Palliser PCN

(Go live date Tuesday, August 1, 2006**)**

Annual Report

Sections 1 and 2

For the period: April 1, 2024 to March 31, 2025

To be submitted to Alberta Health **no later than June 30, 2025**

1. Period Overview

1.1. Summary

The Palliser PCN is in its 19th year of operation and sees maximization in the number of participating physicians, the number of clinics, the number of in-clinic PCN professional staff and the number of patient enrollees.

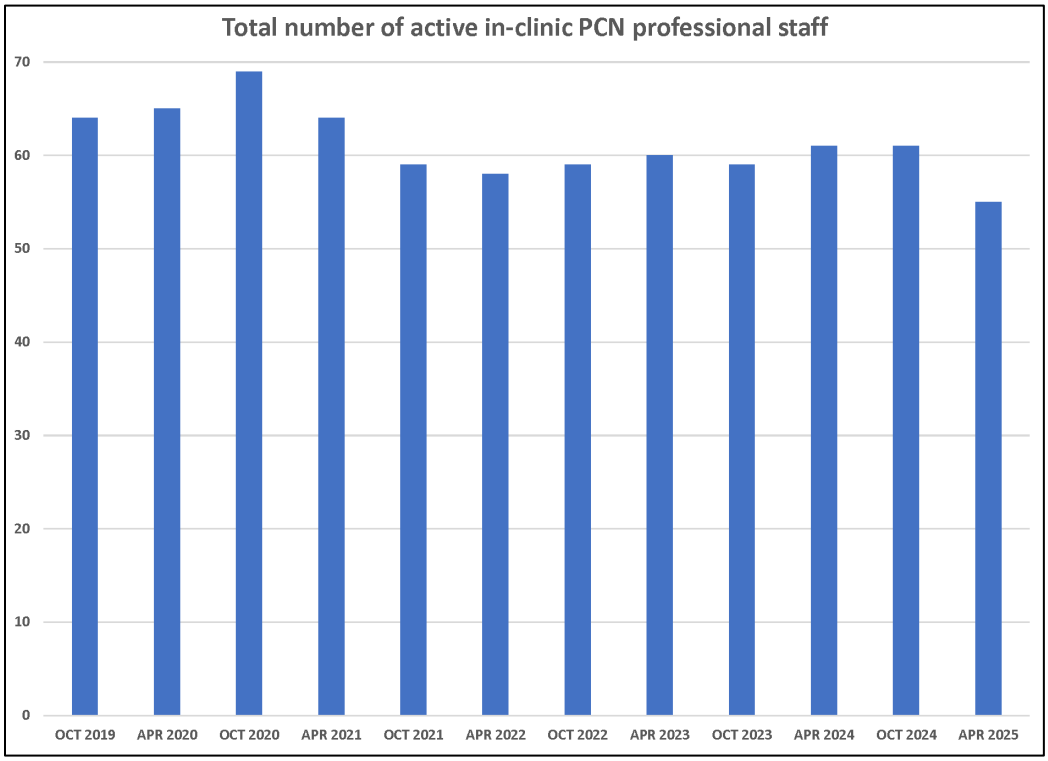


Figure 1 - Active in-clinic PCN professional staff, 2019-2025

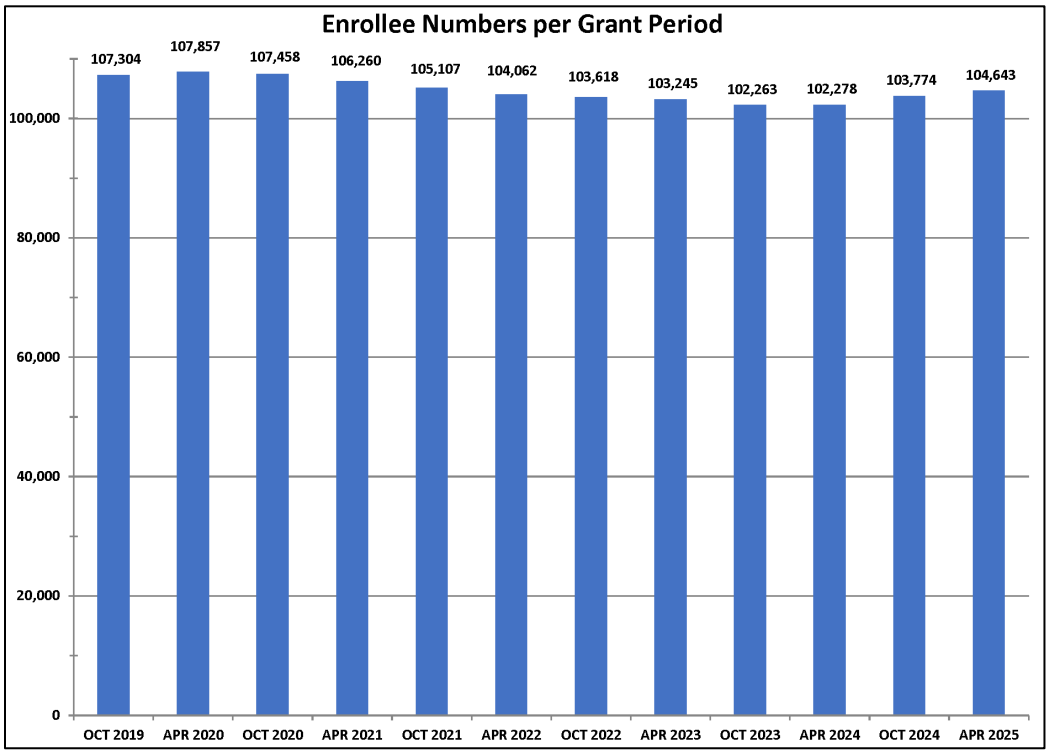


Figure 2 – PCN Enrollee numbers per grant period, 2019-2025

Over the reporting period, the PCN refined its Evaluation Logic Model and Framework to describe and evaluate the activities it undertakes to meet the four PCN Provincial Objectives. The PCN continues to seek that current and future activities align with at least one of the four PCN Provincial Objectives. This approach ensures the PCN is a responsible steward of public funds and operates with a foundation of service excellence.

Palliser Primary Care Network's 4 key elements of Service Excellence[1]:

1. Delivering the promise (e.g. quality health care, efficient human resource support, defendable stewardship of public funds).
2. Providing a personal touch.
3. Going the extra mile.
4. Resolving problems well.

Palliser PCN's performance measurement and evaluation plan utilizes the Eco-Normalization model of innovation evaluation introduced by Hamza and Regehr[2]. Evaluation questions resultant from the model's application to the PCN's current context:

- How well do the PCN's activities align with provincial PCN strategic directions and priorities?
- How well do the PCN's vision, mission and purpose align with the provincial PCN strategic directions and priorities?
- How well aligned are the needs and preferences of the PCN's patients, physicians, staff, partners, and stakeholders with provincial PCN strategic directions and priorities?
- How well does the PCN support employees, physicians, health home teams, patients and health home neighbourhoods to move towards the desired change?
- How successfully do the PCN's activities enable PCN physicians, employees and health home teams to achieve provincial priorities?
- How well do the PCN's activities achieve its vision, mission and purpose?

The PCN's current Evaluation Logic Model, which integrates the PCN's vision, mission and purpose, is below:

Vision: We value patients as partners and advocate for a team-based approach to responsibly provide efficient, effective, and innovative resources to support our Health Homes.
Mission: We work collaboratively to engage patients, physician members, clinic teams, and community stakeholders through the Health Home to optimize the health of our community.
Purpose: Local solutions for local health care problems.
Context: Social, cultural, political, policy/legislative/regulatory, economic, education and physical, population characteristics, technological, unanticipated external variables.

Provincial PCN Strategic Directions	Provincial PCN Priorities	Palliser PCN Enablers	Palliser PCN Priority Initiative Applicability	Palliser PCN Activities	Palliser PCN Short-term Outcomes	Palliser PCN Medium-term Outcomes	Provincial PCN Long-term Outcomes
A. Bring about cultural change B. Enhance delivery of care C. Establish building blocks for change D. Population needs based design E. Increase value & return on investment	Accountable & Effective Governance	• Diverse board membership • Clear and effective governance roles, structures, processes • Physician member capability to participate in strategic planning activities (e.g. business planning)	1. Professional Support in Health Homes 2. Measurement and Practice Improvement	• New board member orientation • Physician member Town Halls and other physician engagement activities • Board eBulletin communication to member physicians • Renewal and updating of PCN policies • Board retreats and strategic planning • Risk mitigation, insurance, privacy and security training and assessments • Completion of board self-assessment and development of performance improvement plan • Annual performance assessment of Executive Director	• Maximize uptake of board member attendance at meetings and retreat • Maximize uptake of board member attendance at PCN events • Increased board member effectiveness, satisfaction and confidence in PCN governance • Increased physician engagement	• Efficient, effective and innovative PCN governance • PCN governance achieves the provincial objective of shared accountability and primary healthcare evolution	A. Quality B. Albertans as partners C. Integration D. Indigenous cultural safety E. Access
	Patient's Medical Home	• Historical and sustained high physician and patient satisfaction with co-located PCN registered health professional support • Existing high PCN registered health professional satisfaction and retention		• Co-located registered health professionals in Health Homes • Quality improvement design, implementation, measurement, maintenance support for Health Home efficiency and effectiveness initiatives	• Increased integration of co-located registered health professionals in Health Homes • Increased number of Health Home teams measuring and improving access • Increased number of Health Home teams surveying patient experience • Increased number of Health Home teams engaging in disease screening and management quality improvement • Increased number of Health Home teams discussing, measuring and improving their effectiveness	• Increased number of Health Home teams maintaining high patient access • Increased number of Health Home teams incorporating patient feedback into clinical process improvements • Increased number of Health Home teams maintaining high disease screening and management rates • Increased number of Health Home teams improving their effectiveness	
	Strong Partnerships & Transitions of Care	• History of partnership, collaboration and integration with community NPC and AHS partners • Membership on local, zonal and provincial teams for the purpose of integration and collaboration • Partnerships with AMA ACTT, Alberta Find-A-Doc and other groups to maximize continuity of information		• Inclusion of community referral details on PCN website to facilitate Health Home coordination with referral sources • Find a Family Doctor listing on PCN website, synchronized to Alberta Find-A-Doc website • Regular communication with AMA ACTT to ensure accuracy of CPA/OII information on Health Home teams • Participation in Provincial Improvement activities (e.g. H2H2M PIN) to support AHS and Health Home coordination of care, continuity of information	• Increased CPA/OII enrollment • Increased Health Home team efficiency/effectiveness in coordinating with formal/informal Health Home when patients change family doctors • Increased timeliness of hospital discharge summaries to Health Homes • Increased accuracy of identification of family doctor at ED/Hospital	• Increased information, relationship and management continuity between Health Homes and across the Health Home's neighborhood • Reduced PCN and physician-level cross-panel rates	
	Health Needs of the Community and Population	• Existing use of provincial, zonal and local data to perform high quality assessments of population needs • Regular formal and informal community engagement to assess current and forecast future community needs		• Linkages with AHS, HQCA, CIHI and others to critically evaluate data sources and understand limitations of existing data • Education of and clinical case discussion between PCN, IHC providers	• Increased utilization of obstetrical nurse to support low risk obstetrical population needs • Increased advancement of Behavioural Health Consultant model	• Increased effectiveness of low risk obstetrical care in Palliser PCN	

Figure 3 – Palliser PCN Evaluation Logic Model: activities aligned with each provincial PCN Objective

This model aligns with the provincial context, being bookended by the provincially-identified Strategic Directions[3] and four PCN Objectives on the left and the long-term Provincial Outcomes on the right. Palliser PCN's internal activities and

[1] Palliser Primary Care Network. (2025). 2025 Employee Handbook.
[2] Hamza, D. M., & Regehr, G. (2021). Eco-normalization: Evaluating the longevity of an innovation in context. Academic Medicine, 96(11S). https://doi.org/10.1097/acm.0000000000004318
[3] Alberta Health (2014). Alberta's Primary Health Care Strategy. https://open.alberta.ca/dataset/9781460108635

evaluation objectives are defined within this framework and focus predominantly on progress toward achievement of its short-term and medium-term outcomes.

With remote access to 100% of health home EMRs, the PCN's use of its Activity and Clinical Measures Sheet supports focused clinical quality improvement prioritization and evaluation. With a primary focus on *measurement for improvement*, as opposed to that of accountability or research[4], clinical data is extracted from health home EMRs and presented in various forms – most regularly, an Activity and Clinical Measures Sheet – to health home teams, typically to PCN RNs/OHPs and PCN physicians and nurse practitioners. These sheets frequently become the starting point for clinical practice improvement work. A secondary opportunity this data provides is in aggregating the extracted EMR data at a regional level to support *measurement for accountability*. This supports annual reporting and regional evaluation needs, and provides the PCN with specific measures to evaluate the success of co-location of the PCN's 60 Registered Nurses and Other Healthcare Providers (RNs/OHPs) in health homes to support teams led by PCN physicians and nurse practitioners.

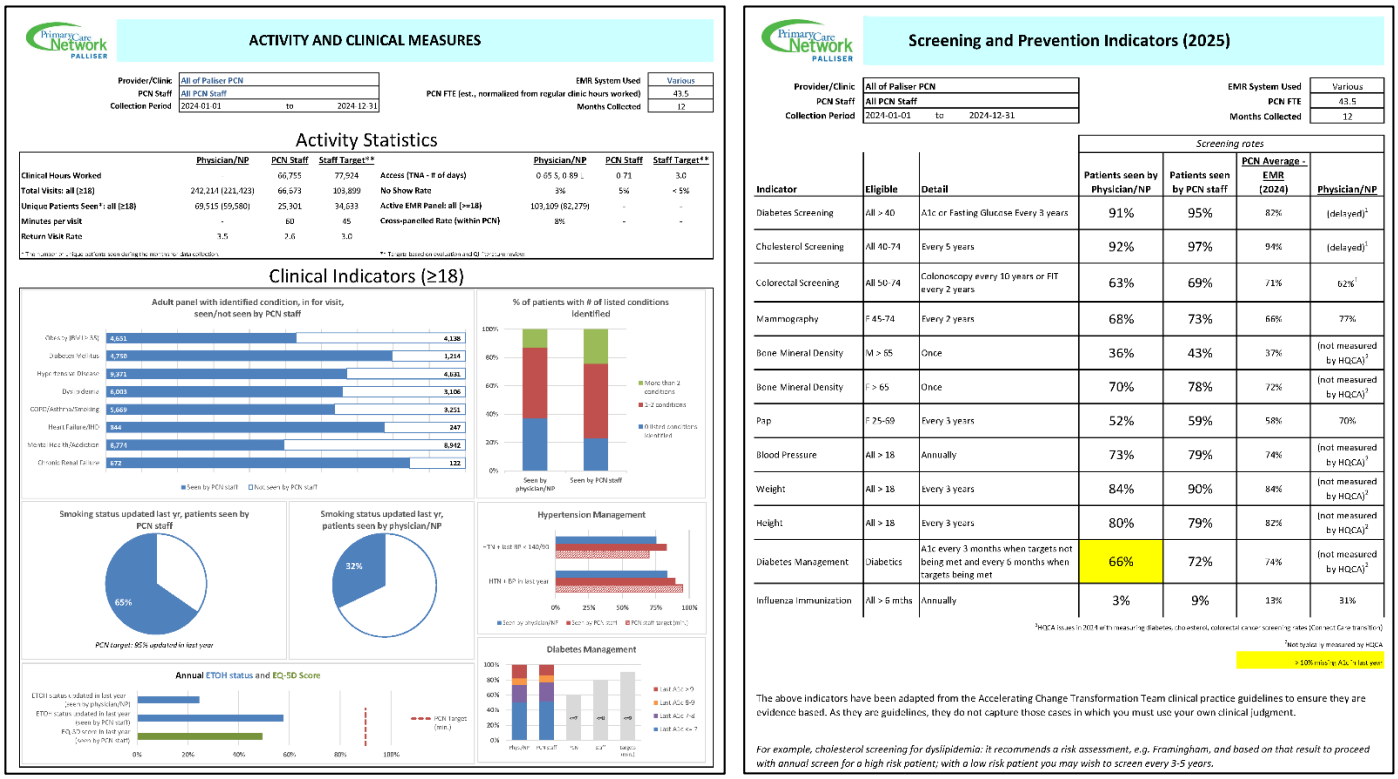


Figure 4 – 2025 PCN Activity and Measures Sheet: EMR-sourced data for PCN physicians, NPs, RNs/OHPs

During the reporting period, four nurse practitioners operating under the Nurse Practitioner Primary Care Program (NPPCP) were added as participating providers and received PCN support akin to participating physicians. Throughout this document, efforts were made to discriminately report PCN physician-related or physician/NP combined measures as applicable.

Eligibility for PCN professional staffing is determined by assessing an interested physician or nurse practitioner's profile of family practice and reviewing their PCN-measured EMR-sourced family practice panel, with cross-panelled patients removed, as indicated in the following table:

[4] Solberg, L I et al. "The three faces of performance measurement: improvement, accountability, and research." *The Joint Commission journal on quality improvement* vol. 23,3 (1997): 135-47. doi:10.1016/s1070-3241(16)30305-4

<table>
<tr><th>Profile</th><th>Definition</th><th>Eligibility for PCN professional staffing</th><th>Eligibility for PCN quality improvement support</th></tr>
<tr><td>No Family Practice</td><td>Physician/nurse practitioner has no family practice patients.</td><td rowspan="2">Not eligible</td><td rowspan="3">PCN facilitators currently assist all interested physicians/nurse practitioners and teams to plan and test improvements related to their practice, e.g.:
- access,
- continuity,
- cross-panelled rate,
- supply, demand, activity
- disease screening and management
- ideal panel size
This assistance is offered regardless of the physician/ nurse practitioner’s desire to grow, sustain or reduce their current family practice panel. This includes measurement and evaluation support for the above items.</td></tr>
<tr><td>Minority Family Practice</td><td>Physician/nurse practitioner has fewer than 500 family practice patients.</td></tr>
<tr><td>Core Family Practice</td><td>Physician/nurse practitioner has 500 or more family practice patients.</td><td>Eligible, based PCN-measured EMR-sourced non-cross-panelled patients*:
<table>
<tr><th>Step</th><th colspan="2">Panel Size</th><th>FTE Allowed</th></tr>
<tr><td>1</td><td>500</td><td>900</td><td>0.5</td></tr>
<tr><td>2</td><td>900</td><td>1200</td><td>0.7</td></tr>
<tr><td>3</td><td>1200</td><td>1500</td><td>0.9</td></tr>
<tr><td>4</td><td>1500</td><td>></td><td>1.0</td></tr>
</table></td></tr>
</table>

Figure 5 - Palliser PCN Physician and Nurse Practitioner Profiles Summary

*Measurement process for PCN professional staffing eligibility: (1) Measure all PCN physician/nurse practitioner active EMR family practice panels. (2) Identify all cross-panelled patients, i.e. those who are identified on more than one panel. (3) Exclude cross-panelled patients to determine number of non-cross-panelled patients on each active EMR family practice panel.

The PCN pulls physician/nurse practitioner EMR family practice panel data twice a year (October & April) and provides it directly to the core and minority family practice physician/nurse practitioner along with strategies and support from the PCN to increase and/or stabilize their panel numbers as well as decrease their cross-panel rate. As additional quality improvement conversations occur throughout the year, (e.g. PCN Activity and Measures Sheet review during PCN RN/OHP performance assessment process), this information is incorporated.

The Physician and Nurse Practitioner Profile process has created a change lever related to panel identification and management, indicated in the significant drop in PCN cross-panelled rate since its introduction in 2020.

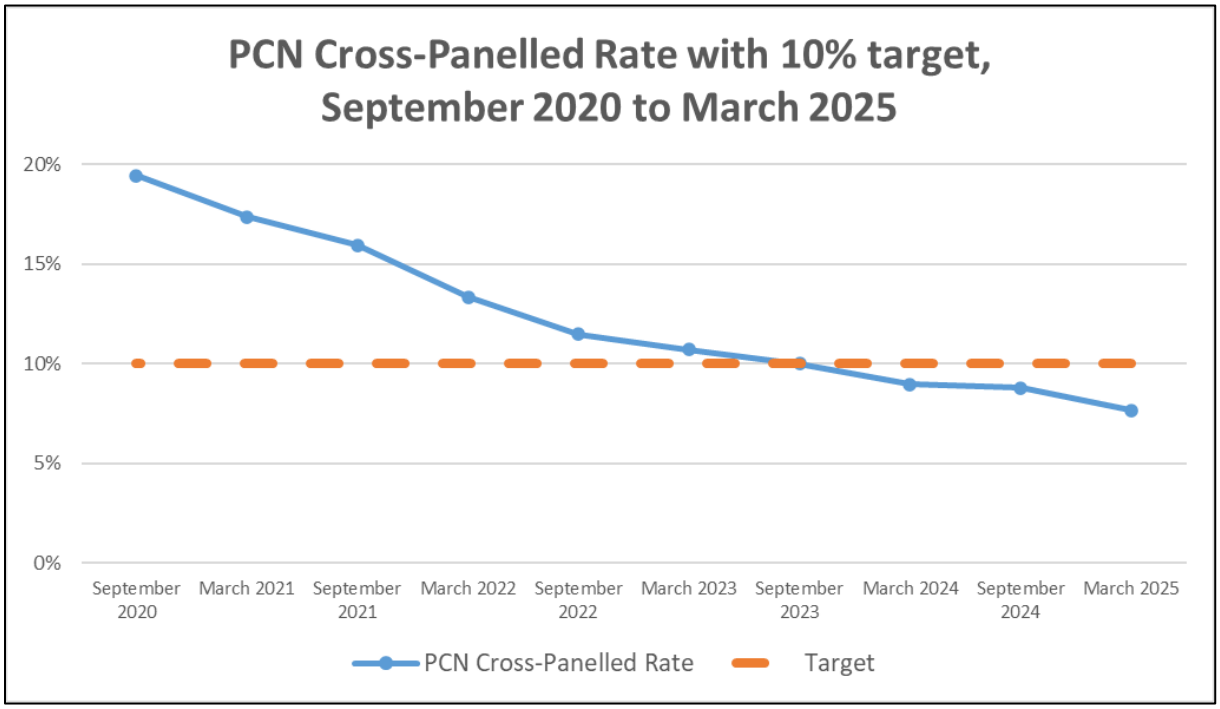


Figure 6 - Overall PCN Cross-Panelled Rate Over Time

This has enabled teams to more accurately measure and plan their practice, including increasing their panel size on the basis of removing cross-panelled patients who have been confirmed to have a different family doctor or nurse practitioner. Reduction in cross-panelled patients has contributed to minimization of unattached patients in the region.

Distribution of population with attachment status		**# of patients**
Total population estimate within Palliser PCN geographic area		114,840
Attached to Palliser PCN physicians' active family practice EMR panels		96,183
Attached elsewhere	Attached to a provider in an area not served by Palliser PCN	Negligible due to known patient preference / patterns
	Attached to a non-PCN family physician in the area served by the PCN	~3,000
Imminently attached	Will be attached to NPs	~3,600
	Capacity to be attached to PCN physicians currently accepting new patients	~2,500
Able to be attached after reduction in physician cross-panelled rate	Removing cross-panelled patients will provide capacity for existing PCN physicians to accept additional patients	~5,000
Unattached	**Seeking a family physician** in the area served by the PCN	**~4,500**
	Not seeking a family physician in the area served by the PCN	

Figure 7 - Palliser PCN regional population distribution and attachment – March 2025

During the reporting period, an average of 10 PCN family physicians and nurse practitioners were accepting new patients at any time. When considered in the context described in Figures 6 and 7, a stable state may exist of minimized unattached population mainly comprised of individuals who are not seeking a family physician or nurse practitioner due to personal choice rather than availability.

The PCN continued to evolve its Health Home Optimization Model, refining the tool that supports it to understand where health homes exist in it as they move towards the Patient's Medical Home model in the domains of Panel, Access, EMR, Screening and Team-based Care. This forms an essential component of measuring the value of health home supports such as the Health Home Expedition and PCN practice improvement staffing.

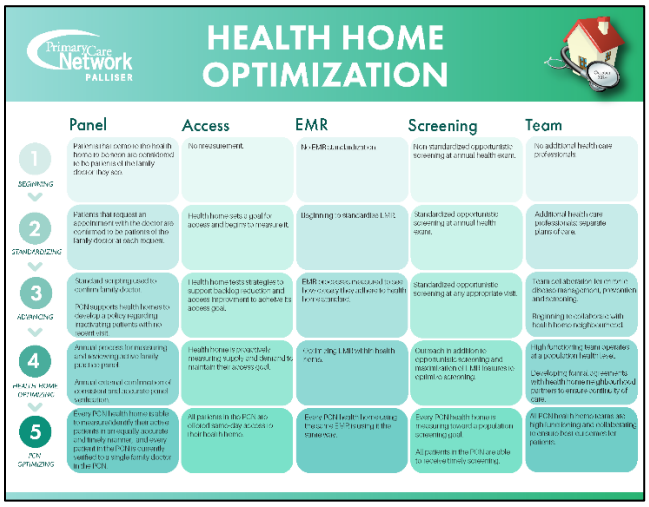


Figure 8 - Palliser PCN Health Home Optimization Model

Return on Investment

During the reporting period, the PCN performed a return-on-investment calculation to support evaluation of its highest budgeted PCN activity: addition of PCN RNs/OHPs in health homes.

Basic Cost per Palliser PCN RN/OHP Patient Visit

$$Cost\ per\ Patient\ Visit = \frac{\text{Annual Budget}}{\text{Number of Patient Visits per Year}} = \frac{\$6{,}340{,}000}{66{,}673} = \sim \$95\ per\ PCN\ RN/OHP\ visit$$

Basic Cost per Unique Patient seen by Palliser PCN RN/OHP annually

$$Cost\ per\ Unique\ Patient = \frac{\text{Annual Budget}}{\text{Number of Unique Patients Seen per Year}} = \frac{\$6{,}340{,}000}{25{,}301} = \sim \$251\ per\ patient\ per\ year$$

Figure 9 - Palliser PCN Return on Investment Calculation Results

Compared to alternative return-on-investment calculations, the above calculations are simple and lend themselves to assessment against other organizations and their services. A barrier the PCN has encountered to perform this comparative analysis is the lack of publicly available metrics from these organizations.

1.2. Period Overview

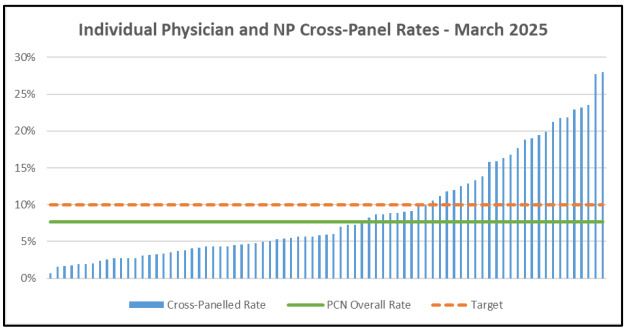
Name of Priority Initiative	Professional Support within Health Homes		
Element	**Planned Achievement**	**Status**	**Status Explanation**
Addition of RNs / Other Professionals to Physician Offices	Ongoing development of interdisciplinary family practice teams/programs to support family practice physicians 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).	On-going	**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 for this reporting period is 45.70 FTE, comprised of: 0.61 NP, 39.09 RN, 6.0 Behavioural Health Consultant (compared to budget forecast of 47 FTE). Average utilization: 60 minutes per patient. Access: 69% of submitted TNA values were 5 or fewer calendar days; 57% of TNA values were 3 or fewer days. Physician satisfaction: 93% physician agreement with survey question regarding recommending employment of RNs/OHPs to other physicians. Patient satisfaction: 97% overall satisfaction with care provided by RNs/OHPs. **3. Multi-disciplinary Teams** Percentage of physicians working in a health home teamlet integrated with PCN RNs/OHPs is 80%. For core family practice physicians: 89%. Explanation: All but four core family practice physicians are working in a health home teamlet with a PCN RN/OHP or are ready to recruit an imminent placement. 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		
Element	**Planned Achievement**	**Status**	**Status Explanation**
Implement measurement and practice improvement methodologies	Engage 5.0 FTE to support the development of the Health Home in participating clinics.	On Target	**1. Practice Improvement Staffing** Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement.

	Key achievements include clinic team development, EMR optimization, identifying and optimizing clinic efficiencies, and clinic linkages with specialists and the community		**2. Collaborative Learning Sessions** In January 2024, 10 health home teams (18 physicians and 34 clinic team members) embarked on the Health Home Expedition – an approximately 18-month collaborative learning series delivered by quality improvement faculty that previously supported Alberta AIM and other longitudinal team-based collaborative QI initiatives. This Expedition is a customized approach to the local context, including the PCN's priority focus on Access and Team-based care. The Health Home Expedition timeline comprises the following components: • **January 2024**: Virtual kick-off session (1 hour) • **March 2024**: In-person initial learning session (1.5 days) • **4 action periods** (3-4 months) with intermittent team debriefs before and after **3 mid-expedition in-person learning sessions** (1 day each) • **June 2025**: A final in-person session to celebrate and develop processes to sustain progress past the learning series (1 day) Four action periods and three mid-expedition in-person learning sessions occurred during the reporting period. The PCN administrative team co-hosts and supports facilitation of in-person learning sessions. PCN practice improvement facilitators figure prominently in supporting teams to plan, implement, and study QI tests during action periods. Expected outcomes from this collaborative learning series include increasing administrative team QI competency and increased Health Home Optimization scores among health home teams. 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
Hitting our Target: Staying Sharp on Diabetes and CVD (April 25, 2024)	49	97%
Promoting Wellness in the PCN (May 15, 2024)	46	99%
Brain Matters: Gaining Knowledge & Facilitating Growth (September 26, 2024)	44	92%
Cancer & Beyond (November 20, 2024)	51	90%
Breathe Easy (January 21, 2025)	49	92%
Health Home Expedition #2 (June 14, 2024)	47	89%
Health Home Expedition #3 (October 18, 2024)	45	82%
Health Home Expedition #4 (February 18, 2025)	42	82%

Figure 10 - Education Event Details and Satisfaction

			4. CPAR/CII enrollment: At the end of the reporting period, CPAR/CII enrollment is at 90% among eligible core and minority family practice physicians and nurse practitioners. **5. Minimization of PCN cross-panelled rates:** 68% of core and minority family practice physicians and nurse practitioners have a PCN cross-panel rate under 10%. 39% have a cross-panel rate under 5%.  **Figure 11 - Anonymous Physician/NP Cross-Panel Rates, with 7.7% PCN Rate and 10% target** **6. Health Home Optimization:** The PCN sees improvement in Health Home Optimization scores across all domains: Panel, Access, EMR, Screening and Team-based Care. Panel: 75% of health homes have a Panel score of 2.5 or greater. Access: 23% of health homes have an Access score of 2 or greater. EMR: 68% of health homes have an EMR score of 2.5 or greater. Screening: 18% of health homes have a Screening score of 2.5 or greater. Team-based care: 25% of health homes have a Team score of 2.5 or greater.

Restricted Grants and Central Allocation Key Activities: (E.g., Evaluation, IT, etc.)			
Activities	**Planned Achievement**	**Status**	**Status Explanation**
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.			

2. EVALUATION

2.1. Contextual Questions

Question	Response	Comments
Does your PCN have an existing evaluation framework?	Yes	The PCN has a comprehensive Evaluation Framework which provides guidance for activities and 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?	Yes	The PCN has an Evaluation Logic Model that supports its activities and evaluation. 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? *Identify resources*	Yes	Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement.
If answered "Yes" above, how have the evaluation processes been used to guide the improvement of program offering?	The PCN's Evaluation Logic Model and Framework guides the evaluation of its activities to meet the four PCN Provincial Objectives and align with the long-term primary care Provincial Outcomes (detailed in Section 1.1). As the PCN plans future activities and reassesses its current initiatives, it measures against relevant short-term and medium-term PCN outcomes and continually seeks to align each activity with at least one of the four PCN Provincial Objectives.	

2.2. Evaluation by PCN Objective

2.2.1. Objective 1 – Accountable and Effective Governance

Objective 1	**Accountable and Effective Governance** Establish clear and effective governance roles, structures and processes that support shared accountability and the evolution of primary healthcare delivery**.**
Summary and/or Achievements	Over the reporting period, the PCN integrated the activities related to Objective 1 into its Evaluation Logic Model and Framework. A summary of the Objective 1 activities oriented within the overall framework can be seen below:

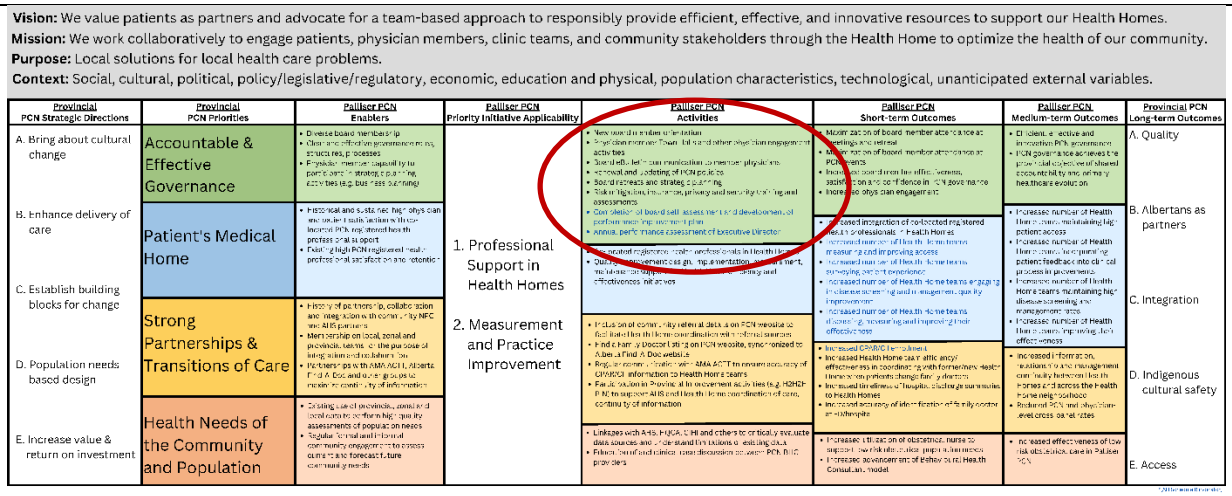


Figure 12 - PCN Evaluation Logic Model with Objective 1 activities circled

Highlights of the PCN's achievements related to Objective 1 during the reporting period:

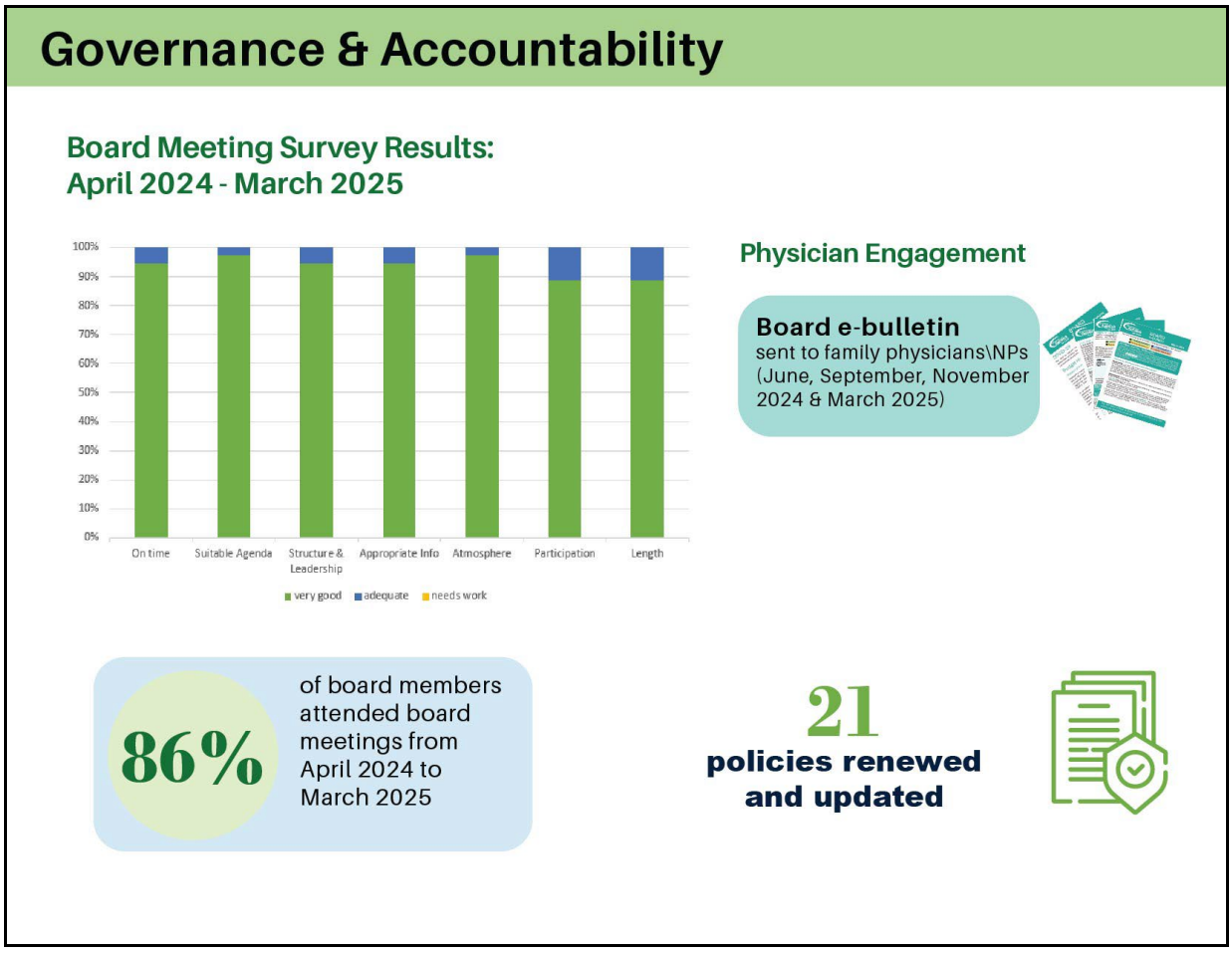


Figure 13 - Governance and Accountability Objective Highlights

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

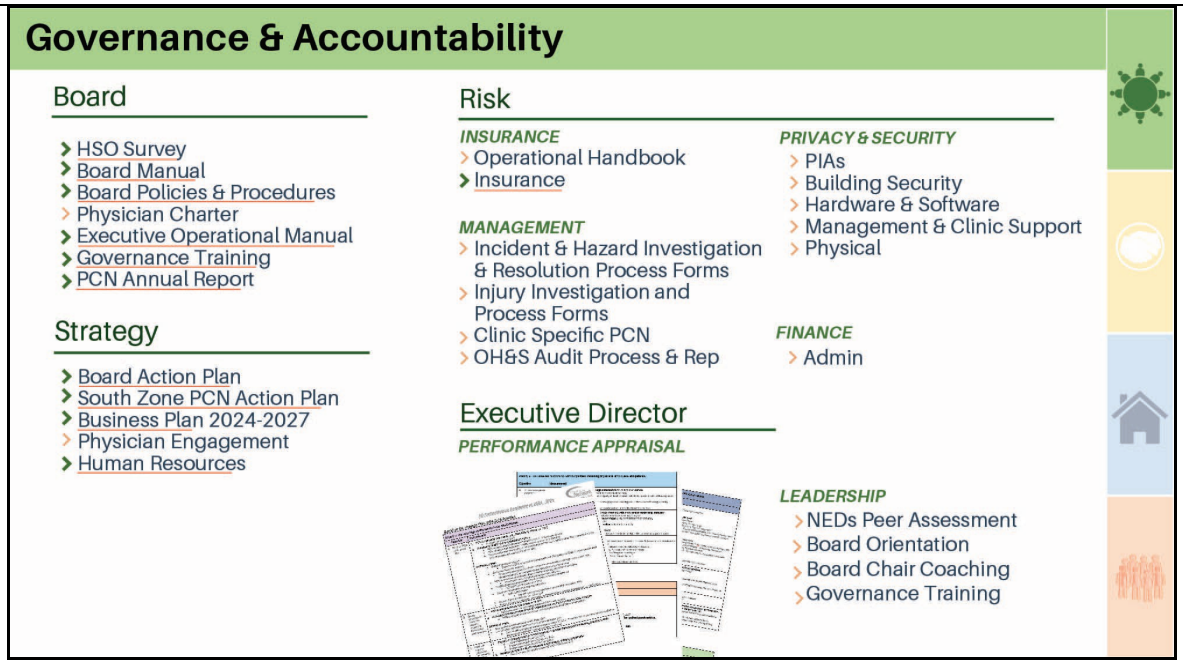


Figure 14 - Governance and Accountability Objective Activities
(performance appraisal detail not intended for legibility)

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 2024 Board e-bulletin: QI Award, New Board Member Intro, Ava EMR
    - June 2024 Palliser PCN Physician Society AGM
    - September 2024 Board e-bulletin: MAPS Update, AI Tools, New Workshops, NPSP
    - October 2024: MAPS Engagement Session (Taber)
    - November 2024 Board e-bulletin: TB Referral Info, MAPS Update, PCA Updates
    - February 2025 MAPS Engagement Session (Taber)
    - March 2025 Board e-bulletin: PCPCM, CanTalk Release, MAPS Timeline, AGM Info
    - 2024-2025 Palliser PCN Facilitated Education Events
        - Clinical Workshops - April, May, September, November 2024, January 2025
        - Health Home Expedition Sessions – June, October 2024, February 2025

Evaluation indicators for Objective 1 related to identified short-term outcomes in Palliser PCN's Evaluation Logic Model:

Outcome	Indicator	Measure
Maximization of board member attendance at meetings and retreat	• Percentage of board members attending board meetings	**86%**
	• Percentage of board members attending retreat	**89%**
Maximization of board member attendance at PCN events	• Percentage of board members that attended a PCN event	**55%**
Increased board member effectiveness, satisfaction and confidence in PCN	• Individual post-board meeting survey	**Completed**
	• Executive Director performance assessment *[AH Schedule B indicator]*	**Completed**
Increased physician engagement	• Percentage of physicians who attended a PCN engagement event	**36%**

Figure 15 – PCN Evaluation Indicators for Objective 1 (Governance and Accountability)

<table>
<tr><td>Barriers</td><td>Time and human resources to increase/accelerate initiatives/achievements</td></tr>
<tr><td>Schedule B Indicator</td><td>

- *Governance Indicator*

Palliser PCN has engaged in governance training and goal setting for several years. The Accreditation Canada tool was used again in FY 24/25 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 2024/25	FY 2023/24
Did the PCN Non-Profit Corporation Board / Joint Governance Committee complete **both** the following activities during the year? 1) Collective self-assessment of the PCN Non-Profit Corporation Board / Joint Governance Committee as a whole. 2) Performance improvement plan for the PCN Non-Profit Corporation Board / Joint Governance Committee.	YES	YES
Did the Board use Health Standards Organization's Governance Functioning Tool in their self-assessment process?	YES	YES

Figure 16 – Governance Indicator

- *Leadership Indicator*

The PCN Board chose to move away from a retrospectively scored performance evaluation to a prospective-focused improvement conversation. The PCN developed and led an Alberta PCN Executive Director Peer Assessment (*Developing Executive Director Competency in Organizational Effectiveness in PCNs*, March 2018; report available upon request). This continues to position the PCN and Executive Director to provide mentorship to other PCN Executive Directors, local not-for-profit Executive Directors and some physicians leaders in the province. 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 is a nationally recognized primary care leader. During this reporting period the Executive Director has had one manuscript published, presented at 10 conferences and provided expert advice to two different provinces in the area of primary care transformation and change management.

LEADERSHIP INDICATOR	FY 2024/25	FY 2023/24
Was a performance assessment completed during the year for the PCN Administrative Lead and all other staff members directly reporting to the PCN Non-Profit Corporation Board/Joint Governance Committee?	YES	YES

Figure 17 - Leadership Indicator

</td></tr>
<tr><td>PCN Evaluation Logic Model Indicators</td><td>Please see Figure 15 for applicable evaluation indicators from the PCN's Evaluation Logic Model.</td></tr>
</table>

2.2.2. Objective 2 – Strong Partnerships and Transitions in Care

Objective 2	**Strong Partnerships and Transitions in Care** Coordinate, integrate and partner with health services and other social services across the continuum of care..
Summary and/or Achievements	Over the reporting period, the PCN integrated the activities related to Objective 2 into its Evaluation Logic Model and Framework. A summary of the Objective 2 activities oriented within the overall framework can be seen below:

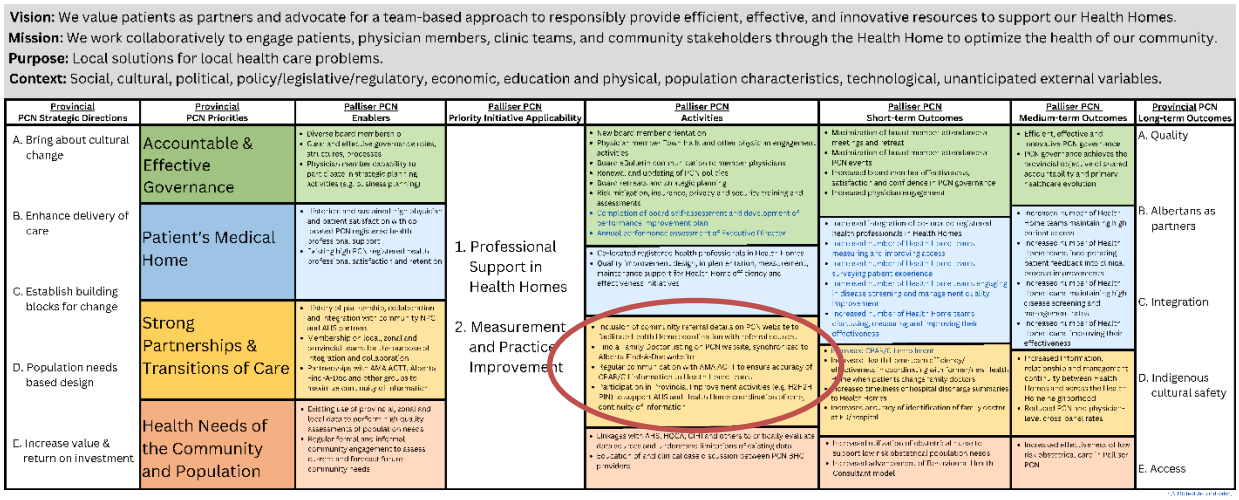


Figure 18 - PCN Evaluation Logic Model with Objective 2 activities circled

Highlights of the PCN's achievements related to Objective 2 during the reporting period:

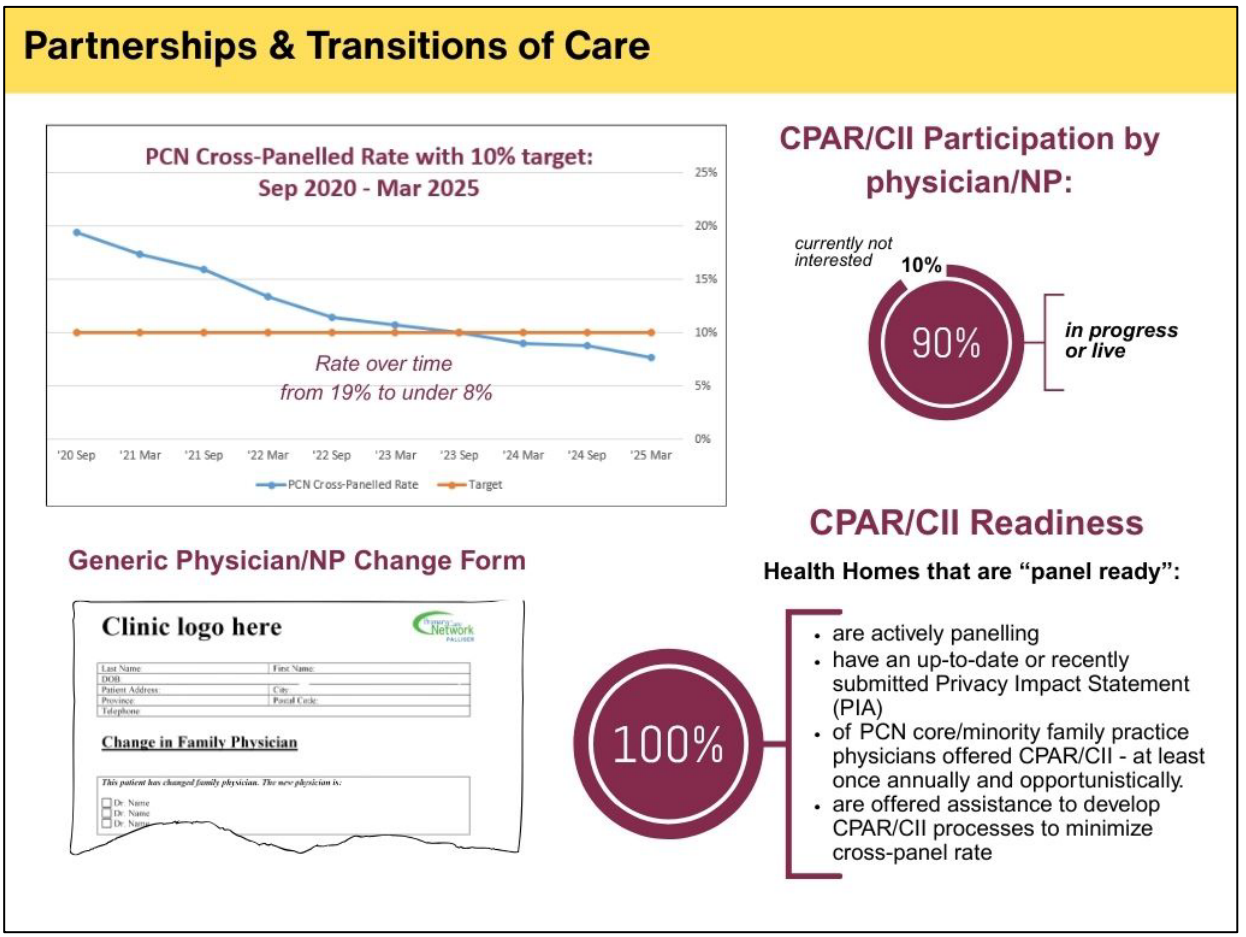


Figure 19 - Partnerships and Transitions of Care Objective Highlights

Evaluation Activities

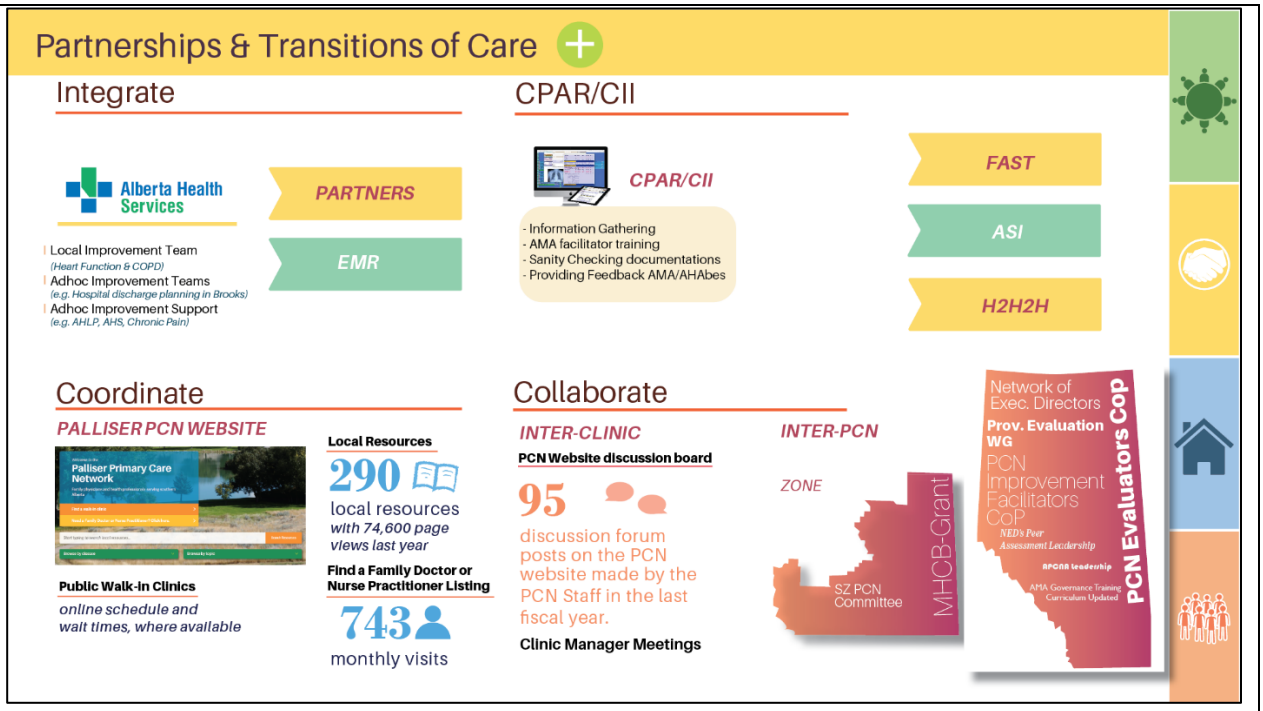


Figure 20 - Partnerships and Transitions of Care Objective Activities

Details related to Objective 2 highlights:

1. PCN has prioritized supporting member physician participation in CPAR/CII.
2. Panel readiness and CPAR/CII prerequisites have been met across health homes.
3. 71 physicians/nurse practitioners live or in-progress on CPAR/CII across 35 health homes
    - 90% of PCN physicians/nurse practitioners with active family practice panels
4. Additional CPAR/CII participation anticipated with:
    - Increased physician participation in PCPCM, causing increased interest in panel accuracy
    - 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
5. Some 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 performance appraisal process
    - Discussion at clinic manager meetings, discussion at individual physician member meetings
    - Topic included intermittently in Board e-Bulletin communications

Additional initiatives/achievements:

6. 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 (8,900 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 visitors geo-located within Palliser PCN geographic area: 15,000 annual engaged sessions
        ii. Uncertain # of Palliser PCN patients visiting PCN website and AFAD website. Further, patients would be unaware that AFAD source data is the Palliser PCN website, i.e. AFAD website is redundant for Palliser PCN patients

7. Shared health record within physician clinic.
    - Ongoing optimization of EMR usage with family physician clinics supported by PCN Central Office Administration team
    - 100% remote access to health home EMRs for Evaluation and Improvement purposes
8. Increased awareness of and access to transition supports.
    - Optimization of the use of electronic referral documents integrated into health home EMRs, adoption of electronic referral processes e.g. eFax, internal EMR e-referral
    - 290 Community Resources listed on Palliser PCN website: bidirectional communication between PCN and community services ensures website is up-to-date and accessible
        i. Examples include caregiver support groups, newcomer supports, day programs, financial support
    - Third-party supports, e.g. Alberta Facilitated Access to Specialized Treatment (FAST) Program
        i. Physician awareness of FAST Program is high, but local adoption of Alberta FAST Program is limited due to reliance on personal relationships between health homes and specialists. Communication regarding rollout is carefully managed to avoid saturation of health homes with future anticipated rollout timelines.
        ii. Physician perception of bureaucratic primacy reduces trust and adoption. E.g. lack of FAST team exercising clinical judgment when referral prerequisites are overdue, such as a baseline x-ray 93 days ago as opposed to 90 days ago.
9. 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. Dr. Colter Hart – Optometric Role in Primary Care
        ii. Yusuf Mohammed – Cultural Humility
        iii. Unison Connect – Social Prescribing Program
        iv. Wellspring Alberta – Cancer Support
        v. Robin Clark – Nutrition and Diet in Primary Care
        vi. YW Continuing Education – Domestic Violence in Primary Care
10. 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 in relevant education activities.

Evaluation indicators for Objective 2 related to identified short-term and medium-term outcomes in Palliser PCN's Evaluation Logic Model (next page):

Short- or Medium-Term	Outcome	Indicator	Measure
Short	Increased CPAR/CII enrollment	• Number and percentage of physicians and NPs who enrolled in CPAR/CII *[AH Schedule B indicator]*	70 (**89%**) live or in progress
		• Associated CPAR/CII readiness indicators *[AH Schedule B indicator]*	Collected in CPAR Schedule B data table
	Increased Health Home team efficiency/effectiveness in coordinating with former/new Health Home when patients change family doctors or nurse practitioners	• Number and percentage of health homes that use a Physician/Nurse Practitioner Change Form when patients change family doctors or nurse practitioners	35 (**88%**) using a Physician/Nurse Practitioner Change Form
	Increased timeliness of hospital discharge summaries to Health Homes	• Distribution of delays between hospital discharge and receipt of Health Home hospital discharge summaries, per hospital	Initial stages of AHS/ACA/PCA collaboration: connected with AHS and PCA to initiate a pilot of H2H2H related activities, including those related to accurate and timely discharges to health homes
		• Opportunity for AHS/ACA/PCA collaboration to define a hospital discharge timeliness indicator	Initial stages of AHS/ACA/PCA collaboration as indicated above: would require collaboration regarding data access
	Increased accuracy of identification of family doctor at ED/hospital	• Number and percentage of times incorrect identification of family doctor occurred	Initial stages of AHS/ACA/PCA collaboration with PCN health homes to quantify occurrence, as indicated above
		• Opportunity for AHS/ACA/PCA collaboration to measure ED/hospital admission family doctor identification processes at ED/hospital	Initial stages of collaboration as indicated above to measure family doctor identification at ED/hospital
Medium	Increased information, relationship and management continuity between Health Homes and across the Health Home neighbourhood	• PCN average physician and clinic continuity	**78%** physician and **87%** clinic continuity: *HQCA PCN Proxy Report 2024* (2025 HQCA Report not available until late May 2025)
		• H2H2H implementation measures	Initial stages of AHS collaboration - initial H2H2H implementation measure source is AHS
	Reduced PCN and physician-level cross-panel rates	• PCN overall cross-panel rate	**7.7%**
		• Number and percentage of physicians in each stratification of cross-panel rate (< 5%, 5-10%, 10-20%, >20%)	<5%: 31 (**39%**) 5-10%: 23 (**29%**) 10-20%: 17 (**22%**) >20%: 8 (**10%**)

Figure 21 – PCN Evaluation Indicators for Objective 2 (Partnerships and Transitions)

Barriers	Some health home supports (e.g. Connect Care, CPAR/CII, FAST, Netcare, EMR vendor products) indicate a promise of services that are not currently or universally accessible to Palliser PCN health home teams. This is related to geography, cost, IT literacy and system IT infrastructure. Some of the same supports (e.g. FAST) come with additional barriers, such as perception of increased administrative burden, bureaucratic primacy, lack of clinical judgment included in support. FAST barriers discussed in above Evaluation Activities section. Additional CPAR/CII participation anticipated with: • Increased provider interest in reducing Palliser PCN cross-panel rate, in order to improve panel accuracy and increase ability to define panel needs for incoming PCN RN/OHP (as providers newly qualify for PCN RN/OHP) • Increased physician participation in PCPCM, causing increased interest in panel accuracy • 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 o With 90% PCN participation, approximately 80% of within-PCN conflicts are able to be measured[5] through CPAR and made visible to the patient's circle of care ▪ This suggests the provincial CPAR conflict rate of 11.9% reflects only 80% of all provincial conflicts, making the total estimated provincial conflict rate is 14.9%. This is lower than the total estimated provincial conflict rate in the previous reporting period of 19.1%, using the same methodology. Palliser PCN has not seen an estimated provincial conflict rate reported in provincial CPAR/CII participation reporting, but anticipates potential utility in reporting this in order to evaluate the comprehensiveness of CPAR data and estimate the number of provincial conflicts not currently visible to participating physicians.
Schedule B Indicator	None indicated in Annual Report Guidelines; CPAR-related Schedule B indicators are described throughout, including in above areas of Section 2.2.2 as well as in pillar 4g of Section 2.2.4.
PCN Evaluation Logic Model Indicators	Please see Figure 21 for applicable evaluation indicators from the PCN's Evaluation Logic Model.

2.2.3. Objective 3 – Health Needs of the Community and Population

Objective 3	**Health Needs of the Community and Population** Plan service delivery on high quality assessments of the community's needs through community engagement and assessment of appropriate evidence.
Summary and/or Achievements	Over the reporting period, the PCN integrated the activities related to Objective 3 into its Evaluation Logic Model and Framework. A summary of the Objective 3 activities oriented within the overall framework can be seen below:

[5] Wagen, et al. "How to Calculate the Number of Wires for a Fully Meshed Network." X, x-engineer.org/wires-fully-meshed-network/. Accessed 6 June 2024.

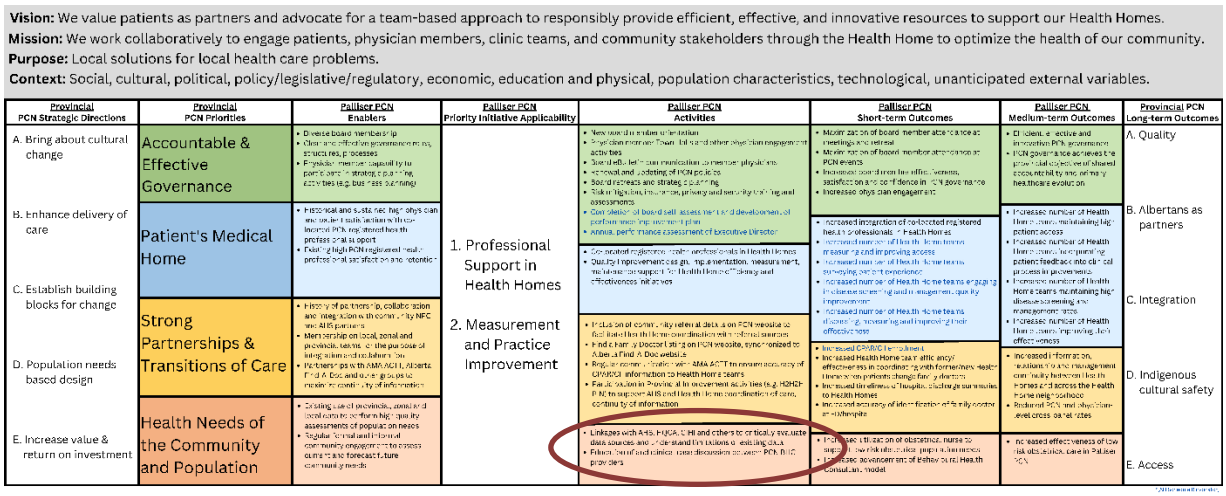


Figure 22 - PCN Evaluation Logic Model with Objective 3 activities circled

Highlights of the PCN's achievements related to Objective 3 during the reporting period:

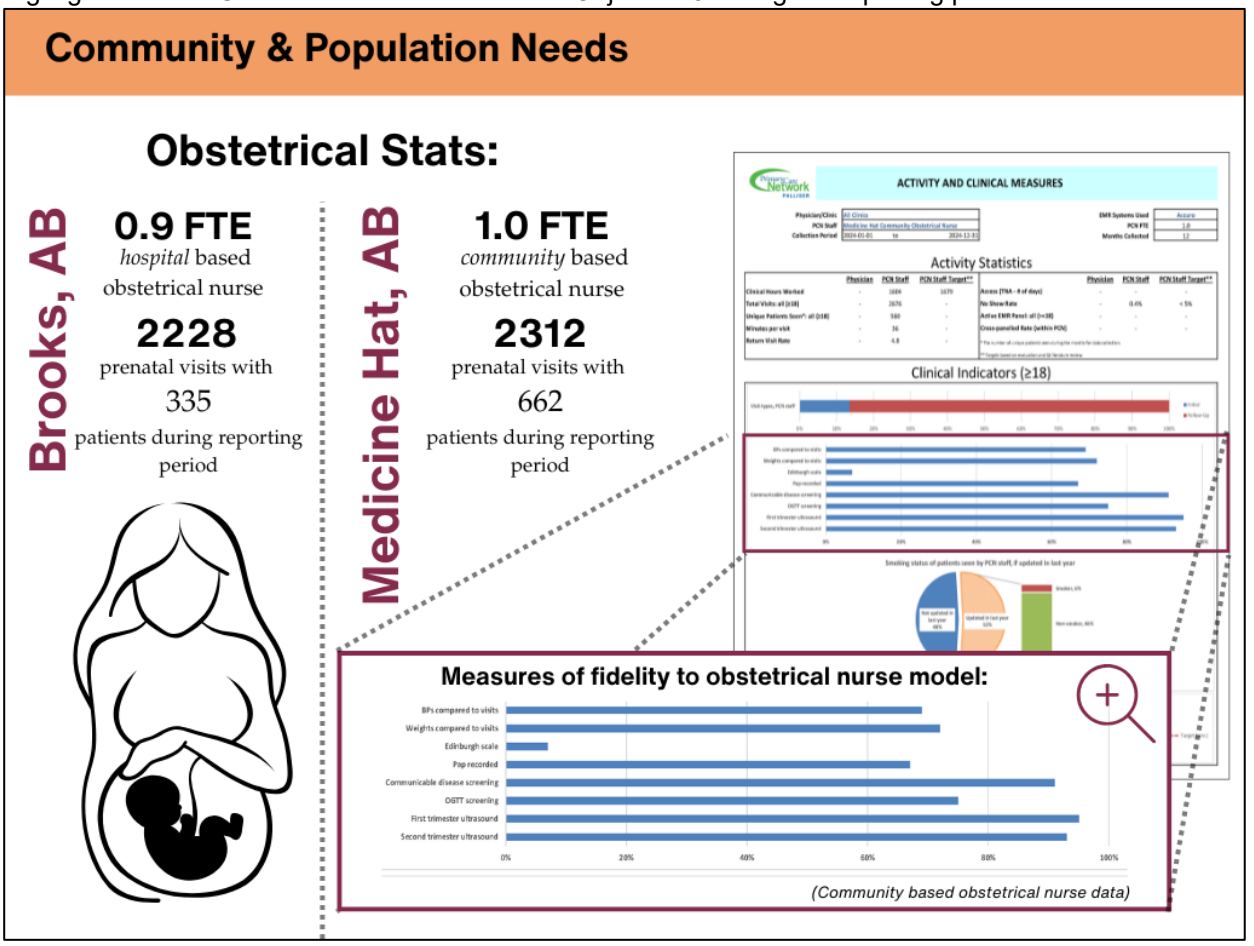


Figure 23 - Community and Population Needs Objective Highlights

During the reporting period, the PCN participated in MAPS Engagement Sessions (3 sessions, from June to September 2024) and MAPS Design Workshops (2 sessions, October 2024 and February 2025) which included a discussion of population needs for physicians or nurse practitioners accepting new patients. The PCN most recently measured this information in March 2025, seen on the next page:

Distribution of population with attachment status		# of patients
Total population estimate within Palliser PCN geographic area		114,840
Attached to Palliser PCN physicians' active family practice EMR panels		96,183
Attached elsewhere	Attached to a provider in an area not served by Palliser PCN	Negligible due to known patient preference / patterns
	Attached to a non-PCN family doctor in the area served by the PCN	~3,000
Imminently attached	Will be attached to NPs	~3,600
	Capacity to be attached to PCN doctors currently accepting new patients	~2,500
Able to be attached after reduction in physician cross-panelled rate	Removing cross-panelled patients will provide capacity for existing PCN physicians to accept additional patients	~5,000
Unattached	**Seeking a family doctor** in the area served by the PCN	**~4,500**
	Not seeking a family doctor in the area served by the PCN	

Figure 24 – Palliser PCN regional population distribution and attachment – March 2025

Engaging in this measurement:

- enables data-informed population and workforce planning that includes consideration of patient access (e.g. Figure 24's "able to be attached to PCN doctors currently accepting new patients" measure considers individual provider supply and demand context)
- facilitates a fulsome engagement with provincial entities that estimate unattached patients (e.g. AMA[6])
- socializes a differentiation between patients who may be inadvertently considered to be "unattached" and those who do not have a family doctor or nurse practitioner, when a data source is unable make this distinction (e.g. Calgary Rural PCN unattached patient screening program)
- assists AHS in its local planning responsibility for family practice provider recruitment.

During the reporting period, the PCN continued to use a variety of Patient Reported Outcome Measures (PROMs) at the micro and meso level. A detailed explanation follows in the Evaluation Activities section below.

Evaluation Activities

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

[6] "AB's Family Medicine Crisis: AMA." *Alberta Doctors*, www.albertadoctors.org/advocacy/strategic-priorities/system-leadership-and-partnership/abs-family-medicine-crisis/. Accessed 9 May 2025.

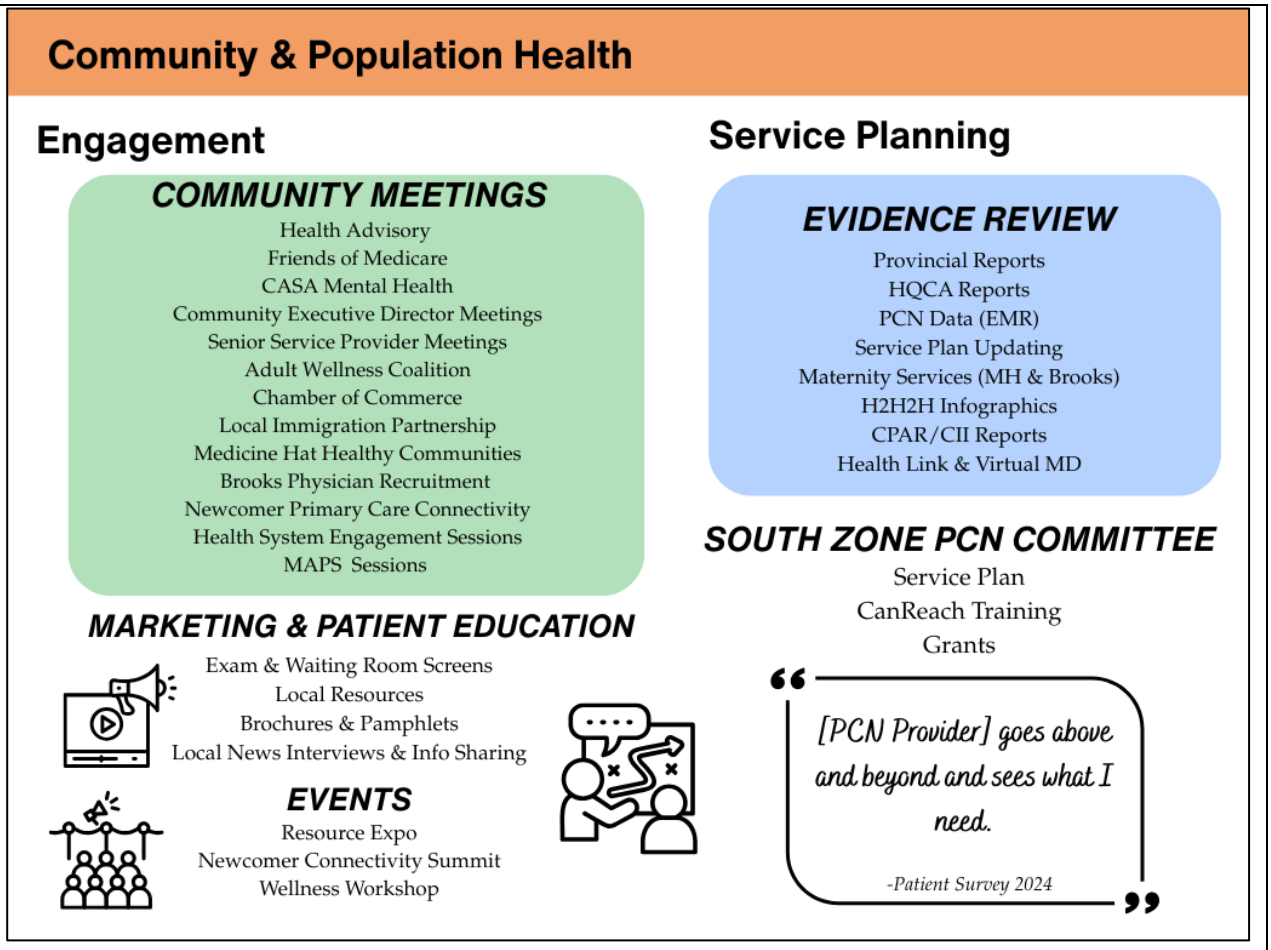


Figure 25 - Community and Population Health Objective Activities

Details related to Objective 3 highlights:

- PCN airborne illness support to health homes included:
  - N95 mask fit testing for PCN RNs/OHPs; offered to PCN physicians and clinic staff, and dissemination of key messages to health home teams
  - Support with patient messaging, including regular updating of local measles exposure advisories on 59 waiting room and exam room screens located in 26 health homes
- 1.0 FTE community obstetrical nurse utilized to support prenatal care in Medicine Hat and co-located in three health homes, supported prenatal visits including referrals for necessary screening, and completion of Alberta Prenatal Record

Additional initiatives/achievements:

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

- Screening
- Transitions
- Health management.

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

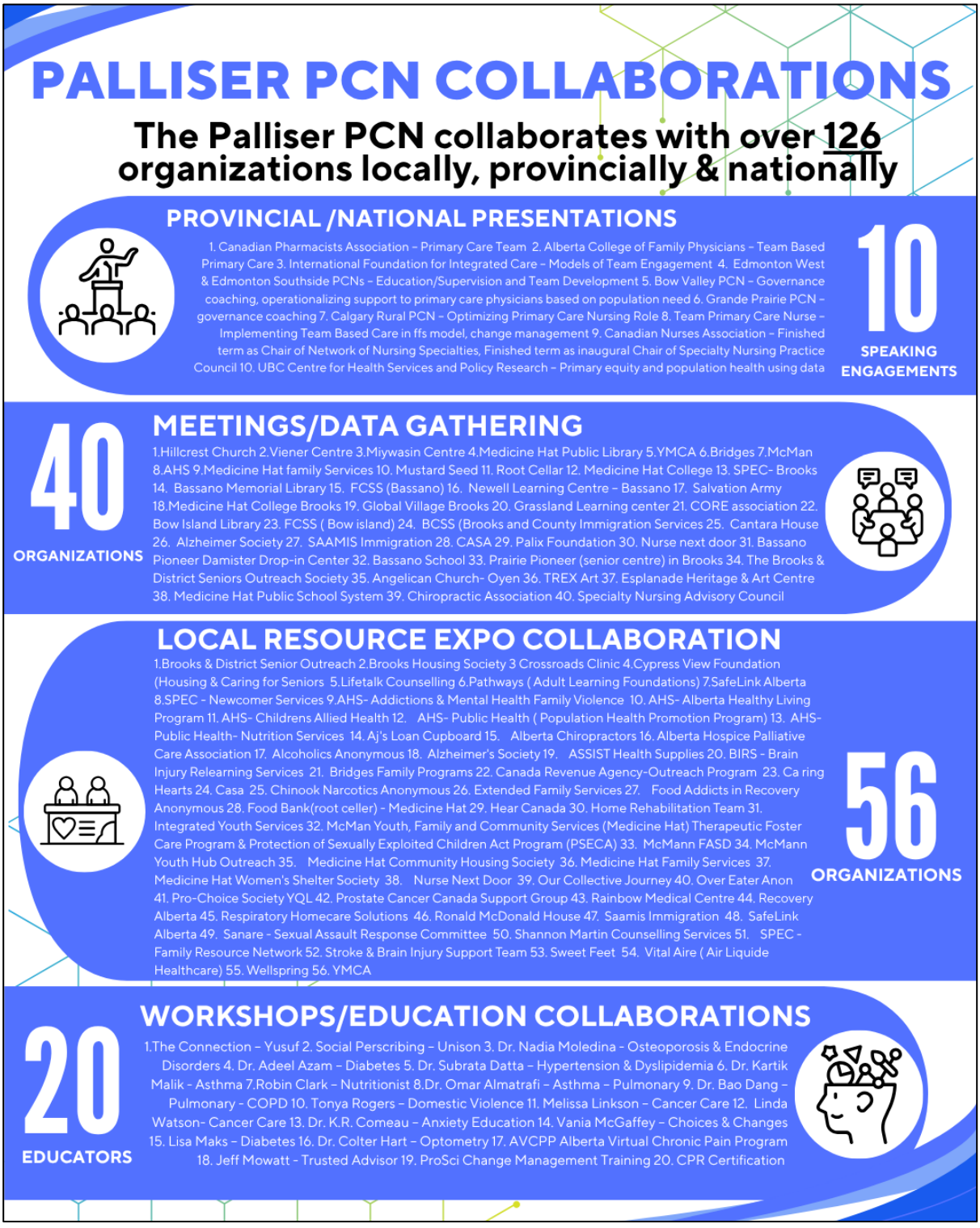


Figure 26 - Palliser PCN Collaboration Activities

5. Advancement of the Behavioural Health Consultant (BHC) model
    - 7 distinct BHC staff during the year, 6 FTE at the end of this reporting period
    - Using PHQ-9, GAD-7, BHC-7 (Palliser PCN-developed) and Burns Anxiety/Depression Inventory Assessments (*Patient Reported Outcome Measures – PROMs*) for clinical care:
        - 8,680 BHC Initial or Follow-up visits with 2,240 patients in the reporting period
            - 1,490 Initial and 7,190 Follow-up visits
        - 7,220 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 lower than the previous reporting period's estimated model fidelity of 90% (2022/23: 93%) potential factors: model fidelity decreased related to increase in average BHC utilization (78 minutes/visit) compared to 2023/24 reporting period (previous period: 79 minutes/visit; 2022/23 period: 82 minutes/visit; 2021/22 period: 69 minutes/visit); model fidelity stabilized due to increased BHC familiarity/comfort with model
            - 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, 7,460 PHQ-9 and 5,400 GAD-7 assessments completed by patients who saw these providers.
    - BHC checklists and EMR charting workflows refined during the reporting period (e.g. charting template enhancement, including reminder to ask patient about last flu shot).
    - Summary of BHC information seen in Figure 27 on next page.
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.
    - 12,500 EQ-5D scores for different patients were collected during the reporting period.
    - Compared to 10,300 EQ-5D scores in 2023/24, 11,300 EQ-5D scores in 2022/23, 15,900 EQ-5D scores in 2021/22, 12,500 EQ-5D scores in 2020/21, 5,800 EQ-5D scores in 2019/20, 3,700 EQ-5D scores in 2018/19
    - 19% increase in EQ-5D collection since previous reporting period. Potential reason: stabilization of EQ-5D collection processes after a surge of EMR migrations to Ava EMR during the previous reporting period: required change management to evolve EQ-5D collection processes.
    - Potential barrier to increased collection: perception of this PROM as minimally micro-level[7] oriented. Compare to BHC-7, PHQ-9 and GAD-7 PROMs used by PCN BHCs: developed and incorporated into PCN workflows as PROMs that straddle both micro and meso level usages; potentially correlated with substantially higher adoption.
7. Crisis Prevention Institute Nonviolent Crisis Intervention and Prevention First Training
    - CPI training continues to be held on an ongoing basis as needed. Certificate is good for 3 years.
8. Facilitate patients seeking a family doctor or nurse practitioner with access to accurate information regarding family doctors or nurse practitioners accepting new patients.
    - PCN updates a listing of doctors and nurse practitioners accepting new patients every month.
    - 9,000 annual visits to this listing on the "Find a family doctor or nurse practitioner accepting new patients" link on PCN website homepage.

[7] Al Sayah, Fatima et al. "A multi-level approach for the use of routinely collected patient-reported outcome measures (PROMs) data in healthcare systems." *Journal of patient-reported outcomes* vol. 5,Suppl 2 98. 12 Oct. 2021, doi:10.1186/s41687-021-00375-1

- During the reporting period, an average of 10 family physicians and nurse practitioners were accepting new patients at any time. This is an increase from the previous reporting period average of 6 family physicians accepting new patients at any time. 13 family physicians and nurse practitioners are accepting new patients at the end of this reporting period.

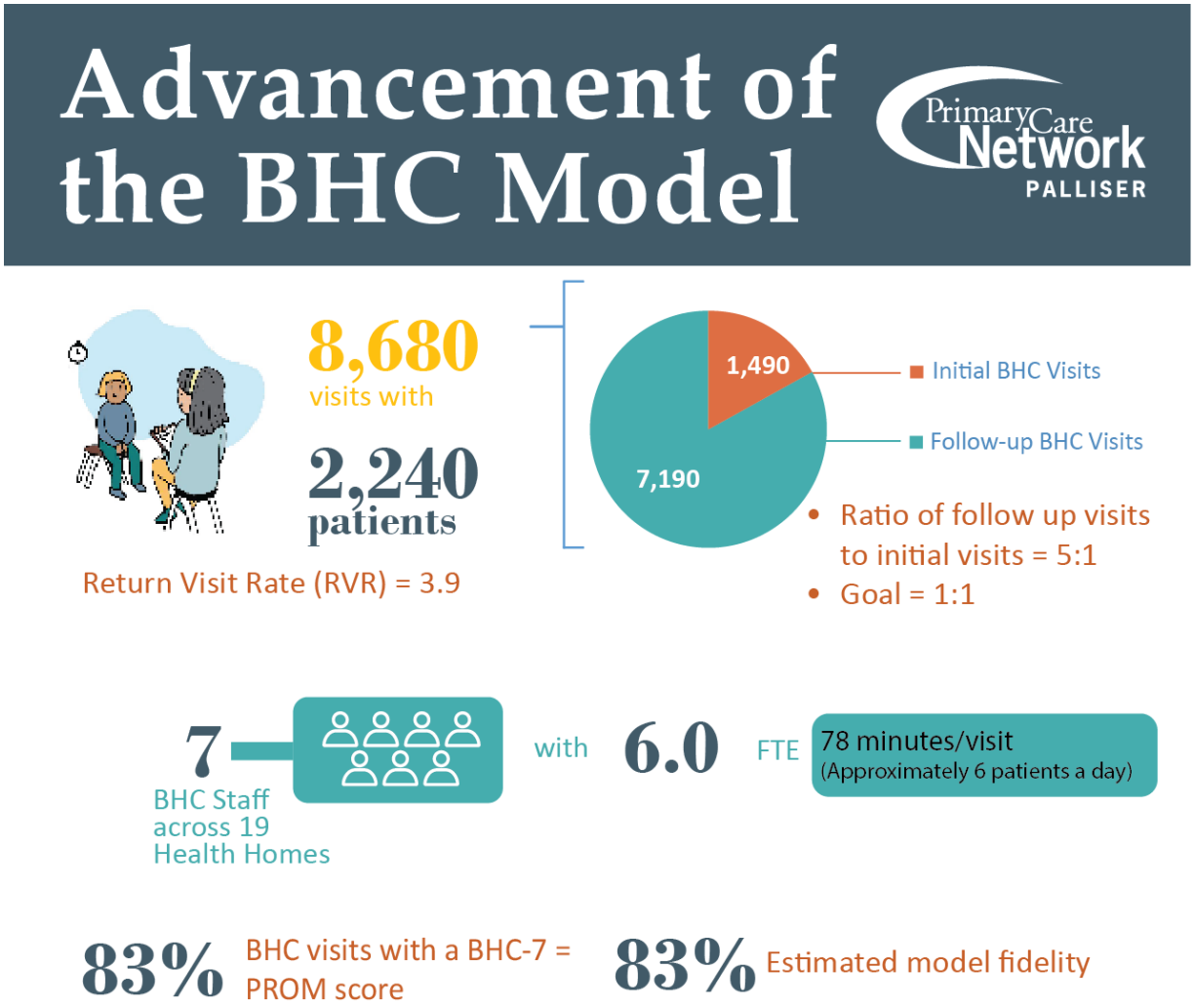


Figure 27 - Advancement of the BHC Model

Evaluation indicators for Objective 3 related to identified short-term and medium-term outcomes in Palliser PCN's Evaluation Logic Model:

Short- or Medium-Term	Outcome	Indicator	Measure
Short	Increased utilization of obstetrical nurse to support low risk obstetrical population needs	• Number of unique patients and visits by obstetrical nurse	**997** obstetrical patients seen for **4540** visits (Medicine Hat and Brooks obstetrical nurses)
	Increased advancement of Behavioural Health Consultant model	• Number of unique patients and visits by PCN BHC providers	**2240** patients seen for **8799** visits
		• Number of visits with BHC-7, PHQ-9 and GAD-7 assessments occurring	BHC-7: **83%** of visits; PHQ-9: **86%** of visits; GAD-7: **62%** of visits

	Medium	Increased effectiveness of low risk obstetrical care in Palliser PCN	• Fidelity measures to obstetrical nurse model (vitals, disease screening, ultrasound)	BPs: **69%** of visits; Weights: **39%** of visits; Pap: **67%** of patients; Communicable disease screening: **91%**; OGTT: **75%**; First trimester ultrasound: **95%**; Second trimester ultrasound: **93%** (Community obstetrical nurse)
			• Opportunity for collaboration with AHS to define a low-risk obstetrical care effectiveness indicator	Initial stages of AHS collaboration

Figure 28 – PCN Evaluation Indicators for Objective 3 (Community and Population Health)

Barriers	1. Health workforce shortage • All professions; shortage in workforce size and reduction in existing workforce wellness 2. Challenges in deriving actionable community and population health information from data sources that vary in: • Age: e.g. Current Alberta Health "PCN Dashboard" accessed in April 2025 was last updated in March 2023, but data ends March 31, 2021 • Level of aggregation – data not always specific to PCN or community: e.g. i. some Alberta Health Community Profile data cannot be drilled down beyond the zone level, other data cannot be subdivided beyond the LGA, down to individual cities/towns ii. Health Link 811 Nursing and Virtual MD statistics are only reported at a South Zone level: this data gap prevents the PCN from meaningfully probing utilization and utility for population residing in its geographic region
Schedule B Indicator	The PCN's use of the EQ-5D Patient Reported Outcome Measure is described in the above Evaluation Activities section. The PCN also uses other PROMs to evaluate its Behavioural Health Consultant model (BHC-7, PHQ-9), described further above. EQ-5D *PROM* collection continued for all non-BHC PCN clinical staff during this reporting period. 12,500 EQ-5D scores for different patients were collected during the 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 more closely approach goal of one EQ-5D assessment per patient per year.
PCN Evaluation Logic Model Indicators	Please see Figure 28 for applicable evaluation indicators from the PCN's Evaluation Logic Model.

2.2.4. Objective 4 – Patients Medical Home (PMH)

Objective 4	**Patient's Medical Home (PMH)** Implement PMH to ensure Albertans have access to the right services through the establishment of interdisciplinary teams that provide comprehensive primary care.
Initiatives/ Achievements	Over the reporting period, the PCN integrated the activities related to Objective 4 into its Evaluation Logic Model and Framework. A summary of the Objective 4 activities oriented within the overall framework can be seen below:

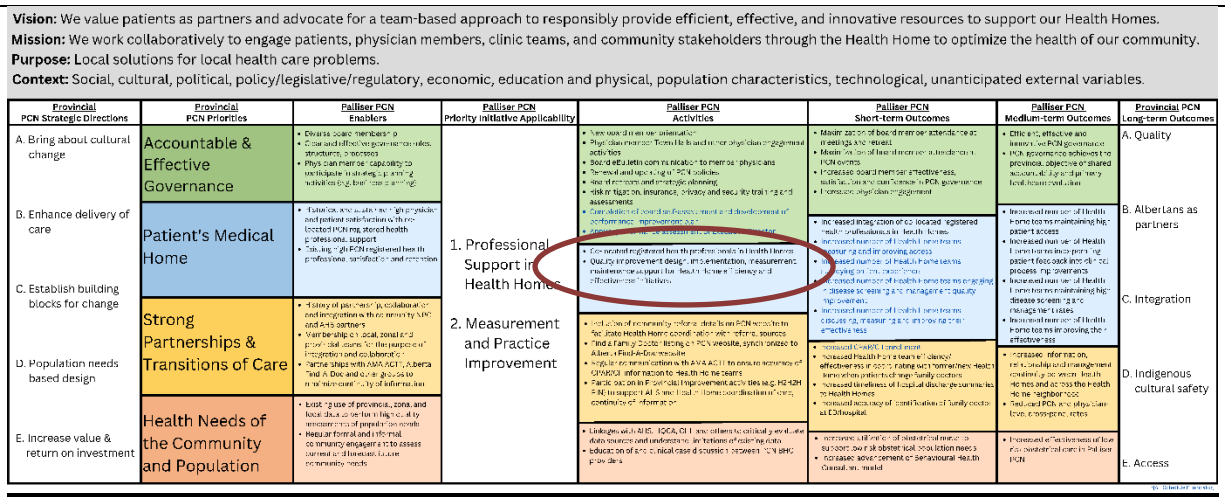


Figure 29 - PCN Evaluation Logic Model with Objective 4 activities circled

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

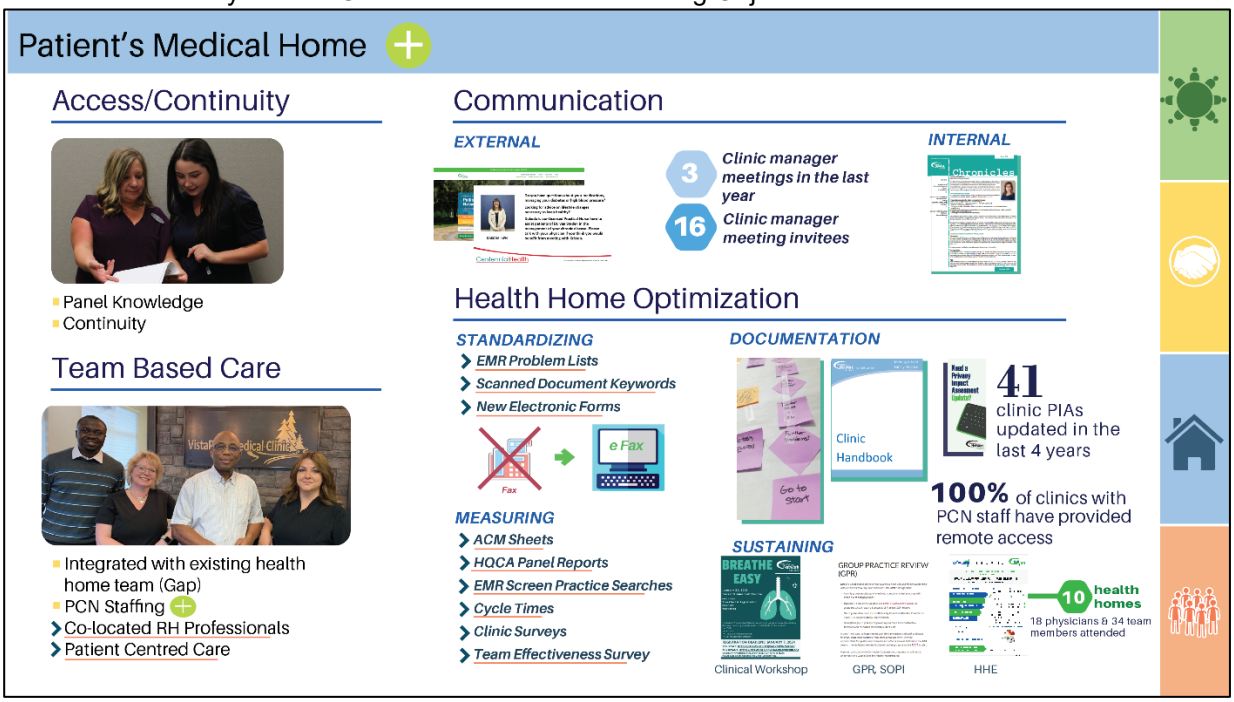


Figure 30 - Patient's Medical Home Objective Activities

A highlight of the PCN's activities within Objective 4 is its success in reducing physician cross-panel rates, as seen below:

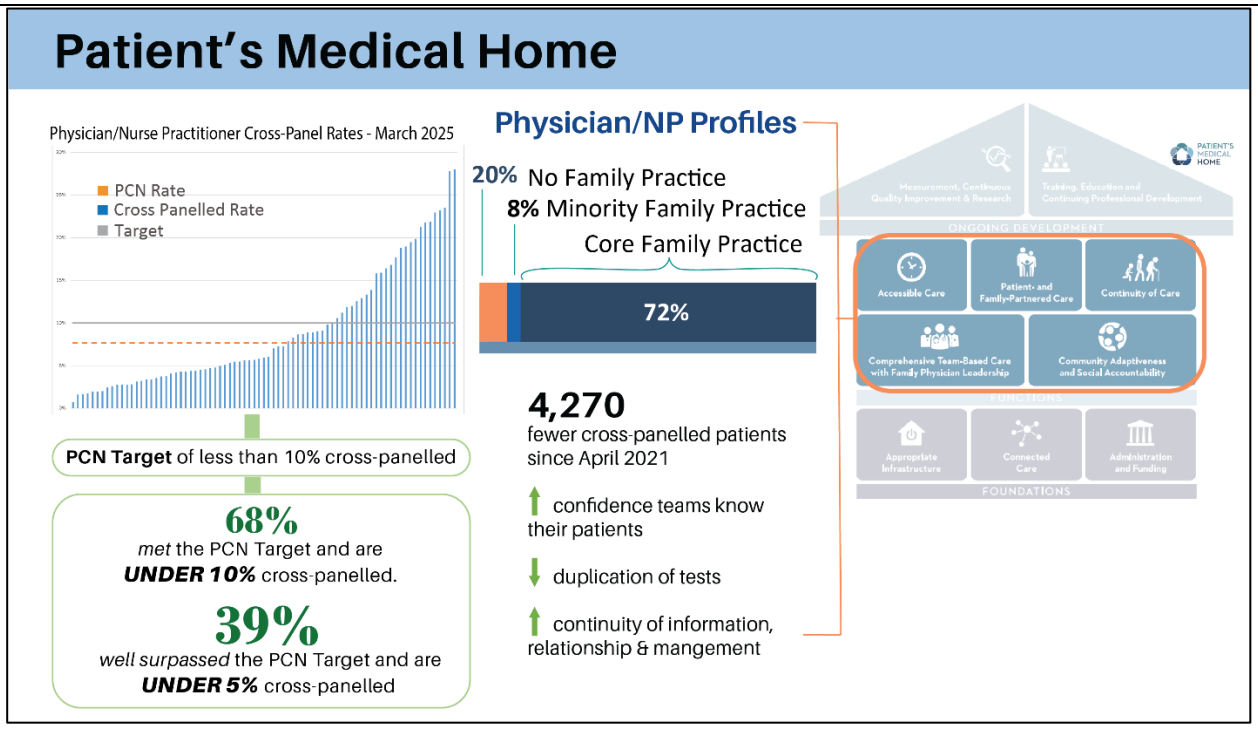


Figure 31 – Patient's Medical Home Objective Highlights

Details related to Objective 4 highlights:

- Measurement of the EMR family practice panel excludes cross-panelled patients (7.7% of patients at the PCN level, compared to 8.9% in FY 2023-24, 11% in FY 2022-23 and 13% in FY 2021-22). 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 & NPs) to increase and/or stabilize their panel numbers, including to those physicians who will need to make an FTE reduction and have a two-year notice period in which they are supported to increase their panel. This includes supporting teams to review panels, contact patients, and administratively inactivate patients who have not been in to the clinic in three years. (Typically, three years is chosen as patient fidelity to a health home has been experientially noted to drop off significantly if a patient has not presented during this time). These strategies combine to develop and sustain processes to buttress panel accuracy.
- Health homes that anticipated the addition of new physicians were supported to establish processes to clearly identify family practice patients as the new physicians arrived – processes which align with the CPSA standards of practice regarding establishing the patient-provider relationship.
- 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.
- 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*)
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-4g*)
3. PCN professional staff training (pillars *4c-4g*)
4. Office Practice Redesign including:

a. Panel identification & management (pillars *4f-4g)*
b. Form and support Health Home teams and implement practice improvement methodologies including panel identification and management (pillars *4e-4g*)

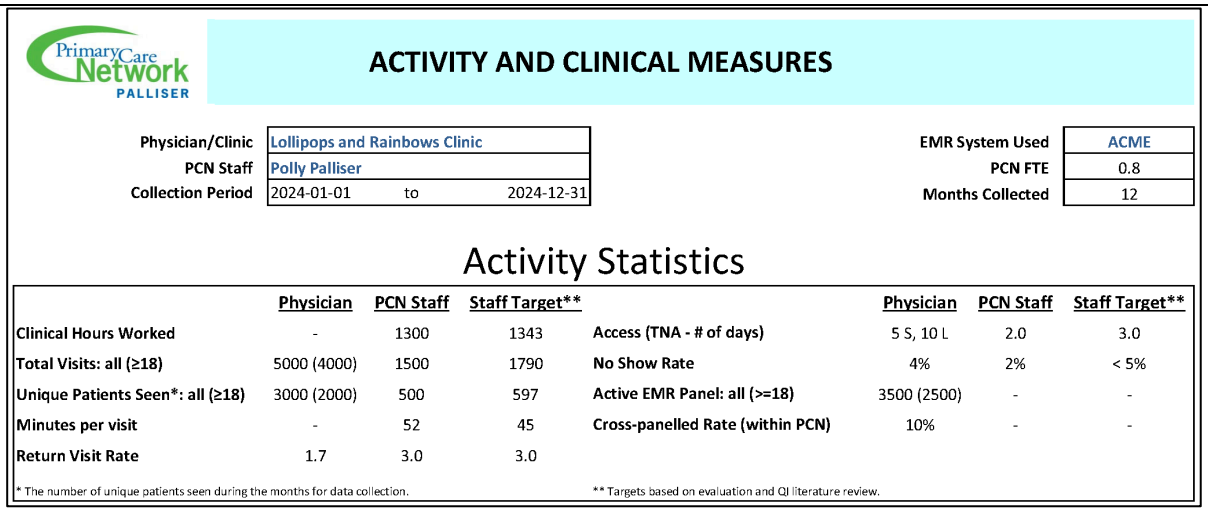
5. EMR optimization within the PCN Health Home Optimization Model (pillars *4a, 4b, 4d-4g*)

Evaluation indicators for Objective 4 related to identified short-term outcomes in Palliser PCN's Evaluation Logic Model:

Outcome	Indicator	Measure	Related Pillar(s)
Increased integration of co-located registered health professionals in Health Homes	• Number of co-located registered health professionals in Health Homes and stratification of roles	60; by FTE, comprising 39.09 RN, 6.0 Behavioural Health Consultant and 0.61 NP	4a-4g
	• Number and percentage of Health Homes with access to a PCN registered health professional	32 **(80%)**	4a-4g
Increased number of Health Home teams measuring and improving access	• Number and percentage of physicians/NPs and PCN OHPs measuring Time to Third Next Available Appointment *[AH Schedule B indicator]*	87 physicians and NPs **(100%)** 60 PCN OHPs **(100%)**	4b, 4d, 4e
	• Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Access score of 2 or higher	9 **(23%)**	4b, 4d, 4e
Increased number of Health Home teams surveying patient experience	• Number and percentage of teams surveying patient experience	Palliser PCN Patient Survey (patients who saw a PCN RN/OHP): **100**% of teams with a PCN RN/OHP; Health Home Patient Survey (patients who visited the health home): 5 **(13%)**	4c, 4e
	• Percentage of patients reporting "Excellent" or "Very Good" to last six months overall care survey question *[AH Schedule B indicator]*	**99%**	4c, 4e
Increased number of Health Home teams engaging in disease screening and management quality improvement	• Disease screening and management activity completion rates *[AH Schedule B indicator]*	DM Screening: **91%**; Cholesterol Screening: **92%**; Colorectal Cancer Screening: **63%**; Breast Cancer Screening: **68%**; BMD Screening, males: **36%**; BMD Screening, females: **70%**; Cervical Cancer Screening: **52%**; Hypertension Screening: **73%**; Weight Screening: **84%**; Height Screening: **80%**; DM Management: **66%**	4c-4e
	• Number and percentage of teams with a HHO Screening score of 2.5 or higher	7 (**18%**)	4c-4e
Increased number of Health Home teams discussing, measuring and improving their effectiveness	• Number and percentage of teams measuring team effectiveness *[AH Schedule B Indicator]*	Using mandated instrument: 3 (**7.5%**) Any instrument: 4 (**10%**)	4d
	• Number and percentage of teams with a HHO Team score of 2 or higher	13 (**33%**)	4d

Figure 32 – PCN Evaluation indicators for Objective 4 (Patient's Medical Home)

4a	Care Coordination
Summary and/or Achievements	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.
Evaluation Activities	The annual Palliser PCN physician survey contains a question regarding transitions of care. With feedback gathered through the PCN employee performance assessment process and PCN facilitator support offered to health homes to increase efficiency of care coordination (e.g. CPAR/CII participation, establishment of referral processes), a triangulation of perspectives regarding the current state of care coordination in Palliser PCN health homes was made possible. **Annual Physician Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (92% 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, I have been satisfied with the support the PCN staff in my office provides with patient transitions into/out of acute and/or specialty care (e.g. hospital discharge follow-ups)"* resulted in an average rating score of 86%.
PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4b	**Enhanced Access**
Summary and/or Achievements	Integration of PCN staff within 92% 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.
Evaluation Activities	**Annual Physician Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (92% return rate). Personal Experience / Multi-disciplinary Team: "*I would recommend employment of PCN staff to other physicians"* resulted in an average rating score of 93%. 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 (81% 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%. Teams are regularly measuring Time to Third Next Available Appointment in order to support reporting of the mandated Schedule B Indicator. This includes **100% of PCN RNs/OHPs** measuring Time to Third Next Available Appointment. Physician and PCN RN/OHP access measures are reflected back to teams annually as part of the PCN RN/OHP performance assessment process. Teams which engage in access improvement, such as those participating in the Health Home Expedition (described throughout this document, including in the preceding paragraph) are supported to measure supply, demand, activity, delay, panel size, no show rate, return visit rate and continuity to inform tests of change.



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic	EMR System Used	ACME
PCN Staff	Polly Palliser	PCN FTE	0.8
Collection Period	2024-01-01 to 2024-12-31	Months Collected	12

Activity Statistics

	Physician	PCN Staff	Staff Target**		Physician	PCN Staff	Staff 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)	10%	-	-
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 33 – PCN Activity and Clinical Measures Sheet (portion with access measures)

Four action periods and three mid-Health Home Expedition in-person learning sessions occurred during the reporting period. The PCN administrative team co-hosts and supports facilitation of in-person learning sessions (see Section 4d for details). PCN practice improvement facilitators figure prominently in supporting teams to plan, implement, and study QI tests during action periods. This involves a customized approach to the local context, including the PCN's priority focus on Access and Team-based care. Individual health home teams are supported to measure baseline access and set a specific, measurable, achievable, reliable, and time-bound (SMART) goal related to access. Teams are supported to visualize and interpret access measures to enable of tests of change.

Schedule B Indicator

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, Educators, Supervisors and the Analyst. Please see pillar 4e 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 2023/24	FY 2022/23
Proportion of physicians measuring time to third next appointment	Numerator	89	89
	Denominator	90	90
	Proportion	98.9%	98.9%

Figure 34 – Third Next Available Appointment Indicator

PCN Evaluation Logic Model Indicators

Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.

4b.1 **To increase the proportion of residents with ready access to primary care**

Summary and/or Achievements

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

Palliser PCN provides monthly updates to:

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

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

Evaluation Activities	Annual patient visits to “Need a Family Doctor or Nurse Practitioner? Click here.” link on PCN website homepage: **9,000**. This data may be incomplete due to a mid-year Google Analytics version migration.

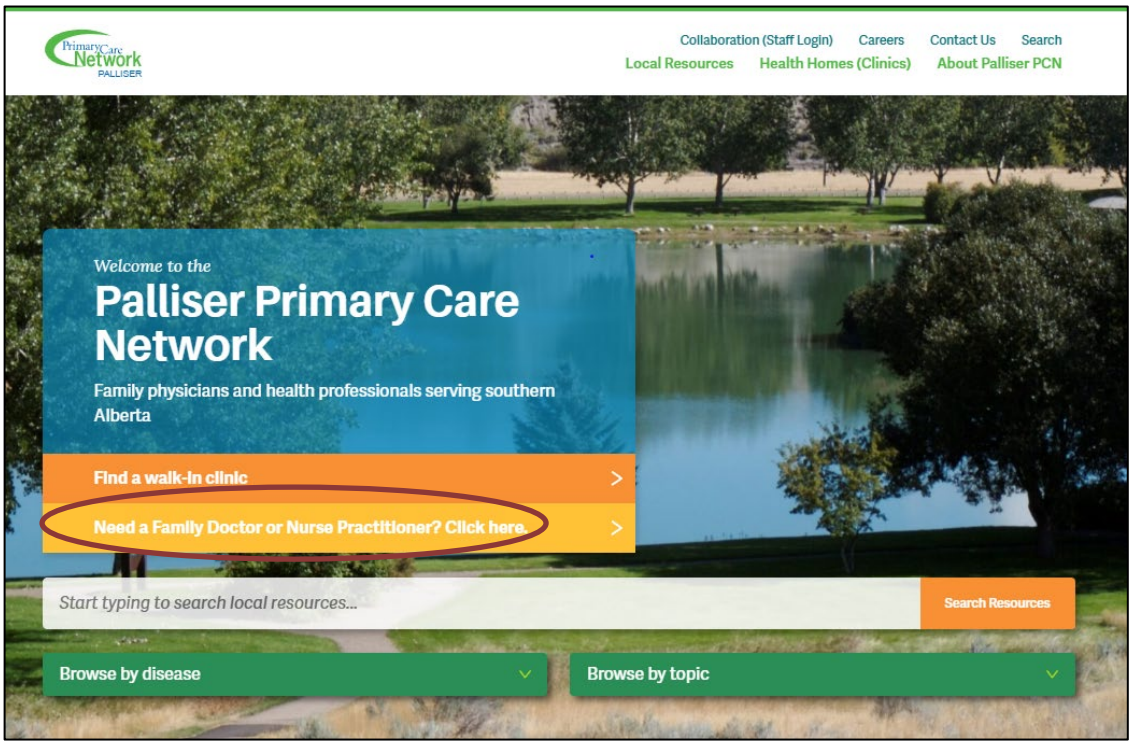


Figure 35 - Website homepage with "Need a Family Doctor or Nurse Practitioner" link circled

Since 2015, the PCN has assisted public walk-in clinics to be listed on the PCN website, including hosting their walk-in schedule if they agree to keep it up-to-date. Annual patient visits to PCN Website walk-in pages: **8,400**.

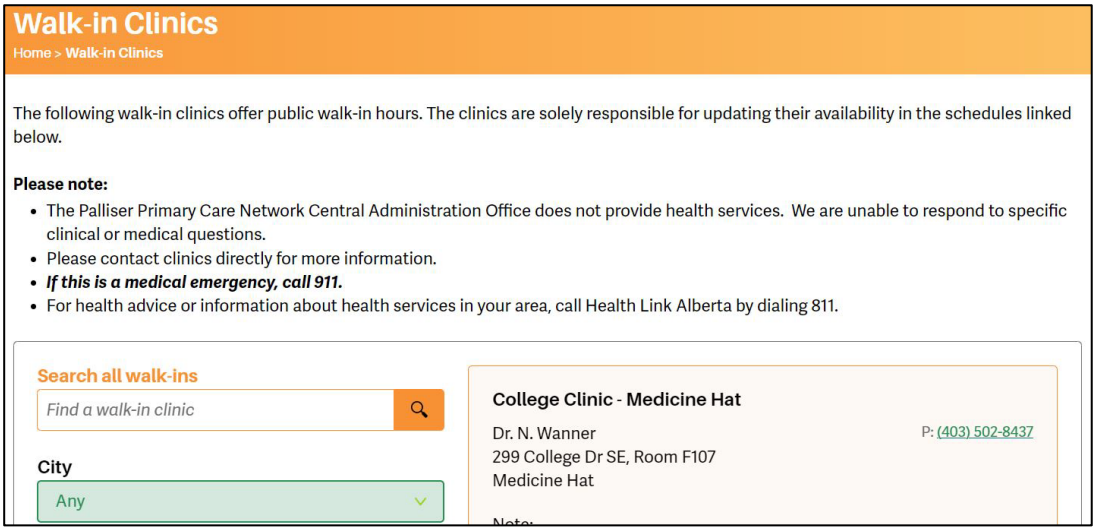


Figure 36 - PCN Website Walk-in Clinics landing page

There are 290 local community resources currently listed on the Palliser PCN website. Examples of listed resources include local caregiver support groups, newcomer supports, day programs and financial supports. Bidirectional communication between the PCN and community resources ensures website is up-to-date. The PCN also mass-contacts all listed resources each summer to ensure accuracy of posted information. Annual PCN website local resources section page visits (all pages): **74,600**.

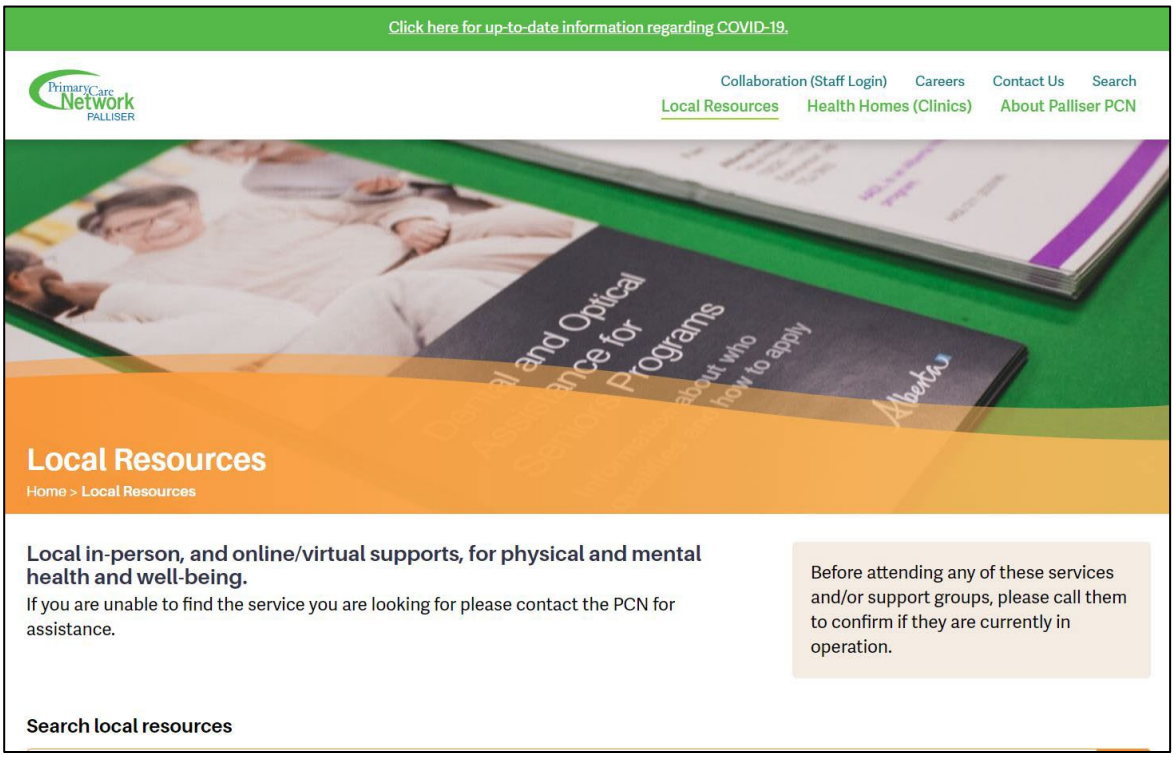


Figure 37 - PCN Website Local Resources landing page

Top 10 most accessed PCN Website Local Resources, 2024/25:

1. Alberta Seniors Benefit Program
2. Allowance for People Aged 60 to 64
3. AHS Collections Sites Diagnostic Labs
4. Alcoholics Anonymous
5. Children's Allied Health (Formerly CHADS)
6. Rainbow Medical Centre
7. Holy Family Parish & Organizations
8. Meals on Wheels
9. Dr. Taylor – Dermatologist
10. Calgary Foot Care Nurses

Schedule B Indicator	Whereas the Annual Report Template indicated to report on the Patient Experience Indicator in this section, the Annual Report Guidelines indicated to use Section 4c. Please see Section 4c for Patient Experience Indicator data and discussion.
PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4b.2	**To provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services**
Summary and/or Achievements	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.

Schedule B Indicators	

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.

Figure 38 - 2024/25 PCN Dashboard

PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4c	**Patient Centered Interactions**
Summary and/or Achievements	The existing Palliser PCN patient survey asks patients to review their experiences over the past 12 months. Average patient satisfaction in areas of patient experience has increased to or maintained above 93%.
Evaluation Activities	The Palliser PCN patient survey audience is patients with an interaction in the last year with a PCN RN/OHP. Highlights related to patient experience over the past 12 months:

PATIENT SURVEY RESULTS
Prepared January 2025
Return Rate: 81%

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	*Total Responses*	PCN Average Satisfaction Score		
Weights	100%	75%	50%	25%	0%		**2024**	2023	2022
During the past 12 months:									
1. Overall, I have been satisfied with the care that I've received.	1075	150	3	2	2	*1232*	**97%**	97%	96%
2. My confidence to manage my health has improved through the support I receive from my PCN provider (e.g. RN, NP, BHC, Dietitian).	948	250	27	3	4	*1232*	**93%**	94%	93%
5. I have felt that my PCN provider is knowledgeable regarding my health.	1035	180	7	4	2	*1228*	**96%**	96%	96%
8. Overall, I felt that receiving care from my health home team has improved my quality of life.	955	203	28	5	3	*1194*	**94%**	94%	93%

Figure 39 – 2024 Patient Survey Results (patient experience)

Schedule B Indicators

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

- The 2024 mandated question, adjusted in April 2024 to query patient experience over the last 6 months, does not match the PCN's pre-existing 12-month lookback on its annual Patient Survey, maintained in its current form for long-term evaluation.
- The mandated question is rated on a 6-point Likert Agreement scale, whereas the existing Palliser PCN Patient Survey uses a 5-point Likert Agreement scale. The most recent Schedule B Patient Experience Indicator Toolkit, including the April 2024 adjustment, did not indicate that PCNs could deviate from the 6-point Likert scale. The PCN has maintained the 5-point Likert Agreement scale on its existing annual Patient Survey for long-term evaluation.

During the reporting period, Palliser PCN supported developing and administering an independent Clinic Patient Survey containing a small number of questions, customized to match the areas the clinic was working on if indicated by survey results, universally beginning with the Schedule B Patient Experience Indicator question, as seen in the below example:

[Clinic Logo]

Primary Care Network PALLISER your health. your team.

CLINIC PATIENT SURVEY

We are improving our services. We appreciate you taking a few minutes to respond to this survey. Please know that your confidentiality will be maintained.

Please check the option which most accurately reflects your opinion.

*Overall, **over the past 6 months**, how would you rate your satisfaction with:*

	Excellent	Very Good	Good	Fair	Poor	Very Poor	Comments
1. The care you received from this clinic							
2. Booking your appointment							
3. The wait time for your appointment							
4. In person visits							
5. Your physician's ability to explain things in a way that was easy to understand.							
6. How well the clinic staff treated you with courtesy and respect.							

Figure 40 - Example Clinic Patient Survey with mandated Patient Experience Indicator (Question #1)

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

PATIENT EXPERIENCE INDICATOR		FY 2024/25	FY 2023/24
Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	122	33
	Denominator	123	35
	Proportion	99.2%	94.3%

Figure 41 - Patient Experience Indicator

Four PCN health homes were approached and chose to utilize this survey. The process included:

- Decision on survey administration:
    1. PCN administrative staff member standing in each health home waiting room and asking patients to complete the single question survey after their visit.
    2. Clinic staff providing each patient with a paper survey on check-in and anonymously receiving the survey on check-out.
    3. Posting a QR code in the clinic waiting room for patients to complete an electronic (SurveyMonkey) survey on their own device.
- Results were tallied for each health home team, with PCN facilitators prepared to assist teams to interpret results and prioritize any areas for quality improvement, depending on if any improvement areas revealed themselves through survey results.

All but one team chose to proceed with survey administration Option 1. This process minimized burden to health home staff and maximized return rate compared to Options 2 and 3. In-clinic surveying required 9 hours of administrative time from Central Office administrative staff, surveying a total of 45 patients, meaning 5 patients were surveyed per hour of administrative staff time. This was a noted increase compared to the previous reporting period administrative burden of 10 hours for a total of 3.5 patients surveyed per hour. The remaining 78 patients completed the survey using Options 2 and 3, with a vast majority (> 90%) choosing the paper survey option when offered.

The PCN continues to note that individual participating clinics are limited in engagement to utilize clinic patient surveys, irrespective of mode. Teams that were most interested were commonly those engaged in the PCN's Health Home Expedition – a workshop series described in above sections. 100% of these

	teams are actively engaged in a QI project and have especially increased in their awareness, desire and knowledge regarding ways to include patients in health home quality improvement activities.
PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4d	**Organized Evidence Based Care**
Summary and/or Achievements	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. These workshops support the PCN objective of ensuring health home teams are able to practice using up-to-date evidence based information. With a goal to maximize evidence based quality improvement activities, in January 2024, 10 health home teams (18 physicians and 34 clinic team members) embarked on the Health Home Expedition – an approximately 18-month collaborative learning series delivered by quality improvement faculty with experience with Alberta AIM and other longitudinal team-based collaborative QI initiatives. This involves a customized approach to the local context, including the PCN's priority focus on Access and Team-based care.

Figure 42 – Palliser PCN Health Home Expedition Overview

Four action periods and three mid-expedition in-person learning sessions occurred during the reporting period. The PCN administrative team co-hosts and supports facilitation of in-person learning sessions. PCN practice improvement facilitators figure prominently in supporting teams to plan, implement, and study QI tests during action periods.

Team effectiveness elements are incorporated throughout the Expedition and include activities that survey team behaviours, attitudes, personality types and communication styles. These team effectiveness activities involve team discussion, individual reflection and group action planning over an 18-month period; this is expected to enable significant team optimization in contexts where teams are at a sufficient stage of readiness to engage in this work.

During the reporting period, Palliser PCN offered to teams to administer the mandated Primary Care Team Dynamics Survey (Song et al., 2015). Participating teams were assisted to review results of the team effectiveness survey and supported to identify/test a possible area of team improvement (e.g. processes for conflict resolution, measured by Survey questions 18-19, chosen by one team).

Another enabler of organized evidence based care is the PCN's maintenance of access to the DynaMed clinical resource for its in-clinic professional staff, as well as interested physicians and nurse practitioners. A summary of usage:

	Mode of Access				***One year prior comparison (FY 2023/24)***
Month-Year	iOS	Web	Android	**Total**	
Apr 2024	91	446	24	**561**	***290***
May 2024	76	418	25	**519**	***313***
Jun 2024	42	273	75	**390**	***198***
Jul 2024	43	241	102	**386**	***202***
Aug 2024	46	200	89	**335**	***269***
Sep 2024	60	286	81	**427**	***127***
Oct 2024	67	349	180	**596**	***155***
Nov 2024	40	263	48	**351**	***211***
Dec 2024	32	197	46	**275**	***403***
Jan 2025	46	360	24	**430**	***562***
Feb 2025	36	351	7	**394**	***395***
Mar 2025	37	300	17	**354**	***471***
Total	**616**	**3,684**	**718**	**5,018**	***3,596***

Figure 43 - DynaMed usage by month and mode, 2024/25 with comparison to 2023/24 monthly usage

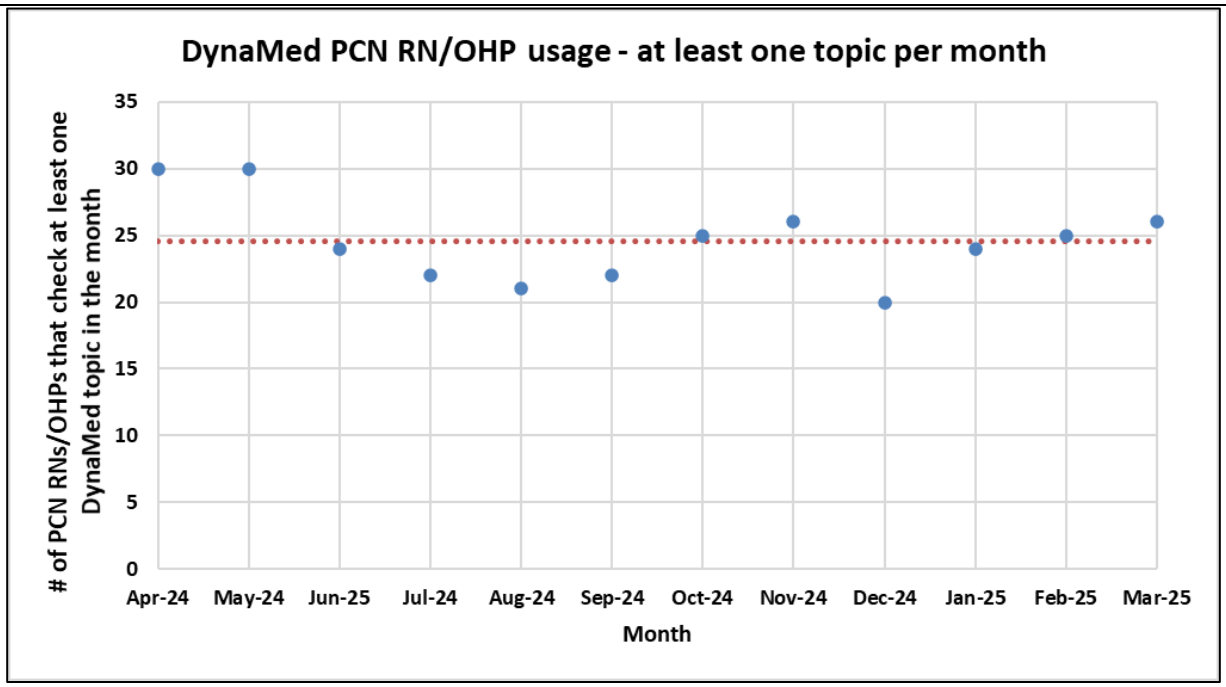


Figure 44 - DynaMed Monthly Usage by PCN RNs/OHPs

Topic Title	Topic Views
Vitamin B12 Deficiency	176
Semaglutide	150
Amlodipine	57
Perindopril	47
Metformin	37
Amitriptyline	35
Gabapentin	34
Postmenopausal Osteoporosis	34
Tamsulosin Hydrochloride	30
Cellulitis	28
Empagliflozin	27
Lisdexamfetamine	27
Rosuvastatin	27
Atorvastatin	26
Escitalopram	26
Apixaban	25
Bupropion hydrochloride	25
Indapamide	25
Naltrexone/Bupropion	25
Irritable Bowel Syndrome (IBS)	24
Duloxetine	23
Sertraline	22
Immunizations in Children and Adolescents	21
Valsartan	21
Candesartan	19

Figure 45 - Top 25 DynaMed topics and total views, April 2024 to March 2025

	The PCN is in initial stages of collaboration with AI scribe vendors to test and evaluate incorporation of AI scribe technology into PCN RN/OHP encounters with a patient privacy and evidence based care focused approach.
Evaluation Activities	The annual Palliser PCN employee survey contains a question related to satisfaction with education. **Annual Employee Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method. 100% return rate. When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes. PCN Management and Administration: "*During the past 12 months, I have been satisfied with the amount and type of support and education that I receive from the PCN."* resulted in an average rating score of 93%.
Schedule B Indicators	Schedule B Screening Indicator results for the reporting period are summarized below:

SCREENING INDICATOR		FY 2024/25	FY 2023/24
Offers of screening maneuvers completed	Numerator	244245	227400
	Denominator	395567	389473
	Proportion	61.7%	58.4%

Figure 46 - Screening Indicator

This aggregate screening maneuver indicator includes 2024 HQCA report influenza immunization information. The 2025 HQCA report is not available until end of May 2025.

It is not possible to derive meaningful, actionable intelligence from the above indicator. It was not possible to find evidence that indicates a single aggregate screening completion indicator incorporating screening for many conditions supports understanding or improvement of primary care screening practices.

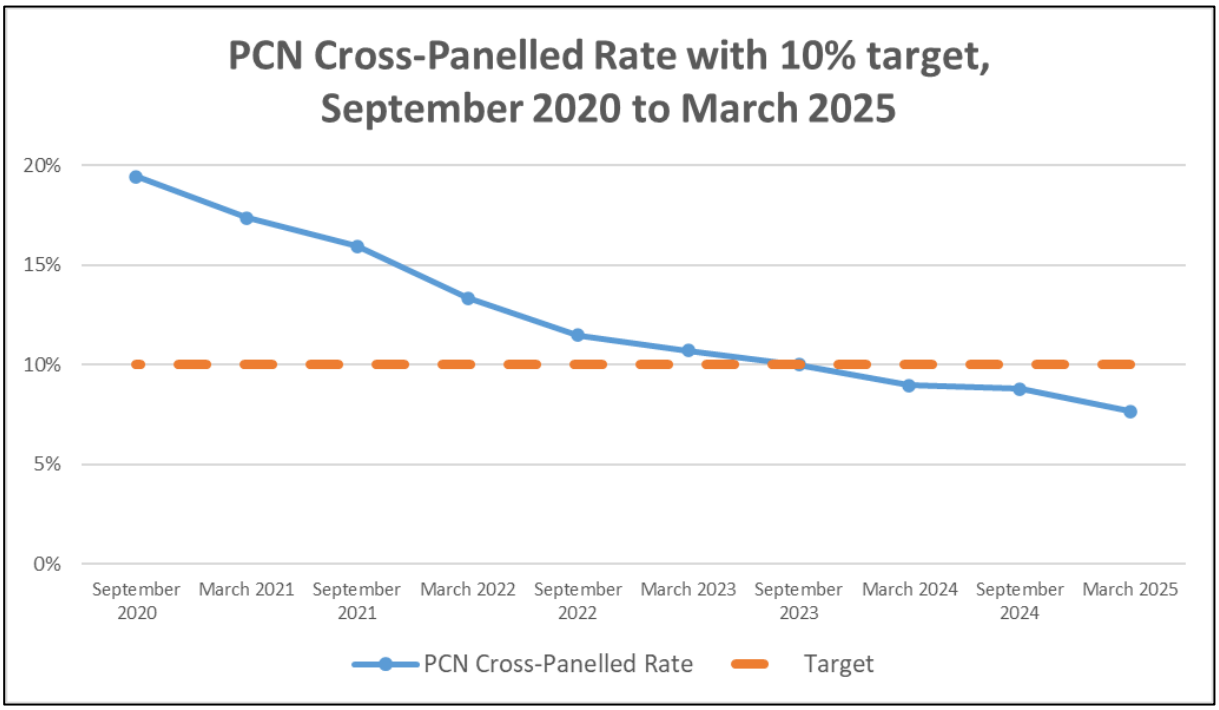
It could be suggested that the increase in proportion of screening maneuvers completed during the reporting period is partially due to changes in patient care modes (e.g. decrease in virtual care and increase in in-person care) and screening contexts post pandemic (e.g. increase in scheduled lab appointments, 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. 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.

The Schedule B Team Effectiveness Indicator location was not defined in the Annual Report Guidelines or Annual Report template. Results from the 2023/24 reporting period are based on the prior progress indicator instructions and did not use the Primary Care Team Dynamics Survey.

TEAM EFFECTIVENESS PROGRESS INDICATORS		FY 2024/25	FY 2023/24
Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	3	2
	Denominator	40	38
	Proportion	7.5%	5.3%
Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	3	2
	Denominator	40	38
	Proportion	7.5%	5.3%

Figure 47 - Team Effectiveness Indicators

PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4e	**Panel and Continuity**
Summary and/or Achievements	In the reporting period, the PCN supported 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. This included supporting teams to review their panels, contact patients, administratively inactivate patients, understand their CPSA obligations to see panelled patients and assist physicians to enroll in CPAR/CII. Where interested, physicians were also assisted to measure and interpret their access, compare to the current panel size and define an ideal panel size. At a PCN level, the cross-panelled rate is 7.7%, down from 8.9% in the last reporting period. Individual PCN physician/NP cross-panelled rates vary as seen below, with rates as low as 0.7% and as high as 28%. 90% of individual physician/NP cross-panelled rates are below 20% (down from 94% in the last reporting period), with 68% (previously 65%) already under the PCN target of 10% and 39% (previously 26%) under the PCN's stretch goal of 5% cross-panelled.  **Figure 48 - Overall PCN Cross-Panelled Rate over time**

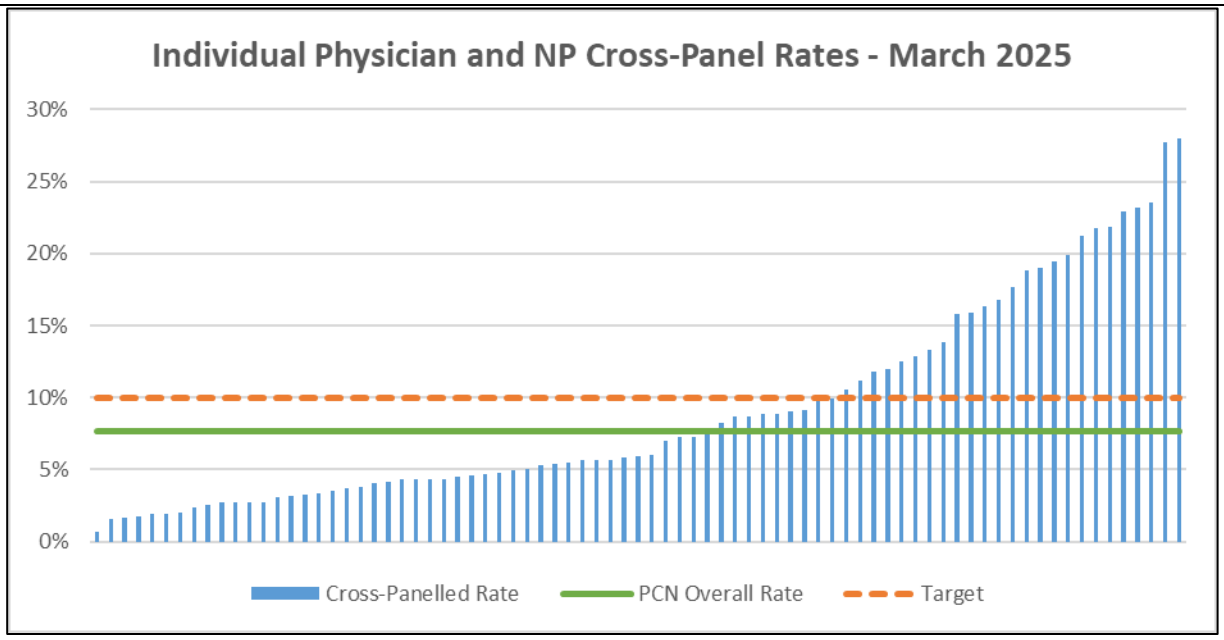


Figure 49 - Anonymous Physician/NP Cross-Panel Rates, with 7.7% PCN Rate and 10% target

Evaluation Activities

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 assess their current state, leveraging their EMR, and consider/test process improvements, ensuring standardized panel processes can be shared within the team (e.g. documented in clinic handbooks) to minimize variation and enable successful cross-coverage.

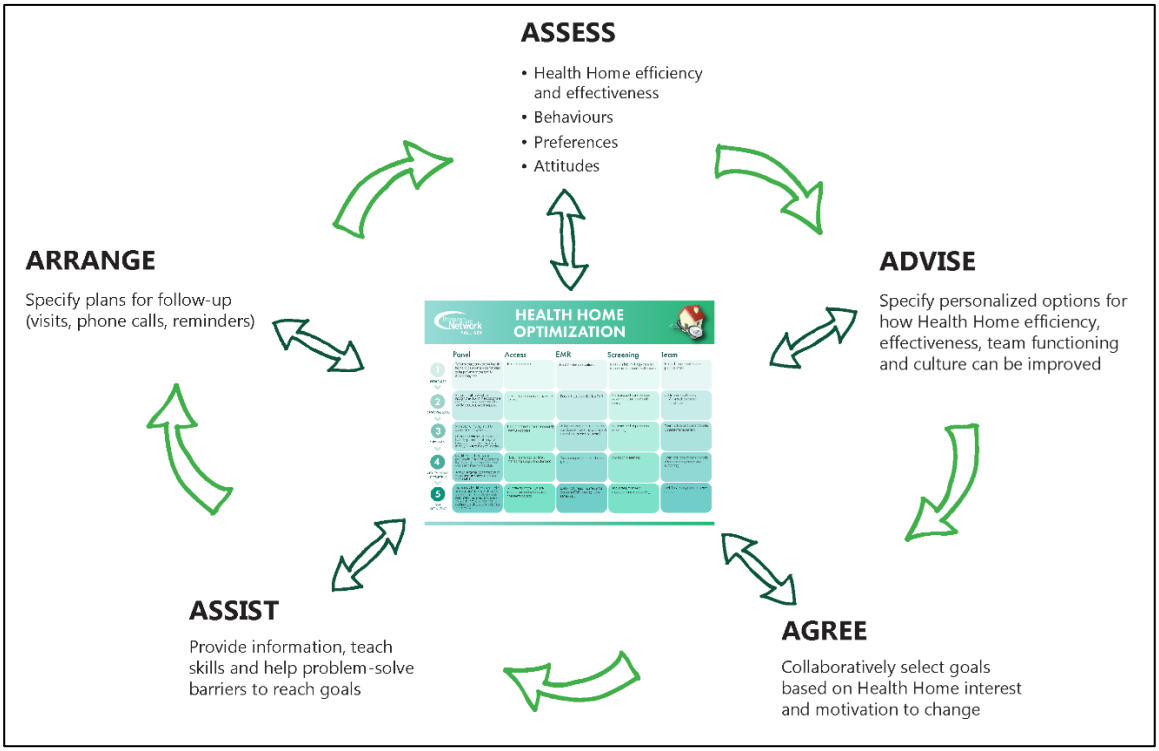
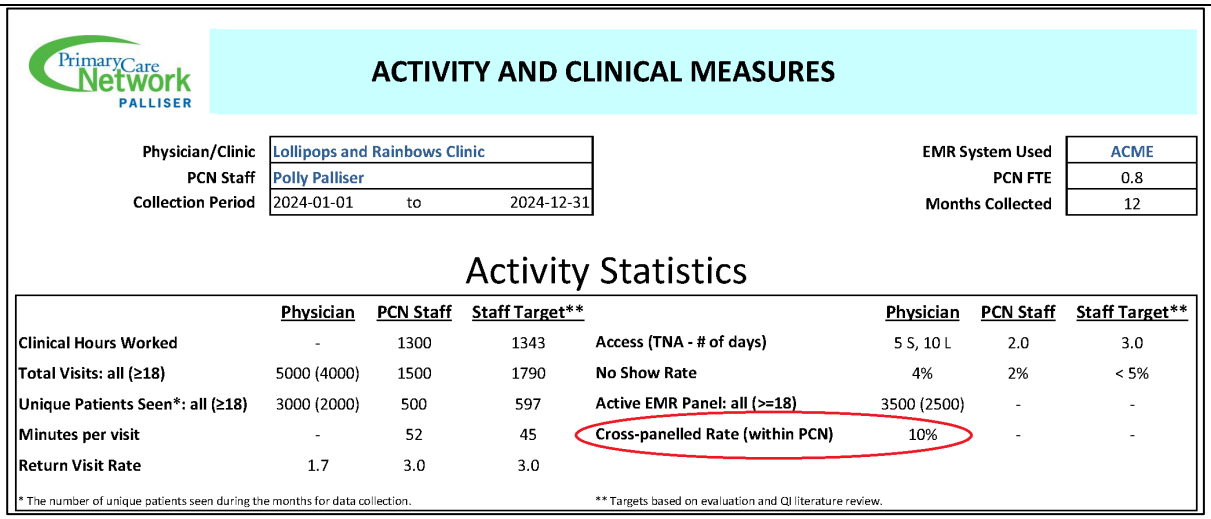


Figure 50 - Palliser PCN's Adapted 5 A's for Health Home Optimization Model

In the current iteration of its Activity and Clinical Measures sheet, the PCN has integrated the physician/ NP cross-panelled rate (seen below in Figure 51 in the Activity Statistics section) to support conversation about panel validation, CPAR/CII enrollment and a population health approach to panel management.



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic			EMR System Used	ACME
PCN Staff	Polly Palliser			PCN FTE	0.8
Collection Period	2024-01-01	to	2024-12-31	Months Collected	12

Activity Statistics

	Physician	PCN Staff	Staff Target**		Physician	PCN Staff	Staff 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)	10%	-	-
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 51 - Sample PCN Activity and Clinical Measures Sheet – Cross-panelled rate circled

A cross-panelled patient is one with more than one PCN family physician or nurse practitioner 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.

At a health home level, the cross-panelled rate is the number of patients on active EMR panels that are cross-panelled divided by the number of total patients on active EMR panels. If a health home with 1000 patients has a 10% cross-panelled rate, this means there are 100 patients identified with *both* a family doctor at this health home and at least one additional family doctor at a different health home across Palliser PCN.

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 (reduces chance of multiple health homes “quarterbacking” care)
- increases relational, informational, management continuity with the patient to maximize care efficiency and effectiveness

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

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

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

The PCN also uses HQCA reports as an additional, confirmatory measure of panel, continuity and screening success. This occurs both at a PCN and individual health home level.

- PCN level: The PCN utilizes its average physician continuity measure (78% in 2024 PCN Proxy Panel Report **– 2025 PCN Proxy Panel Report not available until end of May 2025**) to support a comparison with individual physician continuity when health homes engage in continuity quality improvement conversations and are interested in a baseline average for their local physician peers. When this occurs, a stratification of individual patients by continuity range (<50%, 50-80%, >80%) is often found to be a useful metric for comparison. The PCN’s 2024 stratification by continuity range (data up to March 31, 2023):

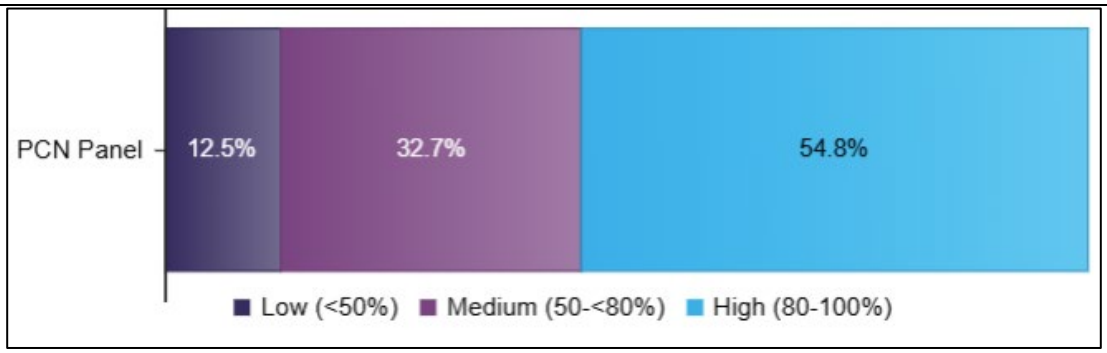


Figure 52 - 2024 HQCA Report Patient Continuity, by range of individual patient continuity (2025 HQCA report not available until end of May 2025)

Using the 2024 HQCA patient continuity rates and Palliser PCN's 2025 physician profile data, there are approximately 12,900 PCN patients with low continuity with their family physician/nurse practitioner. When the PCN looks at its cross-panel rate of 7.7% and measures 4,000 cross-panelled PCN patients (down 11% from 4,500 patients in April 2024 and down 51% from 8,300 patients in April 2021), it is possible to conclude that while some patients may have low continuity with their family physician due to visiting multiple health homes, twice as many patients may be seeking primary health care elsewhere due to other factors, such as delay to see family doctor or nurse practitioner, hours of operation, specialty procedures (e.g. pap by a different physician/nurse practitioners, cosmetic procedures).

- Health home level: Although physicians/nurse-practitioners in a multi-provider clinic are supported by the PCN to measure their internal continuity (percentage of the time patients are seeing their only family physician versus a colleague physician in the same clinic) using their EMR-sourced data, HQCA reports are necessary to measure external continuity.[8] Similar to the discussion at the PCN level, health home teams that are interested in maximizing continuity often drill into stratification of continuity by ranges in order to quantify and identify (with a Confirmed Panel Report) the number of patients with lowest continuity. These teams are supported to develop processes including flagging charts and contacting patients with the lowest continuity (<50%) to ensure that the health home is aware of its patients' primary health care encounters with other physicians/NPs and to identify barriers to patients seeking this care from their health home.

A significant activity related to panel management is the PCN's use of its Activity and Clinical Measures Sheet to support focused clinical quality improvement prioritization and evaluation. 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/NP/health home-level measurement added depending on level of health home team engagement, and
- the health home level – to provide a 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 PCN-defined Screening Indicators defined on the reverse side of the Measures sheet. Although this is used at an individual physician/NP/RN/OHP level, the data shown in the below Figures shows the PCN's aggregate data for all physician/NP and PCN RN/OHP encounters measured during the reporting period:

[8] "Panel Report Stories: Shea Wilks, Palliser PCN - Health Quality Council of Alberta." *Health Quality Council of Alberta*, 3 Oct. 2023, https://hqca.ca/wp-content/uploads/2023/10/HQCA-2023-Primary-Healthcare-Panel-Report-Program-Templates-SHEA-P3V2.pdf .

ACTIVITY AND CLINICAL MEASURES

Provider/Clinic	All of Paliser PCN			EMR System Used	Various
PCN Staff	All PCN Staff			PCN FTE (est., normalized from regular clinic hours worked)	43.5
Collection Period	2024-01-01	to	2024-12-31	Months Collected	12

Activity Statistics

	Physician/NP	PCN Staff	Staff Target**		Physician/NP	PCN Staff	Staff Target**
Clinical Hours Worked	-	66,755	77,924	Access (TNA - # of days)	0-65 S, 0-89 L	0-71	3.0
Total Visits: all (≥18)	242,214 (221,423)	66,673	103,899	No Show Rate	3%	5%	< 5%
Unique Patients Seen*: all (≥18)	69,515 (59,580)	25,301	34,633	Active EMR Panel: all (>=18)	103,109 (82,279)	-	-
Minutes per visit	-	60	45	Cross-panelled Rate (within PCN)	8%	-	-
Return Visit Rate	3.5	2.6	3.0				

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

** Targets based on evaluation and QI literature review.

Clinical Indicators (≥18)

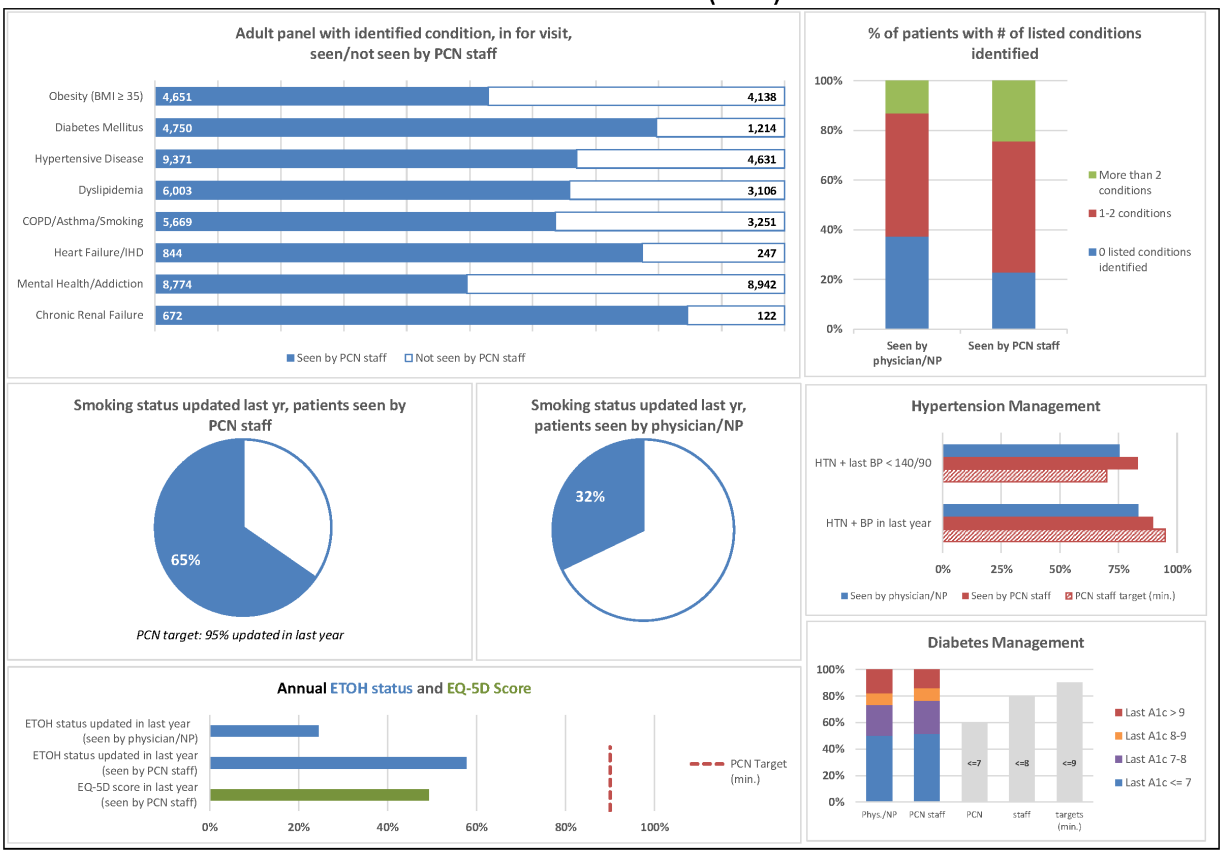


Figure 53 - 2024 PCN Activity and Measures Sheet (PCN physician/NP and RN/OHP EMR data)

Screening and Prevention Indicators (2025)

Provider/Clinic	**All of Paliser PCN**	**EMR System Used**	Various
PCN Staff	**All PCN Staff**	**PCN FTE**	43.5
Collection Period	2024-01-01 to 2024-12-31	**Months Collected**	12

			Screening rates			
Indicator	**Eligible**	**Detail**	**Patients seen by Physician/NP**	**Patients seen by PCN staff**	**PCN Average - EMR (2024)**	**PCN Average - HQCA (2024)**
Diabetes Screening	All > 40	A1c or Fasting Glucose Every 3 years	91%	95%	82%	(delayed)[1]
Cholesterol Screening	All 40-74	Every 5 years	92%	97%	94%	(delayed)[1]
Colorectal Screening	All 50-74	Colonoscopy every 10 years or FIT every 2 years	63%	69%	71%	62%[1]
Mammography	F 45-74	Every 2 years	68%	73%	66%	77%
Bone Mineral Density	M > 65	Once	36%	43%	37%	(not measured by HQCA)[2]
Bone Mineral Density	F > 65	Once	70%	78%	72%	(not measured by HQCA)[2]
Pap	F 25-69	Every 3 years	52%	59%	58%	70%
Blood Pressure	All > 18	Annually	73%	79%	74%	(not measured by HQCA)[2]
Weight	All > 18	Every 3 years	84%	90%	84%	(not measured by HQCA)[2]
Height	All > 18	Every 3 years	80%	79%	82%	(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	66%	72%	74%	(not measured by HQCA)[2]
Influenza Immunization	All > 6 mths	Annually	3%	9%	13%	31%

[1]HQCA issues in 2024 with measuring diabetes, cholesterol, colorectal cancer 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 54 - 2024 PCN Screening Indicator Annual Results on PCN ACM sheet

2024/25 changes to Activity and Clinical Measures Sheet:

- Modification of Diabetes Screening Indicator from A1c or Fasting Glucose every 5 years to 3 years, to align with clinical practice guidelines[9]
- Modification of measurement definition for mental/health addiction conditions to look at 1 year of diagnostic code history instead of 5 years of diagnostic code history in health home billing (retain looking at EMR problem list as well, where standardized entry enables measurement)

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

- Number of patients seen by PCN RNs/OHPs with chronic conditions identified as a proportion of those seen by PCN physician/NP in the last year (*Figure 55: a subsection of Figure 53*)
- Average PCN RN/OHP utilization and access measures (*Figures 56 and 58*)
- PCN RN/OHP and physician/NP no show rates *(Figure 59)*

[9] Diabetes Canada Clinical Practice Guidelines Expert Committee. *Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada*. Can J Diabetes. 2018;42(Suppl 1):S1-S325.

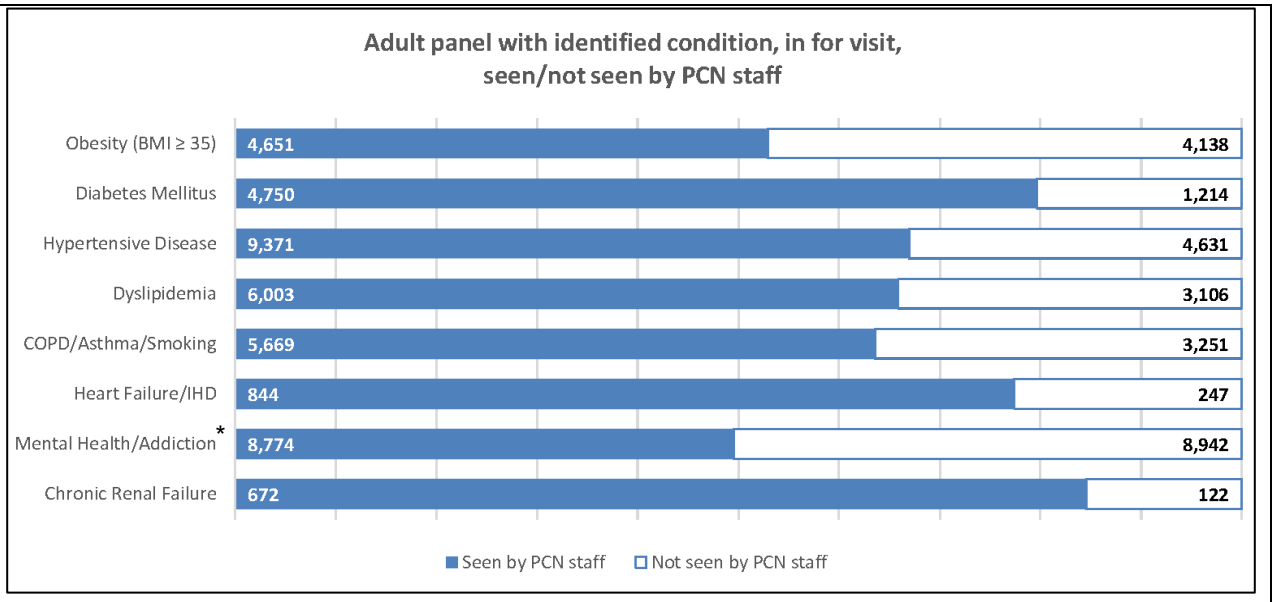


Figure 55 - Patients seen by PCN OHP vs. seen only by physician/NP, per condition grouping

* The number of patients seen by PCN RN/OHP/Physician/NP with Mental Health/Addiction issues is based on billing diagnostic codes and EMR problem list identification. This allows a more accurate count of patients experiencing these issues.

Below are selected aggregate and average PCN RN/OHP utilization measures for 2024/25 found on or calculated from data informing the ACM sheet:

Total unique patients seen by PCN RNs/OHPs	25,301
Total patient visits with PCN RNs/OHPs	66,673
Average number of patients seen by PCN RNs/OHPs per 1.0 FTE	581
Average minutes per patient	60
Average annual return visit rate	2.6

Figure 56 - Aggregate and average PCN RN/OHP utilization measures

It was not possible to find evidence that aggregation of access measures, such as Time to Third Next Available Appointment (TNA), provides actionable intelligence for improvement or accountability. For example, it was not possible to find evidence that average Time to Third Next Available Appointment is a reliable measure to increase understanding of individual provider access or be reliable for comparison between providers. As a result, when a team is looking to engage in access improvement and evaluate specific interventions, the PCN supports interested health home teams to follow best practice and measure access intermittently and for a time limited period. Visualization of an individual provider's TNA often occurs in the form of an annotated run chart, overlaid with other access measures such as Demand and Supply.

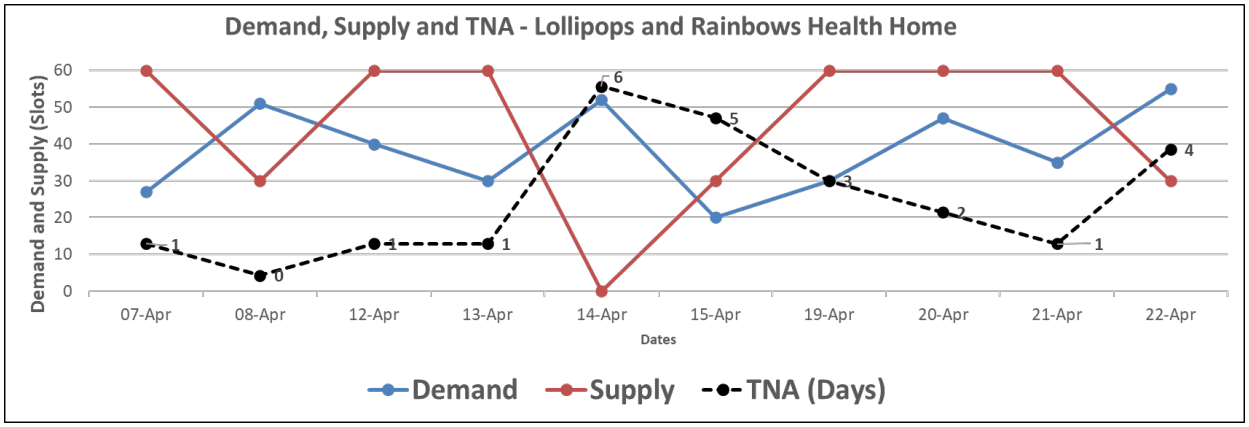


Figure 57 - Example visualization of Time to Third Next Available used in quality improvement

Despite the above reality, the below box and whisker plot may indicate a trend of lower access for PCN RNs/OHPs with smaller FTEs per individual clinic, when compared to those who have a larger FTE at a clinic.

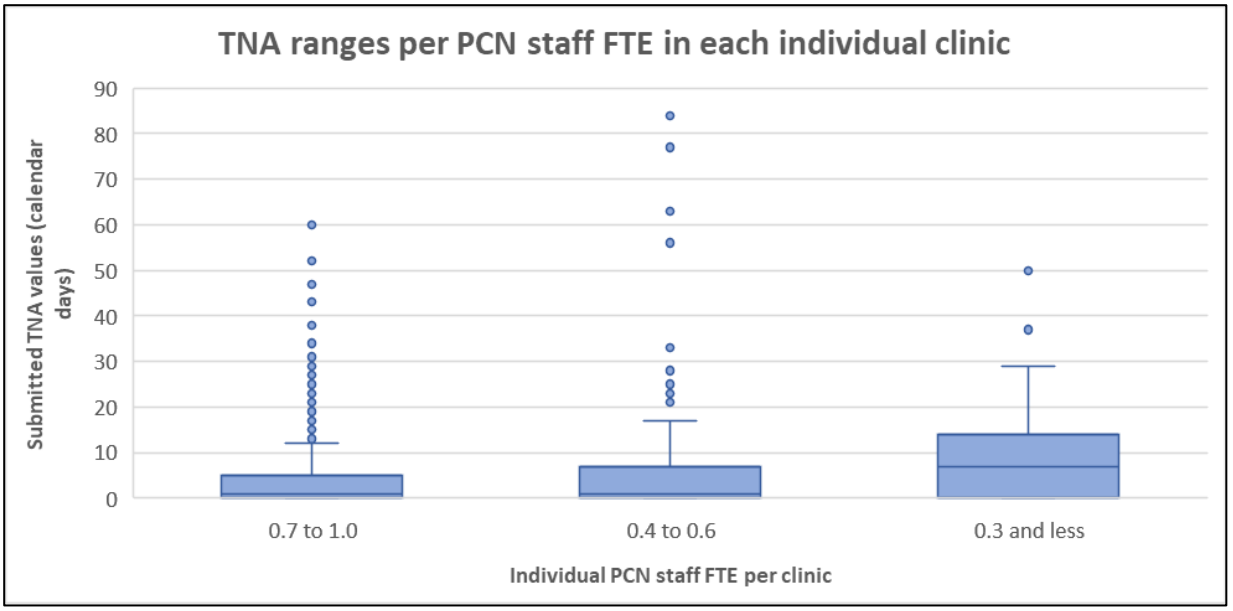


Figure 58 - Ranges of individual submitted TNA values for PCN RNs/OHPs, per staff-clinic FTE

Although there are many limitations including the relatively small number of PCN staff in each FTE range, as well as the lack of high quality published evidence to support measurement of aggregate TNA, the above data supports the informal observation that PCN RN/OHP access is more likely to be maximized (low TNA) with a mid-to-high clinic FTE, as patients can be referred to the RN/OHP during a greater proportion of the week.

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

Average no show rate, physicians	3.4%
Average no show rate, PCN BHCs	8.7%
Average no show rate, PCN non-BHCs	4.7%

Figure 59 - Average no show rates per provider type

The average PCN BHC no show rate, remains higher than other provider groups, but appears to have reduced across several reporting periods (7.4% in 2023/24; appears reduced across these last two reporting periods compared to 11.3% in 2022/23 and 10.4% in 2021/22). The decreased overall BHC no show rate may be the related to implementation of no show reduction strategies and support from PCN facilitators.

Overall, no show rates appear stable for physicians compared to the previous reporting period (3.1% in 2023/24), and has increased somewhat for non-BHC PCN RHPs, when compared to the two previous reporting periods (3.0% in 2023/24; 2.8% in 2022/23). This could be due to increased standardization of no show measurement concurrent with an increase in access measurement and improvement activities among some health home teams, including those participating in the Health Home Expedition.

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.

As seen in Figure 54, the PCN integrates HQCA PCN Proxy Panel screening indicators in the ACM sheet it provides to individual physicians and PCN RNs/OHPs. Unfortunately, HQCA screening information is limited when compared to the PCN's EMR data; accuracy of some HQCA data has been reduced for several years due to the PCN's understanding of HQCA issues with accessing Connect Care lab data.

	Highly engaged health homes also use their own HQCA proxy panel and confirmed panel reports as an additional, confirmatory data source to support review of screening indicators and evaluate patient utilization outside the health home, e.g. hospital admissions and ED utilization.
Barriers	Increased interest in HQCA physician/NP panel reports resultant from physicians' PCPCM and NPs' Nurse Practitioner Primary Care Program participation may provide an enhanced opportunity to increase data literacy among family practice providers and teams as they consider accelerating the use of population data to inform quality improvement prioritization. Increased recognition of the potential utility of HQCA panel reports may increase Health Home Optimization in the areas of Panel and Access as measured by the PCN. An increased understanding of the limitations of HQCA some data elements (described in above Evaluation Activities section) may increase engagement with health home data in general. Some teams may alternatively disengage further with data, including the PCN's EMR-sourced data, if limitations of HQCA data are believed to apply to all health data, including PCN-developed ACM sheets.
Schedule B Indicators	None defined; discussion of the PCN's use of HQCA reports, however, occurs in several locations in the Evaluation Activities above.
PCN Evaluation Logic Model Indicators	Please see Figure 32 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4f	**Engaged Leadership**
Summary and/or Achievements	Please see discussion in Objective 1: Accountable & Effective Governance above.
Schedule B Indicators	Indicator reporting and discussion occurs in Objective 1.
PCN Evaluation Logic Model Indicators	Please see Figure 15 for applicable evaluation indicators from the PCN's Evaluation Logic Model.
4g	**CII/CPAR**

How many participating physicians or participating providers are registered to your PCN?	90
Percentage of participating physicians or participating providers using a CII-CPAR compatible EMR?	94%
Percentage of participating physicians or participating providers routinely verify their panel?	94%
Percentage of participating physicians or participating providers have been included on a confirmation of participation (CoP) for CPAR submission?	94%
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?	94%
Percentage of participating physicians or participating providers are routinely submitting verified panel information to CII/CPAR?	81%

2.3. Primary Health Care Indicator Set – Reporting:

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 2024/25	FY 2023/24
1	Proportion of physicians measuring time to third next appointment	Numerator	90	89
		Denominator	90	90
		Proportion	100.0%	98.9%
#	PATIENT EXPERIENCE INDICATOR		FY 2024/25	FY 2023/24
2	Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	122	33
		Denominator	123	35
		Proportion	99.2%	94.3%
#	SCREENING INDICATOR		FY 2024/25	FY 2023/24
3	Offers of screening maneuvers completed	Numerator	244245	227400
		Denominator	395567	389473
		Proportion	61.7%	58.4%
#	GOVERNANCE INDICATOR		FY 2024/25	FY 2023/24
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 Health Standards Organization's Governance Functioning Tool in their self-assessment process?		YES	YES
4.2	If not, what self-assessment tool was used?		N/A	
4.3	Did the Board receive approval from Alberta Health for the use of this alternative tool?			
#	LEADERSHIP INDICATOR		FY 2024/25	FY 2023/24
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 2024/25	FY 2023/24
6	Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	3	2
		Denominator	40	38
		Proportion	7.5%	5.3%
6.1	Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	3	2
		Denominator	40	38
		Proportion	7.5%	5.3%
#	PCN REPORT ON PATIENT'S MEDICAL HOME READINESS (CII/CPAR)		FY 2024/25	FY 2023/24
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.** (This indicator will serve as a denominator for subsequent indicators.)		90	90
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	85	89
		Denominator	90	90
		Proportion	94.4%	98.9%
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	85	88
		Denominator	90	90
		Proportion	94.4%	97.8%
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	85	57
		Denominator	90	90
		Proportion	94.4%	63.3%
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	85	57
		Denominator	90	90
		Proportion	94.4%	63.3%
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	73	46
		Denominator	90	90
		Proportion	81.1%	51.1%

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

Figure 60 - Schedule B Indicator Report

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

PALLISER PRIMARY CARE NETWORK

FINANCIAL STATEMENTS

March 31, 2025

Palliser PCN

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

March 31, 2025

version 1.0

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 following statements are true.

	Name:	Title:	Approved	Date:
Physician Lead	Dr. Donovan Nunweiler	Board Chair	Yes	
AHS Lead	Dr. Gerry Prince	Board Vice-Chair	Yes	

Palliser PCN
Statement of Operations
For the Year Ended March 31, 2025

	Notes	2025 Budget (Unaudited)	2025 Actual (Audited)	2024 Actual (Audited)
Revenue				
Per Capita Funding - Operating		6,341,236	6,119,619	5,755,017
Per Capita Funding - Capital				
Interest and Investment Income		100,000	102,822	137,882
Fee For Service				
PCN Nurse Practitioner Support Program (NPSP) Funding		232,000	88,915	204,167
Shared Services (Specify in Notes)				
AH-AMA Agreement PCN Investment		478,421	478,421	463,432
Total Revenue		**7,151,657**	**6,789,777**	**6,560,498**
Expenses (Priority Initiatives)				
Professional Support within Health Homes		5,202,657	5,084,495	4,783,883
Measurement & Practice Improvement		689,000	609,506	629,673
PCN NPSP		232,000	88,915	204,167
Zonal Expenses (Specify in Details tab)				
Priority Initiative Subtotal		**6,123,657**	**5,782,916**	**5,617,723**
Expenses (Central Allocations)				
Evaluation				
PCN Administrative Lead Salary		161,000	168,425	164,585
PCN Administrative Lead Benefits		34,000	35,568	34,767
Other Management Salaries (Specify in Details tab)		318,000	290,090	289,674
Other Management Benefits (Specify in Details tab)		34,000	31,946	29,455
Administration (Specify in Details tab)		481,000	480,832	424,294
Information Technology				
Support Services (Specify in Details tab)				
Amortization				
(Gain)/Loss on disposal of Capital Asset(s)				
Central Allocations Subtotal		**1,028,000**	**1,006,861**	**942,775**
Total Expenses		**7,151,657**	**6,789,777**	**6,560,498**
Excess/(Deficiency) of Revenue Over Expenses		**$ -**	**$ -**	**$ -**

Palliser PCN
Statement of Financial Position (Audited)
As at March 31, 2025

		2025 Actual	2024 Actual
Assets			
Current Assets:	Notes		
Cash		$ 1,802,457	$ 1,642,774
Short-term investments		-	-
Accounts receivable		44,901	26,763
Prepaid expenses		49,702	21,702
Other assets		-	-
Total Current Assets		**1,897,060**	**1,691,239**
Capital Assets (Net Amortization) *[Schedule 2]*		-	-
Total Assets		**$ 1,897,060**	**$ 1,691,239**
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued liabilities	Note 4	739,600	706,987
Due to Alberta Health Services		-	-
		739,600	706,987
Non-Current Liabilities:			
Unexpended deferred revenue - AH	Note 5	391,538	385,925
Outstanding BPA Expenses (list in notes)	Note 5	385,212	268,327
Unexpended deferred revenue - Other	Note 5	-	-
Unexpended NPSP funding	Note 5	30,710	-
Unamortized capital contributions	Note 6	-	-
Operational Stability Fund	Note 8	350,000	330,000
Other liabilities		-	-
Total Liabilities		**1,897,060**	**1,691,239**
Net Assets:			
Net Assets *[SCNA]*		-	-
Closing Balance - Net Assets		**-**	**-**
Total Liabilities and Net Assets		**$ 1,897,060**	**$ 1,691,239**

Palliser PCN
Statement of Cash Flows (Audited)
For the Year Ended March 31, 2025

	2025 Actual	2024 Actual
Operating Activities:		
Excess/(Deficiency) of Revenue Over Expenses	$ -	$ -
Non-cash transactions		
Amortization	-	-
(Gain)/Loss on disposal of capital asset(s)	-	-
Amortization of deferred capital contributions	-	-
Change in non-cash working capital:		
(Increase)/Decrease in accounts receivable	(18,138)	(8,052)
(Increase)/Decrease in prepaid expenses	(28,000)	28,000
(Increase)/Decrease in other assets	-	-
Increase/(Decrease) in accounts payable and accrued liabilities	32,613	20,526
Increase/(Decrease) in amount due to Alberta Health Services	-	-
Increase/(Decrease) in Unexpended deferred revenue - AH	5,613	(6,890)
Increase/(Decrease) in Outstanding BPA Expenses	116,885	(142,521)
Increase/(Decrease) in Unexpended deferred revenue - Other	-	-
Increase/(Decrease) in Unexpended NPSP funding	30,710	(6,566)
Increase/(Decrease) in Operational Stability Fund	20,000	330,000
Increase/(Decrease) in other liabilities	-	-
Cash generated from/(used by) operations	159,683	214,497
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	159,683	214,497
Cash and investments at the beginning of the year	1,642,774	1,428,277
Cash and investments at the end of the year	**$ 1,802,457**	**$ 1,642,774**

Palliser PCN
NOTES TO FINANCIAL STATEMENTS
For the year ended March 31, 2025

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.

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 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.

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

c) Measurement of Financial Instruments

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

d) Cash and cash equivalents

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

e) Short-Term Investments

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

f) Capital Assets

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

g) Line of Credit Facility

At March 31, 2025, 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 6.70%.
The line of credit is secured by a general security agreement on the assets of the PCN. At March 31, 2025, there is no amount outstanding on this credit facility (2023 - $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.

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 $nil outstanding to Physicians at year end (2024 - $nil).
- 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 $20,000 outstanding to Alberta Health Services at year end (2024 - $nil).

4. BUDGET

The budget for 2025 was approved by the PCN Board of Directors in March 2024.

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:

	2025						2024
	AH	BPA	NPSP	OSF	Other entities	Total	Total
Balance at the beginning of year	385,925	268,327	-	330,000	-	984,252	810,229
NPSP repayment during the year			-			-	(6,566)
Received or receivable during the year, net of repayments	6,866,033	-	119,625		-	6,985,658	7,038,347
Transfer from Balance at the beginning of the year to approved BPAs	(385,925)	385,925				-	-
Restricted investment income & other income	102,822				-	102,822	137,882
Recognized as revenue - operating	(6,598,040)	(125,495)	(88,915)		-	(6,812,450)	(6,857,758)
Recognized as revenue - Interest	(102,822)		-			(102,822)	(137,882)
Transfer to purchase of Capital Assets	-	-			-	-	-
Transferred to UDR from expired BPAs	143,545	(143,545)			-	-	-
Transfer to OSF	(20,000)			20,000			
Balance at the end of year	391,538	385,212	30,710	350,000	-	1,157,460	984,252

BPA Calculations

BPA Taxonomy	BPAs Brought Forward From Previous Period with Approved Extension	New BPAs Approved	BPA Funds Spent During 2024-2025	Balance	Is the BPA expired as of March 31, 2025?	Expired BPA Funds	Outstanding BPA Funds
PPCN_BPA-2023-24_01	268,327	-	124,782	143,545	Yes	143,545	
PPCN_BPA-2024-25_01	-	385,925	713	385,212	No		385,212
	-	-	-	-			
Total BPA Funds as of March 31, 2025	268,327	385,925	125,495	528,757		143,545	385,212

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:

	2025			2024
	AH	Other entities	Total	Total
Balance at the beginning of year	-	-	-	-
Transferred from unexpended deferred revenue	-	-	-	-
Gains / (Losses) on Disposal of capital assets	-	-	-	-
Proceeds from disposal of capital assets	-	-	-	-
Less amounts recognized as revenue		-	-	
Balance at the end of year	-	-	-	-

7. PER CAPITA REVENUE

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

Calculation of Per capita	Enrollees		Rate	Amount
Eligible per capita payments				
April 2024	102,278	$	31	3,170,618
October 2024	103,774	$	31	3,216,994
Total eligilbe per capital payments for 2024/2025				**6,387,612**

8. OPERATIONAL STABILITY FUND

The Operational Stability Fund (OSF) Policy was reinstated by Alberta Health effective April 1, 2023. The purpose of this policy is to enable a PCN to maintain a fund that will provide operational stability and can be used for operational expenses not anticipated in its approved Annual Budget, or otherwise approved at the Minister's discretion. (Refer to 11.12 Operational Stability Fund Policy (April 2023)).

OSF Calculations			
Balance at the beginning of the year	$	330,000	**A**
OSF Funds spent in 2024/2025	$	-	**B**
Balance at the end of the year	$	330,000	**C = A-B**
Maximum eligible OSF	$	350,000	**D**
Allowable amount PCN Allocation	$	20,000	**E = D-C**
PCN Allocation to OSF	$	20,000	**F (This value should not exceed E)**

9. PCN NURSE PRACTITIONER SUPPORT PROGRAM (NPSP) FUNDING

Payments for NPSP funding are allocated quarterly to PCNs based on the approved number of NP full-time equivalents (FTEs) registered within the PCN NPSP at $145,000/year per 1.0 FTE

10. COMMITMENTS AND CONTINGENCIES

The PCN occupies a leased premises, with lease payments of approximately $63,000 per year until 2030.

11. ECONOMIC DEPENDENT

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

12. APPROVAL OF FINANCIAL STATEMENTS

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

Palliser PCN
Schedule 1 - Expenses by Object
For the Year Ended March 31, 2025

	2025		2024
	Budget (Unaudited)	Actual (Audited)	Actual (Audited)
Physicians: Clinical (Specify in Details tab)			
Physicians: in lieu of FFS			
Physicians: Administrative (Specify in Details tab)	243,000	213,165	203,163
Physicians: Other (Specify in Details tab)	290,000	231,484	216,920
Physicians Subtotal	**533,000**	**444,649**	**420,083**
Alberta Health Services - Purchased Services			
Alberta Health Services - Office Space			
Alberta Health Services - Other (Specify in Details tab)			
Non-Physician Direct Care Providers	4,851,657	4,631,476	4,477,601
Zonal Expenses			
Other Expenses (Specify in Details tab)	1,767,000	1,713,652	1,662,814
Amortization	-	-	-
Total Expenses	**$ 7,151,657**	**$ 6,789,777**	**$ 6,560,498**

Palliser PCN
Schedule 2: Schedule of Capital Assets (Audited)
For the Year Ended March 31, 2025

Cost

	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2024	97,080	-	97,080
Additions	-	-	-
Disposals	-	-	-
Cost at March 31, 2025	**$ 97,080**	**$ -**	**$ 97,080**

	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2024	97,080	-	97,080
Amortization for the period[1]	-	-	-
Amortization on disposals	-	-	-
Accumulated Amortization at March 31, 2025	**$ 97,080**	**$ -**	**$ 97,080**
Net Book Value March 31, 2025	**$ -**	**$ -**	**$ -**
Net Book Value March 31, 2024	**$ -**	**$ -**	**$ -**

Palliser PCN
Nurse Practitioner Support Program Analysis Working Paper (Unaudited)
For the Year Ended March 31, 2025

Quarters	AH Approved FTE(s)	NPSP Funding from AH	PCN Recorded FTE(s)	PCN Recorded NPSP Funding	Note Req'd?
April 1, 2024 - June 30, 2024	1.6	$ 58,000.00	1.045	$ 37,897.00	Yes
July 1, 2024 - September 30, 2024	0.6	$ 21,750.00	1.045	$ 37,897.00	Yes
October 1, 2024 - December 31, 2024	1.1	$ 39,875.00	0.362	$ 13,121.00	Yes
January 1, 2025 - March 31, 2025	0.0	$ -	0.000	$ -	No
Total		**$ 119,625.00**	0.613	**$ 88,915.00**	
Difference between AH and PCN NPSP		$ 30,710.00			

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

NOTES

Total NP Expenses	$ 88,915.00

Total NP Expenses Total Expenses for NPSP Program including salaries, space, EMR, etc

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

Palliser PCN
Staffing Summary (Unaudited)

	Budget as at March 31, 2025			Actual as at March 31, 2025			Actual as at March 31, 2024		
Participating Clinics	40			40			40		
Participating Physicians	97			90			90		
Participating Nurse Practitioners (NPPCP)	0			4			0		
Enrollees	102,278			104,643			102,278		
	Budget FTE as at Mar.31, 2025	**Budget Cost ($) Apr.1, 2024 to Mar.31, 2025**	**Budget Head Count at Mar.31, 2025**	**Actual FTE as at Mar.31, 2025**	**Actual Cost ($) Apr.1, 2024 to Mar.31, 2025**	**Actual Head Count at Mar.31, 2025**	**Actual FTE as at Mar.31, 2024**	**Actual Cost ($) Apr.1, 2023 to Mar.31, 2024**	**Actual Head Count at Mar.31, 2024**
Direct Care Provider (DCP)									
Nurse Practitioner	1.60	232,000	2	0.61	88,915	1	1.63	204,167	2
Registered Nurse	36.90	3,722,907	50	39.09	3,909,561	52	34.00	3,418,884	47
Licenced Practical Nurse									
Social Worker									
Dietitian									
Pharmacist									
Physiotherapist									
Occupational Therapist									
Mental Health Therapist									
Behavior Health Consultant	8.50	896,750	13	6.00	633,000	7	8.10	854,550	12
Cardiac Rehab Exercise Specialist									
Cardiac Rehab Nurse									
Exercise Specialist									
Midwifery Services									
Psychologist									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Total Direct Care Provider	**47.00**	**4,851,657**	**65**	**45.70**	**4,631,476**	**60**	**43.73**	**4,477,601**	**61**
Clinical Support Staffing									
Referral Coordinator									
Medical Office Assistant									
Facilitator									
Program Manager/Coordinator									
Clinical Coordinator									
Clinical Management									
Measurement and improvement	4.50	436,000	5	4.40	421,491	5	4.30	415,471	5
Total Clinical Support Staffing	**4.50**	**436,000**	**5**	**4.40**	**421,491**	**5**	**4.30**	**415,471**	**5**
Admin and Support Staffing									
Administrative Lead - Salary	1.00	161,000	1	1.00	168,425	1	1.00	164,585	1
Administrative Lead - Benefits		34,000			35,568			34,767	
Other Management	3.00	352,000	3	2.70	322,036	3	2.70	319,129	3
Finance									
Human Resources									
Administrative Assistant	3.00	197,000	3	3.20	218,869	4	2.70	187,597	3
Information Technology									
Research									
Evaluation									
Communications									
Communications									
Other {specify}									
Other {specify}									
Other {specify}									
Total Admin and Support Staffing	**7.00**	**744,000**	**7**	**6.90**	**744,898**	**8**	**6.40**	**706,078**	**7**
Total PCN Staffing	**58.50**	**$6,031,657**	**77.00**	**57.00**	**$5,797,865**	**73.00**	**54.43**	**$5,599,150**	**73.00**

Palliser PCN
Details Required by Alberta Health on Line Items (Unaudited)
For the Year Ended March 31, 2025

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

Statement of Operations

Line item	Description	Breakdown
B15	Shared Services	Not applicable
B30	Zonal Expenses	Not applicable
B37	Other Management - Salaries	-
	Patient's Medical Home Optimization Director (1.0 FTE)	128,523
	Clinical Supervisors (1.7 FTE)	161,567
		-
	Total	290,090
B38	Other Management - Benefits	-
	Patient's Medical Home Optimization Director (1.0 FTE)	15,244
	Clinical Supervisors (1.7 FTE)	16,702
		-
	Total	31,946
B39	Administration	-
	Board meeting stipends - Physicians	40,649
	Payroll - Exec assistant, Admin assistant, Finance Clerk (3.2 FTE)	218,869
	Professional Services -legal, accounting, HR, etc.	70,329
	Insurance, computers, telephones, office supplies	73,112
	Central Office – rent, utilities, janitorial	77,873
		-
	Total	480,832
B41	Support Services	Not applicable

Schedule 1: Expenses by Object

Line item	Description	2025 Actual
A8	Physicians: Clinical	Not applicable
A10	Physicians: Administrative	
	Board meeting stipends	$ 40,649
	Supervision/program planning stipends	$ 172,516
	The payments made were in accordance with the payment criteria in the 2025-2028 business plan.	$ -
	Total	$ 213,165
A11	Physicians: Other	
	Office Rental/clinic supports	$ 140,863
	Education/training/QI stipends - Physicians	$ 90,621
	The payments made were in accordance with the payment criteria in the 2025-2028 business plan and the 2024/2025 budget.	$ -
	Total	$ 231,484
A16	Alberta Health Services - Other	Not applicable
A19	Other Expenses	
	Education, training and orientation	$ 83,696
	Medical & IT equipment and renovations	$ 26,018
	DynaMed & ScreenCloud subscriptions	$ 22,027
	RNs/OHCP: Travel and other supplies	$ 71,130
	Measurement and Improvement: Payroll (4.4 FTE)	$ 421,491
	Measurement and Improvement: Travel and other supplies	$ 123,078
	Administrative Lead: Payroll & benefits	$ 203,993
	Other Management: Payroll & benefits	$ 322,036
	Payroll - Exec assistant, Admin assistant, Finance Clerk (3.2 FTE)	$ 218,869
	Professional Services -legal, accounting, HR, etc.	$ 70,329
	Insurance, computers, telephones, office supplies	$ 73,112
	Central Office – rent, utilities, janitorial	$ 77,873
		$ -
	Total	$ 1,713,652

Palliser PCN
Variance Analysis (Unaudited)
For the year ended March 31, 2025

Statement of Operations	2025 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in the Statement of Operations
Revenue				
Per Capita Funding - Operating	(221,617)	-3%	No	Expenses were lower than budgeted. Therefore, revenue (deferral method) is lower.
Interest and Investment Income	2,822	3%	No	
PCN Nurse Practitioner Support Program (NPSP) Funding	(143,085)	-62%	Yes	There were less Nurse Practitioner staff and therefore grant funding decreased for the year.
Shared Services (Specify in Notes)	-	-%	n/a	
AH-AMA Agreement PCN Investment	-	0%	No	
0	-	-%	n/a	
Total Revenue	(361,880)	**-5%**	Yes	Expenses were lower than budgeted. Therefore, revenue (deferral method) is lower.
Expenses (Priority Initiatives)				
Professional Support within Health Homes	118,162	2%	No	There were staff vacancies during the year.
Measurement & Practice Improvement	79,494	12%	Yes	There was less Physician stipends for QI training.
PCN NPSP	143,085	62%	Yes	There were less Nurse Practitioner staff and therefore expenses decreased for the year.
Zonal Expenses (Specify in Details tab)	-	-%	n/a	
Priority Initiative Subtotal	**340,741**	**6%**	**Yes**	There was less Physician stipends and less Nurse Practitioner staff during the year.
Expenses (Central Allocations)				
PCN Administrative Lead Salary	**(7,425)**	-5%	Yes	This 1.0 FTE position is employed by AHS, and the salary/benefit costs are billed monthly to the PCN. The variance relates to the budget being lower than the actual cost of the position.
PCN Administrative Lead Benefits	**(1,568)**	-5%	Yes	
Other Management Salaries (Specify in Details tab)	**27,910**	9%	Yes	There was a staff vacancy during the year.
Other Management Benefits (Specify in Details tab)	**2,054**	6%	Yes	There was a staff vacancy during the year.
Administration (Specify in Details tab)	**168**	0%	No	
Information Technology	**-**	-%	n/a	
Support Services (Specify in Details tab)	**-**	-%	n/a	
Amortization	**-**	-%	n/a	
(Gain)/Loss on disposal of Capital Asset(s)	**-**	-%	n/a	
Central Allocations Subtotal	**21,139**	**2%**	**No**	
Total Expenses	**361,880**	**5%**	**Yes**	There were staff vacancies during the year.
Excess/(Deficiency) of Revenue Over Expenses	**-**	**- %**	**n/a**	

Schedule 1 - Expenses by Object	2025 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in Schedule 1
Physicians: Administrative (Specify in Details tab)	29,835	12%	Yes	Board stipends were lower than budgeted.
Physicians: Other (Specify in Details tab)	58,516	20%	Yes	Education/training stipends were lower than budgeted.
Physicians Subtotal	**88,351**	**17%**	**Yes**	Board stipends and Education/training stipends were lower than budgeted.
Alberta Health Services - Purchased Services	-	-%	n/a	
Alberta Health Services - Office Space	-	-%	n/a	
Alberta Health Services - Other (Specify in Details tab)	-	-%	n/a	
Non-Physician Direct Care Providers	220,181	5%	Yes	There were staff vacancies during the year.
Zonal Expenses	-	-%	n/a	
Other Expenses (Specify in Details tab)	53,348	3%	No	There were staff vacancies during the year.
Amortization	-	-%	n/a	
Total Expenses	**361,880**	**5%**	**Yes**	

Other Statements and Schedules	Explanations
Staffing summary	The physicians choose the employee type that they wish to access within their clinic. For 2025: - There were more RNs chosen by clinics, therefore RN FTE is higher than budget. - There were less BHCs chosen by clinics, therefore BHC FTE is lower than budget.

Palliser PCN
Board of Directors Composition as of March 31, 2025
Legal Model 2

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

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

Director Name	Director Role (as per Articles of Association)	NPC or AHS or Community	Length of term	Term Set to Expire	Additional Information
Dr. Donovan Nunweiler	Chair	Physician group	3 years	Jul 2027	
Dr. Gerry Prince	Vice Chair	AHS	3 years	Jul 2029	
Dr. Nicus Gildenhuys	Director	Physician group	3 Years	Jul 2025	
Dr. Ahmed Al-Abayachi	Director	Physician group	3 years	Jul 2025	
Dr. Sally Bolstad	Director	Physician group	3 years	Jul 2025	
Dr. Gloria Tainsh	Director	Physician group	3 years	Jul 2025	
Dr. Waltie Vermeulen	Non-Voting Director	Physician group	1 year	Jul 2025	
Trevor Inaba	Director	AHS	3 years	Jun 2025	