please see Section 1, Priority Initiative: Measurement and Practice Improvement for workshop listing) are aligned with evidence based care from the planning stage to the follow-up.
The annual Palliser PCN employee survey contains a question related to satisfaction with education.

Annual Employee Survey Results:

- Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method. 100% return rate. When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes.

PCN Management and Administration: "*During the past 12 months, I have been satisfied with the amount and type of support and education that I receive from the PCN."* resulted in an average rating score of 93%.

Schedule B Screening Indicator results for the reporting period are summarized in the figure below:

SCREENING INDICATOR		FY 2022/23	FY 2021/22
Offers of screening maneuvers completed	Numerator	228,588	221,424
	Denominator	371,543	368,890
	Proportion	61.5%	60.0%

Figure 27 - Screening Indicator

Although it is not possible to derive meaningful, actionable intelligence from the above indicator, it could be suggested that the increase in screening maneuvers completed during the reporting period may be partially due to changes in patient care modes (e.g. decrease in virtual care and increase in in-person care) and screening logistics circumstances during the pandemic (e.g. increase in scheduled lab appointments, return of walk-in lab).

Most health homes with integrated PCN professional staff participate in screening measurement in the context of Activity and Clinical Measures sheets described in pillar 4g below. With a focus on clinical improvement, screening measurement predominantly occurs directly out of health home EMR systems. PCN Practice Improvement Facilitators support teams to identify improvement opportunities resulting from screening measurements. When teams are engaged, often the process of developing/reviewing standardized screening processes (including EMR charting processes) becomes more vital to teams and their improvement journey than aggregated screening measurement results themselves. Resultantly, screening measurement and process improvement cannot be unbundled from EMR optimization.

4e: Team Based Care

Results of the Team Effectiveness Progress Indicators are shown in the figure below:

Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	2	1
	Denominator	38	40
	Proportion	5.3%	2.5%
Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	2	1
	Denominator	38	40
	Proportion	5.3%	2.5%

Figure 28 - Team Effectiveness Progress Indicators

Health home teams counted in the above indicators were participants in the Palliser PCN Health Home Development Series, a 3-day collaborative learning series occurring across four months that covered all domains of health home optimization – panel, access, EMR, screening and team-based care. Team effectiveness elements were incorporated throughout the series and included activities that surveyed team behaviours, attitudes, personality types and communication styles. An example of this is the True Colors survey teams perform in Session 3 (Strategies and processes to improve clinical care). Each team member completes an individual assessment that supports them to identify their predominant personality traits. Through facilitation, teams increase their understanding of each member's traits and discuss how different team member "colors" can best be communicated with.

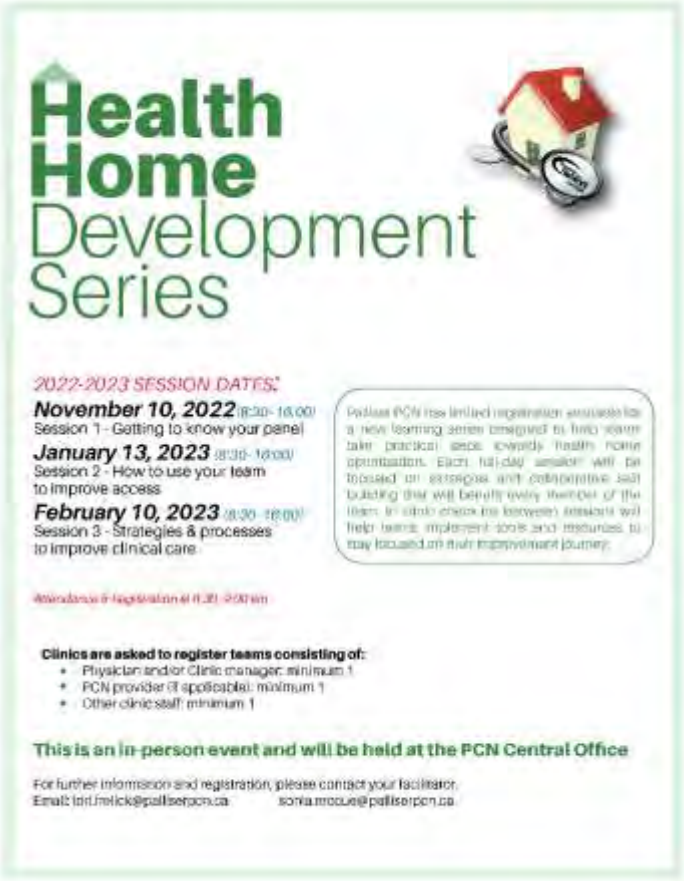


Figure 29 - Health Home Development Series

Additionally, Palliser PCN offers a Team Effectiveness Survey to administer to teams, with a sample paper implementation seen below. A team that is interested in conducting this survey is supported in modifying the sample survey to focus on elements of particular interest.

TEAM EFFECTIVENESS SURVEY

We appreciate you taking a few minutes to respond to this survey. Your feedback will assist in improving the effectiveness of your Health Home team. A summary of these results will be shared with the clinic.

Directions:
1. Please select the option which most accurately reflects your opinion about your work environment.
2. Please provide examples to assist your PCN Facilitator in customizing team development activities.
3. Please provide your name in the event follow up to your examples would help shape team improvement.

	Agree	Disagree	Please provide your examples
During the past 12 months:			
1. I am encouraged to work to the full extent of my ability.			
2. My concerns are addressed effectively, in a time frame that is appropriate.			
3. Team members' behavior supports a positive Health Home culture.			
4. Team members communicate in a respectful and effective manner.			
5. Team members work collaboratively.			
6. Team members trust each other.			
7. Team members respect each other's roles.			
8. I feel valued by my team members.			

Name: _____ Contact information: _____

Figure 30 - Sample Paper Palliser PCN Team Effectiveness Survey

A Team Effectiveness Survey is offered annually to clinics to guide their personal team improvement activities. In previous reporting periods, when individual teams used team effectiveness measurement to feed into team retreat planning, value was found. Overall, a limited number of Palliser PCN health home teams have participated in team retreats. During this reporting period, no clinic completed a survey of this nature.

Regarding activities/initiatives that support patients' self- management: Palliser PCN RNs/OHPs receive Choices and Changes training and education in ongoing motivational interviewing techniques. This instruction supports PCN RNs/OHPs to empower patients to increase their capacity to self-manage.

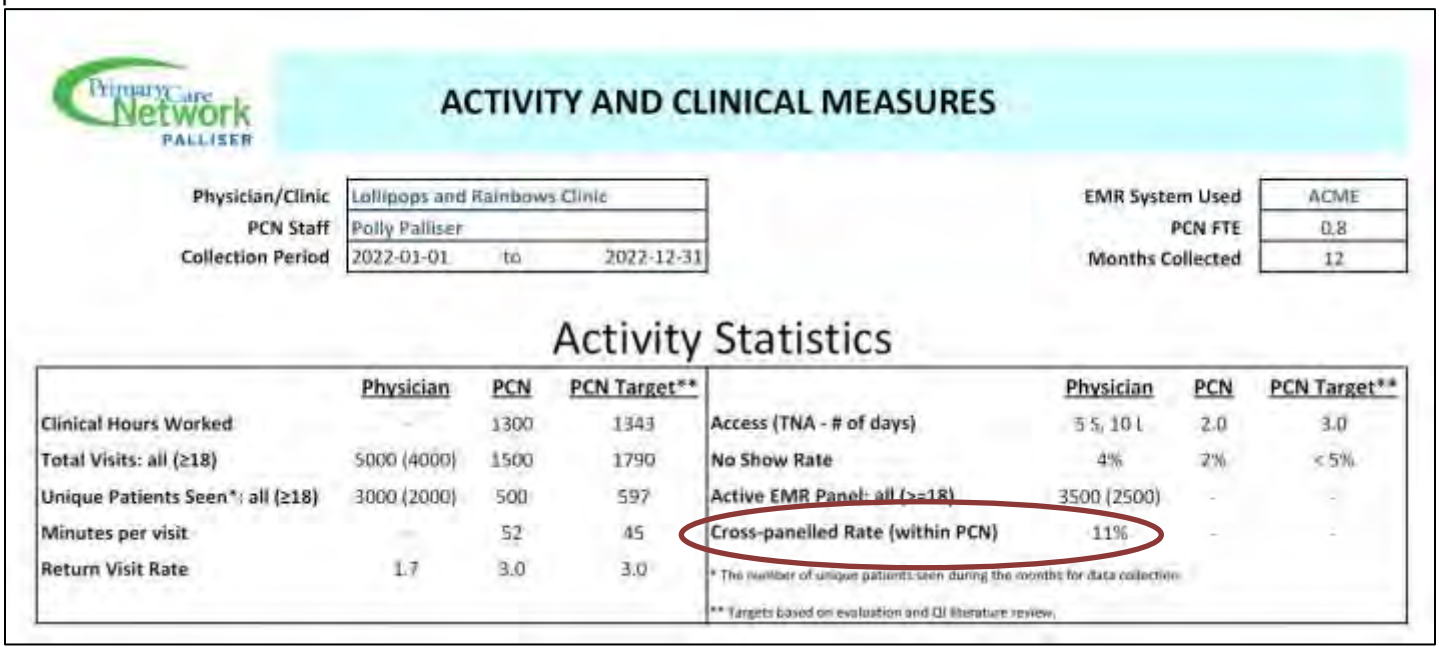
4f: Panel & Continuity

Palliser PCN uses its Adapted 5 A's for Health Home Optimization Model to engage health home teams to optimize in many areas, including panel and continuity. PCN Practice Improvement Facilitators support teams to review their panel, predominantly leveraging their EMR, and where documentation has occurred, standardized panel processes contained in clinic handbooks.

In the reporting period, the PCN sought to ensure PCN physicians who were interested in maintaining/increasing their active EMR family practice panel and minimizing cross-panelled patients to achieve their desired level of PCN staffing support. As described above pillar 4a, this could include supporting teams to review their panels, contact patients, administratively inactivate patients and assist physicians to enroll in CPAR/CII. Further, physicians are offered support to measure their access, compare to the current panel size and define an ideal panel size.

In the current iteration of its Activity and Clinical Measures sheet, the PCN has integrated the physician cross-panelled rate (seen below in Figure 31 in the Activity Statistics section) to support conversation about panel validation, CPAR/CII enrollment and a population health approach to panel management.

A cross-panelled patient is one with more than one PCN family physician who identifies the patient to be on their active EMR family practice panel. This could be due to: a patient switching health homes without notifying the former health home; a patient actively receiving primary health care from multiple health homes; or a record-keeping issue where a patient has received specialty care from one clinic that erroneously identified the patient to be on the family practice panel.



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic		EMR System Used	ACME
PCN Staff	Polly Palliser		PCN FTE	0.8
Collection Period	2022-01-01	to 2022-12-31	Months Collected	12

Activity Statistics

	Physician	PCN	PCN Target**		Physician	PCN	PCN Target**
Clinical Hours Worked	-	1300	1343	Access (TNA - # of days)	5 5, 10 L	2.0	3.0
Total Visits: all (≥18)	5000 (4000)	1500	1790	No Show Rate	4%	2%	< 5%
Unique Patients Seen*: all (≥18)	3000 (2000)	500	597	Active EMR Panel: all (>=18)	3500 (2500)	-	-
Minutes per visit	-	52	45	Cross-panelled Rate (within PCN)	11%	-	-
Return Visit Rate	1.7	3.0	3.0				

* The number of unique patients seen during the months for data collection

** Targets based on evaluation and QI literature review.

Figure 31 - PCN Activity and Clinical Measures Sheet - partial - Physician Cross-panelled Rate circled

At a health home level, the cross-panelled rate is the number of patients on active EMR panels that are cross-panelled divided by the number of total patients on active EMR panels. If a health home with 1000 patients has an 11% cross-panelled rate, this means there are 110 patients identified with *both* a family doctor at this health home and at least one additional family doctor at a different health home across Palliser PCN.

At a PCN level, the cross-panelled rate is 11%, down from 13% in the last reporting period. Individual PCN physician cross-panelled rates vary as seen below, with rates as low as 2% and as high as 34%. 91% of individual physician cross-panelled rates are below 20% (up from 80% in the last reporting period), with 64% already under the PCN target of 10% (up from 43% in the last reporting period).

By reducing the number of cross-panelled patients, a PCN physician and health home team:

- maximizes its knowledge of which patients consider it their health home
- reduces duplication of tests (reduce chance of multiple health homes "quarterbacking" care)
- increases relational, informational, management continuity with the patient to maximize care efficiency and effectiveness

Methods by which health homes reduce their cross-panelled rate include:

- establishing and maintaining panel verifying processes – e.g. verifying patient demographics and family doctor at every appointment, supporting teams to differentiate between active family practice patients and those seen for non-family-practice purposes like cosmetics
- communicating with a patient's former health home when a patient is newly accepted onto a family practice panel

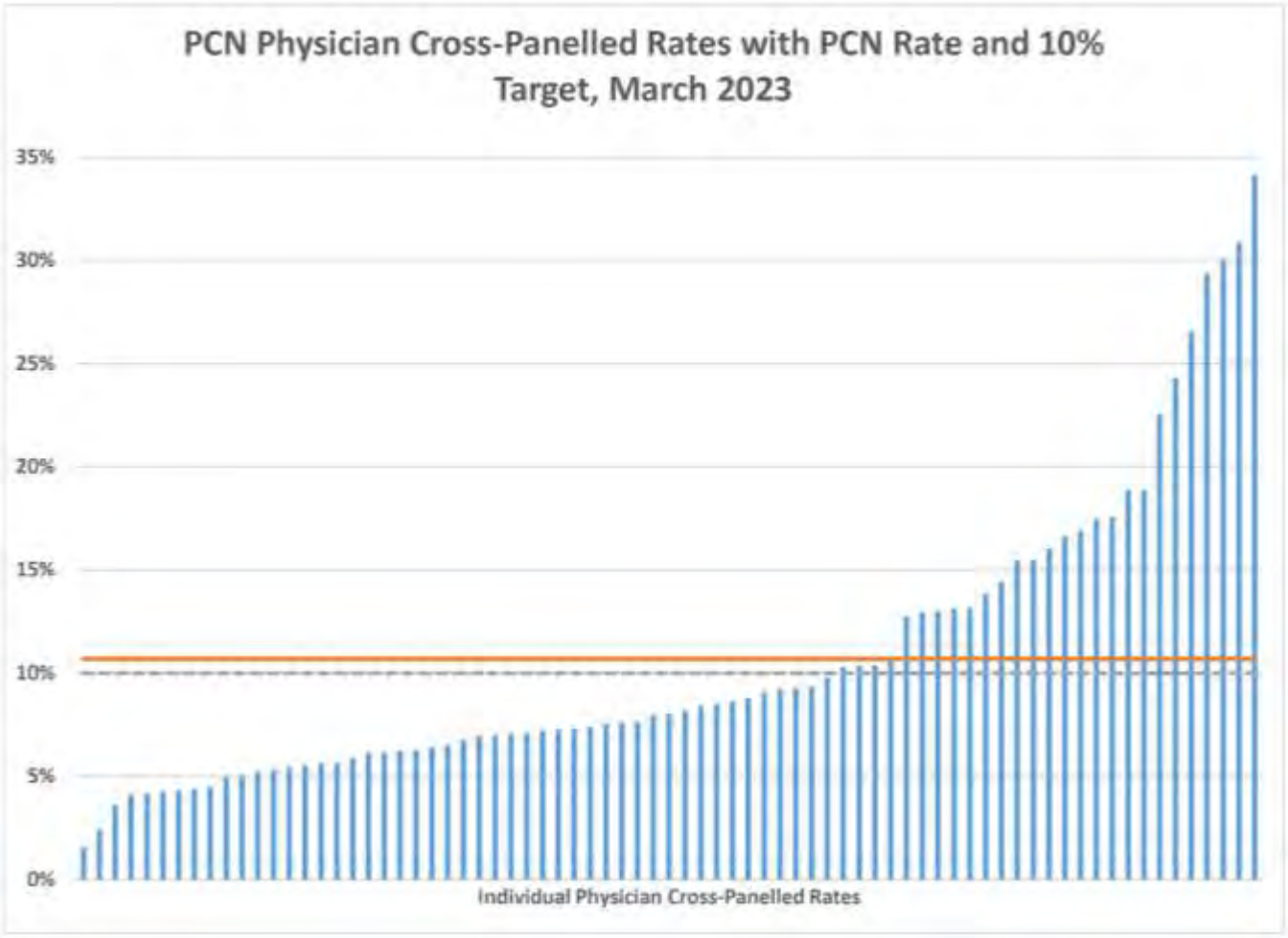


Figure 32 - Anonymous Physician - and PCN-level Cross-Panelled Rates, March 2023

Use of the above cross-panelled rates is discussed in the Objective 4 highlights and details above pillar 4a.

The PCN also uses HQCA reports as an additional, confirmatory measure of panel and continuity.

4g: Capacity for Improvement
Palliser PCN measures of health homes' capacity for improvement and framework for increasing that capacity by using its Health Home Optimization (HHO) Model and Scoring Matrix and its Adapted 5 A's of Health Home Optimization.

Historically, the PCN has found success in engaging health home teams in continuous improvement activities only when ongoing direct facilitator relationships with health home teams persisted.

With a primary focus on *measurement for improvement*, clinical data is extracted from health home EMRs and presented in an Activity and Clinical Measures Sheet to members of health home teams, typically to PCN RNs/OHPs and PCN physicians. These sheets frequently become the starting point for clinical practice improvement work.

Activity and clinical measures are taken both at:

- the PCN RN/OHP level – with physician/health home-level measurement added depending on level of physician engagement, and
- the health home level – to provide a more globally accessible population health perspective to health home teams.

PCN RN/OHP-level measures continue to provide a retrospective measure of each PCN staff's productivity in their clinic (e.g. number of clinical hours, visits, unique patients, return visit rate, no show rate), an indication of chronic diseases identified for patients seen by that staff, and some measures related their ongoing management of and screening for chronic diseases. This continues to exist as a component of the PCN staff's performance assessment process.

The below Figures display the current Palliser PCN Activity and Clinical Measures (ACM) sheet and the Screening Indicators defined in the bottom section of the ACM sheet (indicators on the reverse side of the Measures sheet):

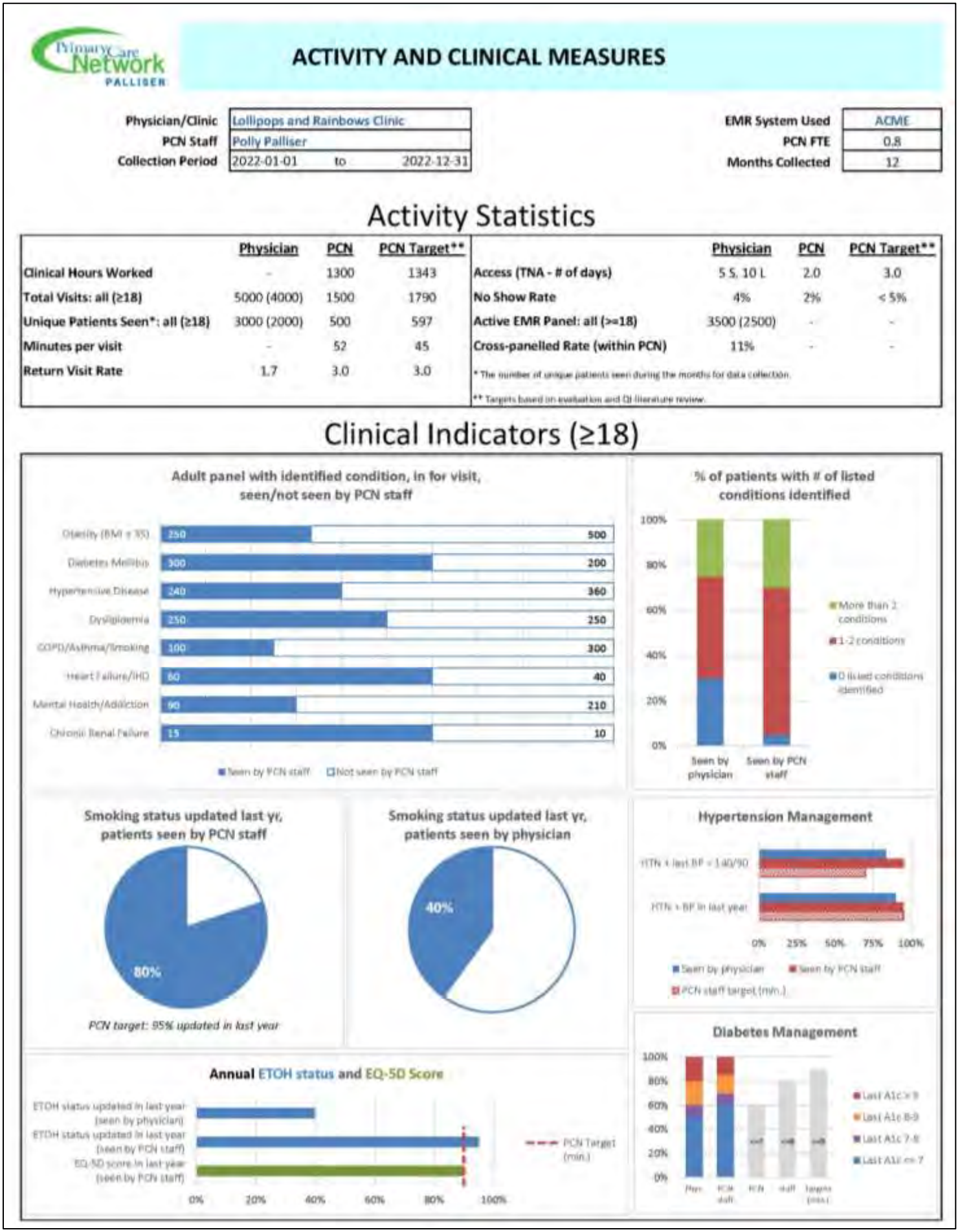
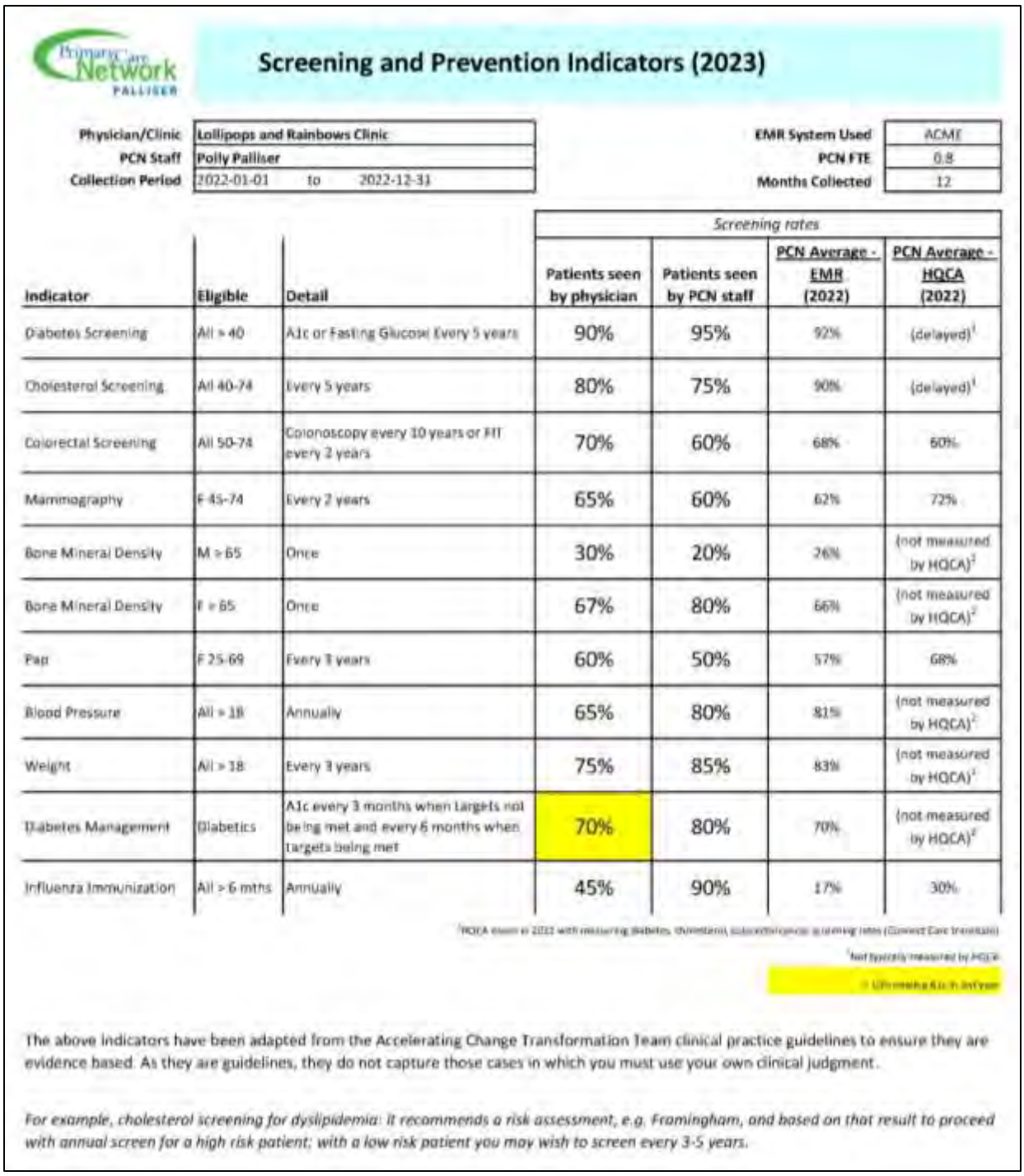


Figure 33 – Sample 2023 Palliser PCN Activity and Clinical Measures Sheet, Front Page



Screening and Prevention Indicators (2023)

Physician/Clinic	Lollipops and Rainbows Clinic	EMR System Used	ACME
PCN Staff	Polly Palliser	PCN FTE	0.8
Collection Period	2022-01-01 to 2022-12-31	Months Collected	12

			Screening rates			
Indicator	Eligible	Detail	Patients seen by physician	Patients seen by PCN staff	PCN Average - EMR (2022)	PCN Average - HQCA (2022)
Diabetes Screening	All > 40	A1c or Fasting Glucose Every 5 years	90%	95%	92%	(delayed)[1]
Cholesterol Screening	All 40-74	Every 5 years	80%	75%	90%	(delayed)[1]
Colorectal Screening	All 50-74	Colonoscopy every 10 years or FIT every 2 years	70%	60%	68%	60%
Mammography	F 45-74	Every 2 years	65%	60%	62%	72%
Bone Mineral Density	M > 65	Once	30%	20%	26%	(not measured by HQCA)[2]
Bone Mineral Density	F > 65	Once	67%	80%	66%	(not measured by HQCA)[2]
Pap	F 25-69	Every 3 years	60%	50%	57%	68%
Blood Pressure	All > 18	Annually	65%	80%	81%	(not measured by HQCA)[2]
Weight	All > 18	Every 3 years	75%	85%	83%	(not measured by HQCA)[2]
Diabetes Management	Diabetics	A1c every 3 months when targets not being met and every 6 months when targets being met	70%	80%	70%	(not measured by HQCA)[2]
Influenza Immunization	All > 6 mths	Annually	45%	90%	17%	30%

[1] HQCA ... 2022 with measuring diabetes, cholesterol, colorectal cancer screening rates (Connect Care transition)

[2] Not typically measured by HQCA

The above indicators have been adapted from the Accelerating Change Transformation Team clinical practice guidelines to ensure they are evidence based. As they are guidelines, they do not capture those cases in which you must use your own clinical judgment.

For example, cholesterol screening for dyslipidemia: it recommends a risk assessment, e.g. Framingham, and based on that result to proceed with annual screen for a high risk patient; with a low risk patient you may wish to screen every 3-5 years.

Figure 34 - 2023 Activity and Clinical Measures Sheet Screening Measures and Definitions

2022/23 changes to Activity and Clinical Measures Sheet:

- Addition of physician-level smoking and ETOH update statistics to increase team-wide engagement with lifestyle status updates

Aggregate measures resulting from wide-scale measurement out of clinic EMRs include:

- Number and proportion of patients seen by PCN RNs/OHPs with chronic conditions identified (*Figures 35 and 36*)
- Percentage of patients with chronic conditions identified seen by PCN RNs/OHPs proportional to those seen by PCN physicians (*Figure 37*)
- Average PCN RN/OHP utilization and access measures
- PCN RN/OHP and physician no show rates
- Chronic disease management and screening of patients seen by RNs/OHPs and PCN physicians

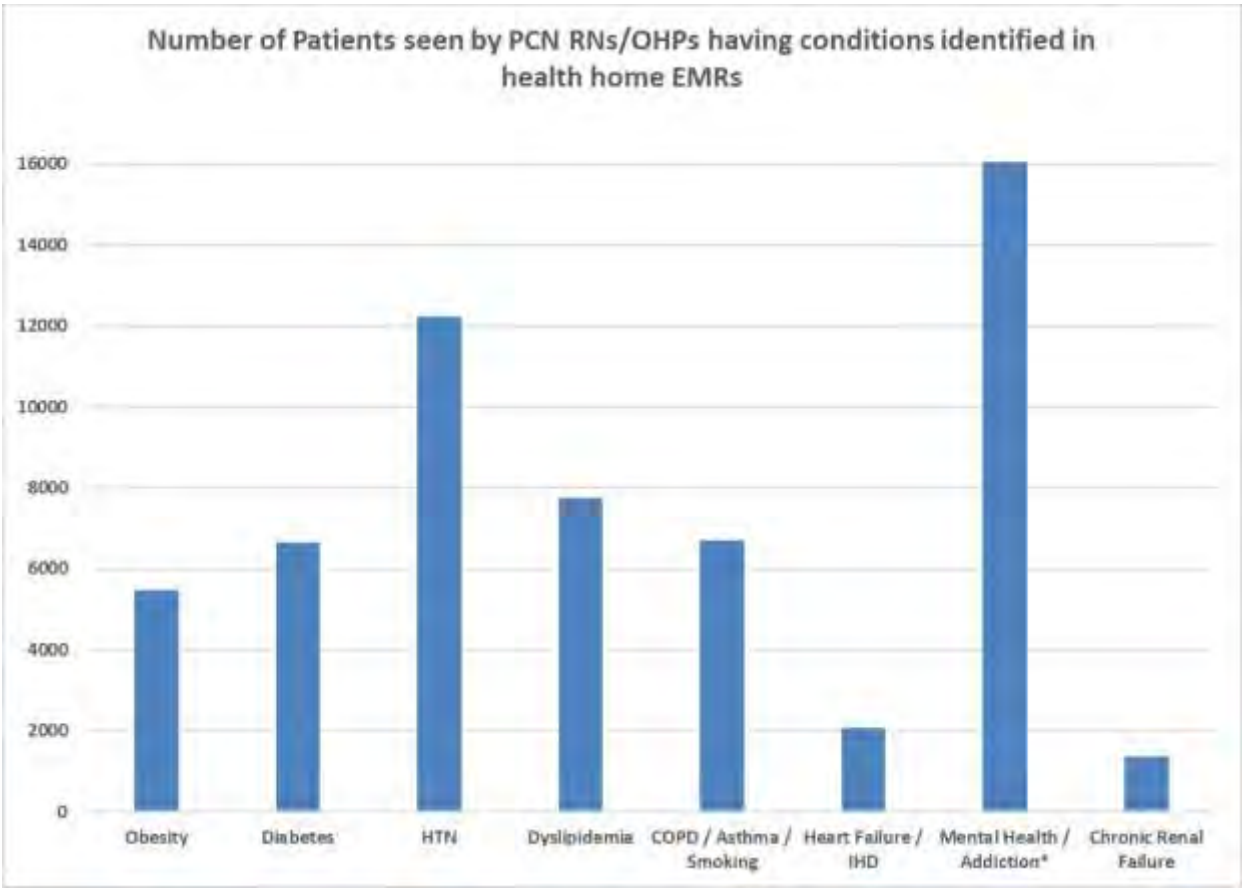


Figure 35 – Number of patients seen by PCN RNs/OHPs, by condition

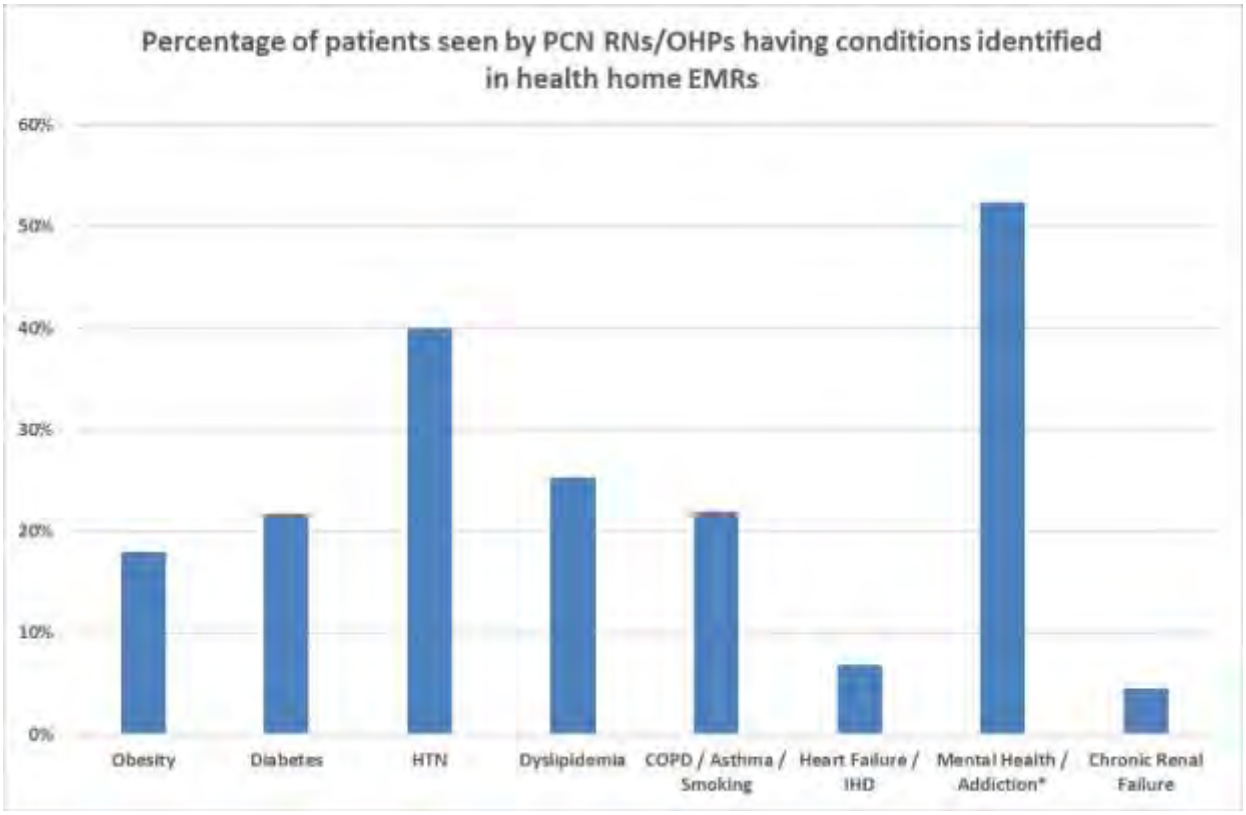


Figure 36 – Percentage of patients seen by PCN RNs/OHPs, by condition

* Figures 35/36/37 the number of patients seen by PCN RN/OHP staff with Mental Health/Addiction issues is based on billing diagnostic codes and not EMR problem list identification. This allows a more accurate count of patients experiencing these issues.

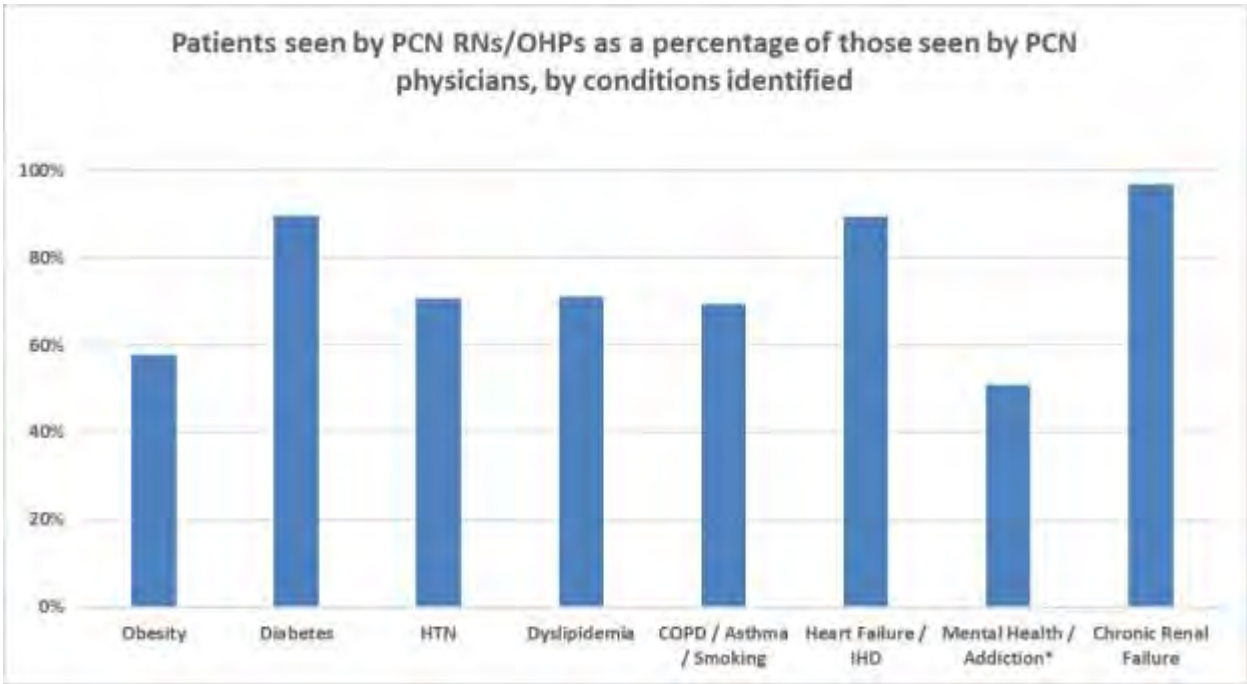


Figure 37 – Patients seen by PCN RNs/OHPs as percentage of seen by physicians, by condition

Below are selected aggregate and average PCN RN/OHP utilization and access measures for 2022/23:

Total unique patients seen by PCN RNs/OHPs	30,601
Total patient visits with PCN RNs/OHPs	78,698
Average number of patients seen by PCN RNs/OHPs per 1.0 FTE	670
Average minutes per patient	53
Average annual return visit rate	2.6
Average time to third next available appointment (TNA)	6.5 days

Highlights: drop in average # of patients seen by PCN RNs/OHPs per 1.0 FTE: from 711 to 670. Increase in minutes per visit: from 49 to 53. Potential reasons: natural variation in utilization between years, effect of recently hired staff who were still working to increase utilization to achieve PCN targets. Increase in average time to third next available appointment: from 6.0 days to 6.5 days. Although it is challenging to draw a conclusion regarding an increase in average TNA (as there is no evidence in literature for its evaluation in aggregate), this could reflect an increase in backlog for some RNs/OHPs coincidental with their increased utilization during the previous fiscal year (2020/21 FY: 615 patients per 1.0 FTE, increased to 711).

No-show rates by provider type for the reporting period were:

Average no show rate, physicians	3.0%
Average no show rate, PCN BHCs	11.3%
Average no show rate, PCN non-BHCs	2.8%

The average PCN BHC no show rate has historically been higher than other provider groups and is also higher compared to the previous reporting period (10.4%). An average PCN BHC no show rate higher than other provider groups may indicate the impact of larger proportions of non-full-time staff on no show rates. It may also indicate increased challenges with gaining patient agreement to seek care from a BHC.

At an individual PCN staff level, no show reduction strategies are offered and supported by PCN facilitators as part of an overall conversation on increasing staff utilization. Overall, no show rates are lower for non-BHC providers compared to the previous reporting period (3.2% for physicians, 5.3% for non-BHC PCN RHPs). This could be due to increased standardization and effectiveness of appointment verifying processes, e.g. patient portals.

Variation between measures for patients seen by RNs/OHPs and physicians could highlight potential improvement opportunities. The PCN Education and Clinical Supervisors, along with PCN Practice Improvement Facilitators, seek to

identify high performing teams who have a high success rate in chronic disease screening and management so that, where possible, other teams might learn from successful processes, workflows, EMR optimizations, etc.

Highly engaged health homes also use HQCA proxy panel and confirmed panel reports as an additional, confirmatory data source to support review of health home EMR measures and develop improvement plans.

4h: Engaged Leadership
Please see discussion in Objective 1: Accountable & Effective Governance above.

4i: CII/CPAR

Results of the Readiness Schedule B indicators are below:

		FY 2022/23	FY 2021/22
How many Participating Physicians or Participating Providers are registered to your PCN (Number of active participating physicians/providers that are members of your PCN as of the last day of the fiscal reporting year. - (This indicator will serve as a denominator for subsequent indicators.)		90	90
		FY 2022/23	**FY 2021/22**
What percentage of Participating Physicians or Participating Providers are are using a CII-CPAR compatible EMR? (Numerator: Aggregate number of participating physicians/providers who are using one of the CII/CPAR compatible Electronic Medical Record (EMR) as of the last day of fiscal year.)	Numerator	89	86
	Denominator	90	90
	Proportion	98.9%	95.6%
		FY 2022/23	**FY 2021/22**
What percentage of Participating Physicians or Participating Providers routinely verify their panel? (Numerator Count of participating physicians and participating providers that are routinely verifying their panels.)	Numerator	88	88
	Denominator	90	90
	Proportion	97.8%	97.8%
		FY 2022/23	**FY 2021/22**
What percentage of Participating Physicians or Participating Providers have been included on a Confirmation of Participation (CoP) for CPAR submission? (Numerator Count of participating physicians and participating providers that have been listed on a CoP for CPAR sent to Alberta Health as of the last day of the fiscal reporting year.)	Numerator	29	14
	Denominator	90	90
	Proportion	32.2%	15.6%
		FY 2022/23	**FY 2021/22**
What percentage of Participating Physicians or Participating Providers have been listed as custodians on a clinic Privacy Impact Assessment (PIA) that has been assessed for CII/CPAR participation as being either current, or requiring only minor revisions? (Numerator Participating physicians and participating providers that are listed as custodians on a clinic PIA that has received a favourable assessment from the eHealth Services Support Team as of the last day of the fiscal reporting year)	Numerator	29	14
	Denominator	90	90
	Proportion	32.2%	15.6%
What percentage of Participating Physicians or Participating Providers are routinely submitting verified panel information to CII CPAR? (Numerator Count of participating physicians and participating providers sending monthly panel data to CPAR at least one time in the fiscal year)	Numerator	29	11
	Denominator	90	90
	Proportion	32.2%	12.2%

Figure 38 - Readiness Schedule B Indicators

Analysis of indicators:

- Primary analysis located in Objective 2 highlight infographic and details
- The chosen denominator for this indicator set neither matches the PCN's internal reporting nor the AMA ACTT provincial reporting regarding CPAR/CII participation. E.g. this denominator includes locums who are not primarily beneficiaries of CPAR/CII

Section 2.b. – Primary Health Care Indicator Set – Reporting:

THIRD NEXT AVAILABLE APPOINTMENT INDICATOR		FY 2022/23	FY 2021/22
Proportion of physicians measuring time to third next appointment	Numerator	89	89
	Denominator	90	90
	Proportion	98.9%	98.9%
PATIENT EXPERIENCE INDICATOR		**FY 2022/23**	**FY 2021/22**
Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	33	100
	Denominator	33	110
	Proportion	100.0%	90.9%
SCREENING INDICATOR		**FY 2022/23**	**FY 2021/22**
Offers of screening maneuvers completed	Numerator	228,588	221,424
	Denominator	371,543	368,890
	Proportion	61.5%	60.0%
GOVERNANCE INDICATOR		**FY 2022/23**	**FY 2021/22**
Did the PCN Non-Profit Corporation Board / Joint Governance Committee complete **both** the following activities during the year? 1) Collective self-assessment of the PCN Non-Profit Corporation Board / Joint Governance Committee as a whole. 2) Performance improvement plan for the PCN Non-Profit Corporation Board / Joint Governance Committee.		**YES**	**YES**
Did the Board use Accreditation Canada's Governance Functioning Tool in their self-assessment process?		**YES**	**YES**
If not, what self-assessment tool was used?			
Did the Board receive approval from Alberta Health for the use of this alternative tool?			
LEADERSHIP INDICATOR		**FY 2022/23**	**FY 2021/22**
Was a performance assessment completed during the year for the PCN Administrative Lead and all other staff members directly reporting to the PCN Non-Profit Corporation Board/Joint Governance Committee?		**YES**	**YES**
TEAM EFFECTIVENESS PROGRESS INDICATORS		**FY 2022/23**	**FY 2021/22**
Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	2	1
	Denominator	38	40
	Proportion	5.3%	2.5%
Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	2	1
	Denominator	38	40
	Proportion	5.3%	2.5%
PCN REPORT ON PATIENT'S MEDICAL HOME READINESS (CII/CPAR)		**FY 2022/23**	**FY 2021/22**
How many Participating Physicians or Participating Providers are registered to your PCN (Number of active participating physicians/providers that are members of your PCN as of the last day of the fiscal reporting year.-		90	90
What percentage of Participating Physicians or Participating Providers are are using a CII-CPAR compatible EMR? (Numerator: Aggregate number of participating physicians/providers who are using one of the CII/CPAR compatible Electronic Medical Record (EMR) as of the last day of fiscal year.)	Numerator	89	86
	Denominator	90	90
	Proportion	98.9%	95.6%
What percentage of Participating Physicians or Participating Providers verify their panel on a yearly basis? (Numerator Count of participating physicians and participating providers that are routinely verifying their panels.)	Numerator	88	88
	Denominator	90	90
	Proportion	97.8%	97.8%
What percentage of Participating Physicians or Participating Providers have been included on a Confirmation of Participation (CoP) for CPAR submission? (Numerator Count of participating physicians and participating providers that have been listed on a CoP for CPAR sent to Alberta Health as of the last day of the fiscal reporting year.)	Numerator	29	14
	Denominator	90	90
	Proportion	32.2%	15.6%
What percentage of Participating Physicians or Participating Providers have been listed as custodians on a clinic Privacy Impact Assessment (PIA) that has been assessed for CII/CPAR participation as being either current, or requiring only minor revisions? (Numerator Participating physicians and participating providers that are listed as custodians on a clinic PIA that has received a favourable assessment from the eHealth Services Support Team as of the last day of the fiscal reporting year)	Numerator	29	14
	Denominator	90	90
	Proportion	32.2%	15.6%
What percentage of Participating Physicians or Participating Providers are routinely submitting verified panel information to CII CPAR? (Numerator Count of participating physicians and participating providers sending monthly panel data to CPAR at least one time in the fiscal year)	Numerator	29	11
	Denominator	90	90
	Proportion	32.2%	12.2%

Figure 39 - Primary Health Care Indicator Set - Reporting

(above not intended for legibility - pasted as Microsoft Excel Worksheet object per Annual Report instructions)

PALLISER PRIMARY CARE NETWORK

FINANCIAL STATEMENTS

March 31, 2023

PALLISER PRIMARY CARE NETWORK
MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING
March 31, 2023

The Accompanying Financial Statements are the responsibility of management. The Financial Statements were prepared using the deferral method of accounting, Canadian Accounting Standards for Not-for-Profit Organizations (ASNPO) and audited in accordance with Canadian Generally Accepted Auditing Standards. There were no changes to accounting policies during the last twelve months.

To discharge its' responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising of written policies, standards and procedures, a formal authorization structure and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained and assets are adequately safeguarded.

In signing below, we certify that the above statements are true.

	Name:	**Title:**	**ReportPCN Approved**	**Date:**
Physician Lead	Dr. Morgan Osborne	Chair	Yes	June 30, 2023
Senior AHS Authorizing Signature	Dr. Douwe Kits	Vice Chair	Yes	June 30, 2023

Independent Auditor's Report

TO THE MEMBERS OF
THE PALLISER PRIMARY CARE NETWORK

Opinion

We have audited the accompanying financial statements of Palliser Primary Care Network which comprise the statement of financial position as at March 31, 2023 and the statements of changes in net assets, operations and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

In our opinion, the financial statements present fairly, in all material respects, the financial position of Palliser Primary Care Network as at March 31, 2023, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of Palliser Primary Care Network in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing Palliser Primary Care Network's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate Palliser Primary Care Network or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing Palliser Primary Care Network's financial reporting process.

Independent Auditors' Report (Continued)

Auditor's Responsibility for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

* Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
* Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization’s internal control.
* Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
* Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exist related to events or conditions that may cast significant doubt on the Organization’s ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause Palliser Primary Care Network to cease to continue as a going concern.
* Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Johnston Morrison Hunter & Co. Professional Corporation

Johnston Morrison Hunter & Co. Professional Corporation
Chartered Professional Accountants

Medicine Hat, Alberta
June 15, 2023

Palliser PCN

Statement of Operations

For the Year Ended March 31, 2023

		2023		2022
		Budget (Unaudited)	Actual (Audited)	Actual (Audited)
	Notes			
Revenue				
Per Capita Funding - Operating		6,451,844	6,045,265	6,141,526
Per Capita Funding - Capital				
Interest and Investment Income		10,000	67,816	9,879
Fee For Service				
PCN Nurse Practitioner Support Program (NPSP) Funding		187,500	244,997	200,521
Shared Services (Specify in Notes)				
Other - (Specify/ List Other Income)				
Total Revenue		**6,649,344**	**6,358,078**	**6,351,926**
Expenses (Priority Initiatives)				
Professional Support within Health Homes		5,036,844	4,821,765	4,876,684
Measurement & Practice Improvement		442,000	407,458	405,762
PCN NPSP		187,500	244,997	207,767
Zonal Expenses (Specify in Details tab)		-	-	-
Priority Initiative Subtotal		**5,666,344**	**5,474,220**	**5,490,213**
Expenses (Central Allocations)				
Evaluation		-	-	-
PCN Administrative Lead Salary		153,000	153,845	150,305
PCN Administrative Lead Benefits		29,000	29,160	28,629
Other Management Salaries (Specify in Details tab)		312,000	285,281	253,655
Other Management Benefits (Specify in Details tab)		33,000	28,661	26,940
Administration (Specify in Details tab)		456,000	386,911	402,184
Information Technology		-	-	-
Support Services (Specify in Details tab)		-	-	-
Amortization		-	-	-
(Gain)/Loss on disposal of Capital Asset(s)		-	-	-
Central Allocations Subtotal		**983,000**	**883,858**	**861,713**
Total Expenses		**6,649,344**	**6,358,078**	**6,351,926**
Excess/(Deficiency) of Revenue Over Expenses		**$ -**	**$ -**	**$ -**

Palliser PCN

Statement of Financial Position (Audited)

As at March 31, 2023

		2023 Actual	2022 Actual
Assets			
Current Assets:	Notes		
Cash		$ 1,428,277	$ 937,367
Short-term investments		-	-
Accounts receivable		18,711	114,432
Prepaid expenses		49,702	76,702
Other assets		-	-
Total Current Assets		**1,496,690**	**1,128,501**
Capital Assets (Net Amortization) *[Schedule 2]*		-	-
Total Assets		**$ 1,496,690**	**$ 1,128,501**
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued liabilities		686,461	702,737
Due to Alberta Health Services	Note 4	-	14,916
		686,461	717,653
Non-Current Liabilities:			
Unexpended deferred revenue - AH	Note 5	392,815	410,848
Outstanding BPA Expenses (list in notes)	Note 5	410,848	-
Unexpended deferred revenue - Other		-	-
Unexpended NPSP funding	Note 5	6,566	-
Unamortized capital contributions	Note 6	-	-
Other liabilities		-	-
Total Liabilities		**$ 1,496,690**	**$ 1,128,501**
Net Assets:			
Net Assets *[SCNA]*		-	-
Closing Balance - Net Assets		**-**	**-**
Total Liabilities and Net Assets		**$ 1,496,690**	**$ 1,128,501**

Palliser PCN

Statement of Cash Flows (Audited)

For the Year Ended March 31, 2023

	2023 Actual	2022 Actual
Operating Activities:		
Excess/(Deficiency) of Revenue Over Expenses	$ -	$ -
Non-cash transactions		
Amortization	-	-
(Gain)/Loss on disposal of capital asset(s)	-	-
Amortization of deferred capital contributions	-	-
Change in non-cash working capital:		
(Increase)/Decrease in accounts receivable	95,721	(69,267)
(Increase)/Decrease in prepaid expenses	27,000	(56,000)
(Increase)/Decrease in other assets	-	-
Increase/(Decrease) in accounts payable and accrued liabilities	(16,276)	(42,599)
Increase/(Decrease) in amount due to Alberta Health Services	(14,916)	14,916
Increase/(Decrease) in Unexpended deferred revenue - AH	(18,033)	409,864
Increase/(Decrease) in Outstanding BPA Expenses	410,848	-
Increase/(Decrease) in Unexpended deferred revenue - Other	-	-
Increase/(Decrease) in Unexpended NPSP funding	6,566	-
Increase/(Decrease) in other liabilities	-	-
Cash generated from/(used by) operations	490,910	256,914
Investing Activities:		
Purchase of Capital Assets	-	-
Proceeds on Disposal of Capital Assets	-	-
Cash generated from/(used by) investing activities	-	-
Financing Activities:		
Capital Contributions received	-	-
Proceeds from long term debt	-	-
Principle payments on long-term debt	-	-
Cash generated from financing activities	-	-
Increase/(Decrease) in cash and investments	490,910	256,914
Cash and investments at the beginning of the year	937,367	680,453
Cash and investments at the end of the year	**$ 1,428,277**	**$ 937,367**

Note 1 Authority, Purpose and Operations

The Palliser Primary Care Network ("the PCN") was incorporated on July 20, 2006 under the Authority of the Alberta Companies Act. The PCN is a non-profit private company under the Income Tax Act and is therefore exempt from the payment of income tax.

The PCN represents a joint venture governed equally by the Palliser PCN Physician Group Not for Profit Corporation and Alberta Health Services ("the participants"). The PCN provides comprehensive primary care services to residents within the PCN's geographical area in accordance within the terms of the approved Business Plan and approved amendments.

The PCN's primary activity is to operate programs in south-eastern Alberta that will:

- Improve care of patients with chronic/complex care needs.
- Increase patient access to primary care.
- Facilitate greater use of multidisciplinary teams and improve coordination and integration with other health care services.

The financial statements combine the participants' share of the assets and liabilities of the PCN. The statements do not include any other assets, liabilities, revenues and expenses of the participants.

Note 2 Significant Accounting Policies and Reporting Practices

The financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations. The following are the significant accounting policies:

a) Revenue Recognition

These financial statements use the deferral method of accounting for contributions, key elements of which are:

- Restricted operating contributions are deferred and recognized as revenue in the year in which the related expenses are incurred.
- Restricted capital contributions are deferred and recognized as revenue in the year the related amortization expense of the capital asset is recorded.
- lnvestment income is recognized as restricted contributions.

b) Financial Instruments and Risks

The PCN's activities expose it to a variety of financial risks. The PCN's overall business strategies, tolerance of risk and general risk management philosophy are determined by the Board of Directors in accordance with prevailing economic and operating conditions.

The financial instruments of the PCN consist of cash and short-term investments, accounts receivable, accounts payable and accrued liabilities. The fair value of these financial instruments approximates their carrying values. The business risks associated with financial instruments are generally categorized as market (comprised of currency, interest rate and other price risk), credit and liquidity risks. It is management's opinion that the PCN is only exposed to market interest rate risk on its financial instruments.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

b) Financial Instruments and Risks (continued)

Market interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in the market rates of interest. The PCN is exposed to market interest rate risk if its temporary investments are invested at fixed rates of interest.

c) Measurement of Financial Instruments

Investments are recorded at fair value. Other financial instruments, including accounts receivable and accounts payable and accrued liabilities, are initially recorded at their fair values and are subsequently measured at amortized cost, net of any provisions for impairment.

d) Cash and cash equivalents

Cash and cash equivalents include cash on deposit. Cash includes restricted and unrestricted balances held with financial institutions.

e) Short-Term Investments

The PCN's policy is to disclose temporary investments with a maturity date within twelve months of the year end as short-term investments.

f) Capital Assets

Purchases of capital assets, for PCN operating use, with unit costs greater than $2,500 are recorded as additions to capital assets. Purchases less than $2,500 are expensed as operating costs when incurred. This is in accordance with PCN Capital Expense Policy released January 2017.
Amortization of leasehold improvements is recorded on a straight-line over the five year term of the lease. In the initial year of expenditure, the amortization is pro-rated to the number of months that the lease was in place for that year.

g) Line of Credit Facility

At March 31, 2023, the PCN had a line of credit available in the amount of $500,000 with interest at the bank's prime lending rate plus 1.75% per annum. The effective interest rate at year end is 8.45%. The line of credit is secured by a general security agreement on the assets of the PCN. At March 31, 2023, there is no amount outstanding on this credit facility (2022 - $nil).

h) Use of Estimates and Assumptions

In preparing the financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from these estimates.

Note 3 Related Party Transactions

Program operating costs include:

- Funds provided to Physicians for supervision of health professionals and program planning, rental of premises for health professionals and clinic supports, and education/training are disclosed in Schedule 1. There was $0 outstanding to Physicians at year end (2022 - $0).
- Funds provided to Alberta Health Services to reimburse the payroll cost of the PCN Executive Director are disclosed in the Statement of Operations. There was $0 outstanding to Alberta Health Services at year end (2022 - $14,916).

Note 4 Approval of Budget

The budget for 2023 was approved by the PCN Board of Directors in March 2022.

Note 5 Unexpended Deferred Revenue

Unexpended deferred operating revenue represents unspent resources with stipulations or external restrictions related to operating expenditures.

Changes in unexpended deferred revenue are as follows:

	2023				2022
	AH	BPA	NPSP	Total	Total
Balance at the beginning of year	410,848		0	410,848	984
Received or receivable during the year, net of repayments	6,027,232	410,848	251,563	6,689,643	6,751,911
Restricted investment income & other income	67,816			67,816	9,879
Recognized as revenue	(6,113,081)		(244,997)	(6,358,078)	(6,351,926)
Transfer to purchase of Capital Assets	-			-	-
Transferred to UDR from expired BPAs	-			-	-
Balance at the end of year	**392,815**	**410,848**	**6,566**	**810,229**	**410,848**

Business Plan Amendment (BPA) calculations are as follows:

Taxonomy	Brought Forward	New BPAs Approved	Funds spent during 2023	Balance at March 31/2023	BPA Expired ?	Expir-ed Funds	Outstanding BPA Funds
PPCN-BPA-2022/2023#01	-	410,848	-	410,848	No	-	**410,848**

Note 6 Unamortized Capital Contributions

Unamortized capital contributions represents Alberta Health funding spent in the acquisition of tangible capital assets, stipulated for use in the provision of services, over their useful lives. Changes in unamortized capital contributions are as follows:

	2023	2022
Balance at the beginning of year	$ 0	$ 0
Less amounts recognized as revenue	0	0
Balance at the end of year	**$ 0**	**$ 0**

Note 7 Per-Capita Revenue

Per-capita revenue is the calculation of the number of identified enrollees at a specific instance, multiplied by the proportion of the yearly rate of $62 per enrollee.

	2023 # of Enrolees	2023 Amount	2022 Amount
Eligible per capita payments:			
April	104,062	$3,225,922	$3,294,057
October	103,618	3,212,158	3,258,317
Total eligible per capita payments		**$ 6,438,080**	**$ 6,552,374**

Note 8 PCN Nurse Practitioner Support Program (NPSP) Funding

Payments for NPSP funding are allocated quarterly to PCNs based on the approved number of NP full-time equivalents (FTEs) registered within the PCN NPSP at $125,000/year per 1.0 FTE

Note 9 Closing Costs Reserve

The 2016 financial statements recorded a Closing Costs Reserve which included estimated severance, leasehold and lease obligation costs due on wind-up of the PCN. This allocation to Closing Costs Reserve in 2016 was consistent with the provincial policy in place at that time.

As of June 2016, Alberta Health removed the requirement for PCNs to have Closing Costs Reserves. The new policy indicates that Alberta Health will fund the PCN's closing costs which are in excess of the PCN's net realized assets, subject to the terms of a funding agreement with the PCN. Under this new policy, the maximum closing costs to be funded by Alberta Health shall be the lesser of the PCN's actual closing costs or 10% of the PCN's per capita funding.

As part of the policy change, a legal opinion was provided. The conclusion of that opinion is as follows: "It is our view that PCN directors are entitled to rely on the commitment from Alberta Health to cover excess closing costs, and the concurrent requirement that PCNs cease the practice of maintaining Closing Cost Reserves." The legal opinion did not specifically address the potential of PCN closing costs being in excess of the 10% maximum that Alberta Health has established.

Pursuant to this policy change from Alberta Health, the PCN has not recorded a closing cost reserve at March 31, 2023.

Note 10 Commitments and Contingencies

The PCN occupies a leased premises, with lease payments of approximately $56,000 per year until 2025.

Note 11 Economic dependence

The PCN relies on the Alberta government to fund its operations. Should this funding cease, the PCN would not be able to continue to operate without alternate sources of revenue.

Note 12 Approval of Financial Statements

These financial statements were approved by the PCN Board of Directors.

Palliser PCN

Schedule 1 - Expenses by Object

For the Year Ended March 31, 2023

	2023		2022
	Budget (Unaudited)	Actual (Audited)	Actual (Audited)
Physicians: Clinical (Specify in Details tab)	-	-	-
Physicians: in lieu of FFS	-	-	-
Physicians: Administrative (Specify in Details tab)	246,000	215,161	213,951
Physicians: Other (Specify in Details tab)	192,000	166,201	223,075
Physicians Subtotal	**438,000**	**381,362**	**437,026**
Alberta Health Services - Purchased Services	-	-	-
Alberta Health Services - Office Space	-	-	-
Alberta Health Services - Other (Specify in Details tab)	-	-	-
Non-Physician Direct Care Providers	4,696,344	4,561,330	4,286,962
Zonal Expenses	-	-	-
Other Expenses (Specify in Details tab)	1,515,000	1,415,386	1,627,938
Amortization	-	-	-
Total Expenses	**$ 6,649,344**	**$ 6,358,078**	**$ 6,351,926**

Palliser PCN

Schedule 2 - Schedule of Capital Assets (Audited)

For the Year Ended March 31, 2023

Cost	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2022	97,080	-	97,080
Additions	-	-	-
Disposals	-	-	-
Cost at March 31, 2023	**$ 97,080**	**$ -**	**$ 97,080**

Amortization	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2022	97,080	-	97,080
Amortization for the period	-	-	-
Amortization on disposals	-	-	-
Accumulated Amortization at March 31, 2023	**$ 97,080**	**$ -**	**$ 97,080**
Net Book Value March 31, 2023	**$ -**	**$ -**	**$ -**
Net Book Value March 31, 2022	**$ -**	**$ -**	**$ -**

Palliser PCN
Nurse Practitioner Support Program Analysis Working Paper (Unaudited)
For the Year Ended March 31, 2023

Quarters	AH Approved FTE(s)	NPSP Funding from AH	PCN Recorded FTE(s)	PCN Recorded NPSP Funding
April 1, 2022 - June 30, 2022	2.10	$ 65,625	2.10	$ 65,625
July 1, 2022 - September 30, 2022	2.10	$ 65,625	2.10	$ 65,625
October 1, 2022 - December 31, 2022	1.65	$ 51,563	1.84	$ 57,497
January 1, 2023 - March 31, 2023	2.20	$ 68,750	1.80	$ 56,250
Total Funding		**$ 251,563**		**$ 244,997**
Variance		$ 6,566		
Total NP Expenses		$ 244,997		

AH Approved FTE(s)	Number of FTEs approved by AH on which payments are based
NPSP Funding from AH	Received Funding from AH - AH NP payments received in the quarter according to payment letter
PCN Recorded FTE(s)	The registered/recorded FTE(s) by the PCN for the quarter
PCN Recorded NPSP Funding	Based on PCN Recorded FTE(s) this is the funding that PCN should have received
Variance	The difference between NPSP Funding from AH and PCN Recorded NPSP Funding
Total NP Expenses	Total Expenses for NPSP Program including salaries, space, EMR, etc

If there is a change in FTE during the quarter, please provide detailed notes below to explain. Notes to include NP start and end date, reduction in FTE etc.

Palliser PCN
Staffing Summary (Unaudited)

	Budget as at March 31, 2023			Actual as at March 31, 2023			Actual as at March 31, 2022		
Participating Clinics	40			40			40		
Participating Physicians	90			90			90		
Enrollees	104,062			103,245			104,062		
	Budget FTE as at Mar.31, 2023	**Budget Cost ($) Apr.1, 2022 to Mar.31, 2023**	**Budget Head Count at Mar.31, 2023**	**Actual FTE as at Mar.31, 2023**	**Actual Cost ($) Apr.1, 2022 to Mar.31, 2023**	**Actual Head Count at Mar.31, 2023**	**Actual FTE as at Mar.31, 2022**	**Actual Cost ($) Apr.1, 2021 to Mar.31, 2022**	**Actual Head Count at Mar.31, 2022**
Direct Care Provider (DCP)									
Nurse Practitioner	1.50	187,500	3	1.96	244,997	3	1.55	189,017	3
Registered Nurse	37.60	3,684,844	51	34.50	3,379,033	46	37.40	3,418,945	47
Licenced Practical Nurse									
Social Worker									
Dietitian	0.50	51,500	1	-	-	-	0.30	29,100	1
Pharmacist									
Physiotherapist									
Occupational Therapist									
Mental Health Therapist									
Behavior Health Consultant	7.50	772,500	11	9.10	937,300	11	6.70	649,900	9
Cardiac Rehab Exercise Specialist									
Cardiac Rehab Nurse									
Exercise Specialist									
Midwifery Services									
Psychologist									
Other (specify)									
Other (specify)									
Other (specify)									
Other (specify)									
Other (specify)									
Other (specify)									
Total Direct Care Provider	**47.10**	**4,696,344**	**66**	**45.56**	**4,561,330**	**60**	**45.95**	**4,286,962**	**60**
Clinical Support Staffing									
Referral Coordinator									
Medical Office Assistant									
Facilitator									
Program Manager/Coordinator									
Clinical Coordinator									
Clinical Management									
Measurement and improvement	5.00	422,000	5	4.60	390,039	5	5.00	391,692	5
Total Clinical Support Staffing	**5.00**	**422,000**	**5**	**4.60**	**390,039**	**5**	**5.00**	**391,692**	**5**
Admin and Support Staffing									
Administrative Lead - Salary	1.00	153,000	1	1.00	153,845	1	1.00	150,305	1
Administrative Lead - Benefits		29,000			29,160			28,629	
Other Management	3.00	345,000	3	2.70	313,942	3	2.60	280,595	3
Finance									
Human Resources									
Administrative Assistant	3.00	178,000	3	2.70	158,369	3	2.40	147,164	3
Information Technology									
Research									
Evaluation									
Communications									
Communications									
Other (specify)									
Other (specify)									
Other (specify)									
Total Admin and Support Staffing	**7.00**	**705,000**	**7**	**6.40**	**655,316**	**7**	**6.00**	**606,693**	**7**
Total PCN Staffing	**59.10**	**5,823,344**	**78**	**56.56**	**5,606,685**	**72**	**56.95**	**5,285,347**	**72**

Palliser PCN
Details Required by Alberta Health on Line Items (Unaudited)
For the Year Ended March 31, 2023

Please provide details for the following items, as instructed in the Guidelines:

Statement of Operations

Line item	Description	2023 Actual
B15	Shared Services	Not applicable
B30	Zonal Expenses	Not applicable
B37	Other Management - Salaries:	
	Patient's Medical Home Optimization Director (1.0 FTE)	125,992
	Clinical Supervisors (1.7 FTE)	159,289
		-
	Total	285,281
B38	Other Management - Benefits:	
	Patient's Medical Home Optimization Director (1.0 FTE)	13,636
	Clinical Supervisors (1.7 FTE)	15,025
		-
	Total	28,661
B39	Administration:	
	Board meeting stipends - Physicians	41,523
	Payroll - Exec assistant, Admin assistant, Finance Clerk (2.7 FTE)	158,369
	Professional Services -legal, accounting, HR, etc.	46,111
	Insurance, computers, telephones, office supplies	61,284
	Central Office – rent, utilities, janitorial	79,624
	Total	386,911
B41	Support Services	Not applicable

Schedule 1: Expenses by Object

Line item	Description	2023 Actual
A8	Physicians: Clinical	Not applicable
A10	Physicians: Administrative:	
	Board meeting stipends	41,523
	Supervision/program planning stipends	173,638
	The payments made were in accordance with the payment criteria in the 2021-2024 business plan.	
	Total	215,161
A11	Physicians: Other:	
	Office Rental/clinic supports	142,113
	Education/training stipends - Physicians	24,088
	The payments made were in accordance with the payment criteria in the 2021-2024 business plan.	-
	Total	166,201
A16	Alberta Health Services - Other	Not applicable
A19	Other Expenses:	
	Education, training and orientation	61,514
	Medical & IT equipment and renovations	24,990
	RNs/OHCP: Travel and other supplies	79,089
	Measurement and Improvement: Payroll (4.6 FTE)	390,039
	Measurement and Improvement: Travel and other supplies	17,419
	Administrative Lead: Payroll & benefits	183,005
	Other Management: Payroll & benefits	313,942
	Payroll - Exec assistant, Admin assistant, Finance Clerk (2.7 FTE)	158,369
	Professional Services -legal, accounting, HR, etc.	46,111
	Insurance, computers, telephones, office supplies	61,284
	Central Office – rent, utilities, janitorial	79,624
		-
	Total	1,415,386

Palliser PCN
Variance Analysis (Unaudited)
For the year ended March 31, 2023

Statement of Operations	2023 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in the Statement of Operations
Revenue				
Per Capita Funding - Operating	(406,579)	-6%	Yes	Expenses were lower than budgeted. Therefore, revenue (deferral method) is lower.
Interest and Investment Income	57,816	578%	Yes	Interest rates were higher than budgeted. Funds are held in an interest bearing operating account.
PCN Nurse Practitioner Support Program (NPSP) Funding	57,497	31%	Yes	There were additional Nurse Practitioner staff recruited and therefore grant funding increased for the year.
Total Revenue	(291,266)	**-4%**	No	
Expenses (Priority Initiatives)				
Professional Support within Health Homes	215,079	4%	No	There were staff vacancies during the year.
Measurement & Practice Improvement	34,542	8%	Yes	There was a staff vacancy during the year.
PCN NPSP	(57,497)	-31%	Yes	There were additional Nurse Practitioner staff recruited and therefore grant funding increased for the year.
Priority Initiative Subtotal	**192,124**	**3%**	**No**	
Expenses (Central Allocations)				
PCN Administrative Lead Salary	**(845)**	-1%	No	This 1.0 FTE position is employed by AHS, and the salary/benefit costs are billed monthly to the PCN. The variance relates to the budget being lower than the actual cost of the position.
PCN Administrative Lead Benefits	**(160)**	-1%	No	
Other Management Salaries (Specify in Details tab)	**26,719**	9%	Yes	There was a staff vacancy during the year.
Other Management Benefits (Specify in Details tab)	**4,339**	13%	Yes	There was a staff vacancy during the year.
Administration (Specify in Details tab)	**69,089**	15%	Yes	There was a staff vacancy during the year. Board stipends and professional fees were lower than budgeted.
Central Allocations Subtotal	**99,142**	**10%**	**Yes**	Staff vacancies during the year. Board stipends and professional fees were lower than budgeted.
Total Expenses	**291,266**	**4%**	**No**	
Excess/(Deficiency) of Revenue Over Expenses	**-**	**- %**	**n/a**	

Schedule 1 - Expenses by Object	2023 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in Schedule 1
Physicians: Administrative (Specify in Details tab)	30,839	13%	Yes	Board stipends were lower than budgeted.
Physicians: Other (Specify in Details tab)	25,799	13%	Yes	Education/training stipends were lower than budgeted.
Physicians Subtotal	**56,638**	**13%**	**Yes**	Board stipends and Education/training stipends were lower than budgeted.
Non-Physician Direct Care Providers	135,014	3%	No	There were staff vacancies during the year.
Other Expenses (Specify in Details tab)	99,614	7%	Yes	Staff vacancies during the year. Professional fees were lower than budgeted.
Total Expenses	**291,266**	**4%**	**No**	

Other Statements and Schedules	Explanations
Staffing summary	The physicians choose the employee type that they wish to access within their clinic. For example, in fiscal 2023, there was reduced Dietician FTE as this was the hiring choice of the physicians.

Palliser PCN
Board of Directors Composition as of March 31, 2023 (Unaudited)
Legal Model 2

Who is considered the Physician Lead of the PCN - or Co-Lead ?	Dr. Morgan Osborne
Additional Co-Lead ?	Not applicable

Note: The Executive Director is not a member of the Board of Directors, the Board is their employer

Director Name	Director Role (as per Articles of Association)	NPC or AHS or Community	Length of term	Term Set to Expire	Additional Information
Dr. Morgan Osborne	Chair	Physician group	3 years	Jun 2024	
Dr. Douwe Kits	Vice Chair	AHS	3 years	Jun 2023	
Dr. Cathy Horsman	Director	Physician group	3 years	Jun 2024	Stepping down June 2023
Dr. Donovan Nunweiler	Director	Physician group	3 years	Jun 2024	
Dr. Sally Bolstad	Director	Physician group	3 years	Jun 2025	
Dr. Gloria Tainsh	Director	Physician group	3 years	Jun 2025	
Dr. Monty van der Westuizen	Non-Voting Director	Physician group	1 year	Jun 2023	
Varley Weisman	Director	Interim Community Member	3 years	Jun 2024	
Dr. Dave Stewart	Director	AHS	3 years	Jun 2026	
Trevor Inaba	Director	AHS	3 years	Jun 2025	
Dr. Gerry Prince	Director	AHS	3 years	Jun 2026	