Palliser Primary Care Network

(Go live date August 1, 2006)

Annual Report

Sections 1 and 2

Version 1.0

For the period

April 1, 2021 to March 31, 2022

To be submitted to Alberta Health **no later than August 1, 2022**

Section 1

Summary of PCN Highlights

The Palliser PCN is in its 16th 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.

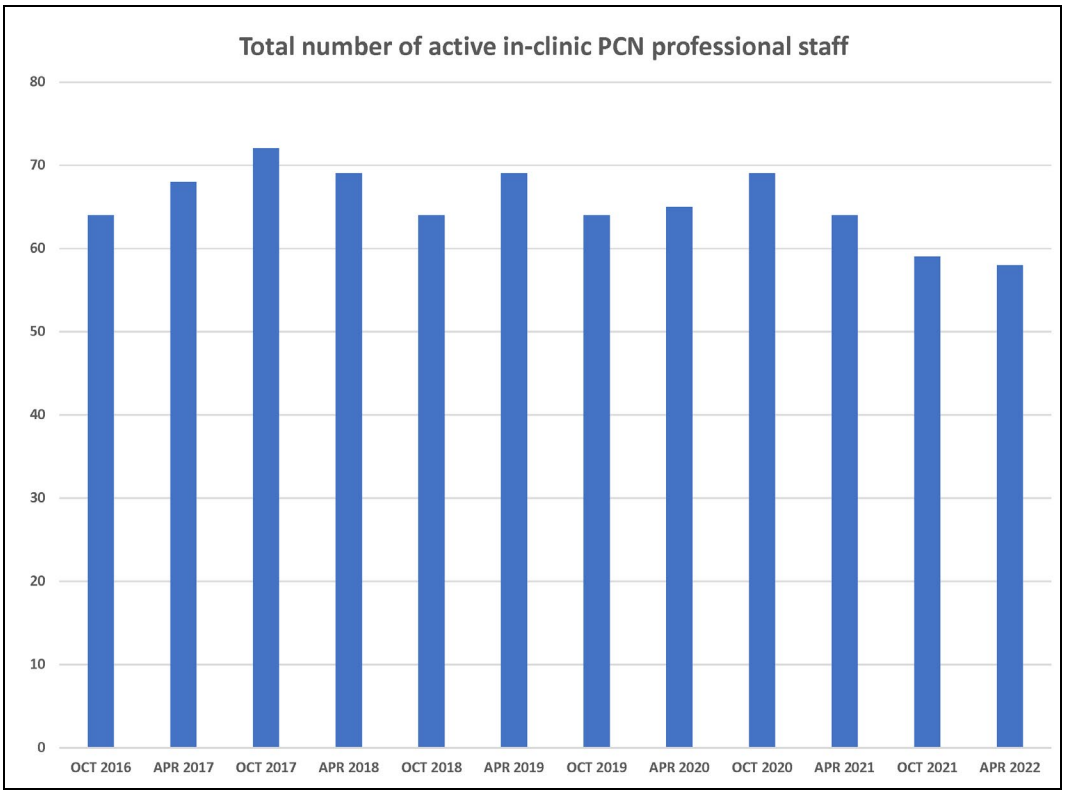


Figure 1 - Total number of active in-clinic PCN professional staff, 2016-2022

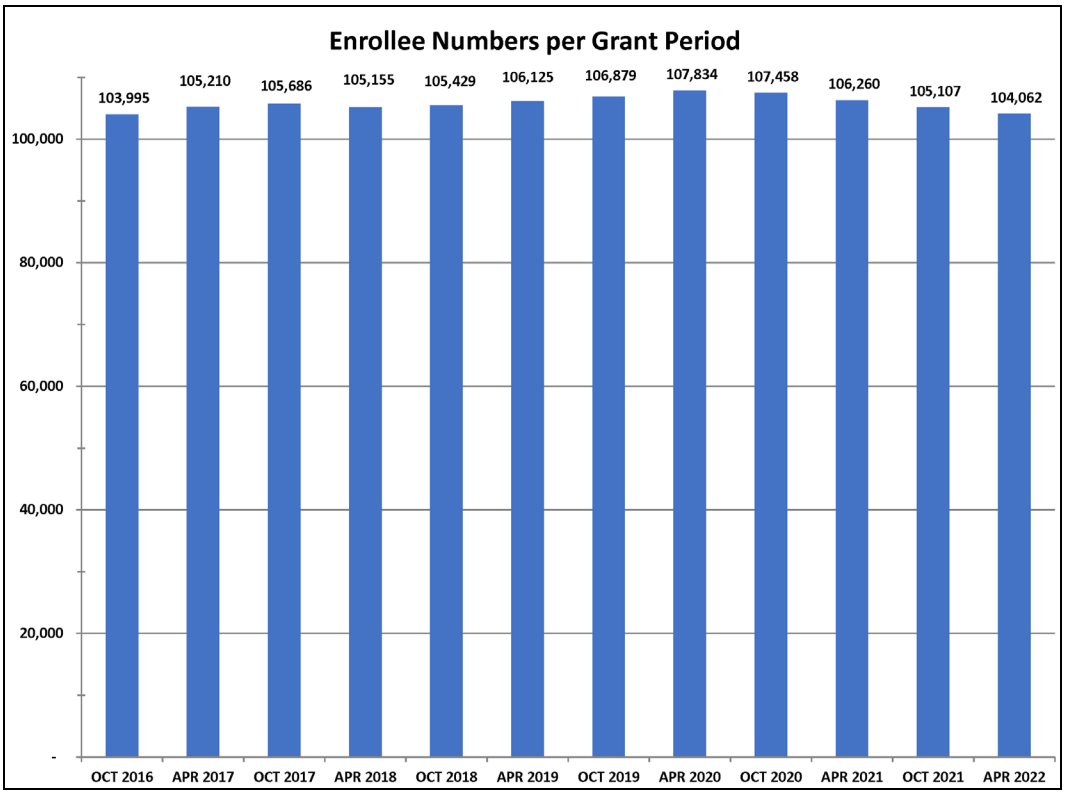


Figure 2 - PCN enrollee numbers per grant period, 2016-2022

In the last year, Covid generated increased work to support clinics in providing virtual care, ensuring adequate PPE and developing processes to protect patients, physicians and staff. The majority of this annual report does not focus on Covid as an entity but instead on the quality improvement and patient care services provided during the reporting period.

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):

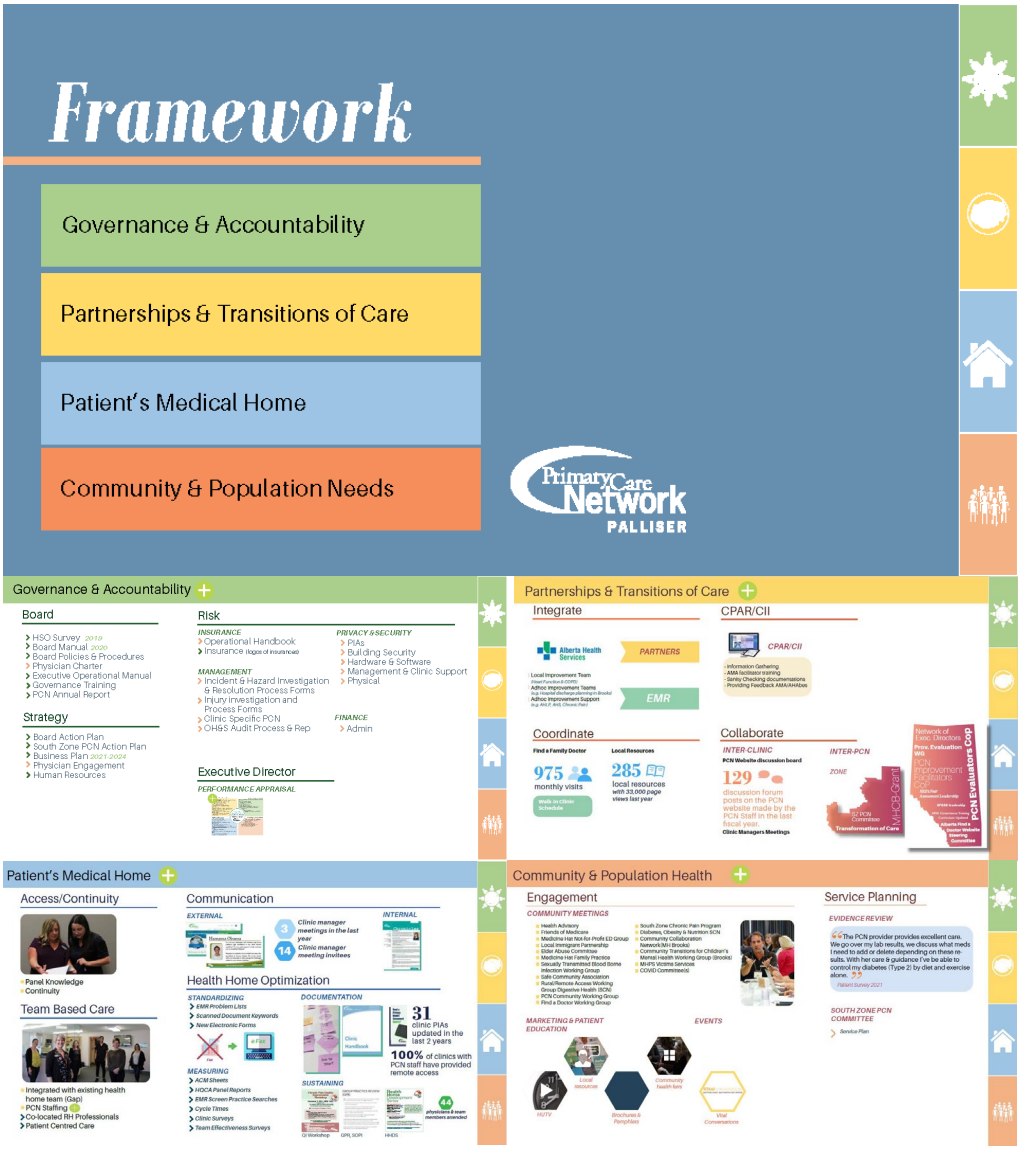


Figure 3 – Palliser PCN Framework: activities aligned with each PCN Provincial Objective

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, 15 PCN physicians newly qualified for PCN staffing. Only one physician 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.

The PCN offered 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 2-year notice period in which they are supported to increase their panel. Strategies offered included process mapping, role definition and documentation, external (e.g. HQCA) panel validation and CPAR/CII participation. Teams that engaged with panel validation work and inactivated significant numbers of patients were able to increase their readiness for participation in CPAR/CII. The PCN saw a 267% increase in physician CPAR/CII participation compared to the previous reporting period.

Period Overview

Name of priority initiative: Professional Support Within Health Homes (approx. 88% 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 45.6 FTE, comprised of: 2.3 NP, 37.12 RN, 6.18 Behavioural Health Consultants, and 0 Dietitians (compared to budget forecast of 51.8 FTE) **3. Multi-disciplinary Teams** Percentage of physicians working in a multi-disciplinary team within their clinic is 88%. Explanation: All but 6 core family practice physicians are working in a multi-disciplinary team within their clinic. 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.

Name of priority initiative: Measurement and Practice Improvement **(approx. 7% of PCN expenditures)**			
Elements	Planned Achievement	Status	Status Explanation
Support Health Home teams and implement practice improvement methodologies including panel identification and management.	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	On Target	**1. Practice Improvement Staffing** 2 facilitators and 3 evaluation staff are currently supporting those clinics participating in practice improvement. **2. Collaborative Learning Sessions** 12 health home teams (44 physicians and clinic team members) participated in two 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. • 2020-21 Series o *(Before reporting period) Sessions 1 and 2* o *May 14, 2021: Session 3 – Strategies & processes to improve clinical care* • 2021-22 Series o *September 24, 2021: Session 1 – Getting to know your panel* o *November 19, 2021: Session 2 – How to use your team to improve access* o *January 21, 2022: Session 3* Successful participation in this series is expected to increase motivation and readiness to pursue improvement activity beyond the Health Home Development Series. Series is planned to recur (with different participants) up to twice annually, with the next iteration scheduled to begin September 2022, ending January 2023. 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:

Event	Participants	Satisfaction
Firing on all Synapses (April 14, 2021)	64	91%
Embracing the Mind (May 4, 2021)	53	76%
Health from the inside out (September 14, 2021)	55	84%
Just the Updates (October 6, 2021)	54	94%
Chronic Pain Quality Improvement (December 3, 2021)	49	90%
Health Home Development Series 2020/2021 – Session 3 (January 21, 2022)	30	77%
Budding Knowledge on Cannabis (February 1, 2022)	51	89%

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.

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		2 facilitators and 3 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:

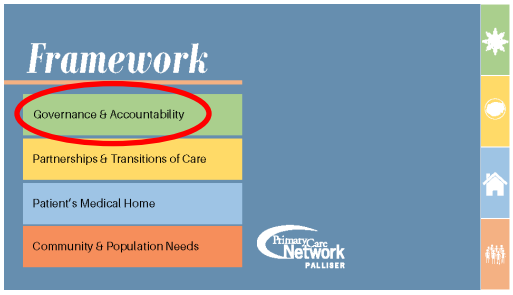


Figure 4 - PCN Framework with Governance and Accountability Objective circled

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

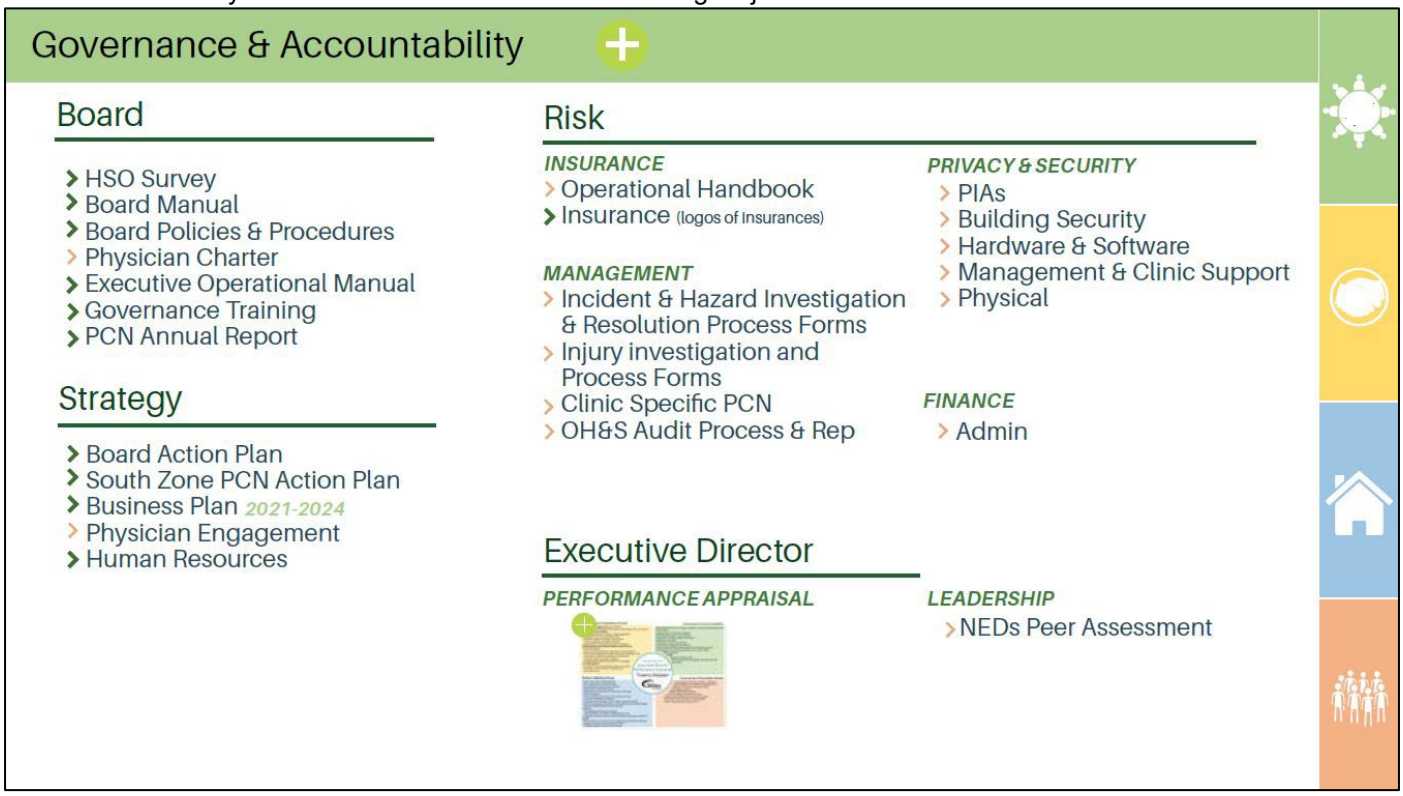


Figure 5 - Governance and Accountability Objective Activities

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

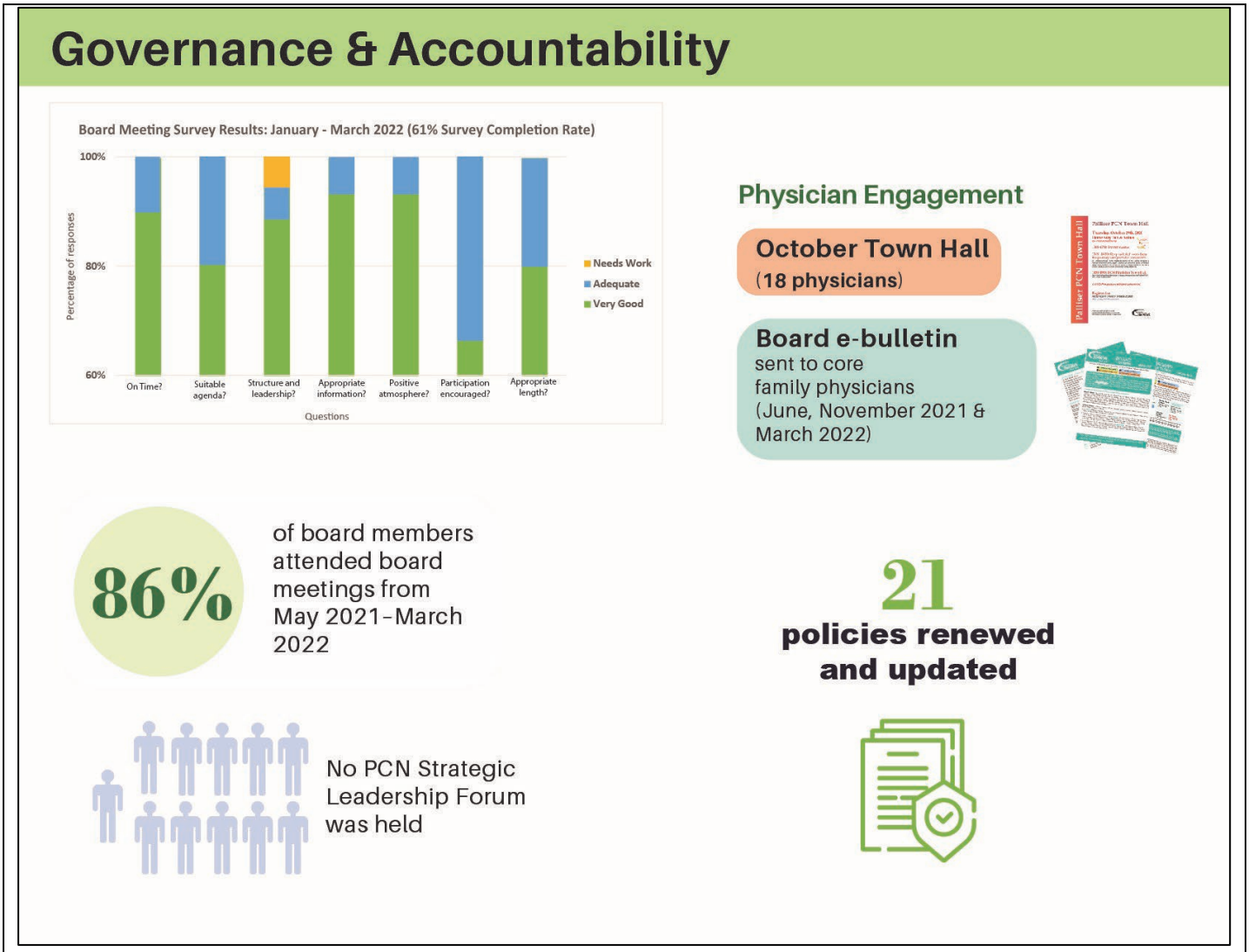


Figure 6 - Governance and Accountability Objective Highlights

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
    - June 2021 Board e-bulletin: Workshop attendance, Physician profiles and obstetrical support
    - November 2021 Board e-bulletin: Health Home Development Series, CII/CPAR
    - March 2022 Board e-bulletin: DynaMed, Town Hall, RATs

<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 21/22 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 2021/22	FY 2020/21
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

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 2021/22	FY 2020/21
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

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:

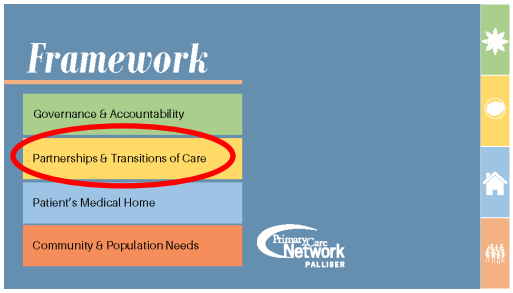


Figure 7 - PCN Framework with Partnerships and Transitions of Care Objective circled

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

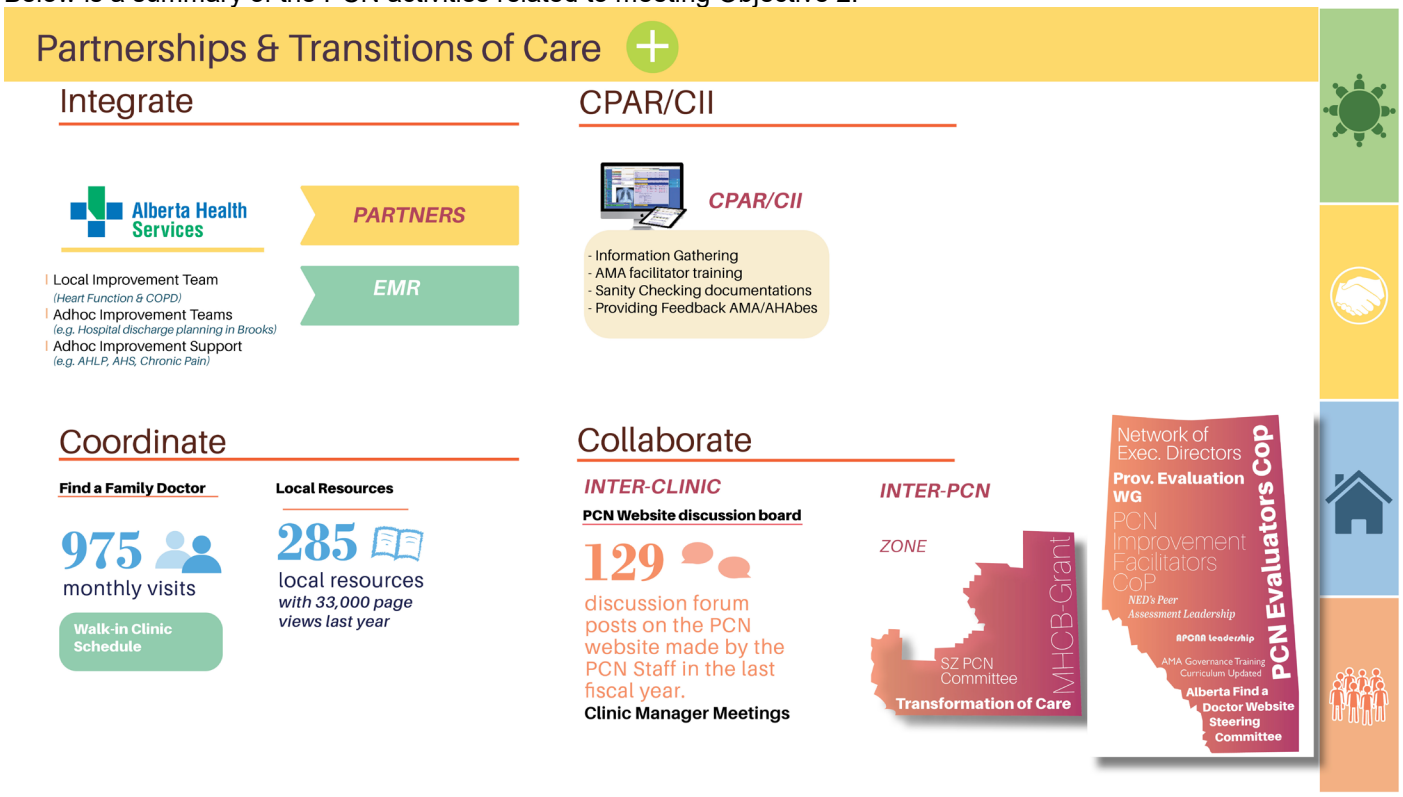


Figure 8 - Partnerships and Transitions of Care Objective Activities

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

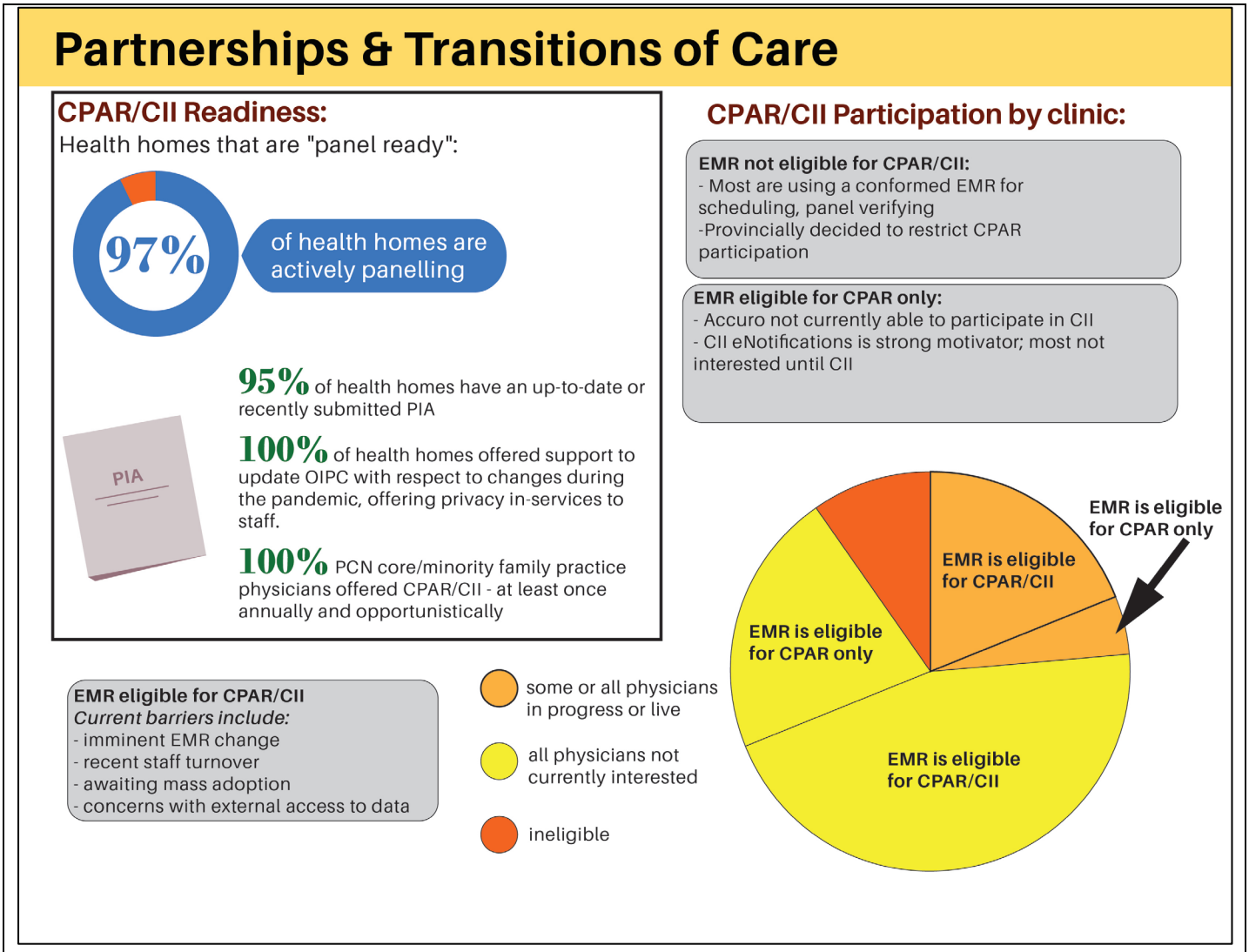


Figure 9 - Partnerships and Transitions of Care Objective Highlights

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
- 11 physicians are live on CPAR/CII across 5 health homes with an additional 9 physicians in progress
    - Almost 1/3 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 (13,000 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: 5,600 annual page views
        ii. Uncertain # of Palliser PCN patients visiting PCN website and AFAD website (would be unaware that AFAD data source is 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
    - 98% remote access to health home EMRs for Evaluation and Improvement purposes
3. Increase 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
    - 285 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. Netcare eReferral
        i. Physician awareness of Netcare eReferral high, local adoption of eReferral limited due to reliance on personal relationships between providers.
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 (6 sessions throughout year)
        ii. Addictions & Mental Health Child, Youth, Family and Prevention Services
        iii. Community Health Services
        iv. Palliative Care south East
        v. South Zone Chronic Pain Program
        vi. Alberta Health Living Program – Heart Failure and COPD
        vii. Alberta Seniors and Housing Program
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. 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:

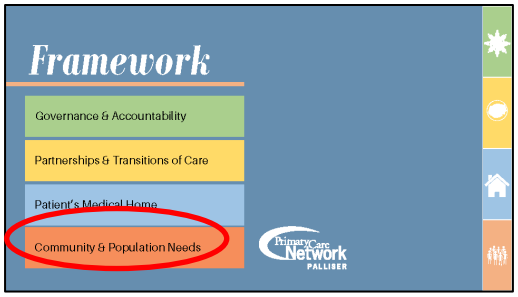


Figure 10 - PCN Framework with Community and Population Health Objective circled

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

Figure 11 - Community and Population Health Objective Activity

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

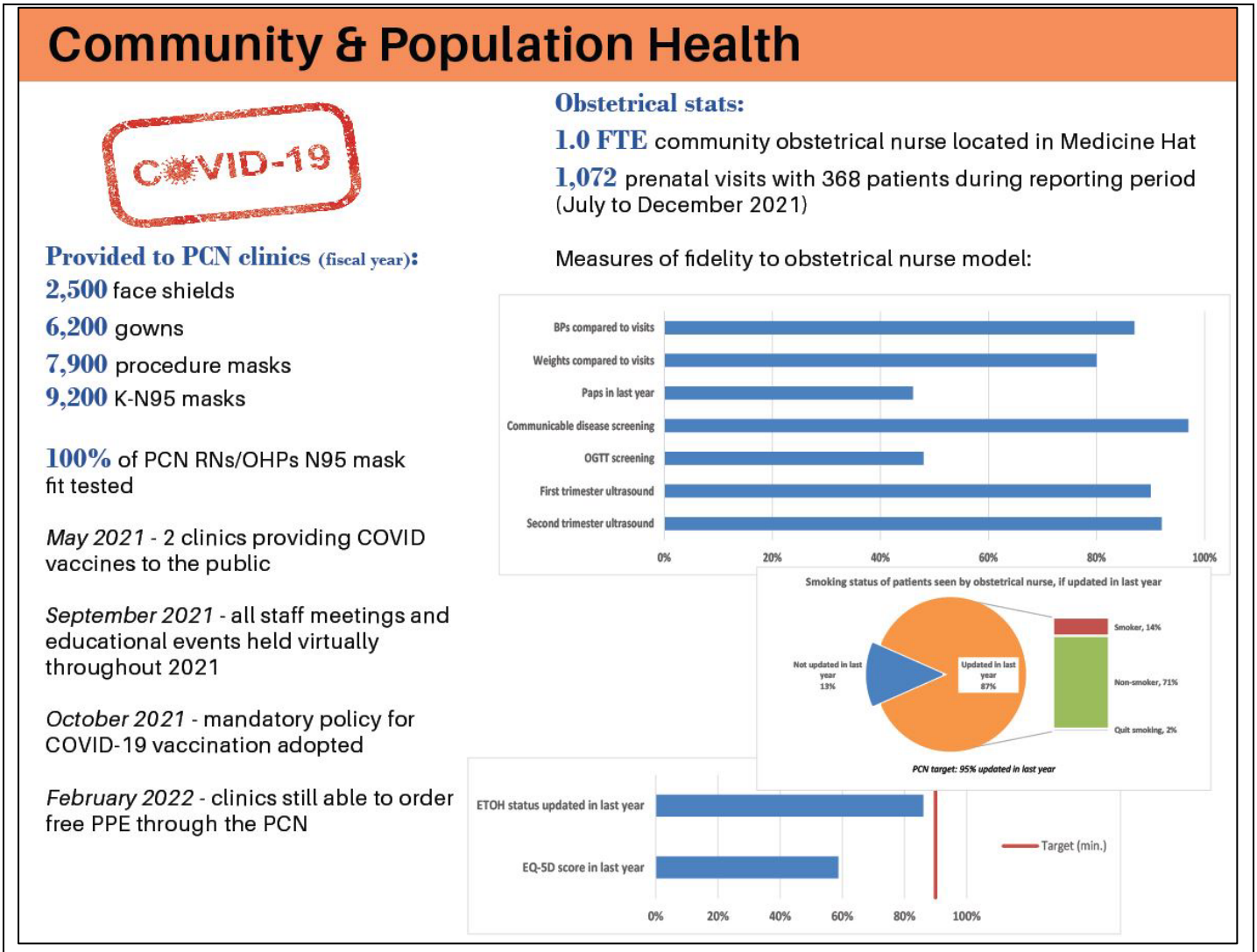


Figure 12 - Community and Population Health Objective Highlights

Details related to Objective 3 highlights:

- PCN COVID support to health homes:
  - PPE ordering and delivery (paid via AHS process and free)
  - N95 mask fit testing for PCN RNs/OHPs, offered to PCN physicians and clinic staff
  - Vaccine administration process development, identification of eligible patients
  - Dissemination of key messages to health home teams, support with patient messaging
- Implementation of 1.0 FTE obstetrical nurse to support prenatal care in Medicine Hat
  - Co-located in 5 health homes, supported prenatal visits including referrals for necessary screening, completion of Alberta Prenatal Record

Figure 13 – Chronic Pain QI Workshop Invite (December 2021)

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.
    - This was the objective of the December 3, 2021 Propelling Population Health PCN Workshop (46 attendees, 88% overall satisfaction rate, workshop invite in Figure 13 above).
    - Individual health home teams are supported by PCN facilitators to set population health goals on an ongoing basis (see 4g: Capacity for Improvement)
2. Utilize high level reports when and where appropriate, predominantly for PCN planning purposes.
    - Consider HQCA, AH, AHS, local community reports (e.g. Supervised Consumption in Medicine Hat report, Medicine Hat Vital Conversations 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, e.g. within the domains of panel, access, screening and transitions
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.
    - Meeting with community groups when invited (e.g. Health Advisory Council, Friends of Medicare)
5. Advancement of the Behavioural Health Consultant (BHC) model
    - 11 distinct BHC staff during the year, 8.2 FTE at the end of this reporting period
    - There are also 2 RNs who incorporate BHC methodology into their clinical care as appropriate
    - Using PHQ-9, GAD-7, BHC-7 (Palliser PCN-developed) and Burns Anxiety/Depression Inventory Assessments (*Patient Reported Outcome Measures – PROMs*) for clinical care
        - 9,200 BHC Initial or Follow-up visits with 2,800 patients in the reporting period
            - 2,200 Initial and 7,000 Follow-up visits
        - 7,600 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 83%
            - This is higher than the previous reporting period's estimated model fidelity of 76%; potential factors: increasing model fidelity while increasing BHC utilization compared to 2020/21 reporting period (9% increase in BHC utilization (69 minutes/visit; previous period: 65 minutes/visit; 2020/21 period: 76 minutes/visit), increased provider comfort with performing the BHC-7 assessment virtually (continued virtual BHC visits due to covid)
            - Increase in BHC utilization a significant achievement; PCN supervisors and facilitators support BHC staff with workflow improvements to maintain quality of care, increase model fidelity with increased patient demand
            - 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, 7,600 PHQ-9, 5,250 GAD-7 and 1,100 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 below Figure
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
    - 15,900 EQ-5D scores on different patients collected during the reporting period
    - Increased rate of collection compared to 12,500 EQ-5D scores in 2021/21, 5,800 EQ-5D scores in 2019/20, 3,700 EQ-5D scores in 2018/19
7. 27% increase in EQ-5D collection since previous reporting period. Increased challenges with mental health
    - Evaluated population-level increase in risk of mental health issues due to circumstances this year

- 46% of Albertans reported deteriorating mental health since onset of the pandemic (https://cmha.ca/wp-content/uploads/2022/02/Key-findings-summary-UBC-round-4-Final.pdf)
- 50% of Canadians reported worsening mental health since the pandemic began with many feeling worried (44%) and anxious (41%) during the pandemic (https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/covid-and-mh-policy-paper-pdf.pdf)
- Sharp increase in suicidality: 8% of Canadians (11% of Albertans) experiencing recent thoughts or feelings of suicide in late 2021, up from 6% per cent in spring 2020 and 2.5 per cent pre-pandemic. (https://www.med.ubc.ca/news/new-national-survey-finds-canadians-mental-health-eroding-as-pandemic-continues/ and https://cmha.ca/wp-content/uploads/2022/02/Key-findings-summary-UBC-round-4-Final.pdf)

8. Crisis Prevention Institute Nonviolent Crisis Intervention and Prevention First Training
    - Classes held Jan-Mar 2022 to support PCN employees, physicians and clinic staff to learn de-escalation techniques and interventions for patients in a crisis
        - 2 PCN staff initially attended Train-the-Trainer education to enable training of PCN audience
        - Blended learning model, included online and in-person education. Options:
            - Prevention First: 1 hour online module and 1 hour in-clinic team strategic planning
                - Attendees: 4 physicians, 18 clinic staff (e.g. MOAs, receptionists) and 3 PCN Central Office staff
            - Nonviolent Crisis Intervention Training: 4 hours of online modules, 6 hours of in-class instruction, 1 hour in-clinic team strategic planning meeting
                - Attendees: 3 physicians, 36 PCN RNs/OHPs, 8 PCN Central Office staff
        - With physician permission, in-clinic planning meeting included local policing authority to identify environmental risks related to crisis prevention (e.g. exam room arrangement to enable provider escape, locking of doors to secure areas) and enable team planning of communication during a crisis
    - CPI training will continue to be held on an ongoing basis as needed. Certificate is good for 3 years.
9. 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 13,000 visits to this listing on the “Find a family doctor accepting new patients” link on PCN website homepage.
    - Approximately 6 family physicians are accepting new patients at any time.

Barriers/Potential Challenges:

1. Anticipated future health workforce shortage
    - All professions; anticipated 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. “PCN Dashboard” released in May 2022 but last updated October 2020 with data ending March 31, 2019
    - Level of aggregation – data not specific to PCN or community: e.g. PCN Zone Profiles last updated March 2021 with data ending March 31, 2019

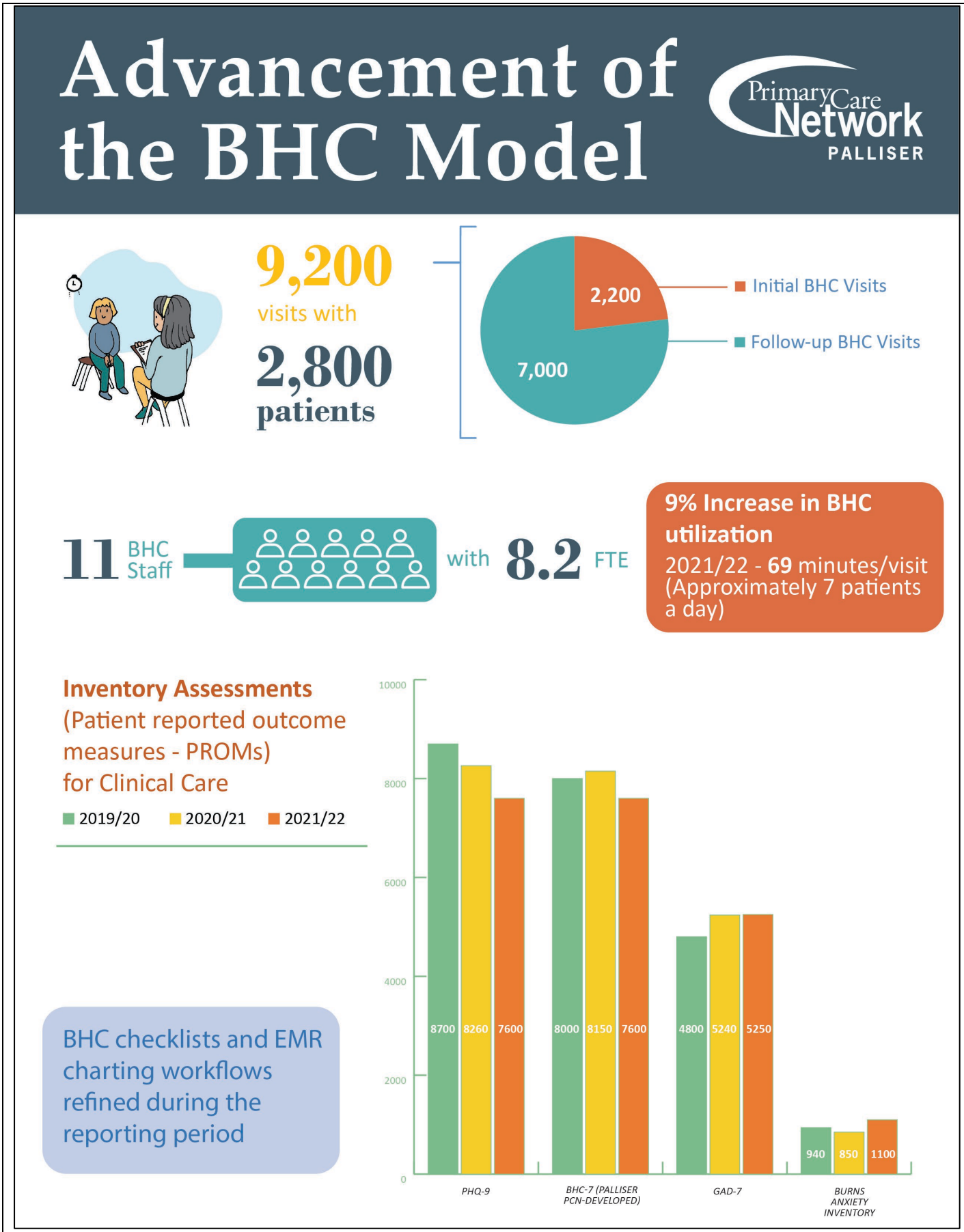


Figure 14 - Advancing the BHC Model - reporting period summary

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:

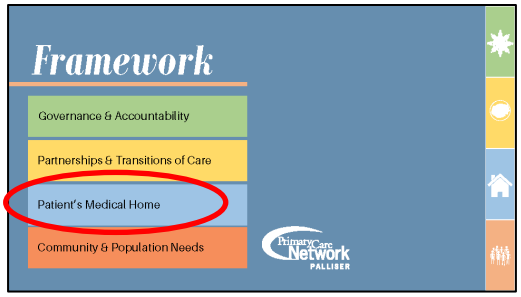


Figure 15 - PCN Framework with Patient's Medical Home Objective circled

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

Figure 16 - Patient's Medical Home Objective Activities

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

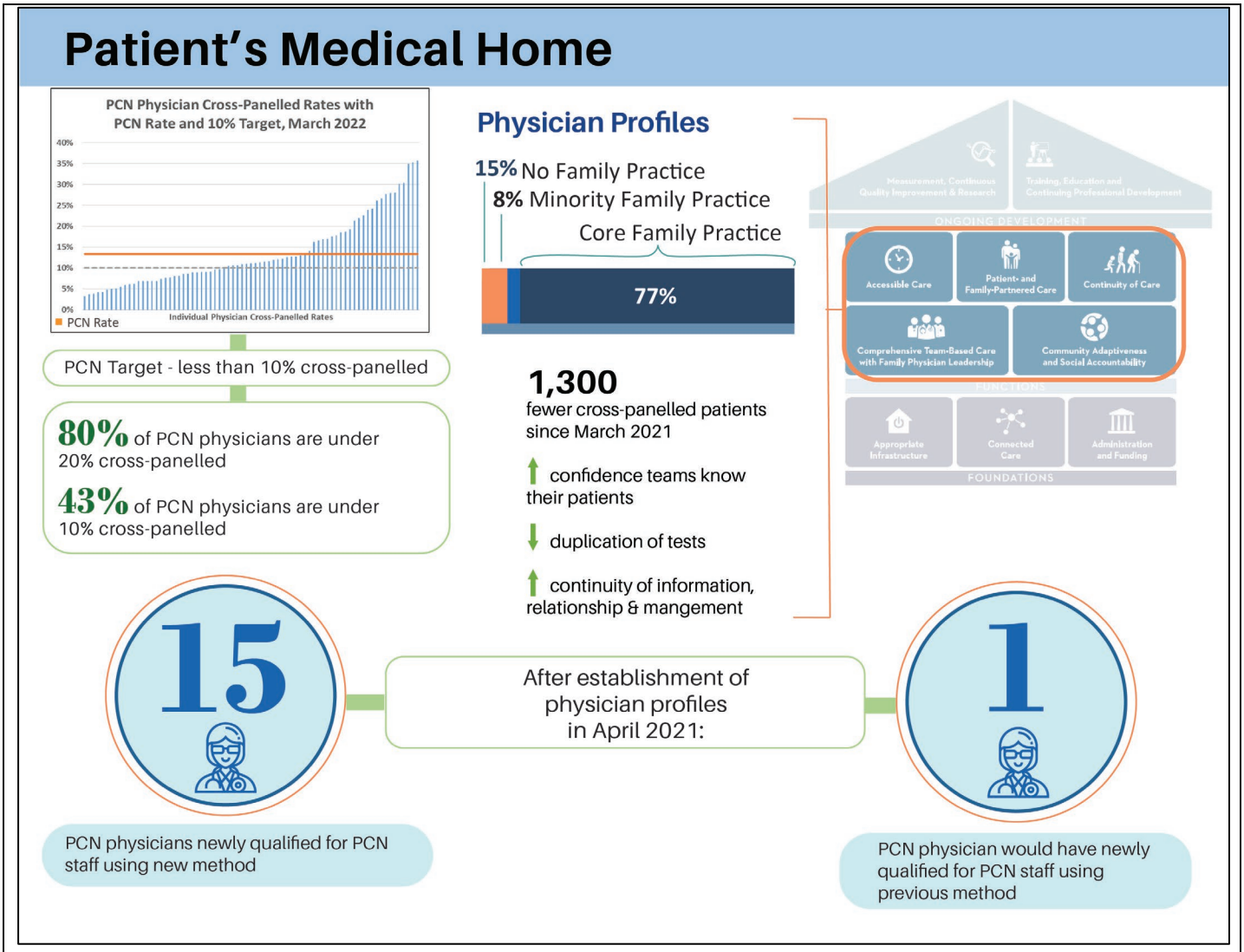


Figure 17 – Patient's Medical Home Objective Highlights

Details related to Objective 4 highlights:

- PCN introduced 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 (13% of panels at the PCN level). 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 2 year notice period in which they are supported to increase their panel. This includes supporting teams to review panels, contact patients, administratively inactivate patients who have not been in to the clinic in many years (e.g. over 5 years), develop long-term processes to buttress panel accuracy.
- Teams that engaged with panel validation work and inactivated significant numbers of patients were able to reduce their average cross-panelled rates by more than half.
- 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.
- 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), this allows a triangulation of perspectives regarding the current state of care coordination in Palliser PCN health homes.

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 2021/22	FY 2020/21
Proportion of physicians measuring time to third next appointment	Numerator	89	84
	Denominator	90	86
	Proportion	98.9%	97.7%

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. 91% 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 88%.

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. 77% 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 93%.

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
- 29 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: **12,000**)

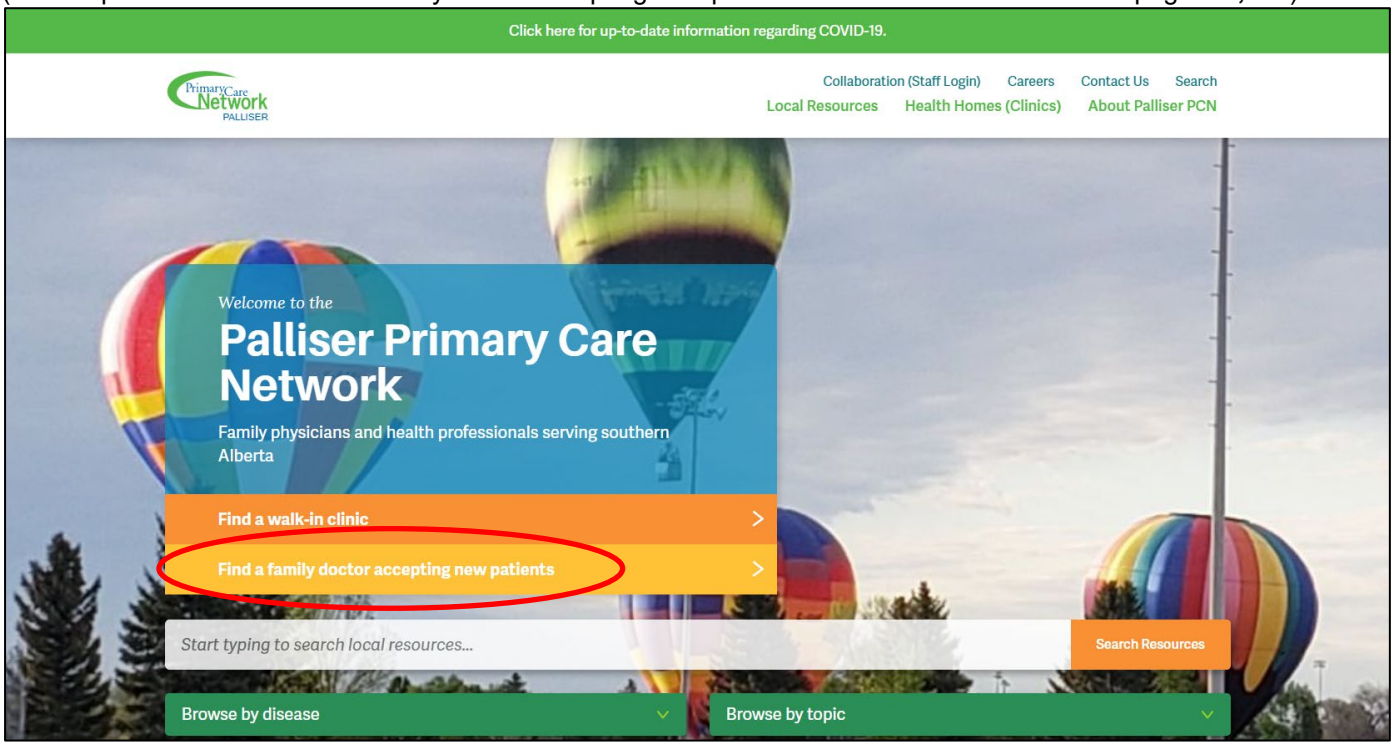


Figure 18 - PCN Website Homepage with "Find a family doctor accepting new patients" link circled

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: **13,000**.

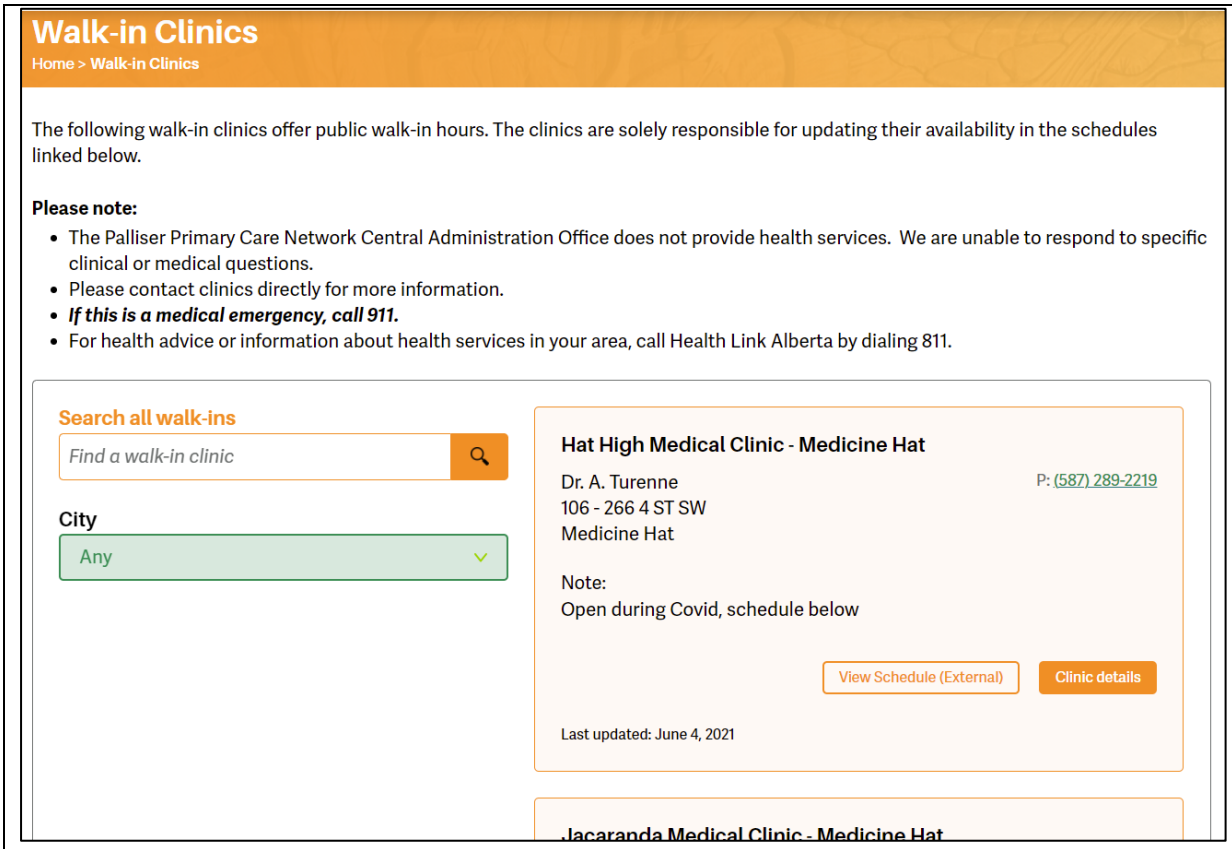


Figure 19 - PCN Website Walk-in Clinics landing page

~300 local community resources are currently listed on the Palliser PCN website. Examples of listed resources include local caregiver support groups, newcomer supports, day programs, 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): **33,000**.

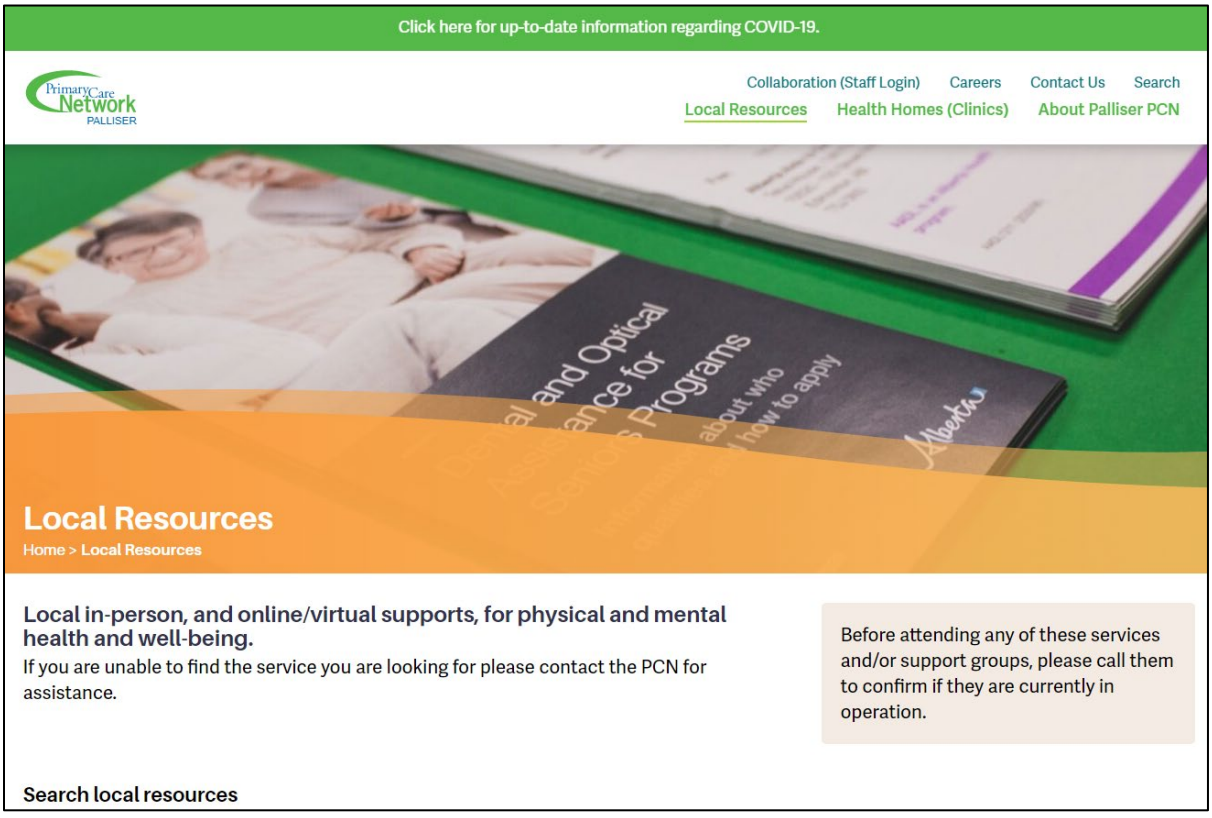


Figure 20 - PCN Website Local Resources landing page

10 most accessed PCN Website Local Resources, 2021/22:

1. Alcoholics Anonymous
2. Rainbow Medical Centre (Echocardiography)
3. Children's Allied Health (formerly CHADS)
4. Addictions & Mental Health – Child, Youth, Family & Prevention Services Medicine Hat
5. Addictions & Mental Health Outreach Services Medicine Hat
6. Holy Family Parish – St. Vincent de Paul
7. Adult Inpatient Psychiatry – Medicine Hat Regional Hospital (5 North)
8. Alberta Healthy Living Program – Classes & Education
9. Al-Anon Family Group
10. Diagnostic Imaging Services (Alberta Health Services)

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.

4c: Patient Centred Interactions

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

PATIENT SURVEY RESULTS
Prepared January 2022

Return Rate: 77%

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

PCN Average Satisfaction Score		
2021	2020	2019

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.	957	145	8	2	2	1114	96%	96%	95%
Self-Management	2. My confidence to manage my health has improved through the support I receive from my PCN provider.	832	238	26	4	2	1102	93%	92%	92%
Patient Satisfaction	5. I have felt that my PCN provider is knowledgeable regarding my health.	934	156	11	1	3	1105	96%	96%	94%
Quality of Life	8. Overall, I felt that receiving care from my health home team has improved my quality of life.	830	228	25	3	2	1088	93%	92%	90%

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 scale, whereas the existing survey uses a 5-point Likert 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:

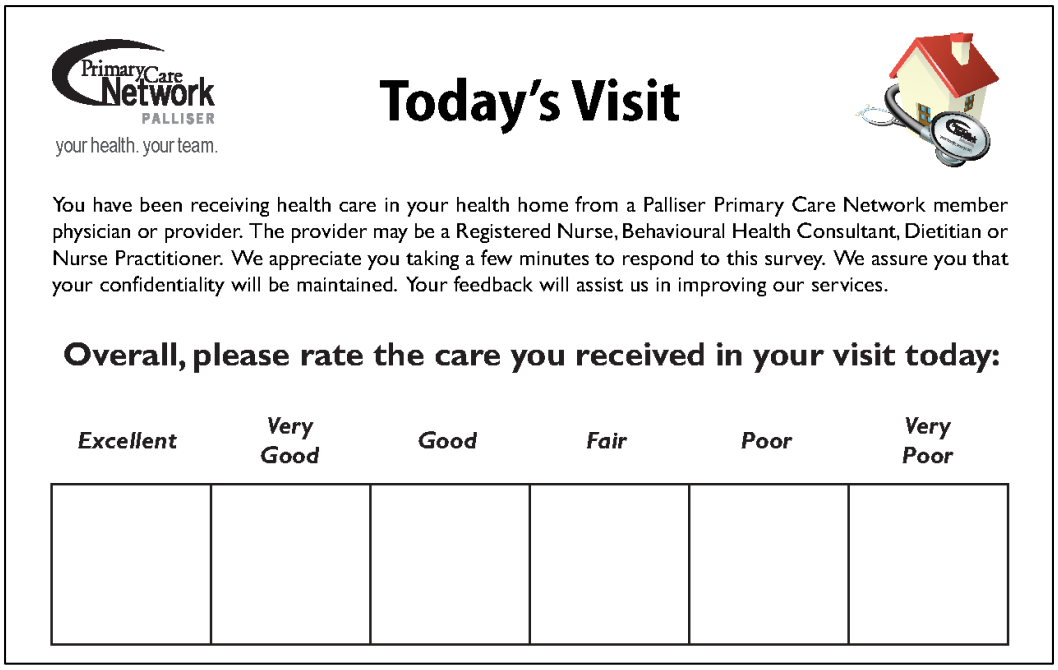


Figure 21 - Clinic Patient Single Visit Satisfaction Survey

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

PATIENT EXPERIENCE INDICATOR		FY 2021/22	FY 2020/21
Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	100	10
	Denominator	110	10
	Proportion	90.9%	100.0%

Due to covid considerations, the 2020/21 PCN phone survey process was continued. Three PCN health homes were approached and agreed to support this survey. Process:

- The PCN analyst identified patients who had been seen for a visit
- Facilitated the clinic to review the list of patients for accuracy
- Stripped all patient identifying information and provided to a PCN central office team member
- Team member called the phone number of each patient (anonymous to the caller) to ask the single patient visit satisfaction question.

110 patients were reached out of 185 calls, taking approximately 3 hours 45 minutes in total. Identifying patients, reviewing, preparing and confirming calling process and script with the health home and team member took approximately 3 person-hours. PCN covid-related priorities superseded expansion of the above phone survey process.

For the next reporting period, the PCN is will consider administrating this survey fully electronically (through posting of QR code at the health home). 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 84%.

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

SCREENING INDICATOR		FY 2021/22	FY 2020/21
Offers of screening maneuvers completed	Numerator	221,424	213,303
	Denominator	368,890	388,579
	Proportion	60.0%	54.9%

Although it would be challenging to derive meaningful actionable intelligence from the above indicator, it could be observed 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.

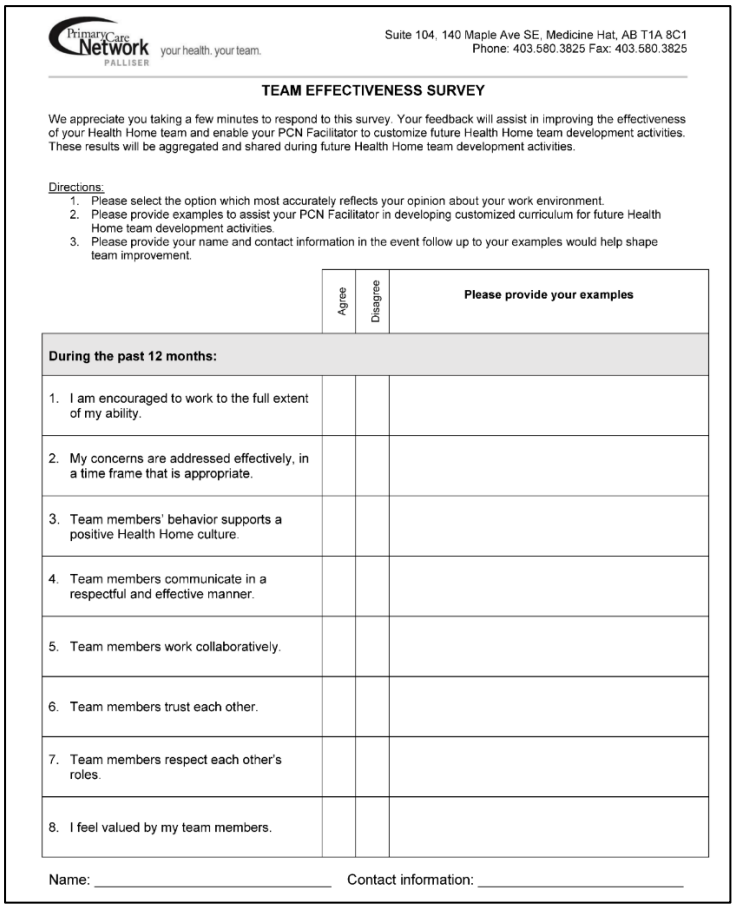
4e: Team Based Care

Results of the Team Effectiveness Progress Indicator relevant to Palliser PCN are shown in the figure below:

TEAM EFFECTIVENESS PROGRESS INDICATORS		FY 2021/22	FY 2020/21
Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	1	1
	Denominator	40	41
	Proportion	2.5%	2.4%

There are no PCN operated clinics; thus, Indicator 6.1 is not displayed here.

During the reporting period, Palliser PCN offered 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 to modify the sample survey to focus on elements of particular interest.



Primary Care Network PALLISER your health. your team.

Suite 104, 140 Maple Ave SE, Medicine Hat, AB T1A 8C1
Phone: 403.580.3825 Fax: 403.580.3825

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 and enable your PCN Facilitator to customize future Health Home team development activities. These results will be aggregated and shared during future Health Home team development activities.

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 developing customized curriculum for future Health Home team development activities.
3. Please provide your name and contact information 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 22 - 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 the reporting period, one clinic completed a paper version of the team effectiveness survey but did not proceed with a team retreat/building activity.

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.

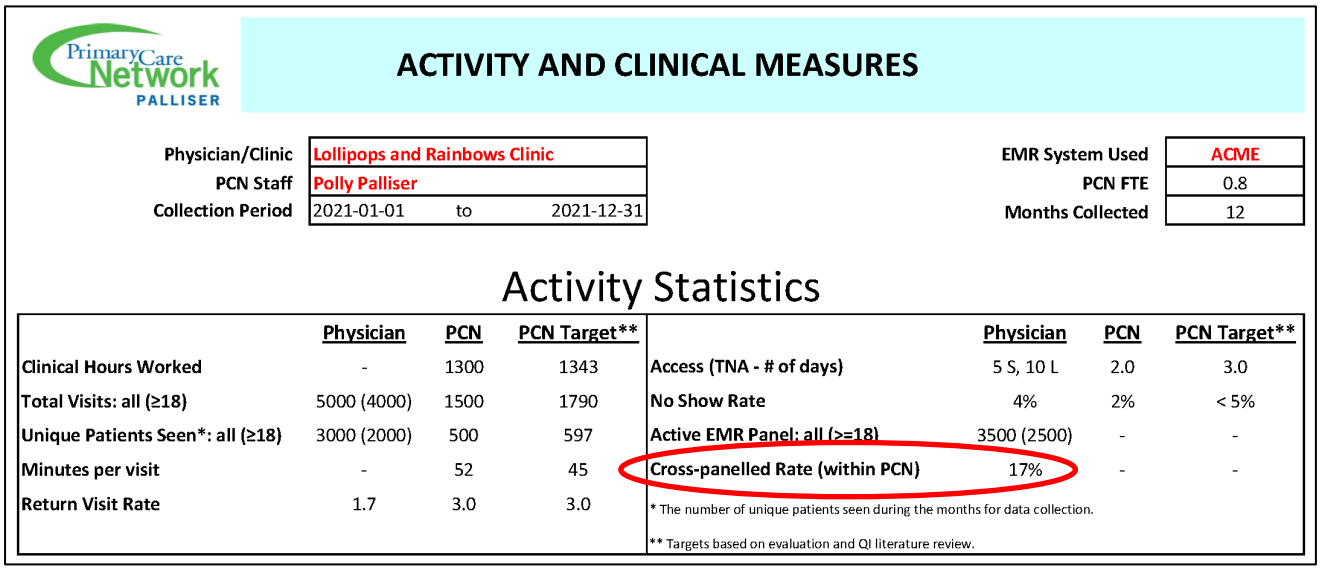
4f: Panel & Continuity

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 23 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.



Primary Care Network PALLISER

ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic		EMR System Used	ACME
PCN Staff	Polly Palliser		PCN FTE	0.8
Collection Period	2021-01-01	to 2021-12-31	Months Collected	12

Activity Statistics

	Physician	PCN	PCN Target**		Physician	PCN	PCN Target**
Clinical Hours Worked	-	1300	1343	Access (TNA - # of days)	5 S, 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)	17%	-	-
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 23 - 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 team with 3500 patients has a 17% cross-panelled rate, this means there are 595 patients identified with a family doctor at this health home and at least one other health home in the PCN.

At a PCN level, the cross-panelled rate is 13%, down from 15% in the last reporting period. Individual PCN physician cross-panelled rates vary as seen below, with rates as low as 3% and as high as 36%. 80% of individual physician cross-panelled rates are below 20% (up from 73% in the last reporting period), with 43% already under the PCN target of 10% (up from 29% 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

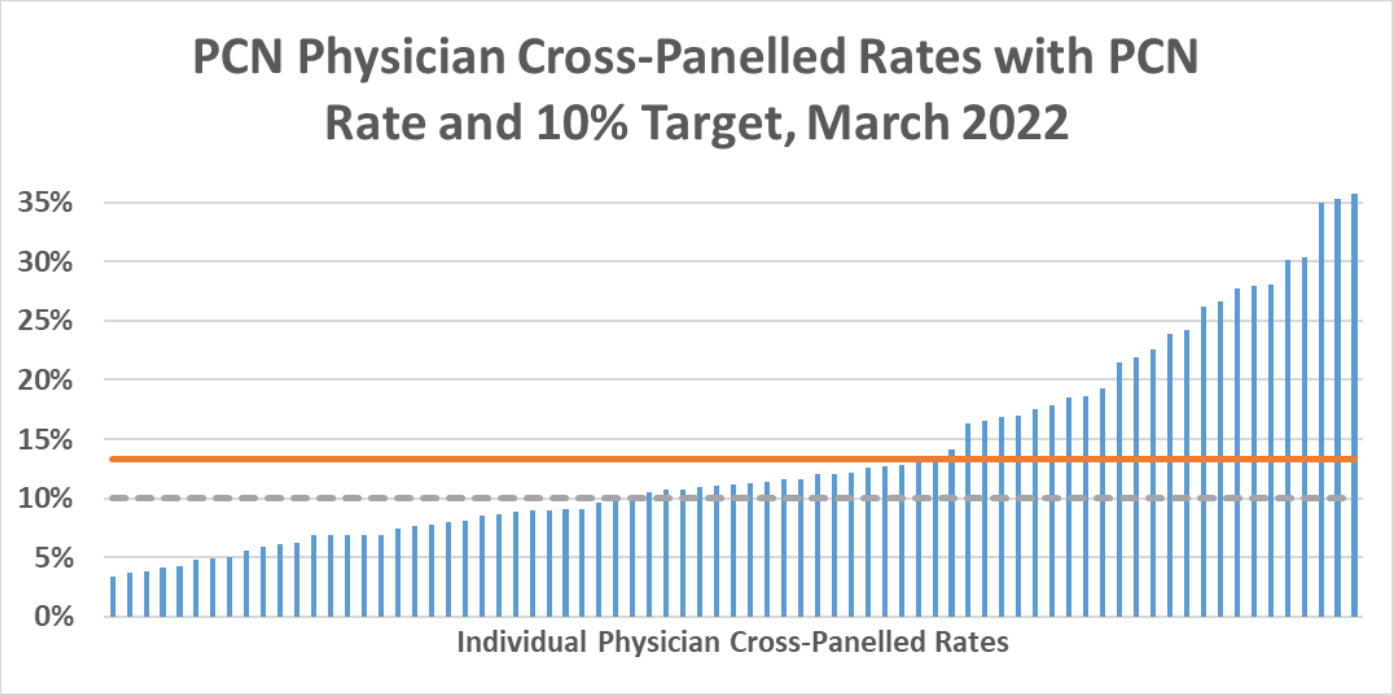


Figure 24 - Anonymous Physician- and PCN-level Cross-Panelled Rates, March 2022

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
- 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):

ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic	EMR System Used	ACME
PCN Staff	Polly Palliser	PCN FTE	0.8
Collection Period	2021-01-01 to 2021-12-31	Months Collected	12

Activity Statistics

	Physician	PCN	PCN Target**
Clinical Hours Worked	-	1300	1343
Total Visits: all (≥18)	5000 (4000)	1500	1790
Unique Patients Seen*: all (≥18)	3000 (2000)	500	597
Minutes per visit	-	52	45
Return Visit Rate	1.7	3.0	3.0

	Physician	PCN	PCN Target**
Access (TNA - # of days)	5 S, 10 L	2.0	3.0
No Show Rate	4%	2%	< 5%
Active EMR Panel: all (>=18)	3500 (2500)	-	-
Cross-panelled Rate (within PCN)	17%	-	-

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

** Targets based on evaluation and QI literature review.

Clinical Indicators (≥18)

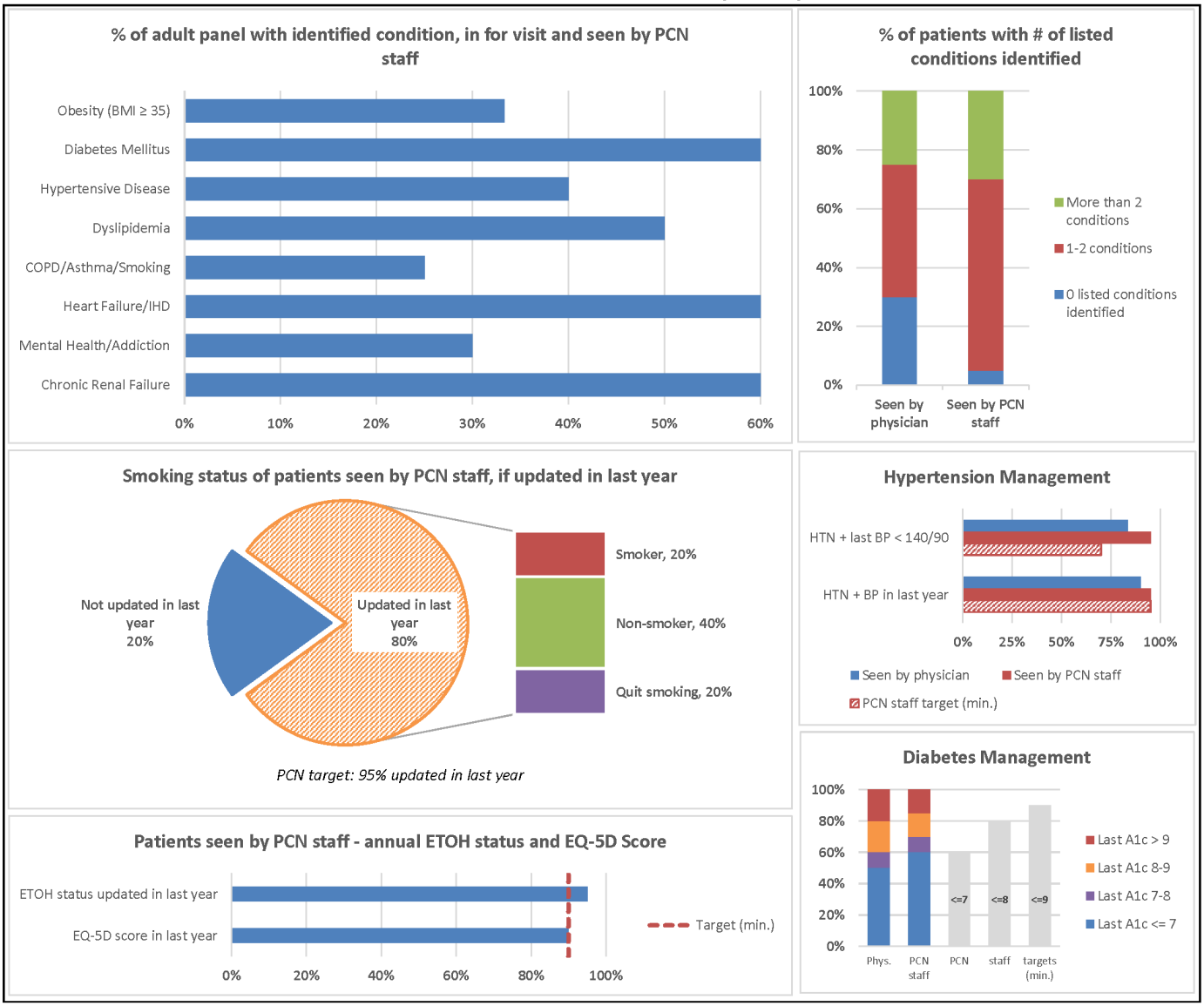


Figure 25 - Sample 2022 Palliser PCN Activity and Clinical Measures Sheet, Front Page

Screening and Prevention Indicators (2022)

Physician/Clinic	**Lollipops and Rainbows Clinic**	**EMR System Used**	ACME
PCN Staff	**Polly Palliser**	**PCN FTE**	0.8
Collection Period	2021-01-01 to 2021-12-31	**Months Collected**	12

			Screening rates			
Indicator	**Eligible**	**Detail**	**Patients seen by physician**	**Patients seen by PCN staff**	**PCN Average - EMR (2021)**	**PCN Average - HQCA[1] (2021)**
Diabetes Screening	All > 40	A1c or Fasting Glucose Every 5 years	90%	95%	93%	(delayed)[1]
Cholesterol Screening	All 40-74	Every 5 years	80%	75%	94%	(delayed)[1]
Colorectal Screening	All 50-74	Colonoscopy every 10 years or FIT every 2 years	70%	60%	67%	(delayed)[1]
Mammography	F 50-74	Every 2 years	65%	60%	69%	74%
Bone Mineral Density	M > 65	Once	30%	20%	19%	(not measured by HQCA)[2]
Bone Mineral Density	F > 65	Once	67%	80%	58%	(not measured by HQCA)[2]
Pap	F 25-69	Every 3 years	60%	50%	56%	70%
Blood Pressure	All > 18	Annually	65%	80%	78%	(not measured by HQCA)[2]
Weight	All > 18	Every 3 years	75%	85%	86%	(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%	91%	(not measured by HQCA)[2]
Influenza Immunization	All > 6 mths	Annually	45%	90%	32%	36%

[1]HQCA issues in 2021 with providing diabetes, cholesterol, colorectal screening rates (Connect Care transition)

[2]Not typically measured by HQCA

> 10% missing A1c in last year

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 26 - 2022 Activity and Clinical Measures Sheet Screening Measures and Definitions

2021/22 changes to Activity and Clinical Measures Sheet:

- Redesign of front side of sheet to increase provider understanding and engagement in quality improvement
- Move of screening measures to rear side of sheet to facilitate peer comparison (with PCN average)

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 27 and 28*)
- Percentage of patients with chronic conditions identified seen by PCN RNs/OHPs proportional to those seen by PCN physicians (*Figure 29*)
- 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

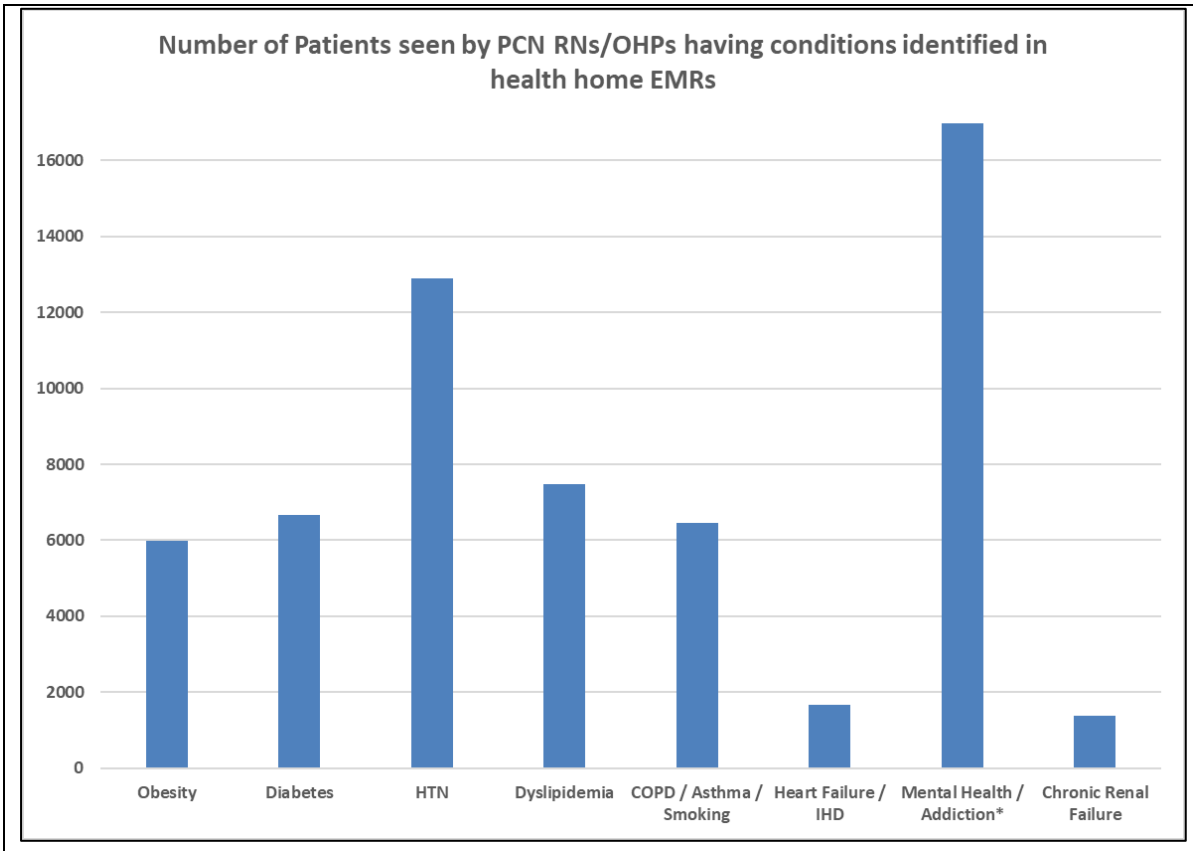


Figure 27 - Number of patients seen by PCN RNs/OHPs, by condition

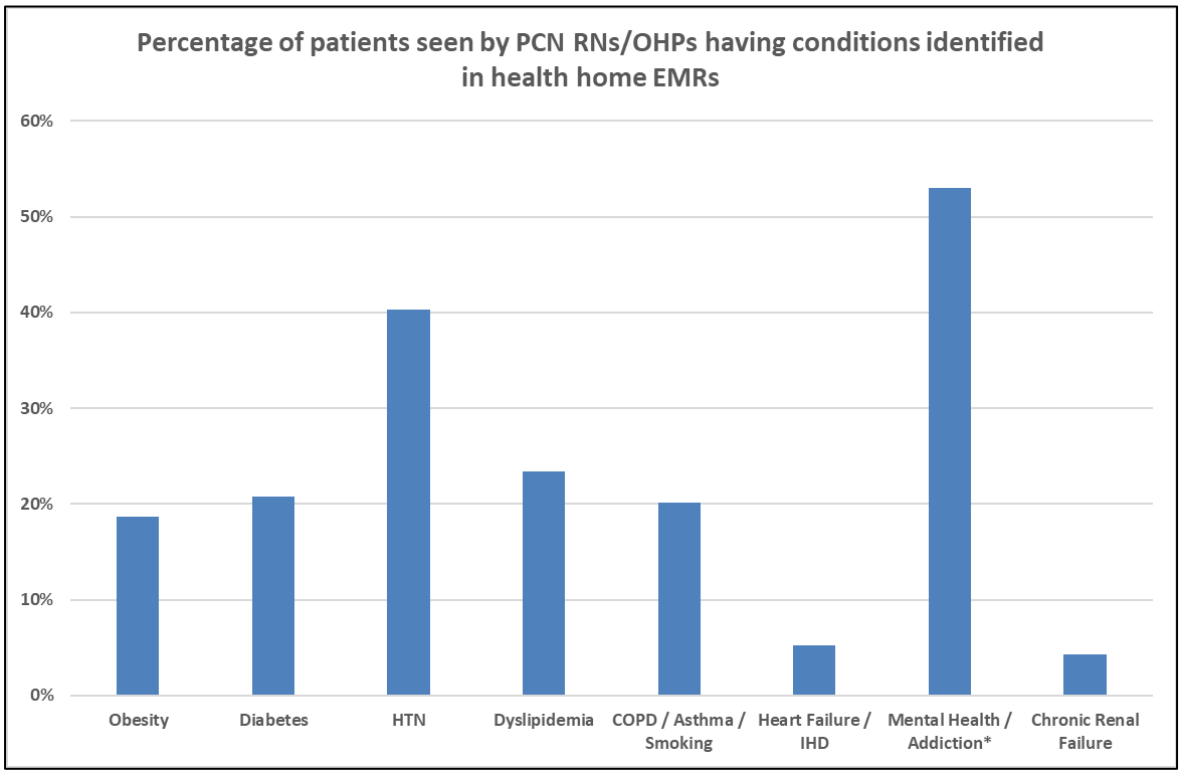


Figure 28 - Percentage of patients seen by PCN RNs/OHPs, by condition

* Figures 27/28/29: 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.

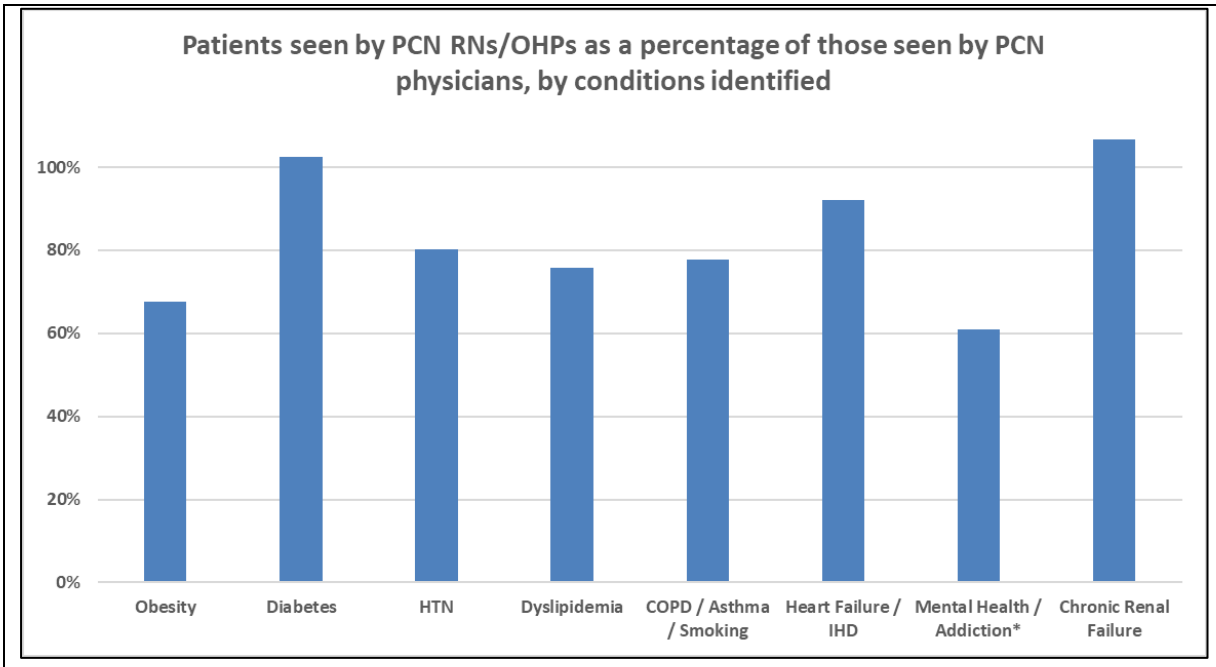


Figure 29 - Patients seen by PCN RNs/OHPs as percentage of seen by physicians, by condition

Below are selected aggregate and average PCN RN/OHP utilization and access measures for 2021/22:

Total unique patients seen by PCN RNs/OHPs	31,999
Total patient visits with PCN RNs/OHPs	85,341
Average number of patients seen by PCN RNs/OHPs per 1.0 FTE	711
Average minutes per patient	49
Average annual return visit rate	2.7
Average time to third next available appointment (TNA)	6.0 days

Highlights: jump in average # of patients seen by PCN RNs/OHPs per 1.0 FTE: from 615 to 711. Could reflect increase in scale of PCN RN/OHP referrals by physician, increased comfort in RN/OHP knowledge/scope. Drop in minutes per visit: from 55 to 49. Could reflect increased staff utilization, improvement in staff onboarding to enable increased utilization. Increase in average time to third next available appointment: from 4.2 days to 6.0 days. Although it is challenging to draw a conclusion regarding a decrease in average TNA (as there is no evidence in literature for its evaluation in aggregate), could reflect increase in backlog for some RNs/OHPs coincidental with increased utilization.

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

Average no show rate, physicians	3.2%
Average no show rate, PCN BHCs	10.4%
Average no show rate, PCN non-BHCs	5.3%

An average 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. Considering the context of covid in 2020/21 and 2021/22, an overall increase in no show rate compared to the previous reporting period (from 4.0% to 5.8% across all PCN RNs/OHPs) may be more due to a return to typical pre-booked in-person appointments and reassertion of typical in-clinic no show measurement processes as opposed to a surge in patient no shows.

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 2021/22	FY 2020/21
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	91
		FY 2021/22	**FY 2020/21**
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	86	87
	Denominator	90	91
	Proportion	95.6%	95.6%
		FY 2021/22	**FY 2020/21**
What percentage of Participating Physicians or Participating Providers routinly verify their panel? (Numerator Count of participating physicians and participating providers that are routinely verifying their panels.)	Numerator	88	86
	Denominator	90	91
	Proportion	97.8%	94.5%
		FY 2021/22	**FY 2020/21**
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	14	6
	Denominator	90	91
	Proportion	15.6%	6.6%
		FY 2021/22	**FY 2020/21**
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	14	6
	Denominator	90	91
	Proportion	15.6%	6.6%
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	11	3
	Denominator	90	91
	Proportion	12.2%	3.3%

Analysis of indicators:

- Primary analysis located in Objective 2 highlight infographic and details
- "What percentage of Participating Physicians or Participating Providers are using a CII-CPAR compatible EMR?": 3/4 of the physicians absent from the numerator are using a compatible EMR but for demographics/scheduling only; upon investigation the PCN learned there is no technical barrier for these providers to participate but it has been determined provincially that teams in this circumstance are not permitted to participate. If this circumstance changes, the PCN will reach out again to these physicians.

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

Alberta

ALBERTA HEALTH WILL NOT ACCEPT ANNUAL REPORTS IF ALL FIELDS ARE NOT COMPLETED

PCN REPORT ON PRIMARY HEALTH CARE INDICATOR SET (SCHEDULE B)

#	THIRD NEXT AVAILABLE APPOINTMENT INDICATOR		FY 2021/22	FY 2020/21
1	Proportion of physicians measuring time to third next appointment	Numerator	89	84
		Denominator	90	86
		Proportion	98.9%	97.7%
#	**PATIENT EXPERIENCE INDICATOR**		**FY 2021/22**	**FY 2020/21**
2	Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	100	10
		Denominator	110	10
		Proportion	90.9%	100.0%
#	**SCREENING INDICATOR**		**FY 2021/22**	**FY 2020/21**
3	Offers of screening maneuvers completed	Numerator	221,424	213,303
		Denominator	368,890	388,579
		Proportion	60.0%	54.9%
#	**GOVERNANCE INDICATOR**		**FY 2021/22**	**FY 2020/21**
4	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**
4.1	Did the Board use Accreditation Canada's Governance Functioning Tool in their self-assessment process?		**YES**	**YES**
4.2	If not, what self-assessment tool was used?			
4.3	Did the Board receive approval from Alberta Health for the use of this alternative tool?			
#	**LEADERSHIP INDICATOR**		**FY 2021/22**	**FY 2020/21**
5	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 2021/22**	**FY 2020/21**
6	Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	1	1
		Denominator	40	41
		Proportion	2.5%	2.4%
6.1	Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	N/A	N/A
		Denominator	N/A	N/A
		Proportion	NO VALUE	NO VALUE
#	**PCN REPORT ON PATIENT'S MEDICAL HOME READINESS (CII/CPAR)**		**FY 2021/22**	**FY 2020/21**
7.0	**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	91
7.1	**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	86	87
		Denominator	90	91
		Proportion	95.6%	95.6%
7.2	**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	86
		Denominator	90	91
		Proportion	97.8%	94.5%
7.3	**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	14	6
		Denominator	90	91
		Proportion	15.6%	6.6%
7.4	**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	14	6
		Denominator	90	91
		Proportion	15.6%	6.6%
7.5	**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	11	3
		Denominator	90	91
		Proportion	12.2%	3.3%

Please Note: Methodology questions are addressed in the **Methodology** tab of this Excel document.

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

PALLISER PRIMARY CARE NETWORK

FINANCIAL STATEMENTS

March 31, 2022

Alberta Government

Primary Care Network

PALLISER PRIMARY CARE NETWORK
MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING
March 31, 2022

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:**	**Signature:**	**Date:**
Physician Lead	Dr. Monty van der Westhuizen	Chair	Signatures on file	(June 2022)
Senior AHS Authorizing Signature	Dr. Douwe Kits	Vice Chair		

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, 2022 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, 2022, 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 7, 2022

PALLISER PRIMARY CARE NETWORK

Statement of Operations

For the Year Ended March 31, 2022

	Notes	2022 Budget (Unaudited)	2022 Actual (Audited)	2021 Actual (Audited)
Revenue				
Per Capita Funding from Alberta Health:				
Operating		$ 6,588,120	$ 6,141,526	$ 6,648,893
Capital		-	-	1,618
PCN Support Program Nurse Practitioner Funding		175,000	200,521	124,998
Interest and Investment Income		10,000	9,879	9,373
Other Income - Restricted Zone Funding				
Other Income {Specify}				
Other Income Fee for Service				
Total Revenue		**6,773,120**	**6,351,926**	**6,784,882**
Expenses (Priority Initiatives)				
Professional Support within Health Homes		5,262,120	4,876,684	5,164,559
Measurement & Practice Improvement		459,000	405,762	514,497
PCN Support Program Nurse Practitioner		175,000	207,767	161,135
Priority Initiative - Zonal Expenses		-	-	-
Priority Initiative Subtotal		**5,896,120**	**5,490,213**	**5,840,191**
Expenses (Central Allocations)				
Evaluation		-	-	-
PCN Admin Lead Salary		147,000	150,305	152,675
PCN Admin Lead Benefits		28,000	28,629	29,081
Other Management Salary (Specify)		293,000	253,655	274,547
Other Management Benefits		29,000	26,940	29,032
Administration (list in notes)		380,000	402,184	457,738
Information Technology		-	-	-
Support Services		-	-	-
Amortization		-	-	1,618
(Gain)/ Loss on disposal of Capital Asset(s)		-	-	-
Central Allocations Subtotal		**877,000**	**861,713**	**944,691**
Total Expenses		**6,773,120**	**6,351,926**	**6,784,882**
Excess /(Deficiency) of Revenue Over Expenses		**$ -**	**$ -**	**$ -**

PALLISER PRIMARY CARE NETWORK

Statement of Financial Position (Audited)
As at March 31, 2022

		2022 Actual	2021 Actual
Assets			
Current Assets:	Notes:		
Cash		$ 937,367	$ 680,453
Short-term investments		-	-
Accounts receivable		114,432	45,165
Prepaid expenses		76,702	20,702
Other assets		-	-
Total Current Assets		**1,128,501**	**746,320**
Capital Assets (Net Amortization) - Sch2		-	-
Total Assets		**$ 1,128,501**	**$ 746,320**
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued liabilities		702,737	745,336
Due to Alberta Health Services	Note 3	14,916	-
		717,653	745,336
Non-Current Liabilities:			
Unexpended deferred revenue - AH	Note 5	410,848	984
Outstanding BPA Expenses (list in notes)		-	-
Unexpended deferred revenue - Other		-	-
Unamortized capital contributions		-	-
Other liabilities		-	-
Total Liabilities		**1,128,501**	**746,320**
Net Assets:			
Net Assets		-	-
Closing Balance - Net Assets		-	-
Total Liabilities and Net Assets		**$ 1,128,501**	**$ 746,320**

PALLISER PRIMARY CARE NETWORK

Statement of Cash Flows (Audited)
For the Year Ended March 31, 2022

	2022 Actual	2021 Actual
Operating Activities:		
Excess/(Deficiency) of revenue over expenses	$ -	$ -
Non-cash transactions		
Amortization	-	1,618
(Gain)/ Loss on disposal of capital assets	-	-
Amortization of deferred capital contributions	-	(1,618)
Change in non-cash working capital:		
(Increase)/Decrease in accounts receivable	(69,267)	(31,317)
(Increase)/Decrease in prepaid expenses	(56,000)	(13,000)
(Increase)/Decrease in other assets	-	-
Increase/(Decrease) in accounts payable and accrued liabilities	(42,599)	34,024
Increase/(Decrease) in amount due to AHS	14,916	(376,912)
Increase/(Decrease) in deferred revenue - AH	409,864	(298,740)
Increase/(Decrease) in deferred revenue - Other	-	-
Increase/(Decrease) in other liabilities	-	-
Cash generated from/(used by) operations	**256,914**	**(685,945)**
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	256,914	(685,945)
Cash and investments at the beginning of the year	680,453	1,366,398
Cash and investments at the end of the year	**$ 937,367**	**$ 680,453**

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.
- Investment 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 and highly liquid money market instruments with a maturity of less than three months at acquisition. 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, 2022, 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 4.45%. The line of credit is secured by a general security agreement on the assets of the PCN. At March 31, 2022, there is no amount outstanding on this credit facility (2021 - $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 (2021 - $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 $14,916 outstanding to Alberta Health Services at year end (2021 - $0).

Note 4 Approval of Budget

The budget for 2022 was approved by the PCN Board of Directors in March 2021.

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:

	2022	2021
Balance at the beginning of year	$ 984	$ 299,724
Less amounts recovered by Alberta Health	(984)	-
Received/receivable during the year:		
- Per Capita Funding	6,552,374	6,350,153
- Nurse Practitioner funding	200,521	124,998
- Investment income	9,879	9,373
- Restricted Zone Funding	-	-
Less amounts recognized as revenue:		
- Per Capita Funding	(6,141,526)	(6,648,893)
- Nurse Practitioner funding	(200,521)	(124,998)
- Investment income	(9,879)	(9,373)
- Restricted Zone Funding	-	-
Balance at the end of year	**$ 410,848**	**$ 984**

The balance at the end of the year is comprised of the following:

- Unspent Per Capita funding	$ 410,848
- Unspent Nurse Practitioner funding	0
Total	**$ 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:

	2022	2021
Balance at the beginning of year	$ 0	$ 1,618
Less amounts recognized as revenue	0	(1,618)
Balance at the end of year	**$ 0**	**$ 0**

Note 7 Per-Diem Revenue

Per-diem 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.

	2022 # of Enrolees	2022 Amount	2021 Amount
Eligible per capita payments:			
April	106,260	$3,294,057	$3,343,572
October	105,107	3,258,317	3,306,305
Total eligible per capita payments		**$ 6,552,374**	**$ 6,649,877**

Note 8 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, 2022.

Note 9 Commitments and Contingencies

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

Note 10 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 11 Approval of Financial Statements

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

PALLISER PRIMARY CARE NETWORK

Schedule 1 - Expenses by Object

For the Year Ended March 31, 2022

	2022		2021
	Budget (Unaudited)	Actual (Audited)	Actual (Audited)
Physicians: Clinical	-	-	-
Physicians: in lieu of FFS	-	-	-
Physicians: Administrative (Specify in notes)	265,000	213,951	254,438
Physicians: Other (Specify in notes)	207,000	223,075	249,726
Physicians Subtotal	**472,000**	**437,026**	**504,164**
Alberta Health Services - Purchased Services	-	-	-
Alberta Health Services - Office Space	-	-	-
Alberta Health Services - Other (Specify in notes)	-	-	-
Non-Physician Direct Care Providers	4,875,120	4,286,962	4,704,771
Zonal Expenses	-	-	-
Other Expenses*	1,426,000	1,627,938	1,574,329
Amortization	-	-	1,618
Total Expenses	**$ 6,773,120**	**$ 6,351,926**	**$ 6,784,882**

* Other: Specify amounts below:

(Unaudited) Other Expenses (2022 Actual) are comprised of the following:

- Education and training $ 45,343
- Medical, IT equipment and renovations $ 101,990
- Website, software and related costs (one-time) $ 108,067
- Virtual classroom, CPI training and related costs (one-time) $ 90,056
- RNs/OHCP: Travel and other supplies $ 35,163
- Measurement and Improvement: Payroll (5.0 FTE) $ 391,692
- Measurement and Improvement: Travel and other supplies $ 14,070
- NP grant funding to Chinook PCN $ 18,750
- Administrative Lead: Payroll & benefits (1.0 FTE) $ 178,934
- Other Management: Payroll (3.0 FTE) $ 280,595
- Central Office: Payroll - Admin and Finance (3.0 FTE) $ 147,164
- Central Office: Professional Services -legal, acctg, HR, etc. $ 61,288
- Central Office: Insurance, computers, phones, office supplies $ 76,155
- Central Office: Rent, utilities, janitorial & related costs $ 78,671

Schedule 2: Schedule of Capital Assets (Audited)

For the Year Ended March 31, 2022

Cost	Leasehold Improvements	Other Capital Assets	Total
Balance April 1, 2021	97,080	-	97,080
Additions	-	-	-
Disposals	-	-	-
Cost at March 31, 2022	**97,080**	**-**	**97,080**

	Leasehold 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, 2022	**97,080**	**-**	**97,080**
Net Book Value March 31, 2022	**-**	**-**	**-**
Net Book Value March 31, 2021	**-**	**-**	**-**

PALLISER PRIMARY CARE NETWORK

Staffing Summary (Unaudited)

	Budget as at March 31, 2022	Actual as at March 31, 2022	Actual as at March 31, 2021
# of Clinics Participating in PCN	40	40	40
# of Core Provider Physicians	90	90	90
Enrollees per AH mgmt report:	106,260	104,062	106,260

	Profess Discip- line (PD)	Budget FTE as at Mar.31, 2022	Budget Cost ($) Apr.1, 2021 to Mar.31, 2022	Budget Head Count at Mar.31, 2022	Actual FTE as at Mar.31, 2022	Actual Cost ($) Apr.1, 2021 to Mar.31, 2022	Actual Head Count at Mar.31, 2022	Actual FTE as at Mar.31, 2021	Actual Cost ($) Apr.1, 2020 to Mar.31, 2021	Actual Head Count at Mar.31, 2021
Direct Care Provider Staffing										
Nurse Practitioner		1.40	$175,000	3	1.55	$189,017	3	1.35	$161,135	2
Registered Nurse	RN	42.00	$3,885,320	56	37.40	$3,418,945	47	40.50	$3,693,536	53
Licensed Practical Nurse	LPN									
Social Worker										
Dietitian		0.90	$87,300	2	0.30	$29,100	1	0.90	$86,100	2
Pharmacist										
Physiotherapist										
Occupational Therapist										
Mental Health Therapist	RN									
Behavioral Health Consultant	other	7.50	$727,500	11	6.70	$649,900	9	8.00	$764,000	10
Midwifery Services										
Exercise Specialist										
Psychologist										
Other DCP (specify)										
Other DCP (specify)										
Other DCP (specify)										
Other DCP (specify)										
Other DCP (specify)										
Other DCP (specify)										
Total Direct Care Provider Staffing[2]		**51.80**	**$4,875,120**	**72.00**	**45.95**	**$4,286,962**	**60.00**	**50.75**	**$4,704,771**	**67.00**
Clinical Support Staffing										
Referral Coordinator	LPN									
Medical Office Assistant										
Facilitator										
Program Manager/Coordinator	RN									
Clinical Coordinator										
Clinical Management										
Panel Manager	NP									
Improvement Facilitators										
Measurement and improvement		5.00	$439,000	5	5.00	$391,692	5	5.30	$465,222	5
Total Clinical Support Staffing		**5.00**	**$439,000**	**5.00**	**5.00**	**$391,692**	**5.00**	**5.30**	**$465,222**	**5.00**
Admin. And Support Staffing										
PCN Administrative Lead Salary[1]		1.00	$147,000	1	1.00	150,305	1	1.00	$152,675	1
PCN Addministrative Lead Benefits			$28,000			$28,629			$29,081	
All Other Management Salary		3.00	$293,000	3	2.60	$253,655	3	2.80	$274,547	3
All Other Management Benefits			$29,000			$26,940			$29,032	
Finance/Accounting										
Human Resources										
Administrative Support/Clerical		2.00	$125,000	2	2.40	$147,164	3	2.00	$118,709	2
Information Technology/Data Mgt.										
Research										
Evaluation										
Communications										
Other Support Staff										
Total Admin and Support Staffing		**6.00**	**$622,000**	**6.00**	**6.00**	**$606,693**	**7.00**	**5.80**	**$604,044**	**6.00**
Total PCN Staffing		**62.80**	**$5,936,120**	**83.00**	**56.95**	**$5,285,347**	**72.00**	**61.85**	**$5,774,037**	**78.00**

PALLISER PRIMARY CARE NETWORK
Schedule 4: Variance Analysis (Unaudited)
For the Year Ended March 31, 2022

Statement of Operations	2022 Actual Vs Budget			Explanation of variances in the Statement of Operations
	Variance	% of budget	note req.	
Revenue				
Per Capita Funding from Alberta Health				
Operating	(446,594)	-7%	Yes	Enrolee numbers were lower during the year and this reduced grant funding.
Capital	-	-	n/a	
PCN Support Program Nurse Practitioner Funding	25,521	15%	Yes	There were additional Nurse Practitioner staff recruited and therefore grant funding increased for the year.
Interest & Investment Income	(121)	-1%	No	
Total Revenue	**(421,194)**	**-6%**	**Yes**	See above variance explanations
Expenses				
Professional Support within Health Homes	385,436	7%	Yes	During 2021/2022, there was an average of 6.0 FTE in unfilled positions, offset somewhat with an increase in non-payroll expenses.
Measurement & Practice Improvement	53,238	12%	Yes	There were new staff employed at lower pay rates than budgeted.
PCN Support Program Nurse Practitioner	(32,767)	-19%	Yes	There were additional Nurse Practitioner staff recruited and therefore costs increased for the year.
Evaluation	-	-	n/a	Evaluation is integrated with "Measurement and Practice Improvement"
PCN Admin Lead Salary	(3,305)	-2%	No	This 1.0 FTE position is employed by AHS, and the salary/benefit costs are billed monthly to the PCN. The total payroll cost has been allocated between salary (84%) and benefits (16%) based on an analysis of the payroll reports provided by AHS. There was no increase during the year to the salary or benefits paid to this employee. The variance relates to the budget being lower than the actual cost of the position.
PCN Admin Lead Benefits	(629)	-2%	No	
Other Management Salary (specify)	39,345	13%	Yes	Other management is comprised of 3.0 FTE positions located in central office (1.0 Clinical director + 2.0 Clinical supervisors). There were vacancies in the supervisor positions for part of the year.
Other Management Benefits	2,060	7%	Yes	
Administration (list in notes)	(22,184)	-6%	Yes	Administration: Actual 2021/2022 is comprised of the following: - Board meeting stipends - Physicians $ 38,906 - Payroll - Exec assistant, Admin assistant, Finance Clerk (2.4 FTE) $147,164 - Professional Services -legal, accounting, HR, etc. $61,288 - Insurance, computers, telephones, office supplies $76,155 - Central Office – rent, utilities, janitorial $78,671. The 2021/2022 deficit reflects additional costs for increased assistant staff (to provide additional support to PCN operations).
Amortization	-	-	n/a	
Total Expenses	**421,194**	**6%**	**Yes**	See above variance explanations
Excess /(Deficiency) of Revenue Over Expenses	**$ -**	**- %**	**n/a**	

Schedule 1 - Expenses by Object	2022 Actual Vs Budget			Explanation of variances in Schedule 1
Physicians: Administrative	51,049	19%	Yes	Physicians: Administrative: Actual 2021/2022 is comprised of the following: - Board meeting stipends - Physicians $ 38,906 - Supervision/program planning stipends $ 175,045 The 2021/2022 surplus reflects reduced supervision/programming stipends, due to reduced in-clinic staff.
Physicians: Other	(16,075)	-8%	Yes	Physicians: Other: Actual 2021/2022 is comprised of the following: - Office Rental/clinic supports $ 142,908 - Education/training stipends - Physicians $ 80,167. Payments to physicians were higher than budgeted in 2021/2022, due to increased workshops and attendance by physicians. The payments made were in accordance with the payment criteria in the 2021-2024 business plan.
Alberta Health Services - Purchased Services	-	-%	n/a	
Non-Physician Direct Care Providers	588,158	12%	Yes	During 2021/2022, there was an average of 6.0 FTE in unfilled positions.
Other Expenses*	(201,938)	-14%	Yes	During 2021/2022, there were one-time additional costs associated with: Renovations; Website, software and related costs; Virtual classroom; CPI training and related costs.
Amortization	-	-%	n/a	
Total Expenses	**421,194**	**6%**	**Yes**	

Schedule 3: Staffing Summary (Unaudited)	Explanation of variances in Schedule 3
Direct Care Provider Staffing	The physicians choose the employee type that they wish to access within their clinic. For example, in 201/2022, there was reduced Dietician FTE as this was the hiring choice of the physicians. During 2021/2022, there was an average of 6.0 FTE in unfilled RN/OHCP positions.
Staffing - Budget cost versus Actual cost	The budget for the year is based on an estimate of the staff that will be in place during the year. The actual costs for the year are dependent on the seniority of the staff, as well as the change in vacation and other payroll liability balances for those staff during the year. For this reason, the actual salaries per FTE may be higher or lower than budget.

PALLISER PRIMARY CARE NETWORK
Schedule 5: Legal Model 2 - Board of Directors Composition (Unaudited)
As at March 31, 2022

Physician Lead of the PCN:	Dr. Monty van der Westhuizen
Additional Physician Co-Lead:	Not applicable

Director Name	Director Role (as per Articles of Association)	NPC, AHS or Community Member	Length of term	Term Set to Expire	Additional Information
Dr. Monty van der Westhuizen	Chair	Physician group	3 years	Jun 2022	
Dr. Douwe Kits	Vice Chair	AHS	3 years	Jun 2023	
Dr. Cathy Horsman	Director	Physician group	3 years	Jun 2024	
Dr. Donovan Nunweiler	Director	Physician group	3 years	Jun 2024	
Dr. Morgan Osborne	Director	Physician group	3 years	Jun 2024	
Dr. Vince Elgersma	Director	Physician group	3 years	Jun 2022	
Dr. Fredrykka Rinaldi	Non-Voting Director	Physician group	1 year	Jun 2022	
Varley Weisman	Director	Interim Community Member	3 years	Jun 2024	
Colin Zieber	Director	AHS	3 years	Jun 2024	
Trevor Inaba	Director	AHS	3 years	Jun 2025	
Dr. Carl Nohr	Director	AHS	3 years	Jun 2024	