Palliser Primary Care Network

BUSINESS PLAN Renewal (BPR)

Version 1.0

April 1, 2024 to March 31, 2027

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Summary of PCN Key Information

Name of the PCN:	**Palliser Primary Care Network**		
Geographic Area:	South Eastern Alberta (including Bassano, Bow Island, Brooks, Medicine Hat and Oyen		
Proposed Term of Plan:	April 1, 2024 to March 31, 2027	**Provincial Legal Model:**	#2

Number of:	**Clinics**	**Core Physicians**	**Panel # of Patients per last management report from AH of** October 1, 2023	**Total Population in PCN area:**
Participating in PCN	43	84		
Within PCN Geographic Area	44	87	102,263	114,800 (est)

Anticipated Direct Care Provider Staffing[1] (FTE) for fully implemented plan:	46.9
36.9 Registered Nurses 1.5 Nurse Practitioners (NP Support Program	8.5 Registered Social Worker (Behavioural Health Consultants – BHC)

All Other Anticipated Staffing (FTE) for Fully Implemented Plan:	11.5

Clinical Support Staffing	**Administrative Staffing**	**Support Staffing**
Measurement & Practice Improvement: 1.0 PMHO Evaluation Manager 1.0 Analyst 2.0 Facilitator 0.5 Executive Associate	*PCN Administrative lead:* 1.0 Executive Director[4] *Other Management:* 1.0 PMHO Director 2.0 Education & Clinical Supervisor *Admin asst.:* 1.0 Executive Assistant 1.0 Finance Clerk 1.0 Admin support	

Anticipated Staffing (FTE[2]) Total for fully implemented plan	58.4

Priority Initiative

1. **Professional Support in Health Homes**
2. **Measurement & Practice Improvement**

[1]Indicates staffing by designation, allowing provincial rollup of data. Staffing by role, indicated in descriptions of Priority Initiatives (Sections 2), is less accurate when rolled up due to customization to local conditions.
[2]NP's not funded under the PCN NP Support Program, i.e. not registered with the PCN or shadow billing.
[3]Document only the Full Time Equivalent (FTE) for the designated Medical Director role.
[4]Cannot exceed 1.0 FTE

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Employee Benefits as a % of Salary	Executive Director benefits as a percentage of salary equals approximately 20%. Other Management benefits as a percentage of salary equals approximately 11%. Non-management employee benefits as a percentage of salary equals approximately 12%.
Contracts Between PCNs	None
Other important Factors	The South Zone is unique in only having 2 PCNs. Patient care pathways do not tend to cross over between PCNs for family practice. The PCNs have worked closely since inception and share expertise where appropriate.

Confirmation of provider engagement

☒ **Palliser PCN** confirms that, as part of the business planning process, all PCN core providers were engaged and properly advised if their responsibility to review this business plan renewal and given appropriate opportunity to submit their feedback.

Provider engagement timeline

TIMELINE	ACTION ITEM	ACTION ITEM DETAIL	STATUS
March 2023	Physician Town Hall	• Physician brainstorming event focused around provincial objectives	Complete
May 2023	Physician Surveys	• Annual survey of physicians	Complete
June 2023	Physician AGM	• Physician AGM held, including open forum opportunity for physicians to provide comments on the current operation of the PCN	Complete
November 2023	Physician Town Hall	• Physicians review excerpts of Draft Business Plan	Complete
December 2023	Physician Member review of Draft Business Plan	• Comment/feedback from physicians to be sent in writing to Executive Director	Complete
January 2024	Physician Member review of significant changes	• Physicians review any significant changes to the Draft Business Plan	Complete
June 2024	Business Plan to each physician	• A copy of the signed business plan will be provided to each physician once approved by Alberta Health	

1. Overview of Local Environment

Priority Initiative(s) and Element(s)	• Professional Support in Health Homes
	  ○ Addition of RNs / Other Professionals to Physician Offices
	• Measurement & Practice Improvement
	  ○ Form and support Health Home teams and implement practice improvement methodologies including panel identification and management

Process for identifying priorities and elements	• Formal and informal physician and non-physician community engagement to assess current needs, forecast future needs • Vital Conversations community engagement activity patient feedback • PCN patient, physician and employee survey • Network of Executive Directors PCN ED participation • PCN Forums and other provincial collaboration activities • Physician town halls and other engagement activities • Quarterly engagement meetings with community not for profit EDs • Review of available community and population data
Sources of Evidence Used to Inform Priorities	**1. Geography and Population:** The PCN covers the patient population in a geographically distinct area in south-eastern Alberta. The PCN has used Statistics Canada Census and Population Estimate numbers from 2016 to 2022 to arrive at a 2023 population estimate of 114,800 residents in the area served by the PCN. The population resides in the following communities: Bow Island and area Total population approx. 6,500 Brooks, Bassano and area Total population approx. 25,200 Medicine Hat and area Total population approx. 80,500 Oyen and area Total population approx. 2,600

	PCN enrollee count at October 2023 is 102,263. Using the population estimate above, there are approximately 12,500 “un-enrolled” patients (11% of population). This comprises patients that are: 1. Not enrolled **and without a family doctor** (i.e. “unattached”) and either: A. Seeking a family doctor in the area served by the PCN B. Not seeking a family doctor in the area served by the PCN 2. Not enrolled **but with a family doctor in the PCN** (“attached” but not enrolled) and either: A. With no visit to a family doctor in the last 3 years (e.g. young, healthy males) B. Having only recently (<3 years) obtained a family doctor in the PCN* *The PCN may be waiting 18-36 months for patients to be enrolled to a new provider using the Alberta Health 4-cut process 3. Enrolled or attached elsewhere; either: A. Enrolled to a provider in an area not served by the PCN (e.g. Taber, Strathmore) B. Enrolled to a non-PCN provider in the area served by the PCN (there may be ~3 of these physicians at a given time) It would be challenging to survey the “unattached” patients (option 1.A. in the above list), given the inability to specifically identify them in any data sets available to the PCN. For example, Alberta Health does not provide the PCN with a list of patients who are enrolled to the PCN – only aggregate counts by physician. As a result, it is not possible to estimate the distribution of these patients into the subcategorizations above in order to know how many patients do not currently have a family doctor. Further, it is unclear if there are system issues affecting the reliability of Alberta Health’s PCN enrollee count process. From 2006-2010 the PCN experienced a steady increase in physician members which in turn led to a steady increase in enrollees. From 2011 to present, the PCN saw maximization in eligible physician membership with the PCN reaching 94% of eligible physicians in the 2021-2024 Business Plan. During this time, patient enrollee numbers rose, peaked in April 2020 and then declined in each subsequent period. As the enrollee number reached its peak, it also came closest to aligning with the PCN population estimate.

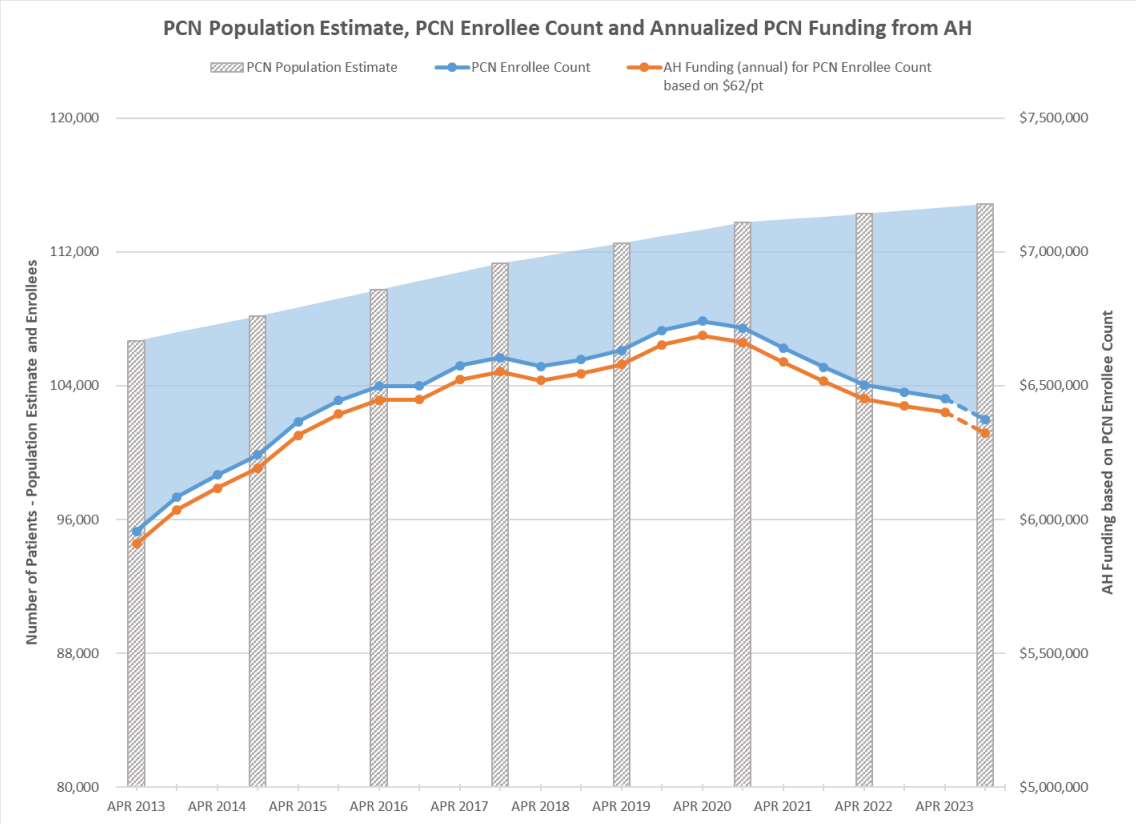


Figure 1 – PCN Population Estimate, Enrollee Count and Annualized PCN Funding from AH, April 2013 to October 2023 (gap between population estimate and enrollee count in blue)

It is difficult to determine exactly why the PCN enrollee count is dropping and diverging from the population estimate. Possible reasons:

- The PCN may be unaware of new physicians to the community and is delayed in signing them up. Currently relying on word-of-mouth to identify new physicians to approach.
- Delay in maintaining enrollees when physicians leave: When physicians leave the community and new physicians join, there is an up-to-three-year delay in having lost patient enrollees return to the PCN enrollee count.
- Patient activity during the pandemic: Perhaps the number of patients receiving any care from a PCN physician dropped during the pandemic. Increased patient use of virtual care from non-PCN physicians (e.g. Telus Health/Babylon) or prescribing pharmacists may have had an effect. (PCNs across the province have seen similar enrollee count drops during this time.)
- Physician activity during the pandemic: Perhaps physicians are seeing fewer patients. This may be a result of reduced demand/capacity because of covid, practice changes including reduction of public walk-in clinics or daily visit cap.
- There is an unknown flaw in the 4 cut method affecting PCN enrollee counts. The PCN does not receive PHNs from Alberta Health and is therefore unable to validate enrollee counts. The PCN has requested this detail, without success, since 2006. Additionally, many other PCNs have reported similar observations with unexpected drops in enrollee counts over the same time period.

Potential remedies:

- Increased communication between AHS and PCN when there is a new physician in the community: to minimize loss of enrollees between leaving and joining physicians
- Patient and physician activity may return to pre-pandemic levels and enrollee counts may grow again.
- Panel cleanup, reduction in cross-panel rate and CPAR participation may result in PCN physicians accepting additional patients.
- During FY 2022/23, there were approximately 3 PCN physicians accepting new patients at any time. The Palliser PCN website homepage link listing this information has been updated monthly since 2015. Last year, there were 13,500 patient visits to this homepage link. The listing is also distributed to:
    - emergency departments
    - walk-in clinics
    - Stabilization & Transition Clinic
    - 24 different community resources (by email)
    - Alberta Find-A-Doc website administrators
- These steps – to widely list physicians currently accepting new patients – have been taken to minimize the number of patients in the area served by the PCN who are unattached and seeking a family doctor.

According to the 2020 HQCA PCN panel report, approximately 10% of Albertans were "Health system non-users". Given that these patients, by definition, have not had an interaction with a GP, specialist, urgent care, emergency departments or hospitals in a 3 year period, it would stand to reason that they cannot be enrolled to any PCN in the province. In 2023, the provincial rate was measured at 2% (please see HQCA Burden of Illness table, page 11). Therefore, it should not be surprising if there is a difference of at least 2-10% between geographic population and PCN enrollee count.

HQCA was asked to speculate on why there may have been such a significant drop in provincial "health system non-users" in only three years. HQCA postulates that the drop in system non-users is related to the significant rise in virtual visits during the pandemic. It is also possible that the methodology for measurement changed dramatically over this time. As indicated above, *there is currently a 10% difference between Palliser PCN area population estimate and enrollee count.*

Data sources considered in measuring geography and population distribution were:

- Statistics Canada 2006, 2011, 2016 Censuses, 2015-2022 Population Estimates, Annual Demographic Estimates
- HQCA Palliser PCN-level proxy report (data up to March 2022)
- Alberta PCN Dashboard (data up to March 2021)
- Alberta Health PCN and LGA Community Profiles (data up to March 2021)
- CIHI Your Health System reports
- Palliser PCN clinic Electronic Medical Record (EMR) systems (97% of clinics with an EMR providing access to the PCN)
- Alberta Health Interactive Health Data Application (data up to 2022)

2. Pertinent demographic characteristics

The population is split almost evenly between male and female (49% to 51%, respectively). A breakdown by age is as follows:

Under 1:	0.7%
1 to 17:	16.2%
18 to 34:	19.9%
35 to 64:	42.2%
65 to 79:	16.0%
80 +	5.0%

Within the PCN, there is a higher percentage of patients over 65 than the provincial average (21.0% within the PCN compared to 15.6% for the province). The average age is also higher (43.8 years vs 39.7 provincially). This results in greater service needs for chronic disease management and seniors care.

(HQCA 2021/22 report provided May 2023)

Within the PCN, there are small Mennonite and immigrant communities. Statistics Canada's most recent Census estimated the Mennonite population in the Palliser PCN geographic area at 1,240. In terms of immigration, Saamis Immigration Services Association in Medicine Hat reported migration of 200 Ukrainian evacuees between 2022 and 2023. Over the same period there were also approximately 200 government assisted refugees primarily coming from Afghanistan, Syria, Congo, Venezuela, Cuba, Iraq, Ethiopia, Columbia and Eritrea. Within the PCN area, the city of Brooks has the largest proportion of immigrant and non-permanent residents, at approximately 37% of population.

(Statistics Canada 2021 Census, Saamis Immigration Association 2023)

Additionally, there is a military base within the PCN boundary. Approximately 0.7% of the PCN enrollees identify as First Nations with treaty status or Inuit, compared to 2.4 % province wide.

(Alberta Health Palliser PCN Profile 2023)

3. Health Status – Specific Health Needs in Health Homes

PCN-level analysis:

The PCN uses data available from PCN Dashboards, Alberta Health Community Profiles, the Health Quality Council of Alberta and PCN clinic EMR systems to look at data trends across the geographic area. As the PCN operates in a decentralized model, it is most commonly interested in the subsets of population in each Health Home in the PCN. This data is primarily contained in clinic specific electronic medical records (EMRs). Over time, reliability of clinic EMR data improves and assists in validating information in other data sets.

Chronic Disease:

- Alberta PCN Dashboard (data up to March 2021)
- Alberta Health PCN and LGA Community Profiles (data up to March 2021)

Use of the Alberta PCN Dashboard, Alberta Health PCN and Community Profile data sets and CIHI Your Health System reports presents challenges for the following reasons:

- Data not current (Alberta Health Dashboard and Profiles: up to March 2021; CIHI reports: data age can be anywhere from 2011-2022, depending on indicator)
- Profiles estimate a PCN area population of 117,014 (Local Geographic Area profiles) or 105,700 (PCN profile); disparity with the 2023 StatsCan-based population estimate for the PCN area of 114,800 causes uncertainty regarding data accuracy, as do disparities between chronic disease incidence between AH and HQCA data (e.g. ischemic heart disease incidence of 4.2% vs 10.2%, respectively).
- For Alberta Health data, the PCN must navigate the option to consider either 5 separate community profiles, a PCN-level profile or South Zone-level data which cannot be drilled down to a Palliser PCN-specific context.

A summary table of age-standardized chronic disease prevalence rates per 100 population is found below:

	AH Community (LGA) Profiles							AH PCN-level Profile	
Chronic Disease Prevalence (%)	**Alberta**	**Medicine Hat**	**Cypress County**	**Newell**	**Oyen**	**County of Forty Mile**	**Average across PCN area**	**Alberta PCNs**	**Palliser PCN**
Hypertension	20.6	21.7	21.6	26.3	23.5	21.3	22.9	18.6	21.4
Diabetes	8.3	8.5	8.4	9.6	8.0	7.2	8.3	7.9	8.2
Ischemic Heart Disease	4.0	6.6	6.6	4.5	4.7	4.5	5.4	2.8	4.2
COPD	2.9	4.2	2.9	5.0	3.4	2.6	3.6	4.7	7.1

(AH 2022 Community and 2023 PCN-level Profiles)

The Health Quality Council of Alberta PCN Proxy Panel Report measures a population of 95,000 (down from 103,000 in 2020) which is lower than the PCN area population estimate of 114,800. An advantage of the HQCA report is that the prevalence rates are provided for each of the PCN, zone and Alberta panels. (Higher prevalence rates than provincial average are **bolded**.)

HQCA: Select Chronic Disease Prevalence (%)	Alberta	Zone Panel	PCN Panel
Hypertension	13.5	15.7	**19.6**
Asthma	12.9	14.2	**15.1**
Diabetes	9.1	9.9	**10.8**
CAD	5.8	6.8	**10.2**
COPD	3.4	4.1	**6.1**
CKD	2.7	1.9	2.3
CHF	1.5	2.2	**2.9**

(HQCA PCN-level Proxy Report, 2023)

Mental Health:

HQCA: Select Mental Health Condition Prevalence (%)	Alberta	Zone Panel	PCN Panel
Depression	8.2	9.2	**11.2**
Anxiety/OCD	12.0	10.7	11.8
Bipolar	3.1	4.5	**6.5**
Dementia	1.2	1.7	**1.9**
Delusional Disorder	1.3	1.3	1.2

(HQCA PCN-level Proxy Report, 2023)

Patient Complexity:

A proxy measure of patient complexity can be seen in the Health System Burden of Illness graph seen below.

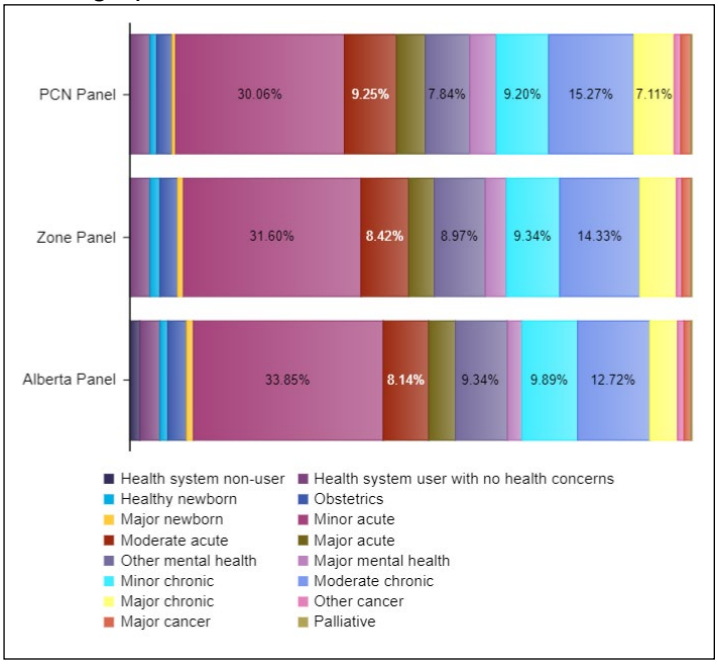


Figure 2 – Comparative complexity of patients by Health System Burden of Illness (PCN, Zone, Province)

(HQCA PCN-level Proxy Report, 2023)

This information may be more easily compared in tabular format. The categories are presented in order of relative health system resource consumption, from highest to lowest. (Higher PCN rates than provincial average are **bolded**.)

Burden of Illness category	PCN Panel	Zone Panel	Alberta Panel
Palliative	0%	0%	0%
Major acute	5%	5%	5%
Major chronic	**7%**	6%	5%
Major newborn	1%	1%	1%
Major mental health	**5%**	4%	3%
Major cancer	**2%**	1%	1%
Moderate acute	**9%**	8%	8%
Moderate chronic	**15%**	14%	13%
Other cancer	1%	1%	1%
Other mental health	8%	9%	9%
Obstetrics	3%	3%	3%
Minor acute	30%	32%	34%
Minor chronic	9%	9%	10%
Healthy newborn	1%	2%	2%
Health system user with no health concerns	4%	3%	4%
Health system non-user	0%	0%	2%

(HQCA PCN-level Proxy Report, 2023)

With this information, one could estimate that the PCN Panel comprises approximately:

- 6,800 patients with a Major chronic burden of illness
- 14,500 patients with a Moderate chronic burden of illness
- 8,700 patients with a Minor chronic burden of illness
- 7,400 patients with an “Other mental health” burden of illness

Totaling this information, one would estimate that, using the CIHI Population Grouping Methodology, 37,400 PCN patients have a major, moderate or minor chronic condition or an “other mental health” condition as their most complex health condition.

Last year, PCN RNs/OHPs saw approximately 30,600 unique patients for 79,000 visits. This included 6,700 BHC visits with 2,100 patients.

(PCN 2022/23 Annual Report)

Using clinic EMR data, it is possible to estimate the following numbers of patients with various conditions were seen by PCN physicians and RNs/OHPs in the last year:

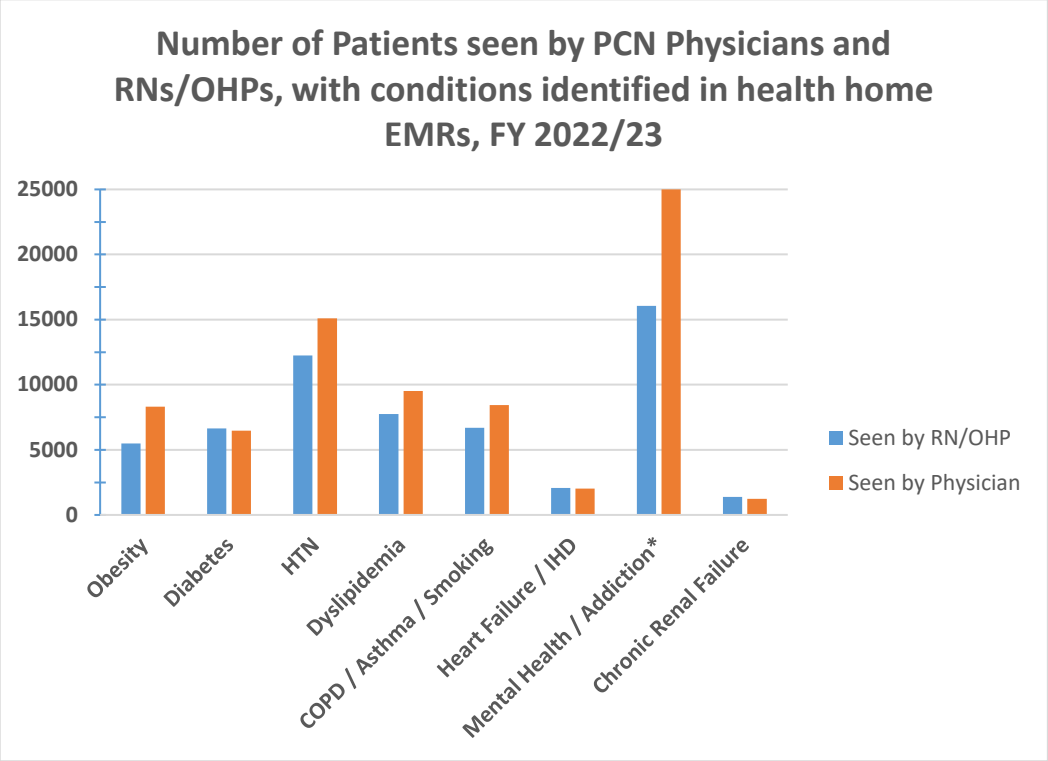


Figure 3 – Patients seen by PCN Physicians, RNs/OHPs by EMR-identified condition

* The number of patients seen with Mental Health/Addiction issues is based on billing diagnostic codes and not EMR problem list identification. This allows a more accurate count of patients experiencing these issues.

(PCN 2022/23 Annual Report)

Taken in association with HQCA disease prevalence estimates:

Condition	# of patients seen last year by PCN providers	HQCA-estimated # of patients with condition on PCN panel	Est. % of total patients seen last year
Obesity (BMI >=35)	8300	(not measured)	*(cannot be estimated)*
Diabetes	6450	10271	*63%*
Hypertension	15100	18606	*81%*
Dyslipidemia	9500	(not measured)	*(cannot be estimated)*
COPD / Asthma / Smoking	8450	(not measured in combined fashion; smoking not measured)	*(cannot be estimated)*
Heart Failure / IHD	2050	2745	*75%*
Mental Health / Addiction	27600	(not measured together)	*(cannot be estimated)*
Chronic Renal Failure	1250	2164	*58%*

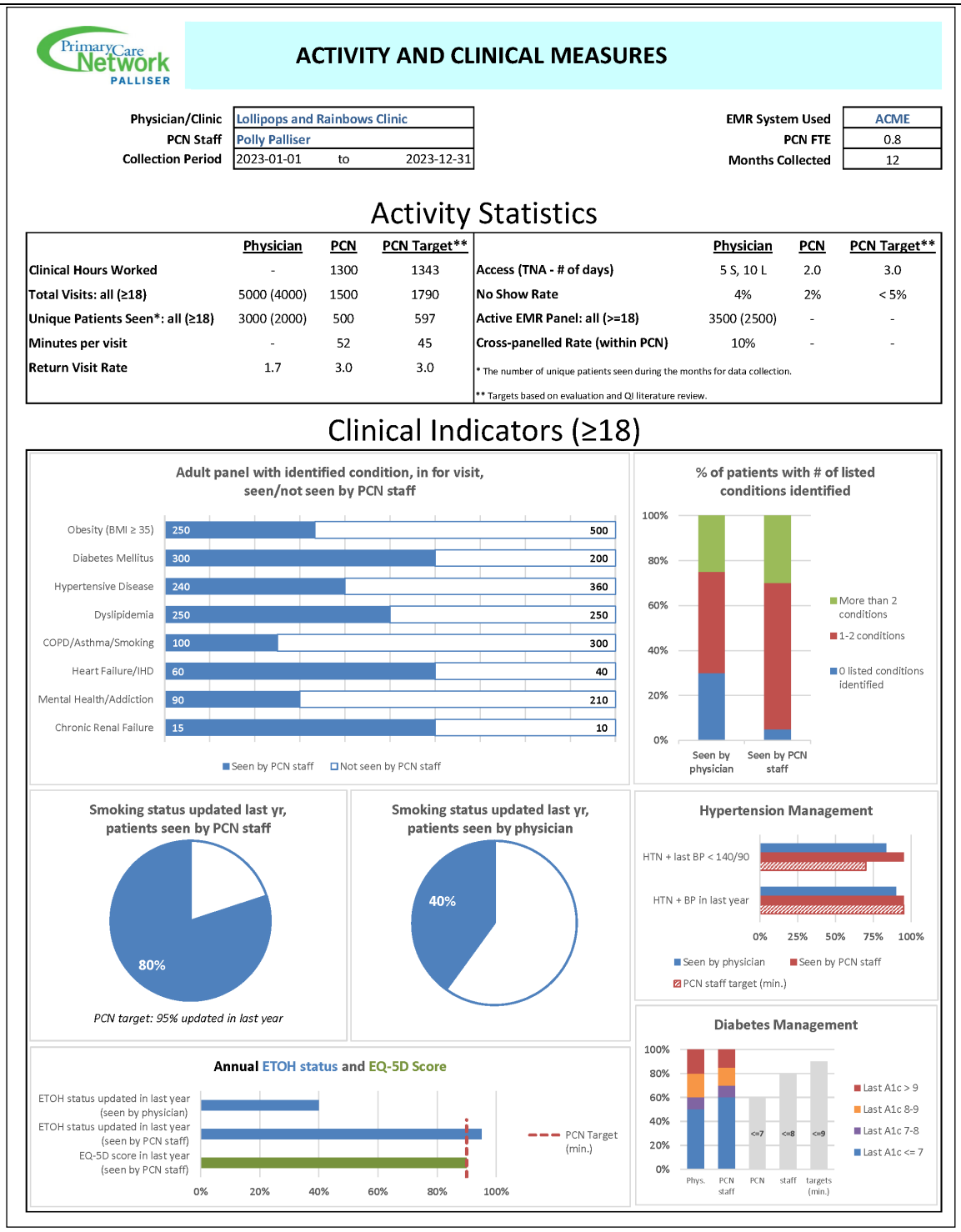
Challenges in interpretation:

- Potential issues with data accuracy in PCN clinic EMRs: some numbers may trend lower because EMR problem lists are not standardly utilized
- Potential inaccuracy with HQCA condition prevalence estimates
- Difficult to establish “ideal” % of patients with each condition that providers should expect to see annually: this could be related to co-morbidity and disease severity
- Data in this format does not present the wide variance in each metric within individual Health Homes; some physicians actively use PCN Activity and Clinical Measures sheets, HQCA Physician Reports and PCN Practice Improvement Facilitator support to assess this information at the Health Home level in order to improve the efficiency and effectiveness of patient care, e.g. to successfully maximize the % of chronic disease patients being seen within the year

Health Home level analysis:

The PCN has 38 unique Health Homes (clinics). Each Health Home is staffed by a team of clinical and non-clinical staff including the physician(s), PCN employees, and clinic employees. Data from the clinics’ EMRs is used to determine what, if any, clinical specialization is appropriate for a given clinic panel. For example, one clinic may have a significant number of smokers and consequently choose to provide in-clinic spirometry and smoking cessation and support. This type of service would not be provided in a clinic where either this need is not identified or other needs have taken precedence.

Physicians/Health Home teams often review their data in the following format – an Activity and Clinical Measures Sheet produced by the PCN using clinic EMR data:



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic			EMR System Used	ACME
PCN Staff	Polly Palliser			PCN FTE	0.8
Collection Period	2023-01-01	to	2023-12-31	Months Collected	12

Activity Statistics

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

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

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

** Targets based on evaluation and QI literature review.

Clinical Indicators (≥18)

Figure 4 – Palliser PCN Activity and Clinical Measures Sheet (2023): Sample (page 1)

Screening and Prevention Indicators (2023)

Physician/Clinic	Lollipops and Rainbows Clinic	**EMR System Used**	ACME
PCN Staff	Polly Palliser	**PCN FTE**	0.8
Collection Period	2023-01-01 to 2023-12-31	**Months Collected**	12

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

[1]HQCA issues in 2022 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 5 – Palliser PCN Activity and Clinical Measures Sheet (2023): Sample (page 2)

(PCN 2022/23 Annual Report)

Information in this format also supports decisions regarding potential areas for clinical and process improvement at a team and individual provider level. The PCN facilitates interpretation of this information and supports development of a team's Health Home Action Plan, including periodic measurement of process and outcome measures to support a team's improvement goal. This activity is spearheaded by PCN Practice Improvement Facilitators who utilize the 5 A's Change Model for Health Home Optimization to develop and refine each Health Home's improvement plan.

Change and quality improvement in Health Homes tends to be slow and challenging for the following reasons:

- Team members typically receive little formal training regarding interprofessional collaboration
- Team members typically receive little formal training on change management and system level quality improvement
- Team members are challenged to remain current with changes to legislation, regulations, and guidelines which impact Health Home optimization
- Team members are challenged to commit dedicated time to quality improvement and Health Home optimization

Practice improvement facilitators are experts in quality assessment, measurement, improvement and change implementation. PCN level centralization of the practice improvement facilitators enables professional quality improvement knowledge to be combined with context specific requirements for change and improvement. The geographic size of Palliser PCN supports best and promising practice sharing between individual Health Homes through the practice improvement facilitators. Additionally, the PCN practice improvement facilitators develop strong and trusting relationships both with the Health Homes and community services such that achievement of quality improvement goals are accelerated.

4. Health care provider populations (family practitioners, specialists, non-physician providers).

Currently operating within the PCN geographical area:

Family practitioners:	84 (approximately)
Specialists:	85 (approximately)
Non-physician providers:	Full range of other private providers including: chiropractors, optometrists, pharmacists, physiotherapists, podiatrists, psychologists, etc.

The PCN is aware of worldwide anticipated challenges with healthcare provider recruitment and retention. Key factors affecting health care provider recruitment and retention: compensation, wellness, personalized lifelong education plans

Physician recruitment and retirement trends: the number of family practitioners anticipated to retire in the next 5 years is equalled by the number of new family practitioners known to be coming to the PCN area in the next year.

5. Available regional and community programs and facilities

Within the PCN geographic area, a full range of comprehensive Outpatient Programs are provided by Alberta Health Services (AHS). Additionally, a broad range of not-for-profit organizations are available to support the holistic needs of the population. The PCN has strong linkages with these programs through maintaining and updating an online compendium of local programs (“Local Resources”) including up to date access information. This information is available on the PCN website: www.palliserpcn.ca . There are currently 254 Local Resources listed on the website and approximately 53,300 annual visits to all Local Resources pages. Additionally, the PCN hosts a Community Resource Expo in Brooks and Medicine Hat (approximately every 18 months) to enable community services to showcase their services and to meet directly with multi-disciplinary

service providers. Finally, the PCN invites community services to PCN staff meetings (approximately 4-8 per year) for the same purpose.

The following local Health Facilities are funded by AHS:

Bassano Health Centre (acute, continuing care, outpatient)
Bow Island Health Centre (acute, continuing care, outpatient)
Brooks Health Centre (acute, continuing care, outpatient)
Medicine Hat Regional Hospital (acute care and outpatient)
Oyen Health Centre (acute, continuing care, outpatient)
Regional Community Health and Mental Health Offices (public health/health promotion/mental health)
Continuing Care Facilities

6. Trends and Current Issues/Challenges/Gaps faced by the PCN patient population

The patients within this PCN have comprehensive primary care services currently available to them but there are improvements that can be made. The required improvements are specific to each Health Home and the specific population they serve. These issues/challenges/gaps will be addressed through ongoing Health Home optimization and practice improvement. Additionally the PCN will be working with the PCN South Zone Committee for support in resolving some of the issues. Some of the current challenges faced by the PCN patient population are outlined below:

Patient-Centered Care:
Although there are many services available to patients these services may not address the patients' specific needs at a given time. Patients may end up receiving fragmented care with partial information and partial plans of care forming the foundation of the care.

Personal Family Physician:
There is at least one family physician accepting new patients in each of the PPCN catchment area communities at this time. This situation could be impacted by physician retirements in the coming years. Additionally patients may seek care outside of their regular family physician office resulting in fragmented care.

Team-Based Care:
Teams within the Health Homes continue to become increasingly robust. However, the size and discipline of these teams is hampered by available resources. Consequently the patient has to receive some services outside of the Health Home. There are fluctuating challenges in the sharing of health information between community health and social programs, Alberta Health Services and the Health Homes.

Timely Access:
Appropriate access continues to be a challenge in many Health Homes in the PCN. Additionally appropriate access to services outside the Health Home (e.g. specialty physician services and AHS programs) continues to be a challenge.

Comprehensive Care:
Many of the Health Homes within the PCN are small teams and will be unable to provide all family practice services and public health needs within the Health Home.

These services are typically available in the community; the referral, appropriate access, and information sharing with these 'outside' services can be challenging.

Continuity of Care:
The PCN has made strides in physician / clinic teams understanding and efforts towards continuity of care. However there is still a gap in relation to patients' expectations of service availability and commitment towards a continuous relationship with their primary care provider.

Electronic Medical Records:
95% of the Health Homes within the PCN have an EMR used for charting. All Health Homes have ongoing work to effectively maintain and meaningfully use their EMRs on behalf of their patients.

Education, Training and Research:
The PCN Health Homes continue to be a robust training site for medical students and residents, registered nurses, nurse practitioners, social workers, etc. Ability to accommodate health professionals in Health Homes is limited by physical space, health provider availability, health provider wellness. A limited number of Health Homes engage in research primarily related to competing demands.

Evaluation and Quality Improvement:
Many Health Homes are at a fledgling stage of engaging in action learning and practice improvement.

Internal and External Supports:
Health Homes have varying levels of internal support in the form of practice administration. Additionally Health Homes have varying levels of engagement with external supports.

7. Effect of the PCN on the Local Environment during its 2006-2024 Business Plans

A. **Primary Provider:** From 2006-2010 the PCN experienced a steady increase in physician members which in turn led to a steady increase in enrollees. From 2011 to present, the PCN saw maximization in eligible physician membership with the PCN reaching 94% of eligible physicians in the 2021-2024 Business Plan. During this time, patient enrollee numbers rose, peaked in April 2020 and then declined in each subsequent period. As the enrollee number reached its peak, it also came closest to aligning with the PCN population estimate. A drop in enrollee numbers beginning October 2020 was in alignment with the majority of Alberta PCNs in Alberta and is being investigated at a provincial level.

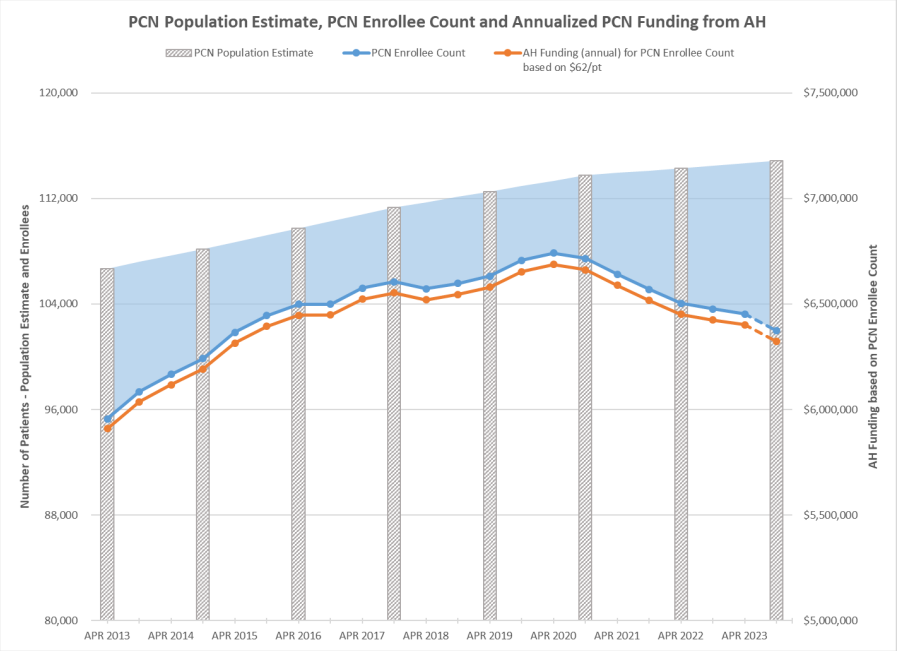


Figure 6 – PCN Population Estimate, Enrollee Count and Annualized PCN Funding from AH, April 2013 to October 2023 (gap between population estimate and enrollee count in blue)

Eligibility for PCN professional staffing is determined by assessing an interested physician'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:

<table>
<tr><th>Profile</th><th>Definition</th><th>Eligibility for PCN professional staffing</th><th>Eligibility for PCN panel support</th></tr>
<tr><td>No Family Practice</td><td>Physician has no family practice patients.</td><td>Not eligible</td><td>Not eligible</td></tr>
<tr><td>Minority Family Practice</td><td>Physician has less than 500 family practice patients.</td><td>Not eligible</td><td>Eligible for PCN Panel Optimization support. For example:
• Practice improvement facilitator
• Paid QI meetings
• Interprofessional collaboration</td></tr>
<tr><td>Core Family Practice</td><td>Physician 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><td>Not eligible</td></tr>
</table>

*Measurement process for PCN professional staffing eligibility: (1) Measure all PCN physician 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 this panel data twice a year (October & April) and provides it directly to the physician member along with strategies and support from the PCN to increase and/or stabilize their panel numbers.

Any physician who will need to make an FTE reduction will have a 2 year notice period. During this 2 year notice period the PCN will offer support and strategies to achieve the physician's desired family practice panel size.

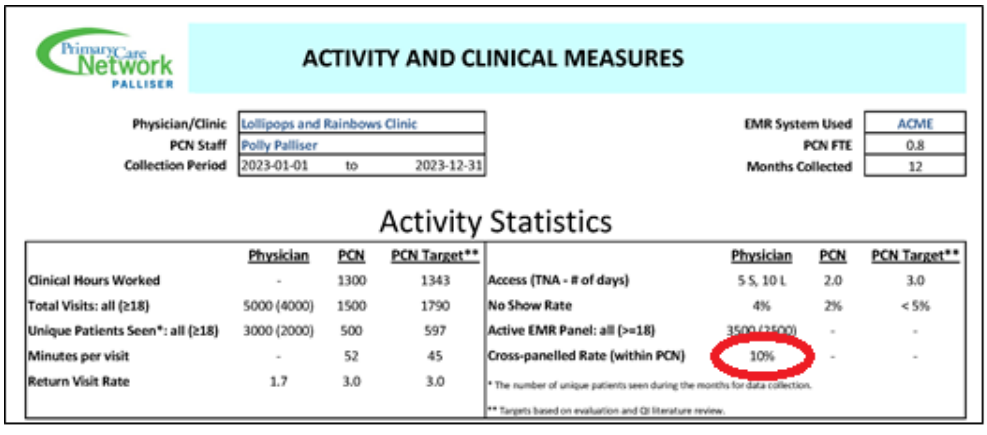
The PCN began using these physician profiles and eligibility criteria for allotting PCN employees to individual Health Homes (physicians) on April 1, 2021. This allowed teams to grow their multidisciplinary team more quickly than in the past. 23 physicians newly qualified over the last business planning period, versus only 4 that would have qualified using the PCN's prior method (AH 4-cut).

(PCN 2022/23 Annual Report)

PCN Facilitators support physicians who are 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 can include supporting teams to review their panels, contact patients, administratively inactivate patients and assist teams to enroll in CPAR/CII. Further, physicians are offered support to measure their access, compare to the current panel size and define an ideal panel size.

In the current iteration of its Activity and Clinical Measures sheet, the PCN has integrated the physician cross-panelled rate (circled below in Figure 7) to support conversation about panel validation, CPAR/CII enrollment and a population health approach to panel management.

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



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic	EMR System Used	ACME
PCN Staff	Polly Palliser	PCN FTE	0.8
Collection Period	2023-01-01 to 2023-12-31	Months Collected	12

Activity Statistics

	Physician	PCN	PCN Target**		Physician	PCN	PCN Target**
Clinical Hours Worked	-	1300	1343	Access (TNA - # of days)	5 S, 10 L	2.0	3.0
Total Visits: all (≥18)	5000 (4000)	1500	1790	No Show Rate	4%	2%	< 5%
Unique Patients Seen*: all (≥18)	3000 (2000)	500	597	Active EMR Panel: all (>=18)	3500 (3500)	-	-
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 7 - PCN Activity and Clinical Measures Sheet - partial - Physician Cross-panelled Rate circled

At a Health Home level, the cross-panelled rate is the number of patients on active EMR panels that are cross-panelled divided by the number of total patients on active EMR panels. If a Health Home with 1000 patients has an 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.

At a PCN level, the cross-panelled rate is 10%, down from 13% in FY 2021/22. Individual PCN physician cross-panelled rates vary as seen below, with rates as low as 2% and as high as 32%. 91% of individual physician cross-panelled rates are below 20% (maintaining its rate in the last reporting period), with 67% already under the PCN target of 10% (up from 64% in the last reporting period). The PCN has identified a stretch target of below 5% cross-panelled, already achieved by 20% of physicians (up from 13% in the last reporting period). This appears to be achievable by teams with a stable panel, demonstrated commitment to maintain panel hygiene and to coordinate with other Health Homes where patients are cross-panelled, e.g. through use of a Physician Change Form.

Clinic logo here

Last Name:	First Name:
DOB:	
Patient Address:	
City:	Province:
Postal Code:	Telephone:

Change in Family Physician

This patient has changed family physicians. The new physician is:

☐ Dr. Name
☐ Dr. Name
☐ Dr. Name

Patient Signature: _____

Please update your EMR to reflect this change.

Figure 8 - Sample Physician Change Form

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

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

Methods by which Health Homes reduce their cross-panelled rate include:

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

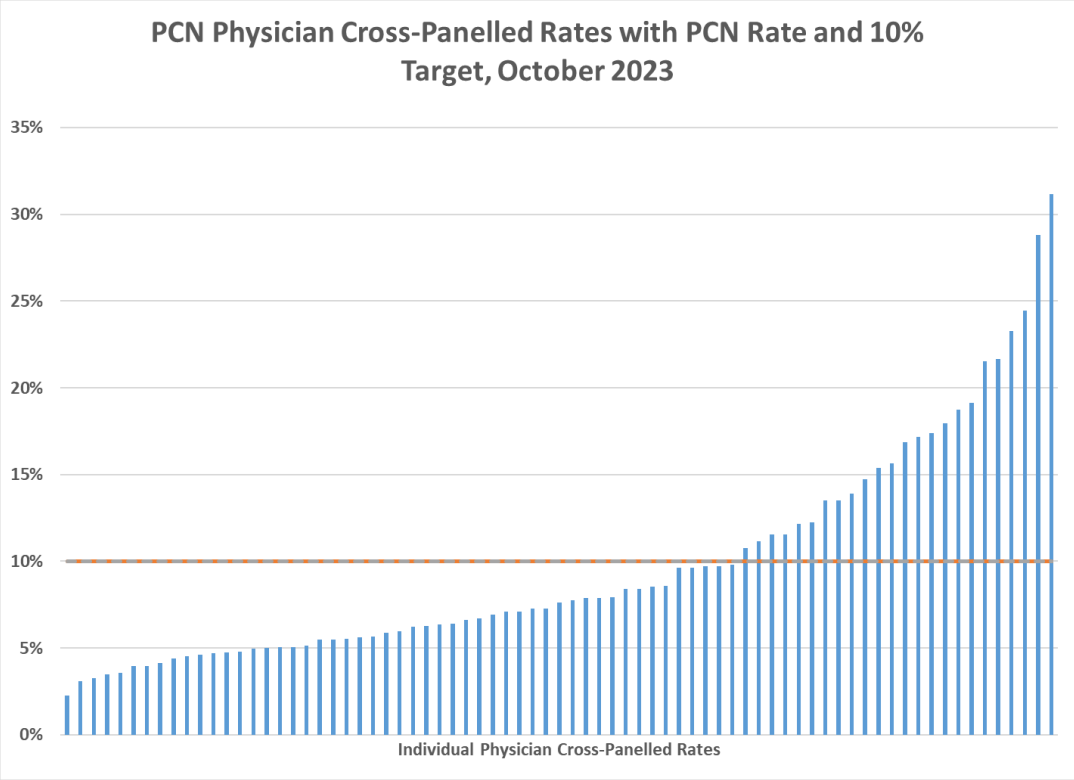


Figure 9 - Anonymous Physician - and PCN-level Cross-Panelled Rates, October 2023

B. **Chronic Disease Management:** Within the PCN, over 94% of physicians are now working in a clinic with a RN/OHP assisting to provide comprehensive chronic disease management. Patients seen by RN/OHP are receiving comprehensive care and have experienced improved health and/or wellbeing in their chronic conditions. The unique patients seen by all PCN RN/OHPs during 2022/23 is approximately 31,000. RN/OHPs completed an estimated 79,000 patient visits, spending on average 53 minutes per patient visit with an average annual return visit rate of 2.6.

Figure 10 – PCN 2022/23 "At A Glance" Infographic, Selected Area

Current PCN EMR remote access (for supervision, measurement for accountability, measurement for practice improvement needs):

- 95% of clinics overall use an EMR for charting.
  - 98% of clinics that have an EMR for charting have provided remote access
  - 100% of clinics that have PCN professional staff and an EMR for charting have provided remote access

C. **Behavioural Health Consultation:** Within the PCN, over 37% of clinics now have access to a BHC working with the physician to provide mental health assessment, referral and counselling. The PCN moved from a mental health counselling to a BHC model to both improve efficiency and effectiveness of mental health care in primary care.

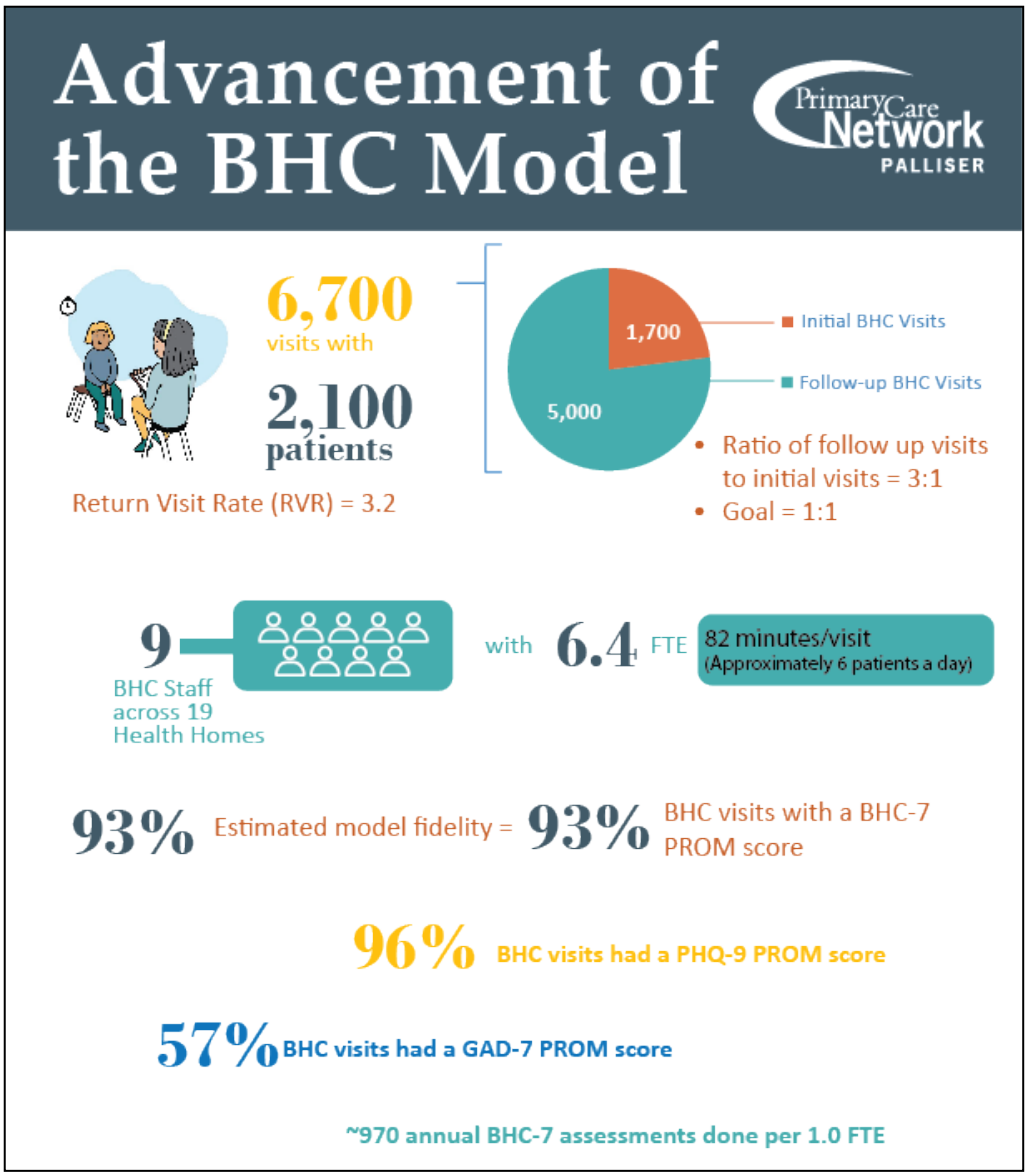


Figure 11 – PCN 2022/23 Annual Report "Advancement of the BHC Model" Infographic

D. **Health Promotion / Disease Prevention:** Within the PCN, RN/OHPs engage in both outreach and opportunistic prevention / screening. Additionally the RN/OHPs work with AHS programs, such as Public Health, to offer vaccinations and public health education as appropriate for the patient.

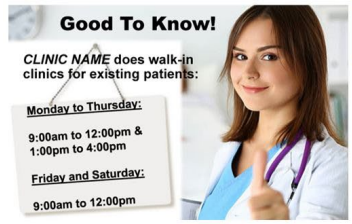
The PCN also supports clinics to participate in the HUTV program (currently 14 clinics – in waiting rooms) and ScreenCloud service (in 13 clinics and 34 individual locations) predominantly in exam rooms; waiting rooms are in trial phase), allowing the clinic to

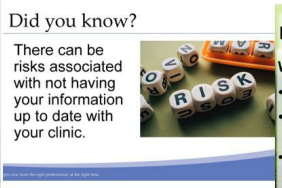
provide topical health education information which may be provided by AHS, the PCN and various external agencies. Using paper and the above electronic services, the PCN provides support to Health Homes that wish to create specific in-clinic messaging for their patients, e.g. introducing care providers, clinic policies and vacation hours.

ScreenCloud stats:

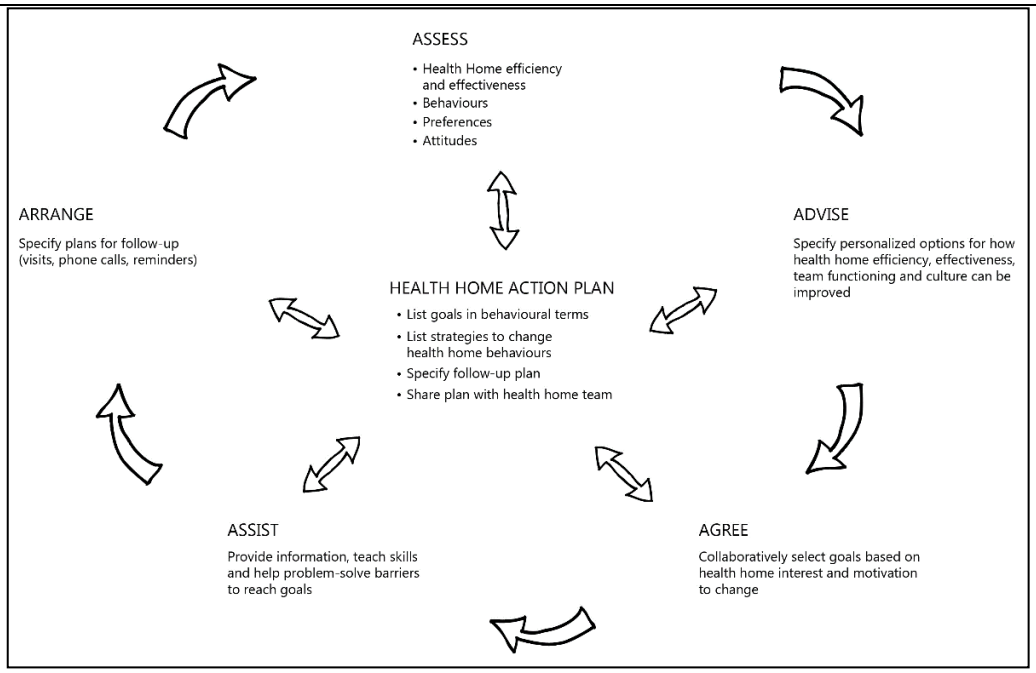
- Average duration of content loop: 14 minutes
- Average number of slides per loop: 41 slides
- Typical duration of each slide: 15-25 seconds

Sample HUTV/ScreenCloud messaging:





E. Measurement and Practice Improvement: The PCN has been involved in practice improvement since 2009. During this time, 36 clinics have participated in practice improvement learning sessions. Improvements have included enhancements in office flow and efficiency resulting in reduced time waiting for an appointment with the primary care team and increased panel size for some physicians. As well, improvements in Electronic Medical Record uptake and usage have resulted in improved screening, consistency in clinical care and better linkages/follow-up. Also, continuing work on clarifying roles within the Health Home team supports ongoing improvements in efficiency and effectiveness. During this business planning period, the PCN has continued to refine its approach for moving clinics towards Health Home Optimization. The PCN has adapted the 5A's Behaviour Change model for this purpose. The below model illustrates the approach taken with the PCN Health Homes to assess, advise, agree, assist and arrange to move forward with a Health Home improvement action plan.



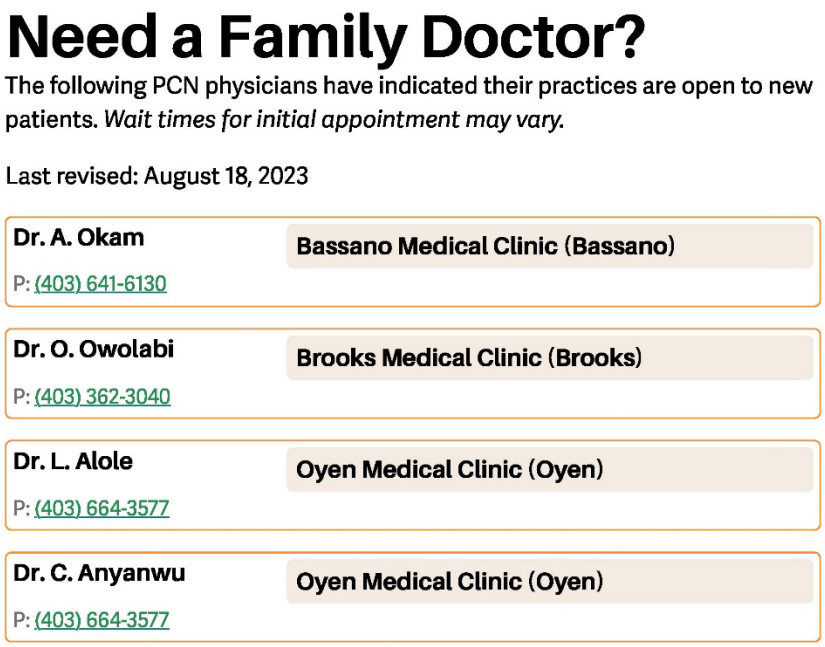
The PCN has supported continuity in the following ways:

- PCN Continuity of Care Form: sent by PCN professional staff to family doctors when a visit occurs outside of the patient's Health Home
- Physician Change Form: sent by Health Homes to a patient's former family doctor to let them know they have changed family doctors and to update their EMR (see Figure 8)
- Hospital discharge follow-up: PCN professional staff assist with discharge follow-up management including updating of EMR medication lists
- Case conferencing: PCN professional staff participates in facility-based case conferencing with Home Care and LTC, only if the physician is unable to attend
- Face to Face networking with referral sources, e.g. at PCN Community Expos, PCN staff meetings, PCN workshops
- PCN supports within individual Health Homes:
- Panel process development – scripting, contingency planning for panel needs e.g. vacation planning
- Cross panel measurement – rates reported twice annually, supports offered to reduce rate
- HUTV, ScreenCloud and poster messaging re: panel and "the importance of having one family physician"
- Posters in clinic and exam rooms
- Newsletter/Newspaper messaging (media & Internal Chronicles Newsletter)
- CII/CPAR adoption and preparation:
    - 53% of PCN physicians are in progress or live on CPAR/CII
    - 100% of PCN Core Family Practice physicians offered CPAR/CII – at least once annually and opportunistically.
    - 95% of Health Homes have an up-to-date or recently updated PIA
    - CII/CPAR application and implementation process supported by PCN facilitators
    - Additional CPAR/CII participation anticipated with:

- Improved AMA ACTT communication re: how CHR and Ava EMR clinics can participate
- Rollout of eNotifications to Accuro clinics (has been delayed for 2+ years with no timeline for resolution provided to PCNs - significant barrier for potential Accuro clinics
- Increased provider awareness of and desire to correct CPAR Primary Provider information displayed in Netcare – significant motivation for some physicians
- Provider awareness of increased local participation in CPAR, resulting in increased value of conflict reports

  - Some of the methods used by Palliser PCN to approach physicians and teams re: CPAR/CII interest:
    - PCN staff meeting discussions, celebrating successes of participating teams in PCN Chronicles Newsletter
    - Follow-ups from PCN staff PA process, discussion at clinic manager meetings
    - Utilizing a 5 A's change management approach, PCN leverages opportunities for scale and spread of CPAR/CII among PCN Health Homes

- Monthly updates of physicians accepting new patients and delivery to 21 locations



Need a Family Doctor?

The following PCN physicians have indicated their practices are open to new patients. *Wait times for initial appointment may vary.*

Last revised: August 18, 2023

Dr. A. Okam P: (403) 641-6130	**Bassano Medical Clinic (Bassano)**
Dr. O. Owolabi P: (403) 362-3040	**Brooks Medical Clinic (Brooks)**
Dr. L. Alole P: (403) 664-3577	**Oyen Medical Clinic (Oyen)**
Dr. C. Anyanwu P: (403) 664-3577	**Oyen Medical Clinic (Oyen)**

- HQCA reports: reviewing activity characteristics of patients including internal and external continuity

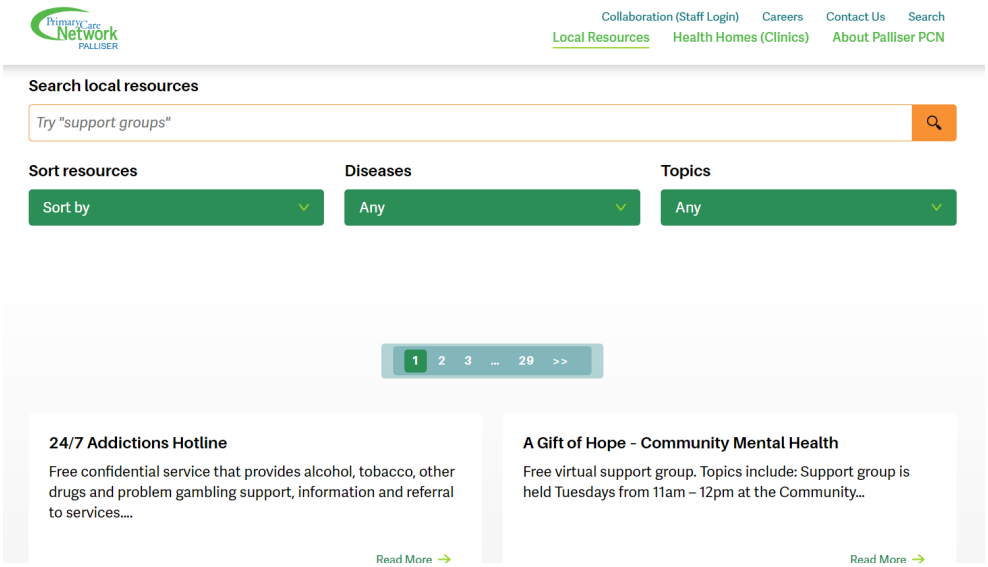
F. **Linkages:** The PCN has continued to improve linkages both within the local community and with provincial programs. Programs (not-for-profit and AHS) and specialist physicians are connected through:

a. Participating in orientation of new PCN employees
b. Showcasing information/services at PCN events such as displays at PCN monthly staff meetings or quarterly workshops,

c. Where appropriate, local programs are invited to provide expert/new information at PCN learning events.

d. Where appropriate, the PCN employee is sent for training with specialists (local and provincial), opening up communication and referral opportunities.

e. The PCN maintains a website that includes an up to date community resource compendium ("Local Resources") to support easy reference to local services and referral processes. The website is used by both the community, patients, and providers.



f. The PCN works with local programs (AHS and Community not-for-profits) to develop improved handoffs and problem solve gaps/barriers as they arrive within their unique Health Home context. Awareness of these problems may be brought to the attention of the PCN by any and all partners.

G. **Physician Engagement:** Physician engagement remains high in the Palliser PCN with physicians having easy and appropriately responsive access to the PCN central office team. 2023 physician surveys (response rate of 83%, overall satisfaction rate of 86%) reported the following:

PCN Communication: *"I have been satisfied with the communication from the PCN"* resulted in an average rating score of 88%.

PCN Practice Improvement Support: *"I have been satisfied with the amount and type of practice improvement support provided by the PCN"* resulted in an average rating score of 89%.

PCN Governance: *"I have been satisfied with the Board governance and decision-making process"* resulted in an average rating score of 86%.

PCN Engagement: *"I have been satisfied with the opportunities to engage with PCN activities and resources"* resulted in an average rating score of 87%.

PCN Staff Support / Education: *"I have been satisfied with the amount and type of support and education that PCN staff receive from the PCN"* resulted in an average rating score of 89%.

PCN Staff Recommendation: *"I would recommend employment of PCN staff to other physicians"* resulted in an average rating score of 93%.

The South Zone Service Plan Priorities were used to inform Palliser PCN BPR priorities and implementation strategy. The PCN reviewed the South Zone PCN Committee Service Plan and the Zone Service Planning Companion Guide to ensure alignment with zone priorities.

Palliser PCN does not plan nor operationalize in departments, projects, nor silos. Reflective of the context of primary care activities are interdependent. As such, most activities will involve several members of the team. The percentage of team member contribution on a given project at a given point in time is dependent on the team member skills and competing priorities. E.g. a mental health workshop will require the support of the Executive Director, PMHO Director, PMHO Evaluation Manager, PMHO Facilitator Manager, Facilitators, Clinical Supervisors and Educators, admin and financial supports and robust engagement of Health Home teams.

South Zone PCN Committee zone priority and description	Palliser PCN integration of zone priority into PCN BPR priorities and planned activities
1. Mental Health Increase primary care capacity to support youth and adults experiencing mental health concerns and improve care coordination among primary care, AHS, and other partners.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** Integrate education support with current 56 PCN employees to ensure stability, longevity and achievement of long-term zone objectives. Coordination of care will include the Resource EXPO, staff meetings, inviting stakeholders, up to date community resources on PCN website. Communication will continue to be fostered between our local partners and will include a focus on supporting adoption of H2H2H guidelines. PCN currently has 12 physicians and 1 NP trained in CanReach, and will continue to seek further CanReach training of health providers. PCN will regularly engage with AHS and other community services (e.g. Big Brothers Big Sisters, SPEC Association, Medicine Hat Police, McMan South Region, Canadian Mental Health Association, Veiner Centre, Medicine Hat College,

				AHS Medicine Hat Addiction Clinic, AHS Addiction and Mental Health, Family and Community Support Services, Lifetalk (faith-based counseling service), SafeLink, Being Human Services, Medicine Hat Women's Shelter) to assess improvement opportunities regarding youth mental health (e.g. wait times and community capacity). PCN will offer an annual mental health workshop. Ensuring all PCN health providers have foundational skills in mental health assessment, treatment and service navigation ensures that patients will receive service regardless of their presenting issue in primary care. PCN other health provider orientation will continue to include motivational interviewing, mental health assessment, Non-Violent Crisis Intervention, Applied Suicide Intervention Skills Training. Inclusion of a mental health assessment and treatment component in all disease/condition specific clinical workshops (e.g. Diabetes, Gastrointestinal, Seniors Health). PCN facilitates timely mental health support (e.g. Mental Health First Aid, Non-Violent Crisis Intervention for clinic staff) where presentation of patient violence appears to be escalating. PCN will continue to employ Behavioural Health Consultants to work in Health Homes. Behavioural Health Consultants to continue to receive 5 days of intensive behavioural health skills orientation, to ensure fidelity to the BHC model, access, competency, evidence-based assessment and treatment plans, intercollaborative care and

			integration into the Health Home team.
		2. Patient's Medical Home Enhance the Patient's Medical Home by improving access, continuity of care, Home to Hospital to Home transitions, and team-based care.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** To ensure stability, longevity and achievement of long-term zone objectives, the PCN will continue to support new physicians through our website and communication to community partners regarding availability of physicians accepting new patients. PCN support will remain to established physicians and other health providers to measure access and engage in ongoing improvement where possible. PCN support for EMR optimization, PCN liaison and problem solving with primary care partners and stakeholders to support ongoing improvement and continuity of care will evolve to meet the changing healthcare system landscape, e.g. with changes to Connect Care, CII/CPAR, Netcare, H2H2H. PCN wide education regarding effective interprofessional practice. In clinic coaching where requested and appropriate. PCN offers a collaborative learning series on a rotational basis to achieve elements of Health Home Optimization: panel, access, EMR, screening and team-based care. Practice improvement facilitator support for team flow efficiencies and effectiveness, including in areas of referrals and care coordination. PCN offers an annual quality improvement workshop as well as integrating concepts of Health Home Optimization into clinical workshops.
		3. Primary Care Sustainability Enhance zone physician recruitment and retention activities and support exploration of alternative primary care funding models.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** To ensure stability, longevity and achievement of long-term zone objectives, PCN will continue to connect with medical and other health professional students as

			opportunity presents. PCN will continue to cultivate relationships with U of C Medical School and Medicine Hat College Nursing and Social Work faculty. PCN will continue to engage with CFPC regarding curriculum redesign. PCN clinics will continue to support education and practicum placements for medical students and residents, nurse practitioners, registered nurses, and social workers where there is room and resources. PCN will continue to support medical residents via their in clinic quality improvement. PCN nursing student in-clinic placements through student and Registered Nursing staff orientation classes. PCN physicians reach out to PCN early in the recruitment process so PCN is able to support new physicians through orientation to PCN services. Improvement with AHS sharing information regarding new family physicians in 2023. PCN will continue to work with AHS in family physician recruitment where resources available and within PCN policy. PCN engaging in a two Physician town hall activities per annum as a mechanism to engage in bidirectional communication with PCN physicians and provide opportunity to engage in physician wellness activities. PCN facilitators work with physicians to problem solve administrative frustrations (e.g. NetCare access) to improve physician satisfaction and in turn retention.
		4. Chronic Pain and Opioids Increase capacity to support patients experiencing chronic pain and opioid dependence and improve care coordination between primary care and AHS.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** To ensure stability, longevity and achievement of long-term zone objectives, the PCN will continue to provide ongoing chronic pain and opioid dependence best practice education. PCN to support in clinic intercollaborative approach to chronic pain and opioid dependence patient care. Offered support includes: facilitated development and testing of in-clinic pathways, team meetings, EMR templates, forms and calculators (e.g. PCN-developed

			opioid dose calculator using McMaster University's Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain), patient messaging, cross-training between staff, ensuring an evidence-based assessment and treatment plan that includes patient navigation and care coordination where needed (e.g. community pharmacies). PCN will capitalize on long standing relationships with community providers engaged in chronic and opioid dependence e.g. SafeLink, AHS Medicine Hat Addiction Clinic, Virtual Opioid Dependence Program, Medicine Hat Recovery Centre, as well as local food banks and social housing services. PCN remains abreast of physician resources and links physicians to these resources as a request is made or a need is identified, e.g. ACFP family physician chronic pain mentoring program.
		5. Committee Core Operations Effectively manage Committee resources and enhance decision making through communication, engagement, evaluation.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** To ensure stability, longevity and achievement of long-term zone objectives, PCN Executive Director sits on Zone PCN Committee as well as, Zone PCN Implementation Committee to support core committee operations. PCN Executive Director able to bring local context to zone committee decision making (e.g. local not-for-profit youth mental health service providers, average percentage of local physician panels seeing youth with mental health issues). PCN physician chair, physician vice-chair, physician non-voting member, community member also sit on Zone PCN Committee to provide expertise on committee core operations.
		6. Pan-Zone Initiatives Partner across multiple zones on similar priorities.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement*

		Activities: As noted above, PCN is an active member of Zone PCN Committee and supports pan-zone initiatives. It is noted that the 2 PCN's in South Zone have significant contextual differences often leading to similar, yet different, implementation of pan-zone initiatives. Given that there are only 2 PCNs in the South Zone the PCN Executive Directors connect regularly and share ideas and documents opening.
	7. Provincial Initiatives Support ongoing and emerging provincial primary care initiatives.	**Applicable PCN priorities:** *1. Professional Support in Health Homes* *2. Measurement & Practice Improvement* **Activities:** PCN supports provincial primary care initiatives (e.g. CII/CPAR) as in alignment with South Zone PCN committee and Palliser PCN priorities, culture, and capacity.
Data Sources	• Statistics Canada Census and Population Estimates, 2016-2023 • Alberta Health PCN Enrollee Numbers, Palliser PCN and all PCNs, 2016-2023 • Canada Health Infoway patient and provider surveys • CIHI Your Health System tool • AHS ZSP mapping tool • Palliser PCN Health Home EMRs • Alberta Find-A-Doc website • Palliser PCN website • Palliser PCN patient, physician and employee surveys • HQCA proxy and confirmed physician and PCN panel reports • AH Zone, PCN and Community (LGA) Profiles • Palliser PCN Activity and Screening Indicators • Local community reports, e.g. Vital Conversations • Alberta Health PCN Dashboard • Alberta Health Interactive Health Data Application and Alberta Community Health Survey • Local immigration associations, e.g. Saamis Immigration Association • South Zone PCN Committee Service Plan • Health care provider recruitment and retirement trends • Statistics Canada Nursing Shortage Statistics	

	• CIHI Physician Shortage Statistics • CPSA Physician Services Report • Palliser PCN physician and employee engagement
Potential Areas for Collaboration (Available Regional and Community Programming Already Serving This Population and Type of Programming Offered)	Palliser PCN collaborates formally and informally with the following organizations, regularly attends community meetings and seeks information regarding wait times, prerequisites for referrals and other details needed to assist with smooth transitions in and out of these areas, understanding their scopes of service and available resources, seeking to avoid duplication in areas where there is service overlap. **AHS Specialty Services:** Collaboration with AHS Alberta Healthy Living programs, seeking to avoid duplication of services in the areas of: - Type 1 pump therapy - Heart failure clinic - Bariatric/weight management clinic - Supervised exercise programs - OT/PT in-home assessments - Cardiac rehabilitation Areas of collaboration with AHS Mental Health: - Children's and youth mental health support - Current awareness of group offerings, e.g. Dialectical Behavioural Therapy, to ensure use of these programs **Community:** Palliser PCN collaborates formally and informally with numerous community agencies and non-profits, including: - Canadian Mental Health Association - McMan South Region - Big Brother Big Sisters - SPEC Association, Brooks - Veiner Centre - AHS Medicine Hat Addiction Clinic - Lifetalk (faith-based counseling service) - Medicine Hat Women's Shelter - Family and Community Support Services - SafeLink Relationship to PCN services and supports: the above organizations provide unique assistance and coordination of care for patients and their families.

	Municipalities: Palliser PCN collaboration with municipal organizations including: - Medicine Hat city community resource workers - Being Human Services - Alberta Supports - Saamis Immigration Services - Brooks & County Immigration Services - Local food banks and housing services Relationship to PCN services and supports: the above entities support addressing social determinants of health. Executive Director attends local municipal meetings where invited and resources (time) permits. **Indigenous Community Supports:** - Miywasin Friendship Centre - Saamis Employment & Training Association Relationship to PCN services and supports: these organizations support enhancement of culturally appropriate care and addressing social determinants of health.
Current Gaps in Service Provision or Challenges Related to Priority	Challenges related to achievement of the PCN's priority initiatives include: *Coordination of care:* • Care providers in each of their specific areas may provide the best programming available but lack of coordination between disciplines and inappropriate access to supports reduces the effectiveness of the care program. • Communication and "patient health sharing" among relevant care providers throughout the health care system • Rapidly changing community supports and referrals make system navigating an ongoing challenge *Information, relationship and management continuity:* • Coordination of the delivery of disease treatment (acute care) and follow-up (primary care) may be impacted by factors including rollout of Connect Care, H2H2H, CPAR/CII, Modernizing Alberta's Primary Health Care System (MAPS) implementation activities • Patients may end up receiving fragmented care with partial information and partial plans of care forming the foundation of the care • Patients may seek care outside of their regular family physician office, resulting in fragmented care • Delays in rollout of full CPAR/CII functionality to provincially available EMRs (e.g. CII eNotifications in Accuro EMR are still not functional in November 2023) • Delays in rectifying issues with redundant notifications between CPAR/CII and Connect Care

	• Misinformation regarding compatibility of CPAR/CII with various provincially available EMRs (e.g. in November 2023, Ava EMR is provincially described as "conformed" and included in metrics of CPAR/CII participation but CPAR panel submission, CED contribution and CII eNotifications are all not functional) *Access:* • Appropriate access continues to be a challenge in many Health Homes • Appropriate access to services outside the Health Home (e.g. specialty physician services and AHS programs) continues to be a challenge *Health Home context:* • Health Home team members typically receive little formal training regarding interprofessional collaboration • Health Home team members typically receive little formal training on change management and system level quality improvement • Health Home team members are challenged to remain current with changes to legislation, regulations, and guidelines which impact Health Home optimization • Health Home team members are challenged to commit dedicated time to quality improvement and Health Home optimization • Health Homes vary in levels of Health Home Optimization: panel, access, EMR, screening and team-based care and are challenged to maintain these states in circumstances such as: EMR migrations, human resource changes (staff turnover, integration of new employees, leaves of absence)
Limitations of Data or Gaps in Information to Support Priority	• Provincial, zonal and local data is often outdated. Examples: ○ AH PCN Dashboard as well as PCN, zone and community profiles are reliant on data up to March 2021 or earlier ○ HQCA proxy panel reports rely on proxy data and are based on data up to March 2022 ○ CIHI data age can range between 2011-2022, depending on indicator • EMR data accuracy is impacted by EMR migration, team agreement to standardize data entry, provincial lab services turnover, Connect Care implementation • Alberta Health does not provide the PCN with a list of patients who are enrolled to the PCN – only aggregate counts by physician • Alberta Health four-cut methodology does not provide an accurate estimate of physician panels when there is a recent change in family physician or when a family physician newly joins a community • Some data not available at a local community level to evaluate service needs ○ E.g. a request to evaluate specialized mental health service demand in one PCN community was limited by relevant data only available at a South Zone level

2. Priority Initiatives

The following are the key initiatives of the Palliser PCN:

1. Professional Support in Health Homes
This is accomplished primarily through the addition of RNs/Other Professionals to physician offices. The principal focus for these individuals is the delivery of complex and comprehensive care, disease prevention, and health promotion, towards development of the Health Home.

2. Measurement and Practice Improvement

Implementation of measurement, EMR optimization and practice improvement processes in physician offices and for the PCN as a whole.

2.1. Priority Initiatives: Professional Support in Health Homes, Measurement and Practice Improvement

1	Professional Support in Health Homes
Brief Description	This initiative enables the PCN to support optimization of the Patient's Medical Home (referred to as the Health Home in Palliser PCN), thereby enhancing delivery of primary care across the PCN in a manner that makes sense for the patients, community and providers within their localized context. The main objectives of this initiative are to: • Improve intercollaborative team care within the Health Home and the Health Neighbourhood. • Improve appropriate access for patients • Enhance linkages with other health providers (e.g. AHS and local not-for-profit organizations) • Enhance consistency and currency of assessment, treatment and care. • Provide coordinated care for complex, multi-morbidity and vulnerable populations • Improve patient partnered care • Improve patient and physician satisfaction • Collaborate with community partners to address local needs

Element(s) with description	Addition of RNs / Other Professionals to Physician Offices.	The intercollaborative teams will be situated within the Health Homes and unique to the specific Health Home needs (e.g. one single physician Health Home may choose to have a 1.0 FTE RN co-located whereas a different single physician Health Home may choose to have a 0.5 FTE RN and a 0.5 FTE BHC). Individual team composition will include registered healthcare professionals and will be based on the physicians' service plan. The PCN clinical employees will normally be located within the physicians' clinics and will typically deliver services on an appointment basis. Patients will normally be assessed by the RN/other professional in an initial appointment of 55 minute average (range of 25-90 minutes) and then receive follow-up appointments of 35 minute average (range of 20-65 minutes) where required. Group education and healthcare visits may also be offered (where deemed appropriate by the healthcare team and the PCN). The intercollaborative teams will work with zonal and provincial programs to support and facilitate development of strategies and programs for primary and secondary prevention, health promotion, disease management, care coordination, system navigation, and risk reduction. The intercollaborative teams will be supported through shared clinical supervision and education (lifelong learning, patient advocacy and navigation services, and system transformation and optimization services.

Resource Allocations/ Budget

Professional Support in Health Homes							
		April 1, 2024 to March 31, 2025		April 1, 2025 to March 31, 2026		April 1, 2026 to March 31, 2027	Full Term
Expenditure Description	FTE	**Budget**		**Budget**		**Budget**	
Element: Professional Support in Health Homes							
Staffing Costs							0.0
Registered nurses	36.9	3,739.7		3,506.3		3,506.3	10,752.2
Behavioural Health Consultants	8.5	861.1		861.1		861.1	2,583.2
TOTAL Staffing Costs	**45.4**	**4,600.7**	**0.0**	**4,367.3**	**-**	**4,367.3**	**13,335.4**
Element: Professional Support in Health Homes							
Non-Staffing Costs							
Physician: Supervision / program planning		185.0		185.0		185.0	555.0
Physician: Office rental & clinic support		151.0		151.0		151.0	453.0
Physician: Clinical Workshop Stipends		40.0		40.0		40.0	120.0
Education, training & orientation (RNs / OHCPs)		100.0		100.0		100.0	300.0
Medical & IT Equipment, and Renovations		30.0		30.0		30.0	90.0
Other expenses (travel and supplies)		80.0		80.0		80.0	240.0
							0.0
TOTAL Non-Staffing Costs	**0.0**	**586.0**	**-**	**586.0**	**-**	**586.0**	**1,758.0**
Total for Priority Initative	**45.4**	**$5,186.7**	**0.0**	**$4,953.3**	**0.0**	**$4,953.3**	**$15,093.4**

Implementation and Performance Indicators

Professional Support in Health Homes								
		Metrics						
Element	**Activity/Milestone**	**Goal**	**Start Date**	**Base**	**Y1 Target**	**Y2 Target**	**Y3 Target**	**End Date**
Addition of RNs / Other Professionals (OHPs) to Physician Offices.	Integration of RNs / OHPs	Achieve 93% of health home teamlets integrated with RNs / OHPs	Apr-2024	88%	88%	91%	93%	Mar-2027
	Optimize utilization of RNs / OHPs	Achieve average RN / OHP utilization of 47 minutes per patient	Apr-2024	53 minutes per patient	51 minutes per patient	49 minutes per patient	47 minutes per patient	Mar-2027
	Optimize access to RNs / OHPs	Achieve 80% of RNs / OHPs with 5 or fewer days Time to Third Next Available Appointment	Apr-2024	65%	70%	75%	80%	Mar-2027
		Achieve 60% of RNs / OHPs with 3 or fewer days TNA	Apr-2024	45%	50%	55%	60%	Mar-2027
	Optimize physician satisfaction with integration of RNs / OHPs	Maintain 93% or greater average physician response to survey question regarding recommendation of employment of RNs / OHPs to other physicians	Apr-2024	93%	93%	93%	93%	Mar-2027
	Optimize patient satisfaction with integration of RNs / OHPs	Maintain 95% or greater average overall patient satisfaction with care provided by RNs / OHPs	Apr-2024	95%	95%	95%	95%	Mar-2027

Impact

Most participating physicians have multi-disciplinary teams working in their respective clinics. These teams share the electronic medical record, care plans, and have the opportunity for frequent informal discussion resulting in improved:

- Delivery of chronic disease management
- Diagnosis, screening and follow-up;
- Coordination and appropriate access to community support programs;
- Communication and “patient health sharing” among relevant care providers within the primary care clinic;
- Navigation and assistance through community supports and referrals;
- Application of current best/promising practices and Clinical Practice Guidelines;
- Improved continuity of care.

Alignments	With Alberta Health	**Health Business Plan Objectives:** 1.2. Attract, recruit and retain health care professionals in order to build health system capacity and sustainability. 1.3 Strengthen and modernize Alberta's primary health care system and implement innovations to ensure all Albertans have access to timely and appropriate primary health care services in the community. 2.6 Increase oversight to improve safety while reducing red tape within the health system by streamlining processes and reducing duplication. 3.1 Safeguard Albertans from communicable disease that can cause severe outcomes. 3.2 Improve access to health services in remote and rural communities by attracting, recruiting and retaining health professionals in these communities and modernizing critical capabilities in the delivery of health care services. 3.3 Improve access for underserved populations and for First Nations, Metis, and Inuit peoples to quality health services that support improved health outcomes. 3.4 Prevent injuries and manage chronic disease and conditions through policy development, health and wellness promotion, screening, strengthening primary health care delivery, and initiatives that facilitate individual and community wellbeing in healthy environments. **Mental health and Addiction Business Plan Objectives:** 1.2 Enhance the capacity and capability to monitor and evaluate addiction and mental health outcomes across health, social and justice systems to ensure evidence-based decision making. 1.4 Strengthen addiction and mental health knowledge, expertise and workforce capacity across Alberta to enable the recovery-oriented system of care and expand and increase access to services. 2.4 Enhance system and service provider accountability to improve quality and safety, with a focus on transitions and integration back to the community to support recovery. 3.1 Ensure Albertans can access a continuum of recovery-oriented supports that meet their unique needs to improve their mental health. 3.5 Enhance innovative virtual services to support recovery regardless of where an individual resides.
	With Provincial Objectives	Patient's Medical Home, Partnerships & Transitions of Care, Community & Population Needs, Governance & Accountability
	With PCN Zone Service Plan Priority Initiative	Mental Health, Patient's Medical Home, Primary Care Sustainability, Chronic Pain & Opioids, Committee Core Operations, Pan-zone Initiatives, Provincial Initiatives.

Risks & Mitigating Activities Specific to Initiative	**Description of Risk**	**Activities to Mitigate/Prevent the Risk from Occurring**	**Strategies to Address the Risk Should it Occur**
	Recruitment and Retention: There is a worldwide health provider shortage which is being most acutely felt with physicians and registered nurses (foundational employees in	• Competitive compensation. • Robust lifelong learning opportunities. • Employee wellness plan.	• Assess resource deployment, consider shared resources where required / available. • Assess impact of employee schedule and adjust where desired by the

	Health Homes). This is impacting both recruitment and makes retention very important.	• Support employees in resolving team related issues. • Connect with local learning institutions to apprise students of opportunities in primary including clinical rotations. • Ensure onboarding processes recognize new employee context (e.g. foreign trained nurses may not have worked in a clinical area for a substantive period of time – 10 years). • Support immigrant employees with navigating the documentation required to be employed in the PCN (e.g. visa documents). • Position the PCN as a strong primary care institution through engagement in local, provincial and national research, education, and planning as PCN resources permit. • Continue to explore multiple and creative avenues to recruit employees.	employee and with acceptable impact on the Health Home team and/or PCN central office. • Temporary redeployment of clinical staff where required and resources available.
	Scope of Practice: Health care providers exceeding scope of practice and/or individual competence in providing care.	• Ongoing RN/other professional learning needs assessment and annual performance assessment. • Ongoing PCN wide educational workshops and individual education, mentoring, training as required. • Ongoing assessment of RN/other professional role and competency. • In-clinic clinical supervision, assessment and ongoing learning plans. • Collaborating with appropriate licensing body in competency assessment.	• Address RN/other professional and/or physician learning needs. • Ensure appropriate insurance coverage.

		• Maintenance and adherence to appropriate job descriptions.	
	Team Development: Physicians and RN/other professional will have varying skills in working in intercollaborative teams.	• During the service plan stage physicians will be provided strategies to maximize team development. • During the interview process the physician and potential employee will be facilitated to discuss team roles and expectations. • RN/other professional will receive ongoing education and mentorship to integrate into the office team. This education may be offered to physicians as well. • PCN Facilitator is available to assist clinic teams in clinic specific team development.	The PCN will assist the physician, RN/other professional, and office team members to collaboratively solve team development issues as required.

2	Measurement and Practice Improvement
Brief Description	This initiative enables the PCN to support optimization of the Patient's Medical Home (referred to as the Health Home in Palliser PCN) through embedding continuous quality improvement thereby enhancing delivery of primary care across the PCN in a manner that makes sense for the patients, community and providers within their localized context. The main objectives of this initiative are to: • Improve evaluation and data literacy among Health Home teams • Enhance standardized processes both within and across Health Homes • Enhance consistency in use of evidence based clinical and non-clinical processes • Support capacity building in use of measurement and evaluation of Health Home teams and community partners • Improve patient and physician satisfaction • Create a culture of continuous quality improvement in all aspects of primary care for Health Home teams and the PCN • Support Health Home teams to incorporate new initiatives into existing workflows and/or develop new workflows if required • Optimize interprofessional team collaboration • Problem solve with service providers (e.g. AHS Connect Care) and Health Home teams where there is a challenge with a process and/or pathway.

Element(s) with description	Implement measurement and practice improvement methodologies	PCN Facilitators and Evaluator are centrally hired and shared among Health Home teams so that individual Health Homes are able to benefit from knowledge sharing across all the Health Homes in the PCN. Individualized, context dependent team practice improvement PDSA (Plan-Do-Study-Act) cycles are embedded into ongoing work with clinics such that practice improvement becomes part of how the teams think about both their clinical and non-clinical work. PCN supports collaborative learning through workshops (both quality improvement / practice improvement dedicated) and ensuring quality improvement is embedded into clinical learning events. PCN supports in-clinic practice improvement team meetings. PCN supports Electronic Medical Record optimization for the purpose of both individualized patient measurement, panel measurement, and broader community data measurement. This work is done through a combination of evaluation team measurement and clinic team capacity building. PCN supports ongoing governance evaluation and improvement through meeting evaluation, analysis and improvement, overall board (and individual board member) evaluation, analysis and improvement and various metrics related to employee and physician satisfaction, attendance, improvement in learning, use of tools and devices (e.g. DynaMed and ScreenCloud).

Resource Allocations/ Budget

Measurement and Practice Improvement							
		April 1, 2024 to March 31, 2025		April 1, 2025 to March 31, 2026		April 1, 2026 to March 31, 2027	Full Term
Expenditure Description	FTE	**Budget**		**Budget**		**Budget**	
Element: Measurement and Practice Improvement							
Staffing Costs							0.0
Facilitators, Analysts, Assistant & Coordinators	4.5	436.0		436.0		436.0	1,308.0
		-		-		-	0.0
TOTAL Staffing Costs	**4.5**	**436.0**	**0.0**	**436.0**	**-**	**436.0**	**1,308.0**
Element: Measurement and Practice Improvement							
Non-Staffing Costs							
Physician: QI Stipends		100.0		-		-	100.0
QI Training - Related expenses		130.0		-		-	130.0
Practice Improvement: Other expenses		23.0		23.0		23.0	69.0
							0.0
TOTAL Non-Staffing Costs	**0.0**	**253.0**	**-**	**23.0**	**-**	**23.0**	**299.0**
Total for Priority Initative	**4.5**	**$689.0**	**0.0**	**$459.0**	**0.0**	**$459.0**	**$1,607.0**

	Measurement and Practice Improvement								
			Metrics						
	Element	Activity / Milestone	Goal	Start Date	Base	Y1 Target	Y2 Target	Y3 Target	End Date
Implementation and Performance Indicators	Implement measurement and practice improvement methodologies.	Increase Health Home Optimization (HHO) activities within the domain of Panel	Achieve 80% CPAR/CII enrollment among eligible core and minority family practice physicians	Apr-2024	53%	62%	71%	80%	Mar-2027
			Achieve 80% of core and minority family practice physicians with under 10% cross-panelled rate	Apr-2024	67%	71%	75%	80%	Mar-2027
			Achieve 35% of core and minority family practice physicians with under 5% cross-panelled rate	Apr-2024	20%	25%	30%	35%	Mar-2027
			Achieve 85% or more Health Homes with a HHO Panel score of 2.5 or greater	Apr-2024	66%	73%	79%	85%	Mar-2027
		Increase HHO activities within the domain of Access	Achieve 40% or more Health Homes with a HHO Access score of 2 or greater	Apr-2024	13%	22%	31%	40%	Mar-2027
		Increase HHO activities within the domain of EMR	Achieve 85% or more Health Homes with a HHO EMR score of 2.5 or greater	Apr-2024	58%	67%	76%	85%	Mar-2027
		Increase HHO activities within the domain of Screening	Achieve 50% or more Health Homes with a HHO Screening score of 2.5 or greater	Apr-2024	16%	28%	39%	50%	Mar-2027
		Increase HHO activities within the domain of Team-based Care	Achieve 50% or more Health Homes with a HHO Team score of 2.5 or greater	Apr-2024	24%	33%	42%	50%	Mar-2027

<table>
<tr><td>Impact</td><td colspan="2">Most participating physicians/clinics engage with the PCN Facilitators and evaluation team on an ongoing basis. Where there are PCN employees in clinics participation in measurement (e.g. access, screening, outcomes) is mandatory for the PCN employee. Member Physicians sign a Charter with the PCN which includes a commitment to leadership, evaluation, engagement in data compilation, analysis and improvement work. This collaboration results in:

• Improved and/or maintained third-next-available for attached patients
• Ongoing panel verification and maintenance processes.
• Improved communication between providers where a patient is cross-paneled
• Decreased average cross-panel rate in the PCN through incorporating processes, pathways, system requirements (CPAR/CII conflict reports) into Health Home patient care processes
• Improved and/or maintained physicians accepting new patients as appropriate to the number of unattached patients at a given point in time.
• Interprofessional teams working to the top of their scope of practice as appropriate in a given context.
• Improvement in screening, surveillance, diagnosis and management as indicated through their EMR.
• Improvement in patient satisfaction with their physician/Health Home team partnership.
• Improved communication with AHS services, medical specialist care and community resource linkages resulting in strengthened and more streamlined relationships throughout the system.
• Improved provider satisfaction with interprofessional team communication and function.
• Improved EMR optimization as evidenced by increase in awareness of the need to integrate the EMR in all aspects of the Health Home, including panel identification and management, standardization of Health Home team day-to-day clinical use of the EMR (rather than engaging in panel verifying and screening as outside the clinical visit activities), building decision support tools (patient assessments and calculators) into the Health Home EMR.</td></tr>
<tr><td>Alignments</td><td>With Alberta Health</td><td>Health Business Plan Objectives:
1.2. Attract, recruit and retain health care professionals in order to build health system capacity and sustainability.
1.3 Strengthen and modernize Alberta’s primary health care system and implement innovations to ensure all Albertans have access to timely and appropriate primary health care services in the community.
2.6 Increase oversight to improve safety while reducing red tape within the health system by streamlining processes and reducing duplication.
3.1 Safeguard Albertans from communicable disease that can cause severe outcomes.
3.2 Improve access to health services in remote and rural communities by attracting, recruiting and retaining health professionals in these communities and modernizing critical capabilities in the delivery of health care services.
3.3 Improve access for underserved populations and for First Nations, Metis, and Inuit peoples to quality health services that support improved health outcomes.
3.4 Prevent injuries and manage chronic disease and conditions through policy development, health and wellness promotion, screening, strengthening primary health care delivery, and initiatives that facilitate individual and community wellbeing in healthy environments.</td></tr>
</table>

		Mental health and Addiction Business Plan Objectives: 1.2 Enhance the capacity and capability to monitor and evaluate addiction and mental health outcomes across health, social and justice systems to ensure evidence-based decision making. 1.4 Strengthen addiction and mental health knowledge, expertise and workforce capacity across Alberta to enable the recovery-oriented system of care and expand and increase access to services. 2.4 Enhance system and service provider accountability to improve quality and safety, with a focus on transitions and integration back to the community to support recovery. 3.1 Ensure Albertans can access a continuum of recovery-oriented supports that meet their unique needs to improve their mental health. 3.5 Enhance innovative virtual services to support recovery regardless of where an individual resides.
	With Provincial Objectives	Patient's Medical Home, Partnerships & Transitions of Care, Community & Population Needs, Governance & Accountability
	With PCN Zone Service Plan Priority Initiative	Mental Health, Patient's Medical Home, Primary Care Sustainability, Chronic Pain & Opioids, Committee Core Operations, Pan-zone Initiatives, Provincial Initiatives.

	Description of Risk	**Activities to Mitigate/Prevent the Risk from Occurring**	**Strategies to Address the Risk Should it Occur**
Risks & Mitigating Activities Specific to Initiative	The demand for analyst and facilitator support may be greater than the resources available.	• Build capacity within the clinic interprofessional team to manage their own data analysis and practice improvement • Where appropriate PCN central office team will be cross trained to support practice improvement demand (i.e. build data literacy, EMR skills, change management skills in Clinical Supervisors & Educator).	• A priority setting system will be developed to ensure that the resources available provide the greatest benefit to clinics and patients.
	Clinics may not wish to engage in Health Home optimization work (e.g. panel verifying).	• The PCN will maximize the use of the 5 A's to work with clinics in a motivating, meaningful and long-lasting manner. • The PCN will engage in ongoing education and capacity building for Facilitator and Clinical Supervisor & Educator employees to support change management and continuous practice improvement.	• A priority setting system will be used to focus PCN attention on clinics who need additional change management support.

Changes to Priority Initiatives and Elements Over-Time

Priority Initiatives and Elements in 2021-2024 Business Plan	Changes since 2021-2024 Business Plan			**New** Priority Initiatives and Elements for Business Plan Renewal 2024-2027 Added (+)	Priority Initiatives and Elements in 2024-2027 BPR
	Added (+)	**Enhanced (Δ)**	**Discontinued (-)**		
PROFESSIONAL SUPPORT IN HEALTH HOMES (addition of RNs / Other Professionals to Physician Offices)					**PROFESSIONAL SUPPORT IN HEALTH HOMES** (addition of RNs / Other Professionals to Physician Offices)
MEASUREMENT AND PRACTICE IMPROVEMENT (this includes: Panel Identification and management, EMR optimization, practice improvement methodologies, development and support of clinic practice improvement teams. Also includes PCN administration and governance measurement & improvement.)					**MEASUREMENT AND PRACTICE IMPROVEMENT** (this includes: Panel Identification and management, EMR optimization, practice improvement methodologies, development and support of clinic practice improvement teams. Also includes PCN administration and governance measurement & improvement.)

3. Financial Plan Summary

The PCN will:

- Comply with Generally Accepted Accounting Principles.
- Adhere to accountability requirements developed by AH (this includes, but is not limited to, financial and evaluation reporting requirements).
- Include only expenditures for goods and services that are being directly purchased by the legal entity of the PCN.
- Use a fiscal year ending March 31.

3.1. PCN Budget Summary

Statement of Operations (3-Year Budget)

Statement of Operations in thousands of dollars with one decimal place	April 1, 2024 to March 31, 2025 Budget	April 1, 2025 to March 31, 2026 Budget	April 1, 2026 to March 31, 2027 Budget	Full Term
Revenue				
Per Capita Funding	$6,340.3	$6,340.3	$6,340.3	19,020.9
Interest and Investment Income	100.0	100.0	100.0	300.0
Fee for Service				0.0
PCN Support Program Nurse Practitioner Funding	262.5	262.5	262.5	787.5
Shared Services				0.0
Other: AH-AMA Agreement PCN Investment	463.4			463.4
				0.0
①Total Revenue	**$7,166.2**	**$6,702.8**	**$6,702.8**	**$20,571.8**
Expenses (Priority Initatives)				
Professional Support in Health Homes	5,186.7	4,953.3	4,953.3	15,093.3
Measurement and Practice Improvement	689.0	459.0	459.0	1,607.0
				0.0
				0.0
				0.0
PCN NSPSP	262.5	262.5	262.5	787.5
Zonal Expenses	0	0	0	0.0
Expenses (Central Allocations)				
Evaluation				0.0
PCN Administrative Lead Salary	161.0	161.0	161.0	483.0
PCN Administrative Lead Benefits	34.0	34.0	34.0	102.0
Other Management Salaries	318.0	318.0	318.0	954.0
Other Management Benefits	34.0	34.0	34.0	102.0
Administration	481.0	481.0	481.0	1,443.0
Information Technology				0.0
Support Services				0.0
Purchase of Capital Assets	0.0	0.0	0.0	0.0
② Total Expenses	**$7,166.2**	**$6,702.8**	**$6,702.8**	**$20,571.8**
Excess/(Deficiency) of Revenue Over Expenses ① minus ②	**$0.0**	**$0.0**	**$0.0**	**$0.0**
Amortization	0.0	0.0	0.0	0.0

Expense Breakdown

Expense Breakdown

Expense Estimate by Priority Initiative and Payment Type

Planned Expenses: 3 year totals **by Major Categories (in thousands of dollars)**

Priority Initiatives	Payments to Physicians 3 year total		Payment to AHS 3 year total		Non-Phys. Direct Care Providers 3 year total		Other Expenses 3 year total		%	3 Year Totals
Professional Support within Health Homes	Supervision/ program planning	555.0		-	RNs / Other Professionals: Pay & benefits	13,335.3	Other non-payroll expenses	630.0		14,520.3
	Office rental & clinic support	453.0		-		-		-		453.0
	Clinical Workshop Stipends	120.0		-		-		-		120.0
		-		-		-		-		-
Professional Support within Health Homes Total		1,128.0		-		13,335.3		630.0		15,093.3
Measurement & Practice Improvement		100.0		-		-		1,507.0		1,607.0
		-		-		-		-		-
		-		-		-		-		-
Measurement & Practice Improvement Total		100.0		-		-		1,507.0		1,607.0
		-		-		-		-		-
		-		-		-		-		-
		-		-		-		-		-
Total		-		-		-		-		-
		-		-		-		-		-
		-		-		-		-		-
		-		-		-		-		-
Total		-		-		-		-		-
PCN NSPSP		-		-		787.5		-		787.5
		-		-		-		-		-
		-		-		-		-		-
PCN NSPSP Total		-		-		787.5		-		787.5
Priority Initiative Allocations	7%	1,228.0	-	-	81%	14,122.8	12%	2,137.0	85%	17,487.8
Allocations not specific to a particular initiative	Medical Director	-		-		-	Evaluation Resources	-		-
Board meeting stipends	PCN (JV Governance)	180.0		-		-	PCN Administrative Lead Total	585.0		765.0
	Non-Profit Corporation	-		-		-	Other Management Total	1,056.0		1,056.0
	Forum, etc	-		-		-	Other administration costs	1,263.0		1,263.0
		-		-		-	IT	-		-
		-		-		-	Support Services	-		-
		-		-		-				
Central Allocations Subtotal		180.0		-		-		2,904.0	15%	3,084.0
Budget Estimate Totals by Category	7%	1,408.0	-	-	69%	14,122.8	25%	5,041.0	100%	20,571.8

Payments to Physician Check		
The total must match the total Payment to Physicans Above		
	3 year total	
Memo:	C	$0.0
Breakdown of Payments	A	$735.0
to Physicians	O	$673.0
Total	**100%**	$1,408.0

4. Risk Assessment

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Financial Risks		
• Occurrence of a deficit	• PCN financial policies are reviewed annually and adhered to. • The PCN Board monitors financial results at the monthly board meeting. This monitoring includes variance analysis. • The PCN Board reviews budget projections twice per annum.	• Adjust spending based on variance analysis at least on a quarterly basis. • The PCN has placed hard caps on its significant expense areas (i.e. employee FTE).
• Uncertain funding amounts as enrollee numbers change	• Monitor policy development regarding funding. • Monitor enrollee data reports, verify where enrollees are receiving services outside of the PCN and bring this information back to the PCN Board with recommendations.	• The PCN may have to adjust its spending should enrollee numbers change unexpectedly.
Patient Safety, Legal, and Liability Risks		
• Liability associated with sharing of care among multidisciplinary team members	• Ensure all PCN clinical employees, are appropriately credentialed and insured. • Ensure PCN clinical employees are appropriately on-boarded, supervised, and engage in ongoing assessment including a lifelong learning plan. • Ensure new/updated national clinical guidelines are brought to the attention of PCN employees where applicable (e.g. new hypertension guidelines brought to a PCN workshop). • Ensure protocols being used between physicians and PCN clinical employees are reviewed, updated and signed annually.	• Address matters of concern promptly.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
• Adverse patient outcomes resulting from presence at or treatment through PCN programming	• Provide a comprehensive ongoing education and supervision program for PCN employees. • Establish protocols for patient treatment and ensure that PCN staff are aware of their professional scope. • The PCN carries comprehensive liability insurance.	• Notify representatives of the Board and Alberta Health. • Ensure appropriate communications channels are utilized promptly.
Human Resource Risks		
• Inability to recruit and retain qualified staff	• Establish a positive work environment for staff. • Provide education and growth opportunities for staff. • Endeavour to promote within. • Provide competitive salary and benefits within means.	• Develop alternate service delivery methodology.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Health Information and Privacy Risks		
• Poor decision making due to lack of experience in making collective decisions	• Continue effective governance through regular bylaw review, nominating and board governance procedures including annual individual and board governance training and monthly (i.e. following each board meeting) meeting surveys. • Continue Board Palliser PCN governance training, evaluation and goal setting to buttress decision making competency, chair support through professional parliamentarian services, additional board governance training (e.g. ACTT training) as needed. • Ongoing assessment of board member conflict of interest and open discussion of same. • Strong relationship between the Executive Director and the board whereby any board members (AHS, physicians, and/or community member) are comfortable to indicate they need more or different information to make well informed decisions. • Effective board communication whereby board members are able to address when the board is wading into operational versus governance decisions. • Annual board retreat which includes team building for board members, communication exercises and education sessions related to effective governance including decision making.	• Adjust decisions, plans and resources as necessary.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
• Breach of patient privacy.	• PCN Employee handbook and professional codes of conduct address privacy risks. • PCN support for physicians, clinic staff and PCN clinical staff to operationalize Privacy Impact Assessments as they pertain to patient privacy. • Annual review of PCN privacy policy/procedure. • New employee on boarding includes review of privacy and confidentiality agreement. • Annual privacy training for PCN central office staff, PCN clinical staff, and physicians and clinic staff based on physician/clinic request. • Review of PCN Information Management Agreement with each physician as they sign into the PCN. • PCN Executive Director and Evaluation Manager assess local, national and international privacy risks as they pertain to the PCN context (e.g. risks brought to our attention through our insurance provider HIROC).	• Address matters of concern promptly as per PCN privacy policy/procedure.
Other Risks		
• Patient volumes overwhelm program resources	• Manage intake. • Implement program delivery on a phased basis.	• Adjust plans and resources as necessary.

Appendix A: Evaluation of the PCN

A.1. Performance measurement and evaluation plan

Palliser PCN's performance measurement and evaluation plan utilizes the Eco-Normalization model of innovation evaluation introduced by Hamza and Regehr[1]. Evaluation questions introduced by the model:

- Does the innovation, as designed, align with the grand aspirations of change?
- Do the system goals align with the grand aspirations of change?
- Do the stakeholders' local aspirations align with the grand aspirations of change?
- Does the innovation interact with the system in a way that will lead to the aspirations of change?
- Does the innovation evoke meaning to actions and agency of the people doing the work that will lead to aspirations of change?
- Does the system support the people doing the work in ways that will lead to aspirations of change?

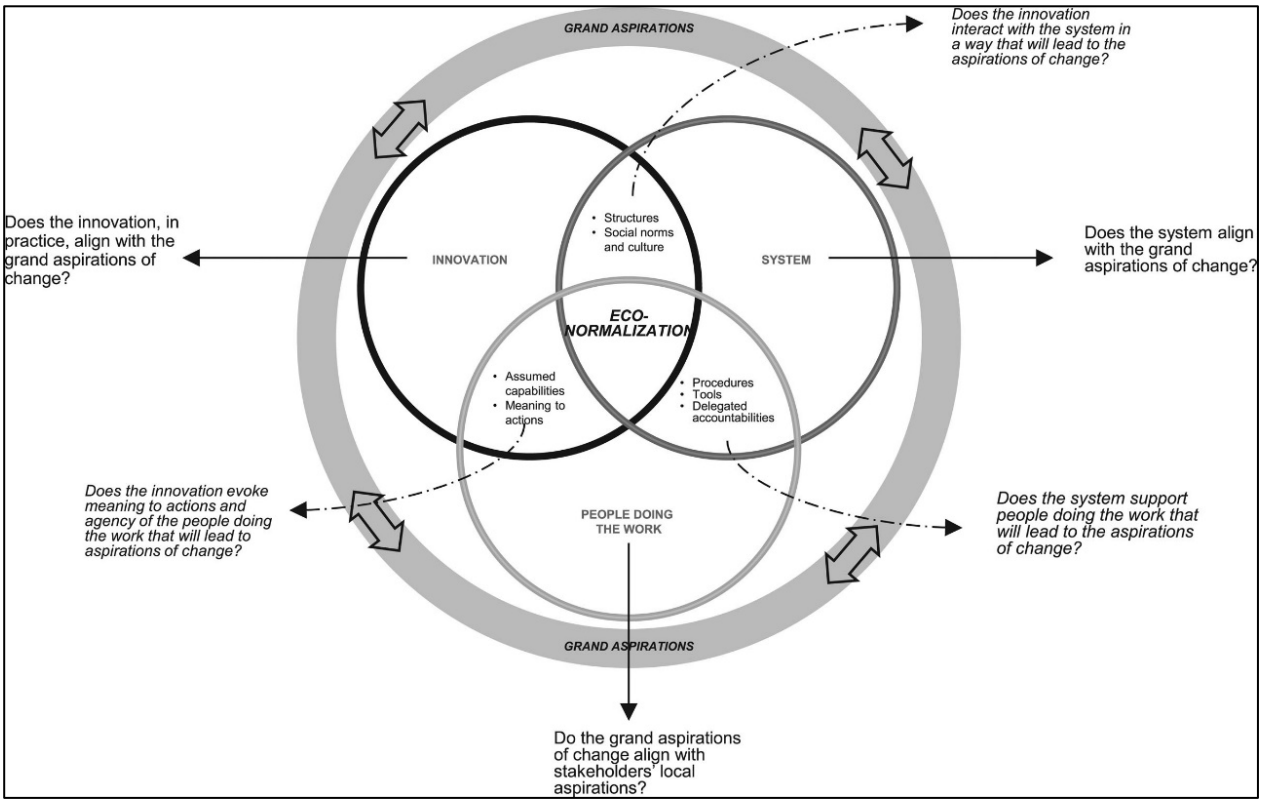


Figure 12 - Eco-Normalization: Six critical evaluation questions about innovation implementation.[2]

[1] 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

[2] Hamza & Regehr (2021).

Provincial and local healthcare system changes during 2024-27 will invariably require the PCN's evaluation plan, logic model, indicators and measurement strategy to be evolved. As such, these elements are will invariably evolve during the 2024-27 BPR period.

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 seen 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 Local Enablers	Palliser PCN Priority Initiative Applicability	Palliser PCN Local Activities	Palliser PCN Short-term Outcomes	Palliser PCN Medium-term Outcomes	Provincial PCN Long-term Outcomes
A. Bring about cultural change	1. 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 [AH Schedule B indicators]	- Maximization of board member attendance at meetings and retreat - Maximization 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	- Quality
B. Enhance delivery of care	2. 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 with Alberta Find-A-Doc website - Regular communication with AMA ACTT to ensure accuracy of CPAR/CII information to Health Home teams - Participation in Provincial Improvement activities (e.g. H2H2H PIN) to support AHS and Health Home coordination of care, continuity of information	- Increased CPAR/CII enrollment *[AH Schedule B indicator]* - Increased Health Home team efficiency/effectiveness in coordinating with former/new 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 neighbourhood - Reduced PCN and physician-level cross-panel rates	- Albertans as partners
C. Establish building blocks for change	3. 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 BHC 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	- Integration
D. Population needs based design							- Indigenous cultural safety
E. Increase value & return on investment	4. 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 *[AH Schedule B indicator]* - Increased number of Health Home teams surveying patient experience *[AH Schedule B indicator]* - Increased number of Health Home teams engaging in disease screening and management quality improvement *[AH Schedule B indicator]* - Increased number of Health Home teams discussing, measuring and improving their effectiveness *[AH Schedule B indicator]*	- 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	- Access

Figure 13 - Palliser PCN Evaluation Logic Model

A.2. Indicators

	Outcome	Indicator	Data Collection Strategy
Short-Term	Maximization of board member attendance at meetings and retreat	• Number and percentage of board members attending board meetings • Number and percentage of board members attending retreat	• PCN board meeting minutes and attendance records reviewed quarterly • PCN retreat minutes and attendance records reviewed annually
	Maximization of board member attendance at PCN events	• Number and percentage of board members that attended a PCN event	• PCN event attendance records reviewed annually
	Increased board member effectiveness, satisfaction and confidence in PCN	• Individual post-board meeting survey • Executive Director performance assessment *[AH Schedule B indicator]*	• Survey conducted after each board meeting • Executive Director performance reviewed after each board meeting
	Increased physician engagement	• Number and percentage of physicians who attended a PCN engagement event	• PCN event attendance records reviewed annually
	Increased CPAR/CII enrollment	• Number and percentage of physicians who enrolled in CPAR/CII *[AH Schedule B indicator]* • Associated CPAR/CII readiness indicators *[AH Schedule B indicator]*	• CPAR/CII enrollment measured monthly, reviewed at board meetings and reported annually • Monthly provincial CPAR/CII reports validated monthly
	Increased Health Home team efficiency/effectiveness in coordinating with former/new Health Home when patients change family doctors	• Number and percentage of health homes that use a Physician Change Form when patients change family doctors	• Use of physician change form measured quarterly, reviewed quarterly by administrative team, reported annually
	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 • Opportunity for AHS collaboration to define a hospital discharge timeliness indicator	• EMR data collected annually regarding timing of hospital discharge summary receipt vs. timing of discharges • Opportunity for AHS collaboration to measure hospital discharge processes in acute care

	Outcome	Indicator	Data Collection Strategy
	Increased accuracy of identification of family doctor at ED/hospital	• Number and percentage of times incorrect identification of family doctor occurred • Opportunity for AHS collaboration to measure ED/hospital admission family doctor identification processes at ED/hospital	• Data collected from Health Homes opportunistically • Opportunity for AHS collaboration to develop data collection strategy
	Increased utilization of obstetrical nurse to support low risk obstetrical population needs	• Number of unique patients and visits by obstetrical nurse	• Health Home EMR data collected annually • Opportunity for AHS collaboration to develop data collection strategy
	Increased advancement of Behavioural Health Consultant model	• Number of unique patients and visits by PCN BHC providers • Number of visits with BHC-7, PHQ-9, GAD-7 assessments occurring	• EMR data collected annually
	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 • Number and percentage of Health Homes with access to a PCN registered health professional	• Health Home EMR data collected annually • Human Resource data analyzed semi-annually
	Increased number of Health Home teams measuring and improving access	• Number and percentage of physicians and PCN OHPs measuring Time to Third Next Available Appointment *[AH Schedule B indicator]* • Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Access score of 2 or higher	• Access data collected monthly, reported annually • HHO Access scores completed semi-annually, reported annually
	Increased number of Health Home teams surveying patient experience	• Number and percentage of teams surveying patient experience • Number of patients reporting “Excellent” or “Very Good” to single visit overall experience survey question *[AH Schedule B indicator]*	• Health Home team patient experience survey data collected semi-annually, reported annually • Single question survey data collected annually

	Outcome	Indicator	Data Collection Strategy
	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]* • Number and percentage of teams with a HHO Screening score of 3 or higher	• Screening and management rates measured annually • HHO Screening scores completed semi-annually, reported annually
	Increased number of Health Home teams discussing, measuring and improving their effectiveness	• Number and percentage of teams measuring team effectiveness [AH Schedule B indicator] • Number and percentage of teams with a HHO Team score of 2 or higher	• Health Home team effectiveness measurement data collected semi-annually, reported annually • HHO Team scores completed semi-annually, reported annually
Medium- Term	Efficient, effective and innovative PCN governance	• Number and percentage of board members with a board member self-improvement plan	• Board member improvement plan data measured annually

	PCN governance achieves the provincial objective of shared accountability and primary healthcare evolution	• Board meeting attendance:
		  ○ Physicians
		  ○ AHS
		  ○ Community
		• Individual board member survey and AMA Board Survey *[AH Schedule B indicator]*
		• Annual board planning retreat attendance
			• PCN board meeting minutes and attendance records reviewed quarterly
			• Individual board member and AMA survey data reviewed annually
			• PCN retreat minutes and attendance records reviewed annually

	Increased information, relationship and management continuity between Health Homes and across the Health Home neighbourhood	• PCN average physician and clinic continuity • H2H2H implementation measures	• HQCA PCN proxy report continuity rates measured annually • Opportunity for AHS collaboration to report H2H2H implementation measures at a PCN, facility level
	Reduced PCN and physician-level cross-panel rates	• PCN overall cross-panel rate • Number and percentage of physicians in each stratification of cross-panel rate (< 5%, 5-10%, 10-20%, >20%)	• PCN and physician cross-panel rates measured semi-annually, reported annually

	Outcome	Indicator	Data Collection Strategy
	Increased effectiveness of low risk obstetrical care in Palliser PCN	• Fidelity measures to obstetrical nurse model (vitals, disease screening, ultrasound) • Opportunity for AHS collaboration to define a low-risk obstetrical care effectiveness indicator	• Health Home EMR data collected annually • Opportunity for AHS collaboration to develop data collection strategy
	Increased number of Health Home teams maintaining high patient access	• Health Home physician and OHP Time to Third Next Available Appointment • Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Access score of 4 or higher	• Health Home access data collected monthly or more frequently, reported at each Health Home PDSA interval • HHO Access scores completed semi-annually, reported annually
	Increased number of Health Home teams incorporating patient feedback into clinical process improvements	• Number and percentage of teams using patient experience survey results or other feedback data to inform a quality improvement aim	• Data collected concurrently with HHO Team scores (completed semi-annually, reported annually)
	Increased number of Health Home teams maintaining high disease screening and management rates	• Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Screening score of 4 or higher	• HHO Screening scores completed semi-annually, reported annually
	Increased number of Health Home teams improving their effectiveness	• Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Team score of 3 or higher	• HHO Team scores completed semi-annually, reported annually
Long-Term	Provincial PCN outcomes identified in PCN Evaluation Logic Model	• As long-term provincial-scale PCN outcomes, these require AH/system-level evaluation, including definition of indicators and a data collection strategy. Palliser PCN will support and collaborate to assist with provincial evolution of indicators and data collection strategy.	

A.3. Data analysis plan

	Outcome	Analysis Plan
Short-Term	Maximization of board member attendance at meetings and retreat	• Results reviewed by board members to inform individual and board improvement plans as appropriate
	Maximization of board member attendance at PCN events	• Results reviewed by board members to inform individual and board improvement plans as appropriate
	Increased board member effectiveness, satisfaction and confidence in PCN	• Results reviewed by board members and Executive Director to inform individual and board improvement plans as appropriate
	Increased physician engagement	• Results reviewed by board members to inform strategic planning regarding physician engagement
	Increased CPAR/CII enrollment	• Results reviewed by board members to inform progress to achieve provincial/board priority • Results reviewed as frequently as weekly by PCN administrative team to use a 5 A's change management approach to leverage opportunities for scale and spread of CPAR/CII among PCN Health Homes
	Increased Health Home team efficiency/effectiveness in coordinating with former/new Health Home when patients change family doctors	• Results reviewed by PCN administrative team to use a 5 A's change management approach to leverage opportunities to increase adoption of Physician Change Form notification processes
	Increased timeliness of hospital discharge summaries to Health Homes	• Results reviewed by PCN administrative team to identify opportunities for collaboration with AHS to improve and measure timeliness of hospital discharge summaries to Health Homes • Where applicable, administrative team identifies within Health Home quality improvement opportunities to increase efficiency and effectiveness of tracking/coordinating processes related to hospital discharge summaries
	Increased accuracy of identification of family doctor at ED/hospital	• Opportunity for AHS collaboration to develop analysis and performance improvement plan
	Increased utilization of obstetrical nurse to support low risk obstetrical population needs	• Results reviewed by PCN administrative team to identify opportunities for increased utilization, additionally integrated into obstetrical nurse performance assessment process
	Increased advancement of Behavioural Health Consultant (BHC) model	• Results reviewed by PCN administrative team to identify opportunities for increased utilization and BHC model fidelity, additionally integrated into BHC performance assessment process

	Outcome	Analysis Plan
	Increased integration of co-located registered health professionals in Health Homes	• Results reviewed by PCN administrative team to identify opportunities for increased utilization, effectiveness and intercollaboration, additionally integrated into registered health professional's performance assessment process
	Increased number of Health Home teams measuring and improving access	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support identification of access as a Health Home Optimization priority, assist with access measurement and evaluate opportunities for improvement • Access measures incorporated into annual Activity and Screening Indicators review offered to each core family practice physician • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and provincial priorities
	Increased number of Health Home teams surveying patient experience	• Results reviewed by PCN administrative team to assist teams to survey patient experience and consider process improvements • Results reviewed by board and PCN administrative team and include measurement and reporting of administrative cost of measuring single visit overall experience Schedule B indicator
	Increased number of Health Home teams engaging in disease screening and management quality improvement	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support identification of screening as a Health Home Optimization priority, assist with screening process optimization with an objective to leverage opportunities for scale and spread of screening process optimizations within and between Health Homes • Screening measures incorporated into annual Activity and Screening Indicators review offered to each core family practice physician • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and provincial priorities
	Increased number of Health Home teams discussing, measuring and improving their effectiveness	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support Health Home teams to assess and improve elements of their effectiveness • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and provincial priorities

	Outcome	Analysis Plan
Medium- Term	Efficient, effective and innovative PCN governance	• Results reviewed by board members to inform strategic planning at board meetings and board retreats
	PCN governance achieves the provincial objective of shared accountability and primary healthcare evolution	• Results reviewed by board members to inform strategic planning at board meetings and board retreats
	Increased information, relationship and management continuity between Health Homes and across the Health Home neighbourhood	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to measure and improve external and internal continuity • Opportunity for AHS collaboration to analyze H2H2H implementation measures and critically evaluate tests of change to improve continuity
	Reduced PCN and physician-level cross-panel rates	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support Health Home teams to optimize elements of the Health Home Optimization domain of panel • Cross-panel rates reviewed by board members semi-annually to inform progress toward PCN panel management objectives • Cross-panel rate measures incorporated into annual Activity and Screening Indicators review offered to each core and minority family practice physician • Cross-panel rate measures incorporated into semi-annual physician profiles process, with facilitated panel management support offered to each core and minority family practice physician
	Increased effectiveness of low risk obstetrical care in Palliser PCN	• Results reviewed by PCN administrative team to identify opportunities for increased effectiveness, additionally integrated into obstetrical nurse performance assessment process • Opportunity for AHS collaboration to analyze effectiveness of low risk obstetrical care and evaluate tests of change to improve effectiveness
	Increased number of Health Home teams maintaining high patient access	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support maintaining high access, assist with measurement and evaluation of tests of change

	Outcome	Analysis Plan
		• Access measures incorporated into annual Activity and Screening Indicators review offered to each core family practice physician, reviewed more frequently within each access PDSA cycle • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and provincial objectives
	Increased number of Health Home teams incorporating patient feedback into clinical process improvements	• Results reviewed by PCN administrative team to assist teams to incorporate patient experience elements into improvement design and evaluation
	Increased number of Health Home teams maintaining high disease screening and management rates	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support sustaining screening processes and maximizing EMR to achieve this goal, assist with screening process optimization with an objective to leverage opportunities for scale and spread of screening process optimizations within and between Health Homes • Screening measures incorporated into annual Activity and Screening Indicators review offered to each core family practice physician • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and • Opportunity for collaboration with HQCA to develop a data analysis plan regarding use of HQCA panel reports
	Increased number of Health Home teams improving their effectiveness	• Results reviewed by PCN administrative team to use a 5 A's change management approach to identify opportunities to support Health Home teams to improve (and maintain high) team effectiveness • HHO score results reviewed by board members semi-annually to inform progress toward meeting PCN and provincial objectives
Long-Term	Provincial PCN outcomes identified in PCN Evaluation Logic Model	• As long-term provincial-scale PCN outcomes, these require AH/system-level evaluation, including a data analysis plan. Palliser PCN will support and collaborate provincially to assist with evolution of an analysis plan.

Appendix B: Internal Financial Controls

Has the PCN read, and acknowledge the PCN is in compliance with 11.8 Internal Financial Controls Policy of the Primary Care Initiative Policy Manual Version 11 (Updated January 2018)? ☒ Yes ☐ No

The Financial Controls Policy details the internal financials controls for the PCN and this policy is included as the next four pages.

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ADMINSTRATION **FINANCIAL CONTROLS POLICY**

Author:	Dr. Treena Klassen
Approved By:	Board of Directors
Effective Date:	November 2009
Reference Documents:	Meeting minutes AH IFC Policy (updated January 2018)
Related Documents:	General Ledger & Monthly Reporting Year End checklist Accounts Payable checklist T4 Preparation checklist Payroll Checklist Cash Control checklist Bank Signatory Documents
Purpose:	To govern the financial accountability and assurance measures of the Palliser Primary Care Network
Principles Based Policy:	In accordance with what is believed to be the best international accounting standards, this has been established as a "principles based" policy, rather than a "rules based" policy. As a principles based policy, this document outlines the overall philosophy and expectations with regard to financial controls and stipulates certain critical processes that must be followed. The PCN Board and Administration will utilize this policy to effect control over the overall finances of the PCN. At an operational/transactional level, PCN staff will use a variety of checklists and instruction sheets (that are compatible with the Policy) to process the day-to-day transactions of the PCN.
Background & General Philosophy:	The Palliser Primary Care Network is a publicly-funded, not-for-profit health care corporation. In keeping with this structure and its objective to enhance the delivery of primary care, the PCN has a duty to be responsible stewards of public funds and takes a very conservative approach to financial management. All revenues received, and specifically those from Alberta Health, shall be securely guarded and used only in the implementation of the PCN's current approved business plan. All financial decisions shall align with the PCN's current approved business plan. All decisions shall be based on the highest ethical and moral standards and shall hold the PCN in the highest esteem. Cash management practices and accounts payable procedures are structured to support the PCN's goals of conservative financial management.

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This policy applies to all personnel (Board Members, PCN Executive Director and PCN Employees) who have cash management duties and/or financial responsibility.

Principles of Financial System:

1. Simplicity
2. Flexibility
3. Minimal administration/cost to manage
4. 100% confidence in the financial controls
5. PCN Board accountability
6. Adherence to the PCN Business Plan
7. Conscious that the PCN disburses public funds and expenditures should demonstrate value for money and be deemed free of real or perceived bias
8. Funds held centrally in a single bank account and accounted for as an overall Palliser PCN surplus. Individual physicians have access to the PCN funds based on their right to resources as detailed in the PCN approved Business Plan

Revenue:

1. Alberta Health Grants:
Grants are normally received twice per year and shall be deposited to the PCN bank account

2. Interest Revenue:
Interest earnings are received monthly based on funds on deposit

Expenses:

1. Payroll:

a. Employees shall be compensated based on a timesheet submitted/signed by employees
b. Timesheets will be reviewed/approved by the physician (or alternate) and confirmed by the direct PCN supervisor (or alternate)
c. Employees may also submit expenses for reimbursement through the payroll system (e.g. travel). Expense reimbursements will be reviewed/approved by the direct PCN supervisor
d. Employees shall be paid monthly by direct deposit
e. The PCN Financial Clerk (or alternate) will enter the timesheet and expense details into the payroll system
f. The PCN Executive Director (or alternate) shall approve the payroll register before finalization of the payroll
g. The payroll payments will then be processed by the PCN Financial Clerk (or alternate)

2. Accounts Payable:

a. Expenses will adhere to the PCN business plan and will be based on invoices and claims submitted.
b. Invoices and claims will be reviewed/approved according the following criteria:
   I. **Up to $10,000**: Approval by the PCN Executive Director (or alternate).

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II. **Over $10,000**: Approval by the PCN Executive Director (or alternate) plus the Chair (or alternate) or Vice-Chair (or alternate).
III. **Reimbursement for the Chair:** Approval by the Vice-Chair (or alternate) and PCN Executive Director (or alternate).
IV. **Reimbursement for the Vice-Chair:** Approval by the Chair (or alternate) and PCN Executive Director (or alternate).
V. **Reimbursement for the PCN Executive Director:** Approval by the Chair (or alternate) and Vice-Chair (or alternate).
VI. **Reimbursement for PCN Employees:** Notwithstanding the above, reimbursements for PCN Employees shall be approved by the direct supervisor and the Executive Director or Patient's Medical Home Optimization Director.

c. Accounts payable shall be processed at a frequency that lends to the efficient and effective operation of the PCN (expected to be a minimum of twice per month). Accounts payable will normally be processed by cheque, but may also be processed by direct deposit.
d. The PCN Financial Clerk (or alternate) will enter the expense details into the accounts payable system.
e. The PCN Executive Director (or alternate) shall approve the accounts payable (cheque) register before finalization of the accounts payable.
f. The accounts payable payments will then be processed (by cheque or direct deposit) by the PCN Financial Clerk (or alternate).
g. The Cheque Register is signed off by the PCN Executive Director (or alternate).

3. Purchase Pre-Approval:

a. All purchases are subject to the above accounts payable processes.
b. Approval Limits:
The Executive Assistant is able to approve purchases up to $500.
The PMHO Manager is able to approve purchases up to $1,000.
The PMHO Director is able to approve purchases up to $2,000.
The Executive Director is able to approve purchases as indicated in 2.b.i-v.
c. Request for Proposal (RFP) shall be required as follows for a single purchase greater than $100,000. The RFP requirements shall be determined by an ad hoc committee of the board.

4. Bank Accounts:

a. **Current Account:** The PCN shall have a current account for the receipt of revenues and the payment of operating expenses (payroll and accounts payable).
b. **Savings/Deposit Account:** The PCN will hold funds that are not required for immediate operating purposes in a savings account. The

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PCN Executive Director (or alternate) shall make transfers between the Current account and Savings account so as to maintain an appropriate level of funds in the current account for the effective operation of the PCN. It is expected that transfers between Current and Savings will occur twice per year (or could be as frequent as once per month).

c. Cheque Signing Authority: Where appropriate written approval has been obtained any two of the following signatures are permitted to sign cheques from the PCN bank account:

- PCN Chair
- PCN Vice Chair
- PCN Executive Director
- PCN Executive Assistant
- PCN Financial Clerk

i. No individual may sign for his/her self.
ii. The PCN Executive Assistant and the PCN Financial Clerk may not sign together

5. Financial Reporting:

The PCN Executive Director shall ensure that:

a. PCN Board: Financial reports shall be provided to the PCN Board to allow for effective oversight and insight into the financial operation of the PCN. Normally, this will include monthly financial reports and annual budget statements. Other ad hoc financial reports may also be requested by the PCN Board.

b. Alberta Health: Financial reports will be provided to Alberta Health to comply with guidelines established by Alberta Health. Normally, this will include semi-annual & annual financial reports and annual budget statements. Other ad hoc financial reports may also be requested by Alberta Health.

The PCN Executive Director will utilize internal staff (e.g. PCN Financial Clerk) and engage external assistance (e.g. local accounting firm) as required to ensure that the financial reporting requirements are fulfilled to a high standard that enhances the reputation of the Palliser PCN.

Effective Date: November 2009
Revised: July 2017
Revised: September 2020
Reviewed: September 2021, 2022, 2023

Signature:

Appendix C: Information Management

IM Current State	IM Desired State	IM Budget	Existing Strategies	Planned Strategies	IM and Technology Plans
PCN has remote access to all Health Home EMRs for panel identification and to 97% of EMRs for screening, disease management and population health information.	PCN has 100% access to all Health Home EMRs for robust screening, disease management and population health purposes.	N/A	- The PCN/Physician Charter establishes that all physicians in the PCN must utilize an EMR and must provide the PCN with remote access. - PCN physicians are provided a dashboard of panel information based on their EMR data. - PCN administrative team supports clinics who wish to optimize their EMRs.	Spread effective EMR practices to other clinics through intra-PCN communication strategies.	Information management agreements, and remote data access permission forms are completed with every PCN physician member.
Health Homes have varying levels of privacy and security policies and procedures.	All Health Homes have robust privacy and security policies and procedures.	N/A	- PCN provides orientation to new physicians and Health Home teams regarding privacy and security. - PCN supports Health Homes to complete and update privacy impact assessments (based on actual in-clinic processes) as needed. - PCN offers Health Home teams in-clinic privacy and security updates as requested.	Spread knowledge of best practices regarding Health Home privacy and security through intra-PCN communication strategies.	PCN IM and Technology Plans do not exist in isolation from strategies and approaches

IM Current State	IM Desired State	IM Budget	Existing Strategies	Planned Strategies	IM and Technology Plans
EMR usage and vendor distribution	All Health Homes within PCN utilizing a CPAR/CII conformed EMR.	N/A	- PCN administrative team supports clinics in gathering information regarding new EMRs, troubleshooting current EMR optimization, support EMR centralized learning sessions to enable spread of promising practices between Health Homes. - PCN administrative team gathers feedback from all clinics to enable robust physician / clinic advocacy discussions with EMR vendors. - PCN administrative team engages with Health Home teams who are using innovative EMR add-ons such as for online booking, screening tools, and communication portals	- Continue to offer Health Home teams the opportunity to share EMR information with each other. - Support minority clinics (i.e. 2) who have a limited EMR system to see the value in a robust EMR. - Support spread of effective and efficient innovations through intra-PCN communication regarding EMR add-ons.	All participating physicians sign a data retrieval form to enable PCN administration to remotely access their specific EMR. Where clinics are interested in these tools they are supported to assess their privacy and security policies, procedures, agreements and update as required.
CPAR/CII participation among core and minority family practice physicians: 53% of PCN physicians with a compatible EMR system	Maximization of CPAR/CII participation, to 80% or greater	N/A	- PCN administrative team supports teams to review their panels, contact patients, administratively inactivate patients and assist teams to enroll in CPAR/CII, including PIA completion, review and submission. Further, physicians are offered support to measure their access, compare to the	Additional CPAR/CII participation anticipated with: - Improved AMA ACTT communication re: how CHR and Ava EMR clinics can participate - Rollout of eNotifications to Accuro clinics (has been delayed for 2+ years with no timeline for resolution	PCN IM and Technology Plans do not exist in isolation from strategies and approaches

IM Current State	IM Desired State	IM Budget	Existing Strategies	Planned Strategies	IM and Technology Plans
			current panel size and define an ideal panel size and use CPAR/CII as an external confirmation of internal panel management processes. - 100% of PCN Core Family Practice physicians offered CPAR/CII – at least once annually and opportunistically. - CII/CPAR application and implementation process supported by PCN facilitators Additional methods used by Palliser PCN to approach physicians and teams re: CPAR/CII interest: - PCN staff meeting discussions, celebrating successes of participating teams in PCN Chronicles Newsletter - Follow-ups from PCN staff PA process, discussion at clinic manager meetings - Utilizing a 5 A's change management approach, PCN leverages opportunities for scale and spread of CPAR/CII among PCN Health Homes	provided to PCNs - significant barrier for potential Accuro clinics) - Increased provider awareness of and desire to correct CPAR Primary Provider information displayed in Netcare – significant motivation for some physicians - Provider awareness of increased local participation in CPAR, resulting in increased value of conflict reports	

Appendix D: Program Information

Do you provide the following services to Albertans?	If so, what is target population or targeted programs?	Priority Initiative	BPR Page #
☐After-Hours Care			
☐Integrated Care or Multi-specialty care services			
X Maternal Health (Prenatal, Obstetrics)	*Prenatal nurse supports multiple Health Homes who see prenatal patients. Funding provided to AHS for family medicine maternity clinic pre-natal nurse.*	Professional Support in Health Home	41
X Women's Health	*Adult females*	Professional Support in Health Home	41
☐Children (<12) / Youth (12-17) Health			
X Mental Health Services	Behavioural Health Consultants – patients experiencing symptoms of mental illness or deteriorating mental health	Professional Support in Health Home	41
X Youth Mental Health and Addictions	Behavioural Health Consultants – patients experiencing symptoms of mental illness or deteriorating mental health	Professional Support in Health Home	41
X Respiratory Health	*All lung disorders including COPD and asthma*	Professional Support in Health Home	41
X Cardiovascular Health	*All cardiovascular disease including Heart Disease, Hypertension*	Professional Support in Health Home	41
X Other chronic disease management not listed above	*All chronic conditions which a patient presents with from an intercollaborative care perspective*	Professional Support in Health Home	41
X Diabetes	*i.e. insulin management, dietary management, lifestyle management and functional support*	Professional Support in Health Home	41
☐Foot Care			
X Cancer and Palliative Care	*Patients experiencing cancer*	Professional Support in Health Home	41
X Geriatric (Seniors) Care	Senior Patients	Professional Support in Health Home	41

X Obesity/Weight Management	Patients experiencing obesity and/or weight management issues	Professional Support in Health Home	41
X Pain Management	Patients experiencing chronic pain	Professional Support in Health Home	41
X Exercise Programs	Develop smart goals with patients, partner with local organizations as needed	Professional Support in Health Home	41
X Nutrition/Dietician Services	All patients (PCN staff receive intensive nutrition orientation)	Professional Support in Health Home	41
X Cognitive Health	*Any patient with / potential experiencing cognitive decline*	Professional Support in Health Home	41
X Behavioural Programs	*Integrated into all aspects of patient care. (PCN staff receive extensive behaviour coaching training)*	Professional Support in Health Home	41
☐Indigenous Health	*i.e. specific tribe/band*	Professional Support in Health Home	
X Sexual Health and Reproductive Health Programs	*STIBBI screening, treatment, lifestyle coaching for any at risk populations. Sexual dysfunction screening and education/treatment for any patients experiencing these issues.*	Professional Support in Health Home	41
X Patient/Community Navigation and Transitions of Care	*Liaison with all not-for-profit agencies to support Social Determinants of Health (e.g. housing, employment, and community supports).*	Professional Support in Health Home	41
☐Other services provided, not listed above	*Please specify*		